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Belgian Healthcare: Overview of the Health System and Financing

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Introduction

Total healthcare expenditures, both public and private, are increasing every year in most western industrialised countries with extended social security systems, and comprise approximately one-tenth of the Gross Domestic Product (GDP) (van den Oever and Volckaert 2008). The underlying determinants of this continuous growth in the costs of healthcare are well-known and similar around the world. Most noted are:

- An aging population;
- Development of new medical technologies;
- Increased influence of mass media and the internet (responsible for creating high expectations among patients in relation to modern medicine and its' ability to care for and cure complex lifethreatening conditions); and
- Increasing personnel costs (healthcare is a costly and labour-intensive sector) (Annemans 2007)

As demands on healthcare increase in general, so too does the demand for care within hospitals' emergency rooms and Intensive Care Units (ICUs). With the increased numbers of aging patients and the strain of global pandemics, a substantial portion of patients will need 24-hour monitoring, causing the ICU to play a central role. As such, the ICU consumes a significant fraction of hospital resources, and consequently of the total healthcare budget (estimated around 1% of the GDP) (Fein 1993; Vandijck et al. 2007).

In 2009, the Belgian population reached 10.5 million, and with its 341 inhabitants per square kilometre, it is one of the most densely populated countries in Europe. Average life expectancy at birth is 80.4 years, and main causes of death are cardiovascular diseases, cancer, traffic accidents and suicides

www.statbel.fgov.be, www.iph.fgov.be/epidemi/epinl/inegalnl/index.htm

Belgian Context: Organisation and Financing of the Health System

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The Belgian healthcare system is mainly organised on two levels: The federal and regional levels. Responsibility for healthcare policy is shared between the federal government, the Federal Public Service Social Security, the National Institute for Sickness and Disability Insurance (INAMI), and the Dutch-, French-, and German-speaking community Ministries of Health. The federal government is responsible for regulating and financing the compulsory health insurance, determining accreditation criteria, financing hospitals and so-called 'heavy' medical care units, as well as legislation covering different professional qualifications, and registration of pharmaceuticals and their price control. The regional governments are responsible for health promotion, maternity and child health services, some aspects of elderly care, implementation of hospital accreditation standards, and financing of hospital investment.

Nowadays, healthcare expenditure as a percentage of GDP in Belgium is about 10%, and expressed in USD purchasing power parity per capita is about 3000, which is the fifth highest healthcare expenditure among all 27 European Union countries (www.oecd.org), and a further 4.5% increase is expected over the following years (OECD, 2003). The Belgian health system is primarily funded through social security contributions and taxation. Public sector funding as a percentage of total expenditure on healthcare fluctuates around 70%.

The Belgian health system is based on the principles of equal access and freedom of choice, with a Bismarckian-type of compulsory national health insurance, which covers the whole population and has a very broad benefits package. Compulsory health insurance is combined with a private system of healthcare delivery, based on independent medical practice, free choice of service provider and predominantly fee-for-service payment (van den Oever and Volckaert 2008). All individuals entitled to health insurance must join or register with a sickness fund. Belgian sickness funds receive a prospective budget from the INAMI to finance the healthcare costs of their members (www.riziv.fgov.be). They are held financially accountable for a proportion of any discrepancy between their actual spending and their so-called normative, that is, risk-adjusted, healthcare expenditures. The reimbursement of services provided depends on the employment situation of the patient, the type of service provided, the statute of the person who is socially insured, as well as the accumulated amount of user charges already paid (Nonneman and van Doorslaer 1994).

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Patients in Belgium participate in healthcare financing via co-payments, for which the patient pays a certain fixed amount of the cost of a service, with the third-party-payer covering the balance of the amount, (i.e. the practice of an insurer (third party) paying providers (second party) directly for services rendered instead of the patient); and via co-insurance for which the patient pays a certain fixed proportion of the cost of a service and the third-party-payer covers the remaining proportion.

There are, respectively, two systems of payment:

- 1) A reimbursement system for which the patient pays the full costs of services and then obtains a refund for part of the expense from the sickness fund, which covers ambulatory care; and
- 2) A third-party-payer system for which the sickness fund directly pays the provider while the patient only pays the co-insurance or co-payment, which covers inpatient care and pharmaceuticals.

In Belgium, in 2005, there were 215 hospitals, of which 146 were general and 69 psychiatric. The general hospital sector consists of acute (116), specialised (23) and geriatric (7) hospitals (Gemmel and Vandijck, 2005). The basic feature of Belgian hospital financing is its dual remuneration structure according to the type of services provided: Accommodation, emergency admission, and nursing activities in the surgical department are financed via a fixed prospective budget system based on diagnosis-related groups; while medical and medicotechnical services such as consultations, laboratories, medical imaging, technical procedures, and paramedical services are remunerated via a fee-for-service system to the service provider.

Although the Belgian healthcare system has not undergone major structural reforms for several decades, various measures have been taken mainly to improve its performance (Corens 2007). Reform policy in recent years has included:

- Hospital financing reform;
- Strengthening primary care;
- Restriction of the supply of physician;
- Promotion of generic substitution of pharmaceuticals;
- Increase of accountability of healthcare providers and sickness funds;
- Tariff cuts; and
- Supplementary emphasis on: Quality of care, equity, evidence-based medicine, healthcare technology, benchmarking with financial consequences and health economic evaluations.

Future Changes

Future health reforms are likely to build on recent reforms and achievements. Changes in provider payment methods (i.e. diagnosis related groups) may improve providers' accountability and increase efficiency. Primary care could be strengthened by the general application of the Global Medical File and the introduction of financial incentives to enable general practitioners to play a more central role in the health system and to promote other forms of primary healthcare, such as home care. Physicians could be rewarded for improved prescribing. One area could include prescribing targets for generics, which is an example of not only cost savings, but also quality improvements in prescribing practices.

Finally, an increased and sustained focus on quality is likely to be a significant element in healthcare policy-making.

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