

Out-of-pocket medical expenditure

Financial protection through compulsory or voluntary health coverage can substantially reduce the amount that people need to pay directly for medical care. Yet in some countries the burden of out-of-pocket spending can still create barriers to health care access and use: households that face difficulties paying medical bills may delay or even forgo needed health care. On average across OECD countries, a fifth of all spending on health care comes directly from patients (see indicator “Financing of health care”).

Out-of-pocket payments rely on the ability to pay. If the financing of health care becomes more dependent on out-of-pocket payments, the burden shifts, in theory, towards those who use services more, and possibly from high to low-income earners, where health care needs are usually higher. In practice, many countries have safety-nets in place to protect vulnerable groups of the population (such as the poor, the elderly, or people with chronic diseases or disabilities) from excessive out-of-pocket payments. These may be partial or total exemptions or a cap on direct payments, either in absolute terms or as a share of income (Paris et al., 2016).

The burden of out-of-pocket medical spending (that is, excluding long-term care services) can be measured either as a share of total household income or consumption. The share of household consumption allocated to medical care varied considerably across OECD countries in 2015, ranging from lows of around 1.5% of total household consumption in France, Luxembourg and the United Kingdom, to more than 5% in Korea and Switzerland (Figure 5.7). On average, across OECD countries, 3% of household spending goes on medical goods and services.

Health systems in OECD countries differ in the degree of coverage for different health services and goods. In most countries, a higher proportion of the cost is paid directly for pharmaceuticals, dental care and eye care than for hospital care and doctor consultations (Paris et al., 2016). Taking into account these differences and also the relative importance of these different spending categories, it is not surprising that there are significant variations between OECD countries in the breakdown of the medical costs that households have to bear themselves.

In most OECD countries, spending on pharmaceuticals and outpatient care (including dental care) are the two main spending items for out-of-pocket expenditure (Figure 5.8). These two components typically account for almost four-fifths of all medical spending by households. Co-payments and additional services can result in a larger proportion of the cost of inpatient care being taken on directly by households – Greece, Belgium and the Netherlands report a

greater share of household spending (20-32%) on inpatient care than the OECD average of less than 10%.

In some Central and Eastern European countries such as Poland, the Czech Republic and Hungary, as well as Canada and Mexico, expenditure on pharmaceuticals accounts for half or more of all out-of-pocket payments. This may be due not only to co-payments for prescribed pharmaceuticals, but also high levels of spending on over-the-counter medicines for self-medication. Therapeutic goods, covering among other items, corrective eye products and hearing aids, can also account for a significant proportion of household spending. In the case of spectacles, compulsory coverage is often limited to paying a contribution for the cost of the lenses, while private households are left to bear the full cost of the frames if they are not covered by complementary private insurance. Overall, therapeutic goods account for more than 20% of household spending in the Netherlands, the United Kingdom, Slovenia, Germany and the Slovak Republic.

Coverage for dental treatment is typically limited and as such dental care plays a significant part in outpatient and overall household spending, accounting for 20% of all out-of-pocket expenditure across OECD countries. In Spain, Norway and Estonia, this figure reaches 30% or more. This can at least partly be explained by the limited compulsory coverage for dental care in these countries compared with a more comprehensive coverage for other categories of care.

