Regional brief

November 2024

World Health Organization
African Region

Trends in financial hardship due to out-of-pocket health spending in the WHO African Region

The goal of universal health coverage (UHC) is to ensure that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship.[1] This brief discusses trends in financial hardship due to out-of-pocket health spending in the WHO African Region.

Financial hardship is monitored within the Sustainable Development Goals (SDGs) framework based on catastrophic and impoverishing out-of-pocket (OOP) health spending indicators. The incidence of catastrophic health spending (SDG indicator 3.8.2) is measured as the proportion of the population with OOP health spending exceeding 10% and 25% of total household expenditure or income (budget). The total population with **impoverishing health spending** includes people **impoverished** (pushed below the poverty line) and **further impoverished** (already below the poverty line but pushed even further below) due to OOP health spending. In this brief, we use the absolute poverty line of US$ 2.15 a day per person in 2017 purchasing power parity (PPP) that defines extreme poverty.

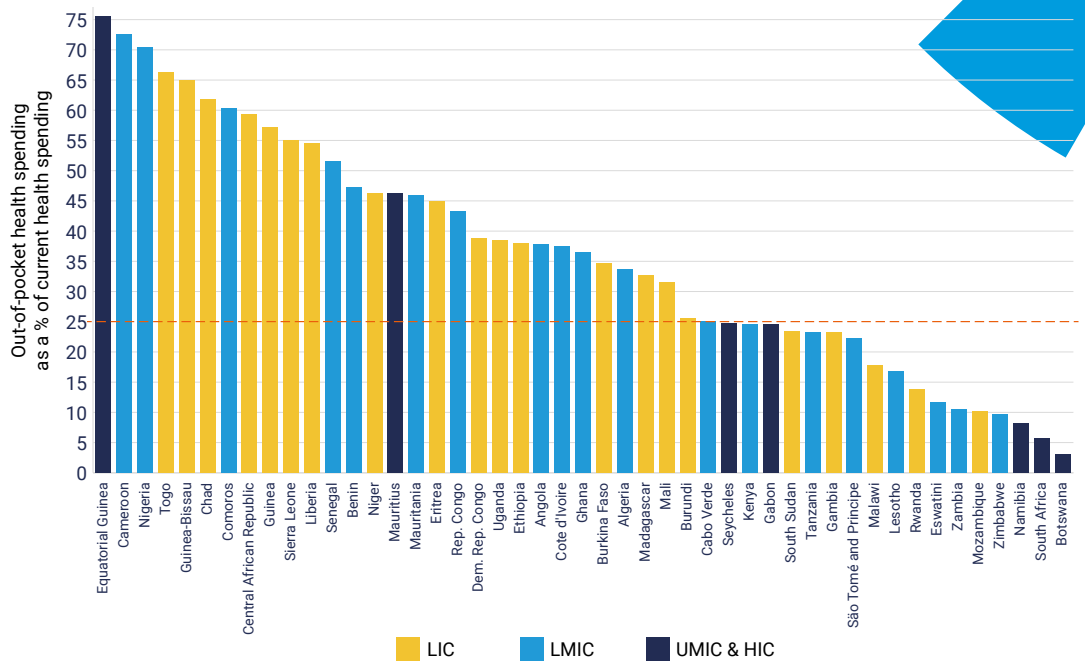
OOP health spending can occur in relation to any type of health product or service, any kind of care by any provider type, any illness or health condition, and any type of setting. It includes both formal and informal expenses directly related to the cost of seeking care.[2]

In countries of the WHO African Region, OOP payments are a significant source of funding for health. In 2019, OOP payments accounted for over 25% of current health spending in 31 countries. Moreover, in 11 countries, OOP payments exceeded 50% of current health spending, and in three countries, the share exceeded 70%. Within the WHO African Region, these payments were higher, particularly in low- and lower-middle-income countries. Only four countries' OOP spending represented less than 10% of their total health spending (Figure 1).

[1] Tracking Universal Health Coverage: 2021 global monitoring report. Geneva: World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2021. (https://www.who.int/publications/i/item/9789240040618, accessed 1 February 2023).

