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Spending on health in Europe: entering a new era

WHO Barcelona Office for Health Systems Financing

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Abstract & keywords

This report analyses health spending in 53 countries in the WHO European Region from 2000 to 2018 (the latest year for which internationally comparable data are available). It reviews key patterns and trends in health spending over time and across countries in the following areas: health spending before the COVID-19 pandemic; the priority given to health in government budgets; the adverse effects of out-of-pocket payments on financial protection; compulsory health financing arrangements and their impact on progress towards universal health coverage; spending on primary health care; the implications of COVID-19 for health spending; and the role of public policy in mitigating the negative effects of the pandemic and building health system resilience.

EUROPE
GLOBAL HEALTH EXPENDITURE DATABASE
HEALTHCARE FINANCING
HEALTH EXPENDITURES
SYSTEM OF HEALTH ACCOUNTS
UNIVERSAL COVERAGE

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Abbreviations

COVID-19	coronavirus disease
EU	European Union
FS	current health spending by revenue of financing schemes
GDP	gross domestic product
HC	health care function [classification]
HF	current health spending by financing schemes
HP	health provider [classification]
IMF	International Monetary Fund
OECD	Organisation for Economic Co-operation and Development
PHC	primary health care
PHI	private health insurance
SDG	Sustainable Development Goal
SHA	system of health accounts
SHI	social health insurance
SWAp	sector-wide approach
UHC	universal health coverage

ALB	Albania
AND	Andorra
ARM	Armenia
AUT	Austria
AZE	Azerbaijan
BEL	Belgium
BIH	Bosnia and Herzegovina
BLR	Belarus
BUL	Bulgaria
CRO	Croatia
CYP	Cyprus
CZH	Czechia
DEN	Denmark
DEU	Germany
EST	Estonia
FIN	Finland
FRA	France
GEO	Georgia
GRE	Greece
HUN	Hungary
ICE	Iceland
IRE	Ireland
ISR	Israel
ITA	Italy
KAZ	Kazakhstan
KGZ	Kyrgyzstan
LTU	Lithuania
LUX	Luxembourg
LVA	Latvia
MAT	Malta
MDA	Republic of Moldova
MKD	North Macedonia
MNE	Montenegro
MON	Monaco
NET	Netherlands
NOR	Norway
POL	Poland
POR	Portugal
ROM	Romania
RUS	Russian Federation
SMR	San Marino
SPA	Spain
SRB	Serbia
SVK	Slovakia
SVN	Slovenia
SWE	Sweden
SWI	Switzerland
TJK	Tajikistan
TKM	Turkmenistan
TUR	Turkey
UKR	Ukraine
UNK	United Kingdom
UZB	Uzbekistan

Foreword

This new report on health spending in Europe could not be more timely, coming at a moment when countries across the WHO European Region are making huge efforts to address the health and economic shock of coronavirus disease (COVID-19) and to build their plans for recovery. It is a difficult moment. Although the pandemic has shown us the importance of good health – for people, society and the economy – and the vital role public social spending plays in securing good health, it has added to the budgetary pressure many governments face.

As countries think carefully about the recovery, the report's analysis – the first to cover health spending in all 53 Member States across nearly two decades – allows us to:

- take stock of regional progress towards universal health coverage (a core priority of WHO's European Programme of Work, 2020–2025);
- track how much countries in the European Region are spending on primary health care (another first) using a global definition to enable international comparison;
- understand the implications for today of shifts in health spending during and after the economic shock of the 2008 global financial crisis; and
- identify ways in which health financing policy can mitigate the negative effects of COVID-19 and build health system resilience.

Public spending on health in Europe grew steadily before the global financial crisis. During the crisis there was a significant shift away from public spending on health, which was not reversed in the post-crisis period. Austerity in the health sector – budget cuts and coverage restrictions – undermined national and regional progress towards universal health coverage, pushing health care costs onto households, increasing out-of-pocket payments, unmet need and financial hardship, and exacerbating socioeconomic inequalities within and across countries. In 2018 out-of-pocket payments were still the dominant source of health financing in almost all lower-middle-income countries and a third of upper-middle-income countries.

Health systems were not as well equipped to meet the challenges posed by COVID-19 as they might have been in the absence of austerity. To avoid the mistakes of the past, governments will need to invest more publicly in health now and in the years ahead – even as they face growing budgetary pressure – to address the backlog created by disruption to health services,

mitigate the negative health effects of foregone care, unemployment and poverty, and strengthen preparedness for future shocks. Governments also need to pay attention to how health system resources are used, to avoid any further widening of inequalities.

For many countries in the European Region, the health spending starting point is challenging. Health systems characterized by low levels of public spending on health, high out-of-pocket payments and heavy reliance on employment (social health insurance schemes), without countercyclical mechanisms, are particularly vulnerable to health and economic shocks. The report sets out steps countries can take to build health system resilience. These include broadening the public revenue base for the health system and strengthening automatic stabilizers to make health spending more countercyclical; de-linking access to health services from health insurance status so that people do not lose coverage when they most need it; re-designing co-payment policy to protect people at risk of poverty or social exclusion and people with chronic conditions; reprioritizing the government budget to secure sustained increases in public spending on health; and using priority-setting processes and other instruments to ensure additional public investment in the health system meets equity and efficiency goals.

WHO calls on countries to allocate an extra 1% of gross domestic product to primary health care as a cost-effective way of speeding up progress towards universal health coverage. Public investment in primary health care offers the potential to improve access to services in middle-income countries, to enhance the quality and efficiency of people-centred services in high-income countries and to improve financial protection in all countries, especially if accompanied by efforts to strengthen coverage policy.

The report's findings underline the importance of making health a political priority, echoing a call to action from the Pan-European Commission on Health and Sustainable Development convened by the WHO Regional Office for Europe. Governments willing to put health and well-being at the heart of the recovery from COVID-19 should find strong support from international financial institutions and the public. Multilateral agencies now recognize the damage austerity caused after the global financial crisis, while survey after survey shows the extent to which people value public investment in health and other social sectors. To achieve this, however, will require a combination of political will, better tax systems and international solidarity.

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Executive summary

Health spending before the COVID-19 pandemic

Before the COVID-19 pandemic the health sector was growing faster than the economy. This led to a rise in the health share of gross domestic product (GDP) from 6.4% in 2000 to 7.5% in 2018. In absolute numbers, current spending on health increased from US$ 1.4 trillion to US$ 2.2 trillion (in constant 2018 dollars).

The amount high- and middle-income countries spend on health is converging but large inequalities across countries persist. Spending on health grew at a much faster rate in middle-income than high-income countries. As a result, the difference in health spending per person between high- and lower-middle-income countries fell from 51 times in 2000 to 28 times in 2018.

Although the health sector has grown, many countries still rely heavily on out-of-pocket payments. In 2018 public spending on health accounted for 64% of current health spending in the WHO European Region and out-of-pocket payments for 30%. These shares did not change over time, as out-of-pocket payments per person grew faster than public spending on health in upper-middle-income countries.

Out-of-pocket payments continue to be the dominant source of financing in almost all lower-middle-income and a third of upper-middle-income countries, indicating slow progress towards universal health coverage (UHC). The past 10 years has seen no or very limited change in the pattern of heavy reliance on out-of-pocket payments, making it difficult to realize significant progress towards UHC. Although many countries have increased public spending on health, which is critical for UHC, they also need to pay attention to reducing out-of-pocket payments to counter unmet need for health and dental care and financial hardship for people using health services. Both of these negative outcomes disproportionately affect poorer households and other groups of people in vulnerable situations.

The role of external funding in low- and middle-income countries has decreased, indicating a lower level of international solidarity, but remains important. In 2018 external funding for health totalled US$ 1 billion in the European Region. It plays a more significant role in low- and lower-middle-income countries, where it accounted for 3% of current spending on health in 2018 (down from 6% in 2010).

Spending on health is a political choice

Spending on health has grown faster than the economy in most countries in the European Region. In 11 countries, however, the economy grew at a faster pace than current health spending, suggesting that some countries did not take full advantage of growing economic and fiscal capacity to invest in health.

Public spending on health has grown faster than out-of-pocket spending but mainly in high-income countries. Although current health spending grew in almost all countries, the public share of health spending only increased in 31 out of 52 countries. Public spending on health per person grew at a faster rate than out-of-pocket payments in 29 mainly high-income countries, reflecting cross-country differences in fiscal capacity and in political choices about public spending priorities.

There is large variation in how much of the government budget countries allocate to health. In 2018 the share of the government budget allocated to health ranged from less than 3% in Azerbaijan to 23% in Germany and Ireland. It was less than 12% in all lower-middle-income countries, most upper-middle-income countries and a quarter of high-income countries. The gap between high-income and upper-middle-income countries in the priority given to health when allocating the government budget has increased over time.

High out-of-pocket spending weakens financial protection. The incidence of catastrophic health spending is generally low in countries where out-of-pocket payments account for less than 15% of current spending on health. In 2018 the out-of-pocket payment share was over 15% in 40 out of 53 countries. Across countries, public spending on health is shown to be much more effective in reducing out-of-pocket payments than voluntary health insurance. To strengthen financial protection, improve access to health services and make progress towards UHC and the Sustainable Development Goals (SDGs), countries need to invest more publicly in the health system and pay careful attention to the design of coverage policy.

Spending on health is in large part a political choice reflecting decisions about how much of the government budget to allocate to health and coverage policy designed to reduce out-of-pocket spending. Although fiscal capacity is more limited in middle-income countries, governments in countries in all income groups have choices. Some governments have not sustained or increased the health share of public spending, even as fiscal capacity has increased. Giving greater priority to health in middle-income countries would narrow the gap with high-income countries, allowing the European Region to enter a new era in which public spending on health reflects political priorities not just economic development.

The evolution of compulsory health financing

Countries in the European Region mainly organize compulsory health financing through government schemes or social health insurance (SHI) schemes. Only two countries have opted to organize compulsory health financing through private health insurance (PHI) schemes.

The type of compulsory health financing scheme in place (government, SHI or compulsory PHI) can be explained historically and has changed over time. Some countries – mainly in western Europe – have moved away from employment-based arrangements to extend health coverage to the whole population. Other countries – all located outside western Europe – re-introduced employment-based schemes in an attempt to secure additional public investment in health or overcome the rigidity of public financial management rules.

The SHI scheme share of compulsory spending on health has fallen in high-income countries and is now highest in upper-middle-income countries. In 2018 the SHI scheme share of compulsory spending on health was highest in upper-middle-income countries and lowest in lower-middle-income countries.

SHI schemes are typically financed through a combination of social insurance contributions and transfers from the government budget. When spending through SHI schemes is broken down by revenue source, it becomes clear that the government budget is a significant source of SHI scheme revenue in many countries in all country income groups.

Gaps in population coverage are larger in countries that are mainly financed through SHI schemes. This clear pattern is a consequence of policy choices. In government schemes entitlement is usually based on residence, whereas SHI schemes generally base entitlement on employment status and payment of contributions, which systematically disadvantages people in vulnerable situations. To make progress towards UHC, some countries with SHI schemes have changed the basis for entitlement from payment of contributions to residence.

There are no systematic differences in UHC as measured through the service coverage index or the share of households with catastrophic health spending between countries with government schemes and SHI schemes. The extent to which a country relies on compulsory spending on health rather than out-of-pocket payments, and the design of coverage policy, have more impact on UHC performance than the way in which compulsory spending on health is financed.

Conventional distinctions between *SHI* and *tax-financed* schemes are no longer meaningful. These classifications do not determine sources of revenue and they mask the fact that all forms of compulsory pre-payment with risk pooling offer people insurance. The key question for policy is how well different health systems do in meeting the UHC goals of universal access to health services with financial protection. By broadening the public revenue base to encompass transfers from the government budget and de-linking entitlement to health care from payment of contributions, some countries have removed the two key features of traditional SHI schemes that limit progress towards UHC. In a new era of health financing for UHC, removing these barriers will be an essential part of health system reforms.

Tracking primary health care spending and its priority in government budgets

Information on primary health care (PHC) spending and how this spending is financed is vital for monitoring country and regional progress towards UHC. Monitoring PHC spending – particularly public spending on PHC – shows the priority countries give to ensuring everyone can use the PHC services they need without financial hardship. Tracking PHC spending in a standard way across countries highlights the patterns and differences in PHC spending and identifies where progress is needed. Nearly 40 countries in the European Region collect data on PHC spending using the System of Health Accounts (SHA) 2011 framework, but there is room for improvement. Eight of these countries also report PHC spending by financing source, allowing them to track public spending on PHC. This analysis demonstrates the diversity of PHC spending in the European Region. It also highlights gaps in reporting by countries and the need for better quality data collection methods that increase international comparability.

PHC accounts for less than half of current spending on health. On average PHC spending accounted for 42% of current spending on health in the 37 countries that report these data, but there is considerable variation across countries. Switzerland spends the most per person (US$ 3923) and Tajikistan the least (US$ 27). The composition of PHC spending also differs across countries. General outpatient care and outpatient medicines account for the largest share of PHC spending.

The priority countries give to PHC when allocating government spending on health varies substantially. Among the eight countries for which PHC spending data are available by financing source, the public share of PHC spending ranges from 42% in Armenia to 12% in Georgia. Public spending on PHC as a share of GDP ranges from 1.2% in the Republic of Moldova and the Russian Federation to 0.3% in Georgia. If these countries invested an additional 1% of GDP in PHC, it would result in an extra US$ 32, US$ 44 and US$ 115 spent publicly per person on PHC in the Republic of Moldova, Georgia and the Russian Federation respectively.

WHO calls on all countries to invest an additional 1% of GDP in PHC. Spending more **publicly** on PHC is the most cost-effective way to make progress towards UHC. It offers the potential to improve access to services in middle-income countries, to enhance the quality and efficiency of people-centred services in high-income countries and to improve financial protection in all countries, especially if accompanied by efforts to strengthen coverage policies. By carefully tracking PHC spending and increasing public spending on PHC by an additional 1% of GDP, countries will enter a new era in health financing.

COVID-19: implications for health spending

Failure to control COVID-19 has led to the deepest economic shock in decades. It has not only hit countries harder than the global financial crisis but also affects a much wider group of countries in the European Region. Without urgent and substantial policy intervention, the economic recovery may take longer and be more uneven than forecasts predict, exacerbating socioeconomic inequalities within and between countries.

Countries were quick to mobilize additional funds for the health system in 2020. This higher level of public investment will need to be sustained in the years ahead to treat and prevent COVID-19, address the backlog created by widespread disruption to health services, mitigate the negative health effects of foregone care, unemployment and poverty and strengthen preparedness for future shocks.

Health financing policy is less resilient to economic shocks in countries where levels of public spending on health are low as a share of GDP and out-of-pocket payments are high, implying significant gaps in health coverage. Health systems are also vulnerable to economic shocks if public spending on health relies heavily on employment (SHI schemes), entitlement to health services is linked to health insurance status, and countercyclical mechanisms to mitigate the effects of rising unemployment and falling wages are lacking or weak.

Well-designed public policy can mitigate the negative effects of COVID-19 and build health system resilience. Key steps countries can take include: broadening the public revenue base for the health system; introducing and strengthening automatic stabilizers; de-linking access to health services from health insurance status; re-designing co-payment policy to protect people at risk of poverty or social exclusion and people with chronic conditions; reprioritizing the government budget to ensure sustained increases in public spending on health; and using priority-setting processes and other instruments to ensure additional public investment in the health system meets equity and efficiency goals.

Countries may find it challenging to invest more publicly in health as government revenue falls, but austerity is not a viable option. Austerity in the health sector in response to the global financial crisis slowed public spending on health, undermined progress towards UHC and increased socioeconomic inequalities. Two factors offer support to governments willing to put improving people's lives and livelihoods at the heart of the recovery from COVID-19. First, international financial institutions strongly encourage countries to continue to invest in health systems now, recognizing the damage austerity has caused and the importance of the health sector to societal well-being, economic development and resilience to future shocks; they should continue to support careful investment in health and well-being in the longer-term. Second, this shift in thinking is closely aligned with public preferences. Survey after survey carried out in the last 10 years has shown the extent to which people value good access to health care.

There is no economic recovery without health security. Health security requires political will, better tax systems and international solidarity. Many of the things people value most in life can only be achieved through the actions of well-resourced governments. All countries will benefit from efforts to reform tax systems so that they are more effective, fairer, better able to redistribute resources and aligned with policies that promote health and well-being. Increased investment in health and other social sectors is unlikely to be possible in all parts of the European Region without greater international solidarity.

Introduction

This report analyses health spending in 53 countries in the WHO European Region from 2000 to 2018 (the latest year for which internationally comparable data are available), drawing on data from WHO's Global Health Expenditure Database (WHO, 2020a).

Its aims are to review key patterns and trends in health spending over time and across countries before the COVID-19 pandemic, understand the impact of changes in health spending on progress towards UHC, and identify the implications of COVID-19 for health spending in the medium and longer-term. Moving towards UHC is a Sustainable Development Goal and a core priority of WHO's European Programme of Work, 2020–2025 (WHO Regional Office for Europe, 2021).

Chapter 1 provides an overview of patterns and trends in health spending before the COVID-19 pandemic. It looks at average annual changes in public and private spending on health and shifts in the breakdown of current health spending by source of revenue across the whole of the European Region, then briefly reviews the role of external funding in low- and middle-income countries.

Chapter 2 looks at cumulative changes in public spending on health and out-of-pocket payments by country. It explores how levels of public spending on health are influenced by political priorities and examines the adverse effects of out-of-pocket payments on financial protection (a core dimension of UHC).

Chapter 3 focuses on compulsory health financing arrangements. The first part of the chapter reviews shifts in compulsory health financing over time, highlighting the role of history – path dependency – in determining current arrangements. The second part of the chapter considers the impact of different compulsory arrangements on indicators of UHC.

Chapter 4 provides an overview of how much countries spend on PHC and the priority given to PHC in government budgets. Information on PHC spending and how this spending is financed is vital for monitoring country and regional progress towards UHC.

Chapter 5 considers the implications of the COVID-19 pandemic for health spending in the medium and longer-term, drawing on changes in health spending during and after the 2008 global financial crisis. It sets out ways in which well-designed public policy can mitigate the negative effects of COVID-19 and build health system resilience.

Chapter 1

Health spending before the COVID-19 pandemic

Summary

Before the COVID-19 pandemic the health sector was growing faster than the economy. This led to a rise in the health share of GDP from 6.4% in 2000 to 7.5% in 2018. In absolute numbers, current spending on health[1] increased from US$ 1.4 trillion to US$ 2.2 trillion (in constant 2018 dollars).

The amount high- and middle-income countries spend on health is converging but large inequalities across countries persist. Spending on health grew at a much faster rate in middle-income than high-income countries. As a result, the difference in health spending per person between high- and lower-middle-income countries fell from 51 times in 2000 to 28 times in 2018.

Although the health sector has grown, many countries still rely heavily on out-of-pocket payments. In 2018 public spending on health accounted for 64% of current health spending[2] in the WHO European Region and out-of-pocket payments for 30%. These shares did not change over time, as out-of-pocket payments per person grew faster than public spending on health in upper-middle-income countries.

Out-of-pocket payments continue to be the dominant source of financing in almost all lower-middle-income and a third of upper-middle-income countries, indicating slow progress towards UHC. The past 10 years has seen no or very limited change in the pattern of heavy reliance on out-of-pocket payments, making it difficult to realize significant progress towards UHC. Although many countries have increased public spending on health, which is critical for UHC, they also need to pay attention to reducing out-of-pocket payments to counter unmet need for health and dental care and financial hardship for people using health services. Both of these negative outcomes disproportionately affect poorer households and other groups of people in vulnerable situations.

The role of external funding in low- and middle-income countries has decreased, indicating a lower level of international solidarity, but remains important. In 2018 external funding for health totalled US$ 1 billion in the European Region. It plays a more significant role in low- and lower-middle-income countries, where it accounted for 3% of current spending on health in 2018 (down from 6% in 2010).

1. This report uses current health spending by revenue of financing schemes (FS) and current health spending by financing schemes (HF) (OECD, Eurostat & WHO, 2011).

2. Current spending on health refers to funds dedicated to health services, excluding capital investment.

Before the COVID-19 pandemic the health sector was growing faster than the economy

This chapter explores patterns and trends in health spending from different sources in the WHO European Region using the SHA methodology (Box 1.1).[3] Before the COVID-19 pandemic the health sector was growing faster than the economy. As a result, the current health spending share of GDP[4] rose from 6.4% in 2000 to 7.5% in 2018 (Table 1.1).

3. Data on small countries should be interpreted with particular caution.

4. GDP is the sum of final consumption, gross capital formation (investment) and net exports. Final consumption includes goods and services used by households or the community to satisfy their individual needs. It includes the final consumption expenditure of households, general government and non-profit institutions serving households.

Box 1.1 What is SHA?

In 2011 the Organisation for Economic Co-operation and Development (OECD), Eurostat and WHO released an updated manual for the collection of health accounts, *A system of health accounts: 2011 edition*. The core set of SHA tables addresses three basic questions.

- What kinds of health care goods and services are consumed?
- Which health care providers deliver these goods and services?
- Which financing schemes pay for these goods and services?

Health accounts provide a systematic description of financial flows related to the consumption of health care goods and services. Their basic intent is to describe a health system from a spending perspective.

As more countries implement and institutionalize health accounts, there are increased expectations from analysts, policy-makers and the general public alike for the more sophisticated information that can be gained through the greater volume of health spending data now available. Health accounts are increasingly expected to provide inputs (along with other statistical information) into improved analytical tools to monitor and assess health system performance.

A key priority is to develop reliable and timely data that are comparable across countries and over time. This is indispensable for in depth analysis of trends in health spending and the factors that drive health spending within countries, which can in turn be used to compare health spending across countries and project how it will grow in the future. Health accounts are crucial for all of these uses.

Source: OECD, Eurostat & WHO (2011).

Table 1.1 Key health spending indicators, 2000–2018

Note: the table does not include data for Montenegro (a lower-middle-income country).

Source: WHO (2020a).

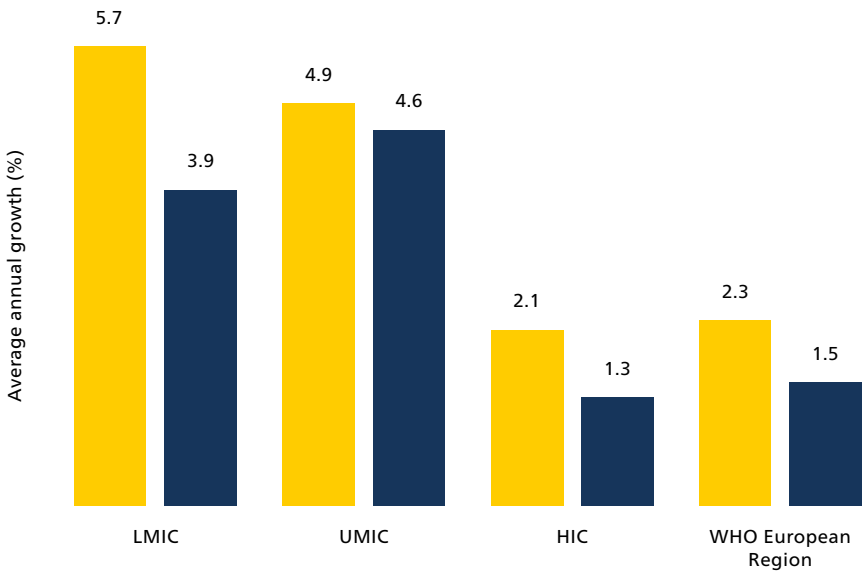
Indicator	Lower-middle-income countries (n=5)		Upper-middle-income countries (n=14)		High-income countries (n=33)		WHO European Region (n=52)	
	2000	2018	2000	2018	2000	2018	2000	2018
Current spending on health (% of GDP)	4.8	6.7	5.8	6.2	7.0	8.2	6.4	7.5
Current spending on health per person (constant 2018 US$)	50	134	186	443	2 523	3 700	1 656	2 480
Public spending (% of current spending on health)	40.9	42.5	50.7	53.0	72.0	71.9	63.3	64.0
Public spending (% of government spending)	6.7	8.6	9.0	10.0	12.5	14.2	11.0	12.5
Out-of-pocket payments (% of current spending on health)	57.4	54.1	44.0	43.5	21.4	20.0	30.9	29.6

Across the European Region, current health spending per person grew in real terms by 2.3% a year between 2000 and 2018, while GDP per person grew by 1.5% (Fig. 1.1).[5] The increase in current health spending varies by country income group[6] and was fastest in lower-middle-income countries, where it rose by 5.7% a year, while GDP grew by 3.9%. In upper-middle-income countries current health spending per person rose by 4.9% a year, while GDP grew by 4.6%. In high-income countries current health spending per person grew by 2.1% and GDP by 1.3%.

5. Average annual growth is calculated as the compound annual rate of growth in constant 2018 US$ per person.

6. Annex 1 shows the 2018 World Bank country income group classification of countries in the European Region (World Bank, 2021). This report includes Tajikistan (a low-income country) in the lower-middle-income group.

Fig. 1.1 Real growth in current spending on health and GDP per person in the European Region by country income group, 2000–2018



Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. No data for Montenegro (UMIC).

Source: WHO (2020a).

The amount high- and middle-income countries spend on health is converging but large inequalities across countries persist

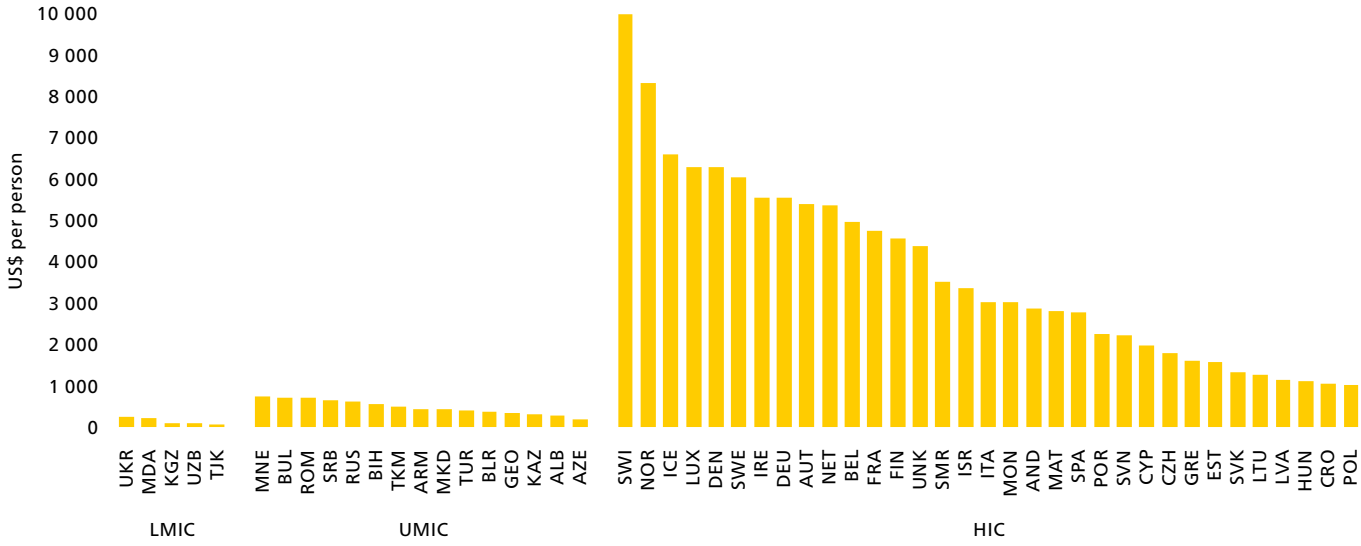
Between 2000 and 2018 the growth in current health spending per person in middle-income countries was more than double the growth in high-income countries (Fig. 1.1). As a result, levels of health spending in high- and middle-income countries are converging: the difference between current health spending per person in high- and lower-middle-income countries has decreased from 51 to 28 times higher in high-income countries.

Still, inequality in health spending across countries persists. In 2018 Switzerland spent US$ 9870 per person on health, which was nearly four times more than the regional average of US$ 2480 (Table 1.1), while Tajikistan spent US$ 60 per person, which was 40 times less than the regional average (Fig 1.2).

Fig. 1.2 Current spending on health per person in the European Region, 2018

Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Tajikistan (a low-income country) is included in the LMIC group.