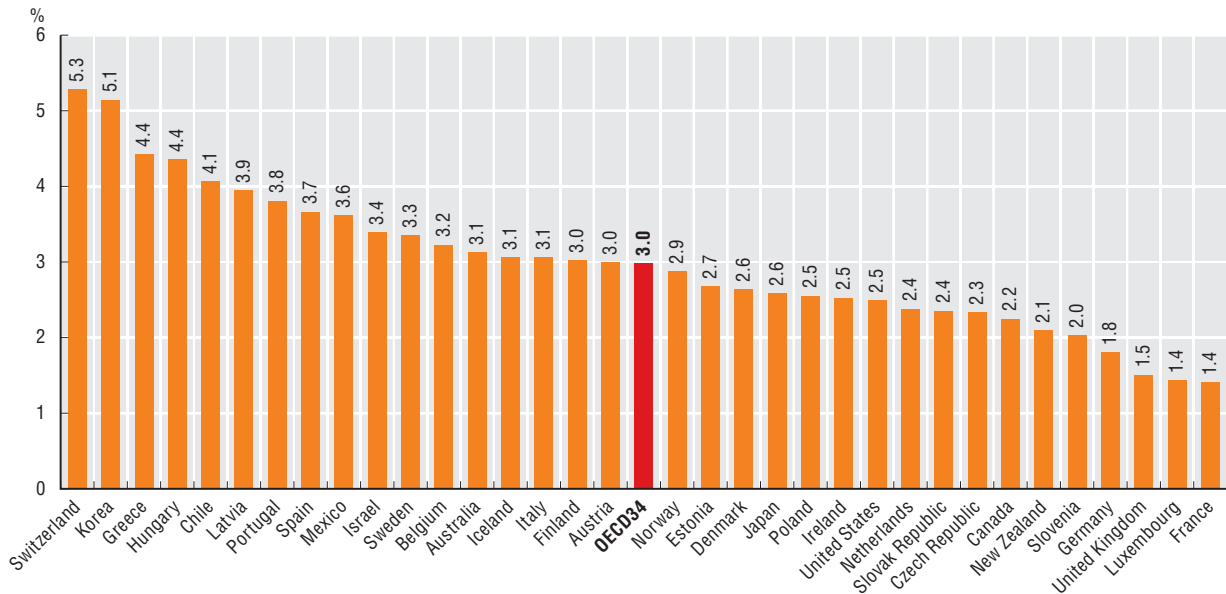
Definition and comparability

Out-of-pocket payments are expenditures borne directly by a patient where neither compulsory nor voluntary insurance cover the full cost of the health good or service. They include cost-sharing and other expenditure paid directly by private households and should also include estimations of informal payments to health care providers. Only expenditure for medical spending (i.e. current health spending less expenditure for the health part of long-term care) is presented here, because the capacity of countries to estimate private long-term care expenditure varies widely.

References

Paris, V. et al. (2016), “Health Care Coverage in OECD Countries in 2012”, *OECD Health Working Papers*, No. 88, OECD Publishing, Paris, <http://dx.doi.org/10.1787/5jlz3kbf7pzu-en>.

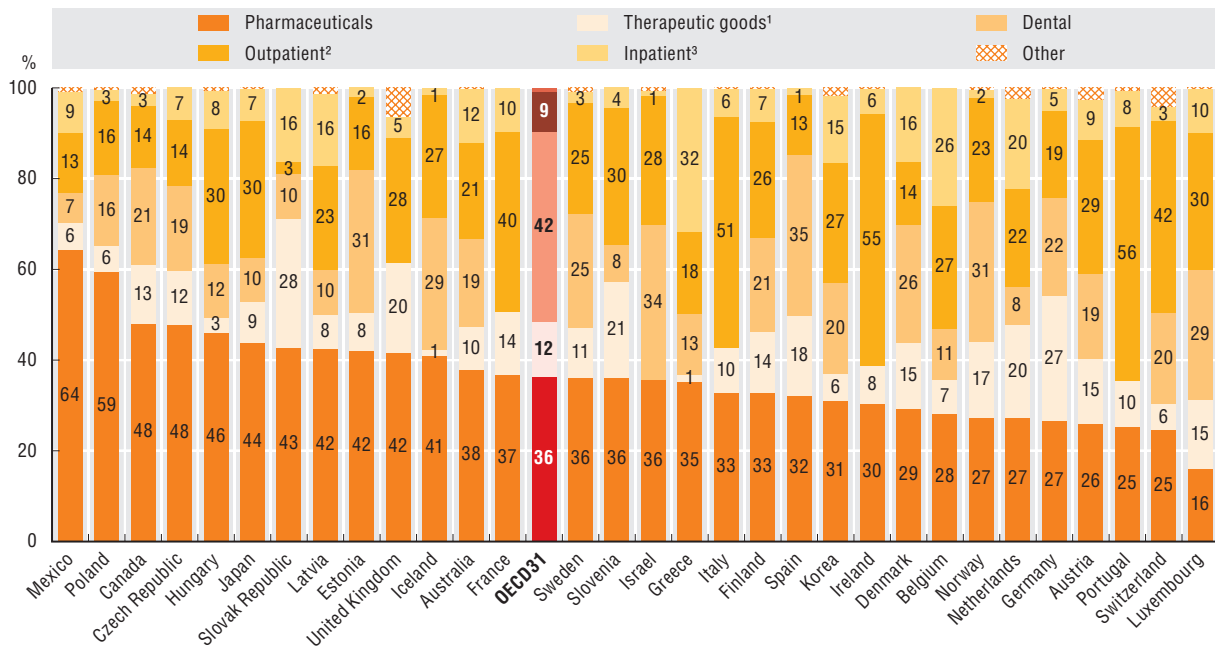
5.7. Out-of-pocket medical spending as a share of final household consumption, 2015 (or nearest year)



Note: This indicator relates to current health spending excluding long-term care (health) expenditure.
Source: OECD Health Statistics 2017.

StatLink <http://dx.doi.org/10.1787/888933603222>

5.8. Out-of-pocket medical spending by services and goods, 2015 (or nearest year)



Note: This indicator relates to current health spending excluding long-term care (health) expenditure.
1. Including eye care products, hearing aids, wheelchairs, etc.
2. Includes home care and ancillary services (and dental if not shown separately).
3. Including day care.
Source: OECD Health Statistics 2017.

StatLink <http://dx.doi.org/10.1787/888933603241>



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