Health Accounts Course

Module 6:

The financing dimension

Submodule 6.4:

Household out-of-pocket spending

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Content

- Out-of-pocket (OOP) health care payment [HF.3]
- Boundary setting of out-of-pocket payment
- Characteristics of out-of-pocket payment schemes
- Main types of out-of-pocket payment schemes
- Main modalities of cost sharing
- Example of financial flows related to out-of-pocket payment [HF.3]
- Revenue and financing agents managing out-of-pocket payment schemes
- Frequently used data sources
- Accounting notes for out-of-pocket payment schemes
- Estimation approaches
- Challenges

Additional Content:

- Questions and Answers
- Suggested reading

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Out-of-pocket (OOP) health care payment [HF.3]

OOP expenditure refers to direct payment for health care goods and services from households' primary income or savings. It occurs **when no other arrangement covers** the totality or covers only a part of the health care bill.

Due to its policy relevance and linkage to **Universal Health Coverage**, particular attention is paid to OOP, as it has significant implications for access and financial protection.

In Health Accounts it is treated as a health care **financing scheme**. It includes household spending through **direct payments**, insurance **co-payments/cost-sharing** and **unofficial payments** to providers [gifts and "under the table" payments].

- When the payment is **without any coverage** of prepaid schemes, the household pays the **full price** of services or goods.
- **Cost-sharing** refers to the amount households have to pay out-of-pocket for services that are partially covered by prepaid schemes.

In some cases, households initially pay for health care but may receive full or partial reimbursement from other schemes. Such **reimbursements** must be deducted from OOP to prevent double counting and overestimation. This means that OOP is registered **net of reimbursements**.

In Nepal, some Ministries reimburse their employees' health care payments [these reimbursements are part of government schemes expenditure, see submodule 6.2].

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Boundary setting of out-of-pocket payment

OOP relies on the **SHA 2011 boundary** for international comparability: the main purpose is health, meaning prevention, treatment, purchase of medicines, and other medical goods.

It includes

Health spending by **residents,** even outside the country, which are **imports.**

Spending on **medical goods and food** to the inpatient when the health facility is not providing or charging the patient for it.

It excludes

Payments by **non-residents**, which are exports**.**

Non-health spending, such as education, faith healing or cosmetic surgery (for non-medical reasons).

Transportation expenses to the health care facility when these are not in an ambulance.

Payments for insurance premiums, contributions, or any other type of health care **prepayment**.

Thailand is known for its well-developed medical tourism industry. Most people who travel abroad for medical care come from high income countries, such as USA, Europe, Australia, and the Middle East. This spending should be **excluded** from HA in Thailand but **included** in the accounts of the home-countries of the tourists.

*Spending outside the boundary can be **displayed separately** for selected items when it is policy relevant. This may be the case for transportation spending, which in many countries is necessary when the facilities are not close to the patients. Their monitoring **below the line** may be relevant to complement the assessment of the need for telemedicine. At the same time, this is often an available amount in household surveys. This approach ensures that OOP payments analysis complies with the health care boundary.*

Characteristics of out-of-pocket payment schemes

Mode of participation

OOP depends on **capacity and willingness to pay**.

It is by convention treated as **voluntary**, as it involves a household discretionary acceptance of the payment to be made.

Benefit entitlement

Services are paid either **fully or partially** by the household.

Many schemes request a **copayment** as a condition for the beneficiary to receive the service.

Basic method for revenue collection

OOP is funded through household **disposable income** and **savings**, sometimes from other households/relatives.

Pooling

In this scheme, there is **no pooling**, which increases the vulnerability to catastrophic spending. However, to reduce financial hardship, special exemptions for certain population groups might exist, such as limits on cost-sharing.

