

HEALTH CARE REFORM IN BELGIUM

*Erik Schokkaert
Carine Van de Voorde
(KULeuven)*

Address of the authors: Centre for Economic Studies, Naamsestraat 69, B-3000 Leuven (Belgium).

E-mail: erik.schokkaert@econ.kuleuven.ac.be, carine.vandevoorde@econ.kuleuven.ac.be

Keywords: health care reform, Belgium.

Summary

Curbing the growth of public sector health expenditures has been the proclaimed government objective in Belgium since the 1980s. However, the respect for freedom of choice for patients and for therapeutic freedom for providers has blocked the introduction of microeconomic incentives and quality control. Therefore - with some exceptions, particularly in the hospital sector - policy has consisted mainly of tariff and supply restrictions and increases in co-payments. These measures have not been successful in curbing the growth of expenditures. Moreover there remains a large variation in medical practices. While the structure of health financing is relatively progressive from an international perspective, socioeconomic and regional inequalities in health persist. The most important challenge is the restructuring of the basic decision-making processes; i.e. a simplification of the bureaucratic procedures and a re-examination of the role of regional authorities and sickness funds.

As in other countries, health care reform in Belgium has been driven by a concern about increasing expenditures, particularly because health care is largely publicly financed and Belgium has one of the highest ratios of government debt over GDP in Europe. However, Belgians are quite satisfied with their health care system [1]. In these circumstances, one cannot expect politicians to have the desire, the courage and the power to introduce drastic changes. Indeed, such changes have not been introduced: expenditures have kept growing faster than in most other countries.

The Belgian system combines many features that can explain this strong growth of expenditure. We describe these features in the first section of this article. We will then show that politicians have only recently realized the importance of microeconomic incentives and will go on to discuss whether the system has produced satisfactory results with respect to equality of access and health outcomes. The picture is mixed. This leads us to our conclusion: while hard choices have not been made in the past, they will most probably become unavoidable in the (near) future.

The goals and structure of the Belgian health care system

The structure of the Belgian health care system

Belgium has a system of compulsory health insurance, covering the entire population and with a very broad benefits package (with some restrictions for the self-employed). Health insurance is organized through private, non-profit sickness funds. Membership of a sickness fund is compulsory, but the choice of sickness fund is free. The sickness funds developed historically along political and religious lines and are grouped at the national level in five associations. The two largest ones, the Christian and the Socialist Mutualities, together insure about 75% of the population. By law the compulsory health insurance market is closed to new entrants. The insurance cover offered and the social contribution rates levied are identical for all funds.

Figure 1 about here

Figure 1 gives an overview of the general financing structure. A central role is played by the National Institute for Sickness and Disability Insurance RIZIV/INAMI. This is a semi-public semi-private institution directed by a General Council with representatives from the government, the trade unions and the employer's associations, the providers and the largest sickness funds. The two main funding sources are social security contributions and taxes. Social security contributions do not depend on the health risks of the insured. Since 1995 the government fixes each year a priori the total budget for health care expenditures. This total budget is made up of different partial a priori budgets for specific health care components (such as doctor fees and pharmaceuticals). A subsidy from general taxes closes the gap between this fixed total budget and the revenue obtained from social security contributions. The budget is distributed by RIZIV/INAMI to the sickness funds. These centrally obtained finances cover the large bulk of medical expenditures. In addition, sickness fund members pay a small flat rate premium directly to their sickness fund: about 10 Euros per year.

Given this financing structure, it is not surprising that the government plays a crucial role in the regulation process. Until now, health insurance has remained at the federal level. However, since 1980 part of the responsibilities for health policy (not directly related to health insurance) has been moved from the federal government to sub-national (Dutch and French-speaking) authorities. The latter are now responsible for the bulk of preventive medicine, for the implementation of hospital standards set at the federal level, for part of the financing of hospital investment, and for co-ordinating home care.

Compulsory health insurance is combined with independent medical practice. Payment is mainly fee-for-service and patients have a large degree of freedom in their choice of provider. In the case of ambulatory care, patients usually pay the complete fee to the providers and are reimbursed partially by their sickness fund on submission of the bill. In the case of hospital care and pharmaceuticals, financing is mainly through third-payer arrangements, in which the sickness funds pay the providers and the patients are only responsible for the co-payment. Own payments are relatively high by international standards, and cover at least 15% of total health expenditures [2].

Hospital care is provided either by private non-profit or by public hospitals. The system of hospital financing distinguishes between medical and non-medical services. The latter refer to the general hospital costs and to accommodation expenses (including also costs of equipment and nursing staff). Since the 1980s there has been a continuous evolution from a cost-based to a prospective financing system. We will return to this evolution later in the paper. The health insurance system covers about 75% of these costs and the remainder is financed directly by the Ministry of Health. The medical services are fully integrated into the system of health insurance and are covered by the sickness funds. With some exceptions to which we will return, remuneration is mainly fee-for service.

The insurance package is defined explicitly through a complex process of negotiations within RIZIV/INAMI. Each year representatives of the sickness funds and the health care providers (including the hospital sector) negotiate a detailed fee schedule for each type of service, the so-called nomenclature. The sickness funds also bargain with the drug companies on reimbursement rates for pharmaceuticals. In all these negotiations the sickness funds act as a cartel and are seen as a kind of representative for patients. As the government has veto power over the fee levels, the whole process resembles a bilateral monopoly supervised by the central government. During the year, health expenditures are closely monitored, and if there is a danger of transgressing the a priori budget, negotiations begin between the government, the providers and the sickness funds to find solutions, which may include a change in the fee schedule and the co-payments. If necessary, the government can impose measures unilaterally.

This complicated decision procedure leads to a rather long delay between medical innovation and inclusion in the compulsory cover. This is especially striking for new pharmaceuticals. Other items not included in the compulsory cover are the supplements that have to be paid in the hospital if one takes a single occupancy room (specialists are then also allowed to ask higher fees), orthodontics, some physiotherapy and non-traditional therapies such as acupuncture and homeopathy. Patients can buy supplementary insurance for these treatments. Given that for profit insurers cannot enter the market for compulsory insurance, traditional sickness funds have huge informational and scale advantages, and more than 90% of their members buy take some form of supplementary insurance from them. Therefore, the private

market share in supplementary health insurance has remained limited and private insurers focus on the higher-income market segment.

