



# State of Health in the EU

# Belgium

## Country Health Profile 2017

## The Country Health Profile series

The *State of Health in the EU* profiles provide a concise and policy-relevant overview of health and health systems in the EU Member States, emphasising the particular characteristics and challenges in each country. They are designed to support the efforts of Member States in their evidence-based policy making.

The Country Health Profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by Member States and the Health Systems and Policy Monitor network.

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## Data and information sources

The data and information in these Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated in June 2017 to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 28 Member States unless otherwise noted.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following StatLinks into your Internet browser:  
<http://dx.doi.org/10.1787/888933593380>

## Demographic and socioeconomic context in Belgium, 2015

	Belgium	EU
Demographic factors	Population size (thousands)	11 274
	Share of population over age 65 (%)	18.1
	Fertility rate <sup>1</sup>	1.7
Socioeconomic factors	GDP per capita (EUR PPP <sup>2</sup> )	34 200
	Relative poverty rate <sup>3</sup> (%)	7.8
	Unemployment rate (%)	8.5

1. Number of children born per woman aged 15–49.

2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.

3. Percentage of persons living with less than 50% of median equivalised disposable income.

Source: Eurostat Database.

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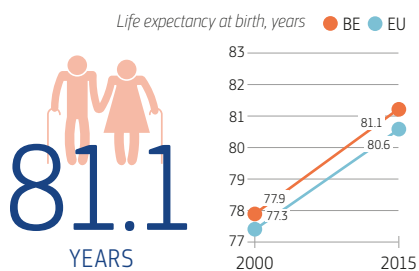
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# 1 Highlights

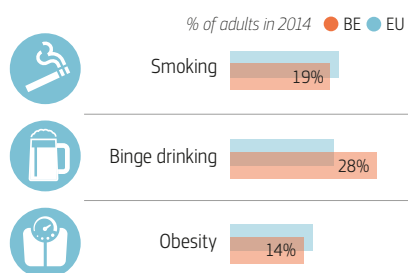
The health status of the Belgian people has improved since 2000. People live longer, although large disparities by gender and socioeconomic group remain. The Belgian health system performs well in saving the lives of people requiring acute care. One of the main challenges is to strengthen prevention and primary care to achieve further gains in population health and reduce health inequalities.

## Health status



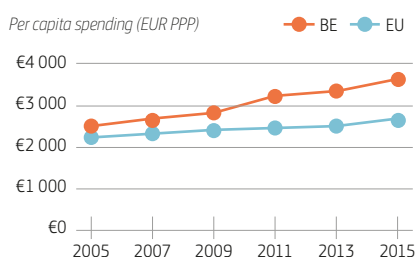
Life expectancy at birth was 81.1 years in 2015, up from 77.9 years in 2000 and remains above the EU average. Most of these gains in life expectancy were driven by reductions in mortality rates after age 65. However, at age 65, Belgian women can expect to live only about 50% of their remaining years of life free of disability and men about 60%.

## Risk factors



In 2014, nearly one in five adults in Belgium smoked tobacco every day. This is close to the EU average, but well above the best-performing countries (e.g. 12% in Sweden). Nearly three in ten adults report regular heavy alcohol consumption, well above the EU average. Obesity has gone up in Belgium: one in seven adults is now obese based on self-reported data (and nearly one in five, 19%, based on actual measures of height and weight).

## Health system

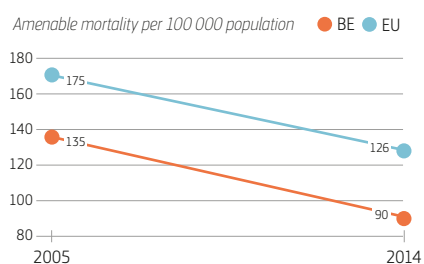


Health spending in Belgium increased steadily over the past 10 years and is higher than in most EU countries. In 2015, Belgium spent EUR 3 568 per capita on health care, compared to the EU average of EUR 2 797. This equals 10.5% of the Belgian GDP, up from 9.0% in 2005, and above the EU average of 9.9%. Public spending accounts for 77% of overall health spending (close to the EU average). Most of the remaining spending is paid directly out-of-pocket by households.

## Health system performance

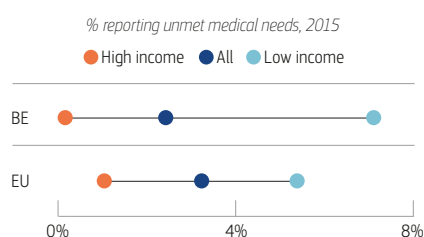
### Effectiveness

Amenable mortality in Belgium is lower than in most EU countries, indicating that the health care system is effective in treating people requiring acute care.



### Access

Access to health care in Belgium is generally good, but there are important disparities in unmet care needs by income group.



### Resilience

Efficiency in hospital care has improved, but the challenge is to strengthen prevention (which is mainly the responsibility of the three regions) and primary care. Addressing these challenges requires strong coordination across different levels of government based on common goals.



## 2 Health in Belgium

### The Belgian population enjoys a relatively high life expectancy

Life expectancy at birth in Belgium has increased by over three years since 2000 to reach 81.1 years in 2015, half a year more than the EU average, but it is lower than in most Western European countries (Figure 1).

A substantial gender gap in life expectancy persists in Belgium, with men living on average nearly five years less than women in 2015. However, no gender gap exists in the number of healthy life years, as women live a greater proportion of their lives with some disabilities.<sup>1</sup> At age 65, both women and men can expect

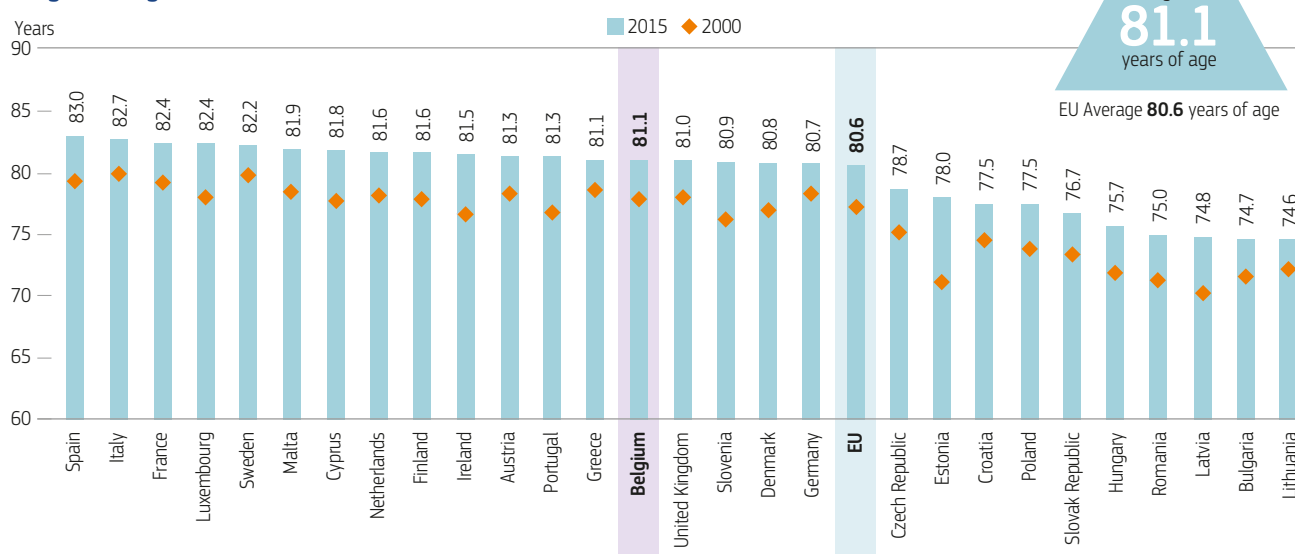
to live about 11 years free of disability, representing 50% of the remaining years of life for women and 60% for men.

There are also large inequalities in life expectancy by socioeconomic status. At age 50, Belgian men with the lowest level of education can expect to live about six years less than those with the highest education level. The gap among women is slightly smaller (about five years).<sup>2</sup>

1. 'Healthy life years' measures the number of years that people can expect to live free of disability at different ages.

2. Lower education levels refer to people with less than primary, primary or lower secondary education (ISCED levels 0–2) while higher education levels refer to people with tertiary education (ISCED levels 5–8). These data come from the Global Future Elderly Model.

