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The Belgian Healthcare System

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Belgium is a federal state. There are three levels of government: federal, regional (three regions and three communities) and local provinces and municipalities). The Belgian healthcare system is mainly organised on the federal and regional level.

The federal government is responsible for regulating the compulsory health insurance, determining licensing criteria for healthcare facilities, financing the operations of healthcare facilities, regulating qualifications of healthcare professionals and registration and price control of pharmaceuticals. Regional government tsare responsible for preventive care and health promotion, maternity and child health services, different aspects of elderly care, implementation of licensing criteria of healthcare facilities and financing of infra structure (within basic rules enacted at federal level).

In 2005, total health expenditure as a percentage of gross domestic product (GDP) was 9.7%. Public sector funding as a percentage of total expenditure on health care fluctuates around 70%.

Key features of the Belgian healthcare system are:

1. Compulsory health insurance, managed jointly by the major stakeholders of the sector (insurers, healthcare providers and public authorities)

2. Liberal ideas of medicine (majority of providers are self-employed, with predominantly fee-for-service payment) and

3. Freedom of patients to choose both their healthcare provider and their hospital.

Healthcare Financing and Expenditure

Compulsory health insurance is financed through employer and employee income contributions as well as through taxation. It covers the whole population and has a broad benefits package.

A public body endowed with legal personality, the National Institute for Sickness and Disability Insurance (RIZIV/INAMI), is charged with the implementation and control of the compulsory insurance scheme. All individuals entitled to health insurance must join or register with a sickness fund: either one of the six not-for profit and privately managed funds or a regional service of the public Auxiliary Fund for Sickness and Disability Insurance. Since 1995, Belgian sickness funds are held financially accountable for a small proportion of any discrepancy between their actual spending and their so-called normative, i.e. risk-adjusted, healthcare expenditures.

Patients participate in healthcare financing via co-payments (fixed amounts) and co-insurance (percentage of the overall charge). For ambulatory care, patients pay the full costs of services to service providers and afterwards receive a refund from the sickness fund. For inpatient care and pharmaceuticals there is a third-party payer system, which means that the sickness fund directly pays the provider, leaving the patient only to pay the co payment or co-insurance.

Healthcare Provision

In the mid-1990s a supply planning system was established for healthcare providers. A quota mechanism is applied immediately after basic training, at the moment of application for recognition as a dentist or physiotherapist and at the application for specialisation for a physician (GP or specialist). In order to achieve these objectives, the communities, which are responsible for education policy, were requested to limit the

number of medical and dental students. In 1997, the Flemish community introduced entrance examinations to limit the number of students entering medical schools. The French community has chosen to limit the number of medical students after their third year of medical education on the basis of the first three years' results.

Delivery of ambulatory care in Belgium is mainly private. The vast majority of physicians work as independent self-employed health professionals. Medical specialists can work in institutions (mostly hospitals) and/or on an ambulatory basis, in private practice. GPs mostly work in private practice. Because there is no referral system between these two different types of physicians, every citizen has free access to medical specialists and hospital care, even as the first point of contact with the health system.

Hospital care is provided either by private non-profit or by public hospitals. The hospital legislation and financing mechanisms are the same in both sectors. In 2005, there were 215 hospitals, of which 146 were general and 69 psychiatric. The basic feature of Belgian hospital financing is its dual remuneration structure according to the type of services provided: Services of accommodation (nursing units), emergency admission (accident and emergency services), and nursing activities in the surgical department are financed via a fixed prospective budget system based on diagnosis- related groups (DRGs); while medical and medico-technical services (consultations, laboratories, medical imaging and technical procedures) and paramedical activities (physiotherapy) are predominantly remunerated via a fee-for-service system.

Pharmaceuticals are exclusively distributed through community and hospital pharmacies. Only physicians, dentists and midwives can prescribe pharmaceuticals. About 2,500 pharmaceutical products are on a positive list and therefore partly or fully reimbursable. The reimbursable percentage of the cost varies depending on the therapeutic importance of the pharmaceutical.

Strengths, Weaknesses and Recent Reforms

The overall strength of the Belgian health system is that care is highly accessible and responsive to patients. The drawbacks of the Belgian system are in its cost and complexity. Although the system has not undergone any major structural reforms since the 1980s, various measures have been taken mainly to improve its performance. Reform policy included: hospital financing reform; strengthening of primary care; restriction of the supply of physicians; increase of accountability of healthcare providers and sickness funds; tariff cuts; and more emphasis on quality of care, equity, evidence-based medicine, healthcare technology, benchmarking with financial consequences and economic evaluations.

Prospects

Three recent policy initiatives are worth mentioning:

Until recently, a difference was made between a general scheme of social health insurance and a scheme for self-employed persons. The latter were only insured for major risks, which mainly coincide with hospital care. As from January 2008, this distinction has been abolished progressively. No difference is made any longer based on the professional situation of the insured.

A second reform concerns the introduction of a so called “maximum billing”. In Belgium, 5% of the patients consume 61% of the total social health insurance expenditure The same 5% are also charged 35% of the total amount of co-payments and co-insurance. In case of a long-term or serious illness, the financial burden can be high. Some years ago, the maximum billing-system was introduced as a solution to this problem. This reform aims to limit the healthcare cost of each family to a maximum amount per year that varies according to the income of the family the person belongs to. Nearly 10% of households are concerned with this reform.

A third reform area consists of pharmaceutical policy. To advance the use of generic pharmaceuticals, a reference pricing scheme was introduced for products with generic equivalents. Furthermore, a lump-sum reimbursement system for pharmaceuticals was introduced for in-hospital patients. And finally, the gross annual budget for pharmaceuticals is now established in consultation with the industry. If the budget is exceeded, a claw-back mechanism is applied and the pharmaceutical industry has to finance part of the overspending.

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