Out-of-Pocket Spending: Access to care and financial protection

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Households are directly responsible for funding a fifth of all health spending across the OECD

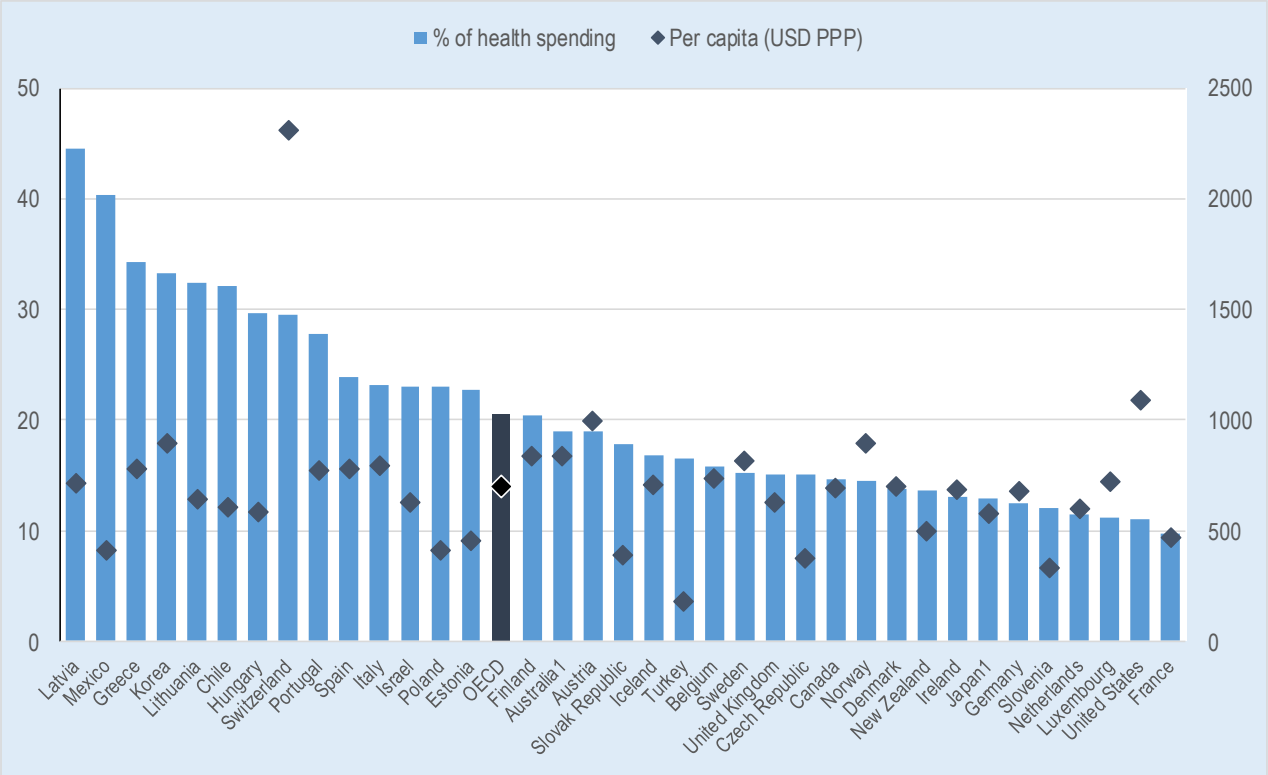
Across the 36 countries of the OECD, direct payments by households - out-of-pocket (OOP) spending (Box 1) - accounted for more than 20% of health spending on average, the equivalent of 700 USD per person.

In Latvia and Mexico, this share was 40% or more, while in Greece, Korea, Lithuania and Chile, around a third of all health spending was still accounted for by OOP payments. On the other hand, the figure was closer to 10% of health spending in France, the United States, Luxembourg, and the Netherlands (Figure 1), although in the case of the United States, this represents more than 1 000 USD per person. Switzerland is notable as both a high overall spender on healthcare, and a country with a significant proportion of this financed directly through household spending.

While average OOP spending as a share of health spending in the OECD as a whole has remained largely constant over the last decade, there have been notable shifts in some countries. As public coverage has expanded in countries such as Chile, Mexico and Turkey, the direct burden on households has fallen. On the other hand, Greece, Spain, and Portugal saw an increasing shift in healthcare financing towards patients, partly as a response to the global financial crisis of 2008.

