

# 5

## *SDG1, eliminating poverty: improvements to health coverage design as a means to create co-benefits between health system and poverty Sustainable Development Goals*

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### 5.1 Introduction

Poverty is often defined as an inability to meet basic needs for human survival and certain normal activities (Ravallion, 2010). Poverty reduction is a top priority of governments around the world, with ‘Ending poverty in all its forms everywhere’ as Goal 1 of the UN Sustainable Development Goals (SDGs).

To address poverty, one must be able to measure it. This is typically done by assessing how many people are living below a poverty line representing some basic standard of living. While the international poverty line is often defined as living on \$1.90 per person per day, there is no universal poverty line in use and a range of poverty lines are used in practice depending on the national setting (United Nations, 2022). A distinction is made between absolute poverty lines, defined by a fixed monetary amount, and relative poverty lines that can vary depending on the average income level of the economy in which one resides. The absolute poverty definition is most commonly used in low- and middle-income countries, while relative poverty is mostly used in high-income settings. Regardless of the poverty line used, the aim of measuring poverty is the same: identifying those who experience severe financial hardship.

To make progress on SDG Goal 1, policymakers must address a wide range of causes of poverty, including economic, social and political factors. Health and health systems also play an important role. For example, people in poor health may be unable to work, and, as we

have seen in recent years, communicable diseases such as COVID-19 can lead to economic disruption.

Health systems can also influence the risk of poverty through exposure to out-of-pocket payments, which are payments for health care goods and services made at the point of use. According to global estimates from the World Bank, almost 90 million people each year fall into poverty due to out-of-pocket spending on health care (World Bank, 2021). Many others experience high levels of out-of-pocket health spending relative to their available financial resources – so-called catastrophic payments – that, while not necessarily causing impoverishment (i.e. when payments push households below or further below the poverty line wherein the most basic standard of living is no longer ensured), result in financial hardship (Saksena et al., 2014). Whether health systems contribute to or alleviate poverty is dependent on coverage policies as well as a range of other factors, such as methods of provision and reimbursement. In this chapter we will focus on the impact of out-of-pocket health spending not only on those experiencing poverty, but also on those who are not necessarily impoverished but still experience financial hardship due to out-of-pocket spending.

This chapter explores the links between health systems and SDG1. While SDG3 is already dedicated to ensuring good health and monitoring progress towards universal health coverage, it is important to explicitly consider the spillover effects of the health system on poverty and financial hardship, particularly given the importance placed on poverty in the SDGs. This chapter will highlight the connection between Target 3.8, which addresses the need to achieve universal health coverage, and SDG1. In particular, the chapter will discuss SDG Indicator 3.8.2, which addresses the proportion of the population with high spending on health as a share of household financial resources. It argues that through coverage policy decisions, health systems play an important role in reducing poverty and financial hardship.

The next section of this chapter will briefly introduce SDG1 and its relevance to this chapter. The second section introduces common measures used to monitor financial hardship in health systems. Section three explores in greater detail how health systems – in particular, coverage policies – can affect the risk of poverty and financial hardship due to out-of-pocket payments. The fourth section presents two case studies:

- Latvia, where during the financial crisis in 2009 the government exempted people living in poverty or near poverty from copayments; and
- Germany, which in 2004 implemented copayments for outpatient care and lifted an income-based exemption.

These case studies demonstrate further the relative importance of copayment design and exemptions in reducing poverty.

## 5.2 Background

The title of SDG1 is very clear in its goal – No poverty – with an official objective to end poverty in all its forms everywhere. SDG1 is broken down further into a series of targets. Targets 1.1, 1.2, 1.3 and 1.B are the most relevant for this chapter. These targets describe an international commitment to:

- **1.1** by 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than \$1.25 a day;
- **1.2** by 2030, reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions;
- **1.3** implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable; and
- **1.B** create sound policy frameworks at the national, regional and international levels, based on pro-poor and gender-sensitive development strategies, to support accelerated investment in poverty eradication actions.

In this chapter we will discuss how out-of-pocket health spending can cause individuals and households to experience financial hardship, to be at risk of impoverishment, to push them below poverty lines (including those in Targets 1.1 and 1.2), or further burden those who are already impoverished. Coverage policies are relevant to Target 1.3 as part of the social protection system for the poor and vulnerable, particularly mindful of how financial hardship intersects with illness. We shall see that health policy should be a leading consideration in new policy frameworks that attempt to eradicate poverty and improve incomes for

