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PRIVATE EXPENDITURE ON HEALTH IN BELGIUM

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SOCIETY
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Summary*

In this Itinera paper, we examine the current status and evolution of not publicly covered health expenses in Belgium. A detailed overview of relevant data for both institutional and ambulatory care is presented, with time trends and comparison with neighboring countries. We observe that private health expenses in Belgium are high and rising. Out-of-pocket expenses even surpass the level of the US. We make far less use of additional coverage possibilities than our neighbors, regardless of the fact that the self-reported negative consequences of the healthcare related financial burden are expanding. To date, the major focus in this debate, and related coverage decisions by government, insurance funds and individual citizens, mainly involved general hospital care. However, the Itinera analysis shows that private expenses for ambulatory care are systematically underestimated. This is especially true for ambulatory medicine use and resident elderly care, two areas in which private expenses surpass the general hospital level. The figures we present put the sustainability of the existing coverage policies into question. The good news is that we could refocus our attention to the priority areas we uncovered, and ambulatory care as a whole. In doing so, there is a large potential to learn from other countries.

*Piet Calcoen expresses his personal views based on his academic research, and does not represent DKV.

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Definitions

We will be using the following definitions:

- Total expenditure on health: sum of public expenditure on health and private expenditure on health;
- Out-of-pocket expenditure on health: private expenditure on health minus reimbursement by addtional health insurance and corporations;
- Basic health insurance: mandatory universal health insurance, organized by the National Institute for Health and Disability Insurance ("Rijksinstituut voor ziekte- en invaliditeitsverzekering [RIZIV]"/"Institut national d'assurance maladie-invalidité [INAMI]") and the sickness funds;
- Additional health insurance: includes substitute, complementary and supplementary health insurance. E.g. substitute: minor risks for the self-employed (until 2007); complementary: co-payments; supplementary: luxury services.[1]1 Both private insurance companies and sickness funds offer voluntary additional health insurance. Additional health insurance offered by sickness funds (i.e. "services and advantages") can be mandatory, based on the statutes of the sickness fund.

1 OECD (2004). Private health insurance in OECD countries. Paris: OECD.

Private expenditure on health in Belgium

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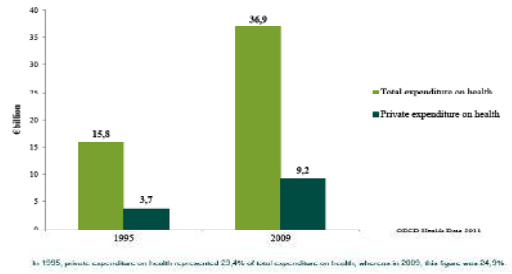
Public versus private expenditure on health

As in many other countries, health expenditure is on the rise in Belgium. In 2009, total expenditure on health represented 10,9% of gross domestic product, whereas in 2001, this figure was 8,3%. (OECD Health Data 2011)

In 2009, private expenditure on health amounted to €9,2 billion whereas total expenditure on health was €36,9 billion. This means that private expenditure on health represented 24,9% of total expenditure on health. (OECD Health Data 2011)

Expenditure on health (OECD)

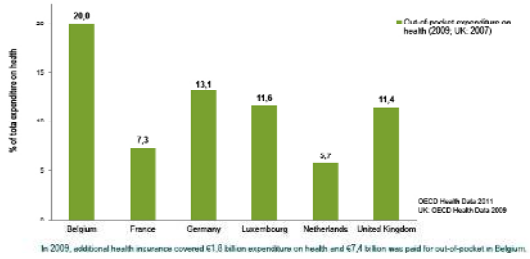


August 2008, Pacolet published a study on the application of the System of Health Accounts in Belgium. He suggested a methodology to be implemented, resulting — for 2003— in total expenditure on health amounting to 11,1% of GDP and private expenditure on health totaling 30,4%.[1] For the same year 2003, the methodology applied for the OECD Health Data 2011 resulted in total expenditure on health amounting to 10% of GDP and private expenditure on health totaling 25,2%.
Pacolet proposes to include additional health care costs into the OECD Health Data.