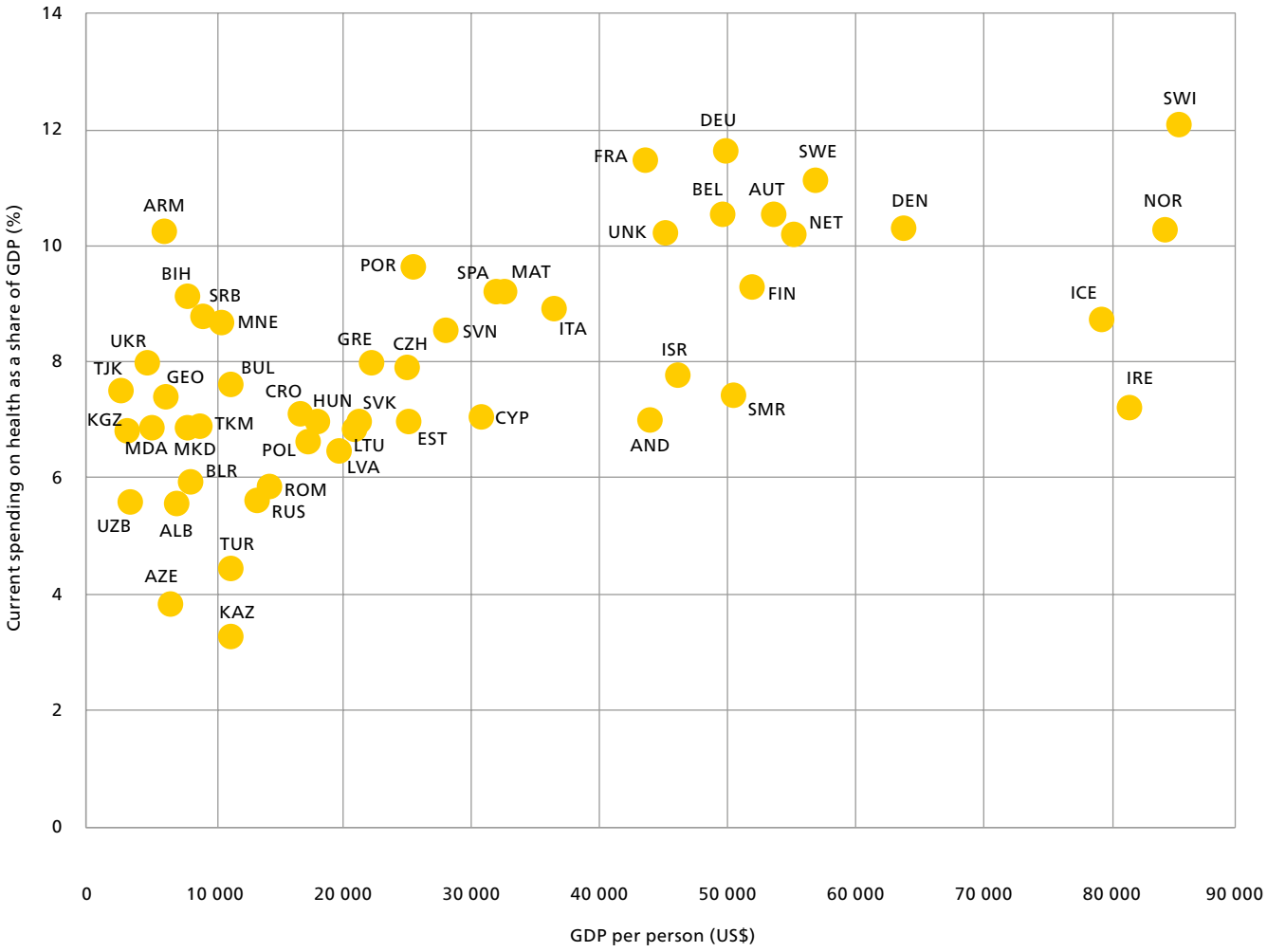
Source: WHO (2020a).



Social and economic context and the priority governments give to the health sector when allocating public resources (see Chapter 2) play a role in influencing how much a country spends on health and the speed at which health spending is growing. Wealthier countries tend to spend a greater share of their GDP on health compared to middle-income countries but there are large variations among countries with similar income levels (Fig. 1.3). For example, Bulgaria spent almost twice as much of its GDP on health than Turkey in 2018, despite having a similar level of GDP per person.

Fig. 1.3 Relationship between current spending on health as a share of GDP and country income level in the European Region, 2018

Source: WHO (2020a).



Although the health sector has grown, many countries still rely heavily on out-of-pocket payments

Health systems are financed from public, private and external sources. Public sources consist of various forms of tax revenues, including individual income and consumption taxes (Jowett & Kutzin, 2015). SHI contributions are also taxes, typically in the form of payroll taxes, and counted as public revenues. Private revenues come from two main sources: out-of-pocket payments (direct payments by individuals for health services at the point of use of services) and voluntary prepayment for health insurance. Revenues from external sources mainly include development assistance for health, which can flow through government or nongovernment channels (WHO, 2018).

The composition of health financing sources affects health system performance and a country's ability to progress towards UHC (WHO, 2010). While private sources play a role in all health systems, evidence shows that public, compulsory and prepaid financing helps countries to make progress towards UHC. Low levels of public spending on health are associated with weak financial protection and high levels of unmet need for health services, particularly among poorer households and other people in vulnerable situations (WHO Regional Office for Europe, 2019).

On average the public and private shares of current spending on health did not change much between 2000 and 2018. Despite a growing health sector, public spending[7] on health accounted for 63% of current health spending in 2000 and 64% in 2018 (Table 1.1) and private spending[8] accounted for 36% and 35% respectively.

Private spending is mainly from out-of-pocket payments. The role of voluntary health insurance in financing health care is marginal in the European Region (and globally), accounting for just 3% of current spending on health throughout the period (WHO, 2020a).

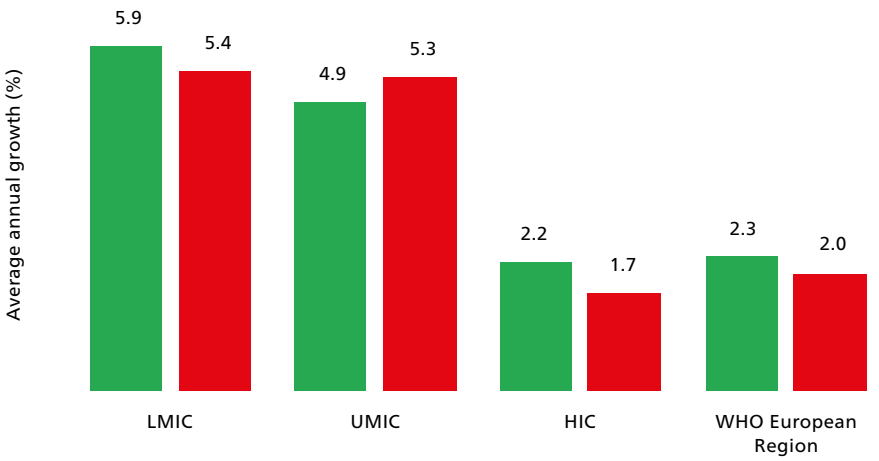
Across the European Region the out-of-pocket payment share of current spending on health fell only slightly over time, from 31% in 2000 to 30% in 2018 (Table 1.1). This stands in contrast to global trends. At global level the out-of-pocket payment share has consistently declined across all country income groups since 2000 (WHO, 2019a).

Between 2000 and 2018 public spending on health per person grew on average by 2.3% a year in the European Region, while out-of-pocket spending per person grew by 2.0% (Fig. 1.4). In high-income countries public spending on health per person (2.2%) grew faster than out-of-pocket spending (1.7%). This was also the case in lower-middle-income countries, with increases of 5.9% and 5.4% respectively, but in upper-middle-income countries out-of-pocket spending per person (5.3%) grew faster than public spending on health (4.9%).

7. Public spending refers to government spending from domestic sources, including transfers from government domestic revenues allocated to health purposes (FS.1) and revenues from social insurance contributions (FS.3).

8. Private spending refers to compulsory prepayments for private insurance (FS.4), voluntary prepayments for private insurance (FS.5) and other domestic revenues including out-of-pocket payments made by households directly at the point of receiving health services (FS.6.1).

Fig. 1.4 Real growth in public spending on health and out-of-pocket payments per person in the European Region by country income group, 2000–2018



Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Public spending on health and out-of-pocket payments per person are in constant 2018 US$. Average annual growth is calculated as the compound annual rate of growth. Public spending includes transfers from government domestic revenues allocated to health (FS.1) and social insurance contributions (FS.3); out-of-pocket spending includes direct payments at the point of receiving health services (FS.6.1). No data for Montenegro (UMIC).

Source: WHO (2020a).

Between 2000 and 2018 out-of-pocket spending per person grew from US$ 26 (here and afterwards in constant 2018 dollars) to US$ 67 in lower-middle-income countries (WHO, 2020a), but the out-of-pocket payment share of current health spending decreased from 57% to 54% (Fig. 1.5). The decline in out-of-pocket payments was partly offset by an increase in public spending on health, which accounted for 43% of current health spending in 2018.

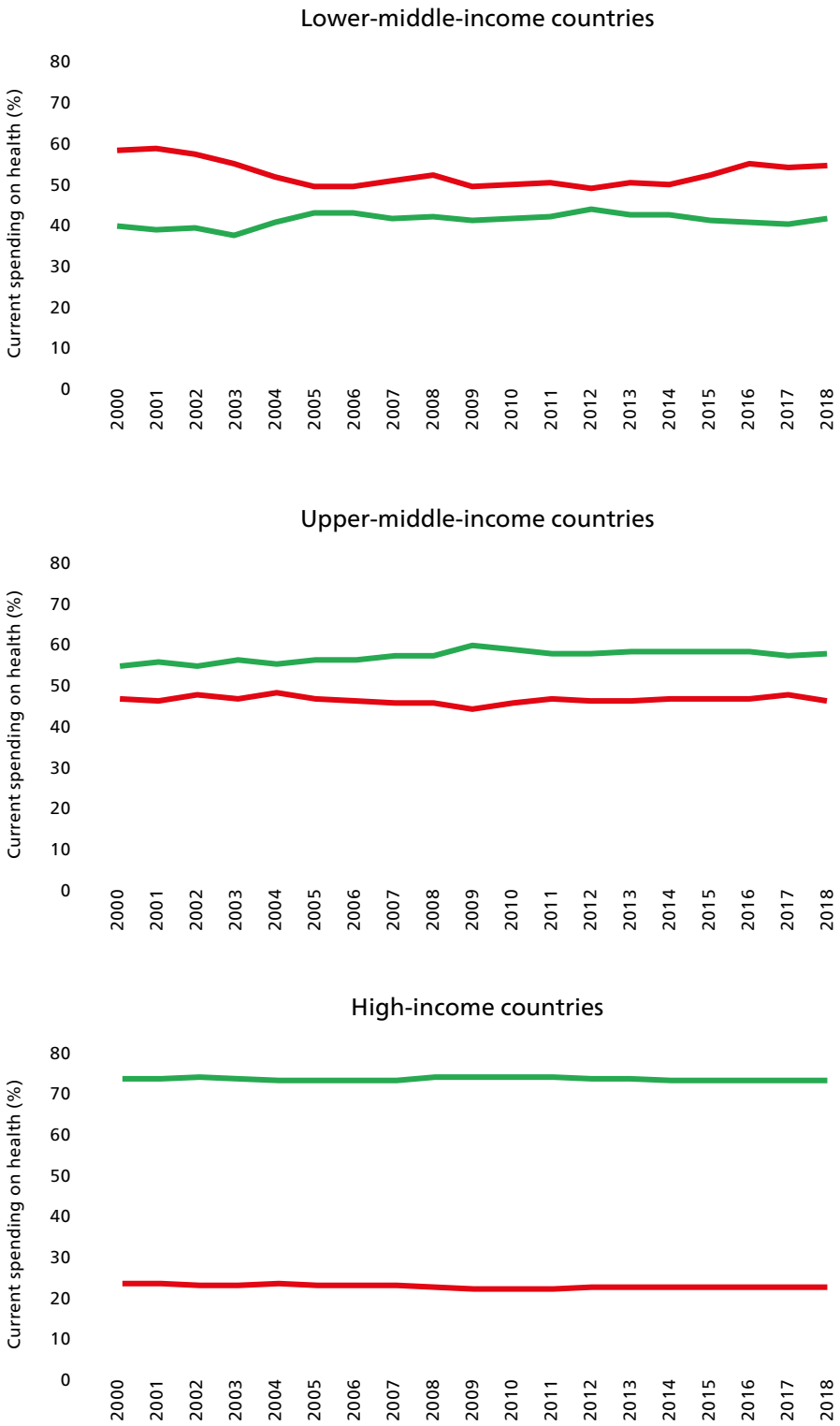
In upper-middle-income countries out-of-pocket spending per person increased from US$ 72 in 2000 to US$ 183 in 2018 (WHO, 2020a). The out-of-pocket payment share of current health spending was 44% in 2000 and 2018. The public share of current health spending rose from 51% to 53%.

In high-income countries out-of-pocket spending per person grew from US$ 493 in 2000 to US$ 664 in 2018 (WHO, 2020a). The out-of-pocket payment share of current health spending decreased slightly from 21% in 2000 to 20% in 2018. The public share of current health spending remained the same at 72%.

On average around three quarters of current health spending in the European Region comes from public sources but there is substantial variation across countries, with the public share in 2018 ranging from 86% in Monaco to 12% in Armenia (Fig. 1.6). In 10 countries – Armenia, Azerbaijan, Cyprus, Georgia, Kyrgyzstan, Switzerland,[9] Tajikistan, Turkmenistan, Ukraine and Uzbekistan – public spending accounted for less than half of current spending on health.

9. In Switzerland about one third of current health spending is through compulsory prepayments to private insurance companies (FS.4).

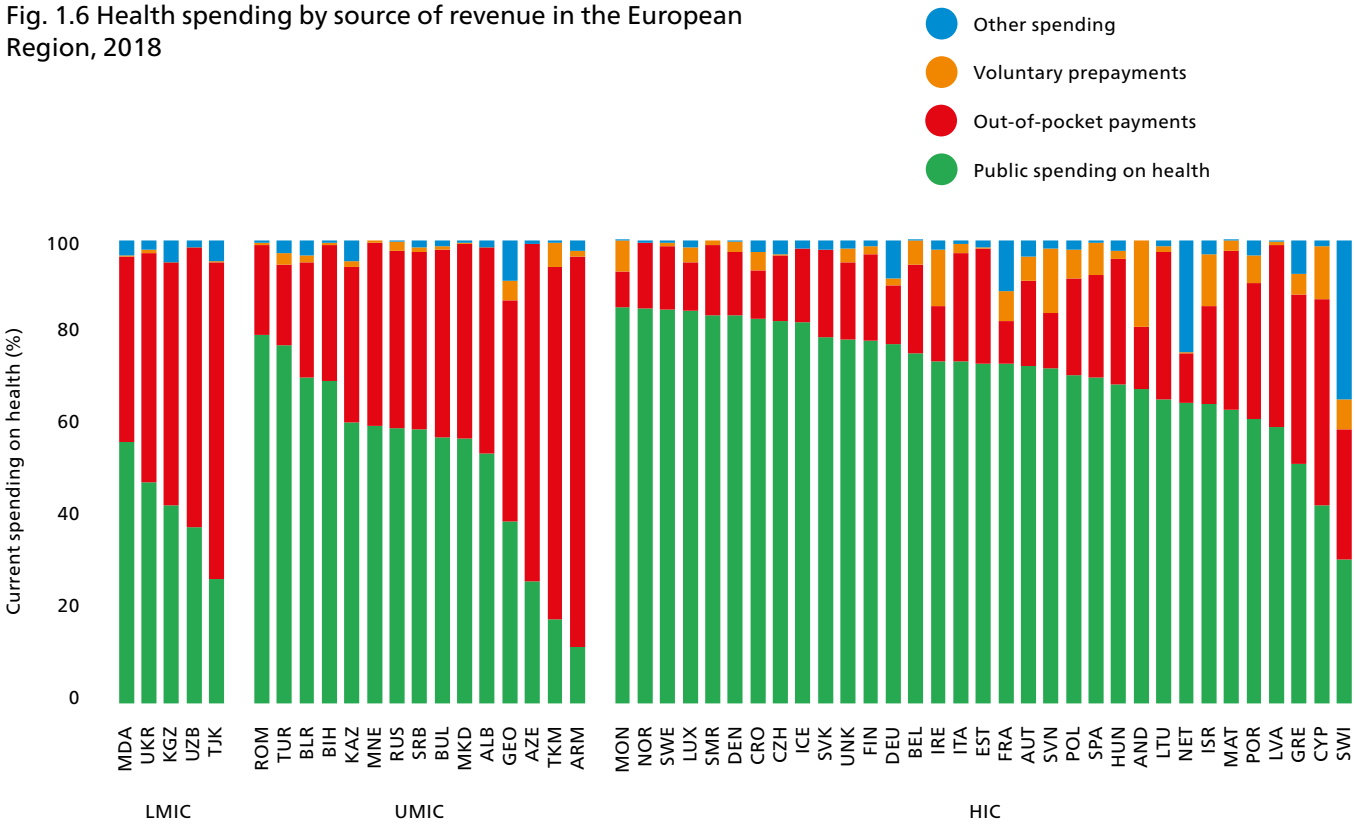
Fig. 1.5 Public spending on health and out-of-pocket payments as a share of current spending on health in the European Region, 2000–2018



Notes: public spending includes transfers from government domestic revenues allocated to health (FS.1) and social insurance contributions (FS.3); out-of-pocket spending includes direct payments at the point of receiving health services (FS.6.1). No data for Montenegro (UMIC).

Source: WHO (2020a).

Fig. 1.6 Health spending by source of revenue in the European Region, 2018



Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Tajikistan (a low-income country) is included in the LMIC group. Public spending includes transfers from government domestic revenues allocated to health (FS.1) and social insurance contributions (FS.3); out-of-pocket spending includes direct payments at the point of receiving health services (FS.6.1); voluntary health insurance includes voluntary prepayments (FS.5); other spending includes donor funding, compulsory prepayments to private insurance and some other marginal spending.

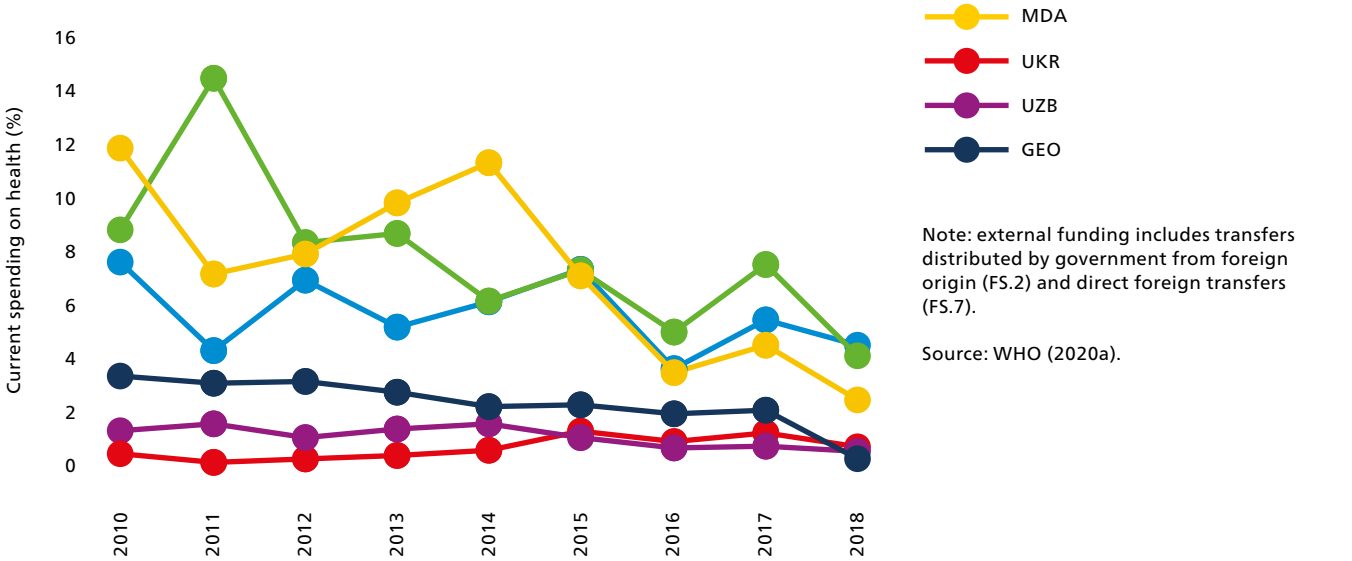
Source: WHO (2020a).

The role of external funding in low- and middle-income countries has decreased, indicating a lower level of international solidarity, but remains important

In 2018 external funding for health totalled US$ 1 billion in the European Region. It is mainly mobilized by multilateral and bilateral donors to support low- and lower-middle-income countries, where it constituted 3% of current spending on health on average in 2018 (WHO, 2020a). Most external aid is directed towards supporting disease-specific programmes (for example, for tuberculosis, HIV/AIDS and immunization). Only a few donors provide general budgetary support for health sector strengthening, as in Tajikistan.

Since 2000 external funding has declined in the majority of countries (Fig. 1.7). As countries have become richer, donors have developed different exit strategies to discontinue their financial support. Box 1.2 outlines the role external funding has played in Kyrgyzstan.

Fig. 1.7 External funding as a share of current spending on health in selected countries, 2010–2018



Note: external funding includes transfers distributed by government from foreign origin (FS.2) and direct foreign transfers (FS.7).

Source: WHO (2020a).

Box 1.2 External funding for health in Kyrgyzstan

Kyrgyzstan has committed itself to UHC and has launched comprehensive reforms to improve the health of its population. These reforms have relied on successful collaboration with international development partners. In 1995 the World Bank, WHO and the United States Agency for International Development initiated a health financing collaboration that worked to the comparative advantages of each organization. The collaboration was initiated as an informal sector-wide approach (SWAp) and carried forward into a formal SWAp, incorporating other development partners over time.

Since 2006, some of the funds from international development agencies for the Kyrgyz health system have been allocated within the framework of a SWAp and integrated into the government budget. External organizations co-financing the SWAp have included the Department for International Development (United Kingdom), the German Development Bank, the Swedish International Development Cooperation Agency, the Swiss Agency for Development and Cooperation and the World Bank. Other external funds for the health system take the form of parallel financing for the implementation of various projects and come from a variety of international organizations. The Ministry of Health has taken the lead in coordinating donor assistance and aligning it with health sector priorities.

Kyrgyzstan has received sustained external support for health system reform over 25 years. Throughout this period donors have maintained close collaborative relationships and coordinated their support. They have been committed to country-led reforms and adopted a pragmatic approach to providing technical and financial support, which has allowed reforms to move forward despite setbacks and changes in the landscape. This level of coordination and length of commitment is rare in the European Region. It has contributed heavily to the success of Kyrgyzstan's reform efforts.

Source: Dominis et al. (2018).

Chapter 2

Spending on health is a political choice

Summary

Spending on health has grown faster than the economy in most countries in the European Region. In 11 countries, however, the economy grew at a faster pace than current health spending, suggesting that some countries did not take full advantage of growing economic and fiscal capacity to invest in health.

Public spending on health has grown faster than out-of-pocket spending but mainly in high-income countries. Although current health spending grew in almost all countries, the public share of health spending only increased in 31 out of 52 countries. Public spending on health per person grew at a faster rate than out-of-pocket payments in 29 mainly high-income countries, reflecting cross-country differences in fiscal capacity and in political choices about public spending priorities.

There is large variation in how much of the government budget countries allocate to health. In 2018 the share of the government budget allocated to health ranged from less than 3% in Azerbaijan to 23% in Germany and Ireland. It was less than 12% in all lower-middle-income countries, most upper-middle-income countries and a quarter of high-income countries. The gap between high-income and upper-middle-income countries in the priority given to health when allocating the government budget has increased over time.

High out-of-pocket spending weakens financial protection. The incidence of catastrophic health spending is generally low in countries where out-of-pocket payments account for less than 15% of current spending on health. In 2018 the out-of-pocket payment share was over 15% in 40 out of 53 countries. Across countries, public spending on health is shown to be much more effective in reducing out-of-pocket payments than voluntary health insurance. To strengthen financial protection, improve access to health services and make progress towards UHC and the SDGs, countries need to invest more publicly in the health system and pay careful attention to the design of coverage policy.

Spending on health is in large part a political choice reflecting decisions about how much of the government budget to allocate to health and coverage policy designed to reduce out-of-pocket spending. Although fiscal capacity is more limited in middle-income countries, governments in countries in all income groups have choices. Some governments have not sustained or increased the health share of public spending, even as fiscal capacity has increased. Giving greater priority to health in middle-income countries would narrow the gap with high-income countries, allowing the European Region to enter a new era in which public spending on health reflects political priorities not just economic development.

Public spending on health has grown faster than out-of-pocket spending but mainly in high-income countries

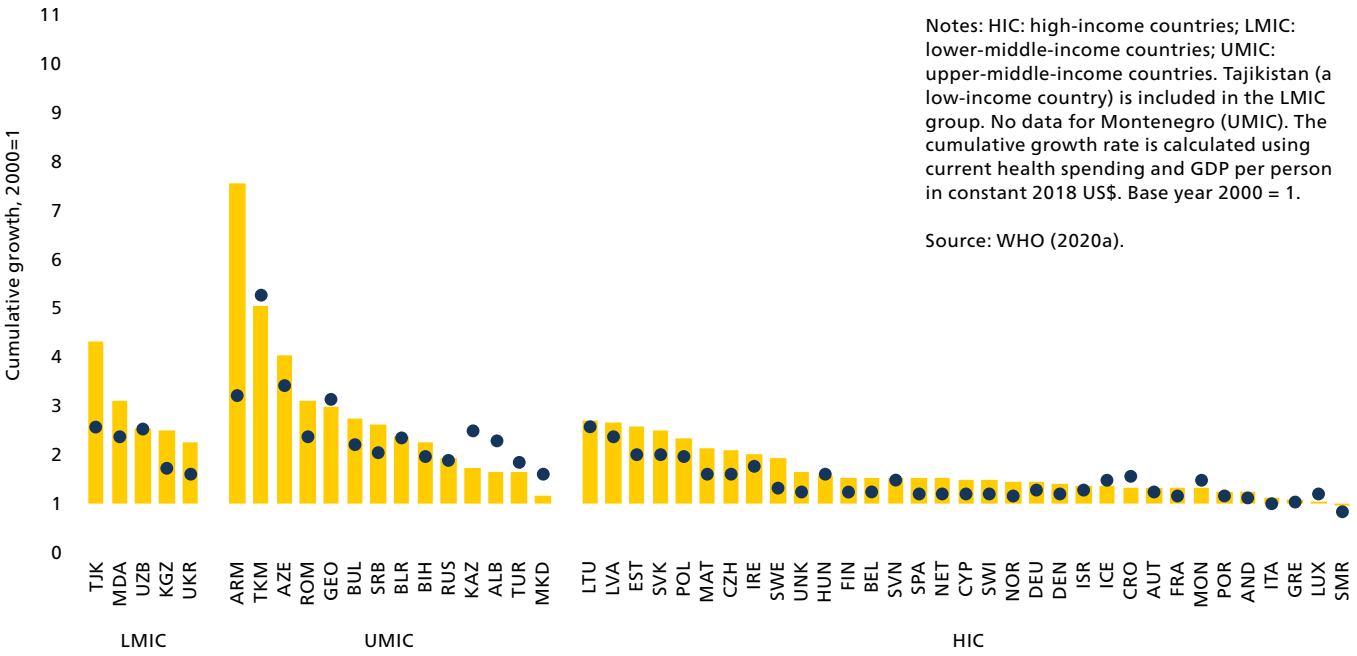
This chapter explores how levels of public spending on health in countries in the European Region are influenced by political priorities, and how heavy reliance on out-of-pocket payments adversely affects financial protection. A reduction in out-of-pocket payments and an increase in the public share of current spending on health are essential for progress towards UHC and the SDGs (WHO & World Bank, 2020).

Between 2000 and 2018 current spending on health per person grew in real terms in every country except San Marino and it grew faster than real GDP[10] per person in most countries in the European Region (Fig. 2.1). This was not the case in 11 countries, however (Albania, Croatia, Georgia, Hungary, Iceland, Kazakhstan, Luxembourg, Monaco, North Macedonia, Turkey and Turkmenistan), suggesting that some countries did not take full advantage of growing economic and fiscal capacity to invest in health. A large body of literature shows that the main factors behind growth in health spending are rising incomes, new medical technologies, increasing prices and volumes, and changing medical practice (Williams et al., 2019; Fan & Savedoff, 2014).

During this period public spending on health per person grew in real terms in every country in the European Region except Greece and was generally larger in lower- and upper-middle-income countries than in high-income countries (Fig. 2.2). The public share of current spending on health grew in only 31 out of 52 countries, however (data not shown). This reflects the fact that out-of-pocket payments grew at a faster rate than public spending on health in 23 out of 52 countries (Fig. 2.2). This faster growth in out-of-pocket payments was particularly evident in Armenia, Azerbaijan, Belarus, Czechia, Estonia, France, Kyrgyzstan, Lithuania, Malta, Portugal, Serbia, Slovakia, Turkmenistan and the Russian Federation.

10. In this report the cumulative growth (CG) of GDP is calculated by using the formula $CG = GDP_{2018}/GDP_{2000}$. The same formula is used to calculate the cumulative growth of different components of health spending. Real per person values are measured in constant 2018 US$.