We can summarize the whole picture of the Belgian financing mix as follows: private insurance plays a very minor role, own payments by patients are relatively high (and cannot be insured against through private insurance), but the bulk of expenditures (more than 80%) are financed through public means. Within these public means, taxes and social security contributions have an almost equal share. A comparison of this financing mix with those of the other countries included in the ECuity-project [3, 4] shows that Belgium shares the latter feature only with Italy. Because of data problems, Belgium was not included in the financing part of the ECuity-project. Only recently has it been possible to calculate the progressivity and redistributive effect for Belgium for the year 1997 [2]. Not surprisingly, own payments and private health insurance turn out to be very regressive. However, this regressivity is compensated by the progressivity of the public financing sources. Overall the Belgian financing mix is among the most progressive in Europe. Although there is no reliable evidence to make statements about the development of progressivity over time, there is no reason to think that the picture has changed considerably since 1997.

Policy goals and the development of total health care expenditures and health care financing

As will have become clear, the decision structure in the Belgian health care system is rather fragmented. Moreover the existing policy documents focus on short-run objectives. It is therefore not easy to derive the broader policy goals of the decision makers from official documents. There can be no doubt, however, that as in other countries concern over the increase in expenditures has been growing since the beginning of the 1980s. As the Belgian public debt situation was especially acute, the objective of keeping government expenditures under control became crucial.

It is informative to confront this proclaimed goal with the facts. As data for total health expenditures from different sources are not consistent, the most adequate approach by which to describe the general trends is to use a narrow but clearly defined concept: the expenditures of RIZIV/INAMI in the compulsory system. Table 1 shows the strong overall increase in these expenditures. Between 1985 and 2002 the proportion of GDP spent on RIZIV/INAMI-health care expenditures has increased from 3.9% to 5.4%. In the mid-1990s there was a slowdown in the growth rate of expenditures in constant prices, but it has increased again since the late 1990s. As we will see, both observations can be related to deliberate policy decisions.

Table 1 also shows the development of some components of the RIZIV/INAMI-expenditures since 1985. As in most European countries the ageing of the population and the use of better-qualified personnel have led to an increase in the expenditure shares of rest and nursing homes and nurse wages. More revealing for the Belgian situation is the development of the three most important categories of expenditure: doctor fees, hospitalisation expenditures and pharmaceuticals. In 1985 the doctor fees accounted for 45% of RIZIV/INAMI-expenditures; in 2002 this share had fallen to 30%. During the same period the share of the general hospital costs decreased also from 27% to 23%. In the next section, we will return to both these developments. At the same time, the share of pharmaceuticals increased between 1985 and 2002 from about 15% to more than 19% of total expenditures. In fact, within the EU in 1997, only France had a larger level of pharmaceutical expenditures per inhabitant.

Table 1 about here

To put these RIZIV/INAMI-expenditures into a broader perspective, we have included in Table 1 some information about other components of total health expenditures. The importance of supplementary and private insurance is small, but increasing: in 1993 they amounted together to 5.3% of RIZIV/INAMI-expenditures; in 1999 this fraction had grown to 6%. The share of private insurance on its own increased from 1.7% to 2.7%: although the data are not fully reliable, there can be no doubt that this private component has remained extremely limited.

Another perspective is offered by an international comparison. The OECD-Health Data (2004) show that expenditure growth in Belgium has been relatively high. While in 1980 Belgian health expenditures as a percentage of GDP were 6.4 % and below the EU-average, in 2002 they had increased to 9.1% of GDP. Only a few countries (such as Greece and Portugal) show a larger growth rate over this period.

The lack of success in curbing expenditures can be understood easily. In the mind of policy-makers and of the population other objectives related to equity and freedom have always been more important. Equal access to high-quality medical care has remained the dominant (proclaimed) policy objective and it has never really been questioned by any political party or any player in the field. Belgian decision-makers have always emphasized the looming danger of a two-track society in which only the richer groups would be able to pay for high-quality health care. Therefore the safeguarding of almost universal insurance coverage in the compulsory system coupled with an equitable financing structure has rarely been questioned.

The easiest way to cut public expenditures - i.e. the restriction of coverage within the compulsory health insurance system - has until now not been seriously considered. The growing importance of private and supplementary insurance during the 1990s was mainly caused by the (partly deliberate) fact that the introduction of new techniques, including new pharmaceuticals, in compulsory coverage was delayed. However, as shown in Table 1, despite this increase, private and supplementary insurance have remained marginal overall. Moreover, this development was perceived as a threat to the basic objectives of the health care system. From 2000 onwards, the compulsory health insurance coverage has again been extended as some expensive treatments have been included (such as the use of endoscopic material and - under some conditions - in-vitro fertilization). It is striking that this decision has been strongly supported by a majority of the population. At the same time, however, it is one of the causes for the recent sharp increase in public expenditures.

If the restriction of the coverage within the compulsory system is not acceptable, the only way to keep expenditures under control is to introduce better incentives. This has proven to be very difficult because of other specific features of the Belgian system, and better incentives remain almost beyond discussion. The first feature is the nearly unlimited freedom of patients to choose their preferred providers and the equally broad therapeutic freedom of the providers. All attempts to restrict this freedom have been met with fierce opposition. This is one of the reasons why quality control (which unavoidably would lead to a restriction of freedom) has never been a dominant objective. The second is the tradition of abundant supply. There are no waiting lists in the Belgian system (except for specific interventions such as organ transplantation) and any sign of their appearance would rapidly lead to a wave of indignation among both patients and providers. It therefore has been very difficult to introduce supply restrictions and/or elements of managed care in the system.

In the two following sections we go deeper into these different issues. We first give an overview of health care reform over the last few decades from the perspective of incentives, both for insurers and providers. We then return to questions of access and outcomes: if these have been the dominant objectives of policy makers, does the system indeed deliver?

Resource allocation, incentives and appropriateness of care

Health care reform in Belgium has followed the same pattern as that broadly observed in other countries [6]. During the 1980s there was a tendency towards closer regulation and supply restrictions mainly in the hospital sector. At the beginning of the 1990s the overall structure of the system changed. However, whilst everything was set in place to introduce a system of managed competition, this step was not taken. Quite the contrary: at the end of the 1990s there was a move towards a more proactive government policy. This has been characterized by two features: the introduction of some microeconomic incentives and a considerable increase in the health care budget. We first discuss the role of the insurers and then the incentives for the providers and the policy with respect to pharmaceuticals.

Budget allocation and the role of the sickness funds

The stated purpose of the Law Moureaux of February 15th 1993 was to increase the cost-consciousness and cost-participation of all the partners in the health care sector. For our purposes two features of the law are crucial.

To limit the growth of expenditures, a “growth norm” was introduced that restricted the annual maximum increase in expenditure to 1.5% in real terms. Since 2001 the limit has been raised to 2.5%. Moreover, the government can introduce exceptions to this rule for specific new interventions. This global budget is then divided into partial budgets or targets, one for each sub-sector of health care. The implementation is monitored closely by a special Commission: on a quarterly basis each sub-sector is confronted with its expenditures and partial budget. In case of a significant target overrun, corrective measures - such as an adjustment in the fee schedule or an increase in co-payments- are undertaken. This close monitoring of the development of expenditures within an a priori budget was the first important innovation of the Law Moureaux.

