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Health and IC in Belgium

Authors

On behalf of the Belgian

Society of Intensive Care Medicine

Koenraad Hendrik

D.K. Vandewoude

Dept.of Intensive Care,

Centre for Solid Organ Transplantation

Ghent University Hospital

Patrick Ferdinande

MD, PhD, Department of Intensive Care,

Universitaire Ziekenhuizen Leuven – Campus Gasthuisberg

Christiaan Decoster

Master in Law,

Director-general - Directorship Healthcare

Facilities Organisation, Federal Public Service for Public Health,

Safety of the Food Chain and Environment, Belgium

Correspondence

koenraad.vandewoude@ugent.be

Dr Vandewoude and colleagues introduce the Belgian healthcare system and organization of intensive care.

Introduction

Belgium is in north-west Europe, covers about 30,500 km 2, and is a parliamentary, representative, constitutional monarchy. There are three official languages: Dutch (spoken by the Flemish, about 59.2% of the population), French (40.2%) and German (0.6%). Through constitutional reforms since 1970, Belgium has become a federal state with three separate regions (the Flemish, Walloon and Brussels-Capital), and three communities: Flemish, Walloon and German. The regions are responsible for territorial matters (e.g. agriculture, transport infrastructure); the communities are responsible for people- rather than territory-related policies (e.g. education, culture, healthcare and social support). Each region and community has a government and a legislative council. The federal authorities remain competent for matters surpassing regions and communities, including the major part of healthcare.

The Belgian population in 2001 was 10,309,725 with a population density of about 315/km 2. The chief causes of death for adults are cardiovascular disease and cancer. Life expectancy at birth is 81.0 for women and 74.3 years for men (1997). Within the EU, Belgium has one of the highest proportions of populations aged over 60, and the number of teenagers is declining. Key healthcare indicators are summarized in table 1. The Gross Domestic Product (GDP) comes to $316.2 billion (2004) or $30508.31 per capita. Total healthcare cost represents 9.6% of GDP (2003), about 1% higher than the mean value in the Organization for Economic Co-operation and Development (OECD) countries, but less than

in the US, Canada and the surrounding countries.

Healthcare

During and after the Second World War, the Belgian Government developed a well organized healthcare system, in close co-operation with all stakeholders (employers, employees and “mutualities” or statutory sickness funds). healthcare insurance is compulsory. Each citizen and resident has easy access to all facilities and waiting lists are almost non-existent. Medical practice is independent, with a free choice of healthcare provider by the patient, and fee-for-service payment of providers with reimbursement by the public insurance via the mutualities

In 1963, the National Fund for Sickness and Invalidity Insurance (RIZIV-INAMI) was founded, with a strict separation of insurance system for medical care from that for invalidity. Financial and administrative agreements between mutualities and the healthcare providers are regulated by law. A fee schedule, by which different medical acts were given a price and a reimbursement rate, was established. INAMI-RIZIV oversees the general organization of the compulsory healthcare insurance, but the task of providing insurance falls to the mutualities (statutory sickness funds). Mutualities are private non-for-profit bodies, but have a public interest mission. They are active members of both the executive and advisory committees of INAMIRIZIV. The Medical Care Service is managed by the General Council and an Insurance Committee. In the General Council, decision-making power is shared between contributors to the financing system (government, employers and employees) and its managers (the mutualities). The Insurance Committee is made up of representatives of insurers and healthcare providers.

Each function of intensive care has a charge nurse, holder of the special professional competence in intensive care and emergency medicine, and the nurse to patient ratio per shift is at least 1:3. At least 50% of the nurses should hold the special professional competence in intensive care and emergency medicine. The law provides that intensive care units should be operating in a closed format in Belgium, but in reality most physicians have only a part time activity in intensive care and have other occupations in the operating theatre, the cardiology department and elsewhere.

Training and accreditation of intensive care physicians is regulated by the Ministerial Decree (MD) of October 5th, 1995, setting standards to obtain a special professional competence certification in intensive care. In Belgium, intensive care and emergency medicine are two distinct professional competences. Specialists in anaesthesiology, internal medicine, cardiology, pneumology paediatrics, and surgery (including plastic surgery, neurosurgery, orthopaedic surgery and urology) and neurology can obtain the special professional title after a training of two years in an accredited hospital intensive care service, including a 6 months training in an emergency care service. Usually, a part of this training is done in a tertiary care university hospital. Reaccreditation is not required, but the title can only be retained if the principal professional activity is devoted to intensive care.

The Royal Decree of February 15th, 1999 provides regulations for internal and external audit of medical activity in hospitals, and establishes the Federal Board of Physicians for the Function of Intensive Care. This Board is commissioned to determine quality indicators and for medical practice, infrastructure and staffing. All hospitals with intensive care facilities should cooperate with the Board for the registration of data based on predetermined indicators. The Board organizes nationwide surveys on quality, resulting in annual reports on predefined topics. In these reports, the Board can formulate specific recommendations for healthcare practitioners and also for healthcare policy makers. The annual reports also serve for benchmarking between intensive care facilities.

In 2002, the Federal Board set up a survey on ICU infrastructure, staffing and equipment. 54% of all accredited intensive care facilities participated in this inquiry, representing 988 ICU beds in Belgium. General information on ICUs in Belgium is summarized in table 2. The number of available beds in a Belgian ICU varies from 6 to 54; 1.63 to 5.56% of total hospital beds are dedicated to intensive care. Data on staffing are reported in table 3. The average ICU physician to ICU bed ratio is 1:6.56 ± 3.59, with more physicians in tertiary teaching hospitals. The generally accepted minimal nurse-to-patient ratio of 1:2 has not yet been achieved, but this correlates with the finding that about half of the admitted patients do not have a strict ICU profile, and hence do not require complex supportive care.

Conclusion

As in other developed countries, intensive care medicine in Belgium has developed from coronary and complex postoperative care units to the present well organized units for critically ill patients. In the context of the Hospital Law of 1963, intensive care structure and staffing has been provided by law since 1998.

The strict training requirements and accreditation standards for the professional medical and nursing competencies in intensive care guarantee a high level of qualification. Not all patients in intensive care facilities require complex intensive care, explaining a lower nurse-to-patient ratio than the international standard. Medical activity in intensive care is guarded by the Federal Board of Physicians for the Function of Intensive Care in a process of registration of quality indicators and peer review.

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