Can people afford to pay for health care?

New evidence on financial protection in Belgium

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The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage. It works with Member States across WHO’s European Region to promote evidence-informed policy making.

A key part of the work of the Office is to assess country and regional progress towards universal health coverage by monitoring financial protection – the impact of out-of-pocket payments for health on living standards and poverty. Financial protection is a core dimension of health system performance and an indicator for the Sustainable Development Goals.

The Office supports countries to develop policy, monitor progress and design reforms through health system problem diagnosis, analysis of country-specific policy options, high-level policy dialogue and the sharing of international experience. It is also the home for WHO training courses on health financing and health systems strengthening for better health outcomes.

Established in 1999, the Office is supported by the Government of the Autonomous Community of Catalonia, Spain. It is part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe.
Can people afford to pay for health care?

New evidence on financial protection in Belgium

Nicolas Bouckaert
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Abstract

This review is part of a series of country-based studies generating new evidence on financial protection in European health systems. Financial protection is central to universal health coverage and a core dimension of health system performance. The incidence of catastrophic health spending is higher in Belgium than in most other countries in western Europe. It is heavily concentrated in the poorest fifth of the population and among households headed by unemployed or inactive people. Rates of unmet need for health care and dental care in Belgium are similar to the European Union average, but there is a significant gap in unmet need between the richest and poorest people. The factors that undermine financial protection in Belgium include gaps in all three dimensions of health coverage (population coverage, service coverage and user charges) and administrative barriers. At least 1% of the population is uninsured, rising to at least 2% in the Brussels region and among younger adults and self-employed people. On average, catastrophic spending is driven by out-of-pocket payments for medical products (owing to gaps in the benefits package) and inpatient care (reflecting widespread balance billing). In the poorest consumption quintile, however, it is mainly driven by outpatient medicines, diagnostic tests and outpatient care. The Government has recently taken steps to strengthen financial protection, but more can be done to simplify Belgium’s unusually complex coverage policy and reduce co-payments and other out-of-pocket payments, particularly for low-income households – for example, abolishing retrospective reimbursement for all health services; extending the annual cap on co-payments to all health services and lowering it for people with very low incomes; granting automatic entitlement to everyone eligible for increased reimbursement (reduced co-payments); limiting balance billing in outpatient and inpatient care; and strengthening regulation of the price of non-covered medical products.

Keywords

BELGIUM
HEALTHCARE FINANCING
HEALTH EXPENDITURES
HEALTH SERVICES ACCESSIBILITY
FINANCING, PERSONAL
POVERTY
UNIVERSAL COVERAGE
About the series

This series of country-based reviews monitors financial protection in European health systems. Financial protection – ensuring access to health care is affordable for everyone – is central to universal health coverage and a core dimension of health system performance.

What is the policy issue? Out-of-pocket payments can create a financial barrier to access, resulting in unmet need, and lead to financial hardship for people using health services. People experience financial hardship when out-of-pocket payments – formal and informal payments made at the point of using any health-care good or service – are large in relation to a household’s ability to pay. Out-of-pocket payments may not be a problem if they are small or paid by people who can afford them, but even small out-of-pocket payments can cause financial hardship for poor people and those who have to pay for long-term treatment such as medicines for chronic illness. Where health systems fail to provide adequate financial protection, people may not have enough money to pay for health care or to meet other basic needs. As a result, lack of financial protection may undermine health, deepen poverty and exacerbate inequalities. Because all health systems involve a degree of out-of-pocket payment, unmet need and financial hardship can occur in any country.

How do country reviews assess financial protection? Each review is based on analysis of common indicators used to monitor financial protection: the share of people foregoing health care due to cost (unmet need) and the share of households experiencing financial hardship caused by out-of-pocket payments (impoverishing and catastrophic health spending). These indicators are generated using household survey data.

Why is monitoring financial protection useful? The reviews identify the health system factors that strengthen and undermine financial protection; highlight implications for policy; and draw attention to areas that require further analysis. The overall aim of the series is to provide policy-makers and others with robust, context-specific and actionable evidence that they can use to move towards universal health coverage.
How are the reviews produced? Each review is produced by one or more country experts in collaboration with the WHO Barcelona Office for Health Systems Financing, part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe. To facilitate comparison across countries, the reviews follow a standard template, draw on similar sources of data (see Annex 1) and use the same methods (see Annex 2). Every review is subject to external peer review. Results are also shared with countries through a consultation process held jointly by the WHO Regional Office for Europe and WHO headquarters. The country consultation includes regional and global financial protection indicators (see Annex 3).

What is the basis for WHO’s work on financial protection in Europe? The Sustainable Development Goals adopted by the United Nations in 2015 call for monitoring of, and reporting on, financial protection as one of two indicators of universal health coverage. WHO support to Member States for monitoring financial protection in Europe is also underpinned by the European Programme of Work, 2020–2025 (United Action for Better Health in Europe), which includes moving towards universal health coverage as the first of three core priorities for the WHO European Region. Through the European Programme of Work, the WHO Regional Office for Europe supports national authorities to reduce financial hardship and unmet need for health services (including medicines) by identifying gaps in health coverage and redesigning coverage policy to address these gaps. The Tallinn Charter: Health Systems for Health and Wealth and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region include a commitment to work towards a Europe free of impoverishing out-of-pocket payments for health. A number of other regional and global resolutions call on WHO to provide Member States with tools and support for monitoring financial protection, including policy analysis and recommendations.

Comments and suggestions for improving the series are most welcome and can be sent to euhsf@who.int.
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Abbreviations

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<th>Description</th>
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<tr>
<td>CHI</td>
<td>complementary health insurance</td>
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<tr>
<td>EHIS</td>
<td>European Health Interview Survey</td>
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<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>EU14</td>
<td>Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain and Sweden</td>
</tr>
<tr>
<td>EU28</td>
<td>Countries in the European Union between 1 May 2004 and 31 January 2020 (as above, plus Bulgaria, Croatia, Cyprus, Czechia, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia)</td>
</tr>
<tr>
<td>EU-SILC</td>
<td>European Union Statistics on Income and Living Conditions</td>
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<tr>
<td>GDP</td>
<td>gross domestic product</td>
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<tr>
<td>GMR</td>
<td>global medical record</td>
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<tr>
<td>GP</td>
<td>general practitioner</td>
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<tr>
<td>MAF</td>
<td>maximum billing [maximumfactuur-maximum à facturer]</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>OTC</td>
<td>over-the-counter</td>
</tr>
<tr>
<td>RIZIV-INAMI</td>
<td>National Institute for Health and Disability Insurance [Rijksinstituut voor Ziekte- en Invaliditeitsverzekering-Institut national d’assurance maladie-invalidité]</td>
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<tr>
<td>SHA</td>
<td>System of Health Accounts</td>
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<tr>
<td>SHI</td>
<td>social health insurance</td>
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<td>VHI</td>
<td>voluntary health insurance</td>
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Executive summary

This review assesses the extent to which people in Belgium experience financial hardship when they use health services, including medicines, and unmet need caused by financial barriers to access. It draws on data from household budget surveys conducted every two years from 2012 to 2020 (the latest available year), data on unmet need for health care and dental care up to 2021 (the latest available year) and information on coverage policy (population coverage, service coverage and user charges) up to 2022.

The review finds that in Belgium:

- in 2020 1.1% of households were impoverished or further impoverished after out-of-pocket payments and 5.2% of households experienced catastrophic out-of-pocket payments – one of the highest rates of catastrophic health spending in western Europe;

- catastrophic spending is heavily concentrated among poor households and among unemployed people, inactive people and people with a lower level of education;

- it is mainly driven by out-of-pocket payments for medical products, diagnostic tests (which include physiotherapy and paramedical services), dental care and inpatient care (although less so for inpatient care in 2020 due to the postponement of non-urgent care in response to COVID-19), with variation across consumption quintiles: outpatient medicines, diagnostic tests and outpatient care are much larger drivers of catastrophic spending for the poorest than the richest households;

- although unmet need for health care and dental care is similar to the European Union (EU) average, the gap between the richest and poorest people is substantially higher in Belgium than in other EU countries.

The factors that undermine access and financial protection, with a disproportionate impact on poorer households, include the following.

At least 1% of the population lacks social health insurance (SHI) coverage, rising to at least 2% in the Brussels region and among younger adults (25–40 years) and self-employed people, which may in part reflect the higher prevalence of international workers covered under international arrangements living and working in Brussels.
SHI coverage of dental care, medical products and over-the-counter (OTC) medicines is limited. Although mandatory complementary health insurance (CHI) may fully or partly cover some of these services, the range of CHI benefits varies across sickness funds. CHI benefits are financed through flat-rate contributions, which are regressive.

Most outpatient care is subject to retrospective reimbursement rather than provided as a benefit in kind, which is highly unusual among health systems in high-income countries. Since 2015 general practitioners have been required to apply third-party payment to people entitled to increased reimbursement (reduced co-payments). In January 2022 the right to apply third-party payment to all patients was extended to all other outpatient health-care providers on a voluntary basis.

User charges apply to all health services, are complex and there is no general exemption from co-payments that targets low-income households. Although several mechanisms are in place to protect people from co-payments, they do not offer sufficient protection for people with low incomes.

Gaps in service coverage and user charges are partly covered by a mix of mandatory CHI and voluntary health insurance (VHI), but take up of VHI is more likely among richer than poorer households.

The Government has recently taken steps to strengthen access and financial protection, but more can be done to simplify the unusually complex design of coverage policy in Belgium and address design features that systematically disadvantage people at risk of poverty or social exclusion. Policy should focus on:

- finding ways to ensure that SHI covers the whole population, so that no one lacks coverage;
- abolishing retrospective reimbursement for all health services covered by SHI; this includes abolishing all up-front payment of co-payments above the maximum billing [maximumfactuur-maximum à facturer] (MAF) threshold;
- granting automatic entitlement to everyone eligible for increased reimbursement (reduced co-payments) to eliminate administrative barriers to take-up; research finds that take-up of reduced co-payments is close to universal when granted automatically but very low when people have to apply for them;
• extending the annual cap on co-payments (MAF) to user charges for prescribed non-covered medicines and long-term psychiatric care and raising awareness of the cap by informing people about it at the beginning of each year instead of waiting until they cross the spending threshold;

• exempting low-income households from co-payments; the reduction of the MAF threshold from €507 to €250 a year for people with very low incomes from 2022 is an important step but does not eliminate co-payments for these households; further lowering the €250 threshold or introducing an additional lower cap targeted at households with very low incomes could be considered;

• limiting balance billing in outpatient and inpatient care through further regulation and reform of the way in which hospitals are financed and by increasing the share of “conventioned” practitioners – those who apply the official tariff – and abolishing partial conventioning (partial application of these tariffs); and

• further strengthening regulation of the price of non-covered medical products such as glasses, contact lenses and hearing aids.

In addition to reducing unmet need and financial hardship for low-income households, these measures would make the health system fairer, less complex and more transparent.

Because the share of the government budget allocated to health is low in Belgium compared to many countries in western Europe, the Government can support these measures and meet equity and efficiency goals by increasing the priority given to health in allocating public spending and devoting a larger share of the SHI budget to protecting households with low incomes.
1. Introduction
This review assesses the extent to which people in Belgium experience financial hardship when they use health services, including medicines, and unmet need caused by financial barriers to access. It covers the period from 2012 to 2022, drawing on data from household budget surveys carried out by Statistics Belgium between 2012 and 2020 (the latest available year), data on unmet need for health services up to 2021 (the latest available year) and information on coverage policy – the way in which health coverage is designed and implemented – up to 2022. The focus is on three key dimensions of coverage policy: population coverage, service coverage and user charges (co-payments).

Research shows that financial hardship is more likely to occur when public spending on health is low relative to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of total spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010; WHO Regional Office for Europe, 2019). Increases in public spending or reductions in out-of-pocket payments are not in themselves guarantees of better financial protection, however. Policy choices are also important.

Belgium experienced a 2% drop in GDP in 2009, following the 2008 global financial crisis. The health system was not significantly affected, however, because it had built up a budget surplus before the crisis through an annual growth cap of 4.5% in real terms, which was in place between 2005 and 2011. It used the surplus to increase public spending on health during and after the crisis and to introduce measures to guarantee access to health services (Cleemput et al., 2015).

Public spending on health as a share of GDP grew from 6% in 2000 to almost 8% in 2009 and remained at this level during and after the crisis. In 2020 public spending on health amounted to 8.5% of GDP (79% of current spending on health), just above the European Union (EU) 14 average of 8.4% but lower than in Austria, Denmark, France, Germany, the Netherlands and Sweden (OECD, 2022). The out-of-pocket payment share of current health spending was 16.4% in 2020, just above the EU14 average of 16.2% but much higher than in Croatia, Czechia, Denmark, France, Germany, the Netherlands, Slovenia and Sweden (OECD, 2022).

The Belgian health system is organized through a mandatory social health insurance (SHI) scheme with sickness funds that offer the same benefits package and compete on the provision of mandatory complementary health insurance (CHI), voluntary health insurance (VHI) and other additional services. Coverage policy is highly complex. Over time, concerns about the negative impact of widespread user charges and the additional fees imposed by some health-care providers have led to the introduction of multiple policies to protect people from out-of-pocket payments. These policies have contributed to the complexity of current coverage arrangements.

A recent study on equity in the Belgian health system assessed financial protection using the same methods and data sources as this analysis, as well as drawing on administrative data on publicly financed health services (Bouckaert, Maertens de Noordhout & Van de Voorde, 2020). The study also provides a brief overview of earlier analysis of financial protection in Belgium.
This review is structured as follows. Section 2 sets out the analytical approach and sources of data used to measure financial protection. Section 3 provides a brief overview of coverage policy. Sections 4 and 5 present the results of the statistical analysis, with a focus on out-of-pocket payments in Section 4 and financial protection (financial hardship and unmet need for health services) in Section 5. Section 6 provides a discussion of results of the financial protection analysis and identifies factors that strengthen and undermine financial protection. Section 7 highlights implications for policy. Annex 1 provides information on household budget surveys, Annex 2 the methods used, Annex 3 regional and global financial protection indicators and Annex 4 a glossary of terms.
2. Methods
This section summarizes the study’s analytical approach and main data sources. More detailed information can be found in Annexes 1–3.

The analysis of financial protection in this study is based on an approach developed by the WHO Regional Office for Europe (Cylus et al., 2018; WHO Regional Office for Europe, 2019), building on established methods of measuring financial protection (Wagstaff & van Doorslaer, 2003; Xu et al., 2003).

2.1 Financial hardship linked to out-of-pocket payments

Financial hardship is measured using two main indicators: impoverishing and catastrophic health spending. Table 1 summarizes the key dimensions of each indicator. For more information on how these indicators are calculated and relate to global indicators, see Annexes 2 and 3.