**Figure 1. Life expectancy in Belgium is higher than the EU average, but lower than in neighbouring countries**

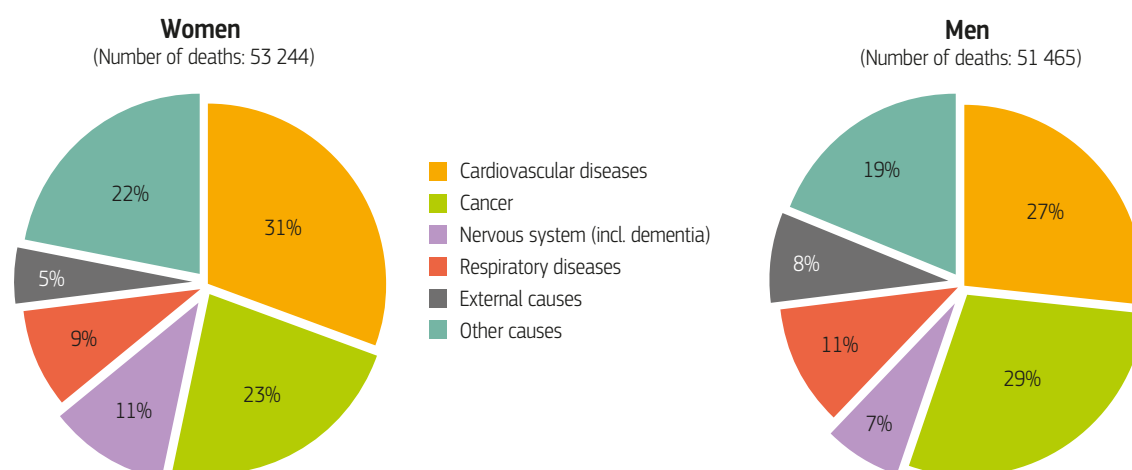


Source: Eurostat Database

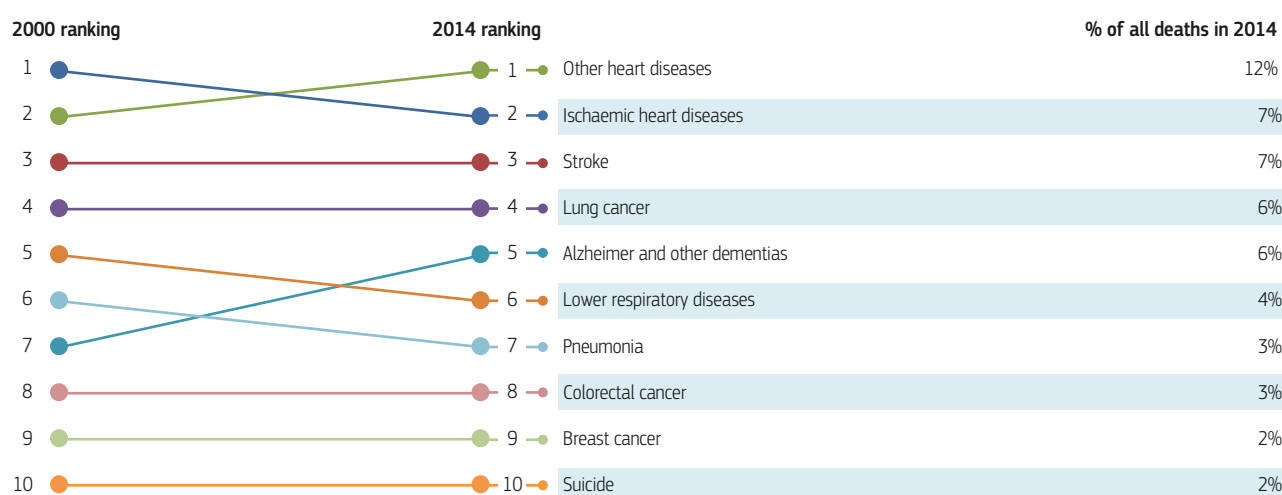
### Cardiovascular diseases and cancer are the leading causes of death

Cardiovascular diseases remain the leading cause of death among Belgian women and the second leading cause of death among men after cancer (Figure 2). In 2014, 30 260 people died from cardiovascular diseases (accounting for 31% of all deaths among women and 27% of all deaths among men), and over 27 200 people died from cancer (accounting for 23% of all deaths among women and 29% of all deaths among men).

Looking at trends in more specific causes of death, heart diseases (both ischaemic and others) and stroke continue to be the leading causes of death, but the number of people dying from Alzheimer's disease and other dementias has risen, reflecting the effect of population ageing, better diagnosis and lack of effective treatments, and changes in coding practices (Figure 3). Lung cancer is the main cause of cancer death, followed by colorectal cancer and breast cancer.

**Figure 2. Cardiovascular diseases and cancer account for most deaths in Belgium**

**Note:** The data are presented by broad ICD chapter. Dementia was added to the nervous system diseases' chapter to include it with Alzheimer's disease (the main form of dementia).  
**Source:** Eurostat Database (data refer to 2014).

**Figure 3. Heart diseases and stroke remain the leading causes of death in Belgium**

**Source:** Eurostat Database.

## Musculoskeletal problems, diabetes and depression are among the leading causes of poor health

In addition to the leading causes of mortality, musculoskeletal disorders (including low back and neck pain), diabetes and major depressive disorders are some of the leading determinants of disability-adjusted life years<sup>3</sup> (DALYs) in Belgium (IHME, 2016). Even if these conditions may not be fatal, they can have serious consequences on health-related quality of life and lead to various types of disabilities.

3. DALY is an indicator used to estimate the total number of years lost due to specific diseases and risk factors. One DALY equals one year of healthy life lost (IHME).

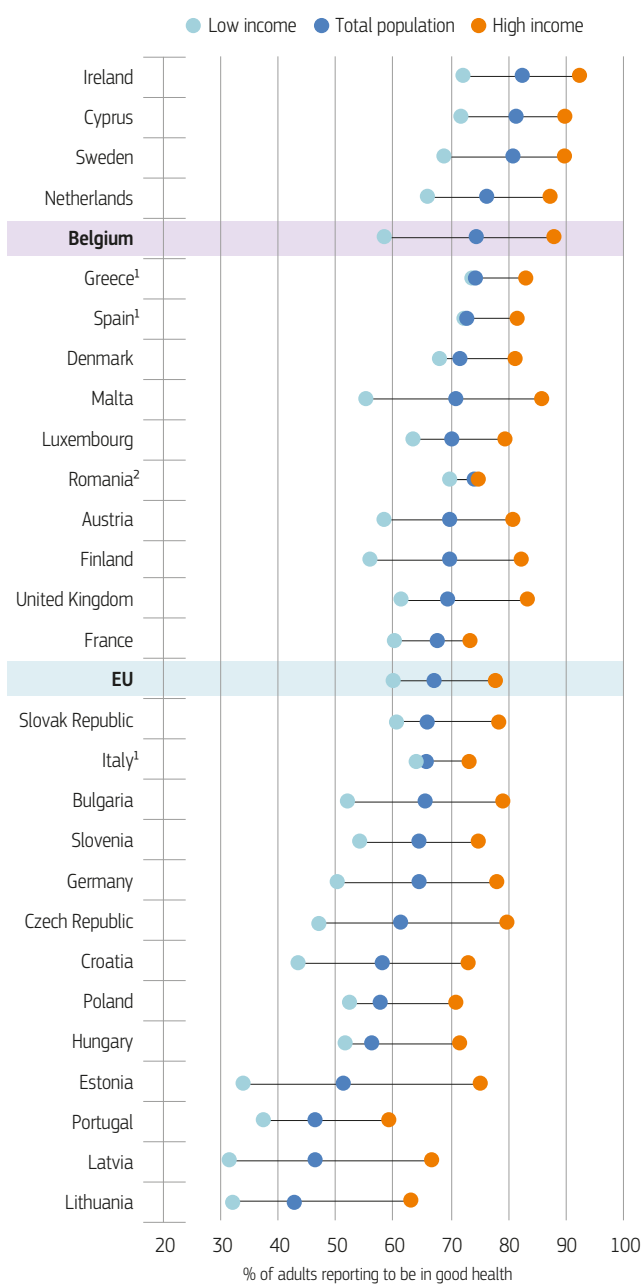
Based on self-reported data from the European Health Interview Survey (EHIS) in 2013, about one in twenty-three people in Belgium live with asthma, one in fourteen live with chronic depression (with the proportion among women being greater – one in twelve – compared to one in twenty among men), and more than one in twenty have diabetes. Wide disparities exist in the prevalence of these chronic diseases by education level, with the prevalence of asthma or other chronic respiratory diseases twice as high among people with the lowest level of education, compared with those with the highest level of education.<sup>4</sup>

4. Inequalities by education may partially be attributed to the higher proportion of older people with lower educational levels; however, this alone does not account for all socioeconomic disparities.

## Most Belgians report being in good health, but disparities by income group are larger than in many other EU countries

Almost three-quarters (74%) of the Belgian population report being in good health, a greater proportion than the EU average (67%). However, a large gap in self-rated health occurs by socioeconomic status: 88% of people in the highest income quintile report being in good health, compared with less than 60% for people in the lowest income quintile (Figure 4).

