1.1. Out-of-pocket (OOP) payments (% of current expenditure on health) (A-2); Out-of-pocket (OOP) medical spending (% of final household consumption) (A-3)

1.1.1. Documentation sheet

Description	A-2 Out-of-pocket (OOP) payments (% of current expenditure on health) A-3 Out-of-pocket (OOP) medical spending (% of final household consumption)
Calculation	A-2 Out-of-pocket (OOP) payments (% of current expenditure on health) **Numerator**: Out-of-pocket (OOP) payments **Denominator**: Current expenditure on health A-3 Out-of-pocket (OOP) medical spending (% of final household consumption) **Numerator**: Out-of-pocket (OOP) payments excluding long-term care **Denominator**: Final household consumption
Rationale	Belgium has made a commitment to universal health coverage (UHC), i.e. everyone should be able to obtain the health services that they need, of high quality, without risk of financial hardship in doing so.[1, 2] Ensuring affordable access to healthcare is at the heart of universal health coverage, and was reaffirmed numerous times as main objective of the Belgian healthcare system.[1] 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. Financial accessibility can be undermined by out-of-pocket (OOP) payments for healthcare. All countries use OOP payments to pay for some healthcare, though to varying degrees. Evidence shows that user charges are not a good instrument for directing people to use resources more efficiently and can have negative effects on equity and efficiency.[3-7] Low-income populations are disproportionately affected by increased cost sharing, as they have higher care needs, are more price sensitive and resource constrained than other income groups. Hence, OOP payments can be a barrier to accessing health services and treatments, resulting in people foregoing or delaying the use of healthcare (unmet need for healthcare, see indicators A-6 and A-7) with potential adverse consequences to their health.[1, 8] By shifting healthcare costs on to households, OOP payments can also lead to financial hardship (e.g. impoverishing or catastrophic health spending, see indicator A-4). In this latter case, people can no longer afford to meet basic needs – food, housing, electricity – because they have to pay out of pocket for healthcare.[2, 3]
Data source	System of Health Accounts (SHA)[9] accessed through OECD Health Statistics (2023), Annual national accounts accessed through Eurostat (2023), Household Budget Survey (HBS), IMA – AIM atlas (co-payments),[10] RIZIV – INAMI (Maximum billing reimbursements / *Maximumfactuur* in Dutch / *Maximum à facturer* in French (MAF))

Technical definitions	**Out-of-pocket (OOP) payments** are expenditures borne directly by a patient because public or voluntary health insurance does not cover the (full) cost of the health good or service.[11] They are identified in SHA by label *HF.3*. OOP payments include cost sharing (co-payment, coinsurance – "*ticket modérateur*" in French and "*remgeld*" in Dutch – or deductible), balance/extra billing ("*suppléments*" in French and "*supplementen*" in Dutch), self-medication and other expenditures paid directly by private households.[9] It does not include all of the patient contributions 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 *healthcare* in the health accounts (the Belgian estimate is limited to the co-payments for nursing and care beds, while payments related to all other expenditures in nursing homes are considered as *social* care, and thus kept out of scope). The calculation of OOP payments in SHA also account for reimbursements of voluntary health insurance and receipt of conditional care allowances (e.g. time credits for palliative care or for heavily sick children or family members, etc…) **Current expenditure on health** equal the sum of all financing schemes, public health insurance, voluntary health insurance and OOP payments (*HF.1, HF.2, HF.3*) We identify **different types of care** as follows in the SHA: - Long-term care: *HC.3* - Inpatient care: *HC1.1 & HC2.1* - Outpatient care: *HC1.3,* excluding *HC1.3.2* - Dental care: *HC1.3.2* - Medical products: *HC5.2* - Outpatient medicines: *HC5.1* - Diagnostic tests: *HC4.1 & HC4.2* **Final household consumption** is obtained through the annual national accounts (Eurostat, NAMA_10_CO3_P3) The current macro-analysis is complemented with a micro-level analysis based on data from the Household Budget Survey.[12]
International comparability	OECD and Eurostat databases are used to calculate the same indicators for all EU countries. However, caution is needed in the comparison as SHA data are not always comparable across countries. There is a continuous process to improve the reliability of the SHA estimates as well as their comparability. This also means that time series can alter retrospectively.
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 OOP spending (under the assumptions above). However, because the capacity of countries to estimate private long-term care expenditure varies widely, this category has been excluded from OOP payments for indicator A-3. Note that the definition of OOP payments in SHA, contrary to national accounts final consumption estimates, account for reimbursements of voluntary health insurance and receipt of conditional care allowances.