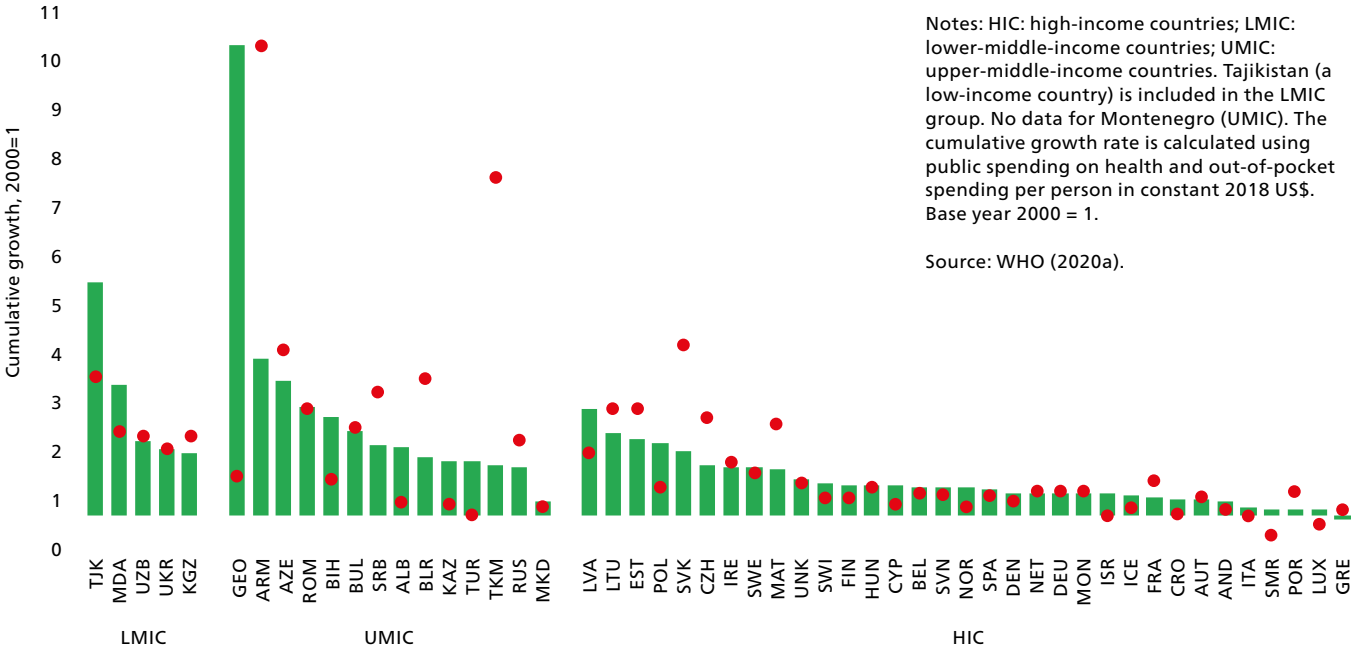
Fig. 2.1 Cumulative growth in current spending on health and GDP per person in the European Region, 2000–2018



Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Tajikistan (a low-income country) is included in the LMIC group. No data for Montenegro (UMIC). The cumulative growth rate is calculated using current health spending and GDP per person in constant 2018 US$. Base year 2000 = 1.

Source: WHO (2020a).

Fig. 2.2 Cumulative growth in public spending on health and out-of-pocket payments per person in the European Region, 2000–2018



Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Tajikistan (a low-income country) is included in the LMIC group. No data for Montenegro (UMIC). The cumulative growth rate is calculated using public spending on health and out-of-pocket spending per person in constant 2018 US$. Base year 2000 = 1.

Source: WHO (2020a).

There is large variation in how much of the government budget countries allocate to health

How much of its GDP a country invests publicly in health depends on two factors.

- **Fiscal capacity** reflects the size of the public sector relative to the economy and is measured in terms of government spending as a share of GDP (Tandon et al., 2014). The greater the fiscal capacity, the greater is the government's ability to spend on different sectors, including health. Fiscal capacity is influenced by a country's ability to collect taxes and its level of economic development.

- **Political priority or choice** determines how much of the government budget to allocate to health.

Although public spending on health as a share of GDP tends to increase with the fiscal capacity of a country, there is large variation among countries of similar income levels (Fig. 2.3). For example, government spending as a share of GDP is the same in Spain, Slovakia and Ukraine (42%), but Spain spends more publicly on health as a share of GDP than Slovakia and almost twice as much as Ukraine.

This shows the importance of political priority in determining how much public revenue a country allocates to health. While long-term efforts are usually needed to increase fiscal capacity, decisions about what share of the public budget should be allocated to health are taken annually and are amendable in the short run (Jakab et al., 2018).

Increased fiscal capacity does not always result in an increase in the priority given to health when allocating the government budget, as Fig. 2.4 shows. In countries in the right-hand quadrants of the figure, government spending grew faster than GDP. Countries in the upper-right quadrant increased the share of the government budget allocated to health (scenario1) but countries in the lower-right quadrant did not (scenario 3). For example, Georgia and Kyrgyzstan experienced substantial growth in fiscal capacity between 2000 and 2018; in Georgia this led to a large increase in the priority given to health, while in Kyrgyzstan the priority given to health was reduced.

In countries in the left-hand quadrants of Fig. 2.4, government spending did not keep pace with GDP growth but most countries opted to sustain or increase the share of the government budget allocated to health (scenario 2). However, in a few cases (scenario 4), such as North Macedonia and Turkmenistan, the priority given to health decreased.

Fig. 2.3 Relationship between public spending on health and government spending as a share of GDP in the European Region, 2018

Source: WHO (2020a).

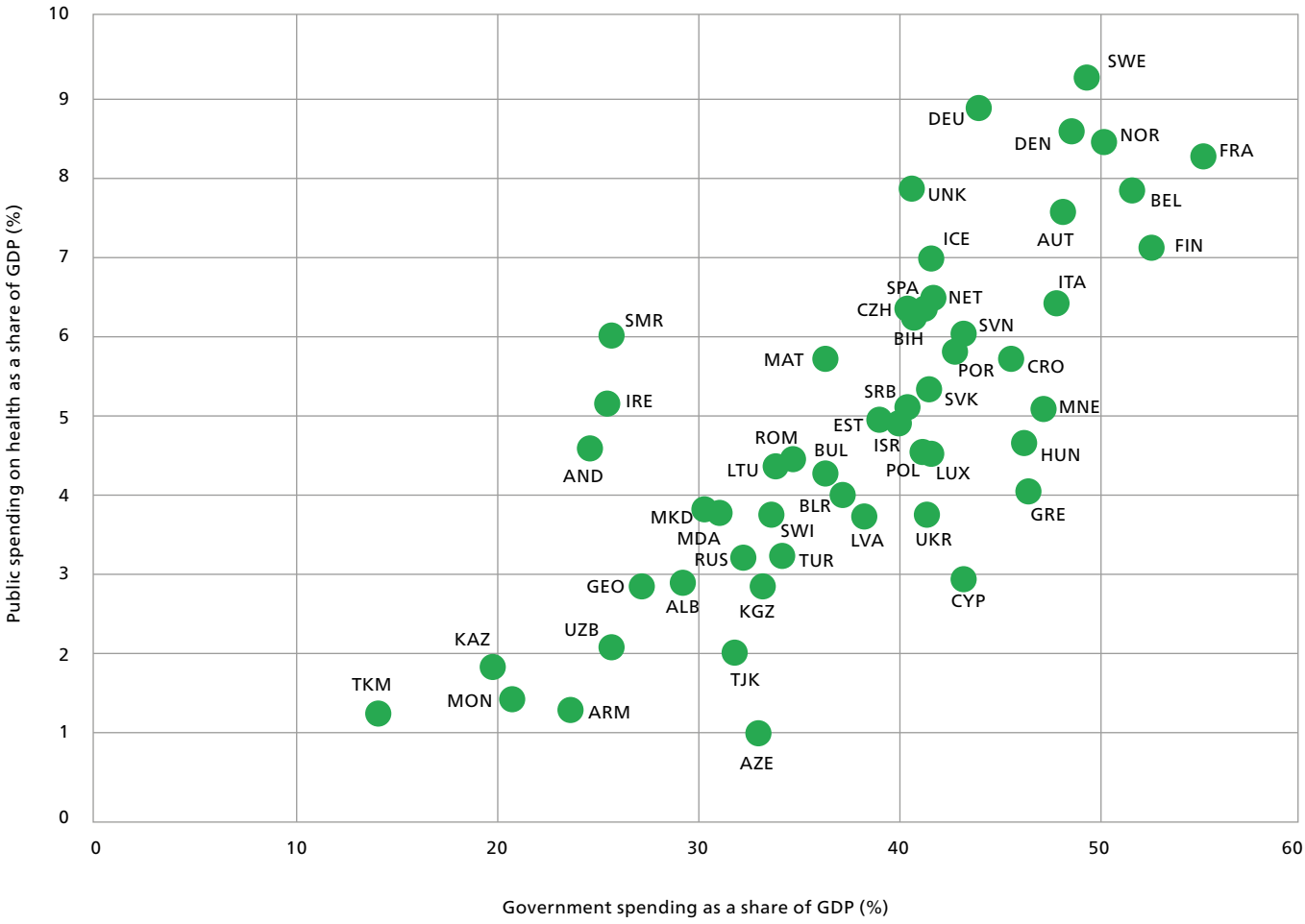
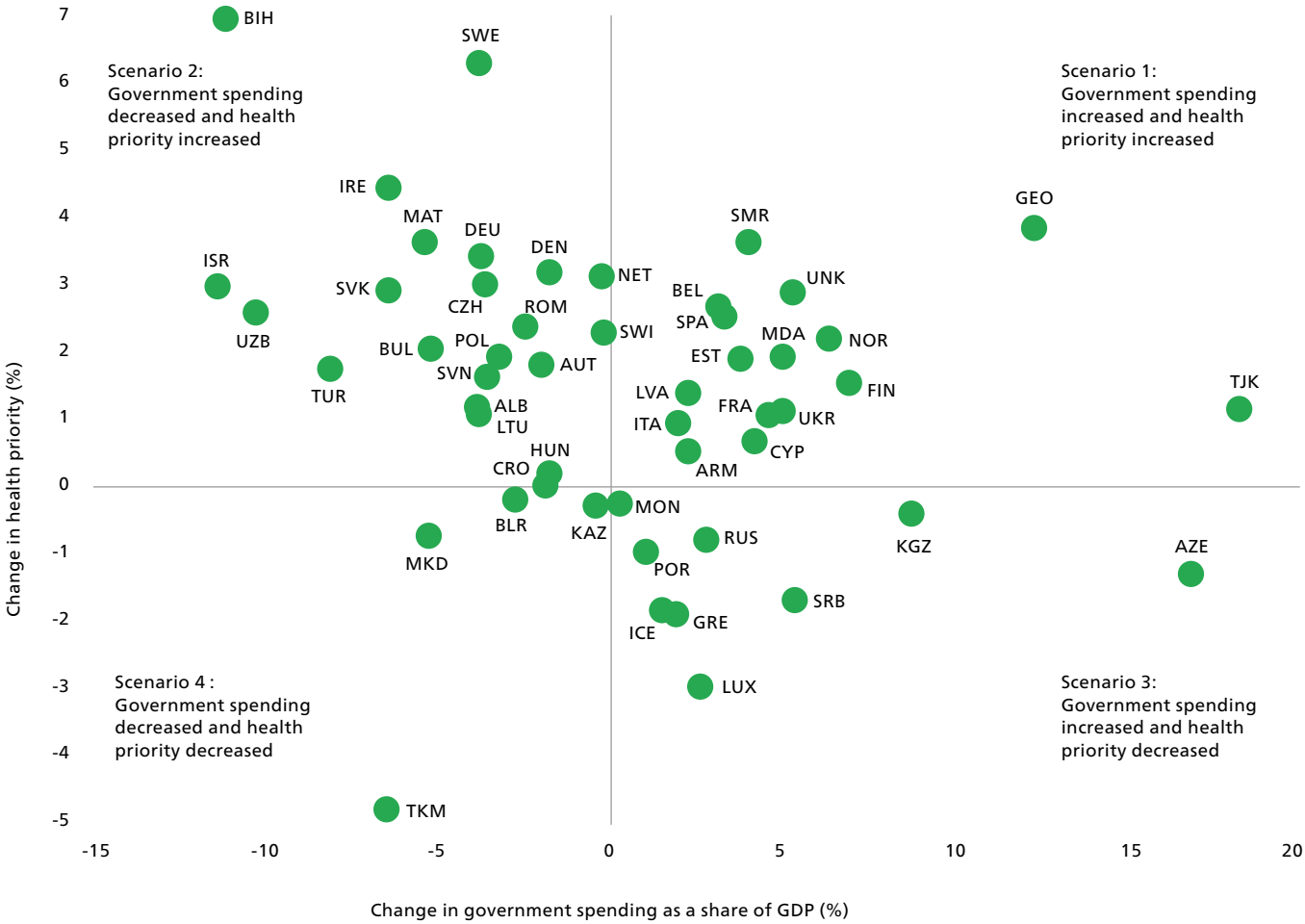


Fig. 2.4 Relationship between public spending on health as a share of government spending on health and government spending as a share of GDP in the European Region, 2000-2018

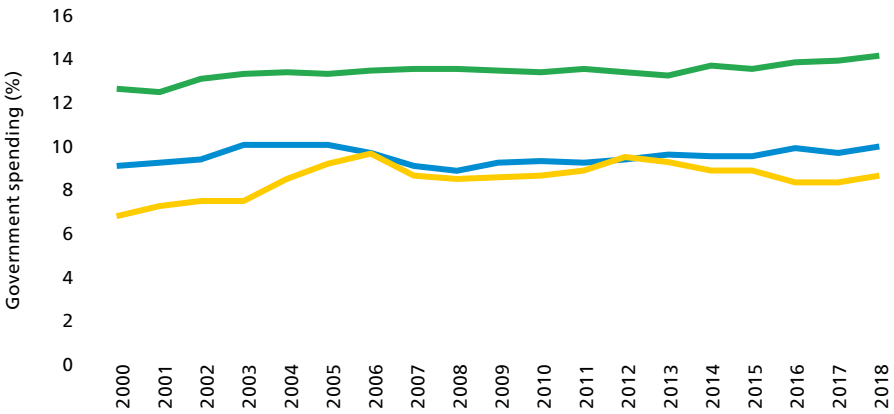
Notes: changes in health priority correspond to the difference between the three-year average of public spending on health as a share of government spending in 2000–2002 and in 2016–2018. Changes in government spending correspond to the difference between the three-year average of government spending as a share of GDP in 2000–2002 and in 2016–2018. No data for Montenegro.

Source: WHO (2020a).



Between 2000 and 2018, the priority given to health in government spending increased slightly in all country income groups (Fig. 2.5). However, the health share of government spending has increased the most in high-income countries and the priority given to health in lower-middle-income countries has fallen since 2012, resulting in a widening gap between high- and lower-middle-income countries.

Fig. 2.5 Public spending on health as a share of government spending in the European Region, 2000–2018

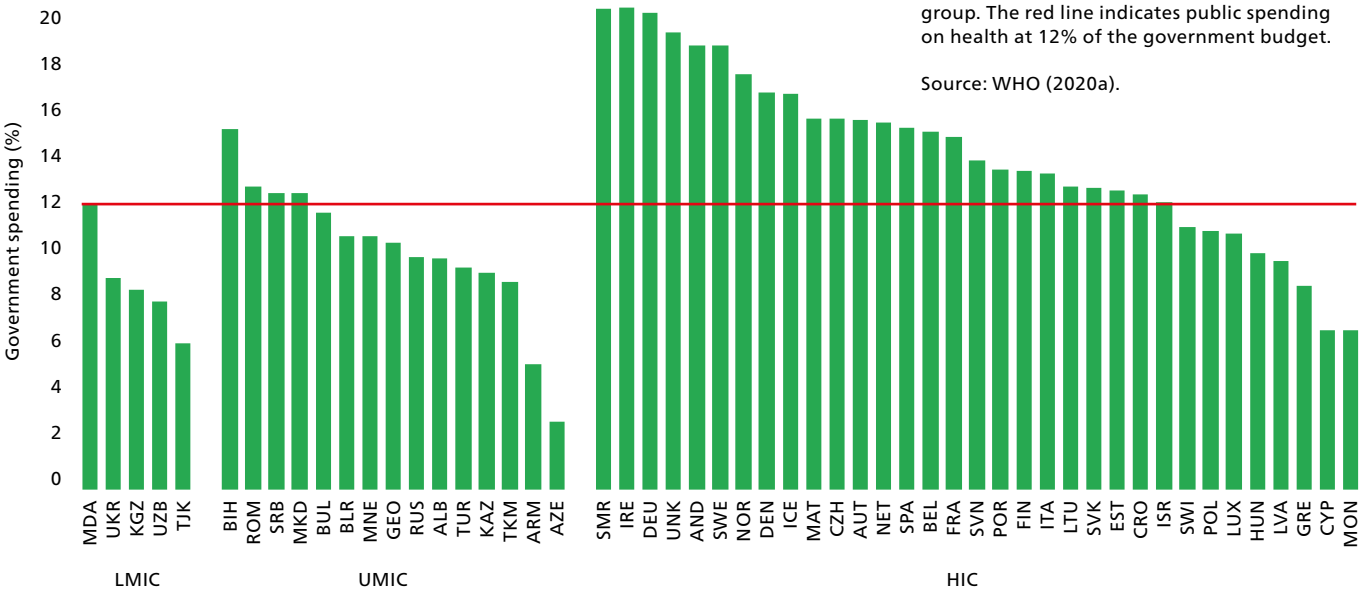


Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Data for Montenegro are only available for 2018 (UMIC).

Source: WHO (2020a).

The priority given to health in government spending remains low in many middle-income countries. In 2018 public spending on health as a share of the government budget ranged from 3% in Azerbaijan to 23% in San Marino, reflecting significant variation in the European Region (Fig. 2.6). Although there is no universally accepted standard of what share of the government budget should be spent on health, in 2018, 23 out of 53 countries in the Region allocated less than 12% of the government budget to health: all lower-middle-income countries, most upper-middle-income countries and a quarter of high-income countries.

Fig. 2.6 Public spending on health as a share of government spending in the European Region, 2018



Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Tajikistan (a low-income country) is included in the LMIC group. The red line indicates public spending on health at 12% of the government budget.

Source: WHO (2020a).

High out-of-pocket spending weakens financial protection

Out-of-pocket payments can create a financial barrier to access, resulting in unmet need for health and dental care. They can also lead to financial hardship for people using health services. There is wide variation in the financial hardship associated with household spending on health among countries in the European Region. Where financial protection is relatively weak, catastrophic health spending is mainly driven by out-of-pocket payments for outpatient medicines (for more details see Box 2.1 and WHO Regional Office for Europe, 2019).

Box 2.1 Financial protection – a core dimension of UHC

Progress towards UHC requires constant effort to ensure that everyone can use the quality health services they need without experiencing financial hardship. Out-of-pocket payments can create a financial barrier to access, resulting in unmet need for health or dental care, and can lead to financial hardship for people using health services. Weak financial protection may force some people to choose between health care and other basic needs such as food and housing. It can lead to or deepen poverty, deteriorate health and widen inequalities.

People pay out of pocket for some health services in all health systems, although not all out-of-pocket spending causes financial hardship. People experience financial hardship when out-of-pocket spending is large compared to their ability to pay, which means that poor people may face financial hardship even when out-of-pocket payments are low.

Financial protection is measured using two widely used indicators.

- **Catastrophic health spending** measures the share of households with out-of-pocket payments that exceed a predefined share of their ability to pay.
- **Impoverishing health spending** measures out-of-pocket payments that push a household below or further below the poverty line.

Different metrics can be used for both indicators; metrics vary in the type of poverty line used and in how a household's ability to pay for health care is defined (Cylus et al., 2018).

The WHO Regional Office for Europe has developed new metrics to measure financial protection in response to concerns that the method used to measure financial protection in the SDGs (SDG indicator 3.8.2), and other global approaches, pose a challenge for equity and have limited relevance for Europe. Building on established methods, the metrics used in the European Region are less likely to underestimate financial hardship among poorer people than the SDG metrics because they account for differences in household capacity to pay for health. The aim is to measure financial protection in a way that is relevant to all countries in Europe, produces actionable evidence for policy and promotes policies to break the link between ill health and poverty (for more details see WHO Regional Office for Europe, 2019; 2020a).

Sources: Cylus et al. (2018); WHO Regional Office for Europe (2019; 2020a).

Evidence shows a strong positive relationship between the incidence of catastrophic health spending and the out-of-pocket payment share of current spending on health. The higher is the share of out-of-pocket payments, the higher is the incidence of catastrophic spending. When out-of-pocket payments exceed 15% of current health spending, it is difficult to maintain strong financial protection (Fig. 2.7). In 2018 the out-of-pocket payment share was over 15% in 40 out of 53 countries in the European Region, and in six countries it constituted more than half of all spending on health (Fig. 2.8).

The out-of-pocket payment share of current health spending is generally lower in countries that spend relatively more publicly on health (Fig. 2.9), but there are large variations among countries. For instance, Kyrgyzstan, the Russian Federation and Turkey all spend around 3% of GDP on health publicly, but in Turkey the out-of-pocket payment share is 17% compared to 38% in the Russian Federation and 52% in Kyrgyzstan. This indicates that it is not just the level of public spending on health that determines the level of out-of-pocket spending or the ability to provide financial protection. Coverage policy – decisions about who is entitled to publicly financed health care, the scope of service coverage and rules around user charges (co-payments) – also plays a key role (for more details see WHO Regional Office for Europe, 2019).

Fig. 2.7 Incidence of catastrophic health spending and out-of-pocket payments as a share of current spending on health in the European Region, latest year available

Notes: data are not available for all countries. Data on out-of-pocket payments are for the same year as data for catastrophic spending.

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

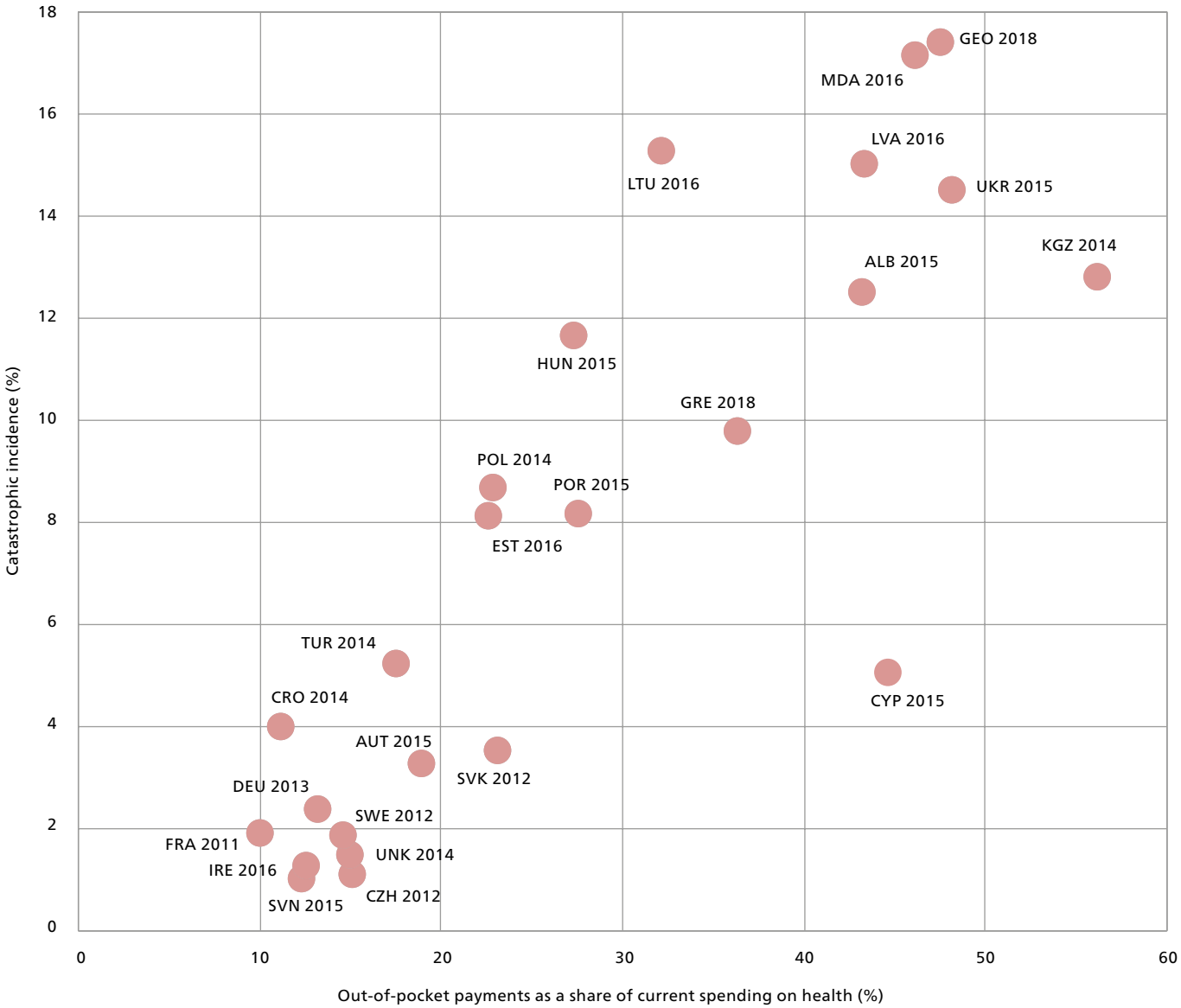
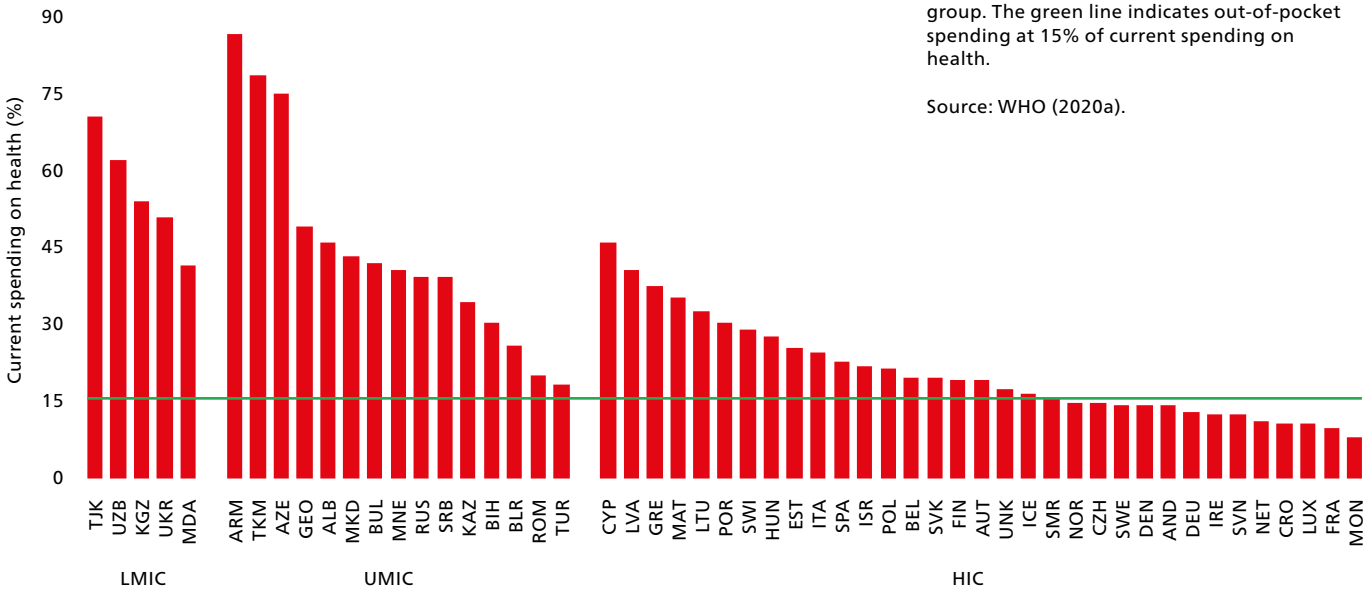


Fig. 2.8 Out-of-pocket payments as a share of current spending on health in the European Region, 2018

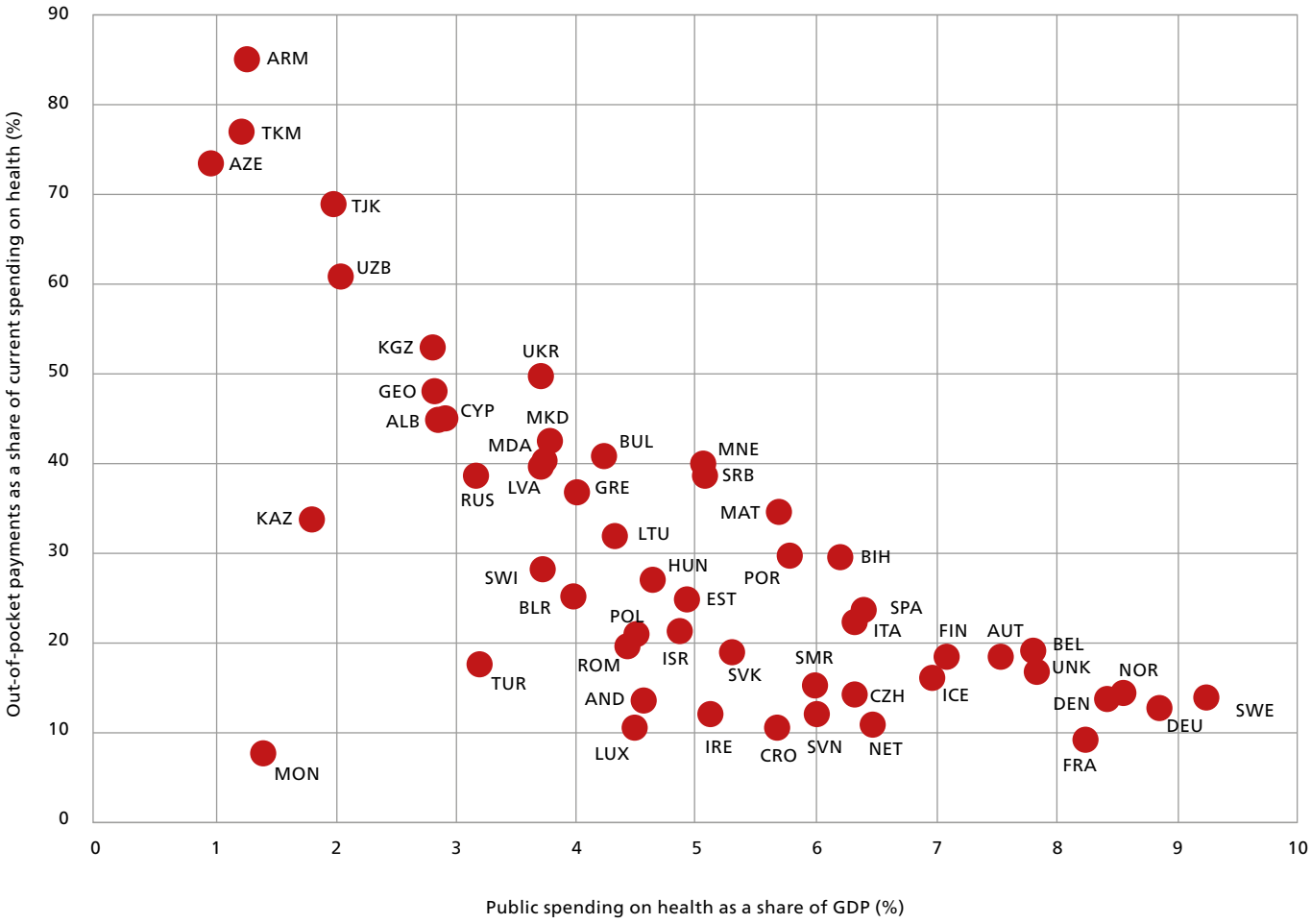


Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Tajikistan (a low-income country) is included in the LMIC group. The green line indicates out-of-pocket spending at 15% of current spending on health.