**Figure 4. Most people in Belgium report being in good health, but a large gap exists by income group**



1. The shares for the total population and the low-income population are roughly the same.

2. The shares for the total population and the high-income population are roughly the same.

**Source:** Eurostat Database, based on EU-SILC (data refer to 2015).

## 3 Risk factors

### Unhealthy lifestyles account for more than one-fourth of the overall burden of disease

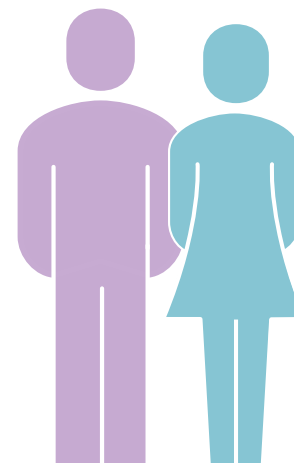
Based on estimations from the Institute for Health Metrics and Evaluation (IHME), 28% of the overall burden of disease in Belgium in 2015 (measured in terms of DALYs) can be attributed to behavioural risk factors – with smoking, alcohol use, dietary risks and lack of physical activity contributing the most (IHME, 2016).

### Smoking rates among adults and adolescents have been reduced substantially

Some progress has been achieved in reducing tobacco smoking in Belgium, following a number of tobacco control policies. The proportion of adults who smoke daily came down from 24% in 2001 to 19% in 2013, so that the smoking rate among adults in Belgium is now lower than in most EU countries (Figure 5). Regular smoking among 15-year-old adolescents also declined sharply in Belgium, from 23% in 2001–02 to 10% in 2013–14, and is also now lower than the EU average (14% in 2013–14).

### Excessive alcohol consumption affects nearly 3 in 10 adults

Alcohol-related harm is a major public health concern in Belgium, and only limited policy actions have been taken so far to address this issue (Section 5.1). In 2014, Belgium reported the second highest consumption of alcohol across the EU (after Lithuania), with a consumption of 12.6 litres per adult (compared to 9.9 litres on average across the EU). In contrast to most EU countries, overall alcohol consumption has increased in Belgium since 2000.



One major challenge is to reduce excessive alcohol consumption among adults: more than one-quarter (28%) of adults reported in 2013 regular heavy alcohol consumption (so-called binge drinking<sup>5</sup>), a higher percentage than the EU average (20%). Such heavy drinking is much more frequent among Belgian men than women (38% versus 18%). About 20% of 15-year-old adolescents reported having been drunk at least twice in their life in 2013–14, down from about 30% in 2001–02. This proportion is now lower than in most other EU countries and the EU average (25%).

## Obesity rates among adolescents and adults are rising, but are lower than in most EU countries

Obesity rates among adults increased in Belgium over the past decade. Based on self-reported data (which underestimate the true prevalence of obesity), one in seven adults (14%) were obese in 2013, up from one in eight (12%) in 2001.<sup>6</sup> This rate nonetheless remains lower than in most other EU countries (the EU average was 16% in 2014). Also based on self-reported data, one in six (16%) 15-year-olds were overweight or obese in 2013–14, up from one in nine (11%) in 2001–02. While this proportion also remains below the EU average, this rise is of particular concern given that being

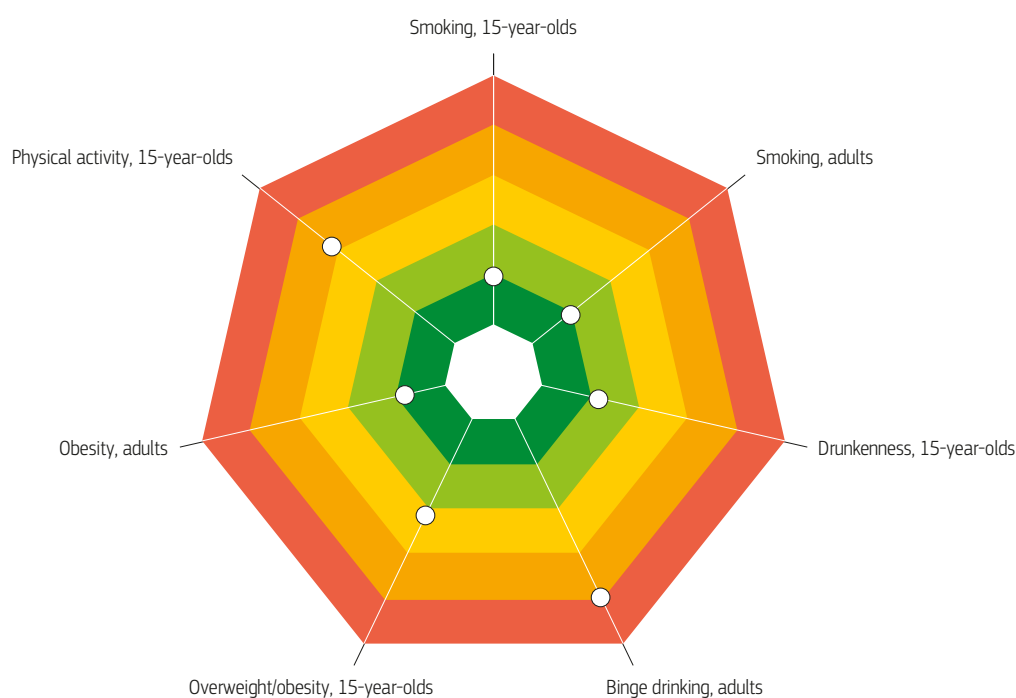
overweight or obese during childhood or adolescence increases the likelihood of becoming overweight or obese as an adult.

In 2013–14, only 13% of 15-year-old adolescents in Belgium reported doing at least moderate physical activity every day, a lower proportion than in most other EU countries. A large difference exists between girls and boys, with only 9% of 15-year-old girls reporting doing physical activity each day, compared to 17% of 15-year-old boys.

## Social inequalities in unhealthy lifestyles are large in Belgium

Many behavioural risk factors to health in Belgium are more common among populations with lower education or income. In 2014, almost a quarter of adults (23%) who had not completed their secondary education were daily smokers, compared to only 10% among those with a tertiary education. Likewise, almost 20% of people without a secondary education were obese, compared to only 10% among those with a higher education. A higher prevalence of risk factors among disadvantaged groups contributes to differences in health status between socioeconomic groups.

**Figure 5. Alcohol consumption and overweight and obesity among adolescents are important public health issues in Belgium**



5. Binge drinking behaviour is defined as consuming six or more alcoholic drinks on a single occasion, at least once a month over the past year.

6. Based on measured rates of obesity, almost one in five adults (18.6%) were obese in 2014.

**Note:** The closer the dot is to the centre the better the country performs compared to other EU countries. No country is in the white 'target area' as there is room for progress in all countries in all areas. Comparable data on physical activity among adults are not available for Belgium.

**Source:** OECD calculations based on Eurostat Database (EHIS in or around 2014), OECD Health Statistics and HBSC survey in 2013–14. (Chart design: Laboratorio MeS).

## 4 The health system

### Compulsory health insurance is nearly universal

The Belgian health system is characterised by the principle of compulsory insurance and achieves nearly universal coverage of the population (99%). Compulsory health insurance is executed through six private, not-for-profit national associations of sickness funds and one public sickness fund.

Federal authorities are responsible for regulating the compulsory health insurance and hospitals, setting minimum standards, legislating professional qualifications, and registering and controlling prices of pharmaceuticals. The federated entities (three regions and three communities)<sup>7</sup> are responsible for: health promotion and prevention; providing maternity and child health care, social services, community care as well as coordination and collaboration in primary health care and palliative care; and financing hospital investment.

The compulsory health insurance is managed by the National Institute for Health and Disability Insurance, which allocates a

7. The Flemish region, the Walloon region and the region of Brussels-Capital; plus the Flemish community, the French community and the German community.