The level of health spending paid directly by patients can indicate potential issues concerning access to services and financial protection against the cost of health care. However, obligations on households to purchase health insurance (e.g. in the United States, Netherlands and France) as well as foregone treatment due to cost need to be taken into account for a full assessment of the financial burden and access to care.

Figure 1. One in every five health dollars is paid out-of-pocket by households across the OECD



1. Data refer to 2015.
Source: OECD Health Statistics 2018 (Data refer to 2016).

Pharmaceuticals and dental services account for over half of household payments on healthcare

Across OECD countries, more than two-thirds of out-of-pocket spending goes on pharmaceuticals (36% of the total), dental care (17%) and outpatient services (16%). Therapeutic appliances and other durable medical goods (such as glasses and hearing aids) (10%) and inpatient care (7%) play a lesser but still important role overall.

Outpatient and dental care services represented more than half the total household spending on health in Israel, Switzerland and Luxembourg. While in Mexico, Poland, Canada and the Czech Republic, payments for pharmaceuticals (including over-the-counter medicines) accounted for the majority of OOP spending.

OOP spending includes both direct payments, where no financial coverage exists (i.e. the patient bears the full cost) as well as arrangements whereby patients share the cost with a third-party payer, such as a social health insurance fund or government scheme. The existence of co-payments or user charges for certain services can impact the overall structure of OOP spending.

For example, in the Netherlands and Korea, cost-sharing for inpatient care accounted for a higher-than-average 15% of household spending on health in both countries, even if the overall OOP share of health spending in Korea was three times that in the Netherlands.

Households fund two-thirds of spending on dental care and medical devices

In most OECD countries, out-of-pocket payments tend to play a bigger role when it comes to funding dental services and pharmaceuticals, and less so in the case of inpatient, outpatient and long-term care services.

In 2016, for example, Mexico and Greece were the only two OECD countries with more than 20% of inpatient care spending coming from OOP payments, compared to an overall OECD average of around 9% (Figure 2). This indicates that in most countries, inpatient care is covered relatively well by public or private health financing schemes.

For outpatient services (excluding dental care), the average share paid out of pocket was higher at around 19%. But this ranged from as little as 6% of outpatient spending in Canada to relatively high levels in Latvia, Hungary and Switzerland, where they represented 45%, 39%, and 34%, respectively.

Dental care and pharmaceuticals, on the other hand, are typically more dependent on direct household payments and private insurance due to limited publicly-funded coverage, although the extent can still vary substantially. Almost two-thirds of dental care spending in OECD countries on average is paid directly, ranging from as low as 20% in Slovenia to being almost fully financed by households in Greece.

The share of OOP payments for pharmaceuticals as a whole is heavily influenced by the scope of coverage, the degree of exemptions and the type of cost-sharing arrangements (including through private insurance) in place. In 2016, the average OOP share of the total spending on prescribed drugs was 29%, with households funding close to half of overall spending in Hungary, Latvia and Norway.