[2] OOP is mapped in division 06 of the UN classification of individual consumption according to purposes (COICOP-2018) https://unstats.un.org/unsd/classifications/unsdclassifications/COICOP_2018_-_pre-edited_white_cover_version_-_2018-12-26.pdf

Fig. 1. Out-of-pocket health spending as a share of current health spending by country, 2019, WHO African Region



Note: Data is available for 47 countries. Dem. Rep. Congo: Democratic Republic of the Congo; Tanzania: United Republic of Tanzania. HIC&UMIC: high-income and upper-middle-income countries; LICs: low-income countries; LMICs: lower-middle-income countries.
Source: WHO Global Health Expenditure Database, 2022[3]

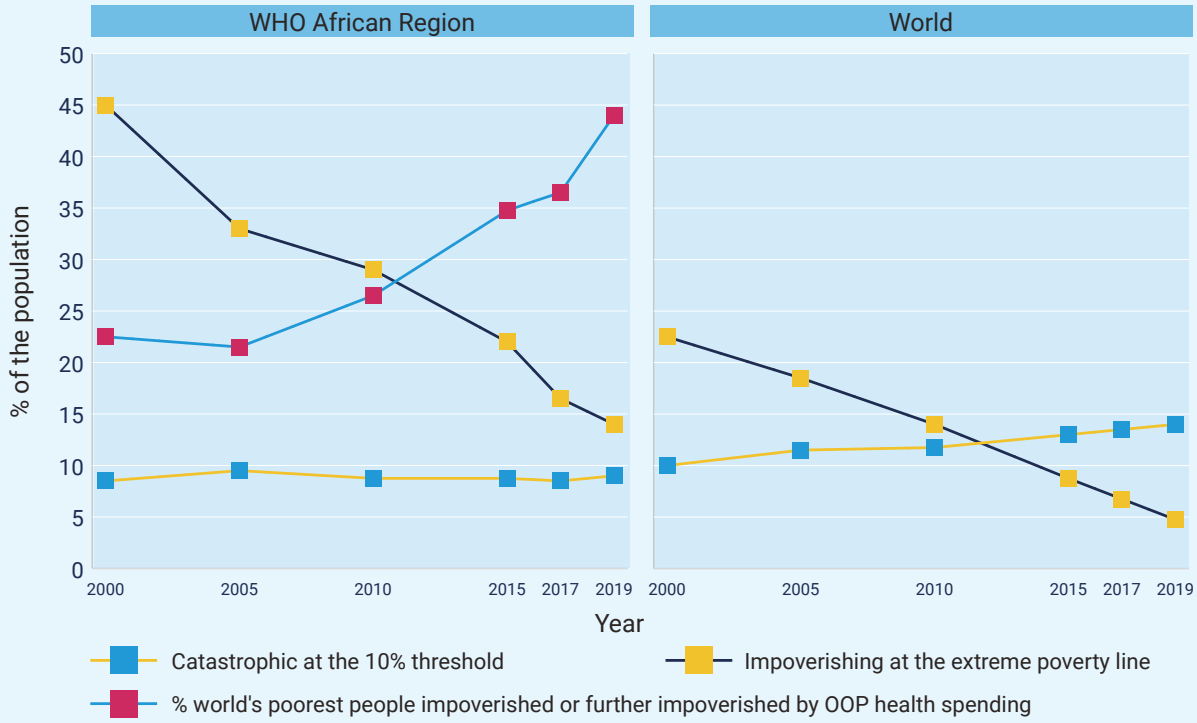
Catastrophic health payment rates in the WHO African Region have continuously increased, but at a slow rate, and more efforts are needed to reverse the trend. The proportion of the population spending more than 10% of their household budget on OOP on health increased from 7.8% in 2000 to 8.6% in 2019. The percentage of people spending more than 25% of their budget on OOP health costs increased from 1.4% in 2000 to 2.6% in 2019 (Figure 2, left panel). The rates of catastrophic payments were highest in the Region's low- and lower-middle-income countries, a pattern similar to that seen in the reliance of countries on OOP payments.[4] Despite this worrying trend, the concentration of the overall population incurring catastrophic health spending in the WHO African Region was on average 8.4% throughout the whole period. In comparison, globally, catastrophic OOP health spending rates increased much faster, from 9.6% in 2000 to 13.5% in 2019 (Figure 2, right panel). Overall, by 2019, ninety-five million people incurred catastrophic health spending in the Region.