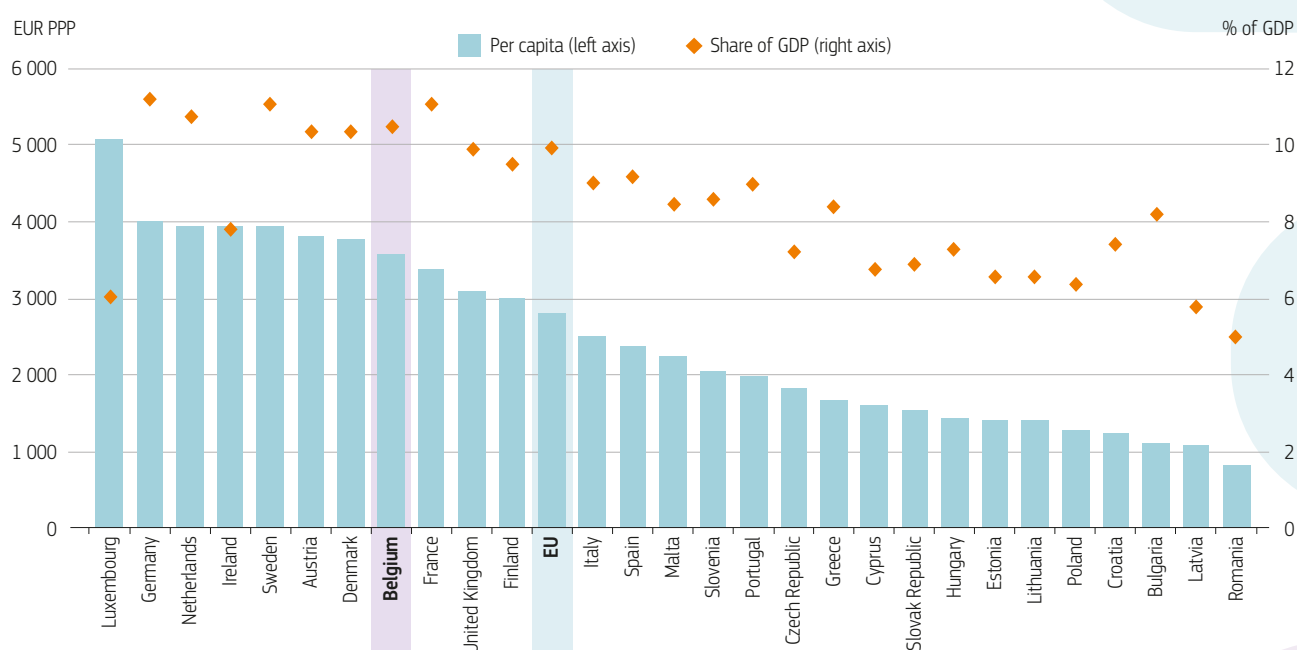
prospective budget to the sickness funds to finance the health care costs of their members. To facilitate cooperation and coordination between the federal authorities and the federated entities, inter-ministerial conferences are regularly organised (Gerkens and Merkur, 2010).

### An annual 'growth norm' guarantees the financial sustainability of the health budget

Belgium spends a relatively high proportion of its GDP on health – 10.5% in 2015 (compared with an EU average of 9.9%). On a per capita basis, this amounts to EUR 3 568 (adjusted for differences in purchasing power), the eighth highest level among EU countries (Figure 6). Public expenditure makes up 77% of overall health expenditure (roughly equal to the EU average), while direct out-of-pocket payments account for most private spending (18% of overall health spending) and private health insurance for a much smaller proportion (5% of the total).

Public financing is based mostly on social security contributions and, to a lesser extent, on general government revenues coming from progressive income taxation of individuals and companies, and other ('alternative financing') sources including earmarked value-added taxes and other sources.

**Figure 6. Health spending in Belgium is higher than the EU average**



Sources: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2015).



The health budget is fixed by a legal real growth norm, which was set at 4.5% from 2004–12, 2% in 2012, 3% in 2013 and 2014, and down to 1.5% since 2015. In practice, this annual growth norm means that the health budget is guaranteed. It helped cushion the impact of the economic crisis because the allocated health budget tended to be greater than the actual expenditure, thereby creating a surplus over many years (except 2012). Since 1995, to encourage cost containment, sickness funds have to fund 25% of the deficit out of their own reserves in case of over-spending (up to a maximum of 2% of their total budget).

A reform of the funding mechanisms of social security programmes including health care was adopted by the Belgian Parliament at the end of March 2017. Beyond tightening the cost-control mechanisms, this reform will also shift some of the tax burden from social security contributions to other revenue sources such as value-added taxes (Box 1).

#### BOX 1. RECENT REFORM OF FUNDING MECHANISMS FOR SOCIAL SECURITY PROGRAMMES AND HEALTH CARE IN BELGIUM

In March 2017, the Belgian Parliament adopted parts of a new reform regarding the funding of social security programmes, including health care. This reform is designed among other things to better control the growth in public spending on health by promoting greater accountability among the social partners and to transfer some of the tax burden from social security contributions to other forms of taxation such as value-added taxes. The main elements of this reform include that:

- **Alternative financing sources** will exclusively include revenues from value-added taxes for health care
- **General government revenues** (which account for about 17% of overall funding) might be increased by an ageing coefficient under certain conditions (including that the real growth of GDP exceeds 1.5% and that people leave the labour market at an older age on average)
- The so-called **'financial equilibrium contribution'** (provided by the federal government to offset any deficits) will depend on a set of macro-level accountability factors.

## Belgium has a low number of physicians, a high number of nurses, and quotas on medical graduates admitted to specialty training

The number of physicians per capita has been quite stable since 2000, whereas it increased in most other EU countries and is below the EU average; the number of nurses in Belgium has increased and is relatively high (Figure 7).

As in many other EU countries, Belgium applies a system of quotas (*numerus clausus*) to limit the number of trainees allowed to specialise as General Practitioners (GPs) and specialists, as well as dentists. The three Communities are responsible for the sub-quotas of trainees allowed to enter into specific medical specialties, and organise exams at the beginning of medical and dental education to limit the number of students entering these programmes each year. The other health professionals have planning systems but without strict regulation concerning the number of students admitted each year.

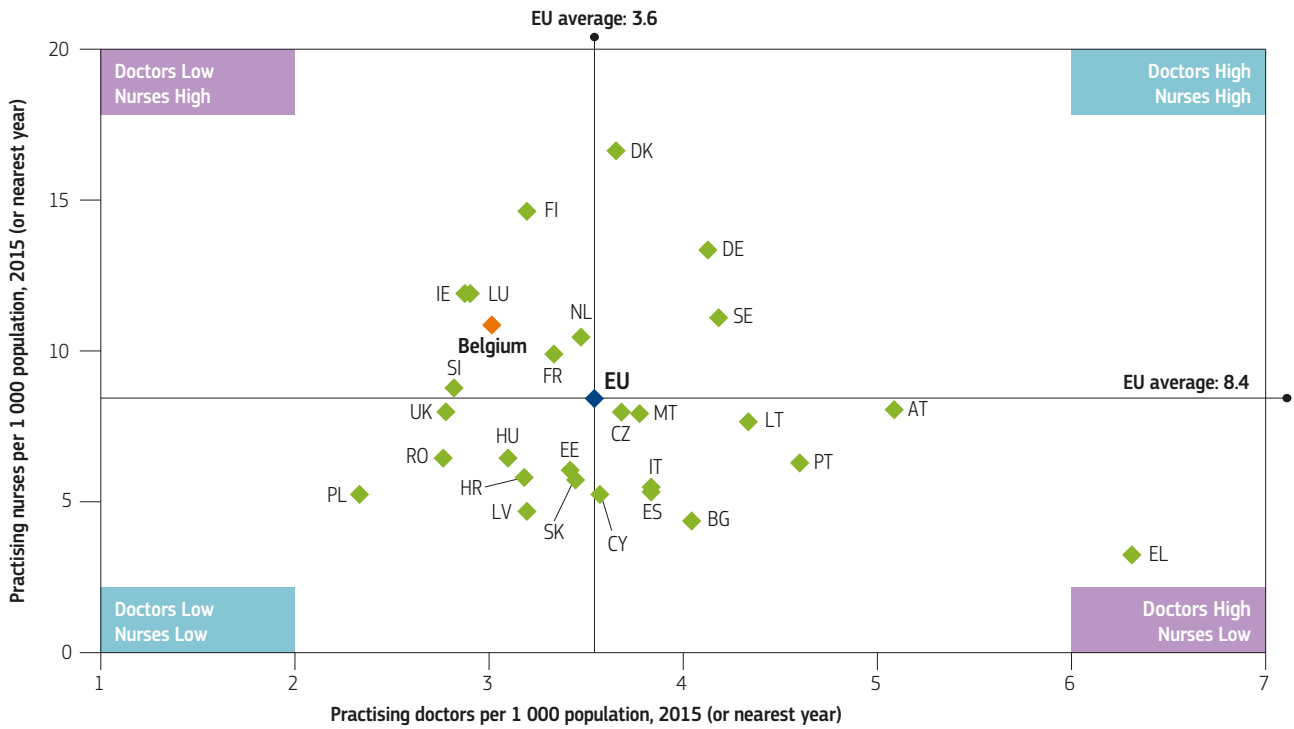
## Belgium has many hospital beds, but admission rates and average length of stay are close to the EU average

Many different types of hospitals exist in Belgium, including general acute care hospitals (115), specialised hospitals (20), geriatric hospitals (8) and psychiatric hospitals (68). Overall hospital admission rates are close to the EU average, and so is the average length of stay (7.8 days in Belgium versus 8.0 days for the EU average). The number of hospital beds has declined steadily in Belgium, though it remains higher than the EU average (619 versus 515 total hospital beds per 100 000 population in 2015, and 565 versus 418 curative care beds per 100 000 population).

## Patients enjoy freedom of choice, and primary care is delivered mainly by self-employed doctors

Health service provision is characterised by the principle of freedom of choice for patients, and primary care doctors are mainly self-employed workers working in solo practices and paid fee-for-services. Because there is no systematic gatekeeping by GPs, people have free access to medical specialists and hospital care. Nevertheless, the average number of physician contacts per person is not greater than the EU average.

