4 ACCESSIBILITY OF CARE

Accessibility can be defined as the ease with which health services are reached by the population in terms of physical access, costs, time, and availability of qualified personnel.[26] Accessibility is influenced by decisions on resource generation and is analysed through three sub-dimensions: financial access, health workforce distribution, health services distribution.

In preparation of the current report, the Belgian HSPA framework has been revised (see KCE report 370).[10] An in-depth review of the dimension accessibility was carried out with the double aim to reduce the number of indicators to the most relevant ones in the Belgian context and to identify potentially missing indicators. As a result, 18 indicators were selected to evaluate the accessibility of the health system with 9 indicators related to financial accessibility (Table 7), 3 indicators on health workforce distribution (Table 8) and 6 indicators on health services distribution (Table 9). Compared to the previous report, there are 9 new indicators while a number of previously included indicators have been renumbered.[21]

4.1 Financial access to healthcare

Belgium has made a commitment to universal health coverage (UHC), i.e. everyone should be able to obtain the health services that they need, of high quality, without risk of financial hardship in doing so.[22, 42]

The ability of a health system to provide its population with affordable healthcare based on needs, depends on the extent to which it can pool risks and resources and produce solidarity between high and low risks and high and low incomes.[22] Financial (or affordable) access to healthcare is thus driven by decisions on 'financial resource generation', and can be described along three dimensions: the breadth of the coverage by the compulsory health insurance (who is covered?), the scope of the coverage (what is covered?), and the depth of the coverage (how much of the healthcare costs is covered?).

Who is covered?

To meet the goals of UHC, the basis for entitlement should encompass everyone living in a country. However, in practice it is almost always more narrowly specified to exclude some groups, using criteria such as legal residence (most EU countries, including Belgium) and/or payment of contributions (most EU countries with social health insurance schemes, including Belgium).[42-45] Comparative research suggests that significant gaps in population coverage are more likely to occur in countries that base entitlement on payment of contributions to a social health insurance scheme than in countries that base entitlement on residence, and cover all residents (not just legal residents) automatically.[43]

Coverage of the compulsory public health insurance system (***indicator A-1***, see Table 7) has been near universal in the past decade (98.9% in 2012 to 99.1% in 2022). However, financial and/or administrative barriers persist that impede full population coverage.[42, 45] The uncovered fraction was slightly higher among males, younger adults (age group 20-39 years), and in Brussels. Lower coverage rates were also found among Belgians living abroad but still affiliated with a Belgian sickness fund. When excluding the group of Belgians living abroad, the compulsory health insurance coverage would have equalled 99.4% in 2022.

Note that persons not affiliated with a sickness fund (e.g. undocumented migrants, asylum seekers (depending on the status of their application)) are not covered by the compulsory public health insurance and not included in the definition of 'population' in this indicator. These groups generally can rely on separate systems of health coverage for a more restricted set of services (for more details on healthcare for vulnerable groups see also Box 9 in the HSPA report of 2019).[21] No good data exist to capture the size of these population groups not covered by the compulsory public health insurance. There is, however, an intention to further broaden the population covered by the compulsory public health insurance. For example, health coverage for prisoners and detainees has been integrated in the general system since January 2023 for care outside the prison.[46]

Recent, reliable and exhaustive data on the number of persons with private health insurance are currently not available.

What is covered?

The Belgian compulsory public health insurance system covers a wide range of services. No indicators have been defined to measure the scope of the coverage (the range of covered services). The services that are covered by compulsory health insurance are described in the nationally established fee schedule (called the nomenclature).[47] Services not included in the fee schedule are not reimbursable.

The extent to which different health services are financed through out-of-pocket (OOP) payments gives a partial indication of the main gaps in health coverage. In Belgium, out-of-pocket payments as share of current spending on health amounted to 65% of spending on dental care, 56% on medical products and 34% on outpatient medicines in 2021. Next to cost sharing arrangements, these high shares are the results of non-covered goods and services.

How much of the healthcare costs is covered?