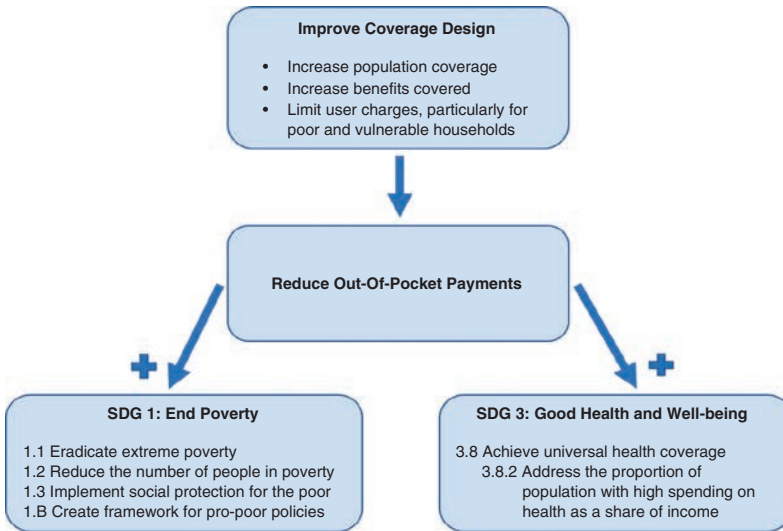


Fig. 5.1 Improvements to coverage design led to benefits for both SDG1 and SDG3

poor people in accordance with Target 1.B. Fig. 5.1 demonstrates how achieving progress in SDG Indicator 3.8.2 through improved coverage design has positive spillover effects on SDG1.

### 5.3 How can we measure the effects of out-of-pocket payments on financial hardship and poverty?

One of the main ways health systems influence the risk of financial hardship is through households' exposure to out-of-pocket payments. Out-of-pocket payments refer to user charges for covered health care goods and services, payments for non-covered goods and services, and informal payments. It excludes any pre-payment for health costs through public or private insurance.

A common way to measure the effect of out-of-pocket payments on the risk of financial hardship is by using two indicators: catastrophic and impoverishing expenditure incidence. These are commonly referred to under the umbrella term "financial protection indicators". Financial protection is monitored in the SDGs through Indicator 3.8.2. Indicator 3.8.2 is a type of catastrophic expenditure indicator: the proportion of

the population spending large (10%) or very large (25%) shares of their total household expenditures or income on health.<sup>1</sup> This is one of the main indicators used globally to monitor progress towards universal health coverage. The UN's recommended data sources for monitoring financial protection are household budget surveys, usually conducted by national statistical offices. Household budget surveys record household spending on all goods and services, including on health, over a reporting period (United Nations, 2019).

While Indicator 3.8.2 is used for global SDG monitoring, there are numerous methods used to measure catastrophic spending incidence, all of which relate households' health expenditure to some measure of its resources and label households as catastrophic spenders once they have crossed some predefined threshold. One of the difficulties with the approach used by the indicator is that it is blind to whether poorer or wealthier people tend to exceed a certain percentage of their income in health spending, which can have significant consequences for the level of concern policymakers attribute to health spending (Wagstaff & van Doorslaer, 2003). In this chapter, we define the *incidence of catastrophic spending* based on the WHO Europe method, which is the share of households with out-of-pocket spending greater than 40% of household capacity to pay for care (Cylus, Thomson & Evetovits, 2018). The 40% share of household capacity to pay has been used in many studies of catastrophic spending, although with different definitions of capacity to pay (Wagstaff & van Doorslaer, 2003; Xu et al., 2007). Capacity to pay in the WHO Europe method is calculated by taking a household's total consumption expenditure and subtracting a normative amount that captures the costs of meeting basic needs for food, housing and utilities. This reflects a judgement that households must meet basic needs before having money available to pay for health care.

An important benefit of this approach is that the effective threshold for a household to become a catastrophic spender is lower for poor households, who must spend a higher proportion of their budget on

<sup>1</sup> There are also other methods for measuring financial protection that are not specifically mentioned in the SDGs. These include health spending as a proportion of income excluding actual food expenditure, health spending as a proportion of income excluding a standard amount representing subsistence food spending, and health spending as a proportion of income excluding subsistence-level spending on food, housing and utilities (Cylus, Thomson & Evetovits, 2018).

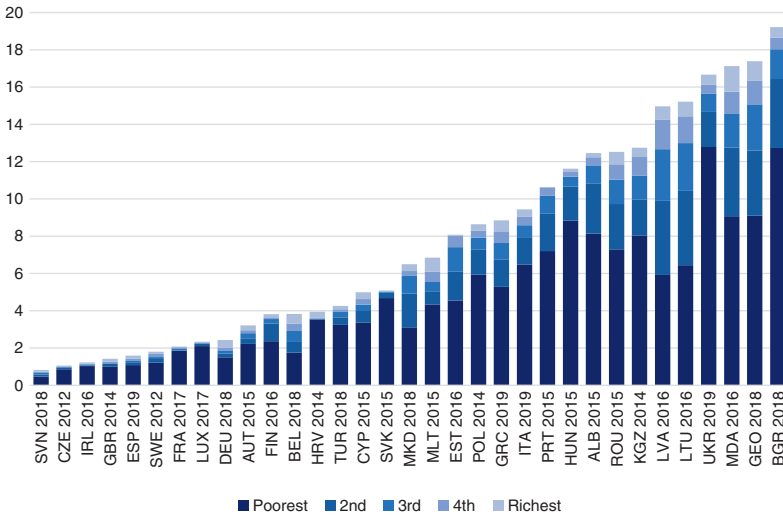


Fig. 5.2 Catastrophic spending using the WHO Europe method, latest year available

basic needs (and thus have a very limited capacity to pay for health), and higher for wealthier households. This creates a more progressive metric for measuring which groups of people suffer the most from high out-of-pocket spending. Fig. 5.2 shows that using the WHO Europe method of calculation, the poorest quintile of households experience the majority of the catastrophic health spending in most European countries.