A second innovation was the introduction of some financial responsibility for the sickness funds [7, 8, 9]. Before 1995 the sickness funds were fully reimbursed. Since 1995 the budget has been distributed over the funds on the basis of a weighted average of so-called normative and actual expenditures. The former are determined on the basis of a regression formula including a long list of risk-adjusters (such as age, gender, socio-economic and environmental variables). The law prescribed that the relative weight of normative expenditures would gradually increase over time to a maximum of 0.40 from the year 2003 onwards. Each sickness fund is held financially responsible for a fraction of the difference between its actual expenditures and its budget. As with the weight of normative expenditures, some dynamics were introduced in the system. While the fraction of financial responsibility was 15% in 1997, from 2001 onwards it was increased to 25%.

Normative expenditures introduce a prospective element in the financing rules and therefore create incentives for cost containment by the sickness funds. In fact, the Law-Moureaux has modelled the Belgian system almost on the blueprint of the model of regulated competition which was introduced at about the same time in the Netherlands [10], yet this seems to have been a coincidence rather than a deliberate policy. In principle, the individual financial incentives embodied in the new system, although limited, could have given the sickness funds the incentives to contract selectively with preferred providers. These preferred-provider arrangements could have created some possibilities for experimentation with new instruments to influence prices, volumes and quality. In the (more remote) future even the introduction of integrated HMO-type organisations of providers and insurers could have been considered. However, none of this has happened because the use of these instruments to exert a real control on expenditures has remained illegal. Selective contracting with providers is not allowed. The capacity of *individual* insurers to influence the behaviour of providers remains extremely limited, and it remains legally forbidden for private insurers to enter the Belgian market for compulsory health insurance.

The efficiency gain from introducing financial responsibility has therefore been very limited. The sickness funds negotiate, as before, as a cartel with the providers and together they have to keep the medical expenses within the global budget. Of course, the introduction of individual financial responsibility has strengthened the incentives to negotiate in a tougher way, but this is not yet regulated competition. Moreover, more than ever, sickness funds and providers are allies in lobbying for a larger budget.

Thus, the Law Moureaux did not introduce a model of regulated competition in the Belgian health insurance system and policy makers generally show little awareness of the importance of microeconomic incentives and instead rely largely on administrative solutions. In these circumstances the introduction of a budget cap is not a powerful instrument. It is not surprising that after 1995 many specific measures remained necessary. The main actor has been the government, and there was a clear continuity in the reform measures taken before and after 1995. We now turn to these measures.

Payments of providers

As noted earlier, the traditional way of remunerating providers in Belgium has been by fee-for-service. It is well known that this system in its pure form does not give any incentives for cost control. The concern about the cost increase has been growing since the early 1980s. The first efforts of cost reduction by the government were situated in the hospital sector. After discussing the payments of hospitals we turn to the regulation of medical supply and fees in the ambulatory sector and will then argue that more fundamental changes to the system have been blocked due to respect for the almost complete freedom of providers and patients.

Payments of hospitals

Supply restrictions have been introduced since the 1980s. First, a moratorium on the number of hospital beds has been introduced. As a result the number of beds decreased from 8.3 per 1000 inhabitants in 1970 to 7.2 per 1000 inhabitants in 1998. This is still well above the European average of 6.4 beds per 1000 inhabitants. Second, the government attempted to realize returns to scale by creating financial incentives for hospital mergers. This process

halved the number of hospitals in the period 1980-1998, while the average capacity of a hospital rose from 177 beds to 311 beds.

Supply restrictions were perhaps a necessary but certainly not a sufficient measure to keep costs under control. In the last decades changes have also been introduced in the financing system. As described before, a distinction is made between medical and non-medical costs. In both cases there was a slow and difficult trend towards more prospective financing. Regarding non-medical costs, before the 1980s hospitals received a fixed per diem for each patient day. This created incentives to increase the length of stay because the marginal cost of an additional patient day was lower than the per diem rate. Since 1982 there has been a gradual move towards prospective financing. Initially the latter was based on the historical situation and on a statistical comparison with other hospitals. From the beginning of the 1990s, however, the importance of DRG-information grew, and since 1995 hospitals with a lower length of stay than a APDRG-weighted reference level got rewarded (and those with a longer length of stay get punished) [11, 12]. The per diem rate, however, was still based on the structure of the hospital and therefore related to costs. In 2002 a final step was taken and the amount of the per diem was also related to the APR-DRG-profile of the hospital patients.

Apparently these measures have to a large extent achieved their goals. Although there has been a slight increase in the admission rate, the total number of patient days has decreased considerably over the two decades. This implies that there has been a marked decrease in the average length of stay (from 21.6 days in 1980 to 12.2 days in 1998). This development shows up in the aggregate Table 1: the share of hospital costs in the overall RIZIV/INAMI-expenditures has decreased. At the same time, however, there is little hard information on the efficiency of Belgian hospitals and on the changes in efficiency over time [12]. It is difficult to disentangle the effects on length of stay of policy measures and of changes in medical technology. However, a recent econometric study [13] suggests that the introduction of DRG-financing has had an independent and significant effect on the length of stay. On the other hand, there is also some evidence of increasing risk selection within DRG-groups [14].

As mentioned earlier, medical services in hospitals are mainly covered by a fee-for-service system. The resulting overproduction problem was especially acute for laboratory testing and medical imaging, where expenditures were booming in the 1970s and 1980s with an average annual growth of more than 10%. It took a while before politicians realized that this problem was caused by the financing system. Between 1970 and 1985 there was an almost continuous policy of tariff reductions - each time there was a short run effect that was soon annihilated by supply reactions. Finally (and at last) a definitive step away from the fee-for-service system was taken in 1988. A fixed national budget was introduced for laboratory testing in the hospital sector, where payment was determined by a daily rate and a lump-sum fee per admission. Both were independent of the number of tests performed. In 1992 similar prospective financing schemes were introduced in the ambulatory sector.

The effects of the prospective payment scheme on expenditures were very pronounced. The very sharp increase observed until 1986 stopped completely. As Table 1 shows, the absolute increase in expenditures for clinical biology has become relatively less important than the increase in other sectors, leading to a continuous decrease in their share of overall expenditures. At the same time, there has never been any complaint about the appearance of waiting lists or problems of access. Indeed, in this case there are hardly any opportunities for cream-skimming. Moreover, everything suggests that there was a real problem of supply-induced overconsumption before the introduction of the prospective financing scheme. The

experience with laboratory testing was important, because it helped to pave the way for a somewhat more positive attitude towards prospective financing techniques in other domains.