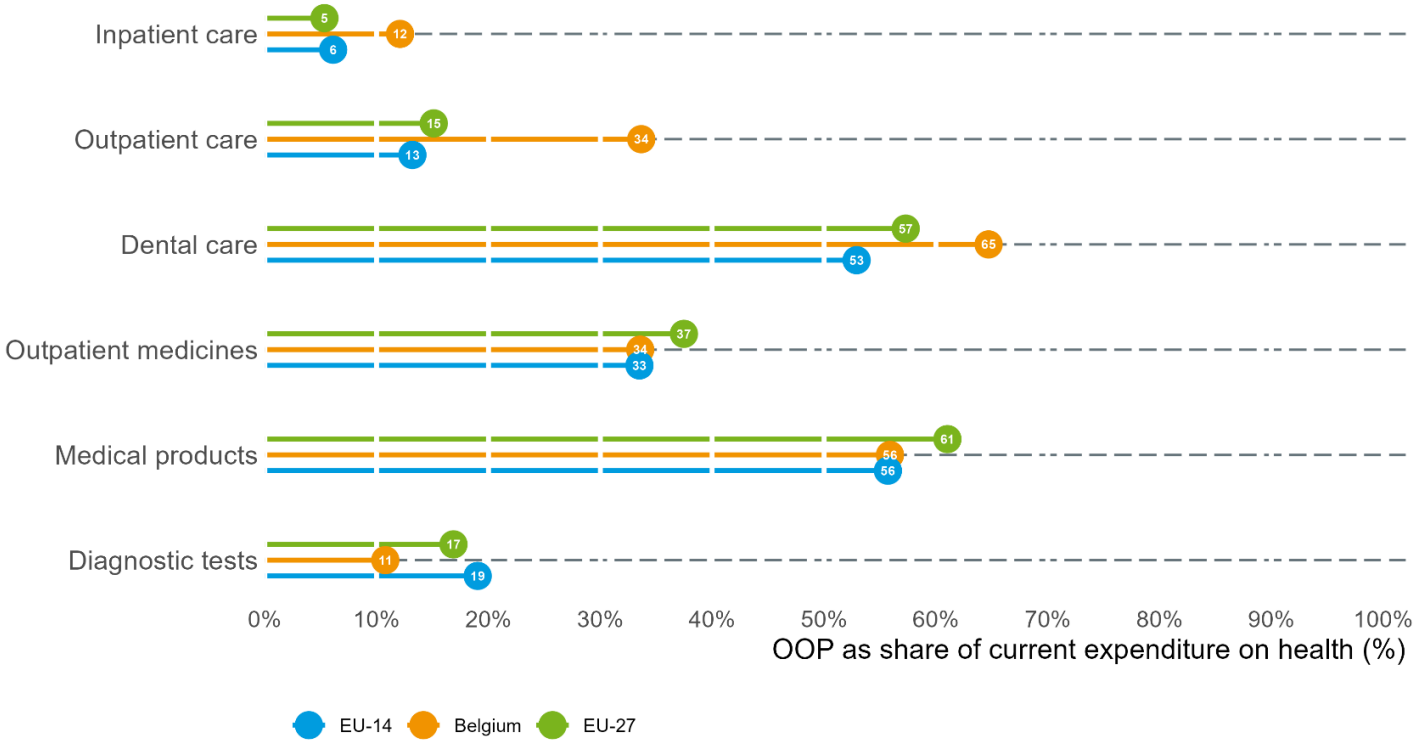
Out-of-pocket payments in Belgium are high

Healthcare is generally considered financially inaccessible when people limit or postpone the use of necessary care because of (excessively) high costs, or when they have to relinquish other basic necessities because they need care. Financial accessibility can be undermined by OOP payments for healthcare. **OOP payments** are expenditures borne directly by a patient when using healthcare because public or voluntary health insurance does not cover the (full) cost of the healthcare good or service.[17] They consist of co-payments, supplements (balance/extra billing) and direct payments for non-covered goods and services. All countries use OOP payments to pay for some healthcare, though to varying degrees and with different cost sharing designs. Evidence shows that user charges are not a good instrument for directing people to use resources more efficiently and can have negative effects on equity and efficiency.[44, 48-51] Low-income populations are disproportionately affected by increased cost sharing, as they have higher care needs, are more price sensitive and resource constrained than other income groups.

OOP payments have increased by 30% over the past decade (2011 to 2021). Co-payments represented only one fifth of total estimated OOP payments in 2021. **As a share of current expenditure on health**, OOP payments have decreased from 19.6% in 2011 to 17.9% in 2021 (***indicator A-2***, see Table 7). The general declining trend was interrupted by a strong surge in 2019 (19.8%) followed by a drop in 2020 (17.4%) and a rebound in 2021 (17.9%) (see also section 8.4). The Belgian health system relied in 2021 more heavily on OOP payments than neighbouring countries such as Luxembourg (8.9%), France (8.9%), the Netherlands (9.3%) and Germany (12.0%).