Source: WHO (2020a).

Fig. 2.9 Relationship between public spending on health and out-of-pocket payments in the European Region, 2018

Source: WHO (2020a).



Chapter 3

The evolution of compulsory health financing

Summary

Countries in the European Region mainly organize compulsory health financing through government schemes or SHI schemes. Only two countries have opted to organize compulsory health financing through PHI schemes.

The type of compulsory health financing scheme in place (government, SHI or compulsory PHI) can be explained historically and has changed over time. Some countries – mainly in western Europe – have moved away from employment-based arrangements to extend health coverage to the whole population. Other countries – all located outside western Europe – re-introduced employment-based schemes in an attempt to secure additional public investment in health or overcome the rigidity of public financial management rules.

The SHI scheme share of compulsory spending on health has fallen in high-income countries and is now highest in upper-middle-income countries. In 2018 the SHI scheme share of compulsory spending on health was highest in upper-middle-income countries and lowest in lower-middle-income countries.

SHI schemes are typically financed through a combination of social insurance contributions and transfers from the government budget. When spending through SHI schemes is broken down by revenue source, it becomes clear that the government budget is a significant source of SHI scheme revenue in many countries in all country income groups.

Gaps in population coverage are larger in countries that are mainly financed through SHI schemes. This clear pattern is a consequence of policy choices. In government schemes entitlement is usually based on residence, whereas SHI schemes generally base entitlement on employment status and payment of contributions, which systematically disadvantages people in vulnerable situations. To make progress towards UHC, some countries with SHI schemes have changed the basis for entitlement from payment of contributions to residence.

There are no systematic differences in UHC as measured through the service coverage index or the share of households with catastrophic health spending between countries with government schemes and SHI schemes. The extent to which a country relies on compulsory spending on health rather than out-of-pocket payments, and the design of coverage policy, have more impact on UHC performance than the way in which compulsory spending on health is financed.

Conventional distinctions between *SHI* and *tax-financed* schemes are no longer meaningful. These classifications do not determine sources of revenue and they mask the fact that all forms of compulsory pre-payment with risk pooling offer people '*insurance*'. The key question for policy is how well different health systems do in meeting the UHC goals of universal access to health services with financial protection. By broadening the public revenue base to encompass transfers from the government budget and de-linking entitlement to health care from payment of

contributions, some countries have removed the two key features of traditional SHI schemes that limit progress towards UHC. In a new era of health financing for UHC, removing these barriers will be an essential part of health system reforms.

Compulsory health financing arrangements differ across countries

This chapter focuses on compulsory health financing arrangements in the European Region. As a category, compulsory health financing[11] encompasses all elements of public spending on health but also includes elements of private spending on health – notably compulsory PHI. The first part of the chapter reviews shifts in compulsory health financing arrangements over time, highlighting the role of history – path dependency – in determining current arrangements. It also looks at trends in compulsory spending on health from 2000 to 2018. The second part of the chapter considers the impact of different compulsory arrangements on indicators of UHC.

Compulsory health financing involves prepayment mechanisms that are typically channelled through two main types of arrangement – what the SHA refers to as "government schemes" and SHI (OECD, Eurostat & WHO, 2011). A few countries organize health financing through a third arrangement known as "compulsory private health insurance". A fourth arrangement, "compulsory medical savings accounts", plays a very limited role globally and does not feature in the European Region.

Table 3.1 sets out the key characteristics of compulsory health financing arrangements in the European Region. Using SHA terminology, it classifies countries according to their *main* compulsory health financing scheme. *Main* is defined as the financing scheme accounting for the largest share of current spending on health in 2018.

In 2018 compulsory health financing was mainly organized through government schemes in 23 countries and through SHI schemes in 28 countries (Fig. 3.1). Although three countries reported spending through compulsory PHI (all of them in the high-income country group), it is the main compulsory health financing scheme in two countries only: the Netherlands and Switzerland. Reliance on financing through SHI schemes was lowest in lower-middle-income countries (one out of five) and highest in upper-middle-income countries (nine out of 15).

11. Public spending on health (as discussed in previous chapters) refers to government spending from domestic sources, including transfers from government domestic revenues allocated to health purposes (FS.1), and revenues from social insurance contributions (FS.3). Compulsory spending on health (the focus of this chapter) refers to government health financing schemes (HF.1.1), SHI schemes (HF.1.2.1), compulsory PHI schemes (HF.1.2.2) and compulsory medical savings accounts (HF.1.3).

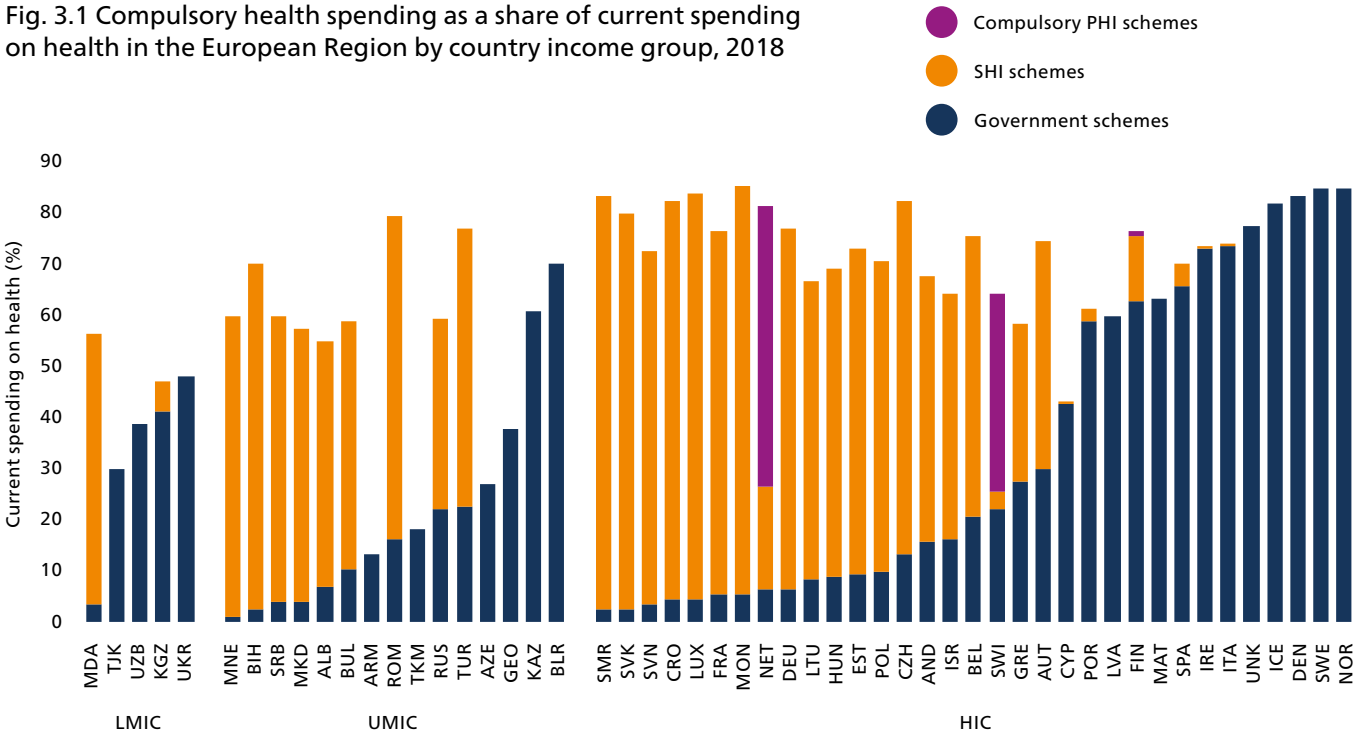
Table 3.1 Characteristics of compulsory health financing arrangements in the European Region, 2018

Type of scheme (SHA code)	**Government schemes** (HF.1.1)	**SHI schemes** (HF.1.2.1)	**Compulsory PHI schemes** (HF.1.2.2)
Mode of participation	**Automatic** for all residents or a specific group of people	**Compulsory** for all residents or a specific group of people	**Compulsory** for all residents or a specific group of people
Basis for entitlement	**Non-contributory:** typically, universal or available for a specific group of people or disease category (e.g., tuberculosis)	**Contributory:** typically based on payment by or on behalf of the insured person	**Contributory:** typically based on the purchase of a policy from a health insurance company or other agency
Main method of raising revenue	Government budget	Contributions, which are typically linked to earnings or income and do not reflect health risk, may be paid by the government on behalf of some non-contributing groups of people; the government may also provide general subsidies to the scheme	Premiums, which are not linked to earnings or income, may reflect health risk and may be subsidized by government
Countries in which this is the main compulsory health financing scheme	**LMIC:** Kyrgyzstan, Tajikistan, Ukraine, Uzbekistan **UMIC:** Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Turkmenistan **HIC:** Cyprus, Denmark, Finland, Iceland, Ireland, Italy, Latvia, Malta, Norway, Portugal, Spain, Sweden, United Kingdom	**LMIC:** Republic of Moldova **UMIC:** Albania, Bosnia and Herzegovina, Bulgaria, North Macedonia, Montenegro, Romania, Russian Federation, Serbia, Turkey **HIC:** Andorra, Austria, Belgium, Croatia, Czechia, Estonia, France, Germany, Greece, Hungary, Israel, Lithuania, Luxembourg, Monaco, Poland, San Marino, Slovakia, Slovenia	**HIC:** Netherlands (flat-rate premiums in addition to wage-based contributions), Switzerland (risk-rated premiums)

Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Tajikistan (a low-income country) is included in the LMIC group. HF.1.1 and HF.1.2.1 are typically counted as public spending in national accounts, but HF.1.2.2 is not. The country classification is based on the characteristics of the main compulsory health financing arrangement. Although Kyrgyzstan has an SHI scheme, financing through the government scheme accounts for a much larger share of current spending on health (see Fig. 3.1). Cyprus and France use wage-based contributions to finance health care, but entitlement is based on residence rather than payment of contributions (see Box 3.1).

Source: adapted from OECD, Eurostat & WHO (2011).

Fig. 3.1 Compulsory health spending as a share of current spending on health in the European Region by country income group, 2018



Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Tajikistan (a low-income country) is included in the LMIC group. Within country income groups, countries are ranked from low to high by spending through government schemes.

Source: WHO (2020a).

There have been major shifts in compulsory health financing arrangements over time

Compulsory health financing originated in schemes based on employment and were typically financed through wage-related contributions (Abel-Smith, 1998; Saltman et al., 2004). This is because before the development of modern medicine the financial risk associated with ill health was loss of earnings rather than health care costs – a risk mainly faced by workers and their families. Germany was the first country to institute compulsory arrangements at a national level, beginning in 1883. It was followed by the United Kingdom in 1911 and other countries in the first half of the 20th century.

Employment-based schemes were not designed to be universal. In the wake of the Second World War, some countries wanted to extend health coverage to the whole population, going beyond workers, so they established universal schemes that were financed through the government budget. The United Kingdom took this path in 1946 and Norway in 1967, followed by Denmark, Iceland, Italy, Portugal, Greece and Spain in the 1970s and 1980s (Table 3.2).

Starting in 1990, countries in central and eastern Europe and countries that had formed part of the Soviet Union shifted away from universal schemes financed through the government budget. Many re-introduced employment-based schemes that had been dismantled under the influence of the Soviet Union, partly to try and secure additional public investment in health through earmarked contributions and, in some cases, to overcome the rigidity of public financial management rules (Kutzin et al., 2010). Two of these countries – Kazakhstan and Georgia – subsequently abandoned their SHI schemes (in 1999 and 2005 respectively), although Kazakhstan re-introduced one in 2020.

Table 3.2 Shifts in compulsory health financing arrangements in the European Region

Source: authors based on European Observatory on Health Systems and Policies (2021), Saltman et al. (2004) and Kutzin et al. (2010).

Historically organized through SHI schemes but shifted to a government scheme	(Re-)introduced SHI schemes, typically during political and economic transition	Introduced then abolished SHI schemes
1946: United Kingdom	1990: Hungary	1995–2005: Georgia
1967: Norway	1991: North Macedonia	1996–1999: Kazakhstan
1973: Denmark	1992: Estonia, Serbia	
1974: Iceland	1993: Croatia, Czechia, Montenegro, Russian Federation, Slovakia, Slovenia	
1978: Italy	1995: Albania	
1979: Portugal	1997: Kyrgyzstan, Lithuania	
1983: Greece (introduced a government scheme but did not abolish its SHI scheme)	1999: Bosnia and Herzegovina, Bulgaria, Poland, Romania	
1986: Spain	2004: Republic of Moldova	
	2020: Kazakhstan	

The two countries with compulsory PHI schemes – the Netherlands and Switzerland – have a long history of organizing health financing through multiple private entities (Thomson et al., 2020). In Switzerland health insurance became compulsory for the whole population for the first time in 1996. People pay risk-related premiums[12] to non-profit private insurance companies. Local governments subsidize premiums for people with low incomes. In the Netherlands the richest third of the population relied on voluntary substitutive PHI until 2006, when the government extended entitlement to publicly financed coverage to the whole population. The universal scheme established in 2006 is organized through a mix of non-profit and for-profit private entities and financed through wage-based contributions[13] and flat-rate premiums.[14] The central government subsidizes premiums for people with low incomes.

12. Classified under compulsory prepayment in SHA (FS.4).

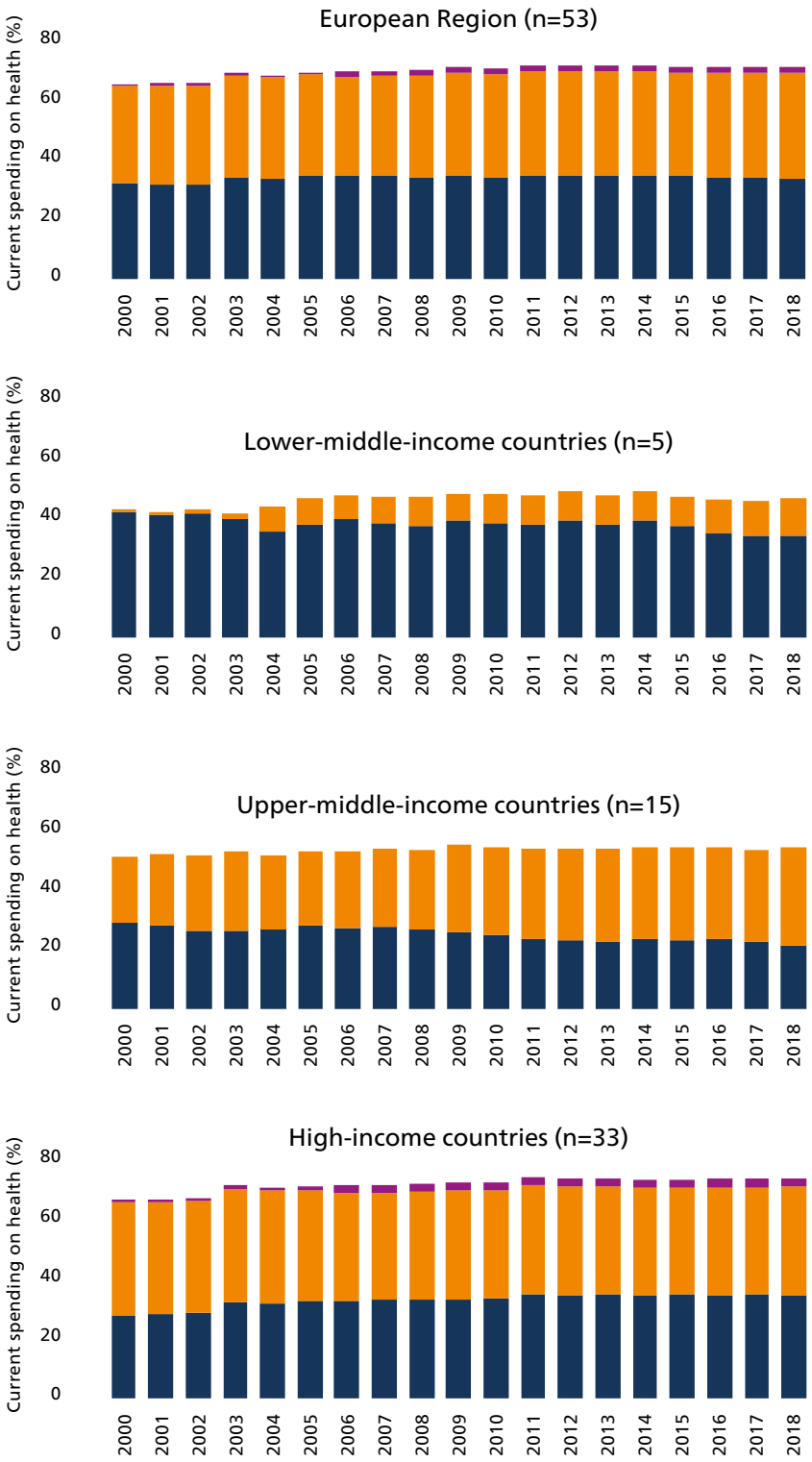
13. Classified under social insurance contributions in SHA (FS.3).

14. Classified under compulsory prepayment in SHA (FS.4).

The SHI scheme share of compulsory spending on health has fallen in high-income countries and is now highest in upper-middle-income countries

Across the European Region compulsory spending on health was evenly divided between spending through government schemes and SHI schemes in 2018, but there was significant variation by country income group: the SHI scheme share of compulsory spending on health ranged from 27% in lower-middle-income countries to 51% in high-income countries and 61% in upper-middle-income countries. Between 2000 and 2018, the SHI scheme share of compulsory spending on health grew in lower- and upper-middle-income countries and fell in high-income countries (Fig. 3.2).

Fig. 3.2 Compulsory spending on health in the European Region by type of scheme and country income group, 2000–2018



Notes: Tajikistan (a low-income country) is included in the LMIC group. Data for Montenegro (UMIC) are only available for 2018. In 2018 government schemes were the main financing arrangement in 23 out of 53 countries in the European Region, 4 out of 5 LMIC, 6 out of 15 UMIC and 13 out of 33 HIC. The increase in the SHI scheme share of compulsory spending in LMIC in 2004 reflects the introduction of an SHI scheme in the Republic of Moldova. The increase in the compulsory PHI scheme share in HIC in 2006 reflects the shift to a universal scheme operated by private entities in the Netherlands.

Source: WHO (2020a).

The increase in the SHI scheme share in lower-middle income countries reflects the introduction of an SHI scheme in the Republic of Moldova in 2004. The fall in the SHI scheme share in high-income countries follows the introduction of a universal compulsory PHI scheme in the Netherlands in 2006.

Compulsory spending on health and out-of-pocket payments have grown at the same rate on average, but growth has varied substantially across countries

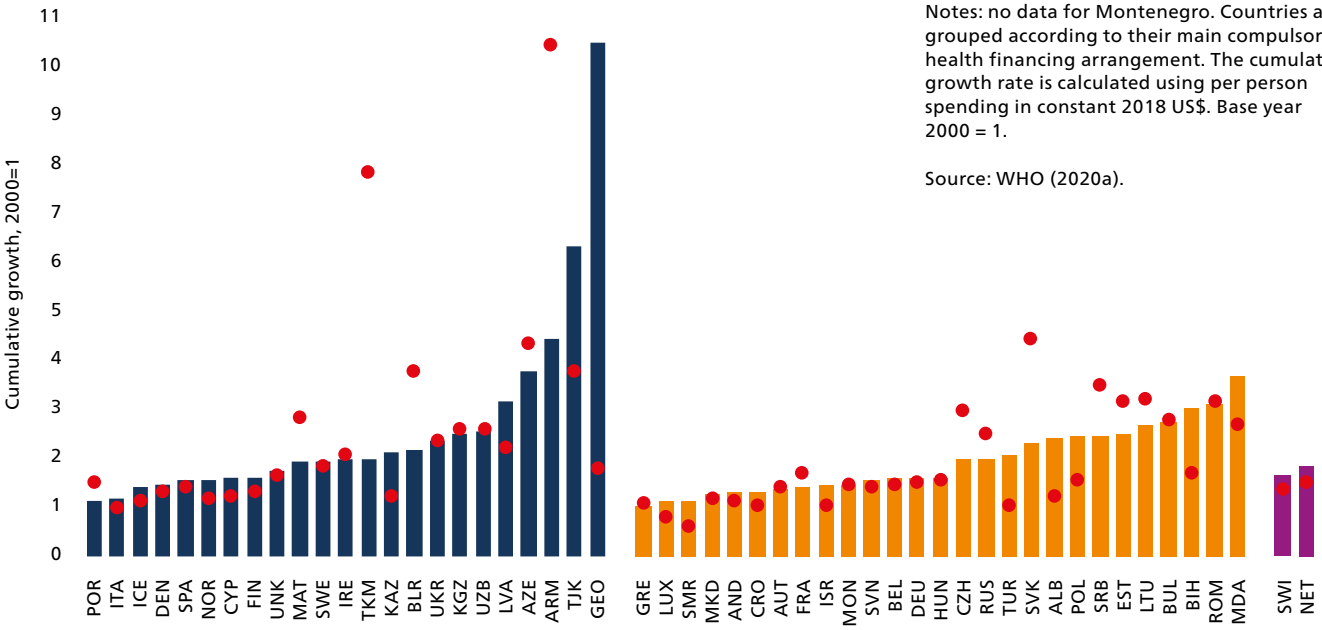
On average, compulsory spending on health and out of-pocket payments per person in the European Region grew by 2.2 times between 2000 and 2018. Growth in compulsory spending on health was generally higher in countries where compulsory health financing is mainly organized through government schemes (2.6 times) than in countries where it is mainly financed through SHI schemes (1.9 times) or compulsory PHI schemes (1.7 times), but this was largely driven by substantial growth in lower-middle-income countries like Georgia and Tajikistan (Fig. 3.3).

The government budget is a significant source of SHI scheme revenue in many countries in all country income groups

Most SHI schemes in the European Region benefit from transfers from the government budget in addition to revenue from social insurance contributions. In 2018 government budget transfers were an important supplement to social insurance contributions in many countries (Fig. 3.4). They amounted to around 25–35% of SHI scheme revenue in Belgium, Bulgaria, France, Greece, Lithuania, North Macedonia, Slovakia and Turkey; around 40% in Luxembourg, the Republic of Moldova and the Russian Federation; and over 50% in Albania, Hungary and Israel.

Viewed in this way, the government budget is seen to be a larger source of compulsory health financing in many countries that are mainly financed through SHI schemes, across all country income groups. In 2018, for example, Fig. 3.4 shows that the government budget was the dominant source of compulsory spending on health in Albania, Greece, Hungary, Israel and the Russian Federation. In the same year social insurance contributions accounted for more than 75% of compulsory spending on health in only 11 out of 28 countries mainly financed through SHI schemes.

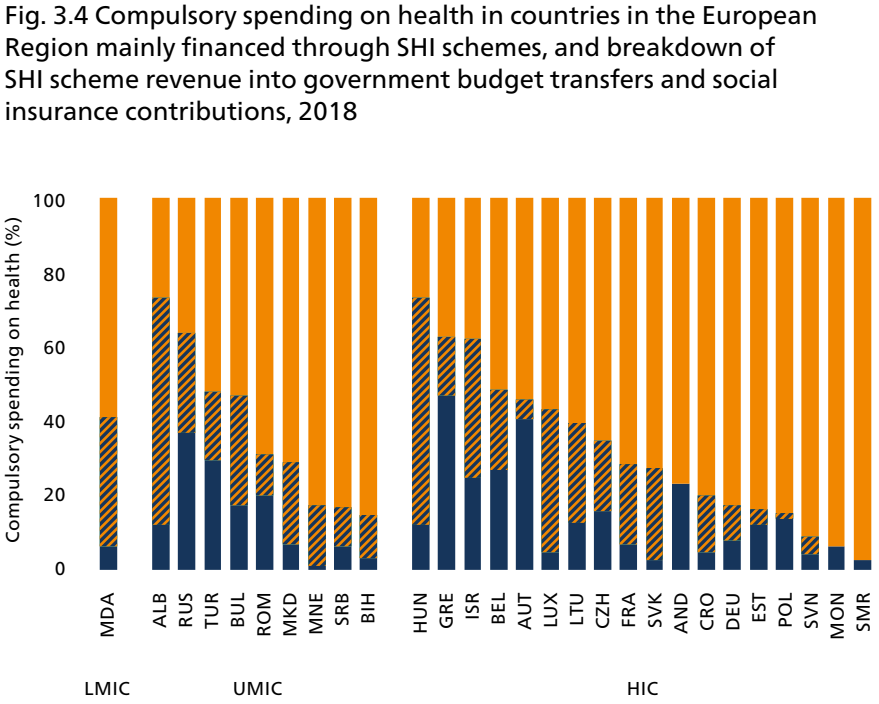
Fig. 3.3 Cumulative growth in compulsory spending on health and out-of-pocket payments per person in the European Region by main compulsory health financing arrangement, 2000–2018



Notes: no data for Montenegro. Countries are grouped according to their main compulsory health financing arrangement. The cumulative growth rate is calculated using per person spending in constant 2018 US$. Base year 2000 = 1.

Source: WHO (2020a).

Fig. 3.4 Compulsory spending on health in countries in the European Region mainly financed through SHI schemes, and breakdown of SHI scheme revenue into government budget transfers and social insurance contributions, 2018



Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Countries are ranked from high to low by government budget financing, which is the sum of government schemes (HF.1.1) and government budget transfers to SHI schemes (HF.1.2.1–FS.3).

Source: WHO (2020a).

Implications for UHC

The goals of UHC are to ensure that everyone can use the health services they need without experiencing financial hardship. These goals are most likely to be met when:

- the whole population is covered;
- the range and quality of services covered is sufficient to meet everyone's health needs; and
- health care costs are largely financed through prepayment with risk pooling, so that no one encounters financial barriers to access (resulting in unmet need for health services) or experiences financial hardship (resulting in catastrophic or impoverishing health spending).

