6.2. Out-of-pocket payments as a share of current expenditure on health (A-2), per capita (A-3), and as a share of final household consumption (A-10); Out-of-pocket payments on dental care as a share of current expenditure on dental care (A-11)

6.2.1. Documentation sheet

Description	A-2 - Out-of-pocket payments on health (% of current expenditure on health) A-3 - Out-of-pocket payments on health (in US $ PPP/capita) A-10 - Out-of-pocket medical spending (% of final household consumption) A-11 - Out-of-pocket payments on dental care (% of current expenditure on dental care)
Calculation	A-2 - Amount of out-of-pocket payments on health (HF .3 in the ICHA-HF classification of healthcare financing) divided by current expenditure on health A-3 - Amount of out-of-pocket payments on health (HF.3 in the ICHA-HF classification of healthcare financing) divided by population (mid-year for the relevant year) A-10 - Amount of out-of-pocket payments on health (HF.3 in the ICHA-HF classification of healthcare financing) excluding long-term healthcare expenditure (HC .3) divided by final household consumption A-11 - Amount of out-of-pocket payments on outpatient curative dental care (HF.XXX in the ICHA-HF classification of healthcare financing) divided by current expenditure on outpatient curative dental care (HC 132)
Rationale	Financial accessibilty is a basic condition for a functional healthcare system. Foregoing necessary treatment because of its cost can be detrimental to a person's health. High out-of-pocket payments that affect other necessary expenses are also considered undesirable. Healthcare is generally considered financially inaccessible when people limit or postpone the use of necessary care because of (excessively) high costs, or when they have to relinquish other basic necessities because they need care. Out-of-pocket medical spending as a share of final household consumption gives a kind of opportunity cost of spending on healthcare. Dental outpatient curative care expenditure is defined in the System of Health Accounts (SHA, OECD).[1] Trends in OOP for dental care are an important indicator of accessibility because dental health care is less covered by the sickness funds than other healthcare services and a high amount is paid by patients.
Primary data source	OECD Health Statistics 2018 (System of Health Accounts (SHA))[1]
Technical definitions	Out-of-pocket payments are expenditure borne directly by a patient because health insurance does not cover the (full) cost of the health good or service. They include cost-sharing (co-payment, coinsurance – "ticket modérateur" in French and "remgeld" in Dutch – or deductible), self-medication and other expenditure paid directly by private households. It does not include all of the patient contribution to long-term care in elderly and nursing homes. This is due to the fact that not all care provided in nursing homes (mostly used by the elderly) is classified under 'health care' in the health accounts (the Belgian estimate is limited to the copayment for 'nursing and care beds' only – copayments related to all other expenditure in nursing homes is considerd as 'social' care, and thus kept out of scope).

Limitations	Final household consumption is available through the national accounts and does not take into account cash allowances that households get (care allowances). In the Belgian SHA, expenditure for long-term healthcare (HC .3) is included for the out-of-pocket medical spending (under the assumptions above), where a correction is applied to the national accounts data, in order to correct for a.o. different care allowances that are available to households (these allowances are reported as public expenditure). Nevertheless, because the capacity of countries to estimate private long-term care expenditure varies widely, caution is needed in the comparison of figures, as comparability is not guaranteed. The patients out of pocket expenditure for dental care reported is also based on the households' final consumption estimation of the national accounts, with some technical corrections. One of these corrections concerns coverage by private insurances but due to a lack of detailed data, this correction is not fully accurate. Nevertheless, private insurances for ambulatory dental care are still limitedly spread in Belgium.
International comparability	The OECD definition was adopted. OECD member countries are at varying stages of implementing the System of Health Accounts (SHA). Therefore, the data reported in OECD Health Statistics 2018 are at varying levels of comparability.
Performance dimension	Accessibility of care
Related indicators	Healthcare expenditure according to the System of Health Accounts (OECD) Delayed contacts with health services for financial reasons