Table 1. Key dimensions of catastrophic and impoverishing spending on health

<table>
<thead>
<tr>
<th>Impoverishing health spending</th>
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<tbody>
<tr>
<td>Definition</td>
<td>The share of households impoverished or further impoverished after out-of-pocket payments</td>
</tr>
<tr>
<td>Poverty line</td>
<td>A basic needs line, calculated as the average amount spent on food, housing (rent) and utilities (water, electricity and fuel used for cooking and heating) by households between the 25th and 35th percentiles of the household consumption distribution that report any spending on each item, respectively, adjusted for household size and composition using Organisation for Economic Co-operation and Development (OECD) equivalence scales; these households are selected based on the assumption that they are able to meet, but not necessarily exceed, basic needs for food, housing and utilities; this standard amount is also used to define a household’s capacity to pay for health care (see below)</td>
</tr>
<tr>
<td>Poverty dimensions captured</td>
<td>The share of households further impoverished, impoverished and at risk of impoverishment after out-of-pocket payments and the share of households not at risk of impoverishment after out-of-pocket payments; a household is impoverished if its total consumption falls below the basic needs line after out-of-pocket payments; further impoverished if its total consumption is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total consumption after out-of-pocket payments comes within 120% of the basic needs line</td>
</tr>
<tr>
<td>Disaggregation</td>
<td>Results can be disaggregated into household quintiles by consumption and by other factors where relevant</td>
</tr>
<tr>
<td>Data source</td>
<td>Microdata from national household budget surveys</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Catastrophic health spending</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>The share of households with out-of-pocket payments that are greater than 40% of household capacity to pay for health care</td>
</tr>
<tr>
<td>Numerator</td>
<td>Out-of-pocket payments</td>
</tr>
<tr>
<td>Denominator</td>
<td>A household’s capacity to pay for health care is defined as total household consumption minus a standard amount to cover basic needs; the standard amount is calculated as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, as described above; this standard amount is also used as a poverty line (basic needs line) to measure impoverishing health spending</td>
</tr>
<tr>
<td>Disaggregation</td>
<td>Results are disaggregated into household quintiles by consumption per person using OECD equivalence scales; disaggregation by place of residence (urban–rural), age of the head of the household, household composition and other factors is included where relevant</td>
</tr>
<tr>
<td>Data source</td>
<td>Microdata from national household budget surveys</td>
</tr>
</tbody>
</table>

Note: see Annex 4 for definitions of words in italics.

Source: WHO Regional Office for Europe (2019).
Financial hardship indicators are generated by analysing data from household budget surveys. This study uses anonymized microdata from the Belgian household budget survey [Huishoudbudget-Budget des ménages] conducted every two years by Statistics Belgium. The study focuses on data from 2012 to 2020 (the latest available year). The data sample consisted of 6578 households in 2012, 6135 in 2014, 4490 in 2016, 6118 in 2018 and 6105 in 2020. Response rates are generally low, ranging from 17% to 9%, and have fallen over time (Minnen, Nagel & Sabbe, 2022; STATBEL, 2022). In all years, the survey excludes people living in facilities such as nursing homes and prisons (STATBEL, 2022).

Household budget surveys collect information on health spending (consumption) in a structured way, dividing health spending into six broad groups: “medicines”, “medical products”, “outpatient care”, “dental care”, “diagnostic tests” and “inpatient care”. Spending on mental health services is not assigned a specific category and may therefore be reported under most of these groups.

A change to the health consumption classification in the 2016 survey had a minor impact on the composition of outofpocket payments by type of health care (Bouckaert, Maertens de Noordhout & Van de Voorde, 2020). To improve data comparability over time, we transferred spending registered as “unspecified purchases at the pharmacy” (Classification of Individual Consumption According to Purpose code 6.1.2 D) from the “medical products” category to the “medicines” category.

A much more significant change to the survey took place in 2018, affecting all areas of consumption. Before 2018 all consumption had been registered over a 1-month period (Bouckaert, Maertens de Noordhout & Van de Voorde, 2020). In 2018 consumption was registered over a 15-day period for all health services except dental care and inpatient care, for which the recall period was extended to 12 months. The 2018 change led to a substantial reduction in the share of households reporting any health spending, particularly among lower-income households. As a result, roughly the same amount of health spending is concentrated in fewer households, leading to higher spending on average in households reporting spending. This change also means that data collected before and after 2018 are not comparable. This break in series is signalled in the figures in sections 4 and 5.

The COVID-19 pandemic affected the 2020 survey in two ways. First, from mid-March 2020 onwards, fieldwork took place by phone and online instead of through face-to-face interviews. Second, it influenced household spending on health care and other things such as recreation, restaurants and accommodation services. For health spending, there was a large increase in spending on medical products, which includes things like facemasks and disinfectants, and in spending on diagnostic tests, the latter mainly due to higher spending on physiotherapy and rehabilitation, which are included in this category.

The review also draws on data from national health accounts up to 2020 (the latest available year). National health accounts use the standardized System of Health Accounts (SHA) to collect internationally comparable data on health spending at national level (OECD, Eurostat & WHO, 2017).
There are important differences between household budget survey and SHA data on out-of-pocket payments. This is in part because SHA data are adjusted to reflect a third source of data: administrative claims data from sickness funds. The differences between these three data sources (household budget survey, administrative claims and national health accounts) are shown in Fig. 1.

Out-of-pocket payments reported in the Belgian household budget survey include spending on all health services, covered and non-covered. The amounts registered reflect what households pay at the point of use before they are reimbursed by SHI, mandatory CHI or VHI. This may overestimate the level of out-of-pocket payments for outpatient care (not including medicines) and inpatient care in Belgium for two reasons. First, retrospective reimbursement applies to most publicly financed outpatient care (not including medicines); thus people typically pay providers first and then receive reimbursement from their sickness fund for some or all of the amount, depending on the level of co-payments in place. Second, people with VHI typically pay for health care upfront – co-payments and balance billing – and are later reimbursed by the insurer. VHI mainly covers inpatient care. Household budget survey inpatient expenses consist of both co-payments and balance billing prior to VHI reimbursements.

However, due to the way in which information is collected, the Belgian household budget survey probably underestimates out-of-pocket payments for inpatient care. Only about 10% to 12% of households in household budget survey waves 2012 to 2016 and 6% of households in waves 2018 to 2020 report inpatient care spending, which is much lower than the 23% of households reported in administrative data from 2016. As Fig. 1 shows, out-of-pocket payments reported in the household budget survey are relatively higher for services that are not covered or only partially covered by SHI (outpatient services such as medicines, dental care and medical products), but substantially lower for services more likely to be covered (other outpatient care and inpatient care).

Out-of-pocket payments in the administrative claims data are not self-reported but registered by sickness funds. They include all SHI benefits and account for retrospective reimbursement, but exclude spending on non-covered services such as over-the-counter (OTC) medicines, some dental care and medical products. Also, information on balance billing in outpatient care is not mandatorily registered and thus limited. As a result, administrative claims data are likely to underestimate out-of-pocket payments for outpatient care, including medicines, dental care and medical products.

The national health accounts data make use of all available information on health spending, including household budget survey data, administrative claim data and data on VHI and take an intermediate position. They also account for retrospective reimbursement.

All currency units in the study are presented in euros.
2.2 Unmet need for health services

Unmet need is measured using data from European or national surveys (Box 1). In 2020 European Union Statistics on Income and Living Conditions (EU-SILC) data collection in Belgium was affected by the COVID-19 pandemic.

Box 1. Unmet need for health services

Financial protection indicators capture financial hardship among people who incur out-of-pocket payments through the use of health services. They do not, however, indicate whether out-of-pocket payments create a barrier to access, resulting in unmet need for health care. Unmet need is an indicator of access, defined as instances in which people need health care but do not receive it because of access barriers.

Information on health-care use or unmet need is not routinely collected in the household budget surveys used to monitor financial hardship, because these surveys are designed to measure household consumption. Household budget surveys indicate which households have not made out-of-pocket payments, but not why. Households with no out-of-pocket payments may have no need for health care, be exempt from user charges or face barriers to accessing the health services they need.

Financial protection analysis that does not account for unmet need could be misinterpreted. A country may have a relatively low incidence of

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Fig. 1. Breakdown of out-of-pocket payments by data source, 2016

![Bar chart showing out-of-pocket payments by data source for 2016.](chart.png)

Notes: The category 'other' refers to medical products and diagnostic tests (including physiotherapy and paramedical services). The higher 'other' spending in the household budget survey reflects the inclusion of physiotherapy, which is mainly classified as outpatient care in the national health accounts.

Source: authors, based on household budget survey data, administrative claims data from Bouckaert, Maertens de Noordhout & Van de Voorde (2020) and data from national health accounts (OECD, 2022).
can catastrophic out-of-pocket payments because many people do not use health care, owing to limited availability of services or other barriers to access. Conversely, reforms that increase the use of services can increase people’s out-of-pocket payments – through, for example, user charges – if protective policies are not in place. In such instances, reforms might improve access to health care but at the same time increase financial hardship.

This review uses data on unmet need to complement the analysis of financial protection. It also draws attention to changes in the share and distribution of households without out-of-pocket payments. If increases in the share of households without out-of-pocket payments cannot be explained by changes in the health system – for example, enhanced protection for certain households – they may be driven by increases in unmet need.

Every year, EU Member States collect data on unmet need for health and dental care through the EU-SILC. These data can be disaggregated by age, gender, educational level and income. Although this important source of data lacks explanatory power and is of limited value for comparative purposes because of differences in reporting by countries, it is useful for identifying trends between social groups and over time within a country (Arora et al., 2015; European Commission Expert Panel on Effective Ways of Investing in Health (EXPH), 2016, 2017).

EU Member States also collect data on unmet need through the European Health Interview Survey (EHIS) carried out every five years or so. The third wave of this survey was launched in 2019. EHIS does not include internationally comparable data on unmet need in Belgium and France.

Whereas EU-SILC provides information on unmet need as a share of the population aged over 16 years, EHIS provides information on unmet need among households reporting a need for care. EHIS also asks households about unmet need for prescribed medicines.
3. Coverage policy
This section describes the three main dimensions of publicly financed health coverage – population coverage, service coverage and user charges (co-payments) – and reviews the role played by VHI.

Coverage arrangements in Belgium are complex. The publicly financed health system is based on the 1963 Health Insurance Act, which laid the foundations of the current system and provided the legal basis for population coverage, service coverage and user charges. The current system is regulated by the coordinated law of 14 July 1994. Reforms in 1980 and 2014 transferred many health competences to the federated entities, but responsibility for legislation and implementation of mandatory SHI remains at the federal level.

The National Institute for Health and Disability Insurance [Rijksinstituut voor Ziekte- en Invaliditeitsverzekering-Institut national d’assurance maladie-invalidité] (RIZIV-INAMI) manages and supervises the mandatory SHI system (Farfan-Portet et al., 2012). It is responsible for the national fee schedule (the so-called “nomenclature”), sets tariffs for health services (including medicines) and determines user charges policy.

Mandatory SHI is provided by sickness funds – private, non-profit organizations that originally developed along political and religious lines and are now grouped in five alliances at the national level (see section 3.1). Most sickness funds also provide mandatory CHI (see section 3.2). VHI is offered by a mix of private for-profit companies and most sickness funds (see section 3.4).

### 3.1 Population coverage

The SHI scheme provides near universal coverage of the population. Opting out is not permitted. Anyone aged over 25 years, or under 25 years and working or receiving social benefits, must register with a sickness fund and pay contributions in order to be covered (Gerkens, 2016). Coverage is automatically extended free of charge to dependent people under 25 years old and dependants with no income or a low income (less than €2762 in the second quarter of 2022).

With the exception of railway workers, who have their own sickness fund, people can choose which fund they want to join. The two largest alliances of sickness funds (the Christian and the Socialist mutualities) covered about 70% of the population in 2020. There is also a public sickness fund, which covers about 1% of the population, giving people a choice of six funds in total (HZIV, 2020). New funds are not allowed to enter the market (Van de Ven et al., 2003).

Income-related employee contributions are automatically deducted from gross wages. Self-employed people also pay contributions based on income. Some residents with no income or a low income (such as working students or self-employed people without work) are exempt from paying social contributions (for pensions, for example), but must pay a personal contribution directly to their sickness fund in order to have access to SHI benefits (Cès & Baeten, 2020). The personal contribution is based
on household income. In 2022 it ranged from €0 for people below the subsistence income level (that is, those eligible for the minimum income scheme) to a maximum of €785.10 per quarter (RIZIV-INAMI, 2022).

According to official statistics, at least 1% of the population (about 115 000 people) is not covered by the SHI scheme – mostly people who are not able to pay social contributions or are not aware of the administrative requirements (Devos et al., 2019; RIZIV-INAMI, 2022). Self-employed people are also more likely to lack SHI coverage, partly due to the complexity of rules around enrolment (Cès & Baeten, 2020). The share of people not covered by the SHI scheme is slightly higher – at least 2% – in the Brussels region and among people aged between 25 and 40 years, which may in part reflect the higher prevalence of international workers covered under international arrangements living and working in Brussels.

The actual share of the population that is uninsured is higher than official statistics suggest, however, because the official statistics do not include undocumented migrants, prisoners or homeless people, who also lack SHI coverage (RIZIV-INAMI & Dokters van de Wereld, 2014). Undocumented migrants can be covered by municipal welfare centres, which entitles them to urgent health care (including, in principle, some preventive and curative health services and medicines) delivered in hospital or in ambulatory settings (Roberfroid et al., 2015). Welfare centres have discretion in the procedures and conditions they apply. Prisoners are currently covered by the Ministry of Justice, but steps have been taken to integrate their coverage with the SHI scheme from January 2023 at the earliest. Homeless people can join a sickness fund if they register at a reference address such as a municipal welfare centre (Cès & Baeten, 2020).

### 3.2 Service coverage

Uninsured people are entitled to urgent health care (as described above) and some preventive services, such as vaccinations for children, which are free at the point of use and co-financed by the federal government and the federated entities. Only insured people have free access to preventive services such as breast cancer screening.

Before 2008 self-employed people lacked coverage for general practitioner (GP) and medical specialist consultations, minor surgical procedures, laboratory tests, outpatient medicines, dental care, physiotherapy and nursing care at home. Since January 2008, however, all insured people have been entitled to the same **SHI benefits package**. No other major changes to SHI benefits have taken place in the last two decades.

An insured person has a legal entitlement to a broad range of SHI benefits, including primary care, outpatient specialist care, inpatient care, nursing care at home, physiotherapy, medicines and dental care.

All SHI services and products except outpatient medicines, hospital stays and lump sums for specific conditions (incontinence, people in need of palliative care, people in vegetative state) are listed in the nomenclature (the national fee schedule), which defines tariffs and user charges. The
The nomenclature is determined by Royal Decree and is updated regularly. It contains more than 15,000 codes.

The Commission for the Reimbursement of Pharmaceuticals, part of RIZIV-INAMI, decides on coverage of outpatient and inpatient medicines (see section 3.1.3). Only prescription-only medicines are covered. Some prescription-only medicines (e.g., benzodiazepines) are not covered. Some covered medicines (e.g., painkillers) can also be obtained without a prescription.

Coverage of medical products includes implants or invasive medical devices on a positive list and non-implantable devices such as hearing aids, glasses, and contact lenses for people with certain medical conditions. Criteria for coverage include therapeutic and social needs, budgetary impact, and cost-effectiveness (Gerkens & Merkur, 2020). As a result, coverage of hearing aids and optical care (glasses and contact lenses) is limited to products and covered people who meet the criteria.

Children (under 18 years old) are entitled to most preventive and restorative dental services, but coverage of orthodontic treatment is limited. Some dental services (e.g., removable dentures and extractions) are covered for people within a specified age category (Gerkens & Merkur, 2020). Better coverage of preventive dental care is part of the new convention agreed between the sickness funds and dentists in December 2021. For example, in 2022 the age limit for coverage of preventive dental services was extended (RIZIV-INAMI, 2021).

Access to specialist outpatient care does not require a GP referral. People can ask a GP to manage their medical information through a global medical record, which improves coordination among health-care providers. The global medical record system was introduced in 2001 and the share of insured people benefiting from it has increased from 32% in 2003 to 78% in 2019 (IMA-AIM, 2022).

Inpatient care and outpatient medicines are provided to insured people as a benefit in kind (this is known as third-party payment). In the past insured people had to pay for all other health services at the point of use and apply for retrospective reimbursement from their sickness fund. A series of reforms is gradually shifting to third-party payment for outpatient care. Since October 2015 GPs have been obliged to apply third-party payment to all consultations with and services provided to people eligible for increased reimbursement (reduced co-payments; see below). From January 2022 health-care providers have discretion to apply third-party payment to all outpatient services; previously, doctors (GPs and specialists), dentists, and speech therapists were not allowed to apply third-party payment in specific situations.

