Can People Afford Their Healthcare?

The quality and accessibility of healthcare are primarily important because they (hopefully) contribute to better health, undoubtedly one of the most important dimensions of well-being. The organisation of healthcare and health insurance also affects well-being in other ways. When people are ill, they have to spend part of their income on healthcare expenditure which reduces their possibilities for consumption. The accessibility of good care for all also contributes to a sense of solidarity and harmony in society: people who do not receive the care they think they need often feel that they are being treated unfairly by the system. The importance of each individual's dignity is a particularly sensitive issue when it comes to suffering, pain and death.

The Use of Healthcare

We will first examine the use of healthcare as reflected in our data. Table 8.1 paints an indicative picture, also immediately illustrating the distribution of this use among the population. We show the percentage of people calling upon different forms of care, also specifying the extent of use for most of these forms of care: the number of days in a hospital, the number of consultations with a care provider and the number of home care visits, for example. These averages are not calculated for the total population, but only for the people who use this form of care. For example, 87.8% of people call upon general practitioners (GP) at least once a year and the



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Table 8.1 U	se of healtl	hcare (per ye	ar)								
	Hospital (%)	Hospital— number of days	GP (%)	GP— number of consultations	Specialist (%)	Specialist— number of consultations	Dentist (%)	Physiotherapist (%)	Physiotherapist— number of consultations	Home care (%)	Number of visits
Global	19.2	7.6	87.8	5.5	58.5	3.5	68.2	26.4	21.9	7.8	19.6
Male	16.9	7.0	84.8	5.2	50.3	3.3	65.7	21.1	19.3	5.2	19.6
Female	21.4	8.0	90.8	5.8	66.3	3.7	70.5	31.8	23.6	10.3	19.5
18-39	15.2	6.6	83.1	4.0	48.8	3.5	6.69	25.3	13.8	3.7	7.6
40-59	16.7	8.5	86.2	5.4	58.5	3.7	74.0	27.5	20.4	5.8	11.2
69-09	21.4	6.6	92.7	5.3	65.4	3.6	69.4	28.3	23.6	8.9	14.5
70-79	29.3	7.0	94.6	7.5	71.0	3.0	55.1	26.5	36.2	13.3	26.9
80+	30.2	9.5	96.9	9.9	65.7	2.8	43.1	23.0	42.3	27.6	36.8
Poor health	35.6	11.0	95.7	8.9	78.5	5.3	65.3	41.1	33.5	17.3	23.2
Medium low	19.9	6.0	81.0	5.0	61.6	3.0	66.6	27.6	20.1	7.4	20.4
Medium high	14.4	5.3	84.9	3.7	54.4	2.8	71.3	23.0	16.1	5.0	12.1
Good health	10.8	2.9	82.0	4.2	46.6	2.4	71.5	19.3	9.2	3.0	7.9
Emotional, low	29.4	11.2	92.7	<i>T.T</i>	72.4	4.8	64.5	39.7	31.6	14.7	23.2
Emotional, medium low	18.3	6.5	87.5	4.3	61.1	3.5	69.0	24.5	16.0	6.9	16.5
Emotional, medium high	16.3	3.6	88.0	4.2	53.6	2.8	71.3	22.8	15.2	5.1	14.7
Emotional, good	15.2	6.3	84.2	5.8	51.9	2.7	70.1	22.4	17.7	5.1	16.2
											continued)

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Table 8.1 (c	continued)										
	Hospital (%)	Hospital— number of days	GP (%)	GP— number of consultations	Specialist (%)	Specialist— number of consultations	Dentist (%)	Physiotherapist (%)	Physiotherapist— number of consultations	Home care (%)	Number of visits
Chronically ill	31.7	9.2	94.6	<i>T.T</i>	78.4	4.6	65.6	38.2	32.1	14.3	22.7
Not chronically ill	13.2	5.5	84.5	4.2	49.2	2.6	70.6	21.4	11.9	4.5	13.5
Education, low	22.1	9.4	88.1	7.1	56.8	3.5	52.9	24.3	27.3	11.9	26.8
Education, medium	18.8	7.1	88.1	4.8	55.6	3.5	72.3	25.0	21.7	5.9	13.0
Education, high	16.6	5.8	87.8	4.8	73.6	3.5	78.9	30.8	18.2	5.9	12.8
Poor	18.3	11.1	82.6	6.4	48.9	3.5	49.6	21.4	25.7	8.2	22.7
Low income	22.7	7.8	90.6	7.4	58.5	3.5	62.2	27.5	25.6	10.8	25.4
Average income	17.9	7.2	89.4	4.5	58.4	3.6	71.8	27.7	23.7	8.0	12.7
Rich	17.5	6.3	87.3	3.9	61.2	3.2	77.5	29.1	14.5	3.6	12.6

average number of GP consultations by these people is 5.5. Among people in poor health, the results are 95.7% and 8.9, respectively.¹

The first row shows the average use of healthcare by the entire Belgian population. These figures are in line with expectations.² We note that almost 20% of people use hospital care, but it must be borne in mind that our questions did not distinguish between day hospital admissions and longer hospital stays. The breakdown of the results between the various groups is rather more interesting.