6.2.2. Results

Table 36 gives the evolution over time (2004-2016) of out-of-pocket payments expressed in million euros, as a percentage of current expenditure on health and in euros per capita. Total out-of-pocket payments (OOP) increased between 2004 and 2014 from 4.93 to 7.09 billion euros and tended to decrease since 2014 (6.73 billion € in 2016, see Table 36). The share of out-of-pocket payments in current expenditure on health remained constant during the same period and even tended to decrease in recent years (18.2% in 2004 and 15.9% in 2016, see Table 36) mainly due to an increase in public funding. Measured in per capita terms, out-of-pocket payments increased from € 473.3 in 2004 to € 632.9 in 2014 and slightly decreased since 2014 to reach € 593.8 per capita in 2016. Official co-payments (a part of these out-of-pocket payments) remains quite stable for the same period. One explanation is that safety nets, such as the maximum billing system or increased reimbursement of medical expenses, target the protection of patients against large amounts of co-payments only. Other out-of-pocket payments such as over-the-counter medicines or supplements are not included in these safety nets.

While OOP have slightly decreased these two latest years, health expenditure covered by voluntary health insurance has continued to slightly increase (from € 132 per capita in 2004 to € 189 per capita in 2016).

Table 36 – Out-of-pocket payments on health in Belgium (2004-2016)

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
OOP payments (in million €)	4 932.5	4 901.4	5 269.1	5 716.9	5 864.1	6 150.2	6 338.0	6 692.1	6 778.3	7 040.5	7 093.7	6 823.8	6 729.0
Official co-payments (in million €); after MAB reimbursements*	1 320.1	1 349.5	1 364.4	1 432.2	1 575.5	1 660.0	1 610.5	1 627.5	1 671.6	1 680.5	1 677.5	1 756.5	-
Voluntary health care payment schemes (in million €)	1 450.6	1 531.4	1 587.0	1 692.1	1 514.1	1 490.6	1 543.5	1 704.7	1 719.2	1 833.8	1 913.2	2 132.9	2 261.9
OOP payments as a share of current expenditure on health	18.2%	17.6%	18.2%	18.7%	17.9%	17.6%	17.6%	17.6%	17.3%	17.5%	17.1%	16.5%	15.9%
OOP payments on dental care as a share of current expenditure on dental care	50.2%	48.8%	51.4%	51.2%	48.4%	49.9%	53.1%	55.4%	55.0%	55.0%	55.5%	56.2%	57.6%
OOP per capita in current prices (€)	473.3	467.8	499.5	538.0	547.5	569.6	581.7	606.3	610.3	630.9	632.9	605.3	593.8
Voluntary health care payment schemes per capita in current prices (€)	132.1	139.2	146.1	150.5	159.2	141.4	138.1	141.7	154.4	154.8	164.3	170.7	189.2
OOP per capita, purchasing power parity in current prices (US$)	$ 532.5	$ 524.5	$ 570.9	$ 611.4	$ 631.6	$ 670.1	$ 696.0	$ 728.8	$ 742.3	$ 782.6	$ 790.9	$ 755.3	$ 738.9

*Source: SHA, OECD Health Statistics 2018; * after Maximum Billing reimbursement (source: Assuralia 2018[2])*

The cost of healthcare for patients or households is not necessarily the same as the financial burden of healthcare. A household financial burden is measured in terms of its capacity to pay rather than an absolute amount of out-of-pocket payment. Hence, the financial burden depends on household income. Since out-of-pocket payments for health displaces resources available for other goods and services, they should be related to household consumption patterns to measure 'financial protection' in health.

The Household Budget Survey (2016) showed that, on average, the share of out-of-pocket payments in total household consumption is 4.6% in Belgium (i.e. € 1 571 on average per household per year and € 689 per inhabitant per year, see Table 36). There were small differences between regions in terms of health expenditure. Higher income households spend twice as much on health as lower income households (€ 2 154 for higher income households versus € 954 for lower income households in 2016).