Gaps in population coverage are larger in countries that are mainly financed through SHI schemes

Ensuring that the whole population is entitled to publicly financed health care is a precondition for UHC. While population coverage on its own is not enough to guarantee that people will not face unmet need or financial hardship, it is not possible for countries to *achieve* UHC without it.

Around 60% of countries in the European Region report covering the whole population (Fig. 3.5). Most of these countries are mainly financed through government schemes. In contrast, all the countries that report not covering the whole population are mainly financed through SHI schemes (with one exception – Georgia).

This clear pattern is a consequence of policy choices. In government schemes entitlement is usually based on residence status, whereas SHI schemes generally base entitlement on employment status and payment of contributions by or on behalf of the insured person.

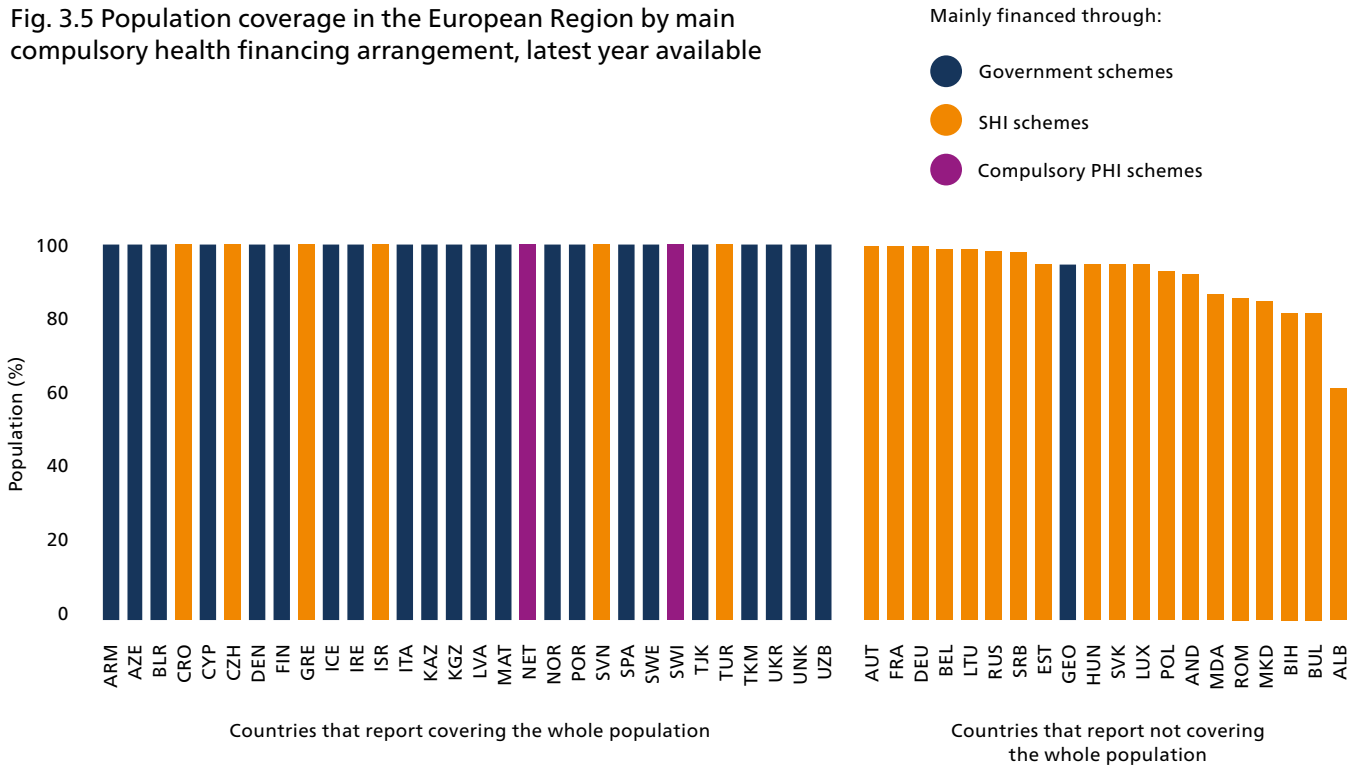
As noted at the beginning of this chapter, SHI schemes were originally developed to cover the risk of losing earnings when ill and unable to work. In this context the schemes were designed to cover a subset of the population only – workers – and there was some logic in linking entitlement to payment of contributions.

Today, a key goal of any health system is to protect people against a different type of risk: the risk of having to pay for health care when ill. Because this risk is universal – it is not limited to workers[15] – there is no reason why contemporary SHI schemes should continue to insist on linking entitlement to employment or payment of contributions. Instead, they should aim to be universal. Box 3.1 highlights problems that occur when health systems base entitlement on payment of contributions.

15. Loss of earnings due to ill health is a risk that is now covered by other parts of the social protection system.

Regardless of whether the basis for entitlement is residence or payment of contributions, undocumented migrants are likely to be excluded or entitled to a limited set of publicly financed benefits in almost every country in the European Region – even in those that report covering the whole population. Other groups of people likely to be systematically underserved include Roma, homeless people and people with mental health problems.

Fig. 3.5 Population coverage in the European Region by main compulsory health financing arrangement, latest year available



Notes: no data for Monaco, Montenegro and San Marino. Population coverage refers to the share of the population entitled to health services financed through pre-payment and risk pooling. Social health insurance schemes in Greece and Kyrgyzstan do not cover the whole population.

Sources: OECD (2020a) for OECD countries, which is based on self-reporting; Health Systems in Transition reports for non-OECD countries (European Observatory on Health Systems and Policies (2021).

Box 3.1 Problems that occur when health systems base entitlement to publicly financed health care on payment of contributions rather than on residence

Linking entitlement to payment of contributions systematically disadvantages people in vulnerable situations. Basing entitlement on payment of contributions automatically excludes people from coverage, leaving a part of the population uninsured. The uninsured are often people who cannot afford to pay contributions because they are in precarious or non-stable work or lack employment. The size of the uninsured population varies across countries. It is generally larger in countries with a high degree of informality in the labour market.

Linking entitlement to payment of contributions in SHI schemes that are supplemented by transfers from the government budget fosters unfairness among taxpayers. Fig 3.4 shows the extent to which SHI schemes in the European Region are financed through the government budget. In 2018 budget transfers accounted for more than 20% of SHI scheme revenue in 15 out of 28 countries (WHO, 2020a). This leads to an unfortunate outcome in which some taxpayers lack entitlement to the SHI scheme even though they are paying for it through taxes on goods, property or income.

Split benefits packages exacerbate inequalities in access to health services. The share of the population not covered by SHI schemes in some countries is substantial. In Albania, Greece and Kyrgyzstan, for example, the SHI scheme does not cover around 20–25% of the population. Although the uninsured are entitled to other publicly financed health services, the scope of these services is limited in comparison to the services covered by the SHI scheme, deepening socioeconomic inequalities in access and financial protection.

Recognizing the threat to UHC posed by linking entitlement to payment of contributions, some countries with SHI schemes are choosing to change the basis for entitlement to residence. France broke the link between entitlement and payment of contributions in 2000, through a new system known as *Couverture Universelle Maladie*. In 2016 this was replaced by *Protection Universelle Maladie*, which grants all residents an individual, automatic and continuous right to health care, without the need for administrative formalities when a person's circumstances change. The new General Health System launched in Cyprus in 2019 changed the basis for entitlement from citizenship, income and payment of contributions to residence, extending publicly financed coverage to the 25% of the population that was previously not covered (Kontemeniotis & Theodorou, 2021).

Source: WHO Regional Office for Europe (2019).

There are no systematic differences in service coverage or financial protection between countries mainly financed through government schemes and countries mainly financed through SHI schemes

Two sets of indicators are commonly used to measure progress towards UHC. The *service coverage index* developed as part of the SDGs (SDG indicator 3.8.1)[16] aims to capture access to health services. Indicators of financial protection – *catastrophic and impoverishing health spending* – aim to capture the extent to which people experience financial hardship when they use health services and have to pay out of pocket for them.

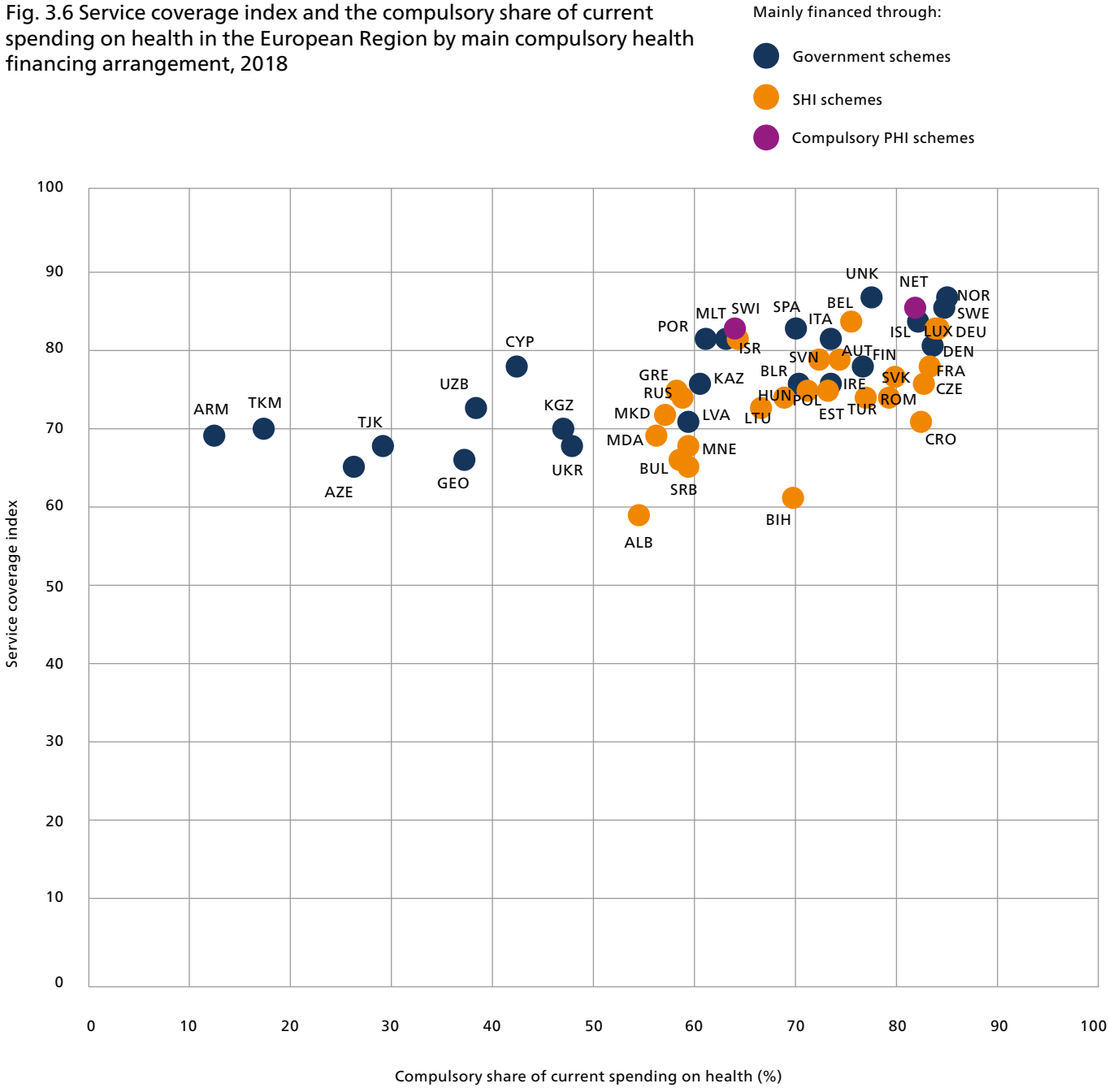
In 2018 the European Region had an average service coverage index of 75 (Fig.3.6). On average, countries where health financing is organized mainly through government schemes achieved a slightly higher score on the service coverage index compared to countries where health financing is mainly organized through SHI schemes (76 versus 74), driven largely by differences in high-income countries (80 versus 76). In middle-income countries, the average service coverage index score was very similar across the two types of health financing arrangement.

The incidence of catastrophic spending on health in the European Region does not differ based on the way in which compulsory health financing is arranged (Fig. 3.7). This is also true of impoverishing health spending (data not shown) (WHO Regional Office for Europe, 2019). Catastrophic incidence ranges from 1% to 17% of households in countries mainly financed through government schemes and in countries mainly financed through SHI schemes.

Measured using these two indicators, there are no systematic differences in UHC performance between countries with government schemes, SHI schemes and compulsory PHI schemes. In the European Region the extent to which a country relies on compulsory spending on health rather than on out-of-pocket payments, and the design of coverage policy – decisions about who is entitled to publicly financed health care, the scope of service coverage and rules around user charges (co-payments) – have more impact on UHC than the way in which compulsory spending on health is financed (WHO Regional Office for Europe, 2019).

16. Self-reported unmet need for health and dental care due to cost, distance and waiting is a better indicator of access to health care than the service coverage index (SDG 3.8.1) but comparable data on unmet need are not available in all countries in the European Region.

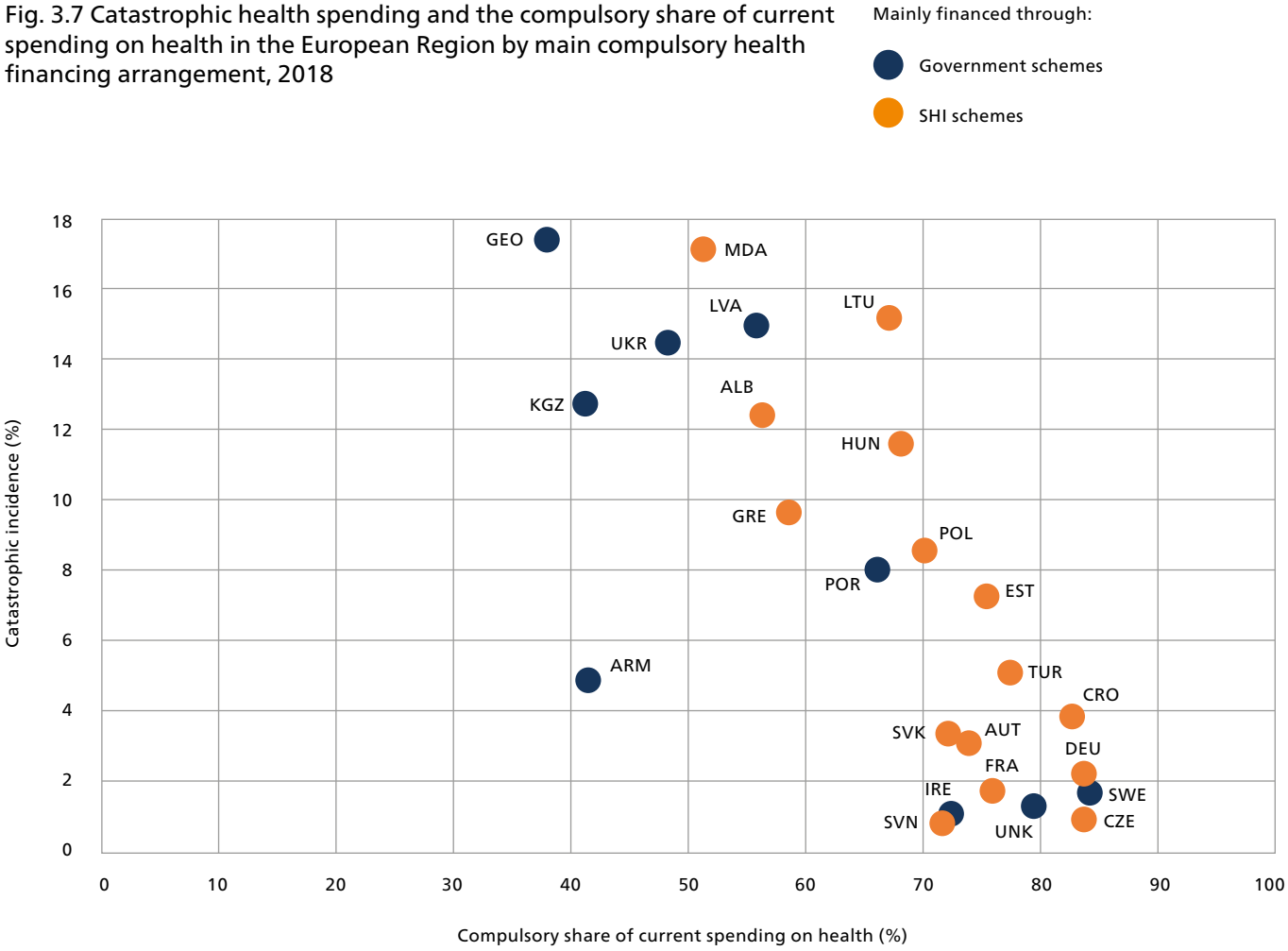
Fig. 3.6 Service coverage index and the compulsory share of current spending on health in the European Region by main compulsory health financing arrangement, 2018



Notes: service coverage index data are for 2017 and not available for Andorra, Monaco and San Marino. The index combines 16 tracer indicators (reproductive, maternal, newborn and child health; infectious diseases; noncommunicable diseases; and service capacity and access) in a single summary measure.

Sources: WHO (2020a); WHO (2019b).

Fig. 3.7 Catastrophic health spending and the compulsory share of current spending on health in the European Region by main compulsory health financing arrangement, 2018



Notes: data on catastrophic incidence are for the latest available year and are not available for all countries. Catastrophic incidence is defined here as the share of households with out-of-pocket payments greater than 40% of capacity to pay for health care. Capacity to pay for health care is defined here as total household consumption minus a standard amount to cover basic needs (food, housing and utilities). Data on compulsory health spending are for the same year as those for catastrophic spending.

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

Chapter 4

Tracking PHC spending and its priority in government budgets

Summary

Information on PHC spending and how this spending is financed is vital for monitoring country and regional progress towards UHC. Monitoring PHC spending – particularly public spending on PHC – shows the priority countries give to ensuring everyone can use the PHC services they need without financial hardship. Tracking PHC spending in a standard way across countries[17] highlights the patterns and differences in PHC spending and identifies where progress is needed. Nearly 40 countries in the European Region collect data on PHC spending using the SHA 2011 framework, but there is room for improvement. Eight of these countries also report PHC spending by financing source, allowing them to track public spending on PHC. This analysis demonstrates the diversity of PHC spending in the European Region. It also highlights gaps in reporting by countries and the need for better quality collection methods that increase international comparability.

PHC accounts for less than half of current spending on health. On average PHC spending accounted for 42% of current spending on health in the 37 countries covered in this chapter, but there is considerable variation across countries. Switzerland spends the most per person (US$ 3923) and Tajikistan the least (US$ 27). The composition of PHC spending also differs across countries. General outpatient care and outpatient medicines account for the largest share of PHC spending.

The priority countries give to PHC when allocating government spending on health varies substantially. Among the eight countries for which PHC spending data are available by financing source, the public share of PHC spending ranges from 42% in Armenia to 12% in Georgia. Public spending on PHC as a share of GDP ranges from 1.2% in the Republic of Moldova and the Russian Federation to 0.3% in Georgia. If these countries invested an additional 1% of GDP in PHC, it would result in an extra US$ 32, US$ 44 and US$ 115 spent publicly per person on PHC in the Republic of Moldova, Georgia and the Russian Federation respectively.

WHO calls on all countries to invest an additional 1% of GDP in PHC. Spending more **publicly** on PHC is the most cost-effective way to make progress towards UHC. It offers the potential to improve access to services in middle-income countries, to enhance the quality and efficiency of people-centred services in high-income countries and to improve financial protection in all countries, especially if accompanied by efforts to strengthen coverage policies. By carefully tracking PHC spending and increasing public spending on PHC by an additional 1% of GDP, countries will enter a new era in health financing. Tracking PHC spending is important for progress towards UHC

17. The global definition of PHC spending used in this chapter may not match the PHC definition used at country level.

Tracking PHC spending is important for progress towards UHC

This chapter provides for the first time an overview on how much different countries in the European Region spend on PHC and the priority given to PHC in allocating government spending. This analysis demonstrates the diversity of PHC spending in the European Region. It also highlights gaps in reporting by countries and the need for data collection methods that increase comparability.

PHC is the most efficient and equitable way of using available resources to make progress towards UHC, a core priority of WHO's European Programme of Work for 2020–2025 (WHO Regional Office for Europe, 2021). When PHC performs well, it addresses a wide range of health needs close to people's homes and communities and ensures people can use the quality services they need without financial hardship, as outlined in the Alma-Ata Declaration in 1978 and confirmed by the Declaration of Astana in 2018 (WHO, 2019b). PHC has played a crucial role during the pandemic, enabling early recognition and referral of people with COVID-19, and providing the coordination and continuity needed to maintain other essential health services (WHO Regional Office for Europe, 2020b). Because of its importance for UHC, WHO recommends that all countries, regardless of income level, allocate an additional 1% of GDP to PHC from public sources (WHO, 2019b).

Monitoring PHC spending – particularly public spending on PHC – shows the priority countries give to ensuring essential health services to all. Tracking PHC spending in a standard way across countries highlights the patterns and differences in PHC spending and identifies where progress is needed.

Until recently, there was no standard method of monitoring PHC spending across countries, partly due to challenges in defining something that is inherently multisectoral and multidimensional, and partly due to data limitations and differences in the way services are delivered in different countries. In 2019 WHO published a first comparative analysis of PHC spending, focusing on low- and middle-income countries globally (Xu et al., 2019). This analysis reflected joint guidelines for a global definition of PHC based on SHA 2011 (OECD, Eurostat & WHO, 2011).

SHA 2011 offers at least three options for constructing PHC spending (OECD, 2019a). The first is to use the health provider (HP) classification, which records health spending by type of service provider – for example, clinics, hospitals and pharmacies. The second is to use the health care function (HC) classification, which records health spending by the primary purpose of each type of health care good or service – for example, curative or preventive. The third is to cross the HP and HC classifications to provide more detailed information on, say, how much a country spends on outpatient services provided by hospitals. After consultation with country representatives, policy-makers, researchers and health accounts experts from around the world, the HC measure was chosen for cross-country comparison (Vande Maele et al., 2019). The HC classification was

selected because it is more comparable than the HP classification. For example, the role of hospitals in providing outpatient care varies widely across countries. Using the HP classification, first contact care provided by hospitals would not be captured, whereas the HC classification captures first contact care regardless of who provides it. The HC classification may not capture all differences in how countries organize service delivery, however, so careful interpretation of the data is needed.

The global definition of PHC spending[18] includes the following categories (with HC codes):

- general outpatient curative care (HC.1.3.1)
- dental outpatient curative care (HC.1.3.2)
- curative outpatient care, not elsewhere classified (HC.1.3.nec)
- home-based curative care (HC.1.4)
- outpatient long-term health care (HC.3.3)
- home-based long-term health care (HC.3.4)
- preventive care (HC.6)
- a share (80%) of medical goods provided outside health care services (HC.5)
- a share (80%) of health system administration and governance costs (HC.7).

Outpatient over-the-counter and prescription medicines (HC.5) are a fundamental element of PHC but the inclusion of the entire HC.5 category would overestimate PHC spending. The global definition of PHC spending therefore includes 80% of all spending under HC.5. The 80% proportion reflects expert opinion based on individual country case studies.

This chapter reviews data for the 37 countries in the European Region that report all the components necessary to monitor PHC spending.[19] Because currently it is not obligatory to report PHC spending by financing sources, just eight of these countries in the European Region report this dimension, which enables analysis of PHC spending by governments and donors.[20] Unfortunately, out-of-pocket spending on PHC cannot be tracked due to poor quality or lack of data. Notably, as of today the rest of the countries in the European Region do not yet report any health care services (HC) spending by financing sources and some of them do not report any health care services (HC) spending at all based on SHA 2011 methodology (Annex 2).

18. The global PHC definition excludes inpatient curative care (HC.1.1), day curative care (HC.1.2), specialized outpatient curative care (HC.1.3.3), unspecified curative care (HC.[1].nec), rehabilitative care (HC.2), inpatient long-term care (HC.3.1), day long-term care (HC.3.2), unspecified long-term care (HC.3.nec), ancillary services (HC.4) and other health care services not elsewhere classified (HC.9).

19. Armenia, Austria, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Kazakhstan, Latvia, Lithuania, Luxembourg, Malta, Netherlands, North Macedonia, Norway, Poland, the Republic of Moldova, Romania, the Russian Federation, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan and Uzbekistan.

20. Armenia, Georgia, Kazakhstan, North Macedonia, the Republic of Moldova, the Russian Federation, Tajikistan and Uzbekistan.

PHC accounts for less than half of current spending on health

On average PHC spending in the 37 countries accounted for 42% of current spending on health in 2018, ranging from 32% in the Netherlands to 62% in Malta (Fig. 4.1).[21] There is no clear relationship between the PHC share of current spending on health and a country's income level (Fig. 4.2).

In absolute terms, PHC spending varies considerably across countries. In the countries with data available, Switzerland spends the most per person (US$ 3923) and Tajikistan the least (US$ 27) (Fig. 4.3). The causes of variation require analysis beyond the data reported here and range from differences in policy choices to nuances in measurement methodology. The impact of medicine prices could be one reason.

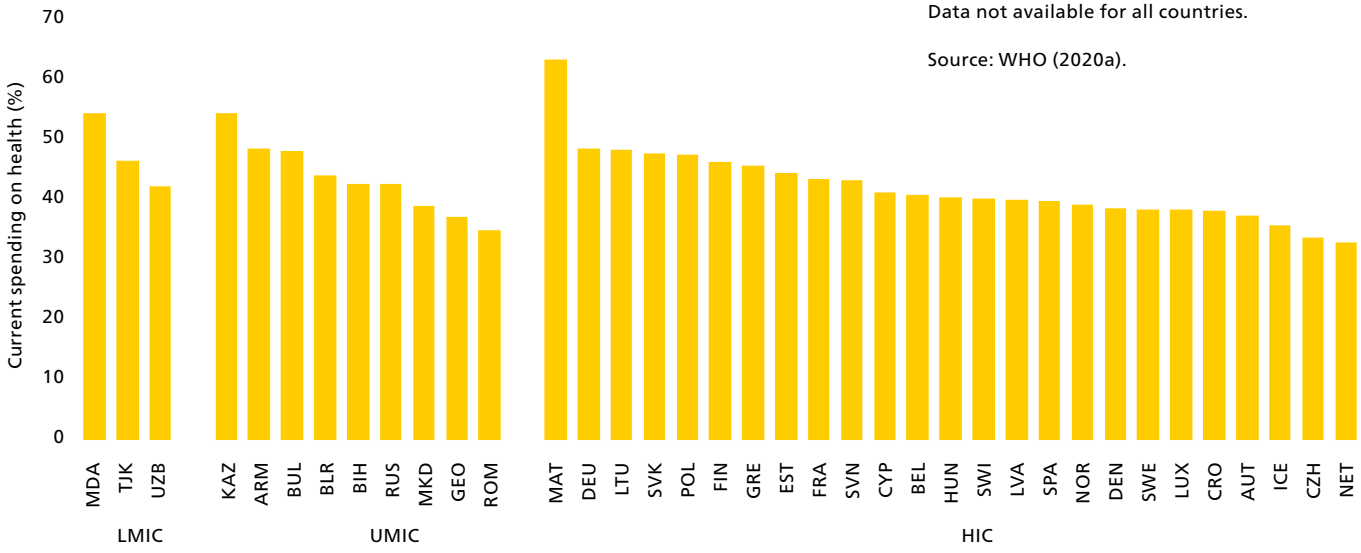
The composition of PHC spending differs between countries. General outpatient care[22] and medicines[23] absorb the greatest share of PHC spending (Fig. 4.4). The share of spending on medicines is related to income level – the richer is the country, the smaller is the share of medicines in PHC spending (Fig. 4.5). This may reflect the impact of differences in medicines pricing and coverage policies but also overall income level and purchasing power of the country. The share of other components of PHC spending varies by countries but cannot be explained by differences in income levels. Other factors, including differences in measurement methodology, may play a role. For example, the SHA 2011 classification captures prevention spending through explicitly defined programmes but faces difficulties in measuring preventive activities integrated in primary and specialist care consultations.

21. PHC spending in Georgia could be underestimated as it does not include voluntary prepayment schemes' spending on PHC spending categories, except administration.

22. Dental care is monitored separately from general outpatient care as dental care is already included in the definition of global PHC.

23. In this chapter, medicines refer to medicines and medical supplies provided outside health care services (HC.5 under the SHA 2011 framework). Only a portion of all medicines are included in this analysis – as those delivered at the point of care are already accounted for in the amounts for inpatient care, outpatient care and so on.

Fig. 4.1 PHC spending as a share of current spending on health in the European Region, 2018



Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Tajikistan (a low-income country) is included in the LMIC group. Data not available for all countries.

Source: WHO (2020a).