[1] http://www.hiva.be/resources/pdf/publicaties/R1223.pdf (accessed April 8, 2010)

In 2009, additional health insurance represented €1,754 billion expenditure on health (private insurance companies representing €824 million and nonprofit sickness funds €930 million). (Assuralia, 2011) In 2009, €1,8 billion out of a total of €9,2 billion private expenditure on health could be allocated to additional health insurance. As a result, €7,4 billion has been paid for out-of-pocket. (OECD Health Data 2011) With 20% of total expenditure on health, out-of-pocket expenditure on health in Belgium is considerably higher than in its neighboring countries.

Out-of-pocket expenditure on health (2009, OECD)



In 2009, additional health insurance covered €1,8 billion expenditure on health and €7,4 billion was paid for out-of-pocket in Belgium.

Analysis of private expenditure on health

National accounts

According to national accounts, private expenditure on health was €9.693 million in 2010, with pharmaceutical products and therapeutic material representing €2.848 million, outpatient services delivered by health care providers €2.388 million and institutional care €4.457 million.

Institutional care

According to national accounts, private expenditure on institutional care —€4.457 million in 2010— can be subdivided into private expenditure for general hospitals (€1.841 million), for psychiatric hospitals, revalidation centers and

other long term institutional care (€451 million) and for retirement and nursing homes for the elderly (€2.165 million).

General hospitals

There is a problem with private expenditure on general hospitals amounting to €1,84 billion in 2010, according to national accounts. Every year, Christian and Socialist sickness funds publish a study on private expenditure in general hospitals. An extrapolation of their figures results in private expenditure on general hospitals in 2010 totaling €0,95 billion (Socialist sickness fund) to €0,98 billion (Christian sickness fund).[2] Question is how the difference between the figures of the sickness funds (approximately €1 billion) —based on an analysis of all hospital bills of their members in 2010— and the figure of the national accounts (€1,8 billion) can be explained? Is it possible that ambulatory services provided in general hospitals are included in the €1,8 billion of the national accounts?

According to OECD Health Data 2011, out-of-pocket expenditure in general hospitals represented €1,74 billion in 2008. This figure is in strong contradiction with the following calculus: private expenditure in general hospitals (€1 billion) minus reimbursement by additional health insurance in general hospitals (€757 million) equals approximately €250 million out-of-pocket expenditure in general hospitals.
How can the difference between €1,74 billion (OECD Health Data 2011) and €250 million be explained? Firstly, we can deduct the €0,8 billion surplus of the national accounts. Secondly, we have to deduct a large share of the reimbursement by additional health insurance in general hospitals (€757 million). Why should we deduct reimbursement by additional health insurance? For the allocation of private expenditure on health to the different health care functions, the following methodology has been applied for the OECD Health Data 2011. From total private expenditure on health (€9.693 million in 2010 according to national accounts) co-payments and reimbursement by additional health insurance have been deducted. The remaining amount has been allocated to the different health care functions using co-payments as the distribution code. Problem is that the bulk of reimbursement by additional health insurance pertains to general hospitals. It may therefore be suggested not to deduct reimbursement by additional health insurance from total private expenditure on health (€9,7 billion), but more specifically from private expenditure on general hospitals (€1 billion).

Psychiatric hospitals

In 2008, there were 68 psychiatric hospitals with a total capacity of 13.481 beds in Belgium. There were almost 54.910 admissions with an average length of stay of 69 days.[3]
DKV Belgium[4] figures for 2010 show that private expenditure in a psychiatric hospital amounts to €12,60 per hospital day, €11,33 per day being reimbursed by DKV Belgium.
This means that private expenditure for a psychiatric hospital stay represents on average about €870. Total private expenditure on psychiatric hospitals is approximately €48 million.

[2] In 2010, the Christian sickness fund represented 41,8% of the Belgian population and the Socialist sickness fund 29,5%. (INAMI/RIZIV)

3 FOD Volksgezondheid, veiligheid van de voedselketen en leefmilieu, directoraat-generaal organisatie van de gezondheidszorgvoorzieningen (2011). Organisatie en financiering van de geestelijke gezondheidszorg in België.

4 About 1,8 million Belgians have subscribed an additional health insurance contract with Deutsche Krankenversicherung Belgium (DKV Belgium).