Impoverishing expenditures are the other main financial protection indicator and perhaps the metric most directly relevant to SDG1. Households are defined as *impoverished* as a result of out-of-pocket health spending if their consumption before out-of-pocket spending was above a poverty line (or in the WHO Europe method, above the cost of meeting the aforementioned basic needs), and their spending after out-of-pocket costs was below the line. Households can also be considered *further impoverished* if their consumption before out-of-pocket spending was already below the poverty line or basic needs line and they still spent out-of-pocket for health care. As Fig. 5.3 shows, most of the burden of impoverishing spending in Europe falls on households that are already poor rather than those who are made poor by out-of-pocket spending. Households are also *at risk of impoverishment* under the WHO Europe method if their consumption after out-of-pocket spending

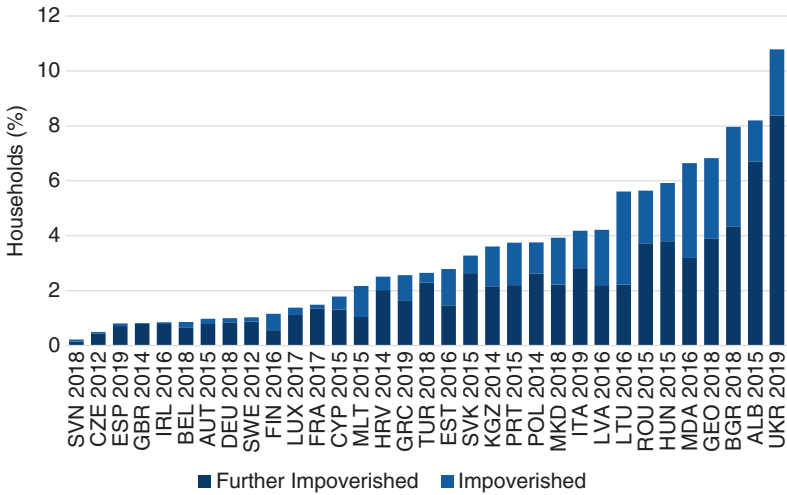


Fig. 5.3 Impoverishing spending by country, latest year available

is within 120% of the basic needs line (not shown in Fig. 5.3). The nuance in these metrics allows us to identify not just those who might fall below an internationally recognized consumption level, but also those who experience financial hardship without explicitly *becoming* poor according to binary indicators.

Catastrophic and impoverishing spending indicators on their own can be easily misinterpreted. For example, a country might have a low incidence of catastrophic spending not because care is affordable, but because large segments of the population face out-of-pocket costs that are beyond their means to pay. They may then use fewer services than needed, or no services at all. In this way, unmet need data gathered through self-reporting is an important complement to financial hardship measures.

#### 5.4 How do health systems influence the risk of poverty and financial hardship?

Now that we have established indicators of financial hardship, we can say more about the links between out-of-pocket spending, catastrophic spending and impoverishment. How much a country relies on out-of-pocket payments to finance health care overall is a strong predictor of the incidence of catastrophic spending (Fig. 5.4). Catastrophic spending

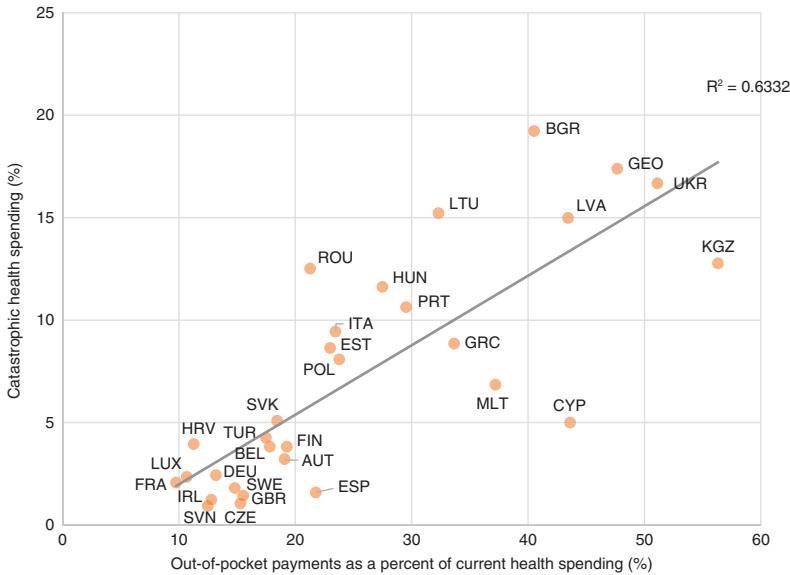


Fig. 5.4 Incidence of catastrophic health spending and out-of-pocket payments as a share of current spending on health, latest year available

tends to be much higher in countries where reliance on out-of-pocket spending to finance health care is high. Within Europe, Latvia, Lithuania and Hungary all have very elevated levels of catastrophic spending, each with more than 10% of their households experiencing catastrophic spending each year. All three countries rely on significantly higher levels of out-of-pocket spending to pay for health care than the OECD average (OECD, 2021). Fig. 5.5 also illustrates the positive correlation between a health system's reliance on out-of-pocket payments and impoverishing spending in European countries.