Items excluded from the nomenclature are typically not covered by SHI – for example, alternative therapies such as acupuncture, homeopathy, and osteopathy. However, these therapies may be partially covered by the mandatory CHI provided by five of the six sickness funds (all except the public fund). People insured by the public fund can obtain mandatory CHI from the other funds. Mandatory CHI covers services like health promotion, orthodontics, optical care (glasses and contact lenses),
osteopathy and chiropractic, as well as emergency medical assistance abroad and ambulance transport. Some sickness funds also cover GP and specialist co-payments for children. Sickness funds can determine the content of the mandatory CHI coverage they offer and use this to try and attract new members. In the past decade, however, stricter regulation has aimed to harmonize mandatory CHI benefits. Also, as local sickness funds in the same national alliance have merged, the merged fund offers the same mandatory CHI benefits, which makes the market more transparent. In contrast to SHI benefits, mandatory CHI is financed through flat-rate contributions, which are regressive. Coverage is automatically extended to dependants free of charge.

Waiting times are not monitored in the Belgian health system.

3.3 User charges (co-payments)

User charges are applied to most health services, including medicines. The design of user charges policy is highly complex, involving co-payments, multiple mechanisms to protect people from co-payments and widespread balance billing.

Co-payments for SHI benefits are determined by law and uniformly applied across all sickness funds, as summarized in Table 2 (outpatient prescribed medicines) and Table 3 (other health services).

Over the years the government has introduced several mechanisms to protect people from SHI co-payments. For example, several changes in outpatient care have aimed to encourage referral and reduce the financial barriers associated with co-payments.

• Co-payments for GP office and home visits are lower for people with a global medical record (since 2001) (IMA-AIM, 2022).

• Co-payments for the first specialist visit in a year (per specialty) are lower if people obtain a GP referral (since 2007).

• Percentage co-payments were replaced by fixed co-payments for GP office visits (not home visits) in 2011 and for specialist visits in 2015.

• People who opt to register with a community health centre are exempt from co-payments for consultations with health-care providers in the centre (GPs, nurses, physiotherapists); if they visit health-care providers outside the centre, however, they pay the full price out of pocket. In 2019 about 4.2% of insured people were registered with a community health centre, with the largest concentration in Brussels and Liège (IMA-AIM, 2022).

In addition, there are important protection mechanisms that apply to co-payments for specific groups of insured people: reduced co-payments and an annual income-based cap on co-payments.
Insured people eligible for reduced co-payments are those considered to be in vulnerable situations. This group is referred to as **people with increased reimbursement (reduced co-payments)**, equal to around 19% of the population in 2021 (RIZIV-INAMI, 2022). The definition of vulnerable has changed frequently over time. The scheme applies co-payment reductions in two ways (see Table 2 and Table 3 for further details):

- **Automatic entitlement to reduced co-payments**: people with a subsistence income (those eligible for the minimum income scheme, which benefited around 1.4% of the population – about 150 000 people – in January 2022); older people with an income guarantee (social assistance for older people); people with disabilities receiving an allowance; disabled children aged under 21 years; orphans; and unaccompanied foreign minors.

- **Entitlement to reduced co-payments on request**: low-income households not in the automatic entitlement category can request reduced co-payments. Low-income households are those in which the household’s annual gross taxable income is less than €20 293 in 2022, increased by €3757 for each household member.

- Since 2015, people in both groups have benefited from third-party payment for GP office visits.

Many people eligible for increased reimbursement (reduced co-payments) do not benefit from it. Data from 2012 suggest that around 480 000 eligible households did not apply for reduced co-payments (Farfan-Portet et al., 2019). Analysis finds that a third of people at risk of poverty in 2016 did not benefit from reduced co-payments (Bouckaert, Maertens de Noordhout & Van de Voorde, 2020). Survey data from 2019–2020 indicate that non-take-up of reduced co-payments is nearly 70% in adults aged between 18 and 64 who are eligible based on low household income and nearly 40% in people aged over 65 (Goedemé et al., 2022). In response to this weakness, RIZIV-INAMI and the sickness funds have been more active in trying to identify and inform potential beneficiaries, working closely with the tax administration (RIZIV-INAMI, 2019).

An **annual cap on co-payments**, known as **maximum billing or MAF** [maximumfactuur- maximum à facturer], has been in place since 2002. The cap is linked to the net taxable income of a household two years previously and applies to almost all co-payments (the main exceptions are co-payments for long-term stays in a psychiatric hospital and for some medicines). A 2014 reform transferred some competences (e.g. residential care for older people) from the federal state to the federated entities; as part of this process it was agreed that co-payments for transferred competences would only be included in MAF until the end of 2019, but the regulations have not yet changed and these co-payments remain in MAF.

MAF benefits all insured people, but the level of the annual cap varies across different groups. Households can be eligible for one or more types of annual cap based on the following criteria (in 2022).

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4. Note that subsistence income [Leefloon-Revenu d’Intégration] is not included in net taxable income, so households whose only revenue source is subsistence income have a net taxable income of €0.
• **Income MAF:** the annual cap ranges from €250 to €2027, depending on household income (see Table 3 for details). Before 2022 the lowest MAF threshold was €507 a year.

• **Child MAF:** the annual cap is set at €732 for children under 19. The right to the child MAF cannot be transferred to other household members.

• **Social MAF:** the annual cap is €507 for people eligible for reduced co-payments and their household members.

• **Chronic condition MAF:** this reduces the child MAF annual cap or the household’s social or income MAF annual cap by €113 for those with the status of person with a chronic condition or people with high co-payments in the two previous calendar years (co-payments of more than €478 in 2020 and €487 in 2021 to be entitled in 2022).

In January 2023 the MAF was frozen so that it would not rise with inflation.

Since 2013 the **status of person with a chronic condition** has been applied to people spending at least €338 (2022) on covered health services for eight consecutive quarters (an indexed amount that includes co-payments as well as payments that may be reimbursed by the sickness fund) and to people who benefit from an annual lump-sum intended to cover non-medical costs. These groups are automatically eligible for the chronic condition MAF.

**Balance billing** is widespread. The negotiated fee or “convention tariff” is determined through agreements (for physicians and dentists) and “conventions” (for all other health-care providers). Physicians who subscribe to the agreement are called “conventioned” practitioners. Physicians who do not subscribe to it, or who only subscribe to it for some parts of the day or week, are allowed to charge more than the convention tariff (balance billing). The share of conventioned physicians varies substantially across medical specialties and regions – for the agreement for 2022–2023, for example, about 8% of GPs did not subscribe to the agreement, rising to 25% of cardiologists and 57% of ophthalmologists (RIZIV-INAMI, Nationale commissie artsen & ziekenfondsen 2022).

For inpatient care, balance billing (fee supplements) is determined by the type of hospital room a person chooses. In 2013 fee supplements were prohibited in shared hospital rooms. In single-occupancy hospital rooms fee supplements can be charged by both conventioned and non-conventioned specialists, except when a single-bed room is needed on clinical grounds or for other reasons beyond the control of the patient. Hospitals are free to set their own rules around the maximum fee supplement. Hospitals can also determine their own additional charges for the choice of a hospital single-occupancy room (room supplements), resulting in large variation in balance billing across hospitals, leading the government to impose restrictions over time (Table 4). In 2022, as a first step to reducing fee supplements, the maximum fee supplement was frozen at the hospital level. Although this measure prevents further increases, it does not address differences between hospitals.

Since 1990 a **Special Solidarity Fund** has provided an additional safety net for “ordinary” coverage. People with serious health conditions receive financial assistance for specific medical services that are not covered and are particularly costly.
Table 2. User charges for outpatient prescribed medicines, 2022

<table>
<thead>
<tr>
<th>Category of medicine</th>
<th>User charges for medicines delivered by a community pharmacy</th>
<th>User charges for medicines delivered by a hospital pharmacy to an ambulatory patient</th>
<th>Exemption</th>
<th>Cap on user charges paid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A: essential medicines (e.g. for diabetes, cancer)</strong></td>
<td>Ex-factory price &lt; €14.38 - No</td>
<td>Ex-factory price ≥ €14.38 - No</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Fa: as above but coverage is a flat rate per treatment and reference pricing does not apply</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B: therapeutically necessary medicines for non-life-threatening diseases (e.g. antihypertensives)</strong></td>
<td>44.20% (for the general population) - €2.50 + 27% (for the general population)</td>
<td>25% (for the general population) - €1.50 + 16% (for people with increased reimbursement)</td>
<td>No</td>
<td>Income-related cap on annual copayments (MAF) and cap per medicine ranging from €8 to €15</td>
</tr>
<tr>
<td>Fb: as above but coverage is a flat rate per treatment and reference pricing does not apply</td>
<td>26.52% (for people with increased) - €1.50 + 16% (for people with increased)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C: medicines for symptomatic treatment (e.g. treatment of chronic bronchitis)</strong></td>
<td>88.39% - €5 + 54%</td>
<td>50%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Cs: flu vaccines or medicines used for allergies</td>
<td>106.07% - €6 + 65%</td>
<td>60%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Cx: contraceptives</td>
<td>141.43% - €8 + 86%</td>
<td>80%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>D: non-covered medicines</strong></td>
<td>Full price</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>For all covered medicines except Fa and Fb</td>
<td>People pay the difference between the reference price and the retail price out of pocket</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>For OTC pain medication for people with chronic conditions</td>
<td>People pay 80% of the price</td>
<td></td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Note: NA: not applicable; % = share of the ex-factory price for community pharmacies. Source: authors.
Table 3. User charges for publicly financed health services, 2022

<table>
<thead>
<tr>
<th>Type and level of user charge</th>
<th>Exemptions</th>
<th>Cap on user charges paid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GP visit:</strong> €6 (€4 with a GMR; €1.50 for people with increased reimbursement or €1 with a GMR)</td>
<td>People registered with community health centres are exempt from co-payments for GP services and physiotherapy and nursing services (if available at the centre)</td>
<td>Income-related cap on annual co-payments (MAF): ≤€11 120: €250 (from 2022) €11 120 – €19 894: €507 €19 894 – €30 583: €732 €30 583 – €41 273: €1126 €41 273 – €51 517: €1577 ≥ €51 517: €2027</td>
</tr>
<tr>
<td><strong>Specialist visit without GP referral:</strong> €12 (€3 for people with increased reimbursement)</td>
<td></td>
<td>Amounts indexed annually on 1 January</td>
</tr>
<tr>
<td><strong>Specialist visit with GP referral</strong> (some specialties only, once a year per specialty): €7 (€1 for people with increased reimbursement)</td>
<td></td>
<td>Does not include co-payments in a psychiatric hospital beyond the 1st year</td>
</tr>
<tr>
<td><strong>Home visit:</strong> €8–€32.13 depending on age, time of visit and GMR (lower co-payments for people with a GMR; co-payments of €2–€7.33 for people with increased reimbursement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Services:</strong> co-payments vary</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic tests and other paramedical services</strong></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Based on the total cost of all performed tests per case: €0, €8.70, €12.96 or €15.67 (€0 or €3.72 for people with increased reimbursement) For specific tests: €8.68 per test (€0 for people with increased reimbursement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical products</strong></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Percentage co-payments range from 0% or 88% (lower for people with increased reimbursement); an extra 10% (up to €148.74) for invasive medical devices and implants to cover storage, sterilization and delivery costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental care</strong></td>
<td>Most preventive and restorative dental services for children &lt; 18 years</td>
<td></td>
</tr>
<tr>
<td><strong>Visit:</strong> €5.50 (€0 for people with increased reimbursement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Services:</strong> co-payments vary (usually 50% less for people who have visited a dentist in the previous year; reduced for people &lt; 18 years for preventive and restorative procedures; vary by age for orthodontics, dentures, dental extraction)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient care</strong></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Fixed co-payments per day in hospital:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Insured people without dependants: €44.51 on day 1, €17.24 from day 2, €28.74 from year 6 in a psychiatric hospital (€6.12 a day and €17.24 from year 6 in a psychiatric hospital for people with increased reimbursement; €33.39 on day 1, €6.12 from day 2 and €17.24 from year 6 in a psychiatric hospital for unemployed people)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Insured people with dependants: €44.51 on day 1, €17.24 days 2–90, €6.12 from day 91 (€6.12 a day for people with increased reimbursement; €33.39 on day 1 and €6.12 from day 2 for unemployed people)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dependents: €33.39 on day 1 and €6.12 from day 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Services:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medicines: €0.62 a day in an acute hospital, €0.80 a day in a psychiatric hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Biological tests: €7.44 per stay (€0 for people with increased reimbursement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical imaging: €6.20 per stay (€1.98 for people with increased reimbursement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical-technical services: €16.40 per stay (€0 for people with increased reimbursement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fees for medical practitioners as defined in the nomenclature</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Specific products, such as blood products or radioisotopes: fixed co-payments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital transport service: fixed amount per km or per trip</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency care</strong></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Fixed co-payment: €21.65 (without referral); €4.82 with referral; €12.03 (without referral), €1.78 with referral for people with increased reimbursement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4. Changes to coverage policy, 2002–2022

<table>
<thead>
<tr>
<th>Year</th>
<th>Change</th>
<th>Health services targeted</th>
<th>People targeted</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>Maximum billing/MAF introduced (an annual income-related cap on co-payments)</td>
<td>Outpatient medicines in category A and B; medical and paramedical services; dialysis; clinical biology; radiology; (most) implants; hospital stays up to 90 days (health services have been gradually added since 2002)</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Reference pricing for outpatient medicines introduced</td>
<td>Outpatient prescription medicines</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Global medical record extended to all insured people</td>
<td>GP care</td>
<td>Insured people</td>
</tr>
<tr>
<td>2003</td>
<td>Fixed co-payment of €12.50 introduced to reduce unnecessary visits to the emergency department (abolished in 2005)</td>
<td>Emergency care</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Extension of MAF</td>
<td>Outpatient medicines category C</td>
<td>Insured people</td>
</tr>
<tr>
<td>2004</td>
<td>Extension of MAF</td>
<td>Hospital stays beyond the 91st day in acute hospitals</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Extension of age limit in MAF for children from &lt; 16 years to &lt; 19 years</td>
<td>All health services covered by MAF</td>
<td>Children &lt; 19y</td>
</tr>
<tr>
<td>2005</td>
<td>Integration of the fiscal MAF into the income MAF</td>
<td>All health services covered by MAF</td>
<td>People entitled to the fiscal MAF</td>
</tr>
<tr>
<td></td>
<td>Exemption from co-payments for dental care</td>
<td>Selected dental care services</td>
<td>Children &lt; 12y</td>
</tr>
<tr>
<td></td>
<td>Abolition of co-payments for emergency care</td>
<td>Emergency department</td>
<td>Insured people</td>
</tr>
<tr>
<td>2006</td>
<td>Extension of MAF</td>
<td>Implants and medical devices</td>
<td>Insured people</td>
</tr>
<tr>
<td>2007</td>
<td>Extension of the benefits package</td>
<td>Analgesic drugs and bandages</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Extension of entitlement to increased reimbursement</td>
<td>All health services</td>
<td>Insured people with low-income</td>
</tr>
<tr>
<td></td>
<td>Reduced co-payment for outpatient specialist visits if with GP referral</td>
<td>Outpatient specialist consultations</td>
<td>Insured people with a GMR</td>
</tr>
<tr>
<td></td>
<td>Coverage of travel expenses for non-hospitalized cancer patients</td>
<td>Travel expenses</td>
<td>People with cancer</td>
</tr>
<tr>
<td></td>
<td>Introduction of co-payments for emergency care</td>
<td>Emergency department</td>
<td>Insured people</td>
</tr>
<tr>
<td>2008</td>
<td>Merger of the two main coverage schemes (self-employed and general schemes) and extension of the benefits package for self-employed people resulting in a single, national benefits package</td>
<td>Ambulatory care and outpatient medicines</td>
<td>Self-employed people</td>
</tr>
<tr>
<td></td>
<td>Extensions of exemption from co-payments for dental care</td>
<td>Dental care services</td>
<td>Children &lt; 15 years</td>
</tr>
<tr>
<td></td>
<td>Extension of MAF</td>
<td>Implants and medical devices</td>
<td>Insured people</td>
</tr>
<tr>
<td>2009</td>
<td>Introduction of MAF for people with chronic conditions</td>
<td>All health services covered by MAF</td>
<td>People with chronic conditions</td>
</tr>
<tr>
<td></td>
<td>Extension of exemption from co-payments for dental care</td>
<td>Dental care services</td>
<td>Children &lt; 18 years</td>
</tr>
</tbody>
</table>

Notes: GMR: Global medical record. Insured people refers to those covered by the SHI scheme.