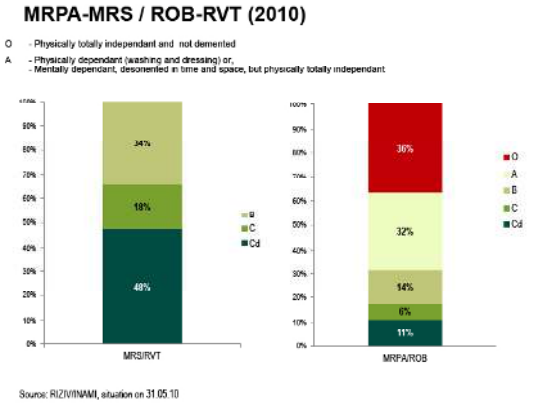
Institutional care for the elderly (Maison de repos pour personnes âgées et maisons de repos et de soins [MRPA-MRS] / rustoorden voor bejaarden en rust- en verzorgingstehuizen [ROB-RVT])

According to the national accounts, private expenditure on MRPA-MRS/ROB-RVT totaled €2.068 million in 2008. When we deduct the money paid to institutionalized elderly by the Flemish community (Flemish long term care insurance; "Vlaamse zorgverzekering") (€95 million) and by the federal state ("allocation pour l'aide aux personnes âgées / tegemoetkoming voor hulp aan bejaarden") (€291 million), we get a total of €1.682 million private expenditure on inpatient long term care for the elderly. However, OECD Health Data 2011 is listing less than €420 million.

The difference can be explained by the methodology applied for the OECD Health Data 2011. For the OECD Health Data 2011 only private expenditure on MRS/RVT is considered to be expenditure on health. Expenditure on MRPA-MRS is not being considered expenditure on health. In the end, only a part of private expenditure on MRS/RVT has been taken into account in the OECD Health Data 2011.

In the OECD Health Data 2011, public expenditure on both MRS/RVT and MRPA/ROB has been taken into account. However, so far as private expenditure is concerned, only MRS/RVT has been taken into account. The question can be raised whether including public expenditure on MRPA/ROB and not private expenditure on MRPA/ROB does not result in an imbalance between public and private expenditure on health.

When we have a look at the degree of dependency of residents in MRS/RVT, we see that 34% is medium dependent and 66% is high dependent (48% being demented residents). At MRPA/ROB, 36% is not dependent physically or mentally, but the other 64% is dependent (32% low dependent and 31% medium and high dependent).[5] With 64% of residents in MRPA/ROB being dependent, it may be hard to maintain the view that only private expenditure on health in MRS/RVT should be included in OECD Health Data and not in MRPA/ROB.



Ambulatory care

Outpatient dental care

In 2009, total public expenditure on outpatient dental care was €731 million according to INAMI/RIZIV and only €586 million according to OECD Health Data 2011. The difference between the two figures can be explained by radiology (€52 million) and prosthetic dentistry (€93 million) not being included in the OECD figure. The €52 million for radiology has been allocated by OECD to "ancillary services to health care: diagnostic imaging". However, since almost all dentists do perform radiology in their own office, we do suggest the €52 million to be allocated to "outpatient dental care". The €93 million for prosthetic dentistry has been allocated to "medical goods dispensed to outpatients: therapeutic appliances and other medical durables". Since the €93 million for prosthetic

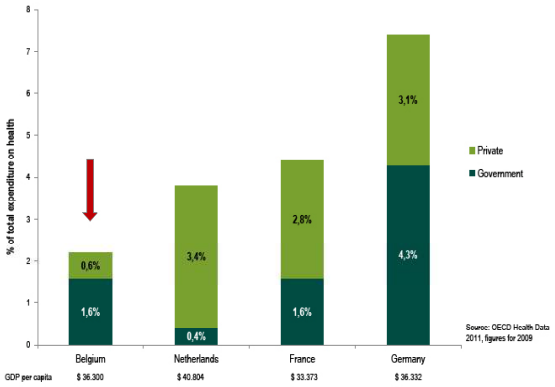
5 Source: RIZIV/INAMI, situation on May 31, 2010.

dentistry is largely constituted of the value added by the dentist and not so much by the isolated medical good, we suggest the €93 million to be allocated to "outpatient dental care" as well.