Figure 2 shows that OOP payments as a share of current expenditure on health in 2021 were highest for dental care (65% up from 55% in 2011), medical products (56%), outpatient care and outpatient medicines (both nearly 34%). Moreover, OOP payments for dental care, outpatient care and inpatient care were above the EU-14 and EU-27 averages in 2021.

Figure 2 – Out-of-pocket (OOP) payments as a share of current spending on health by type of care (2021)



Notes: OOP = out-of-pocket; The category outpatient care excludes dental care
Source: System of health accounts (SHA)

Measured **as a share of final household consumption**, OOP medical spending slightly decreased from 4.0% in 2011 to 3.7% in 2021 (***indicator A-3***, see Table 7), but was consistently above the EU average over the whole period (2.9% in 2021 in EU-14 and EU-27). More details on the impact of the COVID-19 crisis are given in section 8.4. According to the household budget survey (HBS) from Statistics Belgium, households spent €1 805 on healthcare in 2020. This was higher than healthcare spending before the COVID-19 crisis pandemic which amounted to €1 639, due to increased spending on amongst others medical products (including facemasks and disinfectants) and physiotherapy/rehabilitation. OOP payments both in absolute value and as share of household consumption were higher for households with more financial means, with the gap between high and low incomes further increasing between 2018 and 2020 (see also section 7.1).

Fee supplements as driver of OOP payments in hospital care

High out-of-pocket payments in inpatient care are (at least partly) the results of supplements charged to the patient, notwithstanding important restrictions on the use of supplements, such as the prohibition to charge fee and room supplements in double-occupancy and shared rooms.

Out-of-pocket payments for hospital care (**indicator A-5**, see Table 7) amounted to 17.6% of total hospital care expenditures in 2021 (excluding budgetary twelfths)[j] and consisted in 2021 for 69% of supplements (and direct payments). Fee supplements represented 70% of all supplements or nearly 50% of all OOP payments. The share of OOP payments for hospital care was markedly higher in Brussels (23.2% in 2021).

On average, an inpatient stay had an OOP cost of € 660 in 2021 of which € 206 co-payments and € 454 supplements (and direct payments). A day-care admission had on average an OOP cost of € 110 in 2021 of which € 33 co-payments and € 78 supplements. There was large variation: (1) 18.0% of inpatient admissions in 2021 had OOP payments exceeding € 1 000; (2) 10% of patients and 10% of beneficiaries of increased reimbursement paid more than € 1 777 and € 777 out-of-pocket for an inpatient stay in 2021, respectively; (3) average OOP payments of inpatient stays in single-occupancy rooms were almost eight times higher than in shared rooms, mainly due to the difference in supplements.

Supplements reduce price transparency and price security for the patient. They may reduce accessibility of healthcare as existing protection mechanisms, such as the maximum billing (MAF) and increased reimbursement, do not apply to supplements. In 2022, as a first step to reducing fee supplements, the maximum fee supplement was frozen at the hospital level.[52, 53] Although this measure prevents further increases, it does not address existing differences between hospitals.[42]

Access to agreed tariffs in outpatient care

Fee supplements are also widespread in outpatient care. Contrary to supplements charged for a hospital stay, there is little regulation for supplements charged in outpatient care.[54] Limited information is currently available on supplements and non-covered services in outpatient care. Recently, however, registration of supplements in outpatient care is made mandatory in case of electronic invoicing, with the intention to, at a later stage, also collect information on OOP payments for non-covered services. Physicians and dentists are required to implement electronic invoicing by September 2025.[55]

In absence of direct information on supplements in outpatient care, two proxy indicators of affordable access were used on the activity share in outpatient care of, respectively, physicians and dentists who do not charge supplements and thus offer their patients price certainty and transparency.

In Belgium, practitioners are free to subscribe to the tariff agreements negotiated between representatives of the practitioners and sickness funds. Practitioners who accept the agreement, so called “conventioned”

[j] The out-of-pocket payments for hospital care as presented in indicator A-5 and Figure 2 differ in value. They were obtained from different sources and serve different purposes. For indicator A-5, patient level data of IMA – AIM were analysed and budgetary twelfths of the hospital budget (that could not easily be attributed to individual patients) were not accounted for, leading to an overestimation of the OOP payment share. For Figure 2, aggregated and internationally comparable data of the SHA were used that do account for the budgetary twelfths.

practitioners, commit to not charging supplements to patients in outpatient care. The others, "partially conventioned" or "non-conventioned", are allowed to charge fee supplements on top of the official tariff at their discretion, also to low income households (see section 7.1).