Dimension	Accessibility
Related indicators	A-4 Households facing catastrophic out-of-pocket payments (% of respondents, HBS) A-5 Out-of-pocket (OOP) payments for hospital care (% of total hospital care expenditures) A-6 People with self-reported unmet needs for medical examination due to financial reasons (% of respondents, EU-SILC) (ex-A-4) A-7 People with self-reported unmet needs for dental examination due to financial reasons (% of respondents, EU-SILC) (ex-A-4)
Reviewers	Dirk Moens (FOD Sociale Zekerheid – SPF Sécurité Sociale), Carine Van de Voorde (KCE)

1.1.2. Results

Belgium

Table 1 provides information on the evolution over time (2010-2021) of out-of-pocket payments expressed in million euros, as a percentage of current expenditure on health and as a percentage of final household consumption.

Total out-of-pocket (OOP) payments increased between 2010 and 2019 by 40% from €7.3 to €10.2 billion and decreased strongly in 2020 due to lockdowns and the postponement of non-urgent care in response to COVID-19. OOP payments rebounded in 2021, but remained below the level of 2019. Co-payments represented only one fifth of total estimated OOP payments in 2018. Moreover co-payments tended to grow at a slower pace than overall OOP payments (co-payments increased by 13.1% between 2010 and 2018 while OOP payments went up by 26.5% in the same period).

Public health spending also grew substantially, with 37.6% between 2010 and 2019, from €28.3 billion to €38.9 billion. There was no dip in public spending in 2020 and even a strong surge in 2021. The increase in public spending and decrease in OOP payments in 2020 were more or less of the same magnitude, so that the level of current expenditure on health was similar in 2019 and 2020, subsequently going up strongly in 2021 given the increase in both OOP payments and public spending.

Final household consumption as registered in the national accounts followed the same upward trend between 2010 and 2019, although the growth rate amounted to 30%, lower than the rate for OOP payments. There was a dip in household spending in 2020 related to COVID-19 after which household consumption rebounded to the level of 2019.