Payment of doctors and dentists

In a fee-for-service system with a large degree of freedom for patients and providers, the most direct and immediate policy to control expenditures is a decrease in the tariffs. Controlling costs through price regulation has indeed been one of the key instruments during the last decades (see [11] for a complete overview). The most striking example is the linear cut of 3% in medical and paramedical fees and tariffs that was imposed in 1997 after the transgression of the budgetary norm in 1996. An equally straightforward policy is an increase in co-payments to fight moral hazard. Until 1993, co-payment and co-insurance rates increased steadily but slowly. In 1994, however, there was an approximately 50% increase in co-payments for GP and specialist consultations and home visits. Further increases have since been implemented.

The effect of these tariff cuts and increases in co-payments on expenditure growth has been rather limited. This could easily have been predicted given the predominance of the fee-for-service system and the large freedom of the providers, and it simply confirms the early experience with the regulation of laboratory testing. Table 1 shows the effect on doctor fees of the increases in co-payments in 1994 and of the linear tariff cuts in 1997. In both cases there was a short run effect on public expenditures. However, this immediate price effect was compensated by quantity increases in the following years: the sharp increases in 1996 (although partly an accounting effect) and in 1998 are particularly revealing.

On the basis of this raw evidence one cannot draw strong conclusions because it does not distinguish between the positive trend in expenditures on the one hand and the (possible) increased supply inducement on the other hand. Yet it is difficult not to get the impression that the latter has led to an increase in expenditures above the long run time trend so as to negate the direct price effect. This conclusion is corroborated by some more thorough econometric analyses of the 1994-increase in patient co-payments [15,16]. It turns out that after correction for the trend effect (and depending on the social and income status of the patient), the price elasticities are rather small and not beyond the range [0.00,-0.20], which was also suggested by the Rand-experiment [17]. The effects of increasing co-payments on cost reduction therefore must not be exaggerated.

If the hypothesis of supply-induced demand is true, and if there is a positive relationship between the number of doctors and medical expenditures [8], this may be an argument in favour of supply restrictions on the number of practitioners. In fact, Belgium is characterized by one of the highest physician/population ratios of the industrialised countries (39 physicians per 10,000 inhabitants in 2002) as well as by large interregional differences in this density. Physician density is relatively higher in the French-speaking South of the country. Until the mid-1990s the number of medical doctors kept growing, leading to a severe pressure on average practitioner income. This has probably worsened the problem of supply-inducement. Only at the end of the 1990s was there an attempt to introduce restrictions on the supply of providers in the form of a numerus clausus. This idea had to be implemented in the educational system, however, and education is one of the competences of the regional authorities. The Flemish community introduced an entrance examination, the French-speaking community opted for a selection procedure after three years of study. The idea of the numerus clausus has never been generally accepted and at this moment is once again

being questioned. This is particularly the case in the French speaking community because the federal government has formulated the quota in such a way that the existing discrepancy between the North and the South of the country should gradually disappear. Certainly in the short run one should not expect a significant effect of the supply restrictions on health care expenditures.

Tariff cuts, increases in co-payments and supply restrictions are all rather blunt regulatory measures. It seems that more refined changes in the incentive structure are needed to have a real effect on expenditures. Have these been introduced?

Appropriateness of care and more refined microeconomic incentives

Freedom of choice by both patients and providers is one of the basic principles of the Belgian system. Patients can go to the provider or hospital of their own choice. The gatekeeper role of general practitioners is very limited. Downward price competition on the provider markets is forbidden but there is intense quality competition. Providers are very responsive to the subjective needs of the patients. All this may increase the degree of subjective satisfaction, but it is not obvious that it also results in high-quality medicine. Belgium has taken only some very small steps in the direction of health technology assessment and evidence-based medicine. The differences in medical practices between different hospitals and different regions remain huge – and certainly suggest a large degree of suboptimal treatment in some cases. We give two examples ([11], more can be found in [12]). The proportion of caesarean operations in the total number of births varies among hospitals from 8% to 28% (with an average of 14%). No link can be detected with the size of the hospital or with the socioeconomic background of the patients. The proportion of hysterectomies varies among provinces from 2.8 to 4%. These differences remain considerable after correcting for age.

It is therefore no surprise that the need for benchmarking and better quality control was one of the main conclusions in the report of the Advisory Commission of Experts in 1999 [11]. However, recent attempts to move in that direction have been blocked by the associations of providers. Even the mere collection of information on practice differences has been made virtually impossible.

There is some limited experience with benchmarking in the ambulatory sector. As long ago as 1979 so-called ‘profiling commissions’ were at work in the RIZIV-INAMI and medical doctors could compare their own prescribing behaviour with the average of their colleagues. Recently this evaluation procedure has taken into account information about the risk profile of the patients. Outliers have to justify themselves to the commission, but this occurs very rarely. Until now the sanctions remain limited to peer pressure and all attempts to introduce explicit financial incentives in ambulatory care have failed. Another recent development is the introduction of a modest degree of benchmarking *with* financial incentives to tackle the huge practice differences between hospitals. The fate of that measure remains to be seen.

The strong opposition of providers is probably the main reason why differentiated financial incentives have been introduced at the patient (and not at the provider) side in recent years. Yet even here the restrictions on freedom have been minor. To stimulate the gatekeeping role of the general practitioner and to increase the loyalty of the patients towards their GP [18], patients pay lower co-payments if they register with one specific GP and accept that their individual ‘global medical file’ is kept by that GP. This measure was first introduced for older patients and extended to the whole population in 2002. A second innovation, introduced

in 2003, has been the increase in the co-payments for patients who go directly to the emergency unit of a hospital, without having first been seen by a general practitioner. It is too soon to evaluate the effects of these measures.

While the opposition of the providers is already strong enough, the introduction of microeconomic incentives is made even more difficult by the fact that differences in medical practice show clear regional patterns. This is also true in other countries but the Belgian situation is characterized by the linguistic factor and the political trend to devolve the competences on the regions. At regular intervals, some pressure is exerted by important groups within the Flemish-speaking (Northern) community to transfer health care and health insurance to the regional level. This region has a higher average income level - hence contributes more taxes and contributions - and at the same time lower medical expenditures per capita. A large majority in the French-speaking South wants to keep health insurance at the federal level. The whole discussion tends to focus on the difficult question whether the differences in medical expenditures are 'justified'; i.e. linked to differences in morbidity - or, on the contrary 'unjustified'; i.e. linked to differences in medical supply and medical practice [19,20]. Of course, this discussion brings us right into the heart of the debate on therapeutic freedom in the Belgian system. Since the introduction of stronger microeconomic incentives could hit both regions in a different way, practice variations tend to be downplayed by the South. At the same time they are often used by the North simply as an argument for splitting the system. Both positions make it difficult for policy-makers at the federal level to introduce microeconomic incentives. The whole problem remains a sword of Damocles for the federal structure.