Generally speaking, the use of healthcare increases with age and this is clearly the case for home care. There are two exceptions to this trend: the use of dental care and physiotherapists increases up to the age of 60–69, but then decreases. At the same time, the number of consultations shows that elderly people who use physiotherapy do so in a more intensive way, probably for more serious conditions. Women call upon healthcare more than men. This is partly due to the fact that on average, women live longer. However, other studies show that the effect persists even after correction for age. For example, the difference in the use of specialist care is partly explained by consultations with the gynaecologist.

Age and health are, of course, closely linked, and it goes without saying that sick people call upon the care system more often. We show the results for "general health" (the first dimension described in Chap. 6) and "emotional well-being" (the fourth dimension). We find a positive link between illness and the use of healthcare for both dimensions, but the link is stronger for "general health" than for "emotional well-being". People with chronic diseases also use the care system more often than other people: had we found the opposite, our results would not have been particularly credible. Two findings are worth highlighting. Firstly, the number of people who visit a GP is fairly evenly distributed among people with different levels of health (note how this differs from the results for specialist care), except for those with poor health, over 95% of whom ask a GP for advice at least once. The high percentage for all groups (over 80%) suggests that primary care is widely accessible in Belgium. Secondly, we again find different results for dental care here: people with a low score for "emotional well-being" and "general health" pay fewer visits to the dentist.

Next, we examine the relationship between the use of care and socio-economic status. In Chap. 6, we saw that people with lower levels of education and those on lower incomes are generally in poorer health, so we could also expect them to make greater use of the care system. Indeed, people with a lower level of education (below secondary) visit hospitals more often and make greater use of home care. For general practitioners, the picture is slightly different: although the number of users is fairly evenly distributed across all levels of education, as soon as people call upon a GP the number of consultations is higher for people with lower levels of education, probably because they are indeed in poorer health. We find another

¹We do not include the number of consultations for dentists as it does not contain any relevant information: the average number of visits is two for all groups.

²Our figures are in line with the findings of the 2013 Health Survey, but are somewhat higher overall. This brings them closer to the official data of the National Institute for Health and Disability Insurance (RIZIV).

different pattern for physiotherapists: although more highly educated people are more likely to visit a physiotherapist, the average number of visits is lower. More highly educated people are likely to consult the physiotherapist for less severe conditions, relatively speaking. The results for dental care (more highly educated people visit the dentist more regularly) and particularly for specialist care are striking: despite their better level of average health, more highly educated people visit a specialist more frequently. Similar results are also found in other research and for other European countries (e.g. see the work of Van Doorslaer and Masseria 2004).

However, the most striking results are found when we look at income. Poor people, i.e. people living in families with an income below 60% of the median income (here, we use the official method of measuring poverty as described in Chap. 5), make *less* use of healthcare across the board. This finding even applies to visits to their GP. However, if they are admitted to hospital (less often than the other income groups) their stay is longer: this suggests that they must be "sicker" before being admitted to hospital, and in turn this may be due to their lower probability of consulting their GP. At first glance, these results are worrying. We will examine them in more detail later in this chapter.

Financial Consequences of Illness

At this point, we will take a look at Belgians' personal contributions to their care costs. In Belgium (and also in our sample), virtually everyone is insured under the compulsory health insurance system. Most people have no idea about the amount of social security contributions they pay for this and simply regard it as part of their taxes. We will not go into these contributions in more detail here. However, people also pay for their healthcare when they get sick. Even in a system of collective and solidarity-based health insurance that covers most of the expenses, these personal contributions can really add up.

Here, we refer to three different types of personal contributions. First and foremost, these consist of the *patient contributions*, i.e. the patient's own contributions as specified in the collective health insurance system. This is the portion of the official tariff that is not reimbursed by the health insurance. Then we have the *supplements*, which are the additional fees that can, under certain circumstances, be charged by providers on top of the official price. The hospital supplements for patients admitted to a single room are perhaps the most common form of these. Certain types of care (some drugs, for example) are not reimbursed at all and must therefore be funded entirely by the patient. Finally, chronically ill people in particular also incur *additional expenses* that are not directly related to healthcare but can have a considerable impact on their budget: special food will sometimes be needed, travel can become more difficult and in certain cases, their housing will need to be adapted. We will return to the specific situation of the chronically ill at the end of this chapter.