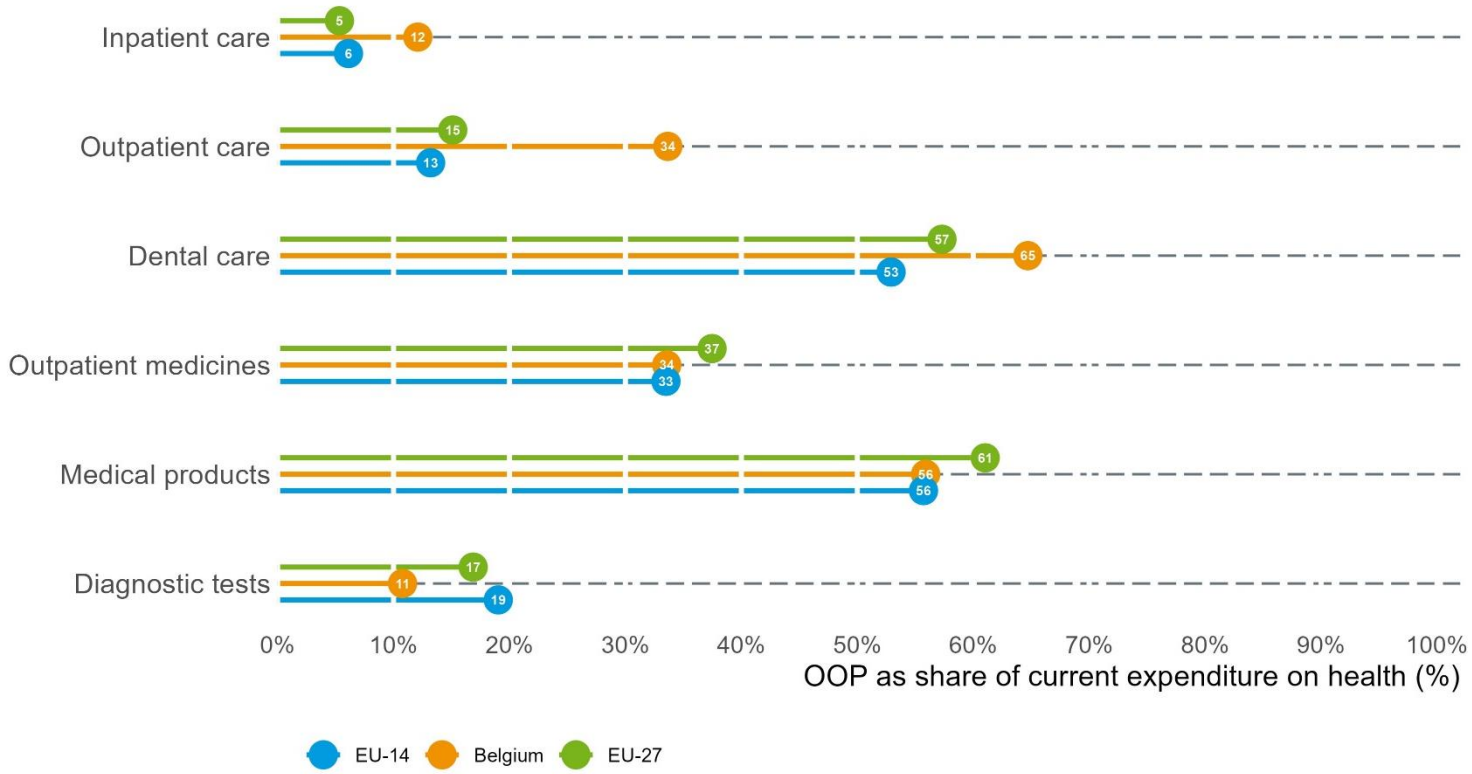
Table 1 shows that the share of out-of-pocket payments in current expenditure on health remained more or less constant around 19.6% between 2010 and 2014, after which a decline set in until 2018 (18.5%). There was a strong surge in 2019 (19.8%) followed by a drop in 2020 (17.4%) and a rebound in 2021 (17.9%). As a share of final household consumption, OOP medical spending – OOP payments excluding OOP payments for long-term care – has fluctuated around 3.9% between 2010 and 2019, implying that the growth in OOP medical spending followed more or less the overall growth in household consumption. In 2020, there was a decrease to 3.6%, because the reduction in OOP medical spending was relatively more pronounced than the overall decline in household consumption.

Table 1 – Out-of-pocket payments, current expenditure on health and final household consumption in Belgium (2010-2021)

Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
OOP payments (in million €)	7 306.2	7 635.7	7 890.0	8 202.8	8 352.5	8 558.9	8 573.6	8 842.7	9 243.7	10 234.8	8 955.9	9 908.9
OOP long-term care (in million €)	341.1	243.8	320.9	336.7	389.3	366.4	383.9	428.0	617.8	855.6	1 075.8	1 261.5
Co-payments after maximum billing reimbursements (MAF) (in million €)♣	1 702.0	1 706.0	1 774.7	1 765.4	1 789.7	1 819.5	1 821.7	1 844.8	1 924.4	1 939.1	1 710.5	1 952.6
Voluntary health insurance (in million €)	1 480.6	1 633.8	1 644.5	1 762.6	1 844.0	2 054.5	2 195.2	2 326.6	2 434.1	2 551.2	2 410.1	2 514.5
Public health insurance (in million €)	28 261.8	29 693.5	31 021.8	31 587.9	32 558.5	34 379.8	35 652.6	36 889.7	38 290.6	38 886.0	40 123.3	43 069.6
Current expenditure on health (in million €)	37 048.6	38 963.0	40 556.3	41 553.4	42 755.0	44 993.1	46 421.5	48 059.0	49 968.3	51 672.0	51 489.2	55 492.9
Final household consumption (in million €)	179 681.8	186 615.3	192 776.2	197 752.7	199 726.8	204 797.5	210 579.1	218 885.7	227 031.4	233 573.8	217 711.0	234 494.4
OOP payments as a share of current expenditure on health	19.7%	19.6%	19.5%	19.7%	19.5%	19.0%	18.5%	18.4%	18.5%	19.8%	17.4%	17.9%
Inpatient care (% OOP)	13.3%	13.8%	14.5%	14.4%	14.3%	13.8%	13.5%	13.4%	14.1%	14.8%	10.3%	12.1%
Outpatient care (% OOP)	41.0%	40.4%	39.9%	40.8%	38.6%	38.9%	38.1%	37.3%	35.4%	38.1%	34.7%	33.7%
Dental care (% OOP)	53.3%	54.6%	54.8%	54.8%	55.9%	59.4%	60.4%	63.2%	63.9%	65.2%	66.1%	64.7%
Outpatient medicines (% OOP)	37.8%	37.8%	37.0%	38.9%	38.0%	36.5%	35.4%	36.1%	35.5%	37.2%	34.6%	33.6%
Medical products (% OOP)	51.2%	50.7%	50.3%	52.9%	52.8%	58.2%	58.1%	59.0%	58.5%	59.4%	53.5%	55.9%
Diagnostic tests (% OOP)	10.9%	11.6%	10.6%	11.7%	13.1%	13.7%	13.8%	13.5%	10.9%	11.7%	12.2%	10.8%
OOP medical spending as a share of final household consumption	3.9%	4.0%	3.9%	4.0%	4.0%	4.0%	3.9%	3.8%	3.8%	4.0%	3.6%	3.7%

Notes: ♣ Co-payments are no separate category in SHA, but were calculated based on information on health expenditure covered by the compulsory public health insurance from IMA – AIM atlas[10] and MAF reimbursements from RIZIV – INAMI.
Source: OECD Health Statistics 2023 (SHA), Eurostat 2023 (national accounts), IMA-AIM Atlas (co-payments)

Figure 1 – OOP payments as a share of current spending on health by type of care (2021)



The out-of-pocket share of current spending on health differs by type of care

Table 1 and Figure 1 give information of the out-of-pocket share of current spending on health by type of care. OOP payments in 2021 were highest for dental care (64.7%) and medical products (55.9%), followed by outpatient care and outpatient medicines (both around 34%) and OOP payments for inpatient care and diagnostic tests represented 12.1% and 10.8% of current spending on health, respectively. Dental care and medical products are types of care where OOP payments are on average more important in all EU countries. Nevertheless, OOP payments for dental care were higher in Belgium than the EU averages (see Figure 1) and have increased substantially over time (see Table 1). Moreover, the level of OOP payments in Belgium was much higher than the EU-average in 2021, in spite of a substantial decline over time from 41.0% in 2010 to 33.7% in 2021. OOP payments for inpatient care were also relatively more important in Belgium than on average in other EU countries.

Table 2 – Average out-of-pocket health expenditure per household and as a share of total household consumption (2012 - 2020)