Table 37 – Average OOP health expenditure per household and as a share of total household consumption per year, in Belgium (2012-2016)

			2012	2014	2016
Average OOP health expenditure per inhabitant (in €)	Region	Belgium	635	716	689
		Brussels	615	726	644
		Flanders	640	740	688
		Wallonia	634	668	705
Average OOP health expenditure per household (in €)	Region	Belgium	1 497	1 655	1 571
		Brussels	1 317	1 520	1 396
		Flanders	1 529	1 738	1 586
		Wallonia	1 503	1 558	1 606
	Income level	Lower income quartile (<Q25)	1 005	983	954
		Top income quartile (>Q75)	1 944	2 346	2 154
OOP health expenditure as a share of total household consumption	Region	Belgium	4.2%	4.6%	4.6%
		Brussels	4.5%	4.9%	4.7%
		Flanders	4.1%	4.6%	4.4%
		Wallonia	4.3%	4.6%	4.9%
	Income level	Lower income quartile (<Q25)	5.1%	4.9%	4.9%
		Top income quartile (>Q75)	3.6%	4.4%	4.2%

Source: Household Budget Survey (2016); https://statbel.fgov.be/fr/themes/menages/budget-des-menages#news

A third dimension of coverage, in addition to population and cost coverage, is service coverage which can be defined as the proportion of primary health coverage in total health spending. Service coverage in Belgium largely varies