Fig. 4.2 Relationship between PHC spending as a share of current spending on health and country income level in the European Region, 2018

Notes: data not available for all countries. Luxembourg is excluded as an outlier.

Source: WHO (2020a).

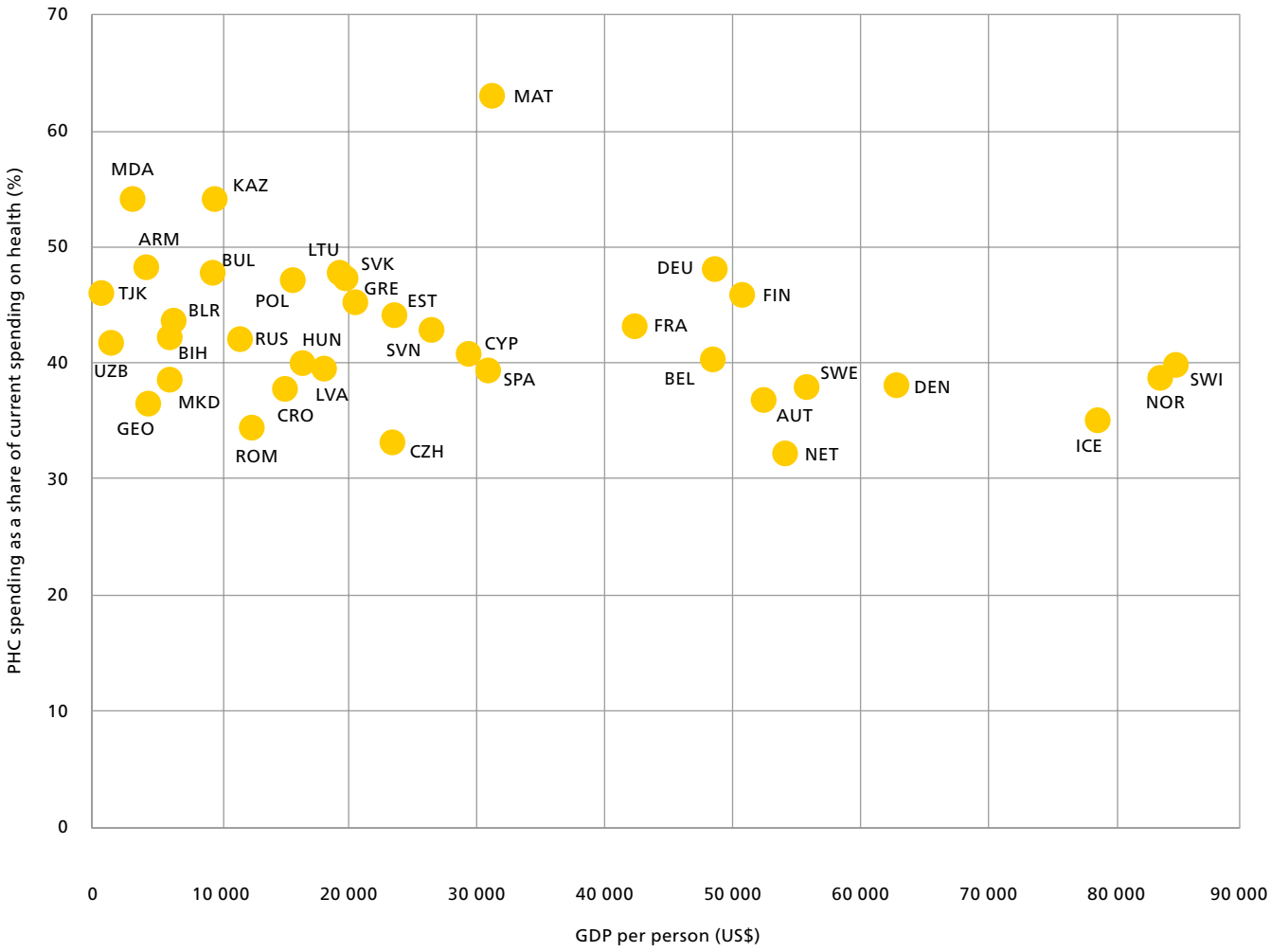


Fig. 4.3 PHC spending per person in the European Region, 2018

Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Data not available for all countries. All PHC spending refers to current spending on health.

Source: WHO (2020a).

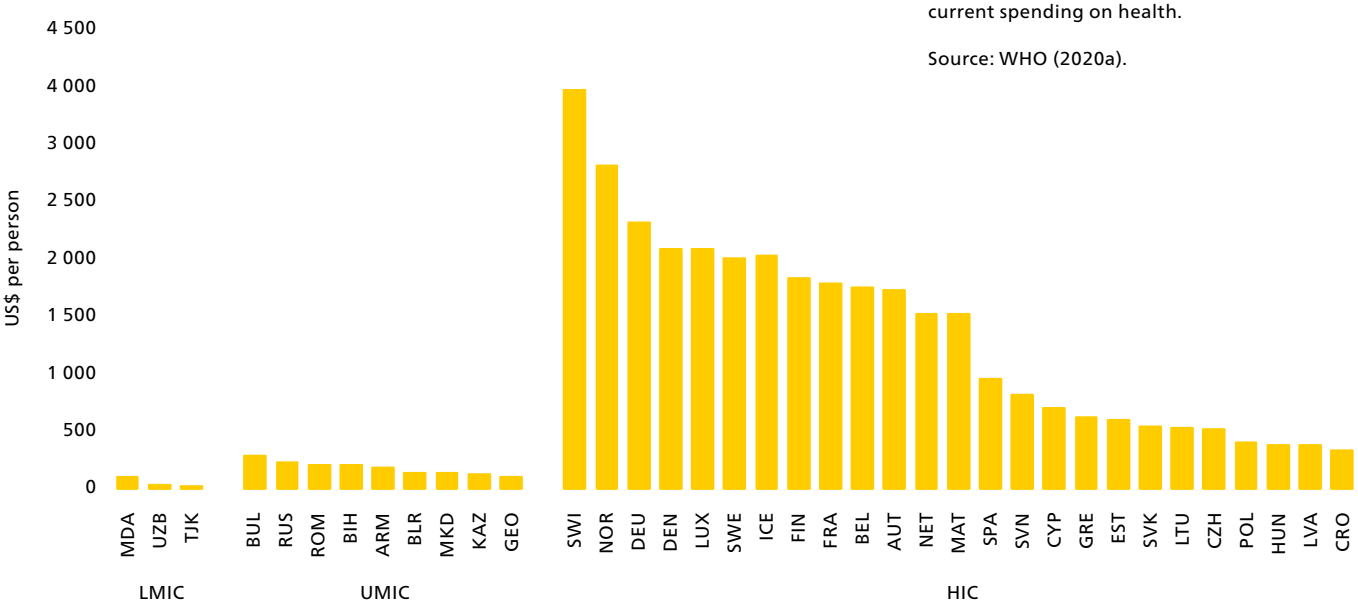


Fig. 4.4 Composition of PHC spending in the European Region, 2018

Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Tajikistan (a low-income country) is included in the LMIC group. General outpatient care (except dental care) corresponds to HC.1.3.1, HC.1.3.nec, HC.1.4, HC.3.3 and HC.3.4; dental care HC.1.3.2; medicines and medical goods 80% of HC.5; administration 80% of HC.7; and preventive care HC.6. Data not available for all countries.

Source: WHO (2020a).

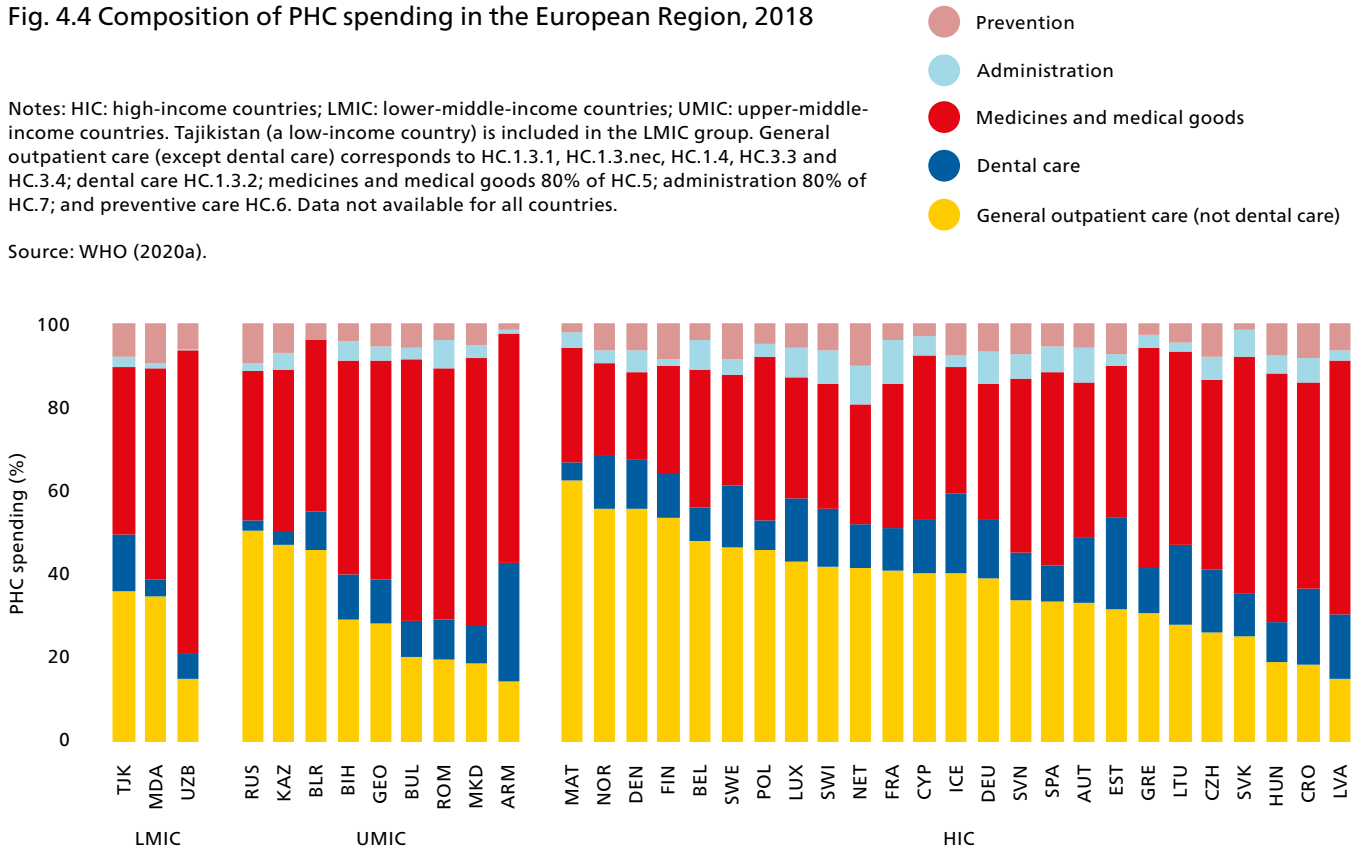
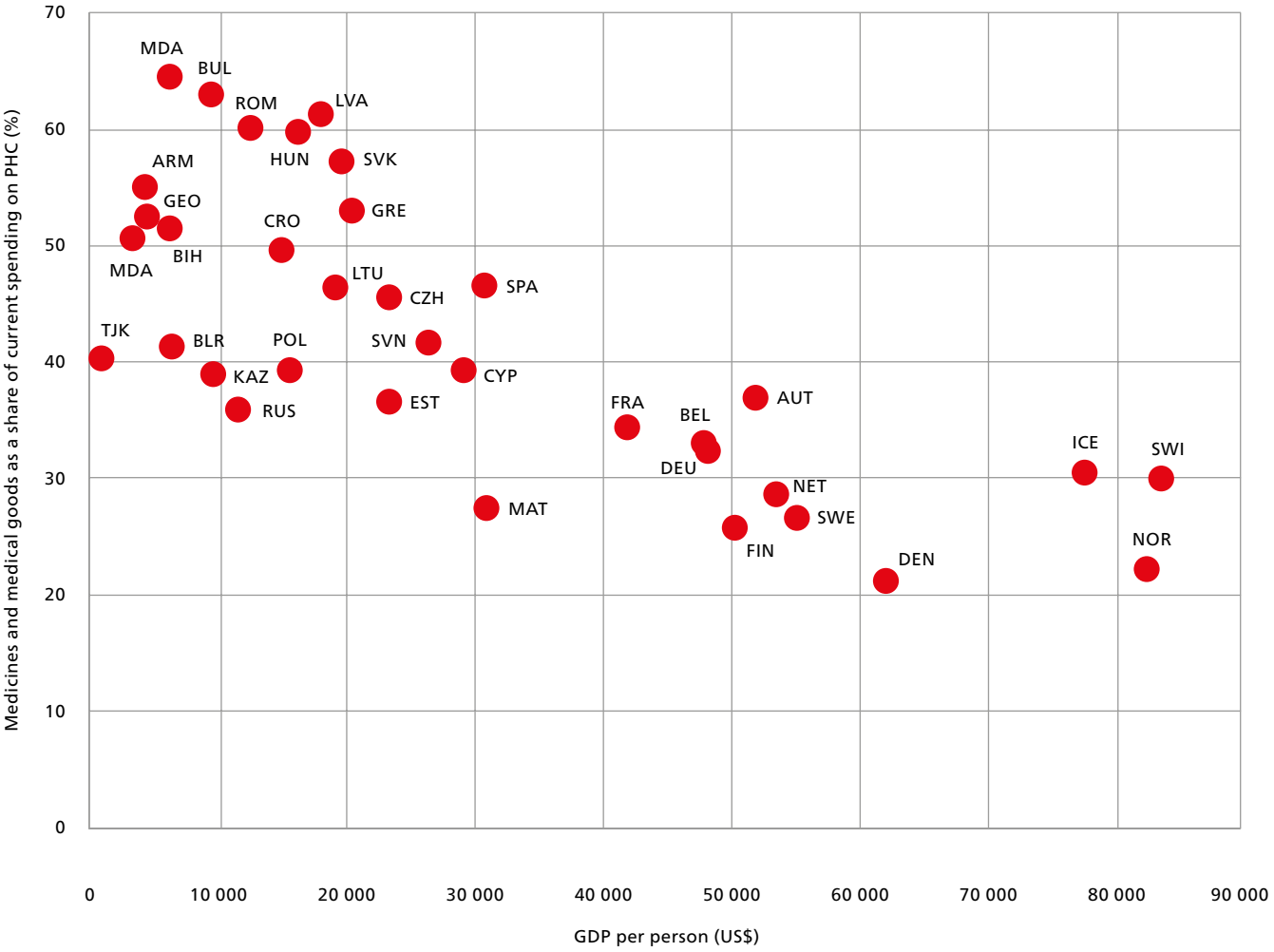


Fig. 4.5 Relationship between spending on medicines and medical goods as a share of PHC spending and country income level in the European Region, 2018

Notes: data not available for all countries. Luxembourg is excluded as an outlier.

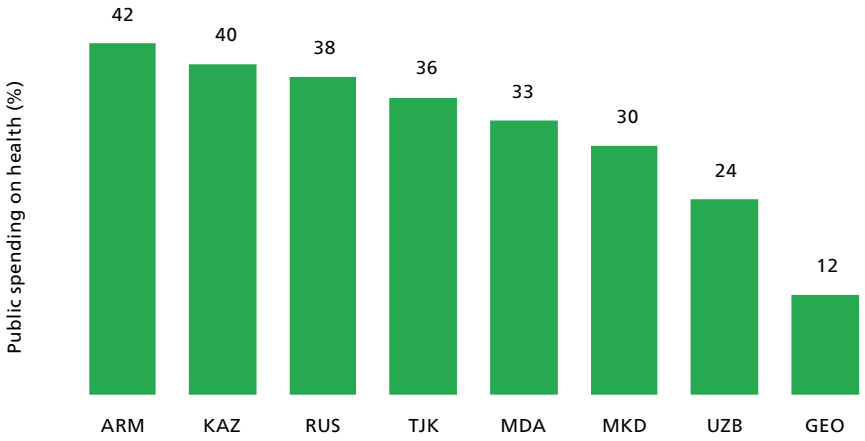
Source: WHO (2020a).



The priority given to PHC in allocating public spending varies substantially

Among the eight countries for which PHC spending data are available by sources, the public share of PHC spending varies substantially from 42% in Armenia to 12% in Georgia (Fig. 4.6). These large variations reflect different policy choices and the role of donor funding in some countries.

Fig. 4.6 PHC spending as a share of public spending on health in the European Region, 2018

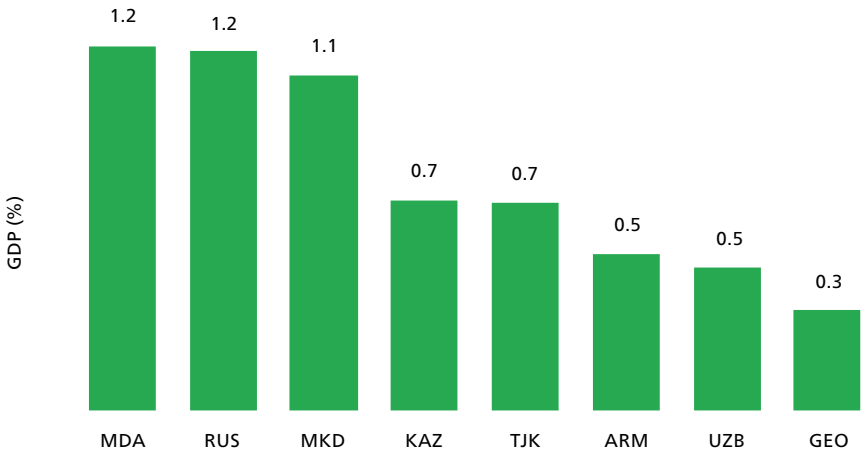


Note: data not available for all countries.

Source: WHO (2020a).

Public spending on PHC as a share of GDP also varies widely, ranging from 1.2% in the Republic of Moldova and the Russian Federation to 0.3% in Georgia (Fig. 4.7). The Political Declaration of the High-level Meeting on Universal Health Coverage calls for increased public spending on PHC (United Nations, 2019). WHO recommends that all countries increase their public spending on PHC by an additional 1% of GDP (WHO, 2019b). This additional investment would amount to an extra US$ 32, US$ 44 and US$ 115 spent publicly per person on PHC in the Republic of Moldova, Georgia and the Russian Federation respectively.

Fig. 4.7 Public spending on PHC as a share of GDP in the European Region, 2018

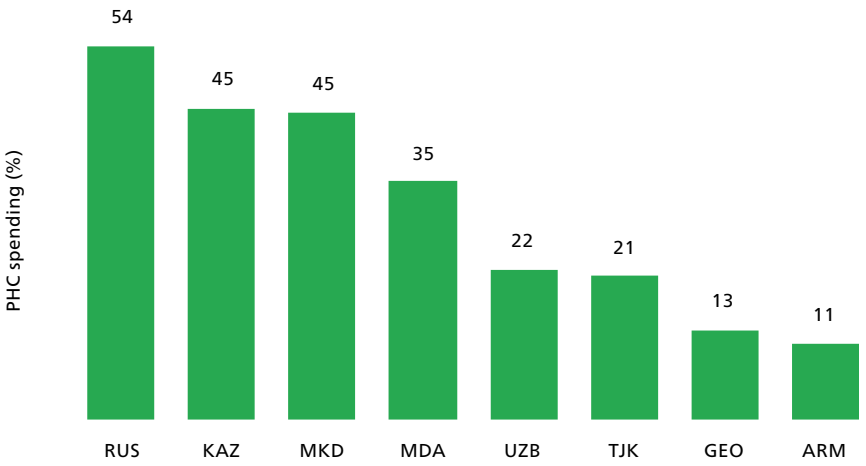


Note: data not available for all countries.

Source: WHO (2020a).

On average, only 31% of PHC spending in the eight countries comes from the government, ranging from 54% in the Russian Federation to 11% in Armenia (Fig. 4.8). Aid is an important additional funding source for PHC in some countries, accounting for 7% of PHC spending in Tajikistan and 4% in the Republic of Moldova (WHO, 2020a). Donor funding is particularly important as a source of funding for prevention. For example, in Tajikistan donor funding comprises about half of all spending on prevention.

Fig. 4.8 Public spending on PHC as a share of PHC spending in the European Region, 2018

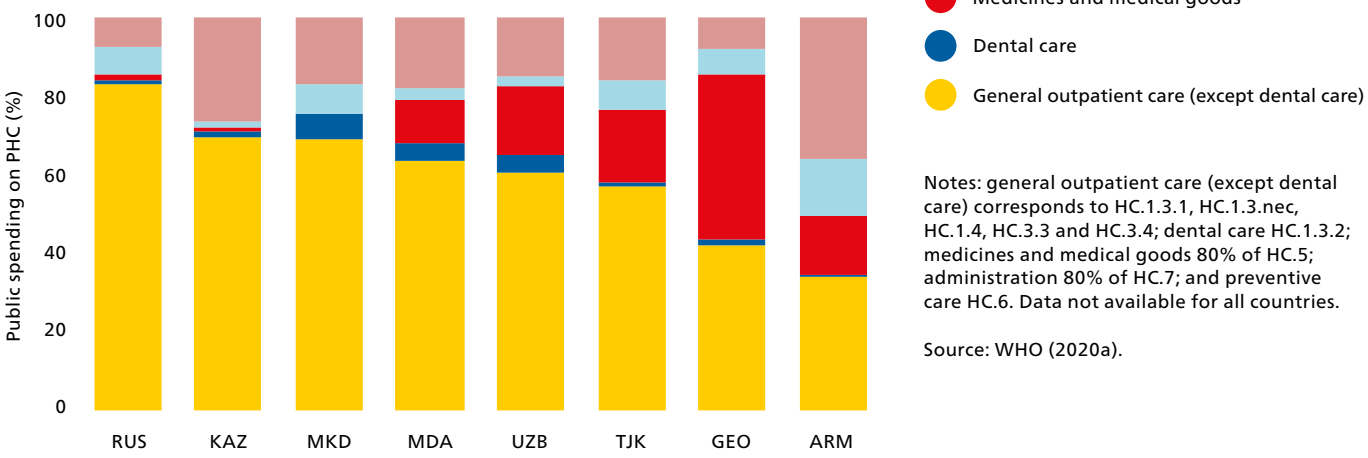


Note: data not available for all countries.

Source: WHO (2020a).

The distribution of government spending across PHC components varies greatly across countries (Fig. 4.9). Medicines account for a higher share of public spending on PHC (Fig. 4.9) in countries that spend more publicly on PHC as a share of GDP, like North Macedonia and the Republic of Moldova (Fig. 4.7).

Fig. 4.9 Composition of public spending on PHC in the European Region, 2018

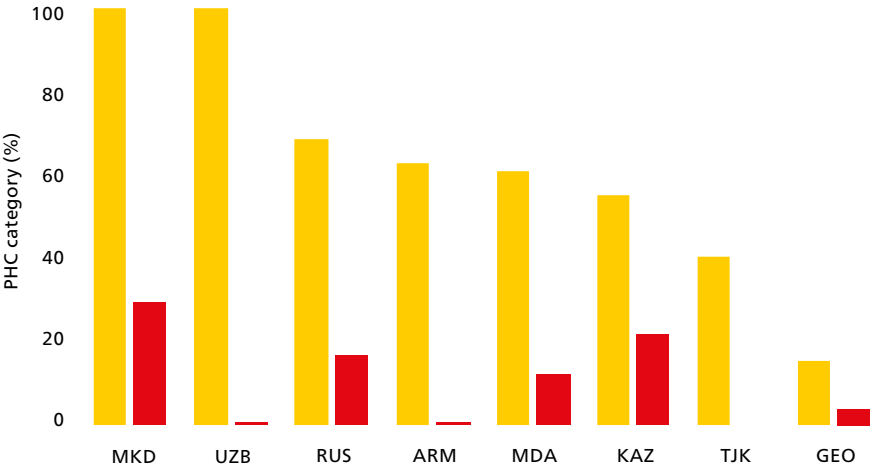


Notes: general outpatient care (except dental care) corresponds to HC.1.3.1, HC.1.3.nec, HC.1.4, HC.3.3 and HC.3.4; dental care HC.1.3.2; medicines and medical goods 80% of HC.5; administration 80% of HC.7; and preventive care HC.6. Data not available for all countries.

Source: WHO (2020a).

Medicines and dental care are an important component of PHC services and should therefore be financed by government but in many countries – including many high-income countries – these PHC components are the least likely to be publicly financed and are heavily reliant on out-of-pocket payments (WHO Regional Office for Europe, 2019). In the eight countries highlighted in this chapter, the public share of spending on medicines and medical goods is consistently much lower than the public share of spending on general outpatient care (Fig. 4.10). The public share of spending on dental care is also consistently very low in these countries – 1% in Armenia and 0.1% in Georgia (WHO, 2020a).

Fig. 4.10 Public spending as a share of spending on selected PHC categories in the European Region, 2018

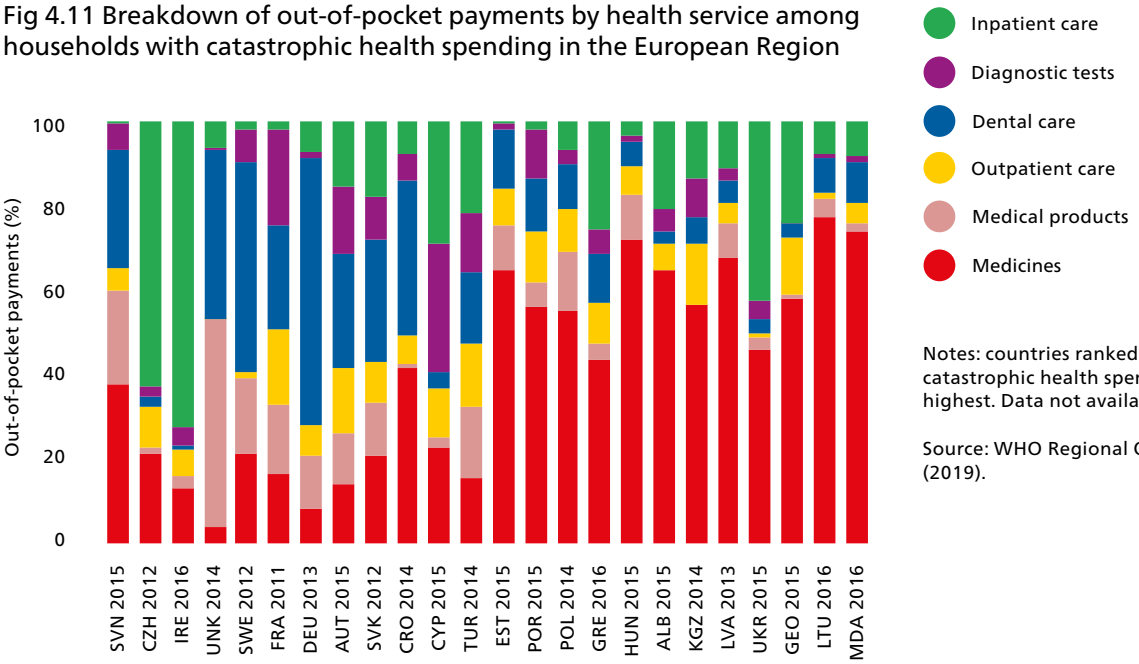


Notes: general outpatient care includes only general practitioners and family doctors (HC.1.3.1). Data not available for all countries.

Source: WHO (2020a).

Because levels of public spending on outpatient medicines and dental care tend to be low in countries across the European Region (not just in the eight countries shown here), medicines and dental care are a major driver of out-of-pocket payments and financial hardship. Fig. 4.11 shows the breakdown of out-of-pocket payments by health service in households with catastrophic health spending. In countries where financial protection is stronger (those on the left of Fig. 4.11), dental care is often the largest single driver of catastrophic health spending, while in countries where financial protection is weaker (those on the right of Fig. 4.11), catastrophic health spending is mainly driven by outpatient medicines. In all of these countries, outpatient medicines are the almost always the main driver of financial hardship among poorer households (WHO Regional Office for Europe, 2019; data not shown).

Fig 4.11 Breakdown of out-of-pocket payments by health service among households with catastrophic health spending in the European Region



Notes: countries ranked by incidence of catastrophic health spending from lowest to highest. Data not available for all countries.

Source: WHO Regional Office for Europe (2019).

Information on PHC spending and how it is financed are needed to monitor national and regional progress towards UHC. This analysis of PHC spending in 37 countries shows how PHC spending patterns vary across countries. Spending more on PHC is the most cost-effective way in which countries can make progress towards UHC. WHO calls on countries to invest an additional 1% of GDP publicly in PHC (WHO, 2019b). Tracking PHC spending is the first step to make this happen.

Increasing public spending on PHC has great potential to improve access to services in middle-income countries and improve the quality and efficiency of people-centred services in high-income countries. It also has the potential to improve financial protection in all countries, especially if accompanied by efforts to strengthen coverage policies.