Reimbursement of pharmaceuticals

As shown in Table 1 the share of pharmaceuticals in overall health care costs has steadily been increasing over time. This has caused much concern among policy makers but it has proven very difficult to introduce drastic changes in the system of reimbursement. At regular times pharmaceutical firms have been obliged to pay a special tax when expenditures for pharmaceuticals were too high. This is of course an extremely blunt measure. More important policy instruments have been price regulation and increases in co-payments. These have turned out to be inefficient measures for controlling costs, for the same reasons as sketched before. Moreover, since reimbursed drugs have to be prescribed by a physician, co-payments for patients cannot be very efficient for curbing expenditures. A specific problem to be mentioned is the low share of generics in the Belgian consumption of pharmaceuticals. Since 2001 the government has tried to stimulate the use of generics by introducing lower co-payments for generics. Again, it can reasonably be asked why stronger incentives have not been created for the prescribers rather than for the users of drugs.

One minor restriction on the freedom of the prescribers has been introduced in the 1980s. For the reimbursement of some expensive pharmaceuticals the sickness funds have to approve explicitly the prescription made by the physician. While this is one of the rare instances where sickness funds can influence expenditures directly, until now they have made use of this opportunity very rarely.

Access and outcomes

We have seen in the previous section that the almost absolute respect for the freedom of patients and providers has made it very difficult to control the growth of medical expenditures. Moreover there are some legitimate worries about the large variation in medical practice. Does the system deliver on what are its main goals: equality of access and health outcomes? We first focus on the concrete policy measures (co-payments and supply restrictions), then turn to the question of health outcomes, and finally sketch the overall picture with respect to equality of access.

User charges

In the mid-1990s there was a general awareness that the increase in co-payments could endanger the ideal of equal access. Therefore, this increase was accompanied by the introduction of income-related annual cost-sharing ceilings (social and tax exemptions). Since there is a third-payer arrangement for pharmaceuticals and the sickness funds did not keep individual patient accounts, expenditures for pharmaceuticals could not be included in the exemptions. Studies [21,22] showed that the total personal bill could become very high for some chronically ill patients and there was also growing evidence of payment difficulties for the very poor in hospitals [23].

The reaction of the Belgian government clearly illustrates its dominating concern for equity and equality of access. There were hardly any worries about the fact that the exemptions could mitigate the incentive effect of the increase in co-payments. Quite the contrary, there was an explicit attempt to increase the exemption system. From 2001 onwards a system of maximum health-care billing has been introduced; i.e. a global (income-dependent) exemption for all insurees. Moreover, because of the improvement in the available information, pharmaceuticals have now been included.

A recent study [24] has shown that the average share of own payments in the household budget has increased since the 1980s. They have become more progressive, however, so that their overall redistributive effect has remained nearly constant. A more in-depth analysis with microsimulation techniques [25] suggests that the maximum-billing system is rather effective in protecting the weaker segments of the population. At the same time about 15% of the households use more than 5% of their budgets for own payments for health care – and about 2% use even more than 10%. The problems are mainly located among elderly households living in the South of the country, and are mainly due to own payments for treatments that are not included in the compulsory cover.

Waiting lists

Despite the decrease in the number of beds and the attempts to restrict the supply of physicians, Belgium has managed to avoid the potential problem of waiting lists. This certainly contributes to a high degree of subjective satisfaction with the system. However, although there is not sufficient hard evidence on hospital efficiency to make strong statements, it can be doubted whether the absence of waiting lists reflects efficiency. It can better be explained by the relatively abundant supply of beds (and the undoubtedly abundant supply of physicians) on the one hand, and by the remaining dominance of the fee-for-service system on the other hand.

Outcomes

Except for some broad indicators there is no long-run evidence on the development of health outcomes in Belgium. This is because of the fragmented structure of decision-making (and hence information collection) and the therapeutic freedom of the providers. To remedy this lacuna, policy-makers at the federal level have encouraged the production of a representative health survey. The survey was organized for the first time in 1997 and was repeated in 2001 [26]. This period is too short to derive any long run-trends, but in the future these surveys should yield a good information base.

Some of the broad indicators are given in Table 2. There has been a continuous increase in the life expectancy of both males and females – and this increase is even larger over the period 1980-2000 than over the two previous decades. The dramatic decrease in child mortality which occurred from 1960 to 1980 has since slowed down. These broad indicators are not very informative about the effects of policy measures.

Table 2 about here

Perhaps more interesting conclusions can be drawn from a comparison with the EU-average as given by the OECD Health Data. Compared to other countries Belgium has over the two previous decades improved its rank with respect to the life expectancy of both males and females and with respect to the mortality rate. On the other hand, its ranking with respect to child mortality has worsened. It is tempting (but at this stage certainly premature) to link these developments to the relatively large increase in health expenditures on the one hand, and the deficiencies in public health policy on the other.

Access and outcomes: the global picture

We noted towards the beginning of this article that the financing structure of the Belgian health care system is among the more progressive in Europe. Moreover, most observers agree that the ideal of equal access was reasonably reached in Belgium around the mid-1990s. Calculations using the methodology of the Ecuity-network [27, 28, 36] indicated an overall pro-poor bias (after correction for health status) in the number of consultations with a general practitioner and the number of hospital visits – and a pro-rich bias for specialist visits. This general finding has been corroborated by some studies using the more recent data (1997) of the Health Survey [29,30]. There is not much reason to think that this overall picture is radically different now. However, there is no evidence available which gives a coherent picture of the development over time.

Two important qualifications are needed. The studies mentioned earlier [27] suggested that the ‘pro-poor’ bias was mainly caused by the middle-income groups and that the situation of the very poor is less favourable. Detailed studies have suggested socioeconomic differences in access to general practitioners [31] and in the quality of treatment in hospitals [14]. Financial factors may be part of the explanation as there are still some gaps remaining in the maximum billing system but these are probably not the only explanation. Moreover, it is hard

to imagine that supply restrictions play an important role. It rather seems that the unequal treatment of the poor does reflect deeper social mechanisms, which cannot be corrected by mechanical economic measures [30].

Equally important is the evidence pointing to large socio-economic inequalities in health. In international comparisons, Belgium does not occupy a favourable position and finds itself in the (bad) company of the US and the UK [27,29]. Especially striking are the significant interregional differences with a higher morbidity in the southern part of the country where both medical supply and medical expenditures are higher [32,33]. To fight these remaining inequalities, measures which go beyond health insurance and extend to public health, prevention, and educational measures are needed. However, these are currently weak points in the Belgian health care system.