According to OECD Health Data 2011, private expenditure on outpatient dental care amounted to €230 million in 2009. This figure is an underestimation.
Co-payments have been used by OECD as the distribution code for the allocation of out-of-pocket expenditure on health to the different health care functions. Co-payments for outpatient dental care have been extrapolated. Problem is that certain provisions of dental care are not at all reimbursed by basic health insurance (e.g. implants, crowns and bridges). When there is no reimbursement by basic health insurance, there is of course no co-payment either. An important share of outpatient dental care not being reimbursed by basic health insurance, allocating total out-of-pocket expenditure on health based on the co-payments paid, results in an underestimation of private expenditure on outpatient dental care.

The Belgian figure for expenditure on outpatient dental care as a percentage of total expenditure is only about half the figure of its neighboring countries. (OECD Health Data 2011; figures for 2009) This supports the idea that private expenditure on dental care is likely to be underestimated.

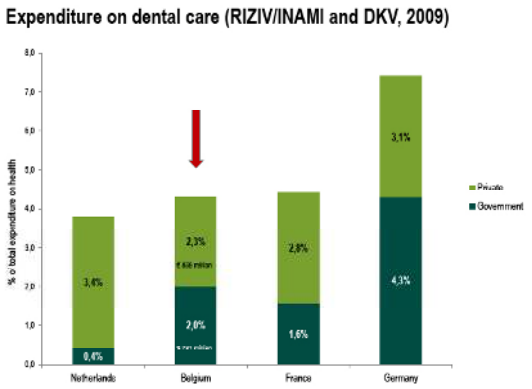
Expenditure on outpatient dental care (OECD, 2009)



We have made an extrapolation, stratified for age, of a sample of 46.813 persons additionally insured with DKV Belgium for dental care (together with hospital care and ambulatory care) through their employer. There is a lower risk of anti-selection with people insured through a group contract.

Extrapolation to the whole of the Belgian population results in €858 million private expenditure on outpatient dental care. This total can be subdivided in €569 million private expenditure on prosthetic dentistry (e.g. implants, crowns and bridges), €195 million on conservative and periodontal dentistry and €93 million on orthodontic dentistry.

When using the alternative figures for expenditure on outpatient dental care (€731 million instead of €586 million for public expenditure and €858 million instead of €230 million for private expenditure), Belgium is in alignment with its neighboring countries.



Today, about €40 million of the €858 million is insured by additional health insurance. Only 2% of the Belgian population is currently carrying additional dental insurance (compared to over 80% carrying additional hospitalization insurance).

Psychotherapy

Ambulatory consultations with self-employed, registered clinical psychologists are not reimbursed by basic health insurance in Belgium.
With additional health insurance reimbursing only about €5 million, out-of-pocket expenditure on psychotherapy amounts to approximately €225 million.

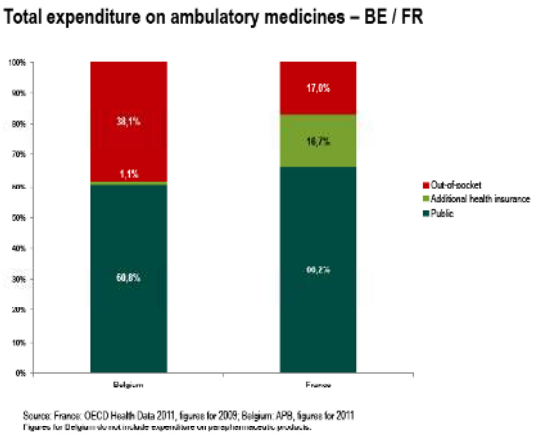
Medicines and therapeutic appliances

Ambulatory medicines

In 2011, private expenditure on ambulatory medicines totaled €1,8 billion, with co-payments on medicines reimbursed by basic health insurance representing €528 million, prescribed, not reimbursable medicines €561 million and over-the-counter medicines €715 million.[6]

Reimbursement by additional health insurance is almost non-existent.

Out-of-pocket expenditure on parapharmaceutical products totals €979 million.[7] Some of these parapharmaceutical products are health care related and some are not.
In many aspects, France and Belgium have similar health care systems. Contrary to Belgium, additional health insurance in France is covering 80% of private expenditure on prescribed ambulatory medicines and 16% of private expenditure on over-the-counter medicines.