What then determines the level of out-of-pocket payments? Out-of-pocket payments for health care are partly determined by the level of public spending on health care (Fig. 5.6). The incidence of financial hardship due to out-of-pocket payments is more likely to be high when public spending on health is low in relation to gross domestic product *and* out-of-pocket payments account for a relatively high share of total spending on health (WHO & World Bank, 2019; Xu et al., 2007).

However, increases in public spending do not necessarily lead to reductions in out-of-pocket spending (WHO, 2019a). Mandating a



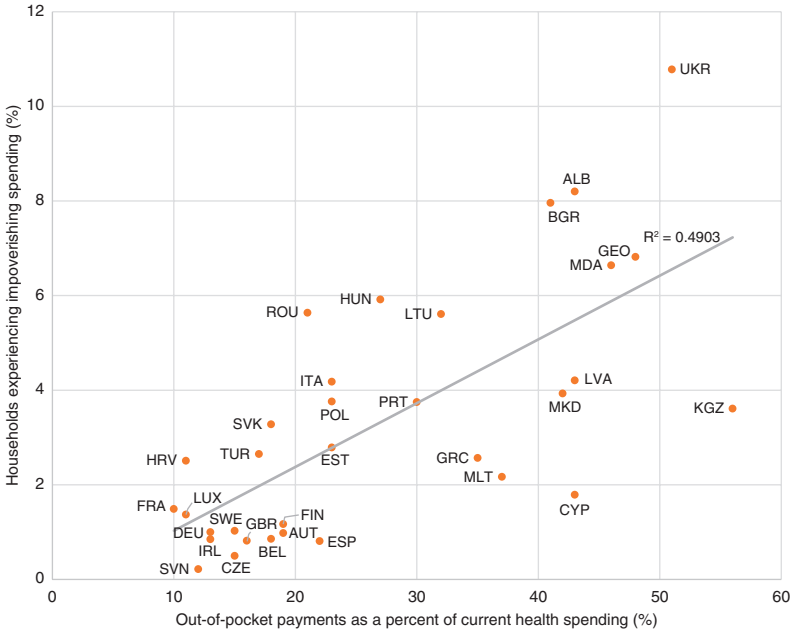


Fig. 5.5 Incidence of impoverishing (i.e., impoverished and further impoverished) spending and out-of-pocket payments as a share of current spending on health, latest year available

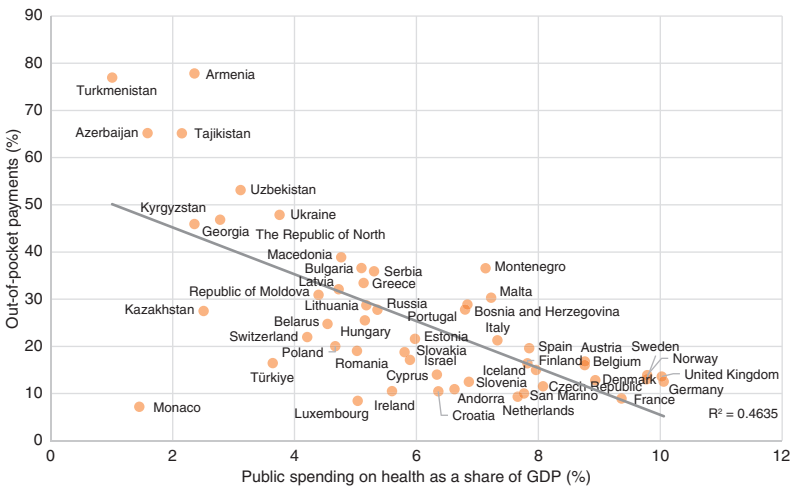


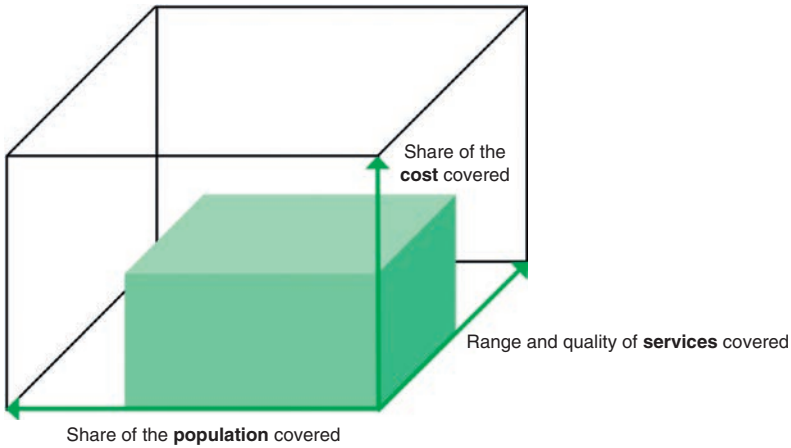
Fig. 5.6 Public spending on health as a share of GDP and out-of-pocket payments, WHO European Region, 2020