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Main types of out-of-pocket payments

Code	Name
HF.3	**Household out-of-pocket payment**
HF.3.1	Out-of-pocket excluding cost-sharing
HF.3.2	Cost sharing with third-party payers
HF.3.2.1	*Cost sharing with government schemes and compulsory contributory health insurance schemes*
HF.3.2.2	*Cost sharing with voluntary insurance schemes*
HF.3.nec	Unspecific household out-of-pocket payment

When the **total amount** of the health service/good is requested from the consumer. For example, privately paid health services and over the counter (OTC) medicine costs without insurance or reimbursement.

Cost-sharing is the amount of spending on health care to be paid by the beneficiary

In Mongolia, SHI requires co-payments for some services, particularly for secondary and tertiary inpatient care, exempting certain population groups.

Include **primary/substitutory** and **complementary/supplementary** insurance schemes.

In the Bahamas, copayments for patients with private health insurance are high, especially for hospitalizations and advanced diagnostics, due to the high cost of private medical care.

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Main modalities of cost-sharing

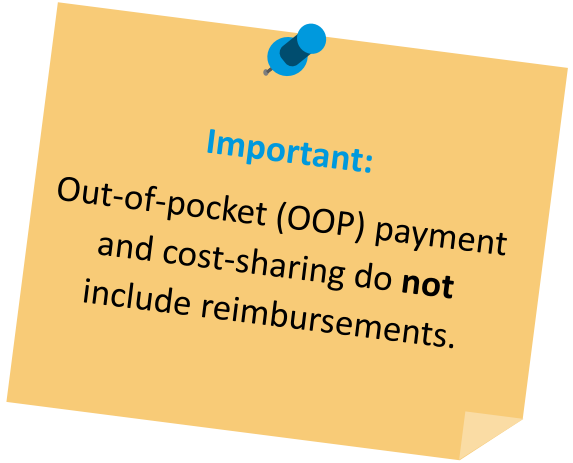
Cost-sharing can have different forms:

Co-payment:
A **fixed amount** paid by the consumer for each service.

Co-insurance:
When insurance applies, the arrangement specifies the **percentage** of the cost the household pays.

Deductibles:
Amounts paid by the household until a certain **threshold** is reached, after which insurance starts to cover.

Ceiling:
In some countries, OOP payments have a ceiling, limiting the **total amount** households pay during a specified period.



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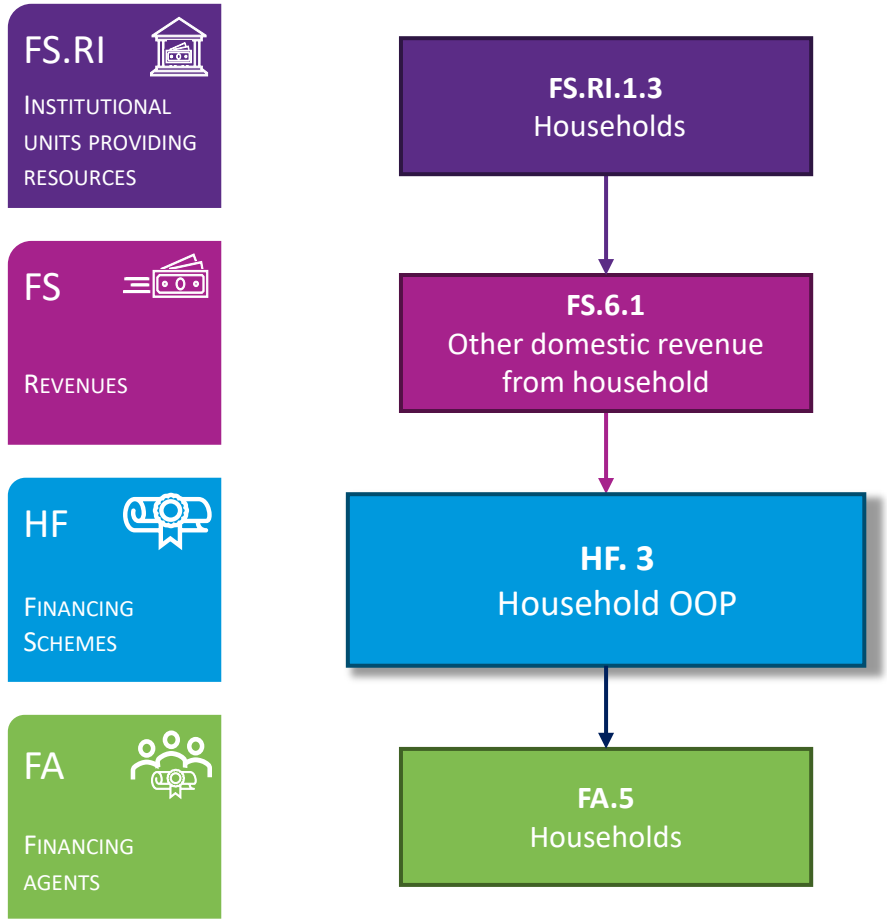
Example of financial flows related to out-of-pocket payment [HF.3]

