

Financial protection for noncommunicable diseases and mental health: why and how?

Technical background paper #5

Technical background papers have been developed by a team of staff from the WHO, the World Bank and the University of Washington with the input of contracted consultants, as needed; all papers have benefited from the review and feedback of an External Technical Expert Group appointed to support the International dialogue on sustainable financing for NCDs and mental health. The papers will undergo further review by the WHO and the World Bank; therefore, they do not represent the official positions of both organizations. The papers are the property of the WHO and the World Bank. They may only be downloaded for the purpose of this web consultation and their content cannot be used for any other purpose.

Summary

- Alongside access to quality services, a central objective of national health policies - and of efforts to move towards universal health coverage more generally - is to protect affected households against the financial risks associated with their ill-health, including use of essential health services. For individuals and households living with noncommunicable diseases (NCDs), mental health conditions, and other chronic conditions, there is a heightened exposure to prolonged OOP spending on treatment and care because of their lengthy or unlimited duration, as well as other long-term impacts such as lost employment or diminished income generation opportunities.
- In the context of low- and middle-income countries, financial protection policies and measures have been primarily designed to mitigate against the risk of households unexpectedly incurring high - and potentially impoverishing - health care costs (such as those involving hospitalization or highly technical medical procedures), or not seeking care in the first place on account of their cost. Emerging evidence from different regions of the world is now pointing to the 'slow burn' of frequent out-of-pocket spending on health care services and products for chronic diseases and conditions as a critical driver of OOP expenditures.
- In this background paper, we summarize available evidence on trends in OOP spending, including medicines as a critical driver, and present both the rationale and also actionable strategies for enhanced financial protection for people with NCDs, mental health conditions and other chronic diseases.

Key messages

- Private out-of-pocket (OOP) spending on health services and products acts as a barrier to appropriate help-seeking and may lead to financial hardship or impoverishment; accordingly, financial protection represents a critical dimension of the concept of – and efforts to move towards - universal health coverage (UHC). Yet in lower income countries, OOP spending continues to account for 40% of total health expenditures.
- Financial protection policies and measures in many LMICs are primarily designed to mitigate against the risk of (poorer) households either unexpectedly incurring high health care costs, or not seeking care in the first place on account of their cost. They are not well attuned to the needs of households with a chronic condition, who end up with high out-of-pocket (OOP) spending because of recurring or constant needs for treatment and care.
- A major driver of OOP spending is medicines; in addition to efforts to lower the price of medicines at the point of use (for example, by negotiating lower prices with manufacturers or by removing import tariffs), countries should consider extending exemptions or limits for the poorest households to those affected by chronic conditions (for example, by capping annual contributions or by using low fixed co-payments).

Section 1: Moving towards Universal Health Coverage for people with NCDs and mental health conditions

The defining goal of a health system is to improve population health; yet there are other important goals too, including equitable access to care, fair financing, service quality, and human rights protection. A health system functions optimally when it is able to protect the right to health for everyone, and that right includes physical or geographical access to essential services, as well as affordable access, such that those in need can use and benefit from services without experiencing financial hardship. Financial hardship occurs when individuals or households end up paying more than they can afford for the health care and treatment they need when ill or sick. Unaffordable levels of spending may be brought about by unplanned or expensive medical procedure or hospitalization, but for poorer households even small outlays for health care services or products can tip the balance. For individuals and households living with NCDs, mental health, and other chronic conditions, there is the prospect of prolonged OOP spending on treatment and care, as well as other long-term impacts such as lost employment or diminished income generation opportunities, which together threaten their economic welfare and elevate the risk of impoverishment (Lund et al, 2019; NCD Alliance 2023; Rahman et al, 2022). Since the incidence and co-occurrence of NCDs, mental health conditions and related disabilities increases with age, older adults can be at especially high risk of heavy spending and financial hardship in the absence of appropriate safeguards and exemptions.

The out-of-pocket cost to households of securing needed health services and goods is a key concern underlying the drive toward universal health coverage (UHC). OOP payments represent a regressive form of health financing—penalizing those least able to afford care or preventing them from using care—and are the main channel through which financial hardship may occur or deepen. Pre-payment through public spending on health more equitably safeguards at-risk populations from the adverse financial consequences of ill-health. Accordingly, ongoing efforts to move toward UHC focus on (a) increasing the proportion of the population entitled to publicly financed health care, (b) increasing the range of health care that is publicly covered, and (c) reducing user charges (co-payments) for covered health care (WHO 2010).