Therapeutic appliances: glasses and other vision products

In 2009, total expenditure on glasses and other vision products amounted to €389 million (ex VAT).[8]
Total expenditure can be subdivided into the following components: frames (30%), glasses (50%), contact lenses (10%) and other vision products (10%).
Public expenditure was only €22,6 million.[9]
Additional health insurance accounted for less than €15 million.[10]
According to OECD Health Data 2011, private expenditure on glasses and other vision prod-

6 Source: Association Pharmaceutique Belge / Algemene Pharmaceutische Bond (2011).

7 Source: Association Pharmaceutique Belge / Algemene Pharmaceutische Bond (2011).

8 Source: Pearle.

9 Source: INAMI / RIZIV.

10 Source: Controledienst voor de ziekenfondsen; DKV Belgium.

ucts was only €0,9 million in 2009. We suggest the following calculus: 80% of (total expenditure – public expenditure). So we get a figure of €293 million (ex VAT) of private expenditure on glasses and other vision products.
This figure is not included in the national accounts' total private expenditure on health.

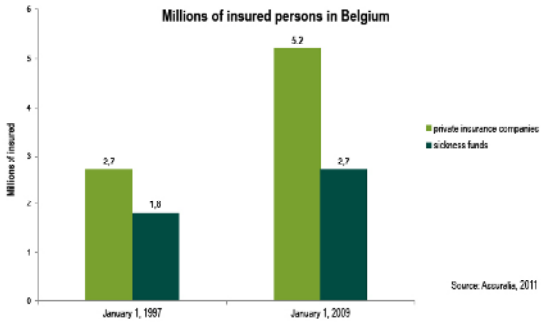
Occupational accident and occupational disease insurance

In 2008, total expenditure on occupational accidents and diseases amounted to €142 million (health care related expenditure, not income replacement related expenditure).
Occupational accident and disease insurance is a part of social security but is privately financed through private insurance companies.
In the OECD Health Data 2011, expenditure on occupational accidents and diseases is a public expenditure. Since the financing source is private, maybe expenditure on occupational accidents and diseases can be considered to be a private expenditure.

Additional health insurance

An increasing number of Belgians carry additional health insurance.

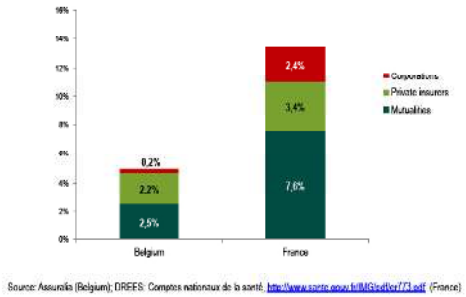
Additional health insurance



Belgium and France have similar health care systems. In France, the share of additional health insurance in total expenditure on health is larger than in Belgium, resulting in a smaller share of out-of-pocket expenditure.

Additional health insurance (2009)

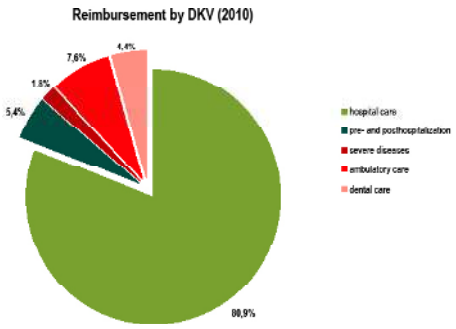
Belgium versus France



Source: Assuralia (Belgium); DREES: Comptes nationaux de la santé; http://www.sante.gouv.fr/IMG/pdf/er773.pdf (France)

Today, additional health insurance in Belgium is mainly focusing on private expenditure on hospitals. When we have a look at DKV Belgium, the market leader for additional health insurance in Belgium, we see that 81% of total reimbursement goes to hospital care.

Reimbursement by DKV



In 2010, 64% of people insured with DKV Belgium chose a private room when hospitalized, compared to 23% of the members of the Christian sickness fund.[11]
According to data from DKV Belgium for 2010, private expenditure for a hospital stay[12] amounts to €1.317 for a private room and €333 for a double or common room, with €1.205 and €274 respectively being reimbursed by additional health insurance.