The **share of activity by conventioned GPs** (***indicator A-8***, see Table 7) was high and further increased from 83.1% in 2012 to 87.3% in 2021 (90.1% in Flanders, 84.4% in Wallonia and 71.2% in Brussels). On the other hand, less than half of the outpatient consultations of **medical specialists** were performed by conventioned medical specialists (***indicator A-8***, see Table 7), with a small declining trend over time (44.0% in Belgium, 37.1% in Flanders, 55.8% in Wallonia and 43.6% in Brussels) Large variation in outpatient activity shares by conventioned physicians was found between medical specialities from as low as 11.1% for dermatologists to as high as 91.1% for oncologists, with other specialties in between, such as ophthalmologists (16.9%), gynaecologists (21.3%), urologists (35.8%), cardiologists (58.3%) and paediatricians (70.7%).

The **share of outpatient activity by conventioned dentists** (***indicator A-9***, see Table 7) declined from 34.3% in 2012 to 26.3% in 2021 (16.6% in Flanders, 40.4% in Wallonia and 45.4% in Brussels). Hence, only 1 in 4 patient contacts was performed by a conventioned dentist. With activity shares below 2% in 2021, it becomes difficult if not impossible to find a conventioned orthodontist or periodontist. The activity share of conventioned general dentists was 29.1% in 2021.

Out-of-pocket payments may lead to financial hardship

By shifting costs on to households, OOP payments can represent a financial burden and lead to financial hardship for people using healthcare, in particular for individuals with high care needs or in households with limited resources. **Catastrophic health spending** (***indicator A-4***, see Table 7) is a widely used indicator to assess financial hardship based on the HBS data from Statistics Belgium. It refers to OOP payments that are greater than 40% of a household's capacity to pay for healthcare, with capacity to pay defined as total household consumption minus a standard amount to cover basic needs (food, housing, and utilities).[48, 56, 57] A correction for basic needs is necessary because poor households devote relatively more of their resources to meeting basic needs and may face a trade-off between consuming basic needs and healthcare.

The incidence of catastrophic health spending in Belgium amounted to 3.8% of the households in 2018 and 5.2% in 2020, during the COVID-19 pandemic. Note that caution is required when comparing the incidence in 2020 with previous years as COVID-19 had a profound impact on household consumption patterns as well as on health spending (see also section 8.4). Catastrophic spending was mainly driven by OOP payments for medical products, physiotherapy/rehabilitation, 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), while outpatient medicines were the most important driver among households in the poorest quintile.

The incidence of catastrophic health spending was substantially higher among households in the poorest quintile (12.2% in 2020), with a low-educated, inactive or unemployed head (8.2%, 10.5% and 8.5% in 2020, respectively) (see also section 7.1).

In comparison to other EU countries, the pre-pandemic rate of catastrophic health spending in Belgium (3.8% in 2018) was situated below the EU-14 average (4.3%) and the EU-27 average (6.5%), but above rates in neighbouring countries.

Out-of-pocket payments can create financial barriers to access healthcare

OOP payments can create a financial barrier to access healthcare services and treatments, resulting in people foregoing or delaying the use of healthcare (also known as unmet need for healthcare) with potential adverse consequences to their health.[22, 58]

Based on the EU-SILC data, the incidence of **self-reported unmet need with costs as main reason** to forego or postpone care in 2022 amounted to 0.9% for **medical examination and treatment** (***indicator A-6***) and 2.5% for **dental examination and treatment** (***indicator A-7***). The share of the population that experienced unmet needs has declined substantially over the past six years (2.2% for medical care and 3.7% for dental care in 2016). The COVID-19 pandemic had no substantial impact on the downward trend in self-reported unmet needs due to financial reasons.

There is important variation around the average. Higher rates and volatility were reported in the poorest income quintile (medical care: 7.7% in 2016 and 2.6% in 2022; dental care: 11.5% in 2016 and 6.6% in 2022, see also section 7.1), while nearly no unmet needs due to financial reasons were reported in the richest income quintile. Rates of unmet needs were also higher in subgroups with lower educational attainment and among working-age individuals in unemployment or in inactivity. Moreover regional differences were substantial with higher rates in Wallonia and Brussels, although this might be related to underlying differences in socioeconomic and sociodemographic characteristics of the regions.