Figure 7. Belgium has fewer doctors per capita than the EU average but more nurses



**Note:** In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. by around 30% in Portugal). In Austria and Greece, the number of nurses is under-estimated as it only includes those working in hospital.

**Source:** Eurostat Database.

Several features of the health care delivery system contribute to enhancing the availability of services in Belgium. For example, home visits to patients by GPs are a regular practice and patients do not usually have to wait long to get access to GPs, although waiting times for more specialised services (e.g. mental health specialists, ophthalmologists, dermatologists) can be longer. Nurses also play a key role in providing home care services to people with chronic diseases or disability.



## 5 Performance of the health system

### 5.1. EFFECTIVENESS

#### Belgium's relatively low level of amenable mortality suggests an effective health care system

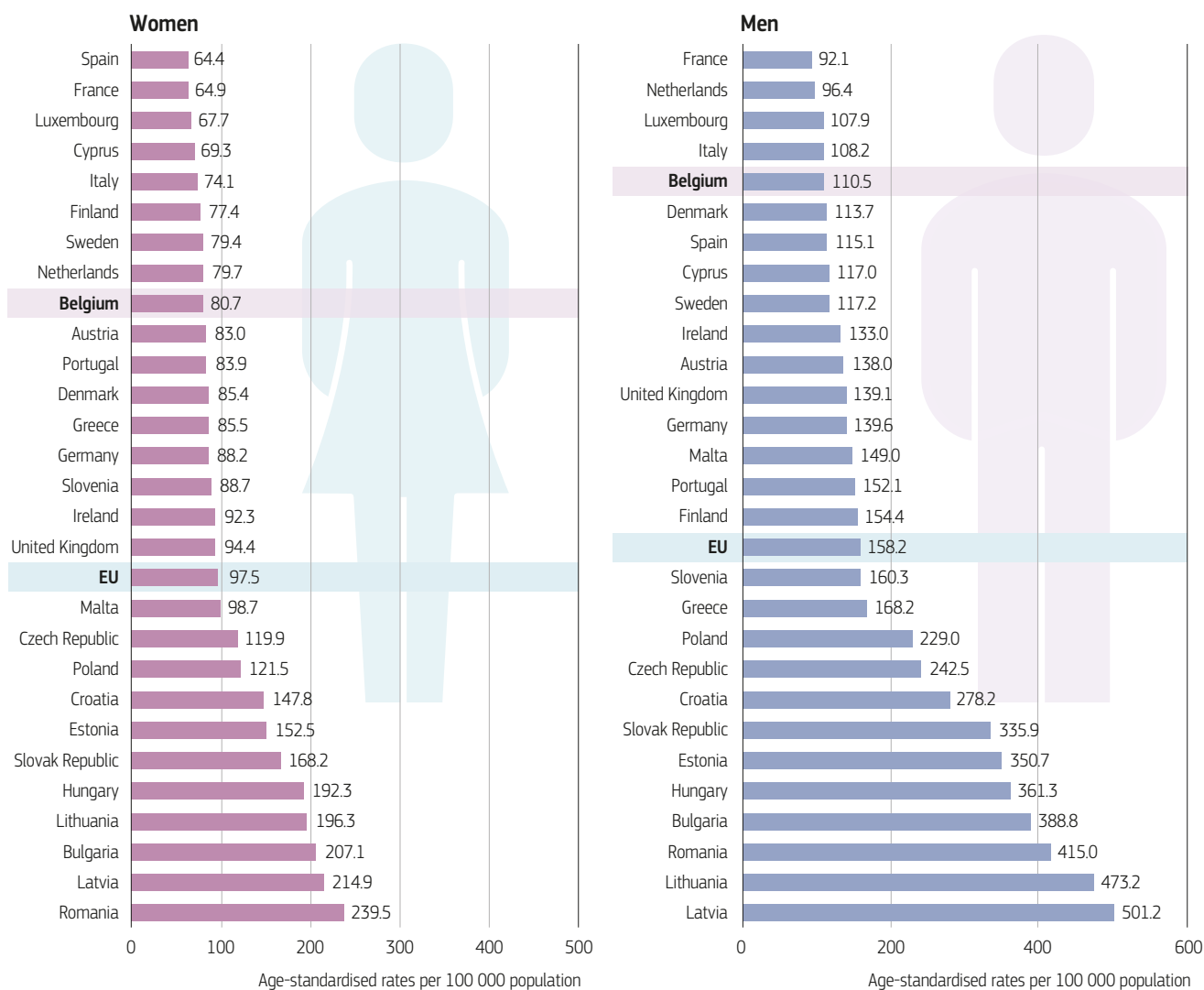
Belgium has a relatively low rate of amenable mortality<sup>8</sup> among men and women, suggesting that the health care system is effective in treating people with acute life-threatening conditions (Figure 8). This good performance is due mainly to low mortality rates from ischaemic heart diseases and stroke.

8. Amenable mortality is defined as premature deaths that could have been avoided through timely and effective health care.

#### The quality of acute care for cardiovascular diseases is better than the EU average

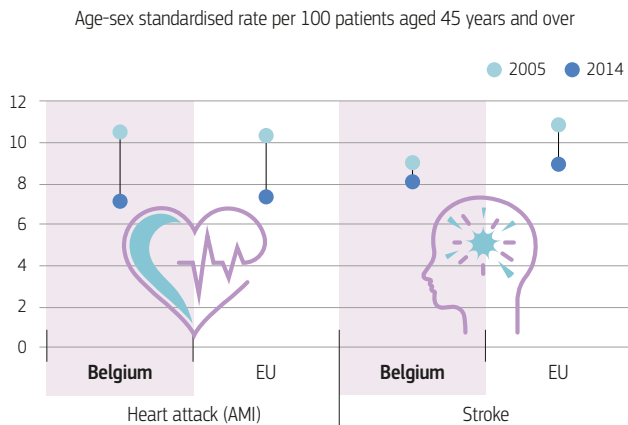
Substantial progress has been achieved in Belgium over the past decade in saving the lives of people admitted to hospitals for an acute myocardial infarction (AMI) and to a lesser extent for stroke. The proportion of patients dying following an admission for AMI fell from 10.4% in 2005 to 7.0% in 2014. For people admitted for stroke, it fell from 9.3% to 8.4% (Figure 9). These improvements reflect a number of changes, including better access to high-quality acute care for AMI and stroke, more rapid transportation of patients to the hospital, and the development of specialised units to treat these serious conditions (OECD, 2015).

Figure 8. Amenable mortality rates in Belgium are lower than in other EU countries



Source: Eurostat Database (data refer to 2014).

**Figure 9. Mortality rates following hospital admission for heart attack and stroke decreased in Belgium**



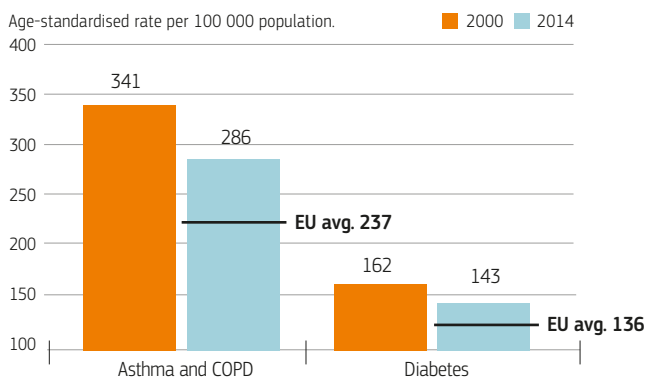
**Note:** These data relate to 30-day mortality rates in the hospital where the patient was admitted. They were age-sex standardised to the 2010 OECD population aged 45+ admitted to hospital for AMI (heart attack) and ischaemic stroke. The EU average is based on the unweighted average of 22 countries with data available in 2005 and 2014 (or nearest year).

**Source:** OECD Health Statistics 2017.

## Potentially avoidable hospitalisations for chronic conditions are above the EU average, suggesting shortcomings in primary care

Avoidable hospital admissions for chronic conditions, such as asthma, chronic obstructive pulmonary disease (COPD) and diabetes, were reduced in Belgium over the past decade, but still remain higher than the EU average (Figure 10). This signals some shortcomings in the effectiveness of primary care. New care pathways for people with diabetes and end-stage renal disease are being developed, involving GPs, specialists and other health care providers.

**Figure 10. Avoidable hospital admissions for chronic conditions declined in Belgium, but remain higher than the EU average**



**Note:** The EU averages are based on 24 countries (unweighted averages).

**Source:** OECD Health Statistics 2017.

## Cancer mortality may be reduced further through greater prevention and early detection

The quality of cancer care in Belgium, as measured by five-year survival for treatable cancers such as breast cancer, cervical cancer and colorectal cancer, is better than the EU average (OECD/EU, 2016).