In the particular context of low- and middle-income countries, financial protection policies and measures have been primarily designed to mitigate against the risk of households either unexpectedly incurring high health care costs, or not seeking care in the first place on account of their cost. Yet there is increasingly clear evidence from different regions of the world to indicate that it is the smaller but more frequent out-of-pocket expenditures on outpatient health care and especially medicines that are now the principal driver of OOP spending.

In this background paper, we summarize available evidence on trends in OOP spending, including medicines as a critical driver, and present both the rationale and also actionable suggestions for enhanced financial protection for people with NCDs, mental health conditions and other chronic diseases.

Section 2: Current patterns of OOP payments and their implications for financial protection

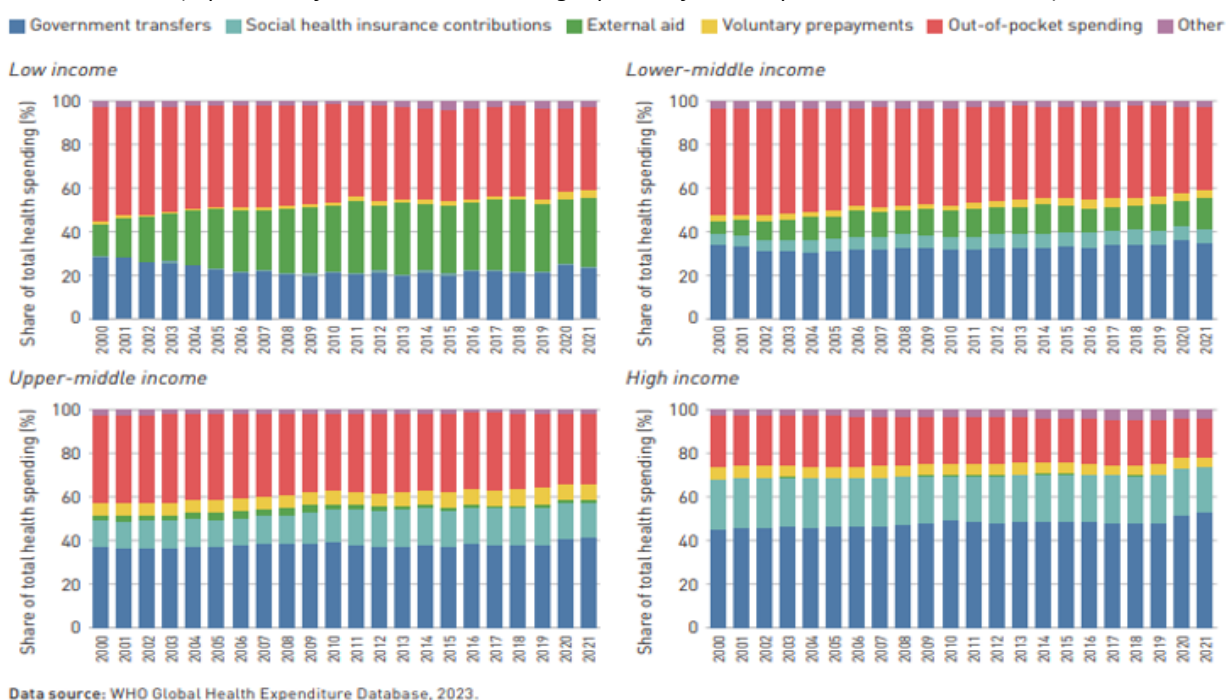
The *Global monitoring reports on financial protection in health 2021* (WHO and World Bank, 2021) and *Tracking universal health coverage 2021 and 2023* (WHO and World Bank, 2023) provide relevant and recent overviews of the current financial protection landscape. The latest one reveals that, in the period preceding the COVID-19 pandemic, 1 billion people worldwide were already spending at least 10% of their household income on health care services and goods, and nearly 300 million were spending over 25%. A clear and relatively strong relationship is shown to exist between the incidence of these catastrophic levels of health spending and a health system's reliance on out-of-pocket payments. COVID-19 has made a bad situation worse because of the squeeze it has placed on national economies and public spending, as well as higher prices for households at the point of use.

Figure 1 shows the distribution of current health spending, by source of funds and by country income group. Two key points stand out: the share coming from direct, out-of-pocket spending has incrementally reduced over time in all country income groups, which indicates a positive trend towards greater financial protection (mainly achieved with government or external funding); yet despite that, the share coming from direct, out-of-pocket spending varies considerably between country income groups: in 2021, around 40% of the total in low-income and lower-income countries, compared to just over 20% in high-income countries. It is not only the costs of treatment that puts people at financial risk, but also related transport costs and the loss of income for individuals and their careers.