The complete flow can be represented in a single chart. The flows related to out-of-pocket payments are specifically linked to households.

The chart provides a simplified view; additional flows may exist.



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Revenue and financing agents managing out-of-pocket payment schemes

FS.RI

Households [FS.RI.1.3] are the origin for out-of-pocket payments. But FS.RI.1.3 can also comprise donations and prepayments.

FS

All out-of-pocket payments are funded by other revenues from households n.e.c. [FS.6.1]. But FS.6.1 can comprise also donations.

HF

The value of the goods and services paid by the household [net of reimbursement] corresponds to the household out-of-pocket schemes [HF.3].

FA

Because households decide what proportion of their resources are allocated to health and which goods and services are purchased, they are the financing agent [FA.5].

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Frequently used data sources [1]

Since there is no single data source that provides all information needed for OOP estimation, several types of data source need to be consulted. HA should be able to link OOP spending with the related provider and associated function, and other financing schemes associated with cost sharing, such as insurance schemes.

National Accounts report household consumption on health and medical goods [medicines and other devices].

a. A first choice is the integrated household data in the **supply and use table**: using International Standard Industrial Classification of All Economic Activities (ISIC) mostly in Q86 health care and Q87 nursing care branches. In Q87, social care may be the largest share. Also important is G4772 on specialized stores of Retail sale of pharmaceutical and medical goods, cosmetic and toilet articles, of which only the health components should be included. G4771 may also have a component of health care sales but in non-specialized stores, such as supermarkets.

b. Using the **Classification of Individual Consumption by Purpose (COICOP)**, these are in section 6 [health]. See version 2018, with coding compatible with SHA 2011 classifications.

c. The **Central Product Classification (CPC)** 931 for human health services includes categories like 9311 for hospital services and 9312 for medical and dental services and 932 residential care services [including social and health], and in section 6 division 621 non-specialised and 622 specialised retailers of health care goods [see annex E in SHA 2011].

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Frequently used data sources [2]

- The **Central Bureau of Statistics [CBS/CSO] Business surveys** and **economic census** may have data on sales of health care, which can be used to estimate OOP. Provider surveys of retailers may include sales revenues from pharmacies, optics, and other medical devices.
- **Household budget and expenditure surveys** include data on OOP. These can be, e.g. the household budget surveys (HBS), the household income and expenditure surveys (HIES), the Statistics on Household Income and Living Conditions survey (SILC), the Demographic and Health Surveys (DHS) OOP module and the Living Standards Measurement Studies (LSMS). Each survey may have a specific national content. Ideally, surveys should be linked to COICOP 2018, which is closer to SHA 2011. Household survey results need to be verified on boundaries, structure of the survey in relation to SHA, and time periods.
- **Records of health insurance companies** may provide data on collected co-insurance, copayments and deductibles, from which OOP can be calculated. Reimbursements need to be deducted to accurately estimate OOP, as previously mentioned.
- Revenue reports of **health care providers** may indicate household payments and their related services.
- OOP paid in public facilities can be reflected in the **executed revenue budget** [MOF], although it may not identify OOP separately, and it may have a different label, such as “technical revenue”. In these records the health reimbursements to households by public agencies may be included.
- For **triangulation purposes**, spending levels of specific OOP components, such as records of pharmaceutical spending in pharmacies and of private facilities including laboratories and imaging centres, can be used [see slide 10].
- In the short term, gaps may be closed by **surveys or expert opinion**. However, to produce annual updates, a strategy for data development is necessary.