However, further progress in reducing cancer mortality can be achieved through greater prevention and early diagnosis. In the early 2000s, Belgium introduced a breast cancer screening strategy as well as cancer care programmes to improve the organisation and delivery of cancer care. In 2008, the governance of cancer care was strengthened through the introduction of a national cancer plan that included a focus on prevention, early diagnosis and treatment, setting specific targets in these areas, and allocating additional funding to achieve these targets.

The available data on participation rate in cancer screening programmes are quite outdated. These data show that only about 60% of women in the target age group (aged 50–69) in 2010 were screened for breast cancer over the two previous years, and only 54% of women aged 20–69 in 2012 were screened for cervical cancer over the three previous years.<sup>9</sup> On a more positive note, the coordination of care for cancer patients in hospitals has improved through greater implementation of multidisciplinary team meetings to ensure continuity between different care providers (Vrijens et al., 2016).

## Recent prevention policies focus on healthier nutrition, but alcohol control policies could be strengthened

Responsibilities for health promotion and disease prevention in Belgium rest mainly with the three Communities. In 2014, the overall expenditure for public health and disease prevention in Belgium accounted for only 2.1% of overall health expenditure, a lower share than the EU average of 3.0%.

In Belgium as in other countries, an important policy issue relates to how to improve the lifestyle of the most disadvantaged people. Health literacy is also characterised by the same socioeconomic gradient that characterises the prevalence of many important risk factors.

9. Self-reported data from the 2013 Belgian Health Interview Survey show higher rates: 76% for breast cancer screening and 69% for cervical cancer screening in 2013.

Recent health promotion campaigns were designed to promote further reduction in tobacco smoking, healthy eating and increased vaccination rates among target groups. Belgium implemented comprehensive smoking cessation services, and smoke-free policies were also implemented (WHO, 2015). As in many other countries, mass media campaigns were launched to promote the '5 a day' target for fruit and vegetable consumption. Belgium imposed a tax on sugar-sweetened beverages in 2016, as is the case in France and Finland, but abandoned a sugar tax on food products.

Regarding alcohol consumption, which is a major public health issue in Belgium (more than 1 400 people died from alcohol-related diseases in 2014, not including injuries and violent deaths related to alcohol), higher taxes are imposed on beer, wine and spirits than in neighbouring countries like France and Luxembourg, although other EU countries have higher taxes. However, beyond that, successive attempts to develop a comprehensive plan to tackle the high level of alcohol consumption have faced industry opposition. No legally binding regulations are in place on advertisement or sales promotion of alcohol, while such regulations exist in many other countries (OECD, 2015).

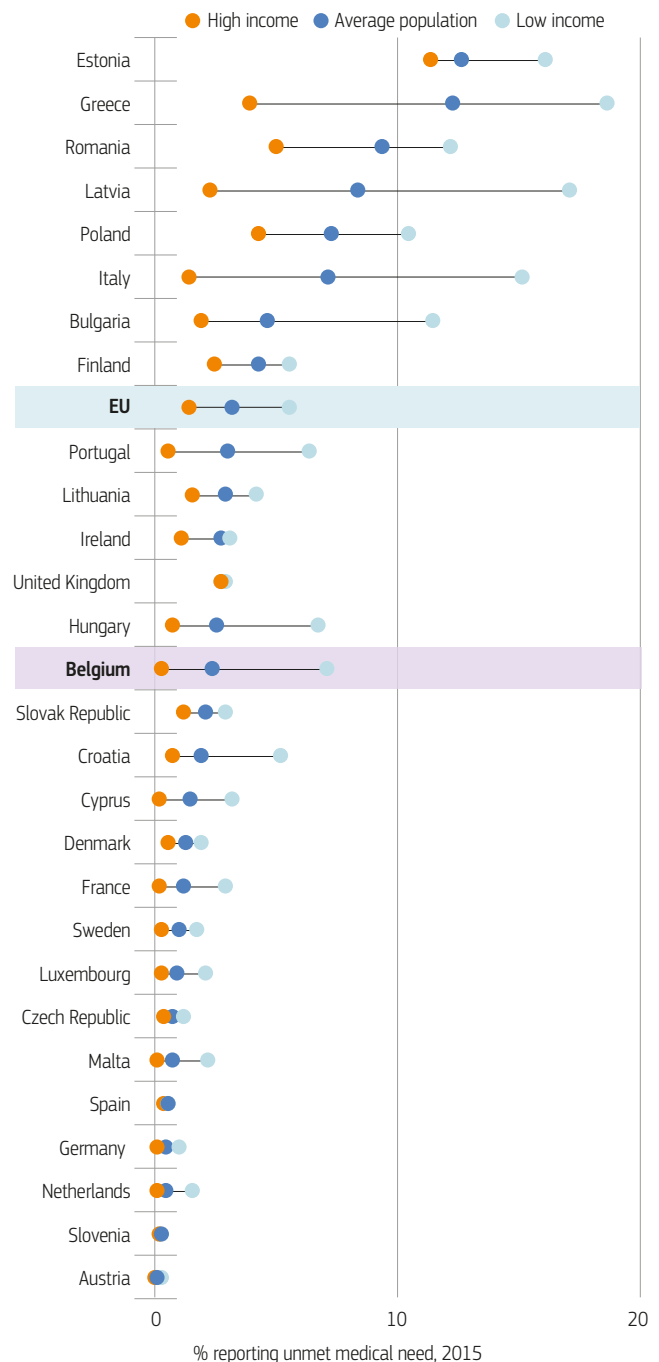
Belgium also faces the challenge of restoring public trust in the benefits of various types of vaccinations, including vaccination against influenza (flu). The percentage of people aged over 65 vaccinated against influenza fell over the past decade, from 64% in 2004 to 58% in 2013. This reduction moved Belgium farther away from achieving the target of 75% coverage set by both WHO and a 2009 EU Council Recommendation on vaccination rates among this population group. Lower vaccination coverage increases the risk for older people to get influenza and related complications that might lead to more hospitalisations or even deaths.

## 5.2. ACCESSIBILITY

### Unmet needs for health care vary widely by income group

As already noted, the Belgian statutory health insurance system provides almost universal coverage, with 99% of the population covered in 2015. Based on the EU-SILC survey, only 2.4% of the Belgian population reported some unmet needs for medical care for financial, geographic or waiting time reasons in 2015 (Figure 11). This proportion is lower than the EU average (3.6%), but there are substantial variations by income group: 7.2% of people in the lowest income group reported going without medical care when needed, while this proportion was close to zero (0.2%) among people in the highest income group.

**Figure 11. Few Belgians report unmet needs for medical care, but large disparities exist by income group**



**Note:** The data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.

**Source:** Eurostat Database, based on EU-SILC (data refer to 2015).

Data from EU-SILC show an increasing trend in unmet needs for medical care since 2011, especially among people with low income. The proportion of people in the lowest income group reporting going without medical care for financial, geographic or waiting time reasons rose from about 4% in 2011 to 7% in 2015. Most of these unmet needs were for financial reasons.

**BOX 2. PREFERENTIAL REIMBURSEMENT STATUS IN BELGIUM**

People receiving social benefits are automatically entitled to preferential reimbursement for health care services. Other people are entitled to preferential reimbursement on the basis of their taxable gross annual income (below EUR 16 965 + EUR 3 140 per dependent in 2013) and after the sickness funds have controlled that their income is below this threshold. In addition, patients with chronic diseases are subject to preferential reimbursement status and exempt from cost-sharing.

Up to 90% of medical costs are covered for people with preferential reimbursement status. Since January 2015, access to preferential reimbursement status is proactively proposed by sickness funds, because some people are not aware of their rights. This measure is designed to remove barriers to health care accessibility.

## Measures to reduce the impact of co-payments for vulnerable groups have been simplified

Patients in Belgium contribute to health care financing through official co-payments and various supplements. The reimbursement to patients for the costs of services depends on the type of service provided, the income and social status of the patient, and the accumulated amount of co-payments already paid in a given year (with a maximum ceiling on the total amount of co-payments per year). People with preferential reimbursement status have lower co-payments (Box 2).

In January 2015, the system of co-payments for medical specialist consultations was simplified: the amount was set at EUR 3 for people with preferential reimbursement and EUR 12 for people without such preferential reimbursement (previously this was calculated on a percentage basis).

For outpatient (or ambulatory) care, patients most often pay upfront the full fee and then claim reimbursement from their sickness fund. The third-party payment system is gradually being enlarged to improve access to ambulatory care, notably for vulnerable people. Since July 2015, patients with preferential reimbursement status only pay co-payments for GP consultations.