One of the less well-documented but insidious impacts of reliance on OOP spending to pay for health care is that it pushes households to adopt harmful coping strategies—such as cutting household spending, using up life savings, selling assets or borrowing—which entrenches poverty and inter-generational disadvantage and can lead to poorer health outcomes. A recent umbrella review of evidence related to the household economic burden of NCDs identified several studies that reported on coping mechanisms with detrimental impacts, including reduced spending on food, education or social activities, as well as the use of savings or the disposal of assets to meet the costs of medical care (NCD Alliance, 2023; see also Rahman et al, 2022). In the area of mental health, a multi-country household survey of the economic impact of mental health conditions showed similar effects and coping mechanisms (see Box 1). Use of such coping strategies shows that current and future non-health consumption choices are being compromised,

including savings and human capital formation of children. Service coverage for mental health conditions is also very low in many countries, which indicates high levels of unmet need.

Figure 1 **Distribution of current health spending, by source and country income group**
(reproduced from *Global monitoring report on financial protection in health 2021*)



Accordingly, there is a continuing strong need and call for greater financial protection in health systems, to mitigate against OOP payments that prevent people from meeting their basic needs, push people into poverty or worsen poverty. In line with this call, new and improved measurement of catastrophic and impoverishing levels of OOP spending have been put forward (WHO Regional Office for Europe, 2023; WHO and World Bank, 2023). Beyond the health system, there is an evident need to improve social assistance to households living with NCDs, mental health conditions and other chronic conditions, for example in the form of disability grants or cash transfers. There is increasingly robust emerging evidence for the benefits of cash transfers for economic welfare, mental health, well-being, reductions in stress and domestic violence (McGuire et al, 2022).

Box 1 **Economic impact of mental, neurological and substance use (MNS) disorders on economic welfare: the Emerald study** (*Source: Lund et al, BJPsych Open, 2018*)

This study provided new evidence on the household economic costs associated with MNS conditions in LMICs. Despite diverse social, economic and cultural contexts in Ethiopia, India, Nepal, Nigeria, South Africa and Uganda, a relatively consistent pattern was ascertained, namely that households with a

member having an MNS condition were economically worse off than control households, using a variety of assessment measures. For example, and with some notable exceptions, households with an MNS disorder had lower levels of adult education (in 11 of 16 MNS condition groups), lower housing standards, as indicated by access to improved sanitation facilities (10/16), lower total household income (11/16), lower effective income (9/16), lower non-health consumption (10/16), less asset-based wealth (10/16), higher healthcare expenditure (12/16) and greater use of deleterious financial coping strategies, including cost management (11/16) and cost minimization (15/16).

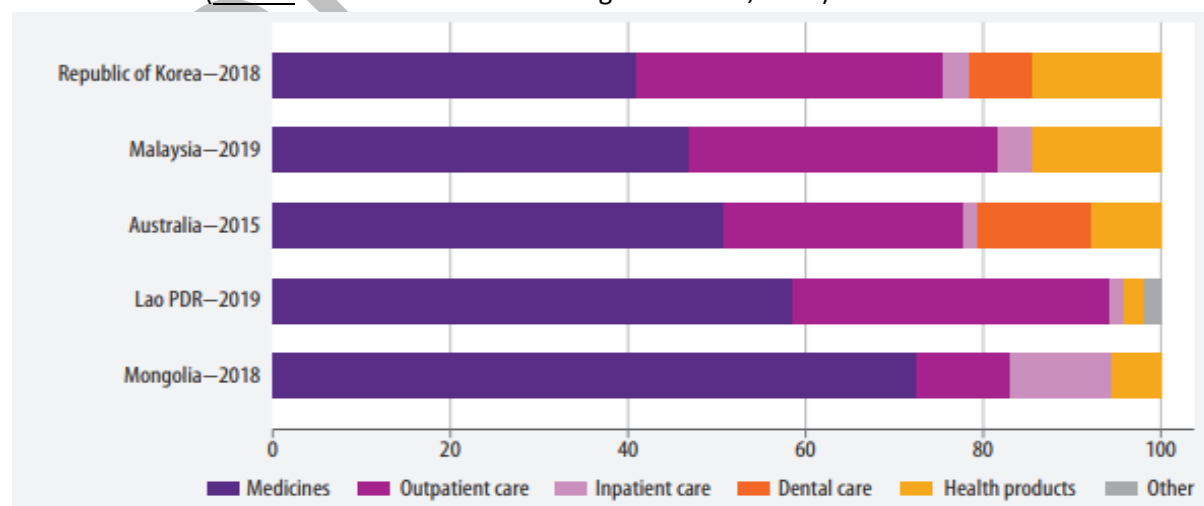
The findings indicate that households affected by MNS conditions have lower effective incomes available to them once their basic subsistence needs have been met, when compared with households without a person with an MNS disorder. In absolute terms these households had extremely limited resource availability to meet the (non-food) needs of their households. In contexts such as these, households are likely forced to make difficult decisions around whether to use these resources for education, housing or healthcare with substantial opportunity costs for all household members.