			2012	2014	2016	2018	2020
Average annual OOP health expenditure per person (in €)	Belgium		636	716	689	730	808
	Regions	Flanders	615	726	644	700	798
		Wallonia	640	740	688	725	808
		Brussels	634	668	705	749	813
	Household equivalized consumption quintiles	First quintile	247	260	251	254	230
		Second quintile	415	508	410	458	466
		Third quintile	665	673	661	713	687
		Fourth quintile	801	891	991	1010	999
		Fifth quintile	1315	1563	1452	1542	2133
Average annual OOP health expenditure per household (in €)	Belgium		1497	1655	1571	1639	1805
	Regions	Flanders	1530	1738	1585	1641	1822
		Wallonia	1503	1558	1606	1688	1802
		Brussels	1317	1520	1396	1490	1725
	Household equivalized consumption quintiles	First quintile	746	772	738	723	658
		Second quintile	1029	1222	1000	1089	1083
		Third quintile	1531	1505	1410	1545	1532
		Fourth quintile	1645	1852	1991	2054	1982
		Fifth quintile	2538	2927	2717	2785	3772
OOP health expenditure as a share of total household consumption	Belgium		4.9%	5.4%	5.5%	5.5%	6.3%
	Regions	Flanders	4.9%	5.4%	5.3%	5.4%	6.2%
		Wallonia	5.0%	5.5%	5.9%	5.9%	6.4%
		Brussels	5.0%	5.3%	5.3%	5.1%	6.1%
	Household equivalized consumption quintiles	First quintile	4.4%	4.6%	4.7%	4.4%	4.2%
		Second quintile	4.6%	5.7%	4.8%	5.1%	5.3%
		Third quintile	5.6%	5.7%	5.8%	6.1%	6.0%
		Fourth quintile	5.1%	5.6%	6.6%	6.5%	6.5%
		Fifth quintile	4.8%	5.4%	5.3%	5.3%	7.2%

Data source: own calculations based on HBS data from waves 2012, 2014, 2016, 2018, 2020.
Note: Total household consumption expenditures exclude imputed rent, i.e. COICOP 042, and expenses unrelated to consumption, i.e. COICOP 129.

Burden of OOP payments on household budgets – analysis by socioeconomic status and region

A breakdown by sociodemographic or socioeconomic group is not possible using the SHA or the national accounts. Therefore, we also relied on data from the Household Budget Survey (HBS) where detailed consumption data of a sample of households are registered during an observation period of 1 month (2012-2016) or 15 days (2018-2020), including OOP payments.[2, 12]

Table 2 indicates that average annual out-of-pocket payments per household increased from €1 497 in 2012 to €1 805 in 2020 with limited variation across regions. There were, however, striking and increasing differences between households categorized by their financial means. In fact, the upward trend in out-of-pocket payments over time was entirely due to an increase in OOP payments in the two richest quintiles, while in quintiles 1 to 3 no increase was observed. A similar picture emerges when looking at the average annual out-of-pocket payments per person.

In 2020, the share of out-of-pocket payments in total household consumption amounted to 6.3% in Belgium, an increase compared to previous years. Variation across regions or income groups was limited, although the poorest quintile consistently had a share below the average.

International comparison

Out-of-pocket payments made at the point of consuming healthcare can be a financial burden, in particular for individuals with high care needs or limited resources. Although the out-of-pocket share of current spending on health has evolved in line with the EU averages (see Figure 2), the Belgian health system still relied more heavily on out-of-pocket payments in 2021 than neighbouring countries such as Luxembourg (8.9%), France (8.9%), the Netherlands (9.3%) and Germany (12.0%) (see Figure 3). In 2021, the out-of-pocket payment share of current spending on health in Belgium (17.9%) was just above the EU-14 average (16.5%) and just below the EU-27 average (18.2%). Twelve countries had a higher OOP share than Belgium, in particular Southern European countries – such as Spain, Italy, Portugal and Greece – and Eastern European countries – such as Bulgaria, Latvia and Poland.

Figure 4 shows the evolution of out-of-pocket medical spending – i.e. OOP payments on healthcare excluding OOP on long-term care to make results more comparable across countries – as a share of final household consumption. Both the Belgian share as the EU average shares were stable over time, but where we observe that the Belgian share decreased in 2020, we find that the EU average shares increased. The decrease in Belgium was due to a larger drop in OOP medical spending than in final household consumption, but it seems that on average in the EU the opposite was true, a larger drop in final household consumption than in OOP. In 6 EU countries, OOP payments in 2020 were at a higher level than in 2019, i.e. Greece, Hungary, Romania, Malta, Bulgaria and Slovenia.