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Accounting notes for out-of-pocket payment schemes

- It is important to **verify what data are available** and compare their strengths and weaknesses.
- Check the content of each data source and **align it to the SHA 2011 boundary**.
- Each data source leads to different results. Select the best data source and use the others to **triangulate** or to fill gaps.
- The most comprehensive single data source is the **use table of National Accounts,** which displays OOP as an aggregate. In its absence, the starting point can be a **report based on the COICOP classification**. However, the most frequently available source is the **household survey**, which can also be used once its processing by CBS is finalized.
- The **administrative or survey records** of specific OOP components, can be used for triangulation and estimation of OOP. For example, sales of providers of medical goods.
- The **share of insurance refunds and reimbursements** can be applied for the calculation of cost sharing by type of service and provider.
- **Reimbursements** from insurance or other schemes need to be identified and deducted.

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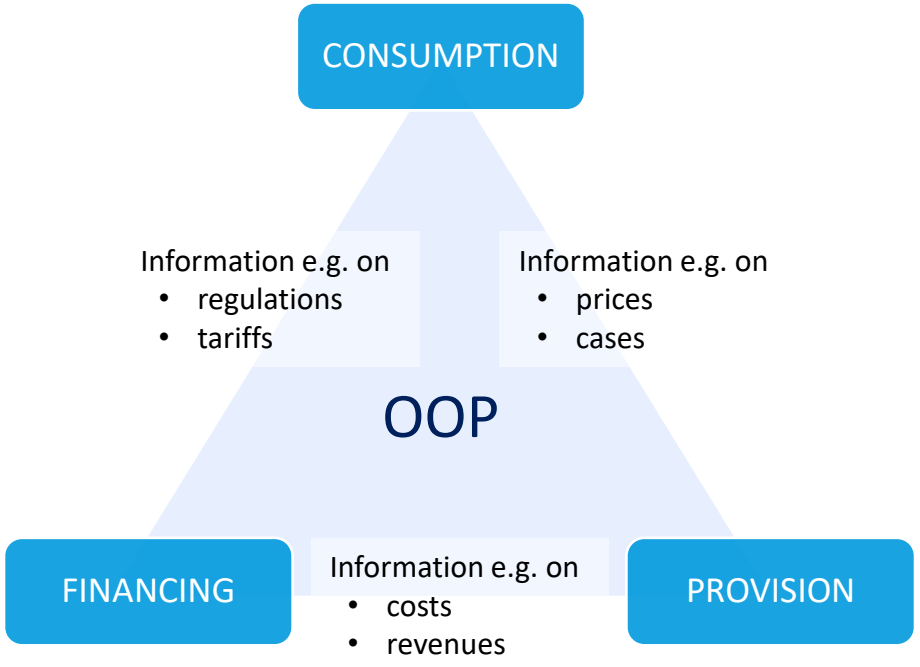
Estimation approaches

Measuring OOP is the biggest challenge for HA teams because it is the only component that usually cannot be 100% observed, and in the majority of countries part (or all), has to be estimated. The procedure used depends on the type of data available (administrative data, National Accounts, surveys) and their content.

To estimate OOP, the "best" method, is the "**integrative approach**" as proposed by SHA 2011. Integration implies selecting and combining the **highest-quality and most detailed data**. It draws on all available data sources, and triangulates estimates from three key perspectives: **financing, provider, and consumption**. This approach leads to more robust results, and more consistent and better-quality data, than estimates of OOP spending derived from a single data source.