Source: Gerkens & Merkur (2020) and authors.
Table 4. Changes to coverage policy, 2002–2022 (contd)

<table>
<thead>
<tr>
<th>Year</th>
<th>Change Description</th>
<th>Related Services</th>
<th>Affected Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Introduction of a cap on reference pricing (€10.80)</td>
<td>Outpatient prescription medicines</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Introduction of a cap on co-payments (€15.50)</td>
<td>Medical specialist consultations (such as oncology, psychiatry, neurology and haematology)</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Introduction of a percentage co-payment on the ex-factory price</td>
<td>Outpatient prescription medicines</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Ban on balance billing for conventioned physicians in shared hospital rooms for inpatient stays</td>
<td>Inpatient care</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Abolition of any balance billing in shared hospital rooms</td>
<td>Inpatient care</td>
<td>Insured people</td>
</tr>
<tr>
<td>2011</td>
<td>Change from percentage to fixed co-payments</td>
<td>GP office consultations</td>
<td>Insured people</td>
</tr>
<tr>
<td>2012</td>
<td>Introduction of categories Fa and Fb</td>
<td>Outpatient prescription medicines</td>
<td>Insured people</td>
</tr>
<tr>
<td>2013</td>
<td>Ban on balance billing for all physicians in shared hospital rooms for inpatient stays</td>
<td>Inpatient care</td>
<td>Insured people</td>
</tr>
<tr>
<td>2014</td>
<td>Introduction of the status of person with a chronic illness</td>
<td>All health services</td>
<td>People with chronic conditions</td>
</tr>
<tr>
<td>2015</td>
<td>Introduction of mandatory third-party payment by GPs for people eligible for reduced co-payments</td>
<td>Ambulatory care</td>
<td>Low-income households</td>
</tr>
<tr>
<td></td>
<td>Ban on balance billing applied to all physicians for shared hospital rooms for same day stay</td>
<td>Inpatient care</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Introduction of automatic application of the MAF threshold in the pharmacy</td>
<td>Outpatient prescription medicines</td>
<td>Insured people above the MAF threshold</td>
</tr>
<tr>
<td></td>
<td>Change from percentage to fixed co-payments</td>
<td>Outpatient specialist services</td>
<td>Insured people</td>
</tr>
<tr>
<td>2016</td>
<td>Cap on reference pricing strengthened from €10.80 to €5</td>
<td>Outpatient prescription medicines</td>
<td>Insured people</td>
</tr>
<tr>
<td>2017</td>
<td>Introduction of indexation</td>
<td>All health services covered by MAF</td>
<td>Insured people</td>
</tr>
<tr>
<td>2018</td>
<td>Introduction of a price reduction (15% of the ex-factory price) for biological products after 18 years of reimbursement</td>
<td>Outpatient prescription medicines</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Extension of the benefits package</td>
<td>All health services</td>
<td>People with a mental illness who have committed a crime</td>
</tr>
<tr>
<td>2019</td>
<td>Extension of the benefits package</td>
<td>Psychological care</td>
<td>Insured people ≥ 18 years and &lt; 65 years</td>
</tr>
<tr>
<td>2020</td>
<td>Extension of coverage to four sessions</td>
<td>Psychological care</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Some health services removed from MAF</td>
<td>Medical specialist consultations in geriatric and rehabilitation hospitals</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Price reduction for biological products changed to 20% of the ex-factory price after 12 years of reimbursement</td>
<td>Outpatient prescription medicines</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Abolition of cap on reference pricing of €5</td>
<td>Outpatient prescription medicines</td>
<td>Insured people</td>
</tr>
<tr>
<td>2022</td>
<td>Extension of MAF; threshold reduced to €250 for households with an annual income up to €11120</td>
<td>All health services</td>
<td>Insured people with low income</td>
</tr>
<tr>
<td></td>
<td>Extension of the voluntary application of third-party payment by health-care providers to all outpatient care</td>
<td>Ambulatory care</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Better coverage of preventive dental services</td>
<td>Dental care</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Better coverage of transport costs for cancer patients and others needing regular visits (e.g. for dialysis)</td>
<td>Treatment of some chronic conditions</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Better coverage of first-line mental health services</td>
<td>Psychological care</td>
<td>Insured people</td>
</tr>
</tbody>
</table>
3.4 The role of VHI

In 2020 VHI accounted for 4.9% of current spending on health (OECD, 2022). It plays a complementary and supplementary role in the health system. Initially it focused on offering subscribers a fixed payment per day in hospital, but over time coverage has been extended to user charges and other out-of-pocket payments for inpatient care because of the increase in balance billing over time (Gerbens, 2016). VHI can also cover dental care and ambulatory services (including balance billing and user charges), but this part of the market is relatively small.

VHI is regulated by the Control Service of Health Insurance Funds. It is offered by private for-profit companies (commercial insurers) and most sickness funds, through non-profit mutual associations linked to national sickness fund associations; the public sickness fund does not offer VHI.

Commercial VHI grew rapidly between 2006 and 2018 due to rising hospital costs (Assuralia, 2021a). Around three-quarters of commercial VHI is sold on a group basis (Assuralia, 2021b), typically offered to employees as a benefit in kind that is exempt from taxes and social contributions for employees and employers. Sickness funds are not allowed to offer group contracts.

Reliable data on the share of the population with VHI are not available. It is estimated that there were 10 million VHI policies in 2018 (60% in commercial insurers and 40% in sickness funds) in a population of 11.4 million people. This is likely to include a significant amount of double counting, however, as individuals can be covered through multiple policies (Assuralia, 2021a; Van de Voorde, Kohn & Vinck, 2011; Controledienst voor de ziekenfondsen, 2020).

The characteristics of people with VHI are only available via survey data. People with tertiary education (87%) and those in the richest income quartile (88%) are more likely to take out VHI than lower-educated people (67%) and people at risk of poverty (42%) (Capéau et al., 2018).

Table 5 highlights key issues in the governance of coverage, summarizes the main gaps in publicly financed coverage and indicates the role of VHI in filling these gaps.
Table 5. Gaps in publicly financed and VHI coverage

<table>
<thead>
<tr>
<th>Coverage dimension</th>
<th>Main gaps in publicly financed coverage</th>
<th>Are these gaps covered by VHI?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population coverage</td>
<td>At least 1% of the population is uninsured, rising to at least 2% in Brussels and among younger adults (25–40 years) and self-employed people. Lack of access to SHI coverage for asylum seekers, undocumented migrants, posted workers (people sent by their employer to carry out a service in another EU Member State on a temporary basis), people with a mental illness who have committed a crime, homeless people and people who cannot afford to pay contributions. People whose social contributions are not automatically collected face complex coverage rules.</td>
<td>No.</td>
</tr>
<tr>
<td>Service coverage</td>
<td>SHI coverage of dental care and medical products (e.g. hearing aids and optical care such as glasses and contact lenses) is limited and SHI does not cover OTC medicines. Benefits in kind (third-party payment) do not automatically apply to all outpatient care, only to inpatient care and outpatient medicines.</td>
<td>VHI covering dental care is available but take up is limited.</td>
</tr>
<tr>
<td>User charges (co-payments)</td>
<td>Heavy and complex co-payments are applied to almost all health services. Balance billing is widespread, particularly in hospitals. There are very few exemptions from co-payments. Reduced co-payments are not automatically granted to low-income households and there are major gaps in take up. Co-payment protection mechanisms do not apply to widespread balance billing, which is especially heavy for inpatient care.</td>
<td>VHI partly covers balance billing and co-payments for inpatient care.</td>
</tr>
</tbody>
</table>
3.5 Summary

Belgium’s coverage arrangements are unusually complex.

Mandatory health insurance covers most of the population, but at least 1% are uninsured because they cannot afford to pay contributions or face administrative barriers (Cès & Baeten, 2020). This share rises to at least 2% in Brussels and among younger adults (25–40 years) and self-employed people.

Although the SHI benefits package is comprehensive, coverage is limited for dental care, medical products (for example, hearing aids and optical care such as glasses and contact lenses, except for specific groups) and OTC medicines. Mandatory CHI provided by the sickness funds covers some of these gaps, but CHI benefits vary across funds, do not cover all costs and are financed through flat-rate contributions, which are regressive.

Before 2022 benefits in kind (third-party payment) were only mandatorily applied to inpatient care and outpatient medicines and to GP care for people eligible for reduced co-payments. For most other health services people had to pay providers up front and apply for retrospective reimbursement from their sickness fund. In 2022 the option to offer third-party payment for outpatient care was extended to all other health-care providers on a voluntary basis.

SHI benefits are subject to heavy user charges: co-payments are applied to almost all health services. Over the years several efforts have been made to protect people from co-payments, including the introduction of an annual income-based cap on most co-payments (known as MAF) and reduced co-payments for households with a low income. However, many people who are eligible for reduced co-payments do not benefit from them, partly due to administrative barriers. The lack of a general co-payment exemption for low-income households is another important weakness.

Balance billing is widespread, particularly in hospitals, in spite of policy efforts to limit it. VHI offers protection against balance billing in hospitals, but take up of VHI is much more prevalent in the richest income quartile (88%) than among households at risk of poverty (42%).
4. Spending on health
The first part of this section uses data from national health accounts to present patterns in public and private spending on health. The second part uses household budget survey data to review out-of-pocket payments (the formal and informal payments made by people at the time of using any good or service delivered in the health system) and the third part considers the role of informal payments.

4.1 Public and private spending on health

Data from national health accounts show that the Belgian health system relies more heavily on out-of-pocket payments than in neighbouring countries such as France, Germany and the Netherlands (Fig. 2). In 2020 (the latest available year of internationally comparable data), the out-of-pocket payment share of current spending on health in Belgium (16.4%) was just above the EU14 average (16.2%). It fell from a peak of 21% in 2003 to 19% in 2012, at the beginning of the study period, and gradually declined further to 18% in 2018. It rose to 19% in 2019, before falling to 16% in 2020.

As a share of GDP, public spending on health is higher in Belgium than in many other EU14 countries, but lower than some countries with a similar or lower level of GDP per person – for example, Austria, France, Germany and Sweden (Fig. 3).
In 2020 the share of the government budget allocated to health in Belgium (14.3%) was below the EU14 average (15.4%) and well below countries like Denmark, Germany, Ireland, the Netherlands and Sweden (Fig. 4).
Although public spending on health per person has increased over time, rising particularly rapidly between 2003 and 2004; 2007 and 2009; and 2014 and 2018, growth has been slow in recent years (Fig. 5). Between 2005 and 2011 an annual cap on growth in public spending on health, set at 4.5% in real terms, slowed growth and enabled a surplus that was used to increase public spending on health during and after the global financial crisis (Cleemput et al., 2015). Between 2012 and 2019, however, public spending on health per person grew by only 1.3% a year in real terms. During this time out-of-pocket payments per person grew even more slowly (1.2% a year), while spending on VHI increased rapidly (4.5% a year).
Broken down by health service and financing scheme, national health accounts data show out-of-pocket payments are the dominant method of financing dental care and medical products (Fig. 6, top panel). VHI plays a significant role in financing inpatient care (9% of current spending on health in 2020) and a very small role in financing outpatient care (1%).

Belgium spends much more through out-of-pocket payments than the EU14 average for outpatient care (36% in Belgium versus an EU14 average of 15%) and inpatient care (11% versus 6%) and quite a bit more for dental care (61% versus 51%) (Fig. 6, bottom panel). The out-of-pocket payment share is lower than the EU14 average for diagnostic tests and similar for other types of care, including outpatient medicines.
Can people afford to pay for health care?

Fig. 6. Breakdown of current spending on health by type of care and financing scheme, Belgium and the EU, 2020

### Belgium

<table>
<thead>
<tr>
<th>Category</th>
<th>Current spending on health (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical products</td>
<td>54</td>
</tr>
<tr>
<td>Outpatient care</td>
<td>36</td>
</tr>
<tr>
<td>Outpatient medicines</td>
<td>34</td>
</tr>
<tr>
<td>Inpatient care</td>
<td>11</td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td>9</td>
</tr>
</tbody>
</table>

Notes: the category outpatient care excludes dental care. Public spending on health refers here to compulsory financing schemes, including compulsory private health insurance in France, Germany and the Netherlands.

Source: data from national health accounts (OECD, 2022).

### EU14

<table>
<thead>
<tr>
<th>Category</th>
<th>Current spending on health (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical products</td>
<td>55</td>
</tr>
<tr>
<td>Outpatient care</td>
<td>15</td>
</tr>
<tr>
<td>Outpatient medicines</td>
<td>34</td>
</tr>
<tr>
<td>Inpatient care</td>
<td>6</td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Public spending on health</th>
<th>VHI</th>
<th>Out-of-pocket payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental care</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>Medical products</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>Outpatient care</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Outpatient medicines</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Inpatient care</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>
4.2 Out-of-pocket payments

Household budget survey data indicate that just over two-thirds (68%) of households reported out-of-pocket payments in 2020 (the latest available year), down from around 80% before 2018 (Fig. 7). The large decrease between 2016 and 2018 cannot be explained by policy changes and is likely to be related to the change in survey in 2018, in which the recall period for most out-of-pocket payments was reduced from 1 month to 15 days (see section 2 for details).

Richer households are consistently more likely to report out-of-pocket payments than poorer households (Fig. 7). In 2020 about three-quarters of households in the richest consumption quintile reported out-of-pocket payments compared to only half of those in the poorest quintile.

In 2020 the average annual amount spent out-of-pocket per person was €808, with the richest quintile spending about nine times more than the poorest quintile (Fig. 8). In previous years the difference in spending between the richest and poorest quintiles was smaller. Between 2012 and 2016 the average annual amount spent per person (in real terms) was stable or fell in the three poorest quintiles but grew in the two richest quintiles, leading to a widening gap (Fig. 8). Between 2018 and 2020 there was an even sharper rise in spending in the richest quintile.
In 2020 out-of-pocket payments accounted for 6.3% of total household consumption (the household budget) on average, with the share ranging from 4.2% in the poorest quintile to 7.2% in the richest quintile (Fig. 9). This overall share is higher than in previous years due to a decrease in overall household consumption and an increase in spending on health.

Looking at the trend between 2012 and 2016, the out-of-pocket payment share of household budgets was higher in 2016 than in 2012 in all quintiles, with the sharpest increases in the richest quintiles (Fig. 9). The fall in real out-of-pocket spending in the three poorest quintiles (see Fig. 8) did not reduce the out-of-pocket payment share of household budgets, reflecting a larger decline in household consumption in these quintiles than in the richest quintile. Between 2018 and 2020 the sharp increase in the richest quintile stands out.
In 2020 out-of-pocket payments were mainly driven by spending on outpatient medicines (26%), medical products (22%) and outpatient care (19%), followed by diagnostic tests (15%), dental care (12%) and inpatient care (7%) (Fig. 10). Between 2012 and 2018 most shares remained relatively stable, although there was an increase in the inpatient care share in 2014, which fell again in 2016, and the dental care and diagnostic tests shares increased in 2016. In 2020 there was a sharp increase in the medical products share (which would include COVID-19-related spending on facemasks and disinfectants) and diagnostic tests (in particular due to spending on physiotherapy and rehabilitation (included in this category)). These increases were offset by a decline in the outpatient and inpatient care shares – not surprising given lockdowns and the postponement of non-urgent care in response to COVID-19.
Outpatient medicines are the largest single driver of out-of-pocket payments in all but the richest quintile in 2020, with a share ranging from 16% in the richest quintile to 38% in the poorest (Fig. 11). There is a similar pattern for outpatient care, but the difference in shares across quintiles is not quite so marked as for outpatient medicines. Richer quintiles are more likely to spend on medical products (33% in the richest quintile vs 13% in the poorest), dental care (13% vs 8%) and inpatient care (8% vs 5%). Only the diagnostic tests share does not vary much across quintiles.