## Waiting times are short for GPs, but can be longer for other services

While waiting times to access a GP or elective surgery are generally short in Belgium, waiting times can be longer to get an appointment with a specialist. For example, in 2013, 38% of the population reported that they had to wait for two or more weeks to get an appointment with a specialist, and although this is short compared with other EU countries, about 10% of these people considered this waiting time as problematic. Waiting times for a first face-to-face contact with an ambulatory mental health centre can also be fairly long. In 2013, 37% of patients had to wait one month or more for a first contact with such centres (Vrijens et al., 2016).

### 5.3. RESILIENCE<sup>10</sup>

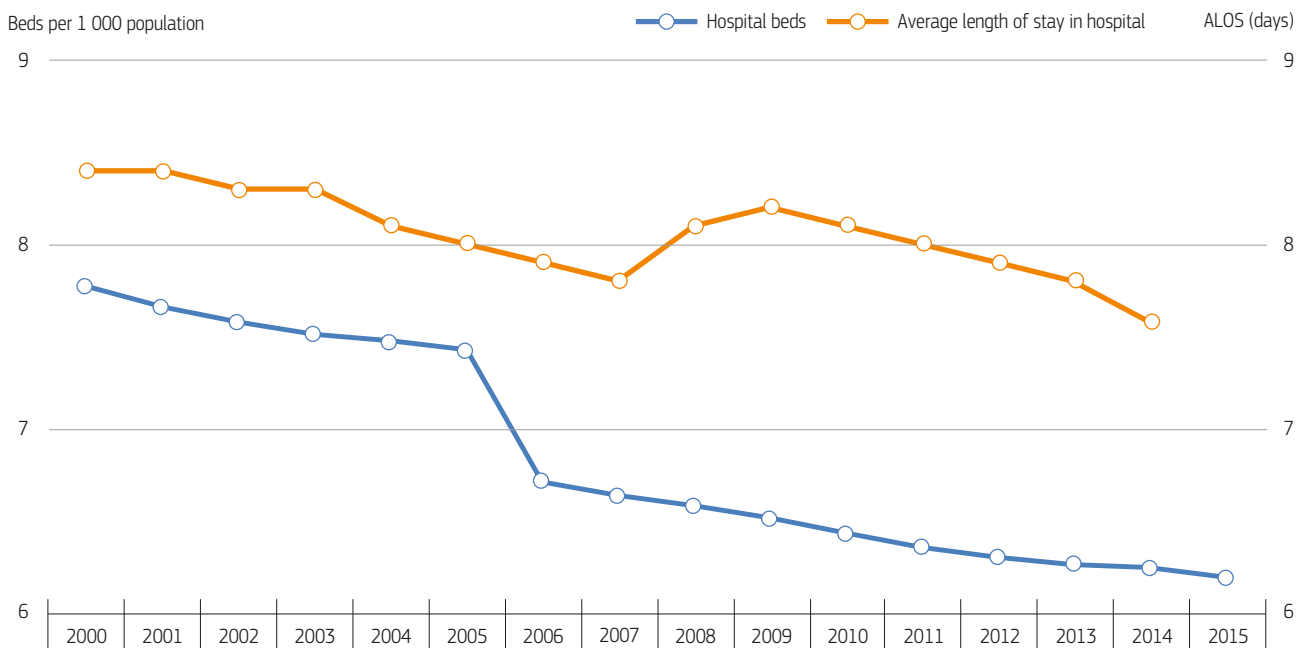
## The growth in public spending on health has been reduced by more than half in recent years

The marked slowdown in the growth of public spending on health in Belgium in recent years was part of broader efforts to reduce the growth in social security contributions and other taxes. As noted in Section 4, the legislated ceiling on public expenditure on health was reduced from a 4.5% growth rate per year from 2004–12, to 3% in 2013 and 2014, and down to 1.5% since 2015. This reduced growth rate was achieved through the implementation of a series of cost-containment measures that affected all spending categories, including hospital, pharmaceuticals and other spending items.

Looking ahead, the EPC Ageing Working Group projected in 2015, based on a number of assumptions regarding future gains in healthy life expectancy and economic growth, that public spending on health care might only increase marginally as a share of GDP between 2013 and 2060. However, public spending on long-term care was projected to increase much more rapidly, by 1.6% as a share of GDP between 2013 and 2060, driven mainly by population ageing (European Commission and Economic Policy Committee, 2015). One of the main challenges therefore will be to ensure that sufficient public funding is available to meet the growing needs for long-term care, while at the same time responding efficiently and equitably to the growing needs for health care.

10. Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises.



**Figure 12. Belgium's number of hospital beds and average length of stay reduced over the past decade**

**Note:** There is a break in the series of hospital beds in 2006 (when beds in psychiatric care institutions were excluded), explaining the large reduction in that year.

**Source:** Eurostat Database.

## Progress was achieved in improving hospital efficiency, but room for improvement remains

The reduction in hospital beds in Belgium since 2000 was accompanied by a reduction in average length of stay (Figure 12). Still, the overall number of hospital beds per capita in Belgium remains substantially higher than the EU average (619 versus 515 per 100 000 population in 2015), suggesting that there is further room for reductions by expanding day care, reducing avoidable admissions and reducing length of stays for certain conditions.

While the use of day surgery in Belgium is fairly widespread for certain operations (e.g. cataract), it still lags behind other countries for many other procedures. There are also large variations within Belgium in the use of day surgery across regions and hospitals, which suggest that a lot of room remains for further development. For example, the national average rate of day surgery for laparoscopic cholecystectomy was only about 6% during the period 2011–13, but this rate varied from 0% in many hospitals to 50% or more in some leading hospitals. A recent Belgian report suggested that it should be possible to reach a level of at least 40–50% of day care for laparoscopic cholecystectomy. The further development of day surgery in Belgium requires proper financial incentives along with greater clinical leadership (Leroy et al., 2017).

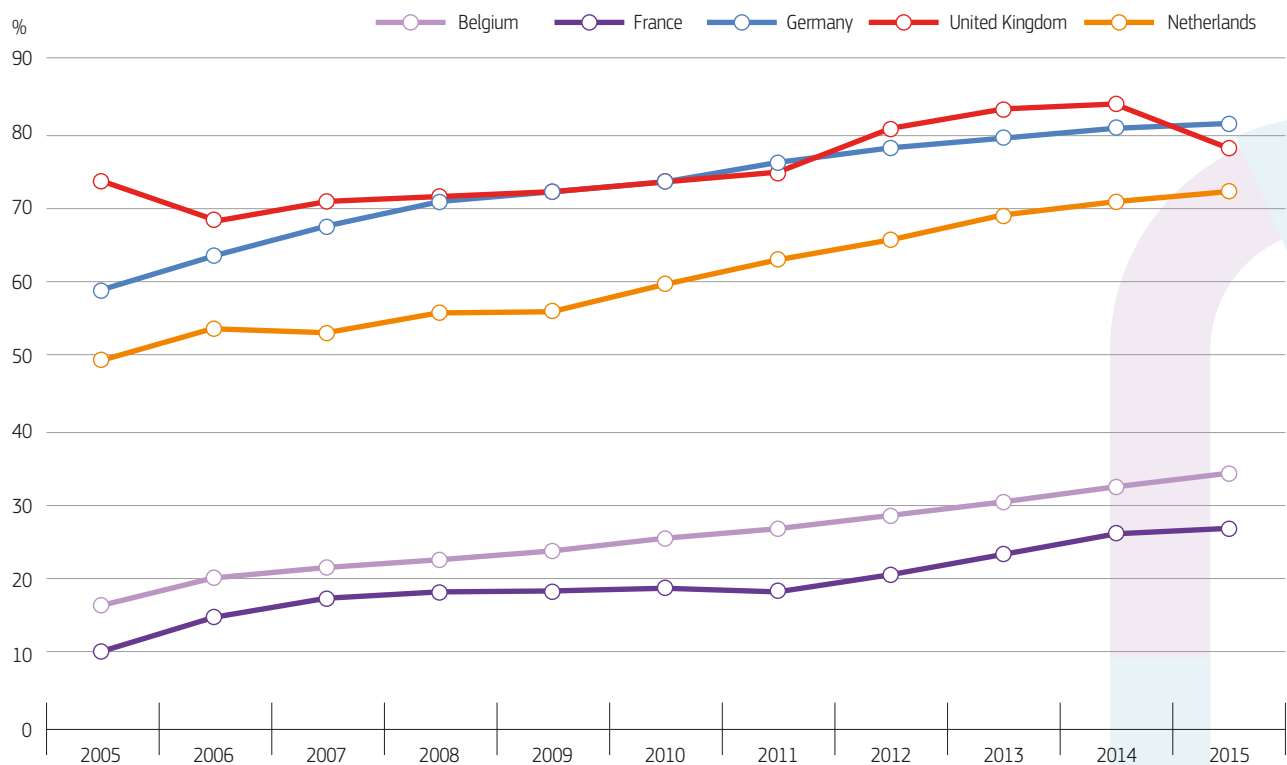
## Progress has been achieved in promoting greater efficiency in pharmaceutical consumption

Belgium took a number of measures in recent years to achieve both access and efficiency in pharmaceutical consumption. The Minister of Health and Social Affairs signed in 2015 a 'Pact for the Future with the Belgian pharmaceutical industry, with the aim of improving access to innovative therapies while containing pharmaceutical spending. The agreement provides a framework that combines cost containment with measures to support innovation (European Commission, 2016).