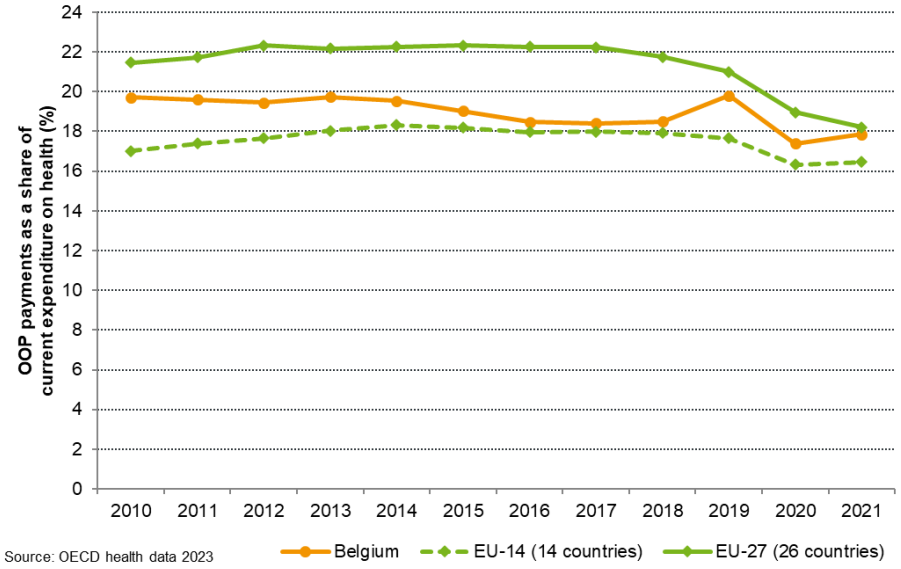
The Belgian out-of-pocket medical share of final household consumption was consistently above the EU averages with only 7 EU countries having a higher share (see Figure 5). The Belgian share in 2021 (3.7%) largely surpassed the share in neighbouring countries such as France (1.3%), Luxembourg (1.3%), Germany (2.1%) and the Netherlands (2.1%).

Impact of COVID-19 pandemic

In Belgium, as well as in most other EU countries, OOP payments decreased due to lockdowns and the postponement of non-urgent care in response to COVID-19. The reduction as well as the rebound afterwards were significant from €10.2 billion in 2019 to €9.0 billion in 2020 and €9.9 billion in 2021 (see Table 1). Final household consumption had a similar dip and rebound due to COVID-19, but less pronounced in relative terms. Public health spending, on the other hand, was not characterized by a decrease in 2020.

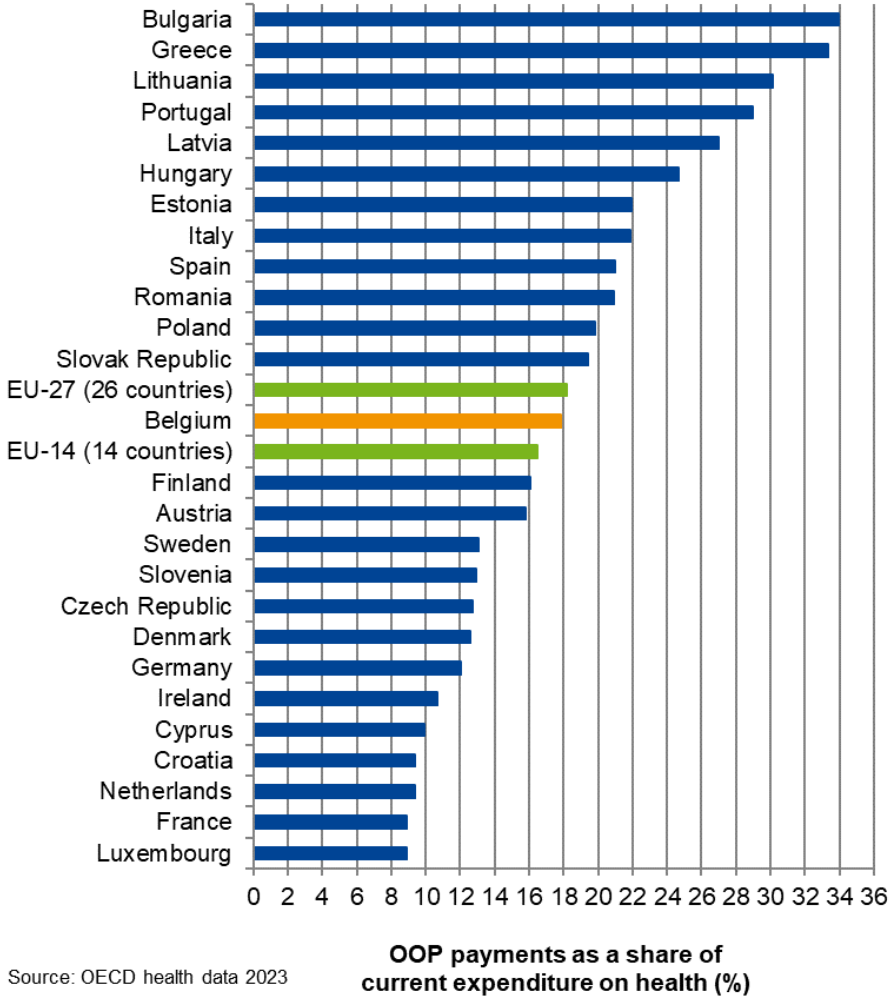
In relative terms, OOP payments both as a share of current expenditure on health and OOP medical spending as a share of final household consumption had an important dip in 2020 and a small rebound in 2021. Interestingly, the EU average OOP medical spending as a share of final household consumption did not show a dip as in Belgium, but rather a small surge.