The social gradient seen in outpatient medicines, outpatient care, medical products and inpatient care is consistent across all years in the study (Fig. 11). A social gradient for dental care was found in some (2012, 2018 and 2020) but not all years.
Fig. 11. Breakdown of total out-of-pocket spending by type of health care and consumption quintile

Notes: Diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment. Break in series in 2018; data before and after 2018 are not comparable.

Source: authors, based on household budget survey data from Statistics Belgium.

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The increase in out-of-pocket payments between 2018 and 2020 (see Fig. 8) was driven mainly by large increases in spending on medical products and diagnostic tests (Fig. 12).
In 2020 people in the richest quintile spent about 23 times more on medical products, 15 times more on inpatient care and dental care and 10 times more on diagnostic tests than people in the poorest quintile (Fig. 13). The differences in spending across quintiles are smaller for outpatient medicines and outpatient care.

The social gradient in spending on medical products and dental care is likely to reflect limited coverage of these types of care; a decrease in the number of conventioned dentists and orthodontists, pushing up balance billing for dental care (De Wolf et al., 2020b); and high levels of unmet need for dental care in the poorest quintile (see section 5).

Higher spending on inpatient care among richer households is also likely to reflect widespread balance billing. Balance billing is partially covered by VHI in Belgium, but VHI reimbursements are not accounted for in the household budget survey, so even though out-of-pocket payments for inpatient care are higher among richer households, these households are also more likely to be covered by VHI.

In 2015 a reform obliged GPs to apply the third-party payer principle for people benefiting from increased reimbursement (see section 3.2). This might explain the drop in outpatient care spending in lower-income households between 2014 and 2016 (Fig. 13).
Fig. 13. Annual out-of-pocket spending per person by type of health care and consumption quintile

Medicines

Outpatient care

Medical products
Fig. 13. Annual out-of-pocket spending per person by type of health care and consumption quintile (contd)

Diagnostic tests

Dental care

Inpatient care

Notes: diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment. Amounts are shown in real terms (base year 2020). Break in series in 2018; data before and after 2018 are not comparable.

Source: authors, based on household budget survey data from Statistics Belgium.
4.3 Informal payments

A 2020 Special Eurobarometer report on corruption finds that 6% of survey respondents in Belgium who had visited a health-care practitioner or institution in the previous 12 months reported having had to make an extra payment or give a valuable gift to a nurse or doctor, or make a donation to the hospital on top of the official fees (European Commission, 2020). This is above the EU14 average of 4% and an increase compared to previous assessments (5% in Belgium in 2017 and 2% in 2014) (European Commission, 2014, 2017, 2020).

Anecdotal evidence suggests that waiting times for outpatient and inpatient care are reduced in return for accepting balance billing and, in rare cases, informal payments (Annemans, 2016; Belgische kamer van volksvertegenwoordigers, 2017; Bertels, 2020; Weeghmans, 2018). It is also possible that some people may mistake balance billing for an informal payment, perhaps due to a lack of information or uncertainty about whether balance billing will be charged, how much it will cost and whether it will be covered by VHI.

4.4 Summary

Data from national health accounts show that there was limited growth in public spending on health per person during the study period. Out-of-pocket payments per person barely grew, unlike spending on VHI, which grew rapidly. In 2020 the out-of-pocket payment share of current spending on health was 16.4%, slightly above the EU14 average of 16.2% and consistently higher than in neighbouring countries such as France, Germany and the Netherlands.

Broken down by health service and financing schemes, SHA data show that out-of-pocket payments are the dominant source of financing for medical products and dental care. VHI plays a significant role in financing inpatient care (9% of current spending on health in 2020) and a very small role in financing outpatient care (1%).

Belgium spends much more through out-of-pocket payments than the EU14 average for outpatient care (36% in Belgium versus an EU14 average of 15%) and inpatient care (11% versus 6%) and quite a bit more for dental care (61% versus 51%).

Household budget survey data show that just over two-thirds of households (68%) reported out-of-pocket payments in 2020. This share fell from about 80% prior to 2018. The sharp fall in 2018 reflects a change in the survey (the recall period for most spending on health was shortened from 1 month to 15 days). Richer households are consistently more likely to report out-of-pocket payments than poorer households.

In 2020 the average annual amount spent out-of-pocket per person was €808. The richest quintile spent about nine times more than the poorest quintile. Out-of-pocket payments accounted for 6.3% of total household
consumption (the household budget) on average, ranging from 4.2% in the poorest quintile to 7.2% in the fourth quintile. This is high compared to previous years. One explanation is a decrease in overall household consumption combined with an increase in COVID-19-related health spending (e.g. on facemasks or disinfectants).

Between 2012 and 2016 the average annual amount spent out of pocket fell in the three poorest quintiles, widening the gap in spending between poorer and richer quintiles. However, the out-of-pocket payment share increased in all quintiles, which suggests that household consumption decreased in the poorer quintiles. Between 2018 and 2020 there was an even sharper rise in spending in the richest quintile.

Outpatient medicines, medical products and outpatient care consistently account for the largest shares of out-of-pocket spending, reflecting balance billing for outpatient care, dental care and inpatient care and limited coverage of medical products and dental care. In poorer households, a larger share of health spending is devoted to outpatient medicines and outpatient care than in richer households, while the reverse is true for medical products, inpatient care and dental care. The increase in out-of-pocket payments over time was driven mainly by large increases in spending on dental care, diagnostic tests and medical products.
5. Financial protection
This section uses data from the Belgian household budget survey to assess the extent to which out-of-pocket payments result in financial hardship for households that use health services. It looks at household capacity to pay for health care, the relationship between out-of-pocket spending on health and poverty – impoverishing health spending – and the incidence, distribution and drivers of catastrophic health spending. The section also draws on other survey data to assess unmet need for health services.

5.1 Household capacity to pay for health care

Household capacity to pay for health care is what is left of a household’s budget after deducting a normative (standard) amount to cover spending on basic needs – food, housing and utilities (water, electricity and heating).

Between 2012 and 2020 (the latest available year) the average cost of meeting basic needs and household capacity to pay for health care decreased in real terms by 12.6% and 15.1%, respectively (Fig. 14). The share of households with household spending below the basic needs line has fluctuated over time; it was 2.0% in 2020.

Fig. 14. Changes in the cost of meeting basic needs, capacity to pay for health care and the share of households living below the basic needs line

Notes: amounts shown in real terms (base year 2020), with nominal amounts for the cost of meeting basic needs and for average household capacity to pay, respectively, at €761/€1772 in 2012, €701/€1833 in 2014, €708/€1666 in 2016, €704/€1765 in 2018 and €734/€1660 in 2020. The basic needs line and capacity to pay for health care are per household. Capacity to pay for health care is measured as a household’s consumption minus a normative (standard) amount to cover basic needs (food, housing and utilities). Break in series in 2018; data before and after 2018 are not comparable.

Source: authors, based on household budget survey data from Statistics Belgium.
Belgium has a strong social security system, capable of absorbing shocks and disruptions. Given relatively mild austerity measures, the impact of the 2008 global financial crisis was more muted in Belgium than in many other EU countries. GDP growth slowed to 0.4% in 2008 and fell by 2% in 2009, against an EU average decrease of 4.3%, but bounced back to 2.9% in 2010. Between 2008 and 2013 the consumption of Belgian households was more resilient than in many other European countries, although consumption has grown more slowly in Belgium than in other countries since 2014 (Basselier et al., 2019). The social security system also played a key role in moderating the economic impact of COVID-19 (Van Dam et al., 2020).

As a result of significant redistribution through taxes and social transfers income inequality in Belgium is among the lowest in the EU (Devos et al., 2019; Eurostat, 2022b; Federal Planning Bureau, 2022a; Van Dam et al., 2020). Nevertheless, close to 20% of the population is at risk of poverty or social exclusion (Fig. 15). While the risk of poverty has systematically fallen among older people, children and working-age people remain at high risk.

Policies introduced between 2012 and 2018 to increase labour market participation (by moderating wage growth, reducing labour taxes and reducing and limiting access to unemployment benefits and early retirement) reduced unemployment but increased the risk of poverty (Fig. 15) (Bijnens, Karimov & Konings 2019; Galand & Termote, 2014; Schepers & Nicaise, 2015; Van Dam et al., 2020). During this period the employment rate rose by 2.5 percentage points but was still substantially lower in 2020 in Belgium (69.7%) than in neighbouring countries like the Netherlands (80.0%), Germany (79.2%) and France (71.4%) (Eurostat 2022a). Unemployment peaked at 8.6% in 2015 before falling to 5.6% in 2020 (Federal Planning Bureau, 2022b). Increased labour market participation led to an improvement in social inclusion, as measured by the share of people under 60 living in households with very low work intensity and people experiencing severe material deprivation (Fig. 15) (Federal Planning Bureau, 2022c). However, benefit reductions pushed inactive people into sickness and invalidity schemes and social assistance (Federal Planning Bureau, 2022a, 2022c; Van Dam et al., 2020), and wage moderation put pressure on real income growth, with real wages per worker actually falling in 2015 and 2016 (Basselier et al., 2019). This had a marked effect on the incomes and purchasing power of low-income households, increasing the risk of poverty. Although fewer people now live in households with very low working intensity, this group has become more vulnerable and increasingly faces health problems (Van Dam et al., 2020).
5.2 How many households experience financial hardship?

Fig. 16 shows the share of households with impoverishing health spending. The poverty line reflects the cost of spending on basic needs among a relatively poor part of the Belgian population (households between the 25th and 35th percentiles of the consumption distribution, adjusted for household size and composition). In 2020 the monthly cost of meeting these basic needs – the basic needs line – was €734.

In 2020 1.1% of households were impoverished or further impoverished after out-of-pocket payments and a further 1.3% were at risk of impoverishment (Fig. 16). There is significant variation over time. The significant decrease in 2018 relates to a change in household budget survey design, which led to fewer people reporting out-of-pocket payments. Consequently, results before and after 2018 cannot be compared.
Households with *catastrophic health spending* are defined (in this review) as those who spend more than 40% of their capacity to pay for health care. This includes households who are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further impoverished (because they had no capacity to pay before paying out of pocket for health care). In 2020 just over 5% of households – nearly 260 000 households – experienced catastrophic health spending (Fig. 17).

Fig. 16. Share of households at risk of impoverishment after out-of-pocket payments

![Chart showing share of households at risk of impoverishment after out-of-pocket payments from 2012 to 2020.]

Notes: a household is impoverished if its total spending falls below the basic-needs line after out-of-pocket payments (OOPs); further impoverished if its total spending is below the basic-needs line before OOPs; and at risk of impoverishment if its total spending after OOPs comes within 120% of the basic-needs line. Break in series in 2018; data before and after 2018 are not comparable.

Source: authors, based on household budget survey data from Statistics Belgium.

Fig. 17. Share of households with catastrophic out-of-pocket payments

![Chart showing share of households with catastrophic out-of-pocket payments from 2012 to 2020.]

Note: break in series in 2018; data before and after 2018 are not comparable.

Source: authors, based on household budget survey data from Statistics Belgium.
The incidence of catastrophic health spending in Belgium is higher than in most other EU14 countries (Fig. 18).

Fig. 18. Incidence of catastrophic health spending and the out-of-pocket share of current spending on health in the WHO European Region, latest year available

Notes: data on out-of-pocket payments are usually for the same year as data on catastrophic health spending, except for Estonia, Greece, North Macedonia and Ukraine (2019). EU14 countries are shown in darker blue. Belgium is shown in red.

Source: WHO Barcelona Office for Health Systems Financing for data on catastrophic incidence (WHO Regional Office for Europe, unpublished data, 2022) and OECD (2022) and WHO (2022) for data on out-of-pocket payments.
5.3 Who experiences financial hardship?

In 2020 catastrophic spending was concentrated among households not at risk of impoverishment after out-of-pocket payments. These households accounted for almost two thirds of all households with catastrophic spending (Fig. 19).

In all years the incidence of catastrophic spending is heavily concentrated among the poorest quintile, although the concentration has diminished since the change in survey design in 2018, falling from 68% in 2012 to 60% in 2014 and 2016, and to 46% in 2018 and 2020 (Fig. 20). Within the poorest quintile the share of households with catastrophic spending fell from 16.2% in 2012 to 12.2% in 2020 (data not shown).

The share of the three richest quintiles has increased over time from 27% to 39%. Catastrophic spending in richer quintiles is at least partly caused by spending on durables such as glasses and hearing aids, with prices affected by people’s design preferences, and by one-off spending as opposed to spending on chronic conditions. These types of spending can have a major but usually only temporary upward impact on household health spending.
Catastrophic spending is also heavily concentrated among inactive people, unemployed people and people with a lower level of education – groups likely to overlap with households in the poorest quintile (Fig. 21). Households with very low work intensity in Belgium have higher health-care needs and often struggle to pay for health services, resulting in higher unmet need for health and dental care due to cost (Bouckaert, Maertens de Noordhout & Van de Voorde, 2020).

Fig. 20. Share of households with catastrophic spending by consumption quintile

Note: break in series in 2018; data before and after 2018 are not comparable.
Source: authors, based on household budget survey data from Statistics Belgium.

Fig. 21. Share of households with catastrophic spending by different types of household, 2020

Note: working status and educational level refer to the head of the household.
Source: authors, based on household budget survey data from Statistics Belgium.
5.4 Which health services are responsible for financial hardship?

In 2020 the main drivers of catastrophic spending were medical products (hearing aids, glasses, dentures, protheses, orthopaedic material, facemasks etc.), diagnostic tests (particularly physiotherapists, rehabilitation, osteopaths, chiropractors and psychologists) and dental care (Fig. 22). The medical products share of catastrophic spending declined between 2012 and 2018 but shot up again in 2020. The diagnostic test share increased in 2016, while the dental care, inpatient and outpatient care shares have fluctuated. Spending on inpatient care and, to a lesser extent, outpatient care, were distorted in 2020 due to lockdowns and the postponement of non-urgent care in response to COVID-19.

For the poorest quintile, outpatient medicines, outpatient care, diagnostic tests and medical products were the main drivers of catastrophic spending in 2020 (Fig. 23). Across all years, outpatient medicines and outpatient care are much larger drivers of catastrophic spending for the poorest quintile than the richest. The breakdown of catastrophic spending in quintiles other than the poorest should be interpreted with caution because of the small numbers involved, leading to considerable fluctuation.
Fig. 23. Breakdown of catastrophic spending by type of health care and consumption quintile

- Medicines
- Inpatient care
- Outpatient care
- Dental care
- Diagnostic tests
- Medical products

Out-of-pocket payments (%)

2012

0 20 40 60 80 100

Poorest 2nd 3rd 4th Richest

2014

0 20 40 60 80 100

Poorest 2nd 3rd 4th Richest

2016

0 20 40 60 80 100

Poorest 2nd 3rd 4th Richest
5.5 How much financial hardship?