In an international perspective, Belgium has performed worse than the European average over a sustained period of time (2015-2021) with respect to unmet needs for medical care due to financial reasons. However, thanks to a persistent declining trend in the past years, the Belgian rate of unmet needs for medical care was below the EU-14 and EU-27 average in 2022. The Belgian incidence of unmet needs for dental care due to financial reasons has been in line with the European average since 2016. In neither of the two indicators, Belgium was among the better performing countries, with only seven EU countries having a higher average rate of unmet needs for medical as well as dental care in 2022. Moreover, the gap in incidence of unmet needs between the richest and poorest income quintiles is particularly large in Belgium.

Conclusion

The Belgian compulsory public health insurance system covers a wide range of services for nearly the entire population. However, out-of-pocket payments in Belgium are high in comparison with neighbouring countries, although the situation is improving over time. In addition to co-payments and non-covered services, high OOP payments are the result of the widespread use of supplements as demonstrated for hospital care, and suggested by the low outpatient activity shares of conventioned medical specialists and dentists. This is problematic as supplements are not covered by protection mechanisms in the public health insurance. OOP payments can be a financial barrier to access health services resulting in unmet needs due to financial reasons, or lead to financial hardship for people using care (catastrophic health spending). In both instances Belgium has an average performance. In particular OOP payments for dental care, medical products and outpatient medicines are high, types of healthcare that were also identified as main drivers for catastrophic health spending. Moreover, for inpatient care and outpatient care, the share of OOP payments is well above the EU average.

Table 7 – Accessibility: Indicators on financial access

(ID) Indicator		Score	Belgium	Year	Flanders	Wallonia	Brussels	Source	EU-14	EU-27
A-1	Compulsory health insurance coverage (% of the population entitled to compulsory insurance)	ST	99.1%	2022	99.5%	99.5%	98.7%	RIZIV – INAMI	99.9%	98.4%
A-2	Out-of-pocket (OOP) payments (% of current expenditure on health)	+	17.9%	2021	—	—	—	SHA	16.5%	18.2%
A-3 (ex A-10)	Out-of-pocket (OOP) medical spending (% of final household consumption)	ST	3.7%	2021	—	—	—	SHA, National Accounts	2.9%	2.9%
A-4 (ex EQ-5)	Households facing catastrophic out-of-pocket payments (% of respondents, HBS)	●	5.2%	2020	4.8%	5.3%	**6.7%**	HBS	4.3% (2018) [BE: 3.8%]	6.5% (2018) [BE: 3.8%]
A-5 ***NEW***	Out-of-pocket (OOP) payments for hospital care (% of total hospital care expenditures (excluding budgetary twelfths))	●	17.6%	2021	16.2%	17.4%	**23.2%**	IMA – AIM		
A-6 *(ex-A-4)*	People with self-reported unmet needs for medical examination due to financial reasons (% of respondents, EU-SILC)	+	0.9%	2022	0.2%	**2.0%**	**1.9%**	EU-SILC	1.2%	0.9%
A-7 *(ex-A-4)*	People with self-reported unmet needs for dental examination due to financial reasons (% of respondents, EU-SILC)	+	2.5%	2022	1.1%	**4.7%**	**3.6%**	EU-SILC	3.3%	2.6%
A-8 ***NEW***	Volume of outpatient activity done by "conventioned"* physicians (i.e. physicians acceding to the agreement on national tariffs) (% of outpatient consultations/contacts with practising physicians)	GP +	87.3%	2021	90.1%	84.4%	**71.2%**	IMA – AIM		
		Specialist ST	44.0%	2021	**37.1%**	55.8%	**43.6%**	IMA – AIM		
A-9 ***NEW***	Volume of outpatient activity done by "conventioned"^^ dentists (i.e. dentists acceding to the agreement on national tariffs) (% of outpatient consultations/contacts with practising dentists)	−	26.3%	2021	**16.6%**	40.4%	45.5%	IMA – AIM		

Good (●), average (●) or poor (●) results, globally stable (ST), improving (+) or trend not evaluated (empty).
For contextual indicators (no evaluation): upwards trend (↗), stable trend (→), downwards trend (↘), no trend (C).

*Notes: *Conventioned practitioners in Belgium are practitioners who subscribe to tariff agreements negotiated by representatives of the practitioners and sickness funds negotiate under the auspices of RIZIV – INAMI. They commit to not charging supplements to the patients in outpatient care*