The future

There have been no drastic reforms in the Belgian health care system over the last two decades. This can be explained by the strong emphasis on equity and on freedom of choice: a rather surprising combination. Moreover, health policy is determined through a complex network of administrative procedures in which the providers and the sickness funds play a crucial role. Attention to microeconomic incentives has always been rather limited among these decision-makers. The reliance on tariff cuts and increases in co-payments during the 1990s could not be efficient in a fee-for-service system with a large degree of freedom for both patients and health care providers. Yet, except for some examples in the hospital sector, prospective financing techniques and benchmarking are largely taboo. Only in recent years has there been a deliberate but very modest attempt to introduce better incentives into the system.

It is doubtful whether this situation is sustainable in the long run. Complaints about the rising expenditures are growing, mainly among liberal political parties and employer organisations. If one wants to avoid the gradual erosion of the compulsory health insurance system - which could have disastrous consequences for equity - it is necessary to make the system perform in a more efficient way. Benchmarking (with financial incentives), evidence-based medicine and prospective financing have to be introduced in one way or another. A first step would be the collection of adequate information on practice differences and the communication of some of this information to consumers. For economists it is easy to agree about the necessity of these policy measures, but the crucial question then becomes: who will introduce these innovations, when their introduction has been blocked by providers in the past? Who will have the courage and the power to restrict the freedom of both providers and patients?

In the light of the recent increase in expenditure growth the topics of prospective financing and evidence-based medicine are hotly debated. However, in our view, the main challenge for the future is the restructuring of the basic decision-making processes, and the exact measures to be implemented will depend on the form that this restructuring takes. At least three basic questions have to be answered:

1) Everybody agrees that a simplification of the administrative decision procedures is needed. A commission of experts counted no less than 150 official commissions [11, p. 162]. However, while everybody agrees about the principle, opinions about its practical implementation differ. Reform initiatives exclusively come from the federal government:

their direction and quality depend largely on compromise of the Minister responsible and on the composition of the coalition government. A long-term perspective is lacking. In fact, the system is trapped in a kind of paradox. On the one hand, the administrative procedures put severe limits on the regulatory power of the government; on the other hand, the inherent conservatism of the existing decision structures increases the need for a proactive and innovative government policy.

2) The situation worsens due to the incoherent division of power between the federal government and the regions, which leads to political tensions and inefficiencies. Examples abound. It is difficult to align preventive and curative activities because the competences are located at different levels. It is difficult to increase the gatekeeper-role of the general practitioner because the idea is less popular in the South than in the North. Even a relatively simple measure like the *numerus clausus* for doctors has been implemented differently across both regions. The basic question is: will it be possible to cure these inefficiencies within the federal organisation or are more drastic changes needed? Whilst recent governments have succeeded in appeasing the Flemish demand for splitting the health insurance system, this is most probably a temporary solution and, unless other structural changes are introduced, it can be predicted with some confidence that this demand will keep arising. The country seems deeply divided over this issue. A possible compromise could be found in a system where the financing remains central (and hence solidarity remains intact), but the regions hold more power over decision-making within a fixed (needs-adjusted) budget [34,35].

3) Finally there remains the ambiguous position of the Belgian sickness funds. They hardly compete on price, since the flat rate premium is too small to influence the choice of the insured. Moreover, the law imposes an identical compulsory insurance cover for all sickness funds. In all negotiations about fees and regulation, the sickness funds act as a cartel. Since they have to reimburse without questioning all of the medical expenditures that conform to the legal rules, they exert hardly any influence on the level of their own expenditures, and they are not allowed to contract selectively with providers within the compulsory system. HMO-type organisations do not exist. In supplementary insurance, sickness funds have more room to act on the costs. In this domain there are an increasing number of examples of managed care and, more specifically, of selective contracting with respect to innovative treatments.

We have argued that the introduction of some financial responsibility did not change the basic structure of the ‘regulated bilateral monopoly’-system - regulated competition has never been considered as a serious option. There are no strong groups on the political scene that openly defend the idea of “more market” in the health insurance sector. The fear of markets is understandable in the Belgian context in which equity and universal access to medical care are prominent values. However, whilst fear of markets is understandable, the present policy is one of playing an ostrich. As soon as one introduces a partially prospective financing scheme, one creates a danger of cream-skimming. This danger is not negligible in the Belgian situation, where the supply of different supplementary insurance policies is possible. *If* the only relevant considerations in evaluating health insurance systems were equity and accessibility, there is no reason to depart from the completely centralised system. However, *if* one wants to increase cost efficiency by giving incentives to the insurers, one has to give them the necessary instruments to influence their expenditures. If these instruments are not provided, the insurers will react to the introduction of prospective financing by turning to risk selection. In our view the individual sickness funds should occupy a more important role in the whole regulatory process. They have built up the necessary expertise and are stronger than the government as a countervailing power to the providers. Changes

have to be introduced cautiously, but an open debate on the future role of the sickness funds is now necessary.

REFERENCES

- [1] Elchardus M., Derks A., Debusscher M., Tresignie, C. *Het draagvlak van de solidariteit*. Mimeo: VUBrussels, 2002.
- [2] Van Camp G, Van Ourti T. *Ongelijkheid in de financiering van medische zorg: progressiviteit en herverdelend effect in België*. Final Report DWTC-project SO/01/005, Part 3: Antwerp/Leuven, 2003.
- [3] Wagstaff A *et al.* Equity in the finance of health care: some further international comparisons. *Journal of Health Economics* 1999; **18**: 263-290.
- [4] De Graeve D, Van Ourti, T. The distributional impact of health financing in Europe: a review. *The World Economy* 2003; **26**: 1459-1479.
- [5] Centrum voor Gezondheidseconomie en Ziekenhuisbeleid. *Handboek Gezondheidseconomie*. Kluwer: Mechelen, 2000.
- [6] Cutler D. Equality, efficiency, and market fundamentals: the dynamics of international medical-care reform. *Journal of Economic Literature* 2002; **40**: 881-906.
- [7] Schokkaert E, Van de Voorde C. Risk adjustment and the fear of markets: the case of Belgium. *Health Care Management Science*, 2000; **3**:121-130.
- [8] Schokkaert E, Dhaene G, Lustig H, Van de Voorde C, Kestens P, Laasman J.-M, Lange B, Lona M. Dépenses normatives des organismes assureurs dans le cadre de l'introduction de la responsabilité financière (1995-1996). *Cahiers Economiques de Bruxelles*, 1996; 3-30.
- [9] Schokkaert E, Van de Voorde, C. Belgium: risk adjustment and financial responsibility in a centralised system. *Health Policy*, 2003; **65**: 5-19.
- [10] van de Ven W. *et al.* Risk adjustment and risk selection on the sickness fund insurance market in five European countries. *Health Policy*, 2003; **65**: 75-98.
- [11] Peers J, Gillet P, Hermesse J, Polus C. *Gezondheidszorg in België: uitdagingen en opportuniteiten*. Report for the Minister of Social Affairs, 1999.
- [12] Gillet P. *La production médicale. Les disparités dans l'utilisation des choix médicaux: vers une responsabilisation de l'offre*. Union Nationale des Mutualités Socialistes, Université de Liege, 1997.
- [13] Perelman J., Closon M-C. *Hospital response to prospective financing of inpatient days – the case of Belgium*. Mimeo: UCLouvain, 2004.
- [14] Closon M-C *et al.* *Impact des facteurs sociaux sur les coûts hospitaliers*. Report: UCLouvain, Centre d'Etudes Interdisciplinaires en Economie de la Santé, 2000.
- [15] Van de Voorde C, Van Doorslaer E, Schokkaert E. Effects of cost sharing on physician