The Belgian system has built-in safeguards. People on a low income pay lower patient contributions; they are entitled to increased reimbursements. The characteristics of these people are summarised in the first column of Table 8.2. It is mainly older people with lower levels of education and lower incomes who are entitled to these increased reimbursements. Because of the link between socio-economic status and health, these people are often less healthy.

When the total level of patient contributions within a family reaches an (income-dependent) threshold, further contributions are reimbursed under the mandatory health insurance. This is known as the maximum billing system (abbreviated to the Dutch acronym MAF). The second column shows how many people have had their patient contributions reimbursed within this system during the previous year.³ Since an (income-dependent) threshold must be reached first, it is logical that the maximum billing system will primarily benefit sick people on a low income. This is confirmed in the second column of the table. Also note that, despite the income dependence of the thresholds, the MAF remains a universal system. The link between income and reimbursement through the MAF is therefore much weaker than the link between income and the entitlement to an increased reimbursement. In relative terms, we can see that the poorest and richest groups benefit least from this. For the poorest groups, this may be connected with the less frequent use of healthcare that we have already described. After all, expenditure must first have been incurred in order to benefit from the MAF.

Supplementary charges are not covered by the MAF. If people do not wish to pay these costs themselves, they can take out supplementary hospitalisation insurance. This is voluntary insurance for which people pay a premium that depends on their age and risk profile but not their income. The results in the third column show that almost 80% of Belgians have this kind of hospitalisation insurance, but also confirm that the coverage of this insurance is very unevenly distributed among the population. Wealthier and more highly educated people are more likely to have it. This immediately leads to the somewhat paradoxical result that it is mainly relatively healthy people who have hospitalisation insurance. The fourth column shows the percentage of people who have received a reimbursement through their hospitalisation insurance: these percentages do not vary greatly with age or socio-economic status (except for the poor who make less use of the care system), but do vary greatly with health.

The last two columns shed a global light on the subjective perception of financial costs associated with healthcare. The last column shows the percentage of people who claim they were unable to pay a health-related bill for financial reasons. The penultimate column shows the percentage of respondents who say that they find it difficult or impossible to budget for their personal contribution to health costs, i.e. the money they have to pay themselves. When interpreting the results, it is interesting to look at these two columns together.

³A more accurate (but cumbersome) wording would be as follows: "How many people over the age of 18 live in a family that received a reimbursement through the maximum billing system in 2015".

	Increased reimbursements (%)	Maximum billing (%)	Hospitalisation insurance (%)	Reimbursement by hospitalisation insurance (%)	Difficult or impossible to fit into the budget?	Unable to pay?
Global	18.4	8.9	78.7	25.9	17.0	7.2
Male	17.2	8.3	77.8	23.1	14.4	7.0
Female	19.5	9.4	79.4	28.6	19.5	7.4
18–39	13.3	4.7	76.2	25.8	15.4	9.1
40-59	17.4	7.7	79.6	25.0	17.0	8.9
6069	20.3	12.1	88.0	26.6	16.1	4.6
70-79	25.1	16.1	76.0	28.4	18.5	1.4
80+	33.0	15.2	63.8	26.4	25.1	4.6
Education, low	27.2	11.4	67.0	24.8	25.9	9.5
Education, medium	17.7	0.0	81.4	25.2	17.9	8.2
Education, high	10.4	6.4	87.1	27.5	7.3	3.7
Poor	36.1	5.6	42.1	14.0	40.3	17.9
Low income	27.3	14.2	73.7	27.3	26.1	11.4
Average income	12.3	7.0	85.4	29.7	9.3	2.3
Rich	8.3	4.2	88.1	25.9	3.6	1.3
Poor health	32.0	19.0	75.3	45.5	35.5	12.7
Medium low	17.6	8.3	82.6	22.7	15.0	7.6
Medium high	13.0	5.4	82.8	20.7	9.3	3.8
Good	12.9	4.0	80.4	18.3	7.8	4.7
Emotional, low	33.6	16.6	71.2	34.0	37.7	15.8
Emotional, medium low	15.6	7.6	78.4	27.3	15.2	6.3
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Table 8.2 Financial consequences of illness