Among households with catastrophic health spending, the average amount spent on health as a share of total household spending rises progressively with income (data not shown). In 2020 households who were further impoverished spent 6% of their budget on health care (Fig. 24). This is similar to the average share of household budgets spent on health – 6.3% in 2020 (see Fig. 9). Among households who were impoverished, the health share of the budget amounted to 17% in 2020 (data not shown).
5.6 Unmet need for health services

Unmet need is a common measure of perceived problems with access to health services, defined as instances in which people need health services but do not receive them because of access barriers (see Box 1). EU-SILC data up to 2021 (the latest available year) indicate that unmet need in Belgium is consistently higher for dental care than health care (Fig. 25). Before 2016 unmet need for both health care and dental care was much lower in Belgium than the EU average, but since then the Belgian average has remained close to the EU average for health care and above the EU average for dental care. In 2020 EU-SILC data collection was affected by the COVID-19 pandemic, with lower response rates and fieldwork taking place by phone from March 2020 onwards.
Income-related inequality in unmet need for health care and dental care is substantial (Fig. 26). It increased substantially in the poorest quintile between 2011 and 2016 and has fallen since then. Since 2014 rates of unmet need in the poorest income quintile have been consistently higher in Belgium (4.6% for health care and 7.7% for dental care in 2020) than the EU average (3.8% for health care and 6.6% for dental care in 2020; data not shown).

Analysis indicates that there is a large overlap between people with unmet need for health care and dental care in Belgium: in 2016 almost 80% of people with unmet need for health care also reported unmet need for dental care, while almost 50% of people with unmet need for dental care also reported unmet need for health care (Bouckaert, Maertens de Noordhout & Van de Voorde, 2020; Cès & Baeten, 2020). Age-related inequality in unmet need does not seem to be an issue (Fig. 26).
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Fig. 26. Income and age inequality in unmet need for health care and dental care due to cost, distance and waiting time in Belgium

Notes: the break in series for Belgium in 2019 is related to survey sampling and income information. Population is people aged 16 years and over. Quintiles are based on equivalised disposable income.

Source: EU-SILC data from Eurostat (2022c).
5.7 Summary

In 2020 1.1% of households were impoverished or further impoverished after out-of-pocket payments and 5.2% of households experienced catastrophic health spending. Belgium has one of the highest rates of catastrophic spending among EU14 countries.

The incidence of catastrophic spending in Belgium should be interpreted with caution: it may be overestimated because the Belgian household budget survey does not account for retrospective reimbursement of household spending on health, which mainly affects outpatient care; and it may be underestimated due to the high incidence of unmet need and non-reporting of out-of-pocket payments among low-income households in Belgium.

In all years catastrophic spending is heavily concentrated among poor households, but the share of households in the poorest quintile among households with catastrophic spending has fallen from two thirds in 2012 to just under half in 2018 and 2020. Catastrophic incidence is also very high among inactive people, unemployed people and people with a lower level of education – groups likely to overlap with households in the poorest quintile.

The main drivers of catastrophic spending are medical products, diagnostic tests (which include physiotherapy and paramedical services) and dental care. Inpatient and outpatient care were key drivers in 2018 but not in 2020, probably due to lockdowns and the postponement of non-urgent care in response to COVID-19. There is significant variation across quintiles, however. Outpatient medicines and outpatient care are consistently much larger drivers of catastrophic spending for the poorest quintile than the richest. This is also the case for diagnostic tests in 2018 and 2020.

Rates of unmet need for health care and dental care in Belgium are similar to the EU average. In the poorest quintile, unmet need for health and dental care rose sharply between 2011 and 2016; it has fallen steadily since then, but remains above the EU average and there is still a significant gap in unmet need between the richest and poorest people.

In spite of the strength of the social security system in Belgium, policies introduced in recent years to increase labour market participation have had a marked effect on the incomes and purchasing power of low-income households and increased the risk of poverty. Although fewer people now live in households with very low working intensity, this group has become more vulnerable and increasingly faces health problems.
6. Factors that strengthen and undermine financial protection
This section considers factors within the health system that help to explain the findings on financial hardship and unmet need in Belgium.

6.1 Coverage policy

Catastrophic health spending is heavily concentrated among the poorest consumption quintile (see Fig. 20). Rates of catastrophic spending are also very high among inactive people, unemployed people and people with a lower level of education – groups likely to overlap with households in the poorest quintile (see Fig. 21). One of the main reasons for this is that gaps in coverage and weaknesses in coverage policy systematically disadvantage low-income households.

Coverage policy in Belgium is highly complex, with some unusual design features. There are three main layers of coverage: the SHI scheme operated by sickness funds, mandatory CHI provided by five out of the six sickness funds (all except the public fund) and VHI provided by five sickness funds and commercial insurers. A major step forward in 2008 granted self-employed people the same benefits as everyone else covered by the SHI system. Since then, policy measures have focused on reducing out-of-pocket payments for people in relatively precarious situations, but gaps and weaknesses persist, particularly for people at risk of poverty or social exclusion.

The basis for population entitlement to SHI benefits is registration with a sickness fund and payment of contributions.

- Due to financial and administrative barriers to obtaining SHI coverage, at least 1% of the population is not covered by the SHI scheme, rising to at least 2% in the Brussels region and among younger adults (25–40 years) and self-employed people. Some of the people not covered by the SHI scheme are international workers covered by international arrangements.

- Undocumented migrants, asylum seekers and prisoners have limited coverage and must rely on services provided by municipal welfare centres, which are limited to urgent health care. The coverage of prisoners will be integrated with the SHI scheme from January 2023 at the earliest.

There are three issues with service coverage.

- The SHI benefits package is relatively broad in scope, and does not vary across sickness funds, but coverage of dental care, medical products (including hearing aids and optical care such as glasses and contact lenses) and OTC medicines is limited.

- Some of these services are covered by mandatory CHI, but CHI benefits vary across sickness funds and are financed through a flat-rate contribution rather than an income-based contribution, which is regressive. As a result, low-income households pay proportionately more for these benefits than richer households.
• The use of retrospective reimbursement still applies to outpatient care, although this is gradually being addressed. GPs have had a legal obligation, since 2015, to apply the third-party payment system (that is, to offer benefits in kind) for people entitled to increased reimbursement. From 2022 all other people can benefit from third-party payment if their health-care provider is willing.

User charges (co-payments) are widespread and complex. In recent years the health system has tried hard to protect people from co-payments. There is an income-based annual cap on most co-payments, which applies to all insured people, as well as reduced co-payments for low-income households. Many other measures to reduce financial barriers to access have been introduced, including the following:

• percentage co-payments were replaced by fixed co-payments for GP office visits in 2011 and specialist visits in 2015;

• third-party payment (benefits in kind, which are the norm for inpatient care and outpatient medicines) was extended to all forms of outpatient care on a voluntary basis in 2022 (in addition to being mandatory, since 2015, for GP services provided to people entitled to increased reimbursement);

• balance billing in hospitals has been restricted; and

• the cap on reference pricing for outpatient medicines has been strengthened.

Several design features continue to require policy attention, however.

• Increased reimbursement (reduced co-payments) are not automatically granted to all eligible households, only to those who already benefit from other means-tested social assistance. Many low-income households have to apply for increased reimbursement. As a result, this protection mechanism is not as effective as it could be: research finds that take up is close to universal when reduced co-payments are granted automatically but very low when people have to apply for reduced co-payments (see section 3.3). Extending automatic entitlement to all those eligible for reduced co-payments would improve access and reduce financial hardship.

• The annual cap on co-payments (MAF) applies to most health services and is related to household income, two important protective design features. Data from 2016 show that the cap mainly benefits households in the two poorest quintiles (Fig. 27, left panel). They also show that while the cap reduces the regressivity of co-payments, it does not remove it: even after the annual cap, co-payments still account for a larger share of disposable income among poorer households than richer ones (Fig. 27, middle panel). This indicates that the lowest annual cap was set too high and should be lowered (Bouckaert, Maertens de Noordhout & Van de Voorde, 2020; Farfan-Portet et al., 2019). In January 2022 a lower cap of €250 was introduced for households with the lowest incomes to improve financial protection and in January 2023 all annual
caps were frozen, so that they would not rise with inflation (see section 3.3). The impact of these measures has not yet been evaluated. By design, the cap also fails to protect people from out-of-pocket payments incurred through balance billing (Fig. 27, right panel).

- Although essential medicines (those in category A; see Table 2) are exempt from co-payments, there are no exemptions from co-payments targeting any group of people and no exemptions targeting people with low incomes, which is unusual for health systems in high-income countries. Given the limitations of the scheme for increased reimbursement (reduced co-payments) and of the annual cap (MAF), it could be effective to exempt low-income households from co-payments. Fig. 24 shows how out-of-pocket payments among very poor households with catastrophic health spending accounted for 6% of the household budget in 2016.

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**Fig. 27. Co-payments and other out-of-pocket payments for SHI benefits as a share of household income among SHI-insured households before and after they benefit from the annual cap on co-payments (MAF), 2016**

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Notes: Q1, Q2, Q3, Q4, Q5: quintiles defined by equivalized annual disposable household income. Each household is represented by a white circle (does not benefit from the annual cap) or a blue triangle (benefits from the annual cap). For some households the out-of-pocket payment share goes beyond 32%. The figure is based on administrative claims data.

Source: adapted from Bouckaert, Maertens de Noordhout & Van de Voorde (2020).
Fig. 27. Co-payments and other out-of-pocket payments for SHI benefits as a share of household income among SHI-insured households before and after they benefit from the annual cap on co-payments (MAF), 2016 (contd)

Co-payments for SHI benefits after MAF

Notes: Q1, Q2, Q3, Q4, Q5: quintiles defined by equivalized annual disposable household income. Each household is represented by a white circle (does not benefit from the annual cap) or a blue triangle (benefits from the annual cap). For some households the out-of-pocket payment share goes beyond 32%. The figure is based on administrative claims data.

Source: adapted from Bouckaert, Maertens de Noordhout & Van de Voorde (2020).
In 2020 the main drivers of catastrophic spending were medical products (reflecting gaps in the SHI benefits package), diagnostic tests (which include physiotherapy and paramedical services) and dental care (see Fig. 22). In 2018 inpatient care was an important driver, reflecting widespread balance billing, which is particularly prevalent in hospitals, but its impact was much lower in 2020 given the postponement of non-urgent care in response to COVID-19. There is significant variation across consumption quintiles, however. In 2020 outpatient medicines, diagnostic tests and outpatient care were much larger drivers of catastrophic spending for the poorest quintile than the richest (see Fig. 23).

Spending on medical products is dominated by out-of-pocket payments (see Fig. 6), reflecting gaps in SHI coverage of hearing aids, glasses, contact lenses, prostheses and dental products such as implants. Although some of these medical products are covered through mandatory complementary health insurance, this layer of coverage may involve conditionalities such as medical condition, age, or prior approval from the sickness fund and only covers part of the cost. Household budget survey data show that out-of-pocket payments for medical products are concentrated among a small group of households and tend to be higher in richer quintiles (see Fig. 13). This suggests unmet needs may be a problem for poorer quintiles.

The role of out-of-pocket payments in financing inpatient care is higher in Belgium (11%) than the EU14 average (6%; see Fig. 6) (Calcoen et al., 2015; De Wolf et al., 2020a; OECD/European Union, 2020; WHO, 2022). Administrative data for 2018 and 2019 show that only a third of out-of-pocket payments for inpatient care were co-payments and two-thirds were balance billing (De Wolf et al., 2020a, 2021). VHI offers some protection against balance billing, but it is likely to benefit richer households the most because take up of VHI is much more heavily concentrated among richer people.

Balance billing in hospitals mainly affects people requesting a single-bed room. In 2018 it occurred in around 21% of inpatient admissions and 7% of day-care treatments (down from 12% in 2014 due to policy changes to limit balance billing in day care). The average co-payment for a single-bed room was €242 in 2018 (compared to €195 in a shared room) and the average amount spent through balance billing was €1829 in a single-bed room (compared to €86 in a shared room). The amount people pay through balance billing has increased substantially over time: the number of inpatient admissions with balance billing exceeding €5000 rose by 50% between 2014 and 2018 (De Wolf et al., 2020a). In addition to driving financial hardship, balance billing undermines the effectiveness of mechanisms that aim to protect people from co-payments (see Fig. 26). It also undermines transparency, increases arbitrariness and may be mistaken for informal payments by some people (see section 4.3).

Outpatient medicines account for the largest share of out-of-pocket payments among households in the poorest quintile with catastrophic spending (Fig. 23). This is likely to reflect several factors: co-payments for prescribed medicines (mainly in the form of percentage co-payments); the lack of co-payment exemptions for low-income households; the lack of automatic entitlement to increased reimbursement (reduced co-payments) for many low-income households; the high level of the annual cap on
co-payments; and the fact that OTC medicines are not covered by the SHI scheme. Household budget survey data indicate that a significant share of households in the poorest quintile (more than a third in 2020) report out-of-pocket payments for medicines only; this illustrates how relatively small out-of-pocket payments can lead to catastrophic spending for this group (see Fig. 24).

The fact that dental care is only a significant driver of financial hardship for the three richest quintiles illustrates the fact that co-payments and balance billing are more likely to result in unmet need among the poorer quintiles (see Fig. 26).

6.2 Summary

Health system factors that undermine financial protection reflect gaps in all three dimensions of health coverage and other features of coverage policy.

Financial and administrative barriers lead to at least 1% of the population being uninsured, rising to about 2% in the Brussels region and among younger adults (25–40 years) and self-employed people.

Service coverage is broad in scope but complex. SHI coverage of dental care, medical products and OTC medicines is limited. Mandatory CHI covers some of these benefits but CHI benefits vary across sickness funds and people pay a flat-rate contribution, which is regressive.

The use of retrospective reimbursement still applies in outpatient care, although this is gradually being addressed. GPs have had a legal obligation, since 2015, to apply the third-party payment system (that is, to offer benefits in kind) to people entitled to increased reimbursement. From 2022 all other people can benefit from third-party payment if their health-care provider is willing.

User charges apply to all health services, are complex and there is no exemption for low-income households. Although several measures are in place to protect people from financial hardship, co-payment design requires further policy attention:

• many low-income households are eligible for reduced co-payments but do not benefit from them due to administrative barriers;

• the annual cap on co-payments (MAF) is not sufficiently protective for low-income households; the reduction of the MAF threshold to €250 a year for people with low incomes in 2022 is an important step forward;

• there are very few exemptions from co-payments;

• none of these mechanisms protects people from balance billing, although there are some legal restrictions to balance billing in place; and
• there is an overall lack of transparency regarding balance billing, physicians who are not – or only partially – conventioned, and eligibility for and take up of protection mechanisms such as reduced co-payments and the annual cap on co-payments (MAF).

Gaps in service coverage and user charges are partly covered by VHI, but take up of VHI is more likely among richer households.

Public spending on health per person has grown slowly since 2012 (see Fig. 5) and the share of the government budget allocated to health is below the level observed in neighbouring countries (see Fig. 4). This gives the Government room to increase the share of public spending allocated to health.

Given the increase in vulnerability among people with very low incomes in recent years, more of the SHI budget could be used to protect these households.
7. Implications for policy
Financial protection is weaker in Belgium than in many other EU14 countries. In 2020 (the latest year available) just over 5% of households experienced catastrophic out-of-pocket payments.

Catastrophic spending is heavily concentrated among households in the poorest quintile. It is also concentrated among inactive people, unemployed people and people with a lower level of education – groups likely to overlap with households in the poorest quintile.

Financial hardship is on average driven by spending on medical products (reflecting gaps in the benefits package), diagnostic tests (which include physiotherapy and paramedical services), dental care and inpatient care (reflecting widespread balance billing). The impact of inpatient care is substantially lower in 2020 given the postponement of non-urgent care due to COVID-19. In the poorest quintile, however, catastrophic spending is mainly driven by outpatient medicines, diagnostic tests and outpatient care. This strongly suggests that current mechanisms to protect people from co-payments and balance billing are not sufficiently effective for low-income households.

Catastrophic spending reflects gaps and weaknesses in all three dimensions of health coverage. These gaps can be seen in the health system’s relatively heavy reliance on out-of-pocket payments.