certain level of public spending on health has not been demonstrated to be an effective way to reduce out-of-pocket spending if not combined with other significant reforms to coverage policy design. For example, from 2004 to 2017 the government of Moldova committed to allocating 12% of its budget to health care every year, resulting in public spending on health that was significantly higher than the average lower-middle-income country in Europe (WHO, 2020). However, outpatient prescribed medicines were still subject to a percentage copayment of up to 50%. As a result, out-of-pocket spending grew over the period, as did the percent of households with catastrophic out-of-pocket spending (WHO, 2020). Indeed, many countries with similar levels of public spending on health differ in terms of their out-of-pocket spending. Public spending on health in 2019 accounted for 8% of GDP in both France and the United Kingdom, but while the former relied on out-of-pocket spending for 9% of health costs, the latter relied on it for 17% (WHO, 2022). Other aspects of health system design must account for the differences in out-of-pocket spending levels.

Coverage policy design is a crucial determinant of whether health systems contribute to or alleviate financial hardship. All health systems face budget constraints, which lead to rationing of care through coverage policy design. Budget constraints can lead to implicit rationing, such as gatekeeping and waiting times, as well as explicit rationing, such as coverage exclusions and out-of-pocket payments. This is true even in systems that purport to have achieved universal health coverage. We can conceptualize progress towards universal health coverage systems through an analysis of the coverage of people, services and cost. The goals of universal health coverage are most likely to be achieved when the entire population is covered, the right services are covered to meet the population's health needs, and costs are financed largely through pre-payment with risk pooling to avoid exposure to financial hardship or financial barriers when people need to access care. This is commonly described through the idea of the coverage cube, shown in Fig. 5.7.

Exploring the three dimensions of UHC helps to understand why countries might rely to a greater or lesser extent on out-of-pocket payments to pay for health care. We can use the conceptualization of the coverage cube as a series of tradeoffs to show how allocating limited resources towards each of the three dimensions affects out-of-pocket payments in different ways (Ochalek, Manthalu & Smith, 2020).

The first dimension is the level of population coverage. Many systems exclude individuals from the health system based on employment,



**Fig. 5.7** The coverage cube demonstrates the three dimensions of health coverage

citizenship, age or income. In some countries, publicly funded services are restricted only to a certain segment of the population, for example, dental care for adults in the English NHS. This means that excluded patients must pay privately if they need care. Population entitlement to publicly financed health care is a prerequisite for protection from financial hardship but does not guarantee it. The share of population entitled is not an intrinsically good indicator of exposure to financial hardship. Incidence of catastrophic health spending in European countries with 100% population coverage varies significantly, from 1% to 14% of households (WHO, 2019b). Reviews of health insurance reforms in nine developing countries found that expanded population coverage was linked to decreased out-of-pocket expenses in six of the countries, but to an increase in out-of-pocket expenses in three of them, partly because of increased service utilization due to coverage (Lagomarsino et al., 2012; Wagstaff & Lindelow, 2008). In some countries, entitlement to care is linked to employment; this can lead to those in precarious or unstable working conditions being excluded from coverage. European countries that have linked health coverage to employment, such as Greece, saw a rise in catastrophic health spending among middle-class households and a rise in unmet health need among those with lower incomes in the years following the Great Recession, when unemployment rose dramatically and many people lost health care coverage (WHO, 2019b).

The second dimension considers the breadth of the benefits package as well as volume limits for treatments that are covered by statutory health care coverage, which can result in long waiting times. If the benefits package is narrow or there are long waiting times, those who can afford it may pay out-of-pocket for care, contributing to poverty and financial hardship. There is considerable variability in the types of goods and services countries cover (WHO, 2019b). Although Health Technology Assessment agencies exist in many high-income health systems to investigate the cost-effectiveness of covering a certain medical intervention, the majority do not make binding decisions and in most cases it is not clear that their recommendations are considered in coverage decisions (Fontrier, Visintin & Kanavos, 2021). Service restrictions can also occur when people are promised benefits that are not supported by adequate funding. This can result in implicit rationing of care through informal payments, which is a significant problem in several European countries. Countries with higher levels of informal payments for health care tend to have higher rates of catastrophic spending (WHO, 2019b). Even when not the primary cause of health-related financial hardship in a country overall, informal payments make it impossible for governments to protect poor people from high out-of-pocket costs through means-tested exemptions. The highly unpredictable nature of informal payments also abrogates the consumption-smoothing benefits to health insurance, either voluntary or public.

The third, and most important, mechanism by which out-of-pocket payments lead to financial hardship is through user charges. While all European countries have some form of user charges, the systems with the strongest financial protection either apply them sparingly or make efforts to protect against financial hardship. Three of the most relevant copayment policy mechanisms are using fixed copayments rather than percentage-based coinsurance, user charge exemptions for poor people, and out-of-pocket maximums (i.e. caps).