Figure 2 – OOP payments as a share of current expenditure on health, evolution Belgium, EU-14 and EU-27 (2010-2021)



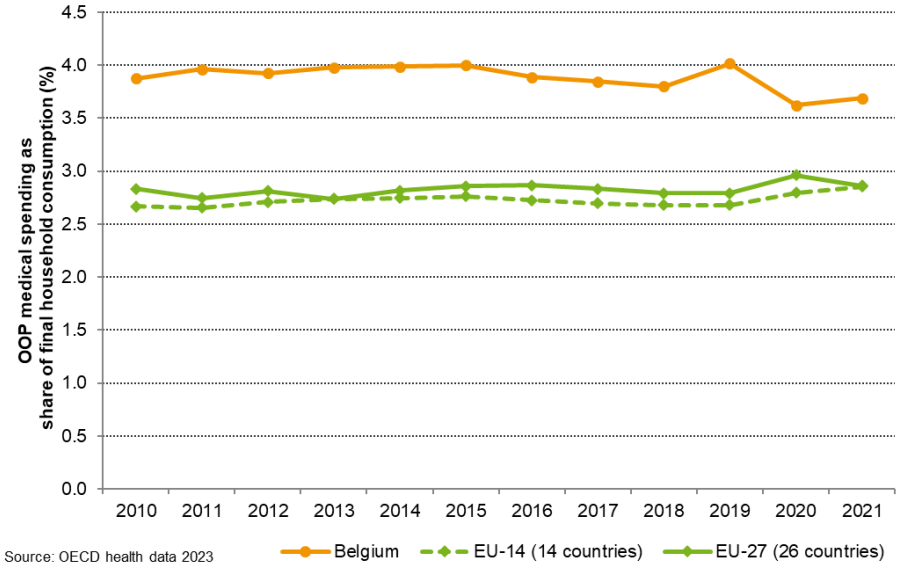
Source: OECD health data 2023

Figure 3 – OOP payments as a share of current expenditure on health in a European perspective (2021)