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Table 8.2 (conti	nued)					
	Increased reimbursements (%)	Maximum billing (%)	Hospitalisation insurance (%)	Reimbursement by hospitalisation insurance (%)	Difficult or impossible to fit into the budget?	Unable to pay?
Emotional, medium high	13.7	5.6	84.6	24.7	7.3	4.6
Emotional, good	11.8	5.9	86.2	19.6	6.4	1.9
Chronically ill	30.3	16.0	79.6	35.7	29.0	10.5
Not chronically ill	12.3	5.1	80.6	20.7	9.8	5.3

In both cases, there is a clear link with socio-economic status. Once again, the results for the poorest group are very striking: although they make less use of healthcare, 40% still say that healthcare expenditure is difficult or impossible to budget for and almost 18% say that they sometimes cannot pay the bills at all. There is also a very strong link with health. It is also striking that 7.3% of highly educated people, 3.6% of people in the highest income quartile and 7.8% of people in good health state that they find healthcare expenditure difficult or impossible to budget for. However, we must bear in mind that subjective feelings rather than objective budget data are involved.

This insight also helps us to understand the results for the demographic characteristics: women and older people are more likely to say that the expenditure is difficult to budget for, but at the same time they report less often that they (have to) postpone the payment of bills. A somewhat daring interpretation (which is nevertheless consistent with the results) is that older people and women attach greater importance to healthcare and thus make their use of care (and the payment of the associated health bills) less dependent on the size of their budget: they continue to use and pay for healthcare, increasing the pressure on their budget as a result. An alternative explanation could be that women and the elderly are sicker and that the care is more necessary. Our findings raise a pertinent question: Are people obliged to postpone care for financial reasons?

Postponement of Care

International and Belgian scientific literature on the accessibility of healthcare focuses strongly on whether people are obliged to postpone the use of care for financial reasons. However, the results of surveys for the same country and period often differ: for example, the Health Survey found that no fewer than 12.3% of people had to postpone care in 2008, while for the same year, the SILC survey found a percentage of less than 1%. It appears that the results of the various surveys are strongly influenced by the specific formulation of the questions (Schokkaert et al. 2017). Our results are in line with those of the Health Survey, partly because it is the one our questions tie in most closely with. Despite the wide variation in the answers, it is interesting to study them, as the distribution across the different groups of the population gives relatively stable results in the various surveys.

Let us first look at the last two columns in Table 8.3. The penultimate column shows the percentage of people living in a family that had to postpone at least one form of healthcare for financial reasons during the previous year. We find that this affects 13.4% of Belgians. The last column shows the percentage of people who have had to postpone urgent care. This share is much lower, at 4.7%. From a social viewpoint, this latter result is perhaps the most relevant.

We note that sick people in particular report that they have had to postpone care. This is not particularly surprising, as the others do not need any (or less) care. What is more interesting is the observation that the postponement of urgent care occurs

	Postponement of GP or specialist	Postponement of operation	Postponement of dental care	Postponement of	Postponement	Postponement of	Any	Postponement
	(%)	01 Uppet at 1011 (%)		presentation muga	(a) cheerig IO		(%)	01 urgent care (%)
Global	7.2	2.2	7.7	5.1	5.8	2.3	13.4	4.7
Male	6.7	2.3	T.T	4.5	5.2	2.0	12.6	3.7
Female	7.7	2.2	T.T	5.7	6.3	2.4	14.1	5.6
18–39	9.8	2.5	9.0	6.3	6.0	2.3	15.7	4.8
40-59	6.7	2.3	9.0	4.1	7.9	3.0	14.6	6.3
69-09	5.6	2.3	6.3	5.0	3.8	2.2	11.2	4.5
70–79	5.4	1.2	3.6	5.5	2.1	0.4	8.0	1.4
80+	5.9	2.3	4.0	4.7	3.4	0.9	9.3	2.1
Education, low	7.6	2.4	7.7	5.6	5.7	2.1	14.2	6.7
Education, medium	8.2	2.4	8.7	5.4	6.7	2.4	15.5	5.8
Education, high	5.5	1.6	6.2	4.0	4.6	1.8	9.7	1.3
Poor	16.1	7.2	17.2	9.8	13.5	3.5	28.1	12.0
Low income	8.5	2.1	8.7	5.4	6.1	3.8	16.9	7.1
Average income	2.7	0.6	3.7	2.2	3.9	1.1	7.0	1.7
Rich	5.3	1.4	4.5	4.1	1.9	1.6	7.0	1.0
Poor health	10.3	4.2	10.5	7.8	9.1	4.6	19.0	10.0
Medium low	5.6	0.5	7.7	3.2	4.3	1.4	12.1	4.9
								(continued)