The proportion of the population impoverished and further impoverished at the extreme poverty line has decreased fast but not as fast as in the rest of the world. Between 2000 and 2019, the proportion of people impoverished or further impoverished at the extreme poverty line of US$ 2.15 (in 2017 PPP) per day due to OOP spending decreased from 45.3% to 13.8% (Figure 2, left panel). Similar to catastrophic OOP health spending, the highest rates of impoverishing OOP health spending were also among low- and lower-middle-income countries. Globally, the proportion of the population with impoverishing health spending reduced much faster, from 22.2% in 2000 to 4.4% in 2019 (Figure 2, right panel). Therefore, the concentration of the world's population impoverished or further impoverished by OOP health spending living in the WHO African Region increased from 22.1% in 2000 to 44.2% by 2019. Overall, by 2019, a total of 152.2 million people incurred impoverishing health spending in the Region. This emphasizes the importance of implementing policies that ensure financial risk protection, especially for the poorest (living on less than US$ 2.15 a day (in 2017 PPP) per person). **Therefore, poor people must be exempt from out-of-pocket health costs.**

[3] Global Health Expenditure Database. Geneva: World Health Organization; 2022 (https://apps.who.int/nha/database, accessed 29 November 2022).

[4] "Towards universal health coverage in the WHO African Region: tracking financial protection." World Health Organization - Regional Office for Africa. Brazzaville: World Health Organization; 2024 (forthcoming).

Fig. 2. Trends in catastrophic and impoverishing health spending, 2000–2019



Source: Global database on financial protection assembled by WHO and the World Bank, 2023 update

Several factors are associated with the lack of financial protection:[4,5]

Household composition

A combined group of older and multigenerational households and households headed by older persons (60 years and older) are more likely to incur catastrophic spending. Impoverishing health spending is more common among younger and multigenerational households and households headed by persons aged 60 years and older.

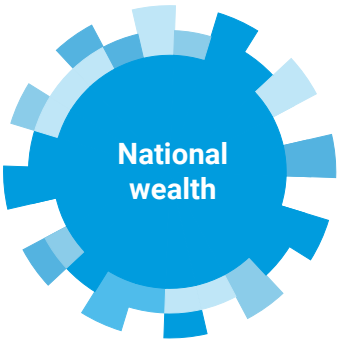
Location

Populations living in rural areas face higher rates of impoverishment due to OOP health spending, which may be explained by the high frequency of poorer households in rural areas. At the same time, populations living in urban areas face higher rates of catastrophic health spending.

Government spending

Countries with relatively high government health expenditure as a share of gross domestic product (GDP) tend to have lower levels of both catastrophic and impoverishing OOP health spending.