Triangulation implies comparing the data, their plausibility, and robustness. It also includes considering the data available for the various OOP components, to identify the best data, or to complement or replace the estimation. This may refer to the expenditure components on OTC and/or prescribed medicines, health care in private sector, doctors' fees, laboratory, imaging, hospital and medical supplies. The estimation can also involve non-expenditure data and costs. It is important to identify ways of reflecting relevant spending, utilization, and regulatory changes.

Triangulation of multiple types of data within an "integrative approach" to measuring OOP:



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Challenges

National Accounts

In National Accounts, household final consumption may not identify the health branch and data may not be available annually.

Time lag

The time lag between the OOP and reimbursement may refer to more than a one year calendar period.

Statistical challenges in surveys

All surveys involve biases, among which the recall bias can be reduced in continuous record expenses during a full month in the most specific household budget surveys.

Limited details

Health components in surveys may be limited in detail and more comprehensive surveys may obtain better results.

SHA 2011 health care boundary

OOP data from household surveys may include non-health components which are sometimes difficult to separate.

Limitations of surveys

Expansion factor may be biased when the survey samples are not specifically designed for health expenditure.

Determination of the accounting period

The OOP payment may be made later than the service used, e.g. in cost-sharing. Health Accounts aim to use accrual accounting and the spending is recorded when the service is consumed, to the extent possible.

Avoid double counting

It is very likely that OOP are accounted in the reported data from schemes and facilities owned by the government or the SHI agency. In that case, to avoid double counting, OOP needs to be excluded from HF.1.1 or HF.1.2.1.

Availability of non-expenditure data

Non-expenditure data, such as morbidity data used for OOP estimation, may not be available annually and may differ from administrative records.

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Questions and answers

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Question & Answer [1]

What is the best data source for OOP expenditure estimation?

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Question & Answer [1]

What is the best data source for OOP expenditure estimation?

Different data sources produce different results; the strength of each source should guide which one is prioritized for what part of the OOP calculation.

The recommended method for estimating OOP is to use the available data and apply an **integrative approach** that triangulates the various data sources to reach the best result.

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Question & Answer [2]

Given that both National Accounts and household surveys may have quality problems, what procedure can verify their plausibility?

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Given that both National Accounts and household surveys may have quality problems, what procedure can verify their plausibility?

A common approach is cross-validation through **triangulation**. This involves comparing key components, such as the estimated spending on pharmaceuticals, inpatient care, and outpatient care expenditures, across the various sources. Additionally, these figures can be compared with non-expenditure data and cost information. Triangulation also includes verifying values against regulations and cost-sharing tariffs to ensure they align with official policies.