Table 8.3 Postponement of care for financial reasons

Table 8.3 (c	ontinued)							
	Postponement of GP or specialist (%)	Postponement of operation (%)	Postponement of dental care (%)	Postponement of prescribed drugs (%)	Postponement of glasses $(\%)$	Postponement of mental healthcare (%)	Any postponement (%)	Postponement of <i>urgent</i> care (%)
Medium high	6.4	2.2	5.9	4.6	4.0	2.1	11.7	2.0
Good	6.2	2.3	7.5	4.7	4.9	1.3	11.0	2.3
Emotional, low	12.5	3.7	15.0	8.3	11.5	5.8	25.1	12.6
Emotional, medium low	6.6	1.9	6.5	5.0	4.9	2.0	12.8	3.7
Emotional, medium high	4.8	1.6	4.5	3.5	3.0	0.3	7.7	1.5
Emotional, good	4.5	2.0	5.6	3.4	2.8	1.1	8.1	0.9
Chronically ill	8.1	3.0	8.6	6.2	7.6	3.8	16.1	7.6
Not chronically ill	6.5	1.9	7.6	4.4	4.4	1.4	11.9	3.1

Postponement of Care

somewhat more frequently in younger people: this confirms the assumption that we formulated above, namely that elderly people continue to use and pay for healthcare even if it proves difficult or impossible to budget for it. In particular, there is a very strong link with education and income. Of the adults living in a family with an income above the median, 7% live in a family in which some form of care has been postponed, but less than 2% of cases involve urgent care. For the poor, these percentages are 28.1 and 12%. This is fully in line with all previous results showing that poor people find it harder to fit healthcare spending into their budgets and are more often unable to pay healthcare bills. Despite the social protection measures already built into the system, ensuring the financial accessibility of care for the poor in our society remains an important concern.

Further insights can be derived from the other columns of the table, which provide similar results for different forms of healthcare. Dental care is most commonly postponed, even by people on above-average incomes. Some people also postpone the consultation of a general practitioner or specialist to times when their budget is less tight. The results for the poor are worrying across the board. For example, we note that almost 10% have postponed the purchase of prescribed medicines and just over 7% have postpone urgent forms of healthcare for financial reasons or even put them on hold indefinitely (given their reduced use of the care system).

People with Chronic Illnesses

The chronically ill deserve special attention in this respect. We define a "chronically ill person" as someone who reported suffering from a chronic condition in the MEQIN survey. In total, 36% of the population are affected. There are, of course, drawbacks to this kind of self-reporting and—as described in Chap. 6—chronically ill people are therefore a heterogeneous group who suffer from very different conditions. Nonetheless, it is still interesting to investigate how good the lives of these chronically ill people are compared to the rest of the population.

The results for the use and accessibility of healthcare have already been included in the tables above. Chronically ill people make greater use of healthcare in general, although they visit the dentist less often. They are more likely to benefit from increased reimbursements and reimbursements under the maximum billing system. Although they are no more likely than other groups to have hospitalisation insurance, a higher percentage has received reimbursements through this insurance. Almost 30% of chronically ill people feel that their healthcare expenditure is difficult or impossible to budget for; just over 10% say that they sometimes cannot pay their health-related bills and 7.6% were obliged to postpone a form of urgent care for financial reasons during the past year.

	Chronically ill people	Non-chronically ill people
How satisfied are you with your health? (0–10)	5.96	7.97
Emotional well-being (0-100)	64.24	76.05
How happy would you say you are? (0-10)	7.15	7.82
How satisfied are you with your life today? (0–10)	6.99	7.63
Average monthly expenditure on leisure activities	25.25 euros	32.18 euros
Can't afford an unexpected expense of 1000 euros	31.7%	20.7%
Below the income poverty line	12.1%	11.1%

Table 8.4 Situation of the chronically ill

However, chronic illness can also affect well-being in other ways. Some relevant indicators are included in Table 8.4. It is not surprising that the chronically ill have lower levels of emotional well-being and are less satisfied with their health. This effect also has a strong negative impact on their happiness and overall life satisfaction. As we will see in Part IV of this book, good health is indeed regarded by most people as one of the most important characteristics of a good life. A chronic illness also has economic consequences. On average, chronically ill people spend less on leisure activities. Almost a third of people with chronic illnesses state that they would be unable to pay an unexpected expense of 1000 euros with their own resources. It should therefore come as no surprise to learn that chronically ill people fall below the poverty line relatively often.