Financial and health problems

There are multiple indications that private expenditure on health is causing financial and health problems for Belgian citizens.

According to the Belgian Health Interview Survey (2004), 29% of households say that private expenditure on health is (very) hard to bear (38% if the reference person is > 75 years old). In 2004, 10.1% of Belgian households had to postpone medical care for financial reasons.[13]

According to the Belgian Health Interview Survey (2008), 34.8% of households say that private expenditure on health is (very) hard to bear (43.9% if the reference person is 65-74 years old). In 2008, 14% of Belgian households had to postpone medical care for financial reasons.[14]

September 2009, the Christian Sickness Fund published a study about the impact of chronic diseases on the financial situation of households. [15] One out of eight households is facing financial problems as a result of private expenditure on health. For 48% of these households, it is difficult to make ends meet, 22% has to ask family, friends or social institutions for help, 53% has to renounce necessary care and 12% has to contract a loan for financing health care. Glasses (31%), dental care (29%), consultations with a specialist (23%) or with a general practitioner (21%) and medicines (20%) are the kind of care which is most often postponed. Measures taken by government to improve accessibility for high risk and low income people compensate only for 13% of private expenditure on health for households confronted with chronic diseases.

September 19, 2008, a newspaper article mentioned the existence of unpaid hospital bills worth €400 million. In the article, the University Hospital of Liège stated that on a monthly basis, 55,000 bills are being sent to patients. To settle these 55,000 bills, 10,000 reminders need to be sent (7,000 first reminders and 3,000 second reminders) and mediation is needed for over 1,000 patients. Between 2005 and 2008 the number of first reminders has increased with 27%.[16]

May 5, 2010, a newspaper article stated that a company specialized in processing unsettled bills for general practitioner care is facing an increase of unpaid bills of 54% over the last year (as a result of the economic crisis).[17]

April 30, 2011, a newspaper article was published on "cancer poverty" (cancer patients being confronted with steep bills to be paid for out-of-pocket).[18]

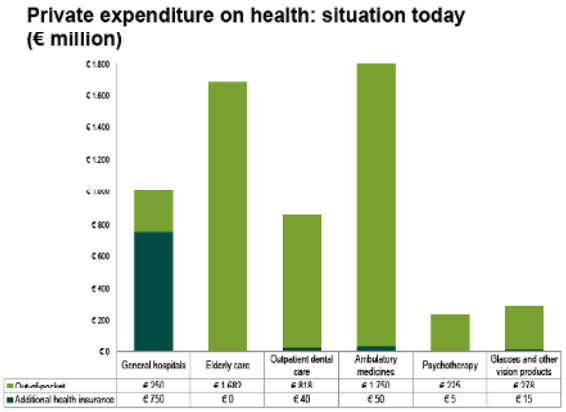
11 DKV; Zevende CM-barometer van de ziekenhuisfactuur 2011.
12 Excluding one-day hospitalization.
13 http://www.iph.fgov.be/EPIDEMIO/EPINL/crospnl/hisnl/table04.htm (accessed August 31, 2010)
14 http://www.iph.fgov.be/epidemio/epinl/index4.htm (accessed August 31, 2010)
15 http://www.cm.be/nl/126/infoenactualiteit/enquetes_en_onderzoeken/chronisch-zieken/index.jsp?ComponentId=62858&SourcePageId=3682 (accessed March 15, 2010)
16 De Morgen, September 19, 2008.
17 Het Laatste Nieuws, May 5, 2010.
18 De Morgen, April 30, 2011.

In a recent report on poverty in Belgium, debt as a result of private health care costs and debt as a result of energy costs are said to be the most important risk factors for sinking into poverty.[19]

Conclusion

We hope that the figures mentioned above will lead to further discussion.

Today, focus is on private expenditure on general hospitals. Maybe time has come to have a closer look at private expenditure on other health care provisions as well. Initiatives that alleviate financial and health problems by reducing financial risk will be welcomed by people facing substantial out-of-pocket expenditure on health.



19 Vranken J, Campaert G, Dierckx D, Van Haarlem A (ed.) (2009). Armoede en uitsluiting. Jaarboek 2009. Leuven: Acco.

For sustained economic growth and social protection.

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