Fixed copayments are a pre-set amount that a user pays that are not dependent on the items' list price. Percentage-based coinsurance refers to a system in which patients will pay for a certain percentage of the list price of an item. The countries that use percentage-based coinsurance tend to have higher rates of catastrophic health spending than countries with low fixed copayments (WHO, 2019b). Poland and Slovakia, for example, have similar out-of-pocket spending as a share of current health expenditure and similar poverty rates (Thomson, Cylus & Evetovits, 2019), but the rate of catastrophic health spending

in the former is more than twice as high than that in the latter (WHO, 2019b). One difference is that Poland uses percentage-based coinsurance while Slovakia uses fixed copayments for user charges associated with outpatient medicines. Percentage-based coinsurance shifts financial risks from the health system to the patient, which in effect creates a regressive cost policy for the poorest users of health services. Percentage-based coinsurance also exposes patients to high levels of price uncertainty, especially when prices are not known to the patient in advance.

Another set of copayment policy options that have proven particularly effective in limiting financial hardship are user charge exemptions for poor people. This is especially the case for those who are impoverished and unable to meet their basic needs even before spending out-of-pocket on health. In Germany, the switch from user charge exemptions for poor people to an annual cap on copayments led to an increase in catastrophic spending, particularly among the poorest consumption quintile (WHO, 2019b). In Latvia, the end of exemptions from copayments for poor people led to a similarly sharp rise in catastrophic spending in the poorest quintile (WHO, 2018a). We will cover these examples in more detail in our case studies.

The justification for user charges for universal health care systems includes additional revenue raising for the health system and reduction of potentially inappropriate demand (i.e. moral hazard) (King's Fund, 2005). However, a number of counterarguments to these justifications have developed. In order for insurance to lead to inappropriate demand, provider incentives must be aligned with overtreatment and consumers must have a significant influence over their treatment choice. This may be true in systems with widespread use of fee-for-service reimbursement but is unlikely to occur in systems that use capitation, fixed salaries or pay-for-performance. Supply constraints, such as direct rationing, waiting times, gatekeeping and payer prior authorization, are often used to deal with potential moral hazard even in systems that have user charges. There is also consistent evidence that user charges reduce medically necessary and unnecessary care equally, which can have negative effects on population health (Thomson, Foubiser & Mossialos, 2010; WHO, 2019b). Out-of-pocket user charges for certain prescription drugs and preventative treatments in the UK, for example, were found to be not efficient as they increased long-term health costs to the NHS (King's Fund, 2005). Fixed charges not related to ability to pay disproportionately lower access to care for the poor, raising issues of equity.

Furthermore, institutions such as the NHS have not traditionally asserted clear boundaries between the basic package of care and supplemental health services (King's Fund, 2005).

It is also worth reviewing the evidence on whether encouraging individuals to take matters into their own hands by purchasing complementary health insurance would be a good way to reduce catastrophic spending. While there are a few countries where complementary health insurance covers out-of-pocket payments (such as Slovenia, France and Croatia), this is the exception rather than the norm. More often complementary health insurance is used in a limited capacity by those who can afford to pay for it to obtain preferential access to care, rather than to provide financial protection. In the European context, research suggests that expanded use of complementary insurance is not an effective solution to lack of population coverage, restrictions in the benefits package, or widespread user charges, with no strong correlation between complementary insurance levels and out-of-pocket costs (WHO, 2019b). Moreover, complementary insurance adds a layer of complexity to coverage reform and individual health management to address issues that could also be solved through changes to the main coverage. Only reform to the design of coverage policies has been shown to reduce out-of-pocket costs, and thus limit financial burdens on households.

## 5.5 Country case studies

To better understand how health systems and coverage policy influence the risk of poverty and financial hardship, we present two case studies: Latvia and Germany. These cases will demonstrate the co-benefits between improving health systems and decreasing financial hardship that we have discussed in a real-world environment.

### 5.5.1 Case 1: Latvia

To cope with the hardship caused by the recession of 2008, Latvian government ministries working in collaboration with external stakeholders improved financial protection for the poorest segments of the population through temporary user charge exemptions. In 2012, however, Latvia discontinued this exemption from copayments for all but the very poorest individuals; the end of exemptions led to an increase in financial hardship for poor people.

All Latvian citizens, as well as many immigrant groups, are guaranteed access to health care under the Latvian National Health Service (NHS). The opportunity for out-of-pocket spending derives primarily from a relatively narrow benefits package and user charges rather than explicit population exclusion from coverage.

In 2009, Latvia raised copayments across almost all services as part of fiscal restraints required by external lenders during the Great Recession. After the financial crisis that arose as a result of the 2008 recession, the Latvian government agreed to cuts to public sector expenditure, tax increases, and public administration reforms, collectively known as the Economic Stabilization and Growth Revival Programme (Taube, Mitenbergs & Sagan, 2015). The lenders included the International Monetary Fund (IMF), the EU and the World Bank, which also provided technical support. The Latvian Cabinet of Ministers explicitly mentioned health care spending as one of the sectors to which public sector cuts would be made, giving the Ministry of Health the space to implement a copayment rise (Taube, Mitenbergs & Sagan, 2015). Some of these increases were considerable – the daily copayment for inpatient hospital stays more than doubled. At the same time, Latvia also introduced the Social Safety Net strategy in 2009, granting exemptions from those user charges for households with incomes below €171 per person per month and substantial reductions to those with incomes below €213. The Social Safety Net strategy was financially supported by the external lenders as a way to mitigate the worst adverse effects of the recession on poorer households. In this sense, changes to the design of the health system were used to create co-benefits for the public sector financial position and for financial hardship.