Chapter 5

COVID-19: implications for health spending

Summary

Failure to control COVID-19 has led to the deepest economic shock in decades. It has not only hit countries harder than the global financial crisis but also affects a much wider group of countries in the European Region. Without urgent and substantial policy intervention, the economic recovery may take longer and be more uneven than forecasts predict, exacerbating socioeconomic inequalities within and between countries.

Countries were quick to mobilize additional funds for the health system in 2020. This higher level of public investment will need to be sustained in the years ahead to treat and prevent COVID-19, address the backlog created by widespread disruption to health services, mitigate the negative health effects of foregone care, unemployment and poverty and strengthen preparedness for future shocks.

Health financing policy is less resilient to economic shocks in countries where levels of public spending on health are low as a share of GDP and out-of-pocket payments are high, implying significant gaps in health coverage. Health systems are also vulnerable to economic shocks if public spending on health relies heavily on employment (SHI schemes), entitlement to health services is linked to health insurance status, and countercyclical mechanisms to mitigate the effects of rising unemployment and falling wages are lacking or weak.

Well-designed public policy can mitigate the negative effects of COVID-19 and build health system resilience. Key steps countries can take include: broadening the public revenue base for the health system; introducing and strengthening automatic stabilizers; de-linking access to health services from health insurance status; re-designing co-payment policy to protect people at risk of poverty or social exclusion and people with chronic conditions; reprioritizing the government budget to ensure sustained increases in public spending on health; and using priority-setting processes and other instruments to ensure additional public investment in the health system meets equity and efficiency goals.

Countries may find it challenging to invest more publicly in health as government revenue falls, but austerity is not a viable option. Austerity in the health sector in response to the global financial crisis slowed public spending on health, undermined progress towards UHC and increased socioeconomic inequalities. Two factors offer support to governments willing to put improving people's lives and livelihoods at the heart of the recovery from COVID-19. First, international financial institutions strongly encourage countries to continue to invest in health systems now, recognizing the damage austerity has caused and the importance of the health sector to societal well-being, economic development and resilience to future shocks; they should continue to support careful investment in health and well-being in the longer-term. Second, this shift in thinking is closely aligned with public preferences. Survey after survey carried out in the last 10 years has shown the extent to which people value good access to health care.

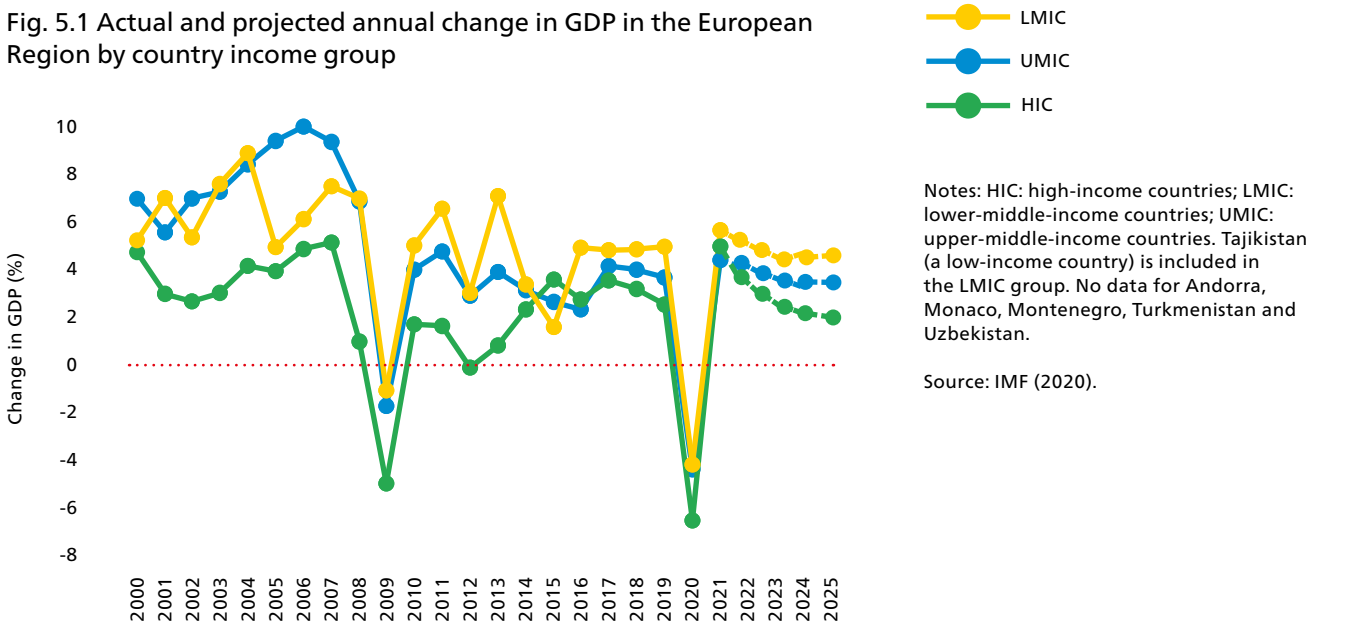
There is no economic recovery without health security. Health security requires political will, better tax systems and international solidarity. Many of the things people value most in life can only be achieved through the actions of well-resourced governments. All countries will benefit from efforts to reform tax systems so that they are more effective, fairer, better able to redistribute resources and aligned with policies that promote health and well-being. Increased investment in health and other social sectors is unlikely to be possible in all parts of the European Region without greater international solidarity.

COVID-19 has led to the deepest economic shock in decades

Failure to control COVID-19 has had a profound impact on societies and economies in Europe. Two key economic indicators – GDP and unemployment – suggest that the shock associated with COVID-19 is likely to be greater than the shock caused by the global financial crisis in 2008: it has not only hit countries harder but also affects a much wider group of countries in the European Region.

Data from the International Monetary Fund (IMF) indicate that the reduction in regional GDP in 2020 (–5.9%) was much larger than the regional reduction in 2009 (–3.8%) and more widespread (Fig. 5.1). In 2009 the economic contraction was deepest in high-income countries but in 2020 it was equally large across all country income groups (Fig. 5.1). Similarly, all country income groups experienced a sharp increase in unemployment in 2020 (Fig. 5.2).

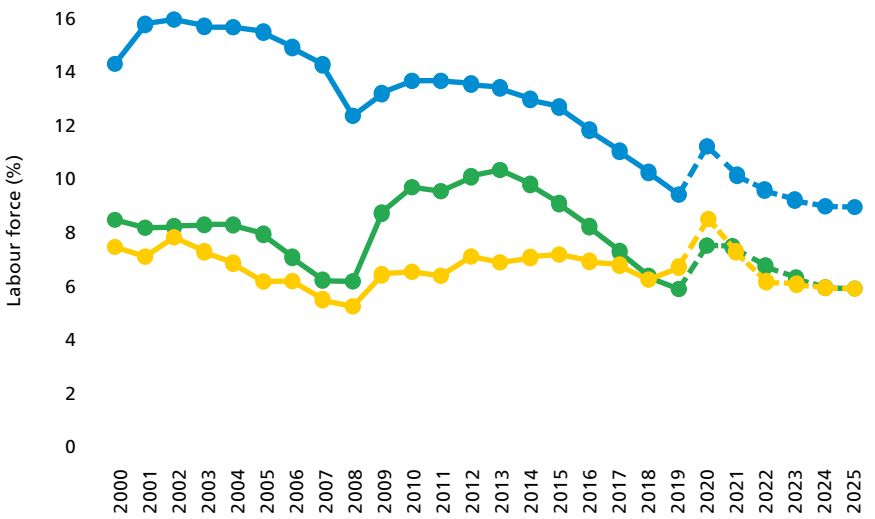
Fig. 5.1 Actual and projected annual change in GDP in the European Region by country income group



Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Tajikistan (a low-income country) is included in the LMIC group. No data for Andorra, Monaco, Montenegro, Turkmenistan and Uzbekistan.

Source: IMF (2020).

Fig. 5.2 Actual and projected unemployment rate in the European Region by country income group



Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Tajikistan (a low-income country) is included in the LMIC group. No data for Andorra, Monaco, Montenegro, Turkmenistan and Uzbekistan.

Source: IMF (2020).

Although IMF projections for GDP and unemployment indicate a relatively swift and even recovery across all country income groups (Fig. 5.1 and Fig. 5.2), these forecasts may be overly optimistic for several reasons.

- After the global financial crisis, it took nearly a decade for high-income countries to return to 2008 unemployment levels (Fig. 5.2).

- People in Europe appear to be among those most heavily affected by a reduction in working hours due to the high prevalence of zero-hour contracts, resulting in reduced wages rather than job loss for many workers, especially workers with low incomes (ILO, 2021; IMF, 2020). Countries in southern Europe, the Caucasus and central Asia experienced the highest reduction in working hours in the European Region in 2020 (ILO, 2021). The reduction in working hours has led to a sharp decline in the flow of remittances to countries, which was expected to shrink by 16% in 2020 (World Bank, 2020a).

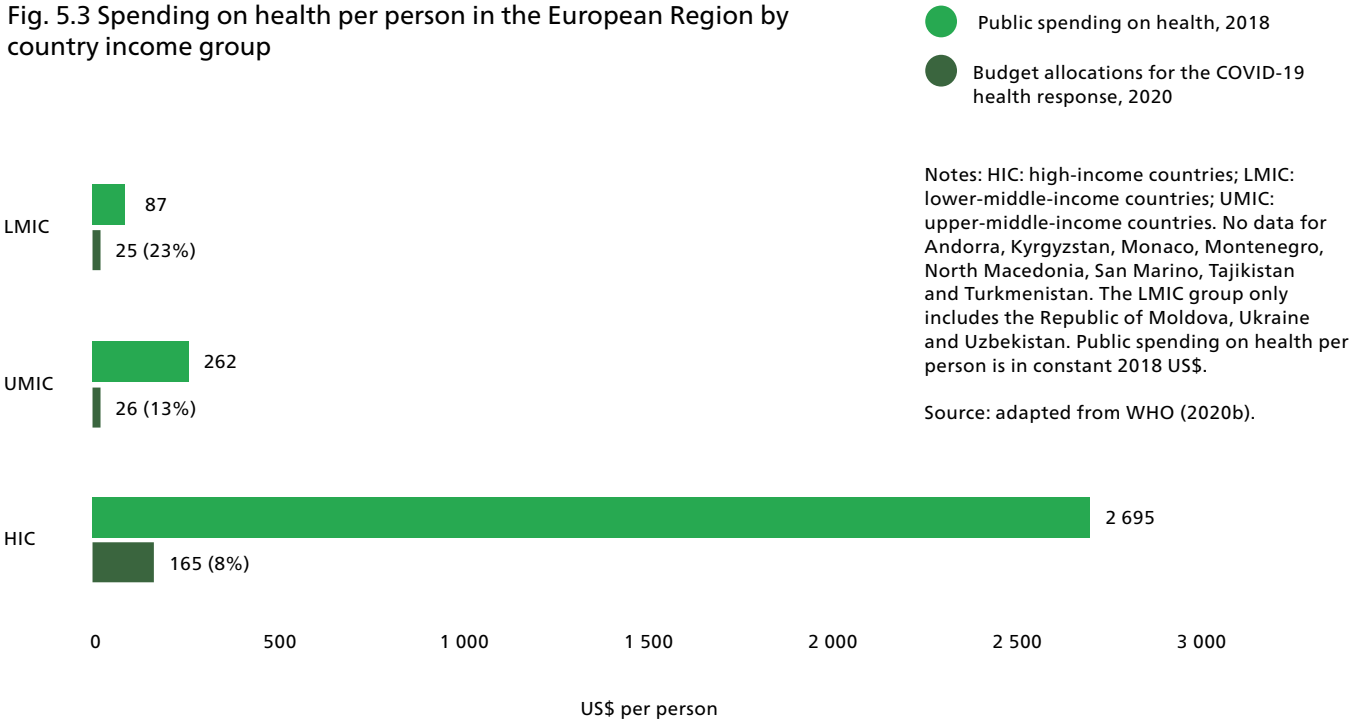
- The pandemic is exacerbating socioeconomic inequalities within and between countries. People who rely on volatile sources of income such as remittances and wages from zero-hour contracts or informal employment are likely to be at high risk of poverty and social exclusion. This is confirmed by World Bank poverty estimates, which suggest that a large increase in poverty in 2020 will widen inequalities across the European Region (World Bank, 2020b).

- So far, the rollout of COVID-19 vaccination programmes has been much faster in some countries than in others. Without substantially greater international cooperation and solidarity, the uneven availability of vaccines will delay the economic recovery in middle-income countries (OECD, 2021).

Countries were quick to mobilize additional public funds for the health system in 2020; this higher level of public investment will need to be sustained in the years ahead

Internationally comparable data on health spending on COVID-19 are not yet available. Some early evidence suggests that countries in the European Region mobilized significant additional public funds for the health system response in 2020. The magnitude of additional funding was proportionately larger in middle-income countries than in high-income countries, but from a much lower starting point in middle-income countries (Fig. 5.3).

Fig. 5.3 Spending on health per person in the European Region by country income group

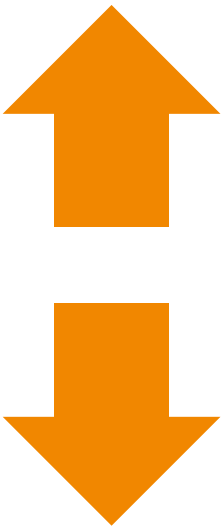


Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. No data for Andorra, Kyrgyzstan, Monaco, Montenegro, North Macedonia, San Marino, Tajikistan and Turkmenistan. The LMIC group only includes the Republic of Moldova, Ukraine and Uzbekistan. Public spending on health per person is in constant 2018 US$.

Source: adapted from WHO (2020b).

The implications of the pandemic for spending on health in 2021 and beyond depend on a range of factors, which are summarized in Fig. 5.4.

Fig. 5.4 Potential sources of pressure on health budgets in the context of COVID-19



Higher spending on health
COVID-19 health response, including vaccine rollout
Maintaining non-COVID-19 health services
Backlog of delayed or cancelled health services
Foregone care: lower health status, higher health service unit costs
Unemployment & poverty: higher demand for publicly financed health services
Preparedness for future shocks

Lower revenue for health
Economic contraction
Rising unemployment
Falling wages
Declining remittances
Increasing poverty
Cuts to external aid

Source: adapted from WHO (2020b).

Many countries will need significantly increased public investment in health to continue to treat and prevent COVID-19, address the backlog created by widespread disruption to health services, mitigate the negative health effects of foregone care, unemployment and poverty, and ensure the health system is prepared for future shocks. Evidence from the United Kingdom illustrates why health systems are likely to need substantial extra public funding in the medium and longer term (see Box 5.1).

Even though countries were quick to mobilize additional public funds for the health system response to COVID-19 in 2020, **pressure on health budgets will increase as government revenue falls** due to economic contraction, unemployment, reduced working hours and lower wages. IMF estimates suggest that government revenue in the European Region fell as a share of GDP by 1.5 percentage points in 2020 and will not revert to its 2019 share before 2026 (IMF, 2020).

As pressure on government budgets grows, governments may be less willing or able to increase public spending on health. Given the evidence highlighted in Box 5.1, however, failing to provide health systems with sustained increases in public investment in the coming years is likely to weaken performance and lower resilience to future shocks.

Box 5.1 Health system costs associated with service disruption and other factors relating to COVID-19 in the United Kingdom (England)

Substantial reductions in **primary care contacts for acute physical and mental conditions** occurred following the introduction of lockdown measures in March 2020, with limited recovery by July 2020 (Mansfield et al., 2021).

Elective admissions to hospital and general practitioner referrals to specialist care were around 70% lower in May 2020 than in May 2019 (Kraindler et al., 2020).

By March 2021, the number of people **waiting for hospital treatment** (4.5 million) was at its highest ever recorded level and the average wait had risen to 12.1 weeks, up from 8.4 weeks in January 2020 (The Health Foundation, 2021).

Without substantial policy intervention, large reductions in new prescriptions for preventive medication and diagnostic tests for heart disease could lead to 12 000 **additional heart attacks and strokes** in the next five years, as well as many **preventable deaths** (Patel et al., 2021).

Cancer screening, diagnosis and treatment have been significantly disrupted (Greenwood & Swanton, 2021), which is likely to result in a large increase in **preventable deaths** from cancer unless there is urgent policy intervention to manage the backlog in diagnostic services (Maringe et al., 2020).

Various studies indicate a deterioration in **mental health and well-being** among the general population, particularly women, young people and people living with small children (Pierce et al., 2020), health care staff in hospitals (Wanigasooriya et al., 2020) and health and social care workers (McFadden et al., 2021).

There is growing evidence of people experiencing **post-COVID-19 conditions**, which can seriously affect ability to work or have a social life and mental health (Rajan et al., 2021).

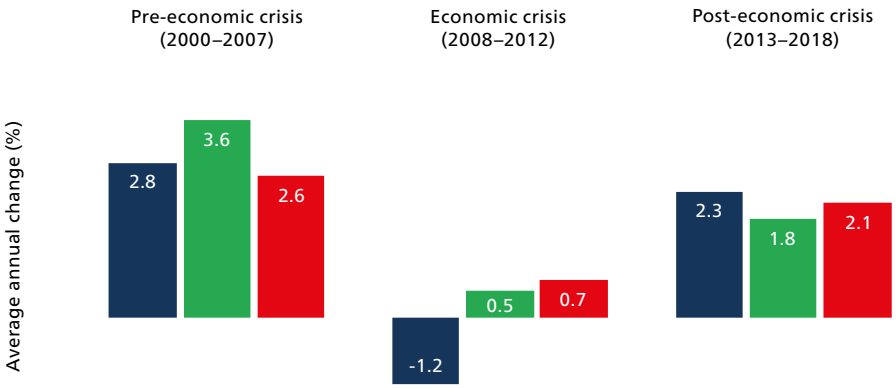
Learning from the global financial crisis: austerity slowed public spending on health, undermined progress towards UHC and increased socioeconomic inequalities

In the face of uncertainty about the health and economic outlook, it is useful to look at how spending on health in the European Region changed during and after the global financial crisis and understand the implications of these changes for health system performance.

Fig. 5.5 shows changes in GDP, public spending on health and out-of-pocket payments across the European Region in three broad periods: before the global financial crisis (2000–2007), during (2008–2012) and after (2013–2018).[24] Between 2000 and 2007, a period of strong economic growth, public spending on health grew faster than the economy and out-of-pocket payments (Fig. 5.5). From 2008 to 2012 GDP declined and out-of-pocket payments grew faster than the economy and public spending on health. Between 2013 and 2018 the economy grew again, but public spending on health did not keep pace with economic growth or, more importantly, with growth in out-of-pocket payments.

24. These periods are somewhat arbitrary because countries were affected at different times and the crisis continued well beyond 2012 in several countries. Changing the years does not change the broad picture, however.

Fig. 5.5 Change in GDP, public spending on health and out-of-pocket payments in the European Region



GDP

Public spending on health

Out-of-pocket payments

Notes: the figure is based on data in real values. No data for Montenegro.

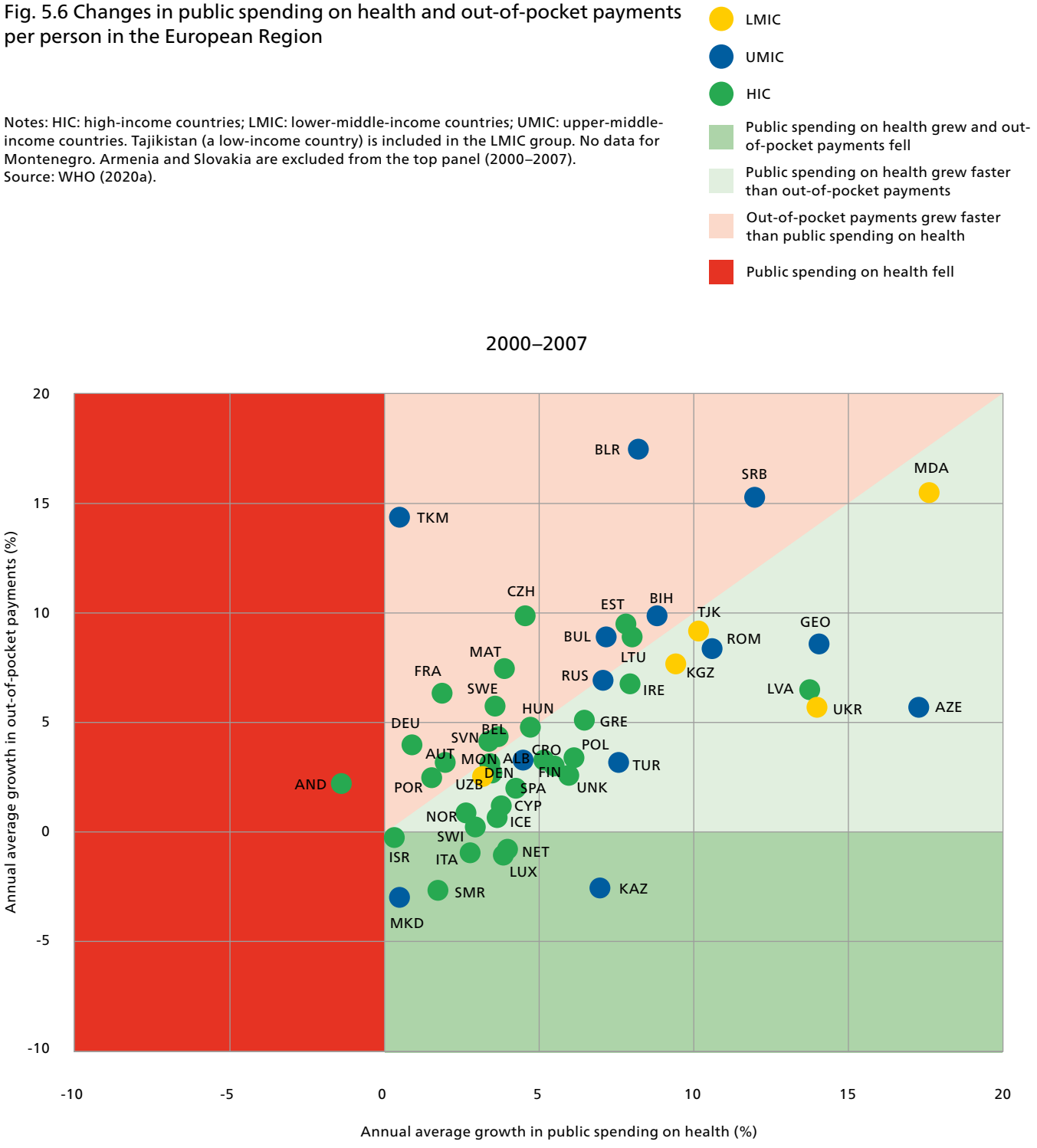
Source: WHO (2020a).

Fig. 5.6 shows changes in public spending on health and out-of-pocket payments across the same three periods by country. The shading in this figure indicates the likely impact of changes in spending on health system performance, ranging from most likely to be positive (darker green) to most likely to be negative (darker red).

The period before the global financial crisis is marked by strong growth in public spending on health across the European Region. Public spending on health grew faster than out-of-pocket payments in all lower-middle-income countries, in two-thirds of high-income countries and in over half of upper-middle-income countries (green shading in the first panel of Fig. 5.6). Public spending on health grew by 10% or more a year in Armenia, Azerbaijan, Georgia, Latvia, the Republic of Moldova, Romania, Serbia, Tajikistan and Ukraine. Out-of-pocket payments grew by 10% or more a year in Armenia, Belarus, Bosnia and Herzegovina, Czechia, the Republic of Moldova, Serbia, Slovakia and Turkmenistan.

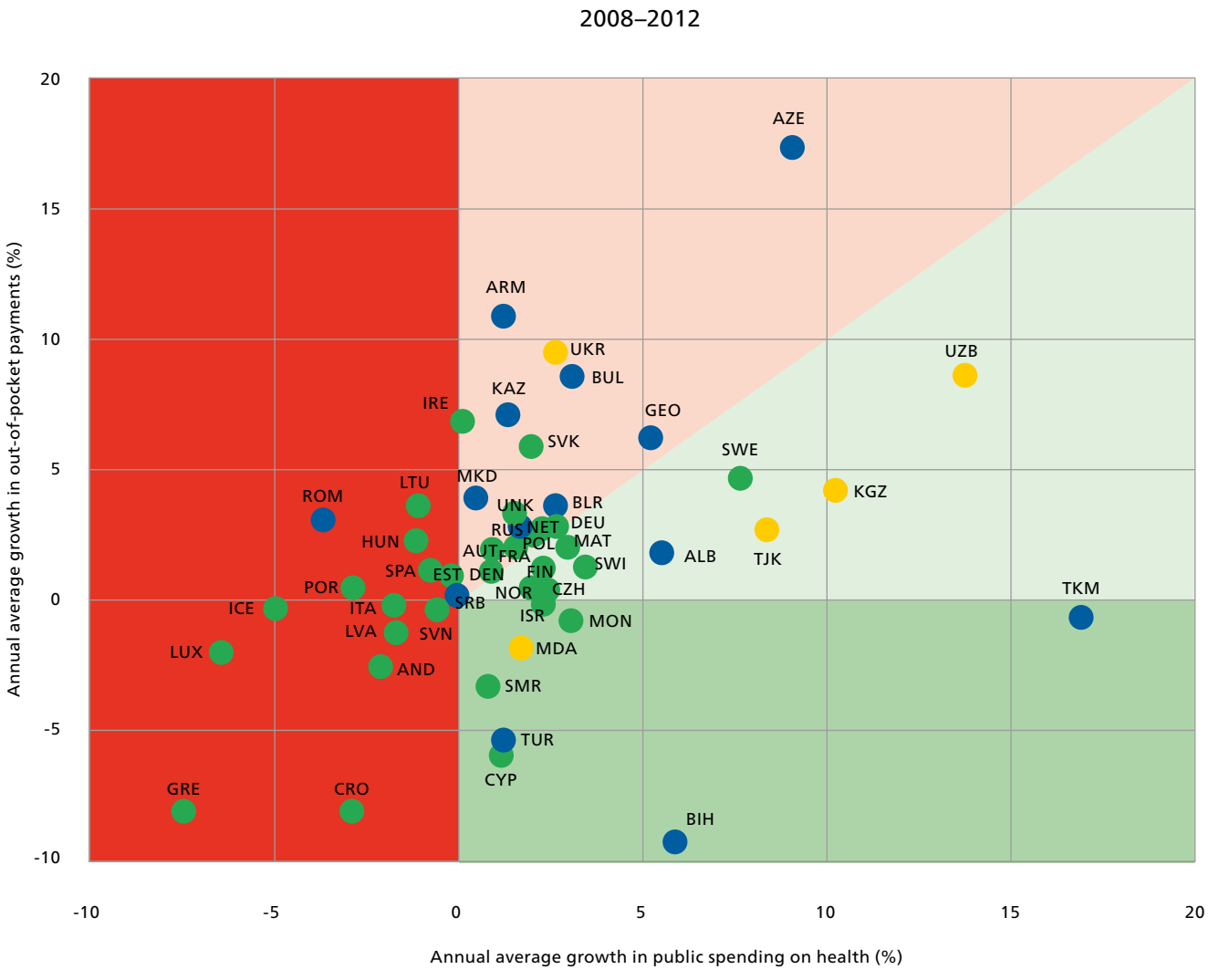
Fig. 5.6 Changes in public spending on health and out-of-pocket payments per person in the European Region

Notes: HIC: high-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Tajikistan (a low-income country) is included in the LMIC group. No data for Montenegro. Armenia and Slovakia are excluded from the top panel (2000–2007).
Source: WHO (2020a).