by function of care: 86.9% service coverage for inpatient care (curative and rehabilitative care), 73.6% for outpatient care (curative care and rehabilitative care, with the lower coverage for dental care, i.e. 42.4%), 94.4% for long-term care, 92.5% for ancillary services, and 70.2% for pharmaceuticals goods (2016 SHA data).

International comparison

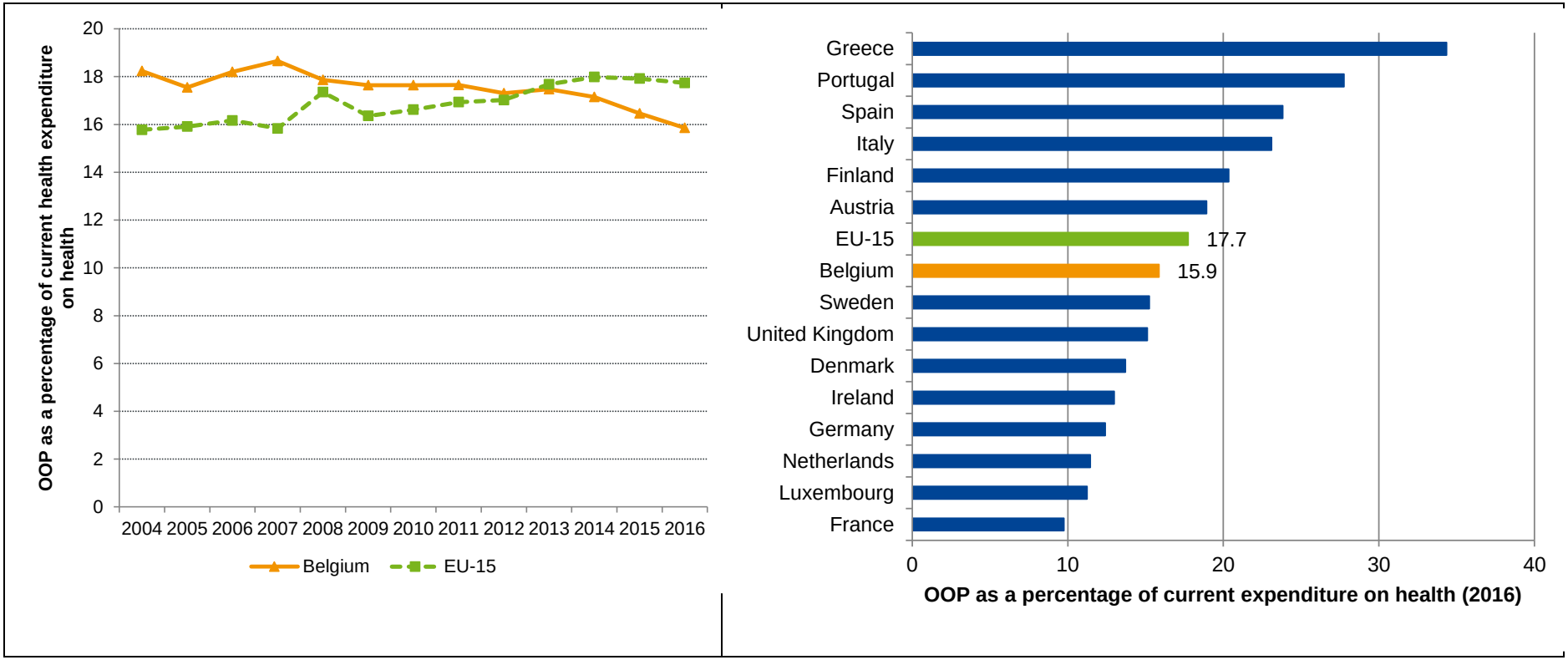
In an international perspective (Figure 65), out-of-pocket payments represent a relatively large share in current expenditure on health in Belgium (15.9%), with only Finland, Austria and the Southern European countries showing a larger share. In Portugal and Greece out-of-pocket payments are more than 25% of current expenditure on health. In France the share is slightly less than 10%. Figure 65 also compares the evolution over time (2004-2016) of the share of out-of-pocket payments in current expenditure on health between Belgium and EU-15. For the whole period the share for Belgium was similar to the share for EU-15 and ranged between 16% and 18%. Since 2013, the share of out-of-pocket payments in current expenditure on health for Belgian is nevertheless below the share for EU-15.