The health reforms during the financial crisis, including the low-income copayment exemptions, took place with few consultations with domestic health system stakeholders (Taube, Mitenbergs & Sagan, 2015). The driving force was a collaboration between government ministries and external lenders. Table 5.1 shows the governance tools used and actions taken during the 2009 health reforms and Social Safety Net strategy. Overall, the reforms were supported by the most important governmental stakeholders, the Ministry of Finance and the Cabinet, giving the Ministry of Health the leeway to implement the copayment rise and low-income exemption with little conflict. As summarized in Table 5.2, the issue also had high political importance given its relevance to the reforms required by the external lenders. Due

Table 5.1 Possible governance actions to achieve SDG1 in Latvia

		Possible governance actions with these tools									
Tools		Goals and targets	Evidence support	Policy guidance	Implementation and management	Coordination	Advocacy	Monitoring and evaluation	Financial support	Legal mandate	
	Tools	Plan	Plan	x	x			x		x	x
Indicators and Targets		Indicators	x	x				x			
		Targets									
Budgeting		Pooled budget									
		Shared objectives	x	x	x	x	x		x		
		Coordinated budgeting				x	x	x		x	
Organization		Ministerial linkages	x					x		x	
		Specific ministers							x		
		Organization	x			x		x		x	
		Legislative committees									
	Interdepartmental committees/units										
	Departmental mergers										
	Civic engagement										
Accountability	Transparent data	x			x		x	x	x		
	Regular reporting	x			x		x	x	x		
	Independent agency/evaluators	x						x	x		
	Support for civil society										
	Legal rights										



**Table 5.2** *Political importance and conflict: eliminating poverty in Latvia*

		Conflict	
		Low	High
Political importance	High	x	
	Low		

to the overall burden of the recession and copayment rise on the poor in Latvia, policies to alleviate financial hardship also had intrinsically high political importance.

The 2009 exemption that the Latvian government put into place with support from external lenders was effective at mitigating the contribution of health spending to financial hardship. The share of households in the poorest quintile reporting no out-of-pocket spending improved from 58% to 70% from 2008 to 2010 (WHO, 2018a). Over the same period, the rate of catastrophic spending for the poorest quintile declined even while overall catastrophic spending in Latvia increased, likely due to the combined effects of the copayment rise and income-based exemptions (WHO, 2018a).

However, the low-income exemption policy was pared back in 2012 after the World Bank ended financial and technical support, leaving the policy's continuation by the Latvian government financially untenable. Only those with incomes below €128 per person per month were still eligible for any reduction, exposing many low-income people to user charges. The effects on financial hardship for the poor were significant. Among the lowest income quintile, the share of households reporting no out-of-pocket payments declined from 70% in 2010 to 57% in 2013 (WHO, 2018a). The rate of catastrophic spending for the poorest households increased significantly, and by 2016, 15% of Latvian households experienced catastrophic health spending – among the highest rates in the EU (OECD, 2021; WHO, 2018a). Inpatient hospital admissions also declined significantly from 2012 to 2013, reversing a longstanding trend and implying that much of the reduction was from unmet need due to unaffordable health costs (WHO, 2018a).

The Social Safety Net strategy was successful at reducing health costs as a source of financial hardship from 2009 to 2012. Without collaboration between the external lenders and the relevant Latvian

ministries, it would have been significantly more difficult for the Latvian government to put financial resources towards the Social Safety Net strategy during a period of fiscal restraint, particularly when the rest of the population was subject to a copayment rise. Indeed, once intersectoral support for the policy in the form of World Bank assistance was withdrawn, the Latvian government was unable to continue the most important provisions of the policy on its own despite the clear benefits for financial protection.

### 5.5.2 *Case 2: Germany*

Overall financial protection in Germany is strong, in line with many other European countries with low reliance on out-of-pocket spending and high public spending on health. Population coverage is near universal, as health insurance has been mandatory for the entire population since 2009. However, Germany's experiences over the past two decades show that coverage policy decisions have notable effects on the risk of financial hardship.

Germany introduced copayments for outpatient visits in 2004 as part of the Hartz reforms, which were aimed at reducing public spending. At the same time, Germany shifted from fixed copayments to percentage-based coinsurance for outpatient medicines and abolished exemptions from user charges for low-income people. These changes shifted some financial responsibility for care to households, coinciding with an increase in the share of out-of-pocket spending on outpatient care from 6.4% in 2003 to 13.8% in 2008. This increase was even more pronounced among the poorest quintile, leading to implications for financial protection. The share of the poorest quintile of households with catastrophic out-of-pocket payments in Germany more than doubled from 2003 to 2008 (WHO, 2018b). The share at risk of impoverishment, impoverished or further impoverished after out-of-pocket payments rose from around 2% to almost 6% (WHO, 2018b).