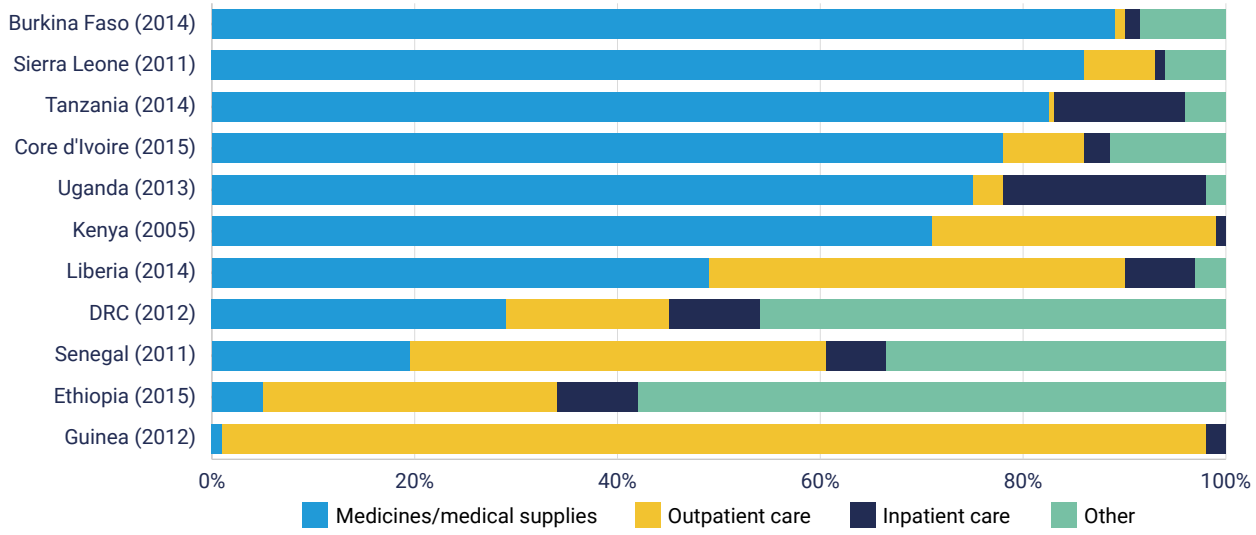
[5] SDG 3.8.2 Catastrophic health spending (and related indicators) [online database]. Global Health Observatory. Geneva: World Health Organization; 2023. (https://www.who.int/data/gho/data/themes/topics/financial-protection)



Countries with higher OOP health spending as a share of private final consumption tend to have higher rates of catastrophic health spending, while poorer countries tend to have higher rates of impoverishing health spending.

Medicines and outpatient services are among the most critical drivers of OOP payments and associated financial hardship (Figure 3). These could be initial options for action to reduce direct payments at the point of service.

Fig. 3. Average composition of households' OOP health spending



Notes: DRC: Democratic Republic of the Congo; Tanzania: United Republic of Tanzania. Estimates of average composition of household's out-of-pocket health spending are available for 11 countries with a median year equal to 2013.
Source: Global monitoring report on financial protection in health 2019. Geneva: World Health Organization, World Bank; 2020 (https://www.who.int/publications/i/item/9789240003958, accessed 9 March 2023).

People face multiple barriers to accessing needed health care, including those relating to the cost of care. When accessing adequate care requires OOP payments, it can exceed people's ability to pay, resulting in foregoing care[6] or relying on other coping strategies such as increasing debt. Hence, improving financial protection requires concrete efforts to eliminate or mitigate the impact of such cost-related barriers and accounting for all key drivers when developing policies and strategies for reform to address financial hardship.

[6] Evidence on this is available from the Global monitoring report on financial protection in health 2021. Geneva: World Health Organization and International Bank for Reconstruction and Development/ The World Bank; 2021 and forthcoming "Towards universal health coverage in the WHO African Region: tracking financial protection." World Health Organization - Regional Office for Africa. Brazzaville: World Health Organization; 2024.

Tracking financial protection is critical to designing and monitoring health financing policy goals. However, countries within the WHO African Region still face challenges with generating, analysing, and using financial risk protection monitoring data due to several reasons:

1. Lack of timely data.

In countries of the WHO African Region, household surveys, a data source for analysing financial risk protection, are conducted, on average, every four years. However, many countries have gone without conducting a survey for more than five years. Furthermore, surveys frequently vary in data collection methods, recall periods, comprehensiveness, and specificity. The lack of standards within and across countries limits the extent to which the components of OOP health spending can be disaggregated and compared over time and across countries.

2. Institutionalization of financial protection tracking

is yet to be realized due to weak collaboration between ministries of health and national statistical offices that generate the data and have the capacity to conduct analyses.

3. Financial protection indicators have not been mainstreamed into health sector reviews

and performance monitoring assessments within Member States of the WHO African Region. This has limited the utilization and hence the demand for financial protection information to inform health financing policy design and monitoring.

In conclusion, countries and partners must invest in efforts to support countries to generate the required data through comprehensive standard surveys. Tracking within the health system monitoring and performance assessment processes must be comprehensive and ongoing.

Reference number: WHO:AFRO/ULC:2024-01