When out-of-pocket payments are expressed per capita, Belgium is above the EU-15 average (US $ 739 PPP, see Figure 66). The EU-15 average amounted to US $ 732 (PPP). Austria, Finland and Sweden are at the top of the ranking (see Figure 66). In France out-of-pocket payments per capita amounted to US $ 466 (PPP) in 2016. Figure 66 also compares the evolution over time (2004-2016) of the share of out-of-pocket payments per capita between Belgium and EU-15. Both in Belgium and in EU-15, the average amount per capita increased between 2004 and 2014 (from US $ 533, PPP to US $ 791, PPP in Belgium). Since 2014, the trend seems to slightly decrease in Belgium, to reach US $ 739, PPP per capita in 2016.

Figure 67 measures the burden of out-of-pocket medical spending (i.e. OOP on health excluding OOP on long-term healthcare to make results more comparable between countries) as a share of final household consumption. The share of household consumption allocated to medical care varied across European countries, ranging from about 1.5% of final household consumption in Luxembourg, France and the United Kingdom, to 4% in Greece. In 2016, Belgian households spent 3% of their final consumption on health (excluding long-term care) and it was higher than the EU-15 average of 2.6% (see Figure 67).

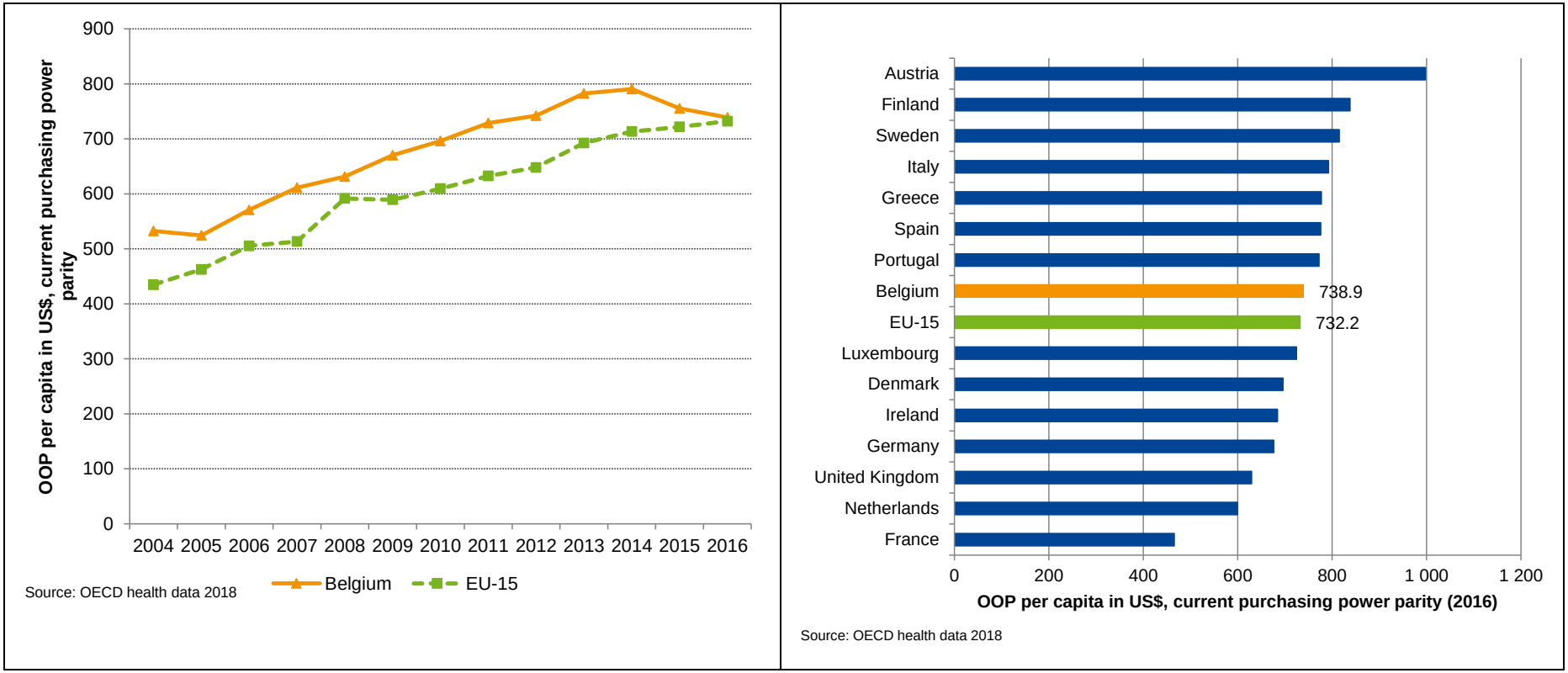
Concerning dental care, the share of out-of-pocket payments is high. With a share of 57.6% in 2016, Belgium is slightly below the European average (based on 10 countries) but is above bordering countries such as Germany (25.5%) and the Netherlands (21.7%). The high European average is mainly due to the fact that dental care in Greece and Spain are almost not covered. Over time (2004-2016), Belgium remain close to the European average but the share of out-of-pocket payments increase slightly from around 50% in 2004 to almost 60% in 2016 (see Figure 68).

Figure 65 – Out-of-pocket payments as a percentage of current expenditure on health: international comparison (2004-2016)