Belgium also increased its use of health technology assessment (HTA) to make coverage decisions on pharmaceuticals. It is participating in the new BeNeLuxA (with the Netherlands, Luxembourg and Austria) collaboration on joint HTA, horizon scanning, information exchange and pricing/reimbursement negotiation for new medicines.

Reinvestment in the coverage of new innovative medicines is funded at least partly by promoting the use of generics and biosimilars and greater competition in the post-patent market. Over the past decade, Belgium expanded its effort to encourage the use of generics



**Figure 13. The share of the generic market in Belgium has increased but remains lower than in other EU countries**

**Note:** These data refer to the share of generics in volume of consumption (not in value).

**Source:** OECD Health Statistics 2017.

through the introduction of financial incentives for patients (taking the form of a financial sanction for people purchasing a brand-name drug when a generic alternative is available), the introduction of prescription quotas for doctors, the introduction of mandatory substitution for some categories of drugs for pharmacists, and education and information campaigns for patients. Between 2005 and 2015, the generic market share in volume doubled from 17% to 35%. However, as shown in Figure 13, generic use in Belgium is still low compared to many other EU countries, such as the United Kingdom, Germany and the Netherlands. Greater competition in the post-patent market may also reduce the prices of generics, which remain high compared to that in neighbouring countries.

Another important challenge is to promote a more appropriate use of pharmaceuticals. This is notably the case for antibiotics. In 2015, Belgium had the third highest volume of antibiotic consumption per capita among EU countries (after Greece and France), with consumption levels nearly three times greater than in the Netherlands. The National Institute for Health and Disability Insurance launched some public awareness campaigns and organised feedback to doctors to reduce the overuse of antibiotics. Since May 2017, it has also increased patient co-payments for some antibiotics, as part of a broad strategy to tackle antimicrobial resistance (see Box 3).

## Health workforce shortages can be addressed through greater training, innovation and collaboration

Concerns are growing about shortages of doctors and other health professionals in Belgium. The concerns around the supply of doctors follow a period between 2004 and 2011 when the *numerus clausus* (annual quota) of medical graduates who were allowed to specialise as GPs or specialists was set at a fairly low level. In 2014, 44% of all doctors were over 55 years of age, up from 24% in 2000, and might therefore be expected to retire in the coming 10 years.

In response to these concerns, the federal government has steadily increased the *numerus clausus* since 2011, with the quota rising from 757 for the years 2008–11, to 890 for 2012, 975 for 2013, 1 025 for 2014 and 1 230 for the years 2015–18. This is a rise of over 60% between 2008–11 and 2015–18. These postgraduate training places are shared between the Flemish- (60%) and French-speaking (40%) regions. Furthermore, the number of GP trainees was increased from a minimum of 300 during the years 2008–14 to 360 during the years 2015–18 to better respond to growing needs for primary care.



In addition, several innovative measures were taken to extend the roles for other health care professionals, such as nurses and pharmacists, to improve access to services for the population. For example, since April 2016, nurses are allowed to administer vaccinations without the presence of a doctor, although this has long been the practice in many other countries. The Belgian Minister of Social Affairs and Public Health in September 2016 also presented the first steps of a broader reform of the practice of health care professionals (the coordinated law of 10 May 2015). This reform aims to promote greater collaboration between health care professionals and a greater recognition of health care professionals on the basis of acquired skills and continuing education.

### Belgium has taken steps to improve its health information system

Belgium has strengthened its information infrastructure in recent years to improve health system governance. A new integrated health data system was developed to facilitate data exchange between health care professionals and researchers ([www.healthdata.be](http://www.healthdata.be)). Since 2008, a comprehensive report on the performance of the Belgian health system is published regularly, including useful comparisons with other EU countries but also across the different regions in Belgium (Vrijens et al., 2016).

Belgium made considerable progress over the past decade towards establishing eHealth. In 2008, a public institution for eHealth (*eHealth platform*) was established to enable safe information exchange between patients, health care professionals and administrative services. All providers and patients are expected to share data on diagnoses, health services and treatments. Over the long term, it is expected that this eHealth platform will increase health care quality and patient safety throughout the country, notably through greater control of medication safety risks and reduced duplication of diagnostic tests.

#### BOX 3. NATIONAL STRATEGY TO ADDRESS ANTIMICROBIAL RESISTANCE

Antimicrobial resistance (AMR) was recognised many years ago as an important public health issue in Belgium. The Belgian Antibiotic Policy Coordination Committee, set up in 1999, is responsible for promoting more appropriate use of antibiotics in humans and animals and for promoting infection control and hospital hygiene, with the overall aim to reduce AMR. Nonetheless, antibiotic consumption still remains too high in Belgium (third highest in the EU in 2015). Recent measures to reduce antibiotic consumption targeted patients (e.g. through public awareness campaigns and increased co-payments for some antibiotics) and doctors (e.g. through organised feedback). Although Belgium performs relatively well in terms of level of resistance for most bacteria under surveillance by the European Centre for Disease Prevention and Control (ECDC, 2017), the incidence rate of hospital-acquired antibiotic-resistant staphylococcus infections is relatively high (Vrijens et al., 2016).

## 6 Key findings

- The Belgian health system makes major contributions to improving population health. Amenable mortality rates in Belgium are among the lowest in EU countries, owing in part to low and decreasing mortality from cardiovascular diseases. Relatively high and increasing survival rates for people admitted to hospital for a heart attack or stroke and for people diagnosed with different types of cancer indicate that the health care system is effective in treating people with life-threatening conditions.
- Large inequalities in health status persist in Belgium by socioeconomic status. These inequalities are due to a large extent to a greater prevalence of risk factors among people with low education or income, including higher smoking rates, excessive alcohol consumption and obesity. An important challenge for public health policies is to find innovative ways to effectively reach these disadvantaged groups. Comprehensive strategies to address these risk factors require strong inter-sectoral collaboration, as well as inter-governmental cooperation between the three communities.
- The management of the growing number of people with chronic diseases in primary care has improved, as measured by potentially avoidable hospital admissions. Still, avoidable hospital admissions for conditions like asthma and diabetes remain higher than the EU average. New care models have been taken introduced in recent years to improve care coordination for people with diabetes and other chronic conditions. It will be important to evaluate the effectiveness of these new care models and expand them if they prove to be cost-effective.
- Belgium spends a relatively high proportion of its GDP on health (10.5% in 2015), and more than three-quarters of this spending is publicly funded. The recent reform in the funding mechanisms of social security programmes (including health care) aims to promote greater accountability and efficiency in public spending. While there is broad agreement on the need to reduce waste and inefficient spending, there are also concerns that the newly lowered public spending ceiling might lead to some shift from public to private funding, thereby increasing direct out-of-pocket payments for people not entitled to preferential reimbursement status.
- Another concern about access to care in Belgium relates to the shortage of health professionals, in particular doctors. To address this concern, the federal government substantially increased the *numerus clausus* of medical graduates who are allowed to pursue their post-graduate training to become GPs or specialists. Some innovative measures have also been taken to extend the role of other health professionals, such as nurses, to improve access to health services.
- Antimicrobial resistance has been recognised as an important public health issue in Belgium for many years now, but antibiotic consumption remains too high (the third highest among EU countries after Greece and France and nearly three times higher than in the Netherlands). The National Institute for Health and Disability Insurance recently took measures to reduce antibiotic consumption by providing feedback to doctors, launching public awareness campaigns, and increasing patient co-payments for some antibiotics.



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## Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Malta	MT	Slovenia	SI
Belgium	BE	Estonia	EE	Ireland	IE	Netherlands	NL	Spain	ES
Bulgaria	BG	Finland	FI	Italy	IT	Poland	PL	Sweden	SE
Croatia	HR	France	FR	Latvia	LV	Portugal	PT	United Kingdom	UK
Cyprus	CY	Germany	DE	Lithuania	LT	Romania	RO		
Czech Republic	CZ	Greece	EL	Luxembourg	LU	Slovak Republic	SK		



# State of Health in the EU

## Country Health Profile 2017

The Country Health Profiles are an important step in the European Commission's two-year *State of Health in the EU* cycle and are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies. This series was co-ordinated by the Commission and produced with the financial assistance of the European Union.

The concise, policy relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU Member State. The aim is to create a means for mutual learning and voluntary exchange that supports the efforts of Member States in their evidence-based policy making.

Each Country Health Profile provides a short synthesis of:

- health status
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

This is the first series of biennial country profiles, published in November 2017. The Commission is complementing the key findings of these country profiles with a Companion Report.

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