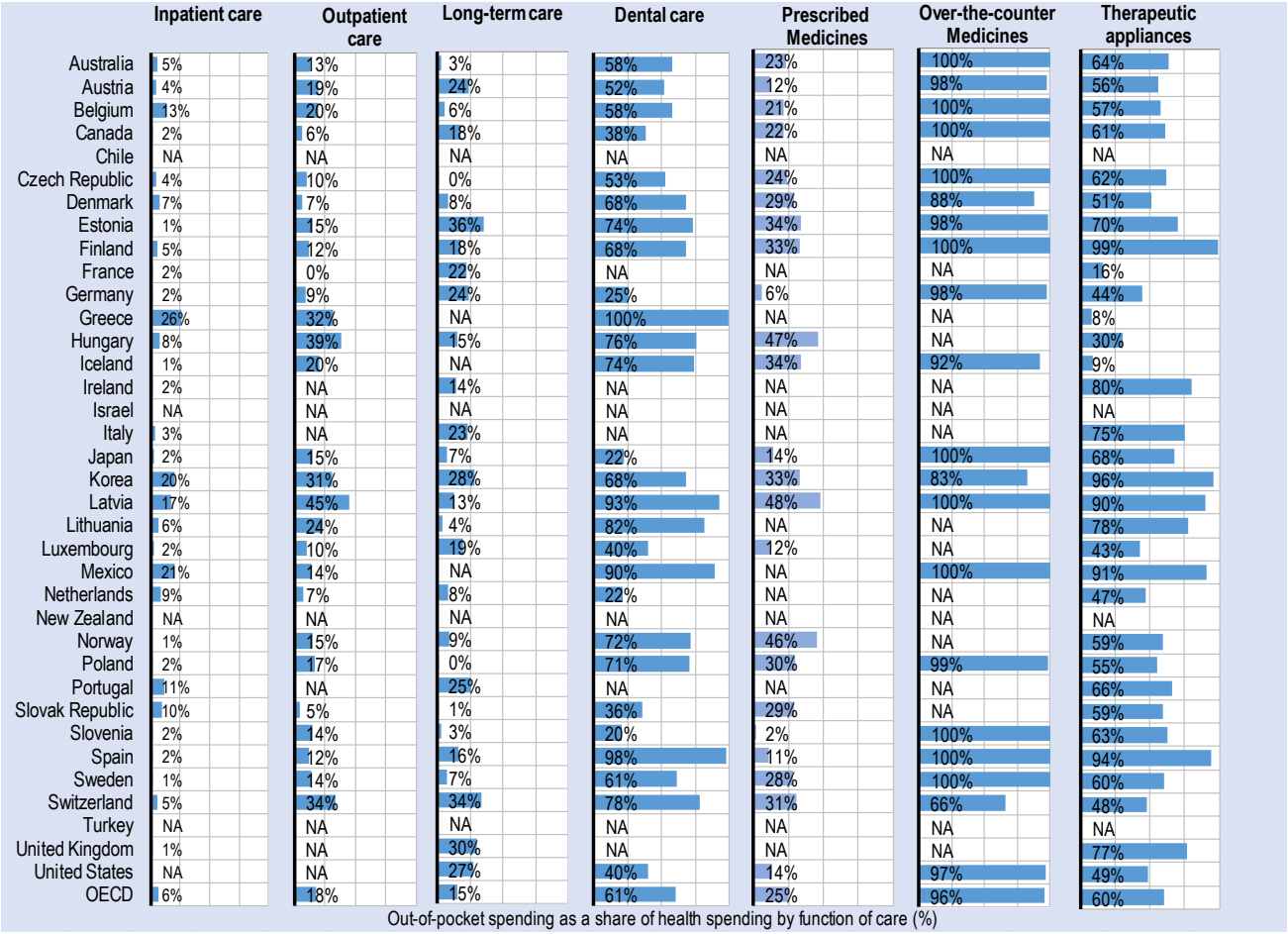
By their very definition, over-the-counter medicines - that is, non-prescribed medicines - are almost exclusively paid for by out-of-pocket payments.

Box 1. What are Out-of-Pocket Payments?

A System of Health Accounts 2011 (SHA 2011), defines out-of-pocket (OOP) as *a direct payment for services from the household primary income or savings*. The payment is typically made by the user at the time of use of service (no third-party payer is involved) and includes cost-sharing and informal payments. OOP spending should be measured net of any reimbursed health costs from government (including tax credit or similar) or insurance as a result of the individual's health payments.

Data sources and methods used by countries to measure out-of-pocket spending differ which can have an impact on detail and overall comparability. Nevertheless, significant progress has been achieved in many countries in recent years to fill reporting gaps and harmonise definitions.

Figure 2. Households finance a large proportion of spending on dental care and medical goods



Source: OECD Health Statistics 2018 (Data refer to 2016).

High levels of out-of-pocket payments can impact on individuals' access to care

There is a strong association between the level of OOP spending and a health system's ability to attain some of the most central health policy objectives. In particular, providing needs-based access and financial protection has proven difficult in countries that are heavily dependent on OOP funding (Rice et al., 2018).

A principal aim is that people should not forego needed health services due to cost. While other access barriers such as waiting times and geographic distance to health care provider play an important role, high reliance on OOP payments increases the risk that a household waives necessary healthcare.

According to the 2014 European Health Information Survey (EHIS), almost 15% of the population across 26 European countries *with a stated need* reported foregoing one or more specific healthcare related services due to financial reasons during the year.

This also shows important socio-economic gradients, such that population groups with lower levels of education reported higher levels of unmet need due to cost compared to those groups with higher education.

Similarly, in the United States, access problems due to underinsurance is more common in low-income groups. In a 2014 survey, delayed or avoided care due to co-payments was more than twice as common among insured adults with an income below 200% of the federal poverty line, compared to those above the same income level (Collins et al., 2014).