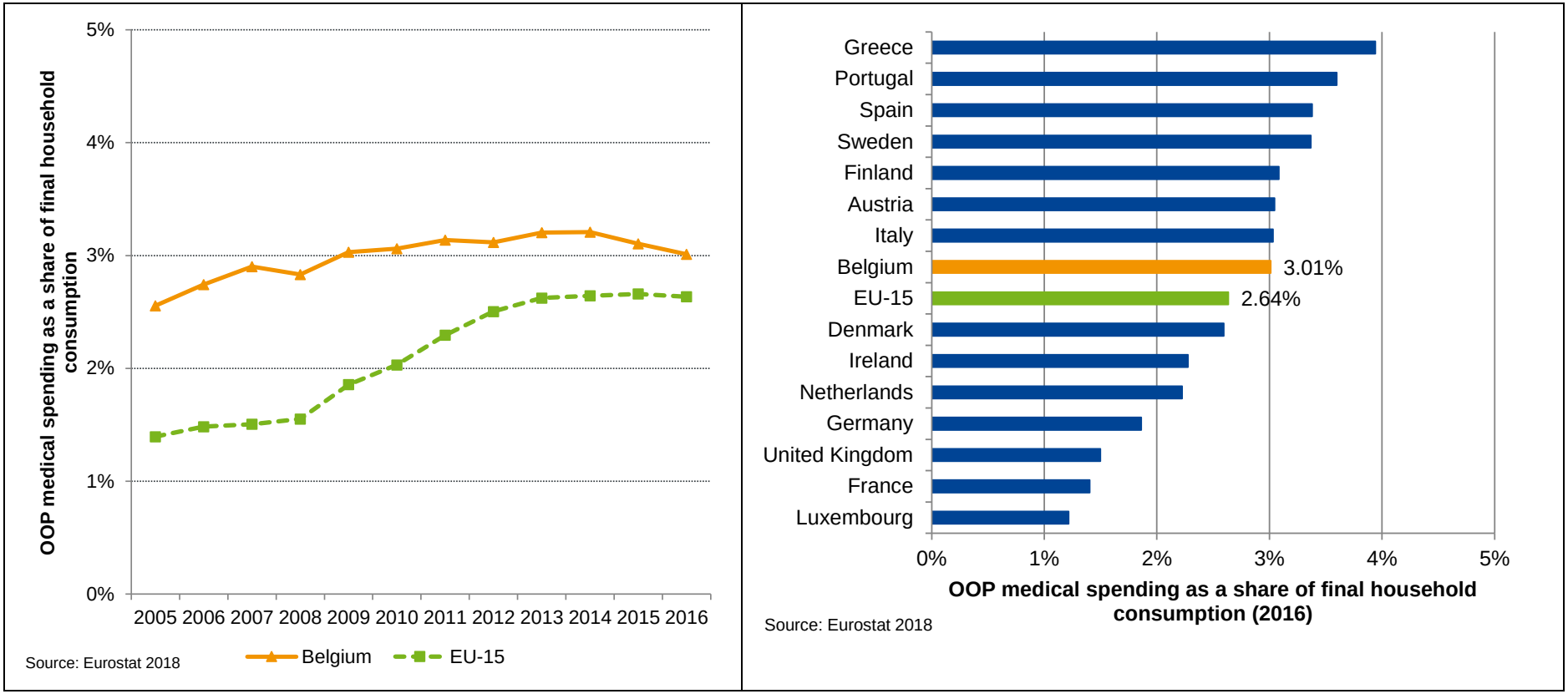
Source: OECD Health Statistics 2018

Figure 66 – Out-of-pocket payments per capita, current prices (US$), purchasing power parity: international comparison (2004-2016)