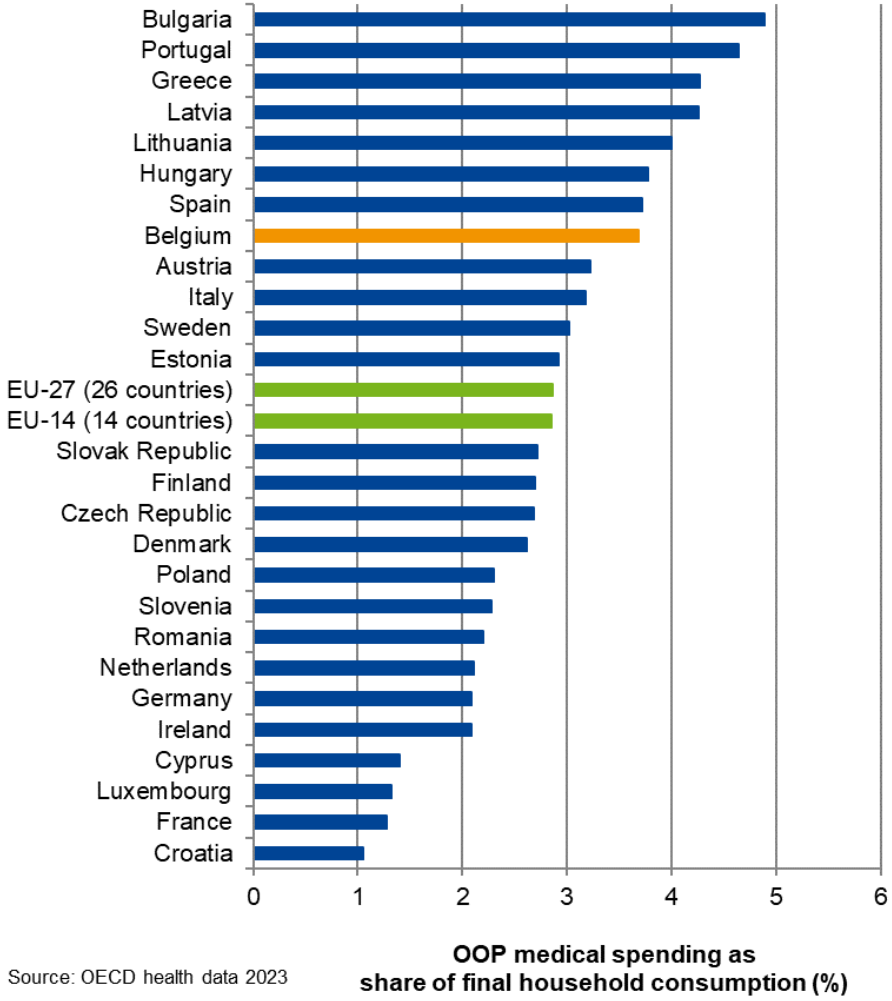
Source: OECD health data 2023

Figure 4 – OOP medical spending as a share of final household consumption, evolution Belgium, EU-14 and EU-27 (2010-2021)



Source: OECD health data 2023

Figure 5 – OOP medical spending as a share of final household consumption in a European perspective (2021)



Source: OECD health data 2023

Key points

- **Out-of-pocket payments made at the point of consuming healthcare can be a financial burden, in particular for individuals with high care needs or limited resources.**
- **OOP payments increased between 2010 and 2019 by 40% from €7.3 to €10.2 billion and decreased strongly in 2020 due to lockdowns and the postponement of non-urgent care in response to COVID-19. They rebounded in 2021, but remained below the level of 2019.**
- **Co-payments represent only one fifth of total estimated OOP payments in 2021.**
- **OOP payments as a share of current expenditure on health were around 19.6% between 2010 and 2014 and declined until 2018 (18.5%). There was a strong surge in 2019 (19.8%) followed by a drop in 2020 (17.4%) and a rebound in 2021 (17.9%). The Belgian share was in line with the EU averages, but the Belgian health system still relied more heavily on out-of-pocket payments in 2021 than neighbouring countries such as Luxembourg (8.9%), France (8.9%), the Netherlands (9.3%) and Germany (12.0%).**
- **OOP payments as a share of current expenditure on health in 2021 were highest for dental care (64.7%), medical products (55.9%), outpatient care and outpatient medicines (both nearly 34%). OOP payments for dental care, outpatient care and inpatient care were above the EU averages in 2021. OOP payments for dental care substantially increased over time.**
- **OOP medical spending as a share of final household consumption fluctuated around 3.9% between 2010 and 2019, followed by a decrease to 3.6% in 2020. The Belgian share was consistently above the EU averages and largely surpassed the share in neighbouring countries such as France (1.3%), Luxembourg (1.3%), Germany (2.1%) and the Netherlands (2.1%).**
- **OOP payments as share of household consumption were higher for households with more financial means.**

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