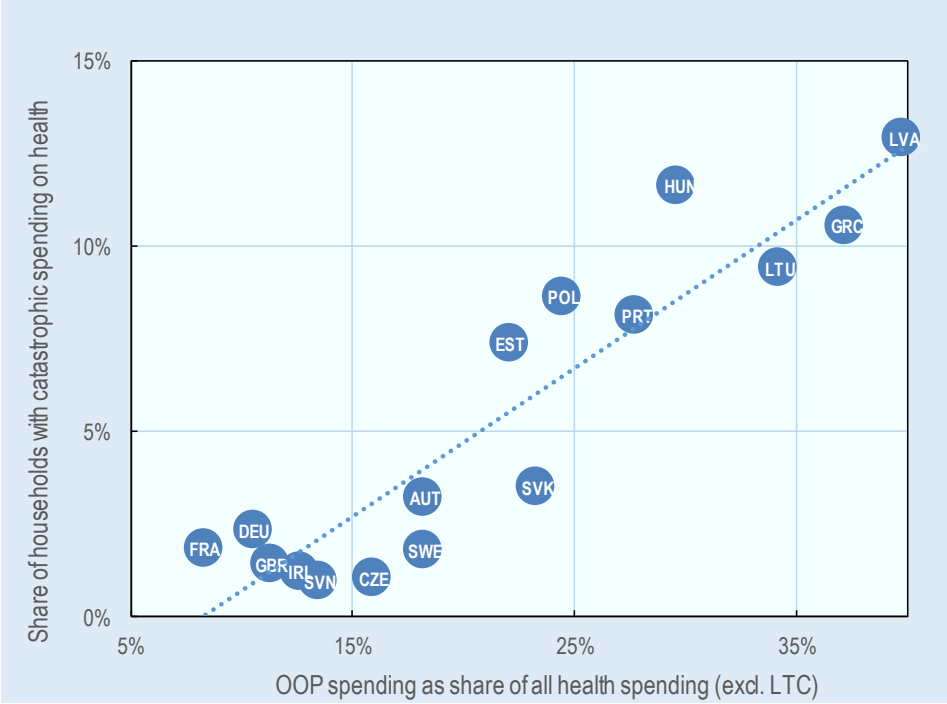
There are also important variations across the different types of services and goods. With the variation in benefits or services covered by pooled insurance, dental care had the largest share of reported unmet need due to financial reasons in all the countries surveyed in the EHIS study, with the exception of the Czech Republic. Shares ranged from 1.4% of the population in the Czech Republic to almost one in three of the population in Portugal.

Reliance on OOP payments can undermine the ability to ensure financial protection

The extent to which countries provide financial protection against health care costs can be measured using the concept of catastrophic health expenditure, which aims to capture the proportion of households that experience financial hardship due to catastrophically high health care costs. Figure 3 shows the incidence of households with catastrophic health spending against the OOP share of spending on healthcare (excluding long-term care services) for 16 OECD European countries (WHO Europe, 2018).

The risk of financial hardship is generally lower in countries with low levels of OOP payments. For example, in Slovenia and Ireland, where OOP spending as a share of health spending in 2015 was close to 13%, only around 1 in a 100 households faced catastrophic expenditures due to healthcare spending. On the other hand, in Hungary and Latvia, with considerably higher levels of OOP (at 30% and 40% respectively in 2015), the incidence of catastrophic expenditure was more than ten times greater. However, it's worth noting that the design of cost-sharing arrangements and other policies are important factors explaining these differences. With the same level of out-of-pocket spending, countries can report very different levels of financial protection (e.g. Estonia and the Slovak Republic).

Figure 3. The level of out of pocket spending can give some hint of the incidence of catastrophic spending



Note: The y-axis refers to the share of households with out-of-pocket payments that are greater than 40% of household capacity to pay for health care, which is taken as household consumption minus a standard amount to cover basic needs (food, housing and utilities).
Source: OECD Health Statistics 2018 and WHO Regional Office for Europe (2018).

References

Collins, S. et al. (2014), *Too High a Price: Out-of-Pocket Health Care Costs in the United States*, The Commonwealth Fund, November 2014.

Rice et al. (2018), *Revisiting out-of-pocket requirements: trends in spending, financial access barriers, and policy in ten high-income countries.* BMC Health Serv. Res. 2018; 18: 371.

WHO Regional Office for Europe (2018). *Can people afford to pay for health care? New evidence on financial protection in Europe.* Copenhagen: WHO Regional Office for Europe.

Useful Links

OECD Health Statistics 2018:
http://www.oecd.org/health/health-data.htm

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