In 2012, an intersectoral consensus of providers, patients and parliamentarians led to the abolition of copayments for outpatient visits, although the percentage-based coinsurance for outpatient medicines remained and the low-income exemptions were not reinstated. From 2008 to 2013, the share of out-of-pocket spending on outpatient care fell from 13.8% to 6.5%. By 2013, the share of the poorest quintile experiencing catastrophic spending had fallen from 2008 levels but remained

above the pre-2004 level (WHO, 2018b). The share of households at risk of impoverishment, impoverished or further impoverished after out-of-pocket payments fell to around 4%, which, while an improvement from 2008, was still twice as high as pre-2004. The fact that the incidence of households impoverished due to health costs remained higher than pre-2004 suggests income-based exemptions from out-of-pocket payments had been effective at providing financial protection.

The decision to abolish copayments for outpatient visits was made through a unanimous vote of the German Federal Parliament following intersectoral collaboration between parliamentarians of multiple parties, the health minister, and civil society groups representing providers and patients (Table 5.3). The copayment was seen by parliamentarians as providing insufficient revenue for the administrative costs it necessitated (Olm et al., 2020). It was largely opposed by providers, who felt burdened by the effort of administering the copayment, as well as patients (Kilham, 2015). The issue was given high levels of coverage by the German media, amplifying its political importance (Olm et al., 2020).

**Table 5.3** Possible governance actions to achieve SDG1 in Germany

		Possible governance actions with these tools									
		Goals and targets	Evidence support	Policy guidance	Implementation and management	Coordination	Advocacy	Monitoring and evaluation	Financial support	Legal mandate	
Tools	Plan	Plan	x	x	x	x	x	x			x
	Indicators and targets	Indicators	x	x				x	x		
		Targets	x	x				x	x		
Budgeting		Pooled budget									
		Shared objectives									
		Coordinated budgeting									

Table 5.3 (Cont.)

		Possible governance actions with these tools									
Tools	Organization	Ministerial linkages									
		Specific ministers	x	x	x	x	x	x		x	x
		Organization	x					x	x		
		Legislative committees									
		Interdepartmental committees/units									
		Departmental mergers									
		Civic engagement	x	x	x				x		
	Accountability	Transparent data		x	x				x	x	
		Regular reporting		x	x				x	x	
		Independent agency/evaluators									
Support for civil society		x	x	x				x			
Legal rights											

Table 5.4 Political importance and conflict: eliminating poverty in Germany

		Conflict	
		Low	High
Political importance	High	x	
	Low		

Given the convergence of interests in abolishing the copayment – federal government, providers and patients – and the widespread nature of the administrative burden, we can categorize the decision as being of high political importance (Table 5.4). The political conflict, in contrast, can be categorized as low as there was widespread consensus for the measure throughout the German Federal Parliament. The key to the success of

this change was intersectoral collaboration between parliamentarians, patients and providers. The co-benefits of collaboration are illustrated by the reduction in financial hardship on the population at large as well as the increased access to outpatient care and lower administrative costs on providers.

## 5.6 Conclusion

The goal of policymakers should be to create policies that ensure that people who are financially vulnerable are not exposed to further hardship as a result of using health services. This goal will be most effectively achieved through intersectoral collaboration between stakeholders with expertise in public finance and health, who can work together to pass policies that will improve the health system while decreasing financial hardship. While not explicitly included in SDG1, people who face potential financial hardship from out-of-pocket health spending should be prioritized through health system policies along with those who face explicit impoverishment. To reduce both poverty and financial hardship in the context of limited public resources, it is advisable, despite the marginal political support, to enact policies that benefit the most disadvantaged households. To ensure these policies are effective, policymakers must have the ability to identify health services that lead to financial hardship and the people most affected by them. While increasing public investment in health overall is a first step, many countries will need to reconsider coverage policies to improve financial hardship outcomes.

Specifically, countries should ensure full population coverage, a comprehensive benefits package, and limited user charges, both for the sake of improving health outcomes as well as to help eradicate poverty. For user charge policy in particular, the countries that have had the most success have implemented policies including fixed copayments rather than percentage-based coinsurance, user charge exemptions for poor households, and out-of-pocket maximums. Of the three, especially in the context of poverty eradication, means-tested exemptions from user charges are likely most effective, though there can be administrative, logistical and measurement challenges in means-testing, in part due to a lack of information about household financial resources in real-time.

The threat from ineffective coverage policy that fails to adequately protect people from financial hardship and impoverishment is clear.

Policies that shift financial responsibility for care onto patients through higher out-of-pocket costs, such as those in the Germany and Latvia case studies, have led to an increase in catastrophic health expenditures. Expanded population coverage alone does not protect individuals from financial hardship, as a full 9% of people in the United States with employer-sponsored health insurance (ESHI) have declared bankruptcy due to medical costs (KFF, 2019). Poorly designed coverage policy has led to the sickest patients simultaneously suffering from disease and the threat of ruinous costs. If countries wish to make progress on reducing poverty and financial hardship, they should focus coverage design efforts on reducing the financial burden placed on those who are most vulnerable.

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