To strengthen financial protection, the health system should find ways to simplify Belgium’s unusually complex coverage policy and to address design features that systematically disadvantage people at risk of poverty or social exclusion.

In recent years the Government has introduced several measures intended to improve financial protection. Building on these efforts, reducing co-payments and other out-of-pocket payments – particularly for households with low incomes – should continue to be a policy priority. Options for achieving this include the following.

Find ways to ensure SHI covers the whole population.

Abolish retrospective reimbursement for all health services covered by SHI. In addition to the mandatory application of the third-party payer system to all services, this includes abolishing all up-front payment of co-payments above the MAF threshold (that is, extending the automatic system in place for inpatient care and in the pharmacy to outpatient services).

Further improve protection from co-payments by:

• Granting automatic entitlement to everyone eligible for increased reimbursement (reduced co-payments) to eliminate administrative barriers to take-up. Research finds that take up of reduced co-payments is close to universal when granted automatically but very low when people have to apply for them.
• **Exempting low-income households from co-payments**. The reduction of the MAF threshold from €507 to €250 a year for people with very low incomes from 2022 is an important step but does not eliminate co-payments for these households. Further lowering the €250 threshold or introducing an additional lower cap targeted at households with very low incomes could be considered.

• **Extending the annual cap on co-payments (MAF)** to user charges for prescribed non-covered medicines and long-term psychiatric care and raising awareness of the cap by informing people about it at the beginning of each year instead of waiting until they cross the spending threshold.

Limit balance billing in outpatient and inpatient care through further regulation and reform of the way in which hospitals are financed and by increasing the share of conventioned practitioners who apply the official tariff and abolishing partial conventioning.

Further strengthen regulation of the price of non-covered medical products such as glasses, contact lenses and hearing aids.

In addition to reducing unmet need and financial hardship for low-income households, many of these measures would make the health system fairer, less complex and more transparent.

To support these measures and meet equity and efficiency goals, the Government can increase the priority given to health in allocating public spending, enhance efficiency in providing health care and using health-care resources and devote a larger share of the SHI budget to protecting households with low incomes.
References


Annex 1. Household budget surveys in Europe

What is a household budget survey? Household budget surveys are national sample surveys that aim to measure household consumption of goods and services over a given period of time. In addition to information about consumption expenditure, they include information about household characteristics.

Why are they carried out? Household budget surveys provide valuable information on how societies and people use goods and services to meet their needs and preferences. In many countries, the main purpose of a household budget survey is to calculate weights for the Consumer Price Index, which measures the rate of price inflation as experienced and perceived by households (Eurostat, 2015). Household budget surveys are also used by governments, research entities and private firms wanting to understand household living conditions and consumption patterns.

Who is responsible for them? Responsibility for household budget surveys usually lies with national statistical offices.

Are they carried out in all countries? Almost every country in Europe conducts a household budget survey (Yerramilli et al., 2018).

How often are they performed? EU countries conduct a household budget survey at least once every five years, on a voluntary basis, following an informal agreement reached in 1989 (Eurostat, 2015). Many countries in Europe conduct them at more frequent intervals (Yerramilli et al., 2018).

What health-related information do they contain? Information on household consumption expenditure is gathered in a structured way, usually using the United Nations Classification of Individual Consumption According to Purpose (COICOP). A new European version of COICOP known as ECOICOP, intended to encourage further harmonization across countries, was introduced in 2016 (Eurostat, 2016).

Information on health-related consumption comes under COICOP code 6, which is further divided into three groups, as shown in Table A1.1. In this study, health-related information from household budget surveys is divided into six groups (with corresponding COICOP codes): medicines (06.1.1), medical products (06.1.2 and 06.1.3), outpatient care (06.2.1), dental care (06.2.2), diagnostic tests (06.2.3) and inpatient care (06.3).

In a very small minority of countries in Europe (Belgium, France, Luxembourg and Switzerland), people entitled to publicly financed health care may pay for treatment themselves, then claim or receive reimbursement from their publicly financed health insurance fund (OECD, 2019). In a wider range of countries, people may also be reimbursed by entities offering voluntary health insurance – for example, private insurance companies or occupational health schemes.
To avoid households reporting payments that are subsequently reimbursed, many household budget surveys in Europe specify that household spending on health should be net of any reimbursement from a third party such as the government, a health insurance fund or a private insurance company (Heijink et al., 2011).

Some surveys ask households about spending on voluntary health insurance. This is reported under a different COICOP code (12.5.3 Insurance connected with health, which covers “Service charges for private sickness and accident insurance”) (United Nations Statistics Division, 2018).

**Are household budget surveys comparable across countries?**

Classification tools such as COICOP (and ECOICOP in Europe) support standardization, but they do not address variation in the instruments used to capture data (e.g. diaries, questionnaires, interviews, registers), response rates and unobservable differences such as whether the survey sample is truly nationally representative. Cross-national variation in survey instruments can affect levels of spending and the distribution of spending across households. It is important to note, however, that its effect on spending on health in relation to total consumption – which is what financial protection indicators measure – may not be so great.

An important methodological difference in quantitative terms is **owner-occupier imputed rent**. Not all countries impute rent and, among those that do, the methods used to impute rent vary substantially (Eurostat, 2015). In this series, imputed rent is excluded when measuring total household consumption.

Can people afford to pay for health care?
Table A1.1. Health-related consumption expenditure in household budget surveys

<table>
<thead>
<tr>
<th>COICOP codes</th>
<th>Includes</th>
<th>Excludes</th>
</tr>
</thead>
<tbody>
<tr>
<td>06.1 Medical products, appliances and equipment</td>
<td>This covers medicaments, prostheses, medical appliances and equipment and other health-related products purchased by individuals or households, either with or without a prescription, usually from dispensing chemists, pharmacists or medical equipment suppliers. They are intended for consumption or use outside a health facility or institution.</td>
<td>Products supplied directly to outpatients by medical, dental and paramedical practitioners or to inpatients by hospitals and the like and are included in outpatient services (06.2) or hospital services (06.3).</td>
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<tr>
<td>06.1.1 Pharmaceutical products</td>
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<td>06.1.2 Other medical products</td>
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<tr>
<td>06.1.3 Therapeutic appliances and equipment</td>
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<tr>
<td>06.2 Outpatient services</td>
<td>This covers medical, dental and paramedical services delivered to outpatients by medical, dental and paramedical practitioners and auxiliaries. The services may be delivered at home or in individual or group consulting facilities, dispensaries and the outpatient clinics of hospitals and the like. Outpatient services include the medicaments, prostheses, medical appliances and equipment and other health-related products supplied directly to outpatients by medical, dental and paramedical practitioners and auxiliaries.</td>
<td>Medical, dental and paramedical services provided to inpatients by hospitals and the like and are included in hospital services (06.3).</td>
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<tr>
<td>06.2.1 Medical services</td>
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<td></td>
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<tr>
<td>06.2.2 Dental services</td>
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<td></td>
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<tr>
<td>06.2.3 Paramedical services</td>
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<tr>
<td>06.3 Hospital services</td>
<td>Hospitalization is defined as occurring when a patient is accommodated in a hospital for the duration of the treatment. Hospital day care and home-based hospital treatment are included, as are hospices for terminally ill persons. This group covers the services of general and specialist hospitals; the services of medical centres, maternity centres, nursing homes and convalescent homes that chiefly provide inpatient health care; the services of institutions serving older people in which medical monitoring is an essential component; and the services of rehabilitation centres providing inpatient health care and rehabilitative therapy where the objective is to treat the patient rather than to provide long-term support. Hospitals are defined as institutions that offer inpatient care under the direct supervision of qualified medical doctors. Medical centres, maternity centres, nursing homes and convalescent homes also provide inpatient care, but their services are supervised and frequently delivered by staff of lower qualification than medical doctors.</td>
<td>This group does not cover the services of facilities (such as surgeries, clinics and dispensaries) devoted exclusively to outpatient care (06.2). Nor does it include the services of retirement homes for older people, institutions for disabled people and rehabilitation centres providing primarily long-term support (12.4).</td>
</tr>
<tr>
<td>06.3.1 Hospitalization</td>
<td></td>
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<tr>
<td>06.3.2 Medical services</td>
<td></td>
<td></td>
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<tr>
<td>06.3.3 Dental services</td>
<td></td>
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<tr>
<td>06.3.4 Paramedical services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

References

6. All references accessed 18 October 2022.


Annex 2. Methods used to measure financial protection in Europe

Background

The indicators used for monitoring financial protection in Europe are adapted from the approach set out in Xu et al. (2003, 2007). They also draw on elements of the approach set out in Wagstaff & Eozenou (2014). For further information on the rationale for developing a refined indicator for Europe, see Thomson et al. (2016) and WHO Regional Office for Europe (2019).

Data sources and requirements

Preparing country-level estimates for indicators of financial protection requires nationally representative household survey data that includes information on household composition or the number of household members.

The following variables are required at household level:

- total household consumption expenditure;
- food expenditure (excluding tobacco and alcohol if possible);
- housing expenditure, disaggregated by rent and utilities (such as water, gas, electricity and heating); and
- health expenditure (out-of-pocket payments), disaggregated by type of health care good and service.

Information on household consumption expenditure is gathered in a structured way, usually using the United Nations Classification of Individual Consumption According to Purpose (COICOP) (United National Statistics Division, 2018).

If the survey includes a household sampling weight variable, calculations should consider the weight in all instances. Information on household or individual-level characteristics such as age, sex, education and location are useful for additional equity analysis.

Defining household consumption expenditure variables

Survey data come in various time units, often depending on whether the reporting period is 7 days, 2 weeks, 1 month, 3 months, 6 months or 1 year. It is important to convert all variables related to household consumption expenditure to a common time unit. To facilitate comparison with other national-level indicators, it may be most useful to annualize all survey data. If annualizing survey data, it is important not to report the average level of out-of-pocket payments only among households with out-of-pocket payments, as this will produce inaccurate figures.
Total household consumption expenditure not including imputed rent

Household consumption expenditure comprises both monetary and in-kind payment for all goods and services (including out-of-pocket payments) and the money value of the consumption of home-made products. Many household budget surveys do not calculate imputed rent. To maintain cross-country comparability with surveys that do not calculate imputed rent, imputed rent (COICOP code 04.2) should be subtracted from total consumption if the survey includes it.

Food expenditure

Household food expenditure is the amount spent on all foodstuffs by the household plus the value of the family's own food production consumed within the household. It should exclude expenditure on alcoholic beverages and tobacco. Food expenditure corresponds to COICOP code 01.

Housing expenditure on rent and utilities

Expenditure on rent and utilities is the amount spent by households on rent (only among households who report paying rent) and on utilities (only among households who report paying utilities) including electricity, heating and water. These data should be disaggregated to correspond to COICOP codes 04.1 (for rent) and 04.4 and 04.5 (for utilities). Care should be taken to exclude spending on secondary dwellings. Imputed rent (COICOP code 04.2) is not available in all household budget surveys and should not be used in this analysis.

Health expenditure (out-of-pocket payments)

Out-of-pocket payments refer to formal and informal payments made by people at the time of using any health service provided by any type of provider (COICOP code 06). Health services are any good or service delivered in the health system. These typically include consultation fees, payment for medications and other medical supplies, payment for diagnostic and laboratory tests and payments occurring during hospitalization. The latter may include a number of distinct payments such as to the hospital, to health workers (doctors, nurses, anaesthesiologists etc.) and for tests. Both cash and in-kind payments should be included if the latter are quantified in monetary value. Both formal and informal payments should also be included. Although out-of-pocket payments include spending on alternative or traditional medicine, they do not include spending on health-related transportation and special nutrition. It is also important to note that out-of-pocket payments are net of any reimbursement to households from the government, health insurance funds or private insurance companies.

Estimating spending on basic needs and capacity to pay for health care

Basic needs expenditure is a socially recognized minimum level of spending considered necessary to ensure sustenance and other basic personal needs. This report calculates household-specific levels of basic needs expenditure to estimate a household’s capacity to pay for health care.
Households whose total consumption expenditure is less than the basic needs expenditure level generated by the basic needs line are deemed to be poor.

Defining a basic needs line

Basic needs can be defined in different ways. This report considers food, utilities and rent to be basic needs and distinguishes between:

- households that do not report any utilities or rent expenses; their basic needs include food;
- households that do not report rent expenses (households that own their home outright or make mortgage payments, which are not included in consumption expenditure data), but do report utilities expenses; their basic needs include food and utilities;
- households that pay rent, but do not report utilities expenditure (for example, if the reporting period is so short that it does not overlap with billing for utilities and there is no alternative reporting of irregular purchases); their basic needs include food and rent;
- households that report paying both utilities and rent, so that their basic needs include food, utilities and rent.

Adjusting households’ capacity to pay for rent (among renters) is important. Household budget surveys consider mortgages to be investments, not consumption expenditure. For this reason most do not collect household spending on mortgages. Without subtracting some measure of rent expenditure from those who rent, renters will appear to be systematically wealthier (and have greater capacity to pay) than identical households with mortgages.

To estimate standard (normative) levels of basic needs expenditure, all households are ranked based on their per (equivalent) person total consumption expenditure. Households between the 25th and 35th percentiles of the total sample are referred to as the representative sample for estimating basic needs expenditure. It is assumed that they are able to meet, but not necessarily exceed, basic needs for food, utilities and rent.

In some countries it is common to finance out-of-pocket payments from savings or borrowing, which might artificially inflate a household’s consumption and affect household ranking. Where this is an issue, it may be preferable to rank households by per equivalent person non-out-of-pocket payment consumption expenditure.

Calculating the basic needs line

To begin to calculate basic needs, a household equivalence scale should be used to reflect the economy scale of household consumption. The Organisation for Economic Co-operation and Development equivalence scale (the Oxford scale) is used to generate the equivalent household size for each household:
equivalent household size = 1 + 0.7*(number of adults – 1) 
+ 0.5*(number of children under 13 years of age)

Each household’s total consumption expenditure (less imputed rent), food expenditure, utilities expenditure and rent expenditure is divided by the equivalent household size to obtain respective equivalized expenditure levels.

Households whose equivalized total consumption expenditure is between the 25th and 35th percentile across the whole weighted sample are the representative households used to calculate normative basic needs levels. Using survey weights, the weighted average of spending on food, utilities and rent among representative households that report positive values for food, utilities and rent expenditure, respectively, gives the basic needs expenditure per (equivalent) person for food, utilities and rent.

Note again that households that do not report food expenditure are excluded as this may reflect reporting errors. For households that do not report any rent or utilities expenses, only the sample-weighted food basic needs expenditure is used to represent total basic needs expenditure per (equivalent) person. For households that report utilities expenditures but do not report any rent expenses, the two basic needs expenditure sample-weighted averages for food and utilities are added to calculate total basic needs expenditure per (equivalent) person. For households that report rent expenditures but do not report any utilities expenses, the two basic needs expenditure sample-weighted averages for food and rent are added to calculate total basic needs expenditure per (equivalent) person. For households that report both rent and utilities, the three basic needs expenditure sample-weighted averages for food, utilities and rent are added to calculate total basic needs expenditure per (equivalent) person.

Calculating basic needs expenditure levels for each household

Calculate the basic needs expenditure specific to each household by multiplying the total basic needs expenditure per (equivalent) person level calculated above by each household’s equivalence scale. Note that a household is regarded as being poor when its total consumption expenditure is less than its basic needs expenditure.

Capacity to pay for health care

This is defined as non-basic needs resources used for consumption expenditure. Some households may report total consumption expenditure that is lower than basic needs expenditure, which defines them as being poor. Note that if a household is poor, capacity to pay will be negative after subtracting the basic needs level.