Section 3: A closer look at medicines

A closer inspection of the composition of OOP spending in different countries and world regions reveals increasingly clear evidence that medicines are a major driver. Assessment of OOP spending in the WHO South-East Asian Region showed that medicines accounted for more than 70% in four of the six countries for which data were available (Bhutan, India, Nepal, Timor Leste); moreover, the incidence of medicines as a driver of OOP spending was found to be higher among the poorest households compared to the richest (WHO, 2017). As shown in [Figure 2](#), a more recent study carried out for a range of countries from the WHO Western Pacific Region reveals a similarly large proportion (40-70%) of OOP expenditures going towards purchase of medicines.

Figure 2 Composition of OOP spending in the WHO Western Pacific Region

(Source: WHO Western Pacific Regional Office, 2023)

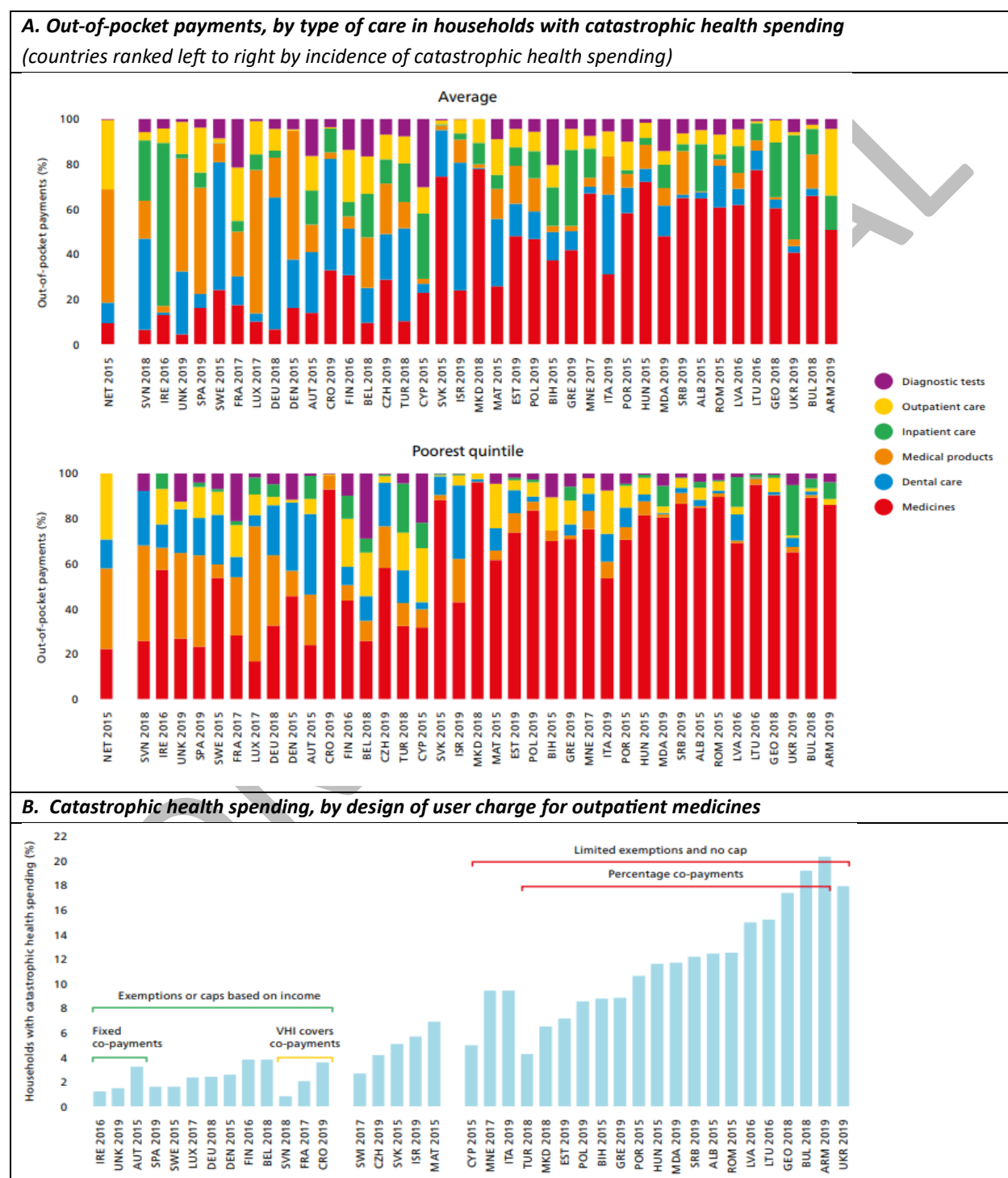


The most comprehensive assessment and analysis of OOP spending on medicines comes from the WHO European Region (WHO Regional Office for Europe, 2023). [Figure 3](#) shows not only the variable but generally significant contribution of medicines to catastrophic OOP payments, especially among poorer households (panel A) but also the influence of the design of user charge policy for outpatient medicines on rates of catastrophic health spending (panel B). Two critical findings stand out: 1) in countries with a higher incidence of catastrophic health spending, financial hardship is overwhelmingly driven by outpatient medicines (and again, this share is at its highest in the poorest consumption quintile); and 2) there is a clear distinction in rates of catastrophic health spending between countries that have put in place income-based caps or exemptions for co-payments for outpatient prescribed medicines versus countries that have no such caps and offer only limited exemption policies.

High levels of household spending on medicines can be attributed to gaps in all three dimensions of health coverage: people not being covered; the range of covered medicines being too limited to meet population health needs; and the presence of user charges (co-payments) for covered health care without effective mechanisms to protect people – particularly people with low incomes or chronic conditions. Other factors also play a role, including insufficient regulation on pricing, inappropriate prescribing and dispensing of medicines, low availability of medicines in pharmacies or health care facilities, and inappropriate choice or use of medicines by households. These issues are discussed in greater detail in an accompanying background paper and scoping review on *Enhancing Access to Essential Medicines for Non-Communicable Diseases*.

Actionable strategies that countries can take to mitigate against impoverishing or catastrophic health spending – both for low-income populations and those affected by chronic conditions – are set out in the final section of this paper. For now the conclusion is that, by primarily targeting rare but high-cost events such as emergency care or hospitalization, many health systems have failed to protect people from lower-cost but more regular and predictable expenditures for outpatient visits and medicines, and this is impacting those on low incomes and with chronic conditions the most.