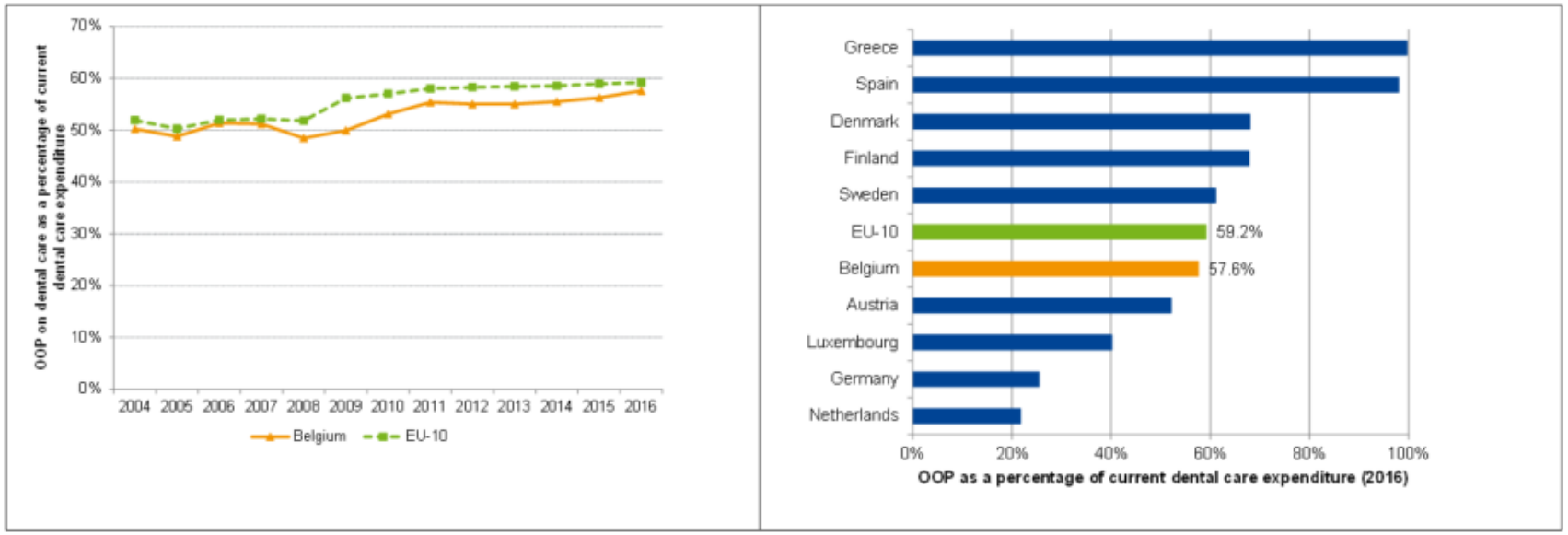
Source: OECD Health Statistics 2018

Figure 67 – Out-of-pocket medical spending* as a share of final household consumption: international comparison (2005-2016)



*Source: SHA - Eurostat 2018; *This indicator refers to current health spending excluding long-term care (health) expenditure. The source differs from results in Table 2 (based on the household budget survey).*

Figure 68 – Out-of-pocket payments on dental care as a percentage of current expenditure on dental care: international comparison (2004-2016)



Source: OECD Health Statistics 2018

Key points

- **High out-of-pocket payments for health, which are private payments at the point of use, may raise issues of accessibility of healthcare.**
- **Out-of-pocket payments in Belgium increased between 2004 and 2014 from 4.93 to 7.09 billion euros and after 2014, tended to decrease. In 2016, OOP payments accounted for 6.73 billion € in absolute amounts and for € 593.8 per capita.**
- **The share of out-of-pocket payments in current expenditure on health for Belgium was similar to the share for EU-15 and ranged between 16% and 18% in the 2004-2016 period. However, the share for Belgium is below the share for the EU-15 since 2013. For dental care, the share of out-of-pocket payments was also similar to the share for EU-10 and increased from 50% to 58% in the 2004-2016 period.**
- **Out-of-pocket payments per capita in Belgium increased from US $533 (PPP) to US $738 (PPP) in the 2004-2016 period and for the whole period they are above the EU-15 average. Since 2014 there has been a decreasing trend in Belgium, but not in the EU-15 countries.**
- **The share of household consumption allocated to medical spending excluding long-term care expenditure amounted to 3% in Belgium in 2016 compared to 2.6% as the EU-15 average.**

References

1. OECD. Health Working Paper (forthcoming) based on 2015 Joint Health Accounts Questionnaire. OECD Publishing: 2015.
2. Assuralia. Les dépenses nationales en soins de santé, 13ième édition. Bruxelles: Assuralia; 2018. Available from: https://www.assuralia.be/images/docs/stats/FR/01_etudes-Assuralia/depenses-nationales-sante-chiffres2015_13edi.pdf