utilization under favourable conditions for supplier-induced demand. *Health Economics*, 2001; **10**:457-471.

[16] Cockx B, Brasseur C. The demand for physician services. Evidence from a natural experiment. *Journal of Health Economics*, 2003; **22**: 881-913.

[17] Manning W, Newhouse J, Duan N, Keeler E, Leibowitz A, and Marquis M. Health insurance and the demand for medical care: evidence from a randomized experiment. *American Economic Review*, 1977; **77**:251-277.

[18] De Maeseneer J *et al.* *Getrouwheid van de patiënt aan de huisarts en gebruik van gezondheidszorg: een multivariate benadering*. Report for RIZIV/INAMI: Gent/Liege, 1997.

[19] Kestens P. De l'ampleur réelle des disparités régionales de dépenses de soins de santé. *Reflets et Perspectives de la Vie Economique*, 1996; **35**:161-173.

[20] Jadot M. *Vierde rapport over de eenvormige toepassing van de wetgeving in heel het land*. Report for General Council of RIZIV/INAMI: Brussels, 1999.

[21] Diels, J. Sociale en fiscale franchise: een evaluatie. *M-informatie (Informatieblad van de Christelijke Mutualiteiten)*, 1996; **171**:10-16.

[22] Van Winckel H, Versieck K, Boly J. Welk prijskaartje voor de verzorging van chronisch zieken? *M-informatie (Informatieblad van de Christelijke Mutualiteiten)*, 1997; **178**:2-12.

[23] Adriaenssen I, De Graeve, D. *Wie valt er door de mazen van het net? Verkennend profiel van de patiënt met betalingsproblemen in het ziekenhuis*. Research Paper 2001-018: University of Antwerp, 2001.

[24] Van Camp G, Van Ourti T, De Graeve, D. *Vergelijking eigen bijdragen doorheen de tijd op basis van huishoudbudgetenquêtes van 1978-79, 1987-88 en 1997-98*. Final Report DWTC-project SO/01/005, Part 2: Antwerp/Leuven, 2003.

[25] Schokkaert E, De Graeve D, Van Camp G, Van Ourti T, Van de Voorde C. *Maximumfactuur en kleine risico's: verdeling van de eigen bijdragen voor gezondheidszorg in België*. Mimeo: Antwerp/Leuven, 2003.

[26] Scientific Institute of Public Health. Health Interview Survey. <http://www.iph.fgov.be/epidemie/epien/index4.htm>.

[27] De Graeve D, Duchesne I. *Equity in health and in medical care consumption in Belgium*. Report 97/341: SESO, University of Antwerp, 1997.

[28] Van Doorslaer E *et al.* Equity in the delivery of health care in Europe and the US. *Journal of Health Economics*, 2000; **19**:553-583.

[29] Adriaenssen I, De Graeve D. *Socio-economische determinanten van medische consumptie*. Research Report: UFSIA Antwerpen, 2000.

[30] Van der Heyden J, Demarest S, Tafforeau J, Van Oyen H. Socio-economic differences in the utilisation of health services in Belgium. *Health Policy*, 2003; **65**: 153-165.

[31] Peersman W, De Maeseneer J. Sociaal-economische status en differentieel gebruik van

gezondheidszorgvoorzieningen. In *De gevelarchitectuur van de welvaartsstaat*, Louckx F (ed.). VUBPress: Brussel, 1995; 65-81.

[32] Gadeyne S, Deboosere P. *Socio-economische ongelijkheid in sterfte op middelbare leeftijd in België*. Working Paper: V.U.B. Interface Demography, 2000.

[33] Gadeyne S, Deboosere, P. De ultieme ongelijkheid: sterfteverschillen bij Belgische mannen en vrouwen naar socio-economische karakteristieken en huishoudenstype. *Belgisch Tijdschrift voor Sociale Zekerheid*, 2002; **44**:57-101.

[34] Vansteenkiste S. Een alternatieve bevoegdheidsverdeling voor de Belgische sociale zekerheid. *Acta Hospitalia*, 1998; **38**:51-62.

[35] Schokkaert E, Van de Voorde C. Interregionale financieringsstromen, defederalising en solidariteit in de Belgische ziekteverzekering. *Acta Hospitalia*, 1998; **38**:63-81.

[36] Van Ourti T. Measuring horizontal inequity in Belgian health care using a Gaussian random effects two part count data model. *Health Economics*, 2004; **13**: 705-724.

Table 1: Development of expenditures for health care over time (in million Euro)

	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
RIZIV/INAMI expenditure in current prices	4,788	7,071	8,044	8,871	9,182	9,421	9,938	10,957	10,656	11,294	12,029	12,819	13,774	14,157
RIZIV/INAMI expenditure in constant prices (1985=1)	4,788	6,370	7,022	7,559	7,615	7,632	7,934	8,571	8,201	8,610	9,069	9,425	9,883	9,993
RIZIV/INAMI expenditure /GDP in current prices (%)	3,93	4,33	4,70	4,94	4,96	4,38	4,92	5,29	4,91	5,01	5,11	5,18	5,42	5,41
Doctor fees	2,141	2,945	3,128	3,312	3,228	3,159	3,349	3,683	3,477	3,708	3,905	4,103	4,344	4,291
of which clinical biology	637	682	732	747	623	599	606	679	636	689	707	736	785	760
Pharmaceuticals	706	1,151	1,315	1,448	1,490	1,599	1,704	1,911	1,945	2,081	2,262	2,440	2,601	2,724
Rest and nursing homes	69	136	338	393	443	498	587	644	641	698	782	868	999	1,111
Nurses fees	117	247	266	298	312	336	381	419	413	472	511	548	563	607
Dentist fees	131	230	269	340	314	314	332	352	357	380	395	405	427	440
Physiotherapy	166	261	252	272	292	295	320	341	332	369	382	393	409	372
Per diem rate (RIZIV/INAMI)	1,295	1,725	1,919	2,085	2,249	2,302	2,494	2,783	2,635	2,644	2,812	2,954	3,159	3,287
Per diem rate (Ministry of Health)	533	653	682	701	736	832	850	946	937	1,032	1,067	1,087	1,075	1,169
Out-of-pocket co-payments	NA	NA	NA	NA	1.223	NA	1,120	1,216	1,199	1,263	1,296	1,314	NA	NA
Out-of-pocket: supplements hospital rooms	80	96	99	101	101	100	101	102	102	103	103	104	NA	NA
Out-of-pocket: non-reimbursable medicines	NA	528	548	588	664	675	708	729	816	848	878	927	940	947
Voluntary and supplementary insurance by sickness funds	NA	NA	NA	332	328	336	356	380	383	391	398	406	NA	NA
Private insurance	NA	NA	NA	NA	159	184	209	234	260	302	328	NA	NA	NA