Figure 3 Catastrophic health spending in the WHO European Region
(Source: WHO Regional Office for Europe, 2023)



Section 4: Considerations and actionable strategies for increased financial protection

Two key points stand out from the preceding sections of this paper:

- OOP spending continues to make up a large share of health care expenditures, particularly in low- and lower-middle countries (40%); and within countries, it is households with lower incomes that are most affected;
- OOP spending is being driven by outpatient care and especially medicines, and this spending is likely higher in households with chronic diseases or conditions, as they are not readily curable, typically endure for a long time, and require regular care and follow-up.

To address these challenges, several actionable strategies can be considered or pursued by countries to improve financial protection and mitigate against the most adverse consequences of financial hardship.

General strategies for increasing financial protection and moving towards UHC

- 1) **Increase public revenues and expenditures on health:** Despite the adverse macro-fiscal environment in many countries, there remain choices and opportunities to increase public revenues and expenditures on health. As set out in background papers 2 and 3 on development assistance for health and on domestic financing, additional sources of revenue for health in general and for NCDs and mental health in particular can be readily derived from increased health taxes, reduced subsidies on fossil fuels, and catalytic development assistance for health, including for climate mitigation and adaptation. These additional resources can contribute towards moving towards national UHC objectives, including the offer, provision and financial coverage of essential services and interventions for households affected by NCDs and mental health conditions, since it is these that make up the largest proportion of (often unmet) service need, financial hardship and national disease burden.
- 2) **Re-design coverage policy:** As discussed and referenced above, substantial evidence is now available concerning the coverage policy choices that are most likely to undermine financial protection. Excluding people from coverage or restricting entitlement to those paying contributions, for example, is both an unfair and inefficient policy choice, because it disproportionately effects people with low incomes and distorts help-seeking and service uptake. Accordingly, countries should de-link entitlement from payment of contributions. Countries can also review and reconsider their policies with respect to service coverage and user charges, including in light of the evidence presented here concerning outpatient care and medicines as drivers of OOP spending; more can be done to cover the costs of diagnostic tests, medicines and medical products as integral elements of primary health care. The same can be said for psychological treatments for mental health conditions, which are recognized