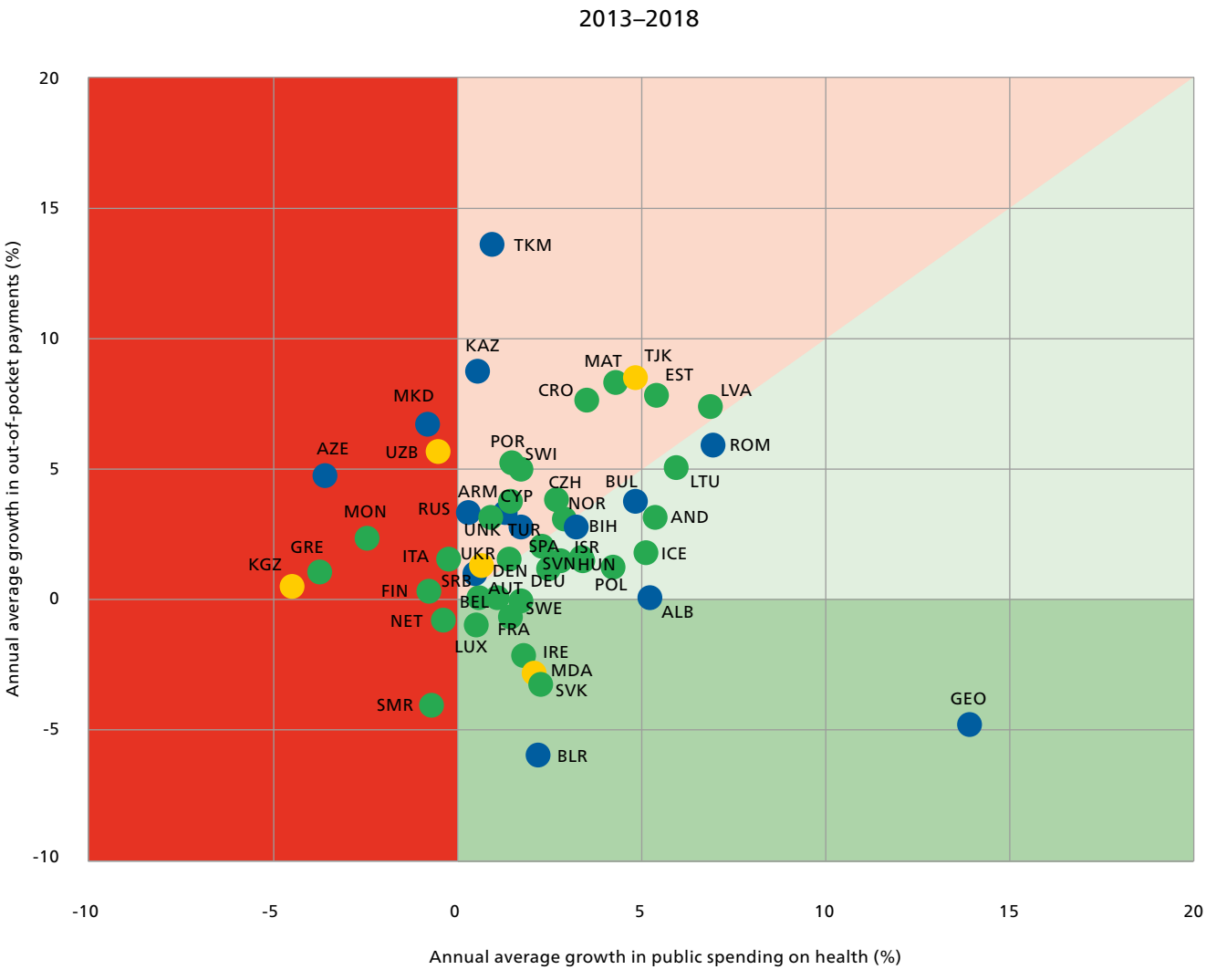
During the crisis, from 2008 to 2012, there was a significant shift away from public spending on health. Many countries moved into the red shaded part of the figure, especially the darker red part. Out-of-pocket payments grew faster than public spending on health in two-thirds of upper-middle-income countries and many high-income countries (red shading in the middle panel of Fig. 5.6). In most lower-middle-income countries, however, public spending on health continued to grow faster than out-of-pocket payments. Public spending on health barely grew in Ireland and Serbia and declined in Andorra, Croatia, Estonia, Greece, Hungary, Iceland, Italy, Latvia, Lithuania, Luxembourg, Portugal, Romania, Slovenia and Spain.

Fig. 5.6 contd



The shift away from public spending on health was not reversed in the post-crisis period. Between 2013 and 2018 out-of-pocket payments grew faster than public spending on health in most lower-middle-income countries and around half of upper-middle-income and high-income countries (red shading in the bottom panel of Fig. 5.6). Public spending on health declined in Azerbaijan, Finland, Greece, Italy, Kyrgyzstan, Monaco, the Netherlands, North Macedonia, San Marino and Uzbekistan. Out-of-pocket payments grew faster than public spending on health between 2008 and 2012 *and* between 2013 and 2018 in Armenia, Azerbaijan, Croatia, Estonia, Greece, Italy, Kazakhstan, Latvia, North Macedonia, Portugal, the Russian Federation and the United Kingdom.

Fig. 5.6 contd



Analysis of policy responses to the global financial crisis shows how health systems in Europe struggled to cope with a reduction in public investment: unable to do *the same* with *less*, many countries cut staff salaries and restricted coverage, often by increasing user charges (co-payments) (Thomson et al., 2015). These austerity measures were sometimes required as part of economic adjustment programmes initiated by the European Union (EU), the European Central Bank and the IMF (known collectively as "the Troika"). In other countries, such as the United Kingdom, austerity was self-imposed.

As a result of austerity in the health sector, several countries in Europe had lower levels of public spending on health per person in 2018 than in previous years (WHO, 2020a). Greece was one of them. Public spending on health per person in Greece fell sharply in real terms between 2009 and 2014, in response to a Troika requirement not just to reduce public spending on health but to keep it below 5% of GDP (Thomson et al., 2015; WHO, 2020a). Out-of-pocket payments per person also fell in real terms between 2008 and 2012, as unemployment and poverty spiked, but grew again from 2013 as cuts and coverage restrictions shifted health care costs onto households (Thomson et al., 2015; Economou et al., 2017; WHO, 2020a). The outcome of austerity in Greece was a prolonged deterioration in access to health services and financial protection, demonstrated by an increase in unmet need for health care and catastrophic health spending (Fig. 5.7), both of which are heavily concentrated among the poorest fifth of the population (disaggregation not shown in Fig. 5.7).

Austerity was accompanied by an increase in unmet need for health and dental care in many countries in Europe and an increase in catastrophic health spending in countries heavily affected by the crisis (Chletsos et al., in press; European Commission, 2016; Eurostat, 2021; Johnston et al. 2020; Kontemeniotis & Theodorou, 2021; Taube et al., 2018). Both of these negative outcomes were consistently more likely to be experienced by people at risk of poverty or social exclusion (WHO Regional Office for Europe, 2019).

The experience of the global financial crisis has important implications for the current situation in Europe.

- Public spending on health slowed at a time when the need for publicly financed health services was growing, creating a gap between the resources health systems needed and the resources available to them. This gap weakened health system performance in many countries, not just in those that were badly affected by the economic crisis.

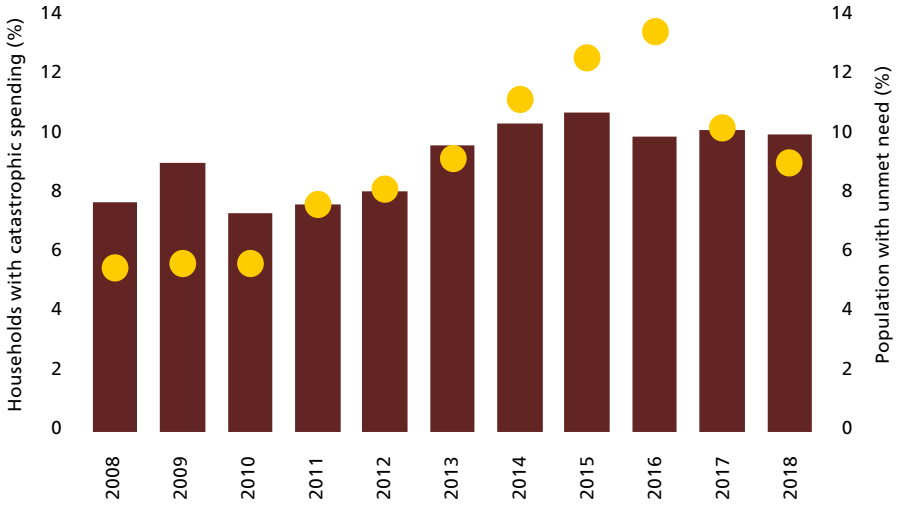
- Austerity in the health sector shifted health care cost onto households, which undermined national and regional progress towards UHC.

- By failing to put in place measures to protect people at risk of poverty or social exclusion, policy responses to austerity exacerbated socioeconomic inequalities.

- Health systems were not as well equipped to meet the challenges posed by COVID-19 as they might have been in the absence of austerity.

As countries recover from the pandemic, investing in health should be a priority for governments, to prevent the emergence of a gap between the resources that health systems require and the resources they are allocated. Governments also need to pay attention to how resources are used, to avoid any further widening of inequalities.

Fig. 5.7 Change in catastrophic health spending and unmet need for health care due to cost, distance and waiting time in Greece, 2008–2018



Notes: population refers to people aged 16 years and over.

Sources: adapted from WHO Regional Office for Europe (2019) and Chletsos et al. (in press). Data on unmet need from Eurostat (2021).

Health financing policy is less resilient to economic shocks in some countries

Health financing policy plays an important role in building health system resilience to shocks (Thomson et al., 2015; Thomas et al., 2020). Health systems are particularly vulnerable to shocks when levels of public spending on health are low as a share of GDP and out-of-pocket payments are high as a share of current spending on health, implying significant gaps in health coverage. In an economic shock, health systems will also be vulnerable if public spending on health relies heavily on employment (SHI schemes) and countercyclical mechanisms to mitigate the effects of rising unemployment and falling wages are lacking or weak.

Chapter 2 showed how low levels of public spending on health generally result in high levels of out-of-pocket payment, which in turn increases the likelihood of unmet need and financial hardship (see Fig. 2.9). It is difficult for countries to provide strong financial protection when out-of-pocket payments account for more than around 15% of current spending on health (see Fig. 2.7). In 2018 three-quarters of the countries in the European Region exceeded this threshold (see Fig. 2.8).

Countries that relied heavily on out-of-pocket payments before COVID-19 – especially if public spending on health was low as a share of GDP – may find it hard to prevent increases in unmet need and financial hardship in the coming years (Fig. 5.8). If out-of-pocket spending slows in the wake of the pandemic, as it did after the global financial crisis (Fig. 5.5), this shift should not be (mis)interpreted as improved financial protection but understood as the likely outcome of foregone care caused by health service disruption and financial barriers to access linked to rising unemployment and poverty. It is clear from the experience of Greece and other countries in Europe that financial hardship can increase even when out-of-pocket spending decreases (WHO Regional Office for Europe, 2019).

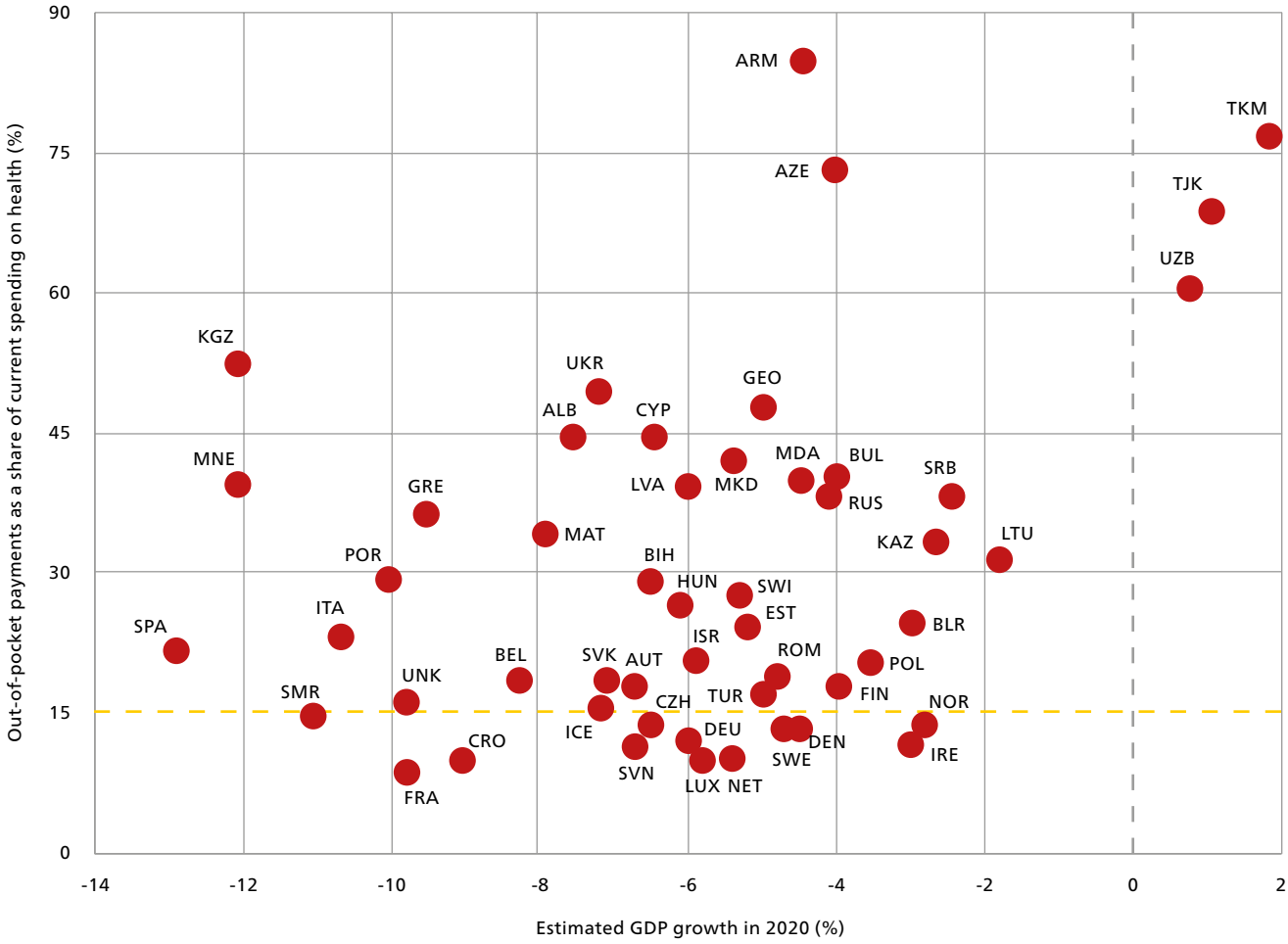
Chapter 3 showed how over half of the countries in the European Region (28 in 2018) mainly channel public spending on health through SHI schemes (see Fig. 3.1). Many SHI schemes rely heavily on contributions levied on wages (payroll taxes), which constitute a narrow public revenue base in comparison to the government budget as a whole. The more a health system is financed through wages, the more cyclical it is likely to be: its revenue will *automatically* shrink when the economy contracts, unless countercyclical mechanisms are in place to prevent this from happening.

Another cyclical design feature commonly associated with SHI schemes is the linking of entitlement to health care to payment of social insurance contributions. This practice has led to gaps in population coverage being systematically larger in countries with SHI schemes (see Fig. 3.5). In the context of an economic downturn, it also means that people are likely to lose health coverage and access to health services just as they need it most.

Fig. 5.8 Out-of-pocket payments as a share of current spending on health in 2018 and estimated GDP growth in 2020 in the European Region

Note: the figure does not include data for Andorra and Monaco. The orange line indicates out-of-pocket payments at 15% of current spending on health.

Sources: IMF (2020), WHO (2020a).



Public policy can mitigate the negative effects of COVID-19 and build health system resilience

The following steps will help countries to tackle cyclicality in the design of health financing policy, ensure that out-of-pocket payments do not result in financial barriers to access or financial hardship, and increase the priority given to health in allocating government spending.

Broaden the public revenue base for the health system. Greater use of government budget transfers can address the problem of cyclicality in SHI schemes (revenue falling as the economy contracts). Almost all SHI schemes in the European Region already benefit from government budget support, but in some countries budget support is low as a share of SHI scheme revenue (see Fig. 3.4) and should be increased. Early evidence suggests several countries quickly moved to increase budget support to prevent a reduction in SHI scheme revenue from wage-based contributions (WHO Regional Office for Europe et al., 2021). Replacing this type of discretionary policy response with automatic stabilizers would help to mitigate uncertainty in the future (Orszag, Rubin & Stiglitz, 2021).

Introduce and strengthen automatic stabilizers. All health systems would benefit from automatic stabilizers – mechanisms that explicitly link the allocation of financial (and human) resources for health to population health needs, enabling resources to increase in line with needs. Some countries in Europe already use formulas to enhance the countercyclicality of government budget transfers to SHI schemes, an example of good practice that should be more widely adopted, alongside other automatic stabilizers.

De-link access to health services from health insurance status. SHI schemes that link entitlement to payment of contributions systematically discriminate against people in relatively vulnerable situations – those who lose jobs or whose wages are falling and can no longer afford to pay contributions. This outcome is also unfair where SHI schemes benefit from government budget support because many people excluded from coverage will have contributed to the government budget through payment of other taxes. De-linking entitlement from payment of contributions, so that people can access health care regardless of health insurance status, will reduce financial barriers to access.

Re-design co-payment policy to protect people at risk of poverty or social exclusion and people with chronic conditions. A large body of evidence indicates that user charges (co-payments) are not a good instrument for guiding health care decision-making, undermine access, financial protection and efficiency, and harm health (Swartz, 2010; Chandra et al., 2021; Chernew et al., 2021). Because there is no economic rationale for user charges, countries should avoid introducing or increasing them. If user charges are already in place, however, they can be re-designed to make them less harmful through exemptions for people at risk of poverty and people with chronic conditions, annual caps on all

co-payments, and the replacement of percentage co-payments with low, fixed co-payments (WHO Regional Office for Europe, 2019). Better co-payment policy helps to reduce financial barriers to access and financial hardship by allowing the health system to target the people most in need of protection.

Reprioritize the government budget to ensure sustained increases in public spending on health. Many health systems in the European Region will need substantial additional public funding in the medium and longer term. Failing to increase public investment is likely to weaken health system performance and lead to negative social and economic outcomes. Increased investment will entail some reprioritization of the government budget in favour of the health system and other sectors that have a significant impact on health, such as social protection and education.

Use priority-setting processes and other instruments to ensure additional public investment in the health system meets equity and efficiency goals. Policy responses to the global financial crisis show how the so-called savings generated by health budget cuts and coverage restrictions were generally likely to undermine efficiency and equity (Thomson et al., 2015). Very few health systems in Europe were able to do *the same* with less, let alone *more* with less. New investment, however, can be directed towards meeting equity and efficiency goals – for example, if additional funds are used to strengthen PHC, core public health functions and preparedness for future shocks; target under-resourced parts of the health system and underserved groups of people; and minimize fragmentation and duplication.

Austerity is not an option: there is no economic recovery without health security

Faced with the need for higher public spending on health and the prospect of a reduction in government revenue, countries may find it challenging to think of reprioritizing government spending to favour health, social protection and education. It is clear, however, that austerity is not a viable option. Health budget cuts and coverage restrictions led to negative outcomes after the global financial crisis. They can only undermine health system performance and the recovery from COVID-19 in the months and years ahead.

Two factors offer support to governments willing to put improving people's lives and livelihoods at the heart of the recovery.

First, international financial institutions strongly encourage countries to invest in health systems and have recently warned against premature withdrawal of government support on the grounds that failing to provide continuing investment would slow the speed of recovery (European Commission, 2021; IMF, 2021; OECD, 2021). Their advice today marks a clear departure from the cuts to public social spending fostered through

earlier economic adjustment programmes. It is a fundamental shift in approach, reflecting on one hand recognition of the damage austerity caused after the global financial crisis (Stuckler et al., 2017; Szczepanski, 2019; Rajmil et al., 2020) and, on the other, the importance of the health sector to societal well-being, economic development and resilience to future shocks.

Second, this shift in thinking among international financial institutions is closely aligned with public preferences. Survey after survey carried out in the last 10 years has shown the extent to which people value access to health care and public investment in health systems and other social sectors (European Bank for Reconstruction and Development, 2011, 2016; OECD, 2019b; United Nations, 2021).

Health security requires political will, better tax systems and international solidarity

Many of the things people value most in life can only be achieved through the actions of well-resourced governments. Prompted by need, and with support from international financial institutions and changing public opinion, all countries will benefit from efforts to reform tax systems so that they are more effective, fairer, better able to redistribute resources and aligned with policies that promote health and well-being. Policy options include closing loopholes that allow individuals and corporations to avoid taxes, closing tax havens, removing tax deductions that favour richer people, taxing wealth and making greater use of taxes that penalize activities harmful to human and planetary health – for example, taxes on carbon, tobacco, alcohol and sugary drinks (European Commission, 2020; IMF, 2020; OECD, 2020b). Carbon and other health taxes do not need to be earmarked for health, however, as earmarking has not been shown to be an effective instrument for increasing public investment in health (Cashin et al., 2017). It is not earmarking so much as political commitment to health that is the decisive factor.

Increased investment in health and other social sectors is unlikely to be possible in all parts of the European Region without greater international solidarity (European Commission, 2020; IMF, 2021; OECD, 2021). As this report has shown, health systems in many countries are characterized by low levels of public spending and heavy reliance on out-of-pocket payments, which already limits progress towards UHC and weakens resilience to shocks. Some of these countries have also experienced a reduction in external aid in recent years (see Fig. 1.7). In 2020 the EU strengthened international solidarity by setting up a Recovery and Resilience Facility to offer its Member States grants and loans financed through EU-wide borrowing – another welcome departure from responses to the global financial crisis – but more needs to be done by all international actors for middle-income countries in the European Region. This is also a matter of political will.

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Annex 1
Country income group classification for 2018

Country	Code	Income group
Albania	ALB	UMIC
Andorra	AND	HIC
Armenia	ARM	UMIC
Austria	AUT	HIC
Azerbaijan	AZE	UMIC
Belarus	BLR	UMIC
Belgium	BEL	HIC
Bosnia and Herzegovina	BIH	UMIC
Bulgaria	BUL	UMIC
Croatia	CRO	HIC
Cyprus	CYP	HIC
Czechia	CZH	HIC
Denmark	DEN	HIC
Estonia	EST	HIC
Finland	FIN	HIC
France	FRA	HIC
Georgia	GEO	UMIC
Germany	DEU	HIC
Greece	GRE	HIC
Hungary	HUN	HIC
Iceland	ICE	HIC
Ireland	IRE	HIC
Israel	ISR	HIC
Italy	ITA	HIC
Kazakhstan	KAZ	UMIC
Kyrgyzstan	KGZ	LMIC
Latvia	LVA	HIC
Lithuania	LTU	HIC
Luxembourg	LUX	HIC
Malta	MAT	HIC
Monaco	MON	HIC
Montenegro	MNE	UMIC
Netherlands	NET	HIC
North Macedonia	MKD	UMIC
Norway	NOR	HIC

Notes: HIC: high-income countries; LIC: low-income countries; LMIC: lower-middle-income countries; UMIC: upper-middle-income countries. Tajikistan (a low-income country) is included in the LMIC group in this report.

Source: World Bank (2021). World Bank Country and Lending Groups. In: The World Bank [website]. Washington (DC): World Bank (https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups, accessed 9 March 2021).

Country	Code	Income group
Poland	POL	HIC
Portugal	POR	HIC
Republic of Moldova	MDA	LMIC
Romania	ROM	UMIC
Russian Federation	RUS	UMIC
San Marino	SMR	HIC
Serbia	SRB	UMIC
Slovakia	SVK	HIC
Slovenia	SVN	HIC
Spain	SPA	HIC
Sweden	SWE	HIC
Switzerland	SWI	HIC
Tajikistan	TJK	LIC
Turkey	TUR	UMIC
Turkmenistan	TKM	UMIC
Ukraine	UKR	LMIC
United Kingdom	UNK	HIC
Uzbekistan	UZB	LMIC

Annex 2
Data availability by health care functions in 2018

Note: (–) means no data are available or no data are reported; (x) means data are reported.

Source: adapted from OECD (2020); WHO (2020).

Country	General outpatient curative care (HC.1.3.1)	Dental outpatient curative care (HC.1.3.2)	Specialized outpatient curative care (HC.1.3.3)	Home-based curative care (HC.1.4)	Outpatient rehabilitative care (HC.2.3)	Home-based rehabilitative care (HC.2.4)	Outpatient long-term care (HC.3.3)
ALB	–	–	–	–	–	–	–
AND	–	–	–	–	–	–	–
ARM	X	X	X	X	X	X	X
AUT	X	X	X	–	X	X	–
AZE	–	–	–	–	–	–	–
BEL	X	X	X	–	X	X	X
BIH	X	X	X	X	X	X	–
BLR	–	–	–	–	–	–	–
CRO	–	–	–	–	–	–	–
BUL	–	–	–	–	–	–	–
CYP	–	–	–	–	–	–	–
CZH	X	X	X	–	X	X	–
DEN	X	X	X	–	X	X	–
DEU	X	X	X	–	X	X	–
EST	X	X	X	–	X	X	X
FIN	X	X	X	–	X	X	–
FRA	–	–	–	–	X	X	–
GEO	X	X	X	X	X	X	–
GRE	–	X	–	–	–	–	–
HUN	X	X	X	–	X	X	–
ICE	X	X	X	–	X	X	–
IRE	–	–	–	–	–	X	–
ISR	–	–	–	–	–		–
ITA	–	–	–	–	–	X	X
KAZ	X	X	X	–	–	–	–
KGZ	X	X	X	X	X	X	–
LTU	X	X	X	–	X	X	X
LUX	X	X	X	–	X	X	X
LVA	X	X	X	–	X	X	X
MAT	–	–	–	–	–	–	–
MDA	X	X	X	X	X	X	–
MKD	X	X	X	X	X	X	–

Home-based long-term care (HC.3.4)	Laboratory services (HC.4.1)	Imaging services (HC.4.2)	Patient transportation (HC.4.3)	Medical goods (HC.5)	Preventive care (HC.6)	Governance, and health system and financing administration (HC.7)	Country
–	–	–	–	–	–	–	ALB
–	–	–	–	–	–	–	AND
–	X	X	X	X	X	X	ARM
X	X	X	X	X	X	X	AUT
–	–	–	–	–	–	–	AZE
X	X	X	X	X	X	X	BEL
X	X	X	X	X	X	X	BIH
–	–	–	–	–	–	–	BLR
–	–	–	–	–	–	–	CRO
–	–	–	–	–	–	–	BUL
–	–	–	–	–	–	–	CYP
X	X	X	X	X	X	X	CZH
X	X	X	X	X	X	X	DEN
X	X	X	X	X	X	X	DEU
X	X	X	X	X	X	X	EST
X	X	X	X	X	X	X	FIN
X	X	X	X	X	X	X	FRA
–	X	X	X	X	X	X	GEO
X	X	X	X	X	X	X	GRE
X	X	X	X	X	X	X	HUN
X	X	X	X	X	X	X	ICE
X	–	–	–	X	X	X	IRE
–	–	–	–	–	–	–	ISR
X	–	–	–	X	X	X	ITA
–	–	X	X	X	X	X	KAZ
–	X	–	–	X	X	X	KGZ
X	X	X	X	X	X	X	LTU
X	X	X	X	X	X	X	LUX
X	X	X	X	X	X	X	LVA
–	–	–	–	–	–	–	MAT
–	X	X	X	X	X	X	MDA
–	X	X	X	X	X	X	MKD

Country	General outpatient curative care (HC.1.3.1)	Dental outpatient curative care (HC.1.3.2)	Specialized outpatient curative care (HC.1.3.3)	Home-based curative care (HC.1.4)	Outpatient rehabilitative care (HC.2.3)	Home-based rehabilitative care (HC.2.4)	Outpatient long-term care (HC.3.3)
MNE	–	–	–	–	–	–	–
MON	–	–	–	–	–	–	–
NET	X	X	X	–	X	X	X
NOR	X	X	X	–	–	–	–
POL	X	X	X	–	X	X	X
POR	–	–	–	–	X	X	–
ROM	–	–	–	–	–	–	–
RUS	–	X	–	–	–	X	X
SMR	–	–	–	–	–	–	–
SPA	X	X	X	–	–	X	–
SRB	–	–	–	–	–	–	–
SVK	X	X	X	–	X	–	X
SVN	X	X	X	–	X	X	–
SWE	X	X	X	–	X	X	–
SWI	X	X	X	–	X	–	–
TJK	X	X	X	–	–	X	–
TKM	–	–	–	–	–	–	–
TUR	–	–	–	–	–	–	–
UKR	–	–	–	–	–	–	–
UNK	–	–	–	–		X	X
UZB	X	X	X	–	–	–	–

Home-based long-term care (HC.3.4)	Laboratory services (HC.4.1)	Imaging services (HC.4.2)	Patient transportation (HC.4.3)	Medical goods (HC.5)	Preventive care (HC.6)	Governance, and health system and financing administration (HC.7)	Country
–	–	–	–	–	–	–	MNE
–	–	–	–	–	–	–	MON
X	X	X	X	X	X	X	NET
X	X	–	X	X	X	X	NOR
X	X	X	X	X	X	X	POL
X	–	–	–	X	X	X	POR
–	–	–	–	–	–	–	ROM
–	X	–	X	X	X	X	RUS
–	–	–	–	–	–	–	SMR
X	X	X	X	X	X	X	SPA
–	–	–	–	–	–	–	SRB
X	X	X	X	X	X	X	SVK
X	X	X	X	X	X	X	SVN
X	X	–	X	X	X	X	SWE
X	X	X	X	X	X	X	SWI
–	X	X	X	X	X	X	TJK
–	–	–	–	–	–	–	TKM
–	–	–	–	–	–	–	TUR
–	–	–	–	–	–	–	UKR
X	–	–	–	X	X	X	UNK
–	X	X	X	X	X	X	UZB

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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