Source: Handboek Gezondheidseconomie [5], RIZIV/INAMI, yearly reports.

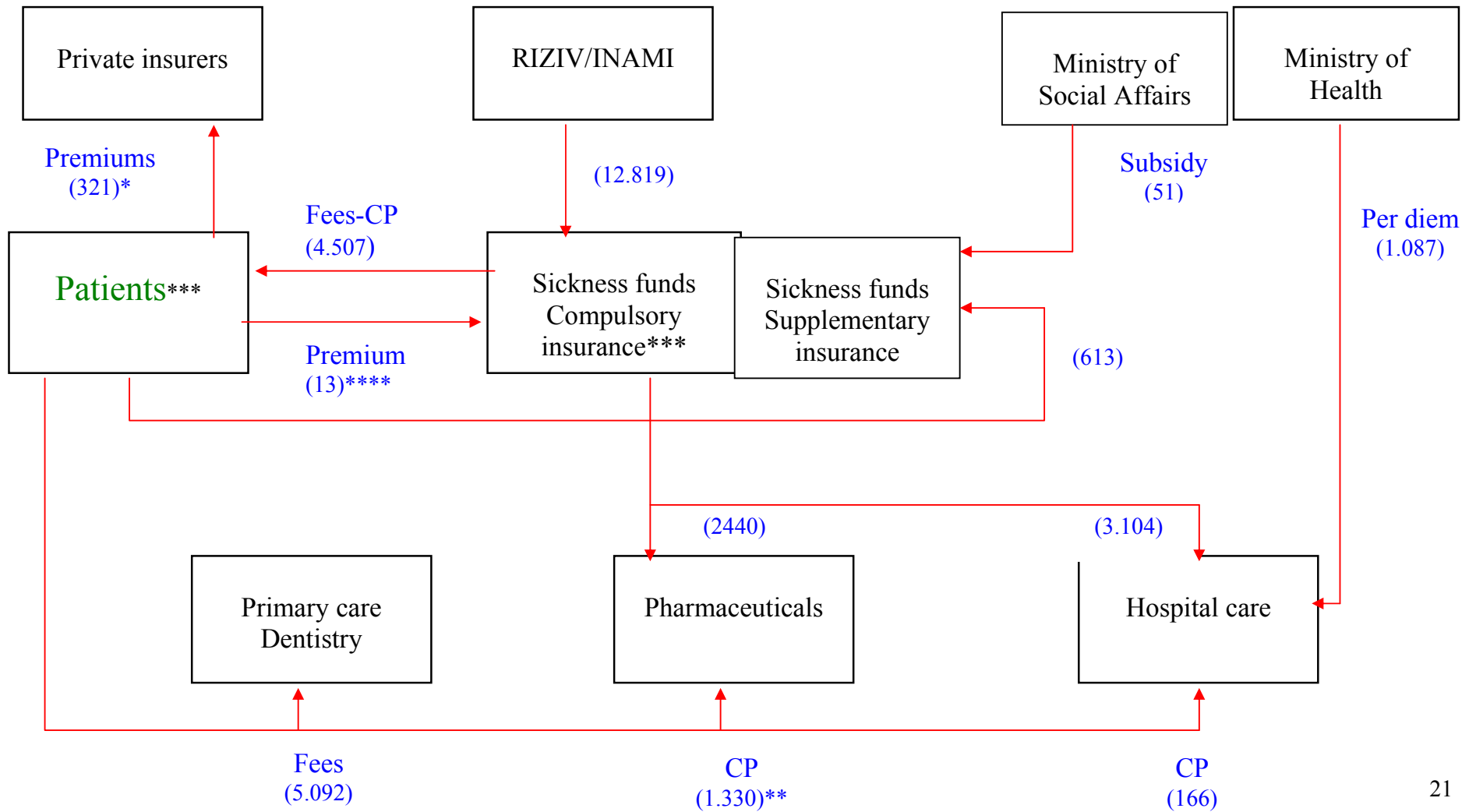
Table 2: Evolution of the life expectancy at birth, child mortality and the death rate

	1960	1970	1980	1982	1984	1986	1988	1990	1992	1994	1996	1998	1999	2000	2001
Life expectancy females	73.5	74.2	76.8	76.8	77.8	77.7	79.1	79.1	79.8	79.9	80.2	81.1	81.4	81.4	81.7
Life expectancy males	67.7	67.8	70.0	70.0	70.8	70.9	72.4	72.4	73.1	73.1	73.5	74.8	74.9	75.1	75.4
Child mortality (per 1.000 life births)	31.2	21.1	12.1	11.0	10.0	9.6	9.1	8.0	8.2	7.6	6.0	5.8	5.3	NA	NA
Deaths (per 100.000 inhabitants)	1,245	1,230	1,159	1,141	1,122	1,132	1,053	1,047	1,030	1,022	1,024	1,024	1,025	1,022	1,003

Source: Belgian National Statistical Institute.

Source: Belgian National Statistical Institute.

Figure 1. Financial flow-chart of the Belgian health care system (2000, millions of Euro)



* Own calculations for 1999.

** For 1999.

*** Copayments for the other sectors amounted to 1.001 million Euro, RIZIV/INAMI expenditure for the other sectors was equal to 2.770 million Euro.

**** This amount includes only the community-rated premiums paid directly by the patients to the sickness funds (omitting the public fund and the fund for railway personnel). It does not include the income-related social security contributions. As explained in the text, this financial stream goes via the government. Since the 1990s social security contributions are no longer earmarked for health care and are supplemented with a subsidy from general taxes. This total amount goes to RIZIV/INAMI and is then distributed over the sickness funds (see arrow in the Figure).