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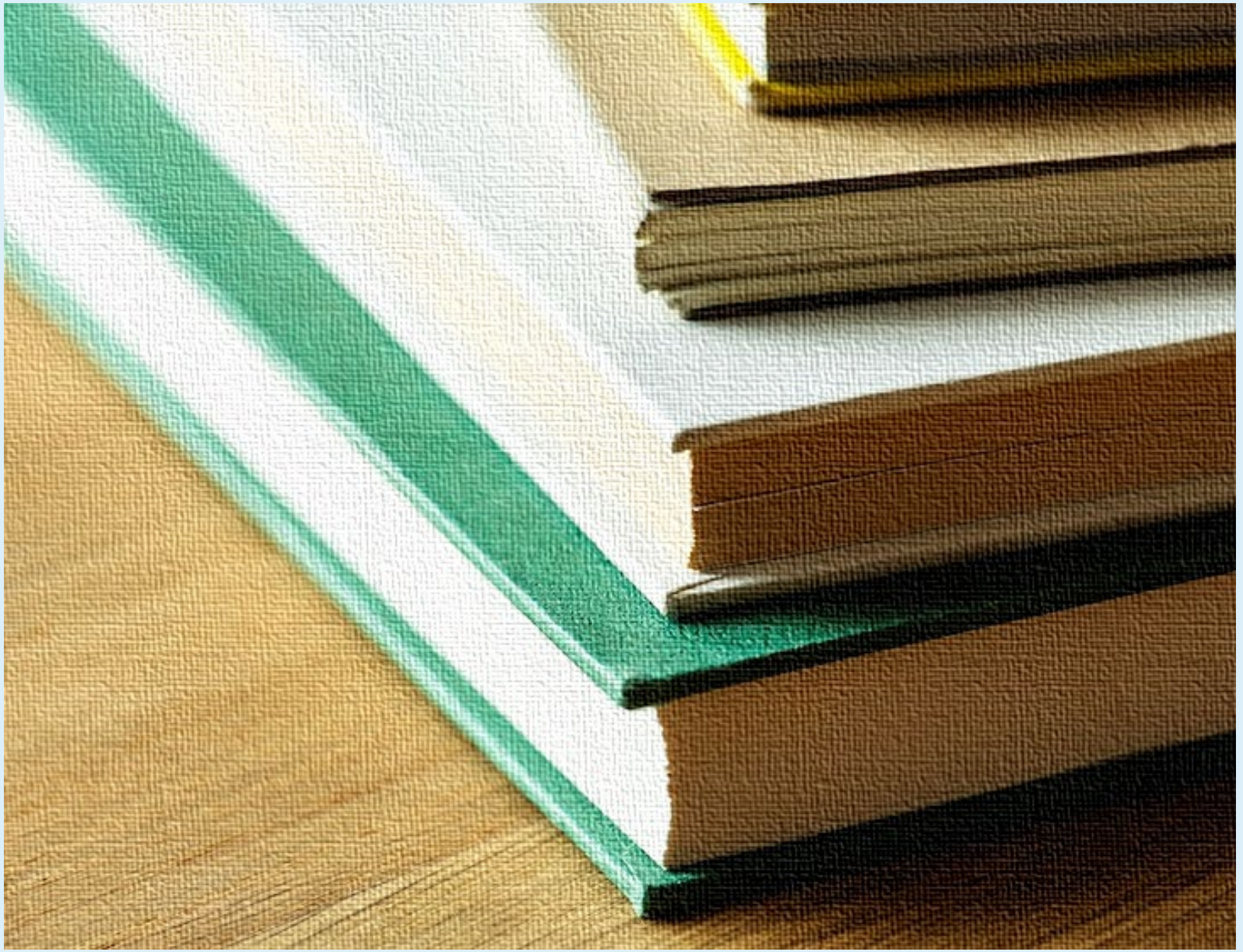
Suggested reading



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Suggested reading

- OECD, EUROSTAT, World Health Organization. A System of Health Accounts 2011: Revised edition. Paris: OECD Publishing; 2017. Available from: https://www.who.int/publications/i/item/9789240042551. Chapters 3-7, 11.
- Tracking out-of-pocket health expenditure under System of Health Accounts 2011. Geneva: World Health Organization; 2025. Licence: CC BY-NC-SA 3.0 IGO.
- WHO. Methodology for the update of the Global Health Expenditure Database. https://www.who.int/publications/i/item/9789240112001
- Global health data methods. National Health Accounts. https://globalhealthdata.org/national-health-accounts/
- OECD. Guidelines for the Implementation of the SHA 2011 Framework for Accounting Health Care Financing; 2014. Available from: https://apps.who.int/nha/database/DocumentationCentre/GetFile/57873381/en
- Global spending on health: emerging from the pandemic. Geneva: World Health Organization; 2024. Chapter 2. Licence: CC BY-NC-SA 3.0 IGO.
- WHO-PAHO. Out-of-Pocket Expenditure: Reliable Data to Monitor Universal Health. https://iris.paho.org/handle/10665.2/61818

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Health Accounts Course

Module 6: The financing dimension

Submodule

6.1 The financing dimension

6.2 Government health care financing schemes

6.3 Health insurance schemes

6.4 Household out-of-pocket spending

6.5 Other health financing schemes

This is the end of the fourth submodule "Household out-of-pocket spending" of Module 6: The financing dimension.

Join us for submodule 6.5 of the course, where you will learn about other health financing schemes.

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