Estimating impoverishing out-of-pocket payments

Measures of impoverishing health spending aim to quantify the impact of out-of-pocket payments on poverty. For this indicator, households are divided into five categories based on their level of out-of-pocket spending on health in relation to the poverty line (the basic needs line):
• no out-of-pocket payments: households that report no out-of-pocket payments;

• not at risk of impoverishment after out-of-pocket payments: non-poor households (those whose equivalent person total consumption exceeds the poverty line) with out-of-pocket payments that do not push them below 120% of the poverty line (i.e. households whose per equivalent person consumption net of out-of-pocket payments is at or above 120% of the poverty line);

• at risk of impoverishment after out-of-pocket payments: non-poor households with out-of-pocket payments that push them below 120% of the poverty line; this review uses a multiple of 120%, but estimates were also prepared using 105% and 110%;

• impoverished after out-of-pocket payments: households who were non-poor before out-of-pocket payments, but are pushed below the poverty line after out-of-pocket payments; in the exceptional case that capacity to pay is zero and out-of-pocket payments are greater than zero, a household would be considered to be impoverished by out-of-pocket payments; and

• further impoverished after out-of-pocket payments: poor households (those whose equivalent person total consumption is below the poverty line) who incur out-of-pocket payments.

Estimating catastrophic out-of-pocket payments

Catastrophic out-of-pocket payments are measured as out-of-pocket payments that equal or exceed some threshold of a household’s capacity to pay for health care. Thresholds are arbitrary. The threshold used most often with capacity to pay measures is 40%. This review uses 40% for reporting purposes, but estimates were also prepared using thresholds of 20%, 25% and 30%.

Households with catastrophic out-of-pocket payments are defined as:

• those with out-of-pocket payments greater than 40% of their capacity to pay; i.e. all households who are impoverished after out-of-pocket payments, because their out-of-pocket payments are greater than their capacity to pay for health care; and

• those with out-of-pocket payments whose ratio of out-of-pocket payments to capacity to pay is less than zero (negative); i.e. all households who are further impoverished after out-of-pocket payments, because they do not have any capacity to pay for health care.

Households with non-catastrophic out-of-pocket payments are defined as those with out-of-pocket payments that are less than the pre-defined catastrophic spending threshold.
For policy purposes it is useful to identify which groups of people are more or less affected by catastrophic out-of-pocket payments (equity) and which health services are more or less responsible for catastrophic out-of-pocket payments.

Distribution of catastrophic out-of-pocket payments

The first equity dimension is expenditure quintile. Expenditure quintiles are determined based on equivalized per person household expenditure. Household weights should be used when grouping the population by quintile. Countries may find it relevant to analyse other equity dimensions such as differences between urban and rural populations, regions, men and women, age groups and types of household.

In some countries it is common to finance out-of-pocket payments from savings or borrowing, which might artificially inflate a household’s consumption and affect household ranking. Where this is an issue, it may be preferable to calculate quintiles based on non-health equivalized per person household expenditure.

Structure of catastrophic out-of-pocket payments

For households in each financial protection category, the percentage of out-of-pocket payments on different types of health goods and services should be reported, if the sample size allows, using the following categories, with their corresponding COICOP categorization: medicines (06.1.1), medical products (06.1.2 and 06.1.3), outpatient care (06.2.1), dental care (06.2.2), diagnostic tests (06.2.3) and inpatient care (06.3). Where possible, a distinction should be made between prescription and over-the-counter medicines.

References


WHO Regional Office for Europe (2019). Can people afford to pay for health care?


Annex 3. Regional and global financial protection indicators

WHO uses regional and global indicators to monitor financial protection in the European Region, as shown in Table A3.1.

### Table A3.1. Regional and global financial protection indicators in the European Region

<table>
<thead>
<tr>
<th>Regional indicators</th>
<th>+</th>
<th>Global indicators</th>
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<tbody>
<tr>
<td><strong>Impoverishing out-of-pocket payments</strong></td>
<td></td>
<td><strong>Changes in the incidence and severity of poverty due to household expenditure on health using:</strong></td>
</tr>
</tbody>
</table>
| Risk of poverty due to out-of-pocket payments: the proportion of households further impoverished, impoverished, at risk of impoverishment or not at risk of impoverishment after out-of-pocket payments using a country-specific line based on household spending to meet basic needs (food, housing and utilities) |  | • an extreme poverty line of PPP-adjusted US$ 1.90 per person per day \[1\]  
• a poverty line of PPP-adjusted US$ 3.10 per person per day \[2\]  
• a relative poverty line of 60% of median consumption or income per person per day |

| **Catastrophic out-of-pocket payments** |  | **The proportion of the population with large household expenditure on health as a share of total household consumption or income (greater than 10% or 25% of total household consumption or income)** |
| The proportion of households with out-of-pocket payments greater than 40% of household capacity to pay for health care |  |  |

Note: PPP: purchasing power parity.
Sources: WHO headquarters and WHO Regional Office for Europe.

### Regional indicators

The regional indicators reflect a commitment to the needs of European Member States. They were developed by the WHO Barcelona Office for Health Systems Financing (part of the Division of Country Health Policies and Systems in the WHO Regional Office for Europe), at the request of the WHO Regional Director for Europe, to meet demand from Member States for performance measures more suited to high- and middle-income countries and with a stronger focus on pro-poor policies, in line with Regional Committee resolutions (see Annex 2).

At the regional level, WHO’s support for monitoring financial protection is underpinned by the European Programme of Work, 2020–2025 (United Action for Better Health in Europe), which includes moving towards universal health coverage as the first of three core priorities for the WHO European Region; the Tallinn Charter: Health Systems for Health and Wealth; and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region 2015–2020.
Global indicators

The global indicators reflect a commitment to global monitoring. They enable the performance of Member States in the European Region to be easily compared to the performance of Member States in the rest of the world.

At the global level, support by WHO for the monitoring of financial protection is underpinned by World Health Assembly resolution WHA64.9 on sustainable health financing structures and universal coverage, which was adopted by Member States in May 2011. More recently, with the adoption of the 2030 Agenda for Sustainable Development and its concomitant Sustainable Development Goals (SDGs) in 2015, the United Nations has recognized WHO as the custodian agency for SDG3 (Good health and well-being: ensure healthy lives and promote well-being for all at all ages) and specifically for target 3.8 on achieving universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. Target 3.8 has two indicators: 3.8.1 on coverage of essential health services and 3.8.2 on financial protection when using health services.

The choice of global or regional indicator has implications for policy

Global and regional indicators provide insights into the incidence and magnitude of financial hardship associated with out-of-pocket payments for health, but they do so in different ways. As a result, they may have different implications for policy and suggest different policy responses.

For example, the global indicator defines out-of-pocket payments as catastrophic when they exceed a fixed percentage of a household’s consumption or income (its budget). Applying the same fixed percentage threshold to all households, regardless of wealth, implies that very poor households and very rich households spending the same share of their budget on health will experience the same degree of financial hardship.

Global studies find that this approach results in the incidence of catastrophic out-of-pocket payments being more concentrated among richer households (or less concentrated among poorer households) (WHO & World Bank 2015; 2017). With this type of distribution, the implication for policy is that richer households are more likely to experience financial hardship than poorer households. The appropriate policy response to such a finding is not clear.

In contrast, to identify households with catastrophic out-of-pocket payments, the regional indicator deducts a standard amount representing spending on three basic needs – food, housing (rent) and utilities – from each household’s consumption expenditure. It then applies the same fixed percentage threshold to the remaining amount (which is referred to as the household’s capacity to pay for health care). As a result, although the same threshold is applied to all households, the amount to which it is applied is now significantly less than total household consumption for poorer households but closer to total household consumption for richer
households. This implies that very poor households spending small amounts on out-of-pocket payments, which constitute a relatively small share of their total budget, may experience financial hardship, while wealthier households are assumed to not experience hardship until they have spent a comparatively greater share of their budget on out-of-pocket payments.

The approach used in the European Region results in the incidence of catastrophic out-of-pocket payments being highly concentrated among poor households in all countries (Cylus et al., 2018). For countries seeking to improve financial protection, the appropriate response to this type of distribution is clear: design policies that protect poorer households more than richer households.

Recent global studies most commonly report impoverishing out-of-pocket payments using absolute poverty lines set at US$ 1.90 or US$ 3.10 a day in purchasing power parity (WHO & World Bank 2015; 2017). These poverty lines are found to be too low to be useful in Europe, even among middle-income countries. For example, the most recent global monitoring report suggests that in 2010 only 0.1% of the population in the WHO European Region was impoverished after out-of-pocket payments using the US$ 1.90 a day poverty line (0.2% at the US$ 3.10 a day poverty line) (WHO & World Bank, 2017).

European studies make greater use of national poverty lines or poverty lines constructed to reflect national patterns of consumption (Yerramilli et al., 2018). While national poverty lines vary across countries, making international comparison difficult, poverty lines constructed to reflect national patterns of consumption – such as that which is used as the poverty line for the regional indicator – facilitate international comparison (Saksena et al., 2014).

References


Annex 4. Glossary of terms

**Ability to pay for health care:** Ability to pay refers to all the financial resources at a household’s disposal. When monitoring financial protection, an ability to pay approach assumes that all of a household’s resources are available to pay for health care, in contrast to a capacity to pay approach (see below), which assumes that some of a household’s resources must go towards meeting basic needs. In practice, measures of ability to pay are often derived from household survey data on reported levels of consumption expenditure or income over a given time period. The available data rarely capture all of the financial resources available to a household – for example, resources in the form of savings and investments.

**Basic needs:** The minimum resources needed for sustenance, often understood as the consumption of goods such as food, clothing and shelter.

**Basic needs line:** A measure of the level of personal or household income or consumption required to meet basic needs such as food, housing and utilities. Basic needs lines, like poverty lines, can be defined in different ways. They are used to measure impoverishing out-of-pocket payments. In this study the basic needs line is defined as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, adjusted for household size and composition. Basic needs line and poverty line are used interchangeably. See poverty line.

**Budget:** See household budget.

**Cap on benefits:** A mechanism to protect third-party payers such as the government, a health insurance fund or a private insurance company. A cap on benefits is a maximum amount a third-party payer is required to cover per item or service or in a given period of time. It is usually defined as an absolute amount. After the amount is reached, the user must pay all remaining costs. Sometimes referred to as a benefit maximum or ceiling.

**Cap on user charges (co-payments):** A mechanism to protect people from out-of-pocket payments. A cap on user charges is a maximum amount a person or household is required to pay out of pocket through user charges per item or service or in a given period of time. It can be defined as an absolute amount or as a share of a person’s income. Sometimes referred to as an out-of-pocket maximum or ceiling.

**Capacity to pay for health care:** In this study capacity to pay is measured as a household’s consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities. This amount is deducted consistently for all households. It is referred to as a poverty line or basic needs line.

**Catastrophic out-of-pocket payments:** Also referred to as catastrophic health spending. An indicator of financial protection. Catastrophic out-of-pocket payments can be measured in different ways. This study defines them as out-of-pocket payments that exceed 40% of a household’s
capacity to pay for health care. The incidence of catastrophic health spending includes households who are impoverished and households who are further impoverished.

**Consumption:** Also referred to as consumption expenditure. Total household consumption is the monetary value of all items consumed by a household during a given period. It includes the imputed value of items that are not purchased but are procured for consumption in other ways (for example, home-grown produce).

**Co-payments (user charges or user fees):** Money people are required to pay at the point of using health services covered by a third party such as the government, a health insurance fund or a private insurance company. *Fixed co-payments* are a flat amount per good or service; *percentage co-payments* (also referred to as co-insurance) require the user to pay a share of the good or service price; *deductibles* require users to pay up to a fixed amount first, before the third party will cover any costs. Other types of user charges include *balance billing* (a system in which providers are allowed to charge patients more than the price or tariff determined by the third-party payer), *extra billing* (billing for services that are not included in the benefits package) and *reference pricing* (a system in which people are required to pay any difference between the price or tariff determined by the third-party payer – the reference price – and the retail price).

**Equivalent person:** To ensure comparisons of household spending account for differences in household size and composition, equivalence scales are used to calculate spending levels per equivalent adult in a household. This review uses the Oxford scale (also known as the Organisation for Economic Co-operation and Development equivalence scale), in which the first adult in a household counts as one equivalent adult, subsequent household members aged 13 years or over count as 0.7 equivalent adults and children under 13 count as 0.5 equivalent adults.

**Exemption from user charges (co-payments):** A mechanism to protect people from out-of-pocket payments. Exemptions can apply to groups of people, conditions, diseases, goods or services.

**Financial hardship:** People experience financial hardship when out-of-pocket payments are large in relation to their ability to pay for health care.

**Financial protection:** The absence of financial hardship when using health services. Where health systems fail to provide adequate financial protection, households may not have enough money to pay for health care or to meet other basic needs. Lack of financial protection can lead to a range of negative health and economic consequences, potentially reducing access to health care, undermining health status, deepening poverty and exacerbating health and socioeconomic inequalities.

**Further impoverished households:** Poor households (those whose equivalent person total consumption is below the poverty line or basic needs line) who incur out-of-pocket payments.
Health services: Any good or service delivered in the health system, including medicines, medical products, diagnostic tests, dental care, outpatient care and inpatient care. Used interchangeably with health care.

Household budget: Also referred to as total household consumption. The sum of the monetary value of all items consumed by the household during a given period and the imputed value of items that are not purchased but are procured for consumption in other ways.

Household budget survey: Usually national sample surveys, often carried out by national statistical offices, to measure household consumption over a given period of time. Sometimes referred to as household consumption expenditure or household expenditure surveys. European Union countries are required to carry out a household budget survey at least once every five years.

Impoverished households: Households who were non-poor before out-of-pocket payments, but are pushed below the poverty line or basic needs line after out-of-pocket payments.

Impoverishing out-of-pocket payments: Also referred to as impoverishing health spending. An indicator of financial protection. Out-of-pocket payments that push people into poverty or deepen their poverty. A household is measured as being impoverished if its total consumption was above the national or international poverty line or basic needs line before out-of-pocket payments and falls below the line after out-of-pocket payments.

Informal payment: A direct contribution made in addition to any contribution determined by the terms of entitlement, in cash or in kind, by patients or others acting on their behalf, to health-care providers for services to which patients are entitled.

Out-of-pocket payments: Also referred to as household expenditure (spending) on health. Any payment made by people at the time of using any health good or service provided by any type of provider. Out-of-pocket payments include: formal co-payments (user charges or user fees) for covered goods and services; formal payments for the private purchase of goods and services; and informal payments for covered or privately purchased goods and services. They exclude pre-payment (for example, taxes, contributions or premiums) and reimbursement of the household by a third party such as the government, a health insurance fund or a private insurance company.

Poverty line: A level of personal or household income or consumption below which a person or household is classified as poor. Poverty lines are defined in different ways. This study uses basic needs line and poverty line interchangeably. See basic needs line.

Quintile: One of five equal groups (fifths) of a population. This study commonly divides households into quintiles based on per equivalent person household consumption. The first quintile is the fifth of households with the lowest consumption, referred to in the study as the poorest quintile; the fifth quintile has the highest consumption, referred to in the study as the richest quintile.
Risk of impoverishment after out-of-pocket payments: After paying out of pocket for health care, a household may be further impoverished, impoverished, at risk of impoverishment or not at risk of impoverishment. A household is at risk of impoverishment (or not at risk of impoverishment) if its total spending after out-of-pocket payments comes close to (or does not come close to) the poverty line or basic needs line.

Universal health coverage: Everyone can use the quality health services they need without experiencing financial hardship.

Unmet need for health care: An indicator of access to health care. Instances in which people need health care but do not receive it due to access barriers.

User charges: Also referred to as user fees. See co-payments.

Utilities: Water, electricity and fuels used for cooking and heating.
The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

### Member States

- Albania
- Andorra
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- Estonia
- Finland
- France
- Georgia
- Germany
- Greece
- Hungary
- Iceland
- Ireland
- Israel
- Italy
- Kazakhstan
- Kyrgyzstan
- Latvia
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- Russian Federation
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