and recommended as an essential technology in the management of mental health conditions, yet remain outside the scope of publicly-funded essential services that are offered in a large majority of countries.

- 3) **Improve strategic purchasing, efficiency and access to essential services:** In addition to ‘more money for health’, countries can also obtain ‘more health for the money’ through more astute channeling of available resources away from high-cost, specialist-dominated service provision towards a) low-cost, population-based measures that reduce demand or exposure to known risk factors for NCDs and mental health conditions (e.g. taxes on alcohol, or universal school-based life skills programmes), and b) early detection, treatment and follow-up of priority NCDs and mental health conditions with cost-effective interventions delivered in PHC and other non-specialized care settings (see / refer to background paper 4). Timely access to such interventions should be included in essential health packages and covered or reimbursed by the publicly financed health care system. Such changes can be expedited through more strategic purchasing decisions and arrangements (that better align ‘what to buy’ with ‘how and with whom to buy’), and can be reinforced through development of a sound and agile public financial management system. Reimbursement processes can be overly complex, so need to be clear and simple enough for beneficiaries to navigate.

Specific strategies for mitigating financial hardship due to OOP spending on medicines

- 4) **Reduce the price of essential medicines for NCDs and mental health conditions:** The final cost to be paid at the point of need or use can be brought down by two main mechanisms: a) negotiating or regulating mark-up prices and supply prices with manufacturers of essential medicines (e.g. those on the Essential Medicines List of a country) (WHO, 2020); this can be done at the national level, for a group of countries (that on their own may have limited bargaining power) or even at a more global level (as demonstrated by entities such as GAVI, GFATM or the Affordable Medicines for Malaria Facility); b) removing import tariffs and taxes on essential medicines, since these are regressive in nature (hitting the poor most) and are essentially imposing a tax on the sick. Collective elimination of such tariffs would not only improve affordability and access to essential medicines but would also stimulate trade.
- 5) **Limit user charges for people with low incomes and those with chronic conditions:** Even at reduced prices, medicine expenditures can become unaffordable for households with low incomes or those with regular or recurring need (i.e. those with chronic conditions). An actionable strategy for countries to consider and plan for is therefore to ensure or extend exemptions from co-payments for households with low incomes, and limit or cap copayments or user charges for those affected by chronic conditions. As illustrated above in [Figure 3B](#), countries should seek to avoid percentage co-payments and instead employ low fixed co-payments, so that there is no difference in co-payments for outpatient prescribed medicines (WHO Regional Office for Europe, 2023); this can be expected to

significantly reduce financial hardship and enhance affordable access to essential medicines for households affected NCDs, mental health conditions and other chronic diseases.

Beyond enhanced financial coverage for health care services and products as an integral part of UHC, countries can also tackle the financial hardship encountered by households with low incomes by extending conditional and unconditional income support, thereby raising their incomes and consumption opportunities. Such policies can help to reduce levels of catastrophic and impoverishing expenditures, even if OOP payments remain unchanged (Sivanu and Sengupta, 2023).

Conclusion

It is important to acknowledge that the ease and speed with which these actionable strategies could be adopted or advanced will vary greatly, depending on each country's macroeconomic situation and fiscal space for health, as well as its existing configuration of health care services and providers and its planned pathway towards UHC. Governments therefore need to carefully consider how they can best meet their joint responsibilities to nurture socioeconomic development and to provide financial and social protection to those in need. Timely and effective prevention, early identification and management of NCDs, mental health conditions and other chronic diseases resides at the intersection of those two policy goals, whereby success or failure in moving towards UHC for people with chronic conditions will either bolster or undermine the resilience of health systems, human capital development, the economic welfare of households, social equity and economic prosperity. To magnify and elevate efforts towards both of these inter-related goals, a joined-up and aligned approach that works for and across different sectors and government departments will be of great value and importance.

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