This document contains links to websites where you can find national legislation and health laws. We link to official government legal sources wherever possible. Where we link to unofficial sources this is noted and users should take this into account before relying on these materials. We recommend checking with the relevant national government if you have questions about the currency or validity of any unofficial source of law.

**Legal system**
Civil law

**National law database**

<table>
<thead>
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<th><strong>Language</strong></th>
<th>Dutch and French</th>
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<tr>
<td><strong>Link</strong></td>
<td><a href="http://www.ejustice.just.fgov.be/">http://www.ejustice.just.fgov.be/</a></td>
</tr>
<tr>
<td><strong>Nature</strong></td>
<td>Official gazette of Belgium</td>
</tr>
</tbody>
</table>

**Organisation responsible for the website:**
Belgian federal ministry of justice

**Legal UHC start date**
1945

**Source:**

**The health system and policy monitor: regulation (PDF)**

As part of its Health Systems in Transition (HiT) series the European Observatory on Health Systems and Policies systematically describes the functioning of health systems in countries as well as reform and policy initiatives in progress or under development. The HiT health system reviews cover the countries of the WHO European Region as well as some additional OECD countries. This PDF includes information about the country’s regulation. To see the complete HiT report of this country go to:
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Regulation

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Regulation

Belgium
HIT: 2010 - Gerkens S, Merkur S
HSPM Members: KCE, Belgian Healthcare Knowledge Centre
HSPM Contributors: Gerkens S, Merkur S
Belgium: Regulation

2.8 Regulation

Three political and administrative levels operate in the Belgian health system: the federal government, the federated governments and the local governments (provinces and municipalities). All levels play important roles, but the federal level is mainly responsible for social security, compulsory health insurance, pharmaceutical policy and hospital legislation. A typical characteristic of the Belgian health system is the participation of several stakeholders in the management of the system. Besides extensive regulation by the federal and federated governments, an important part of the health system is regulated by national collective agreements made between representatives of health care providers and sickness funds.

The basic right to health care has been set out in the Constitution. Article 23(2) of the Belgian Constitution recognizes the right to social security, protection of health and medical assistance. This constitutional right has been further developed in several laws and decrees.

2.8.1 Regulation of third-party payers

Compulsory health insurance is solely administered by sickness funds, which are non-profit-making, non-commercial organizations.

All individuals entitled to health insurance must join or register with a sickness fund. The choice is free, except for railway workers (1.1% of the insured in the general system in 2009), who are automatically covered by the health insurance fund of the Belgian railway company. Sickness funds are mainly organized according to religious or political affiliations into five national alliances: the National Alliance of Christian Mutualities (NACM), the National Union of Neutral Mutualities (NUNM), the National Union of Socialist Mutualities (NUSM), the National Union of Liberal Mutualities (NULM) and the National Union of the Free and Professional Mutualities (NUFPM). In 2009, the NACM and the NUSM together had the largest share of the general system, covering about 42.0% and 28.1% of the population, respectively. The Auxiliary Fund is an additional neutral public body intended for those patients who do not want to affiliate themselves with any of these groups. It accounts for not more than 0.7% of the insured (see Fig2.7) (NIHDI2008c).

By means of the Sickness Funds Act, sickness funds are entrusted with a central position in the compulsory health insurance system. They have to control health care expenditure and ensure it conforms with the legal regulations. Some services are only reimbursed if there has been a prior approval by the so-called advisory physicians of the sickness funds. These advisory physicians can question the prescription of expensive pharmaceuticals, the length of hospital stays and the ascertainment of patients to the various classes of the Katz-scale in long-term care financing (see Section 5.8 Long-term care for the elderly).

Sickness funds act collectively in their negotiations with health care providers. To evaluate and to avoid abuse of their members, they have medical examiners. Moreover, since 1995, Belgian sickness funds have been made more financially accountable for the expenditure of their insured members (see Section 3.3.3 Pooling of funds).

For their role in the compulsory health insurance system, as well as in the administration of the incapacity and disability insurance, sickness funds receive subsidies from the NIHDI to cover their administrative costs. This subsidy is based on the number and social characteristics of their members, with some corrections for efficiency in the management of the system.

The Sickness Funds Act also allows sickness funds to develop services and activities outside mandatory social security so long as they are related to the health and well-being of their members. In the field of VHI, they compete with commercial insurance companies. Unlike the latter, sickness funds are not allowed to operate risk selection.

Competition among sickness funds concentrates mainly on their service to members and the complementary activities and services they offer. Legally, sickness fund members have the opportunity to
change their sickness fund each quarter if they have been enrolled for a period of at least one year. With only about 1% of all members switching each year, insurance mobility has been low (Schokkaert and Van De Voorde 2003).

**Fig27: Distribution of members, 2009**

Source: NIHDI 2009j.

### 2.8.2 Regulation of providers

Providers fall into two groups: (1) health institutions such as hospitals, homes for the elderly and nursing homes, day centres, laboratories and outpatient clinics; and (2) health professionals, such as physicians, dentists, physiotherapists, pharmacists, nursing practitioners and nursing auxiliaries, midwives and paramedical practitioners, who are generally organized as self-employed professionals (except nurses and midwives). Both groups are discussed further in the following subsections.

**Health institutions**

The government plans global hospital capacity by requiring that hospitals obtain accreditation from the regional ministries of public health to operate a certain number of beds for each service category (e.g. acute care, surgery, maternity). Accreditation is granted only if a proposal for hospital opening, extension or alteration respects national planning. Planning usually takes the form of target figures (e.g. 2.9 beds per 1000 inhabitants for general inpatient services; 32 beds per 1000 births for maternity services).

There is a variety of accreditation norms for hospitals. Organizational norms relate to staff requirements (e.g. qualification levels, ratio between qualified personnel and auxiliaries) and responsibilities (e.g. hygiene, ethical requirements); architectural criteria (e.g. the number, size, comfort and hygiene standard of hospital rooms); functional standards (e.g. convenience, accessibility); additional norms relating to minimum activity (e.g. they stipulate that hospitals should have no less than 150 beds; diagnosis/surgical units no fewer than 30 beds; intensive neonatal units no fewer than 15 beds), setting minimum facility standards; and expected staff numbers. Accreditation criteria are developed at the federal level and are implemented and controlled at the community level.

There are also specific accreditation norms for services involving heavy medical equipment (e.g. radiology with CT and MRI, radiotherapy, renal dialysis, nuclear medicine, non-urgent patient transport, centres for human heredity) and for certain hospital functions (e.g. hospital pharmacy, local neonatal care, perinatal care, palliative care, surgical day hospitalization, initial relief of emergency cases, specialized emergency care, intensive care, mobile emergency groups and psychiatric family nursing). Since 1999, the regulation and accreditation of medical hospital services and functions have also gradually been replaced by the accreditation of "care programmes" (see Section 2.6.3 Mechanisms to ensure the quality of care).

The communities are responsible for authorizing hospital building, while capital subsidies are shared by
the communities and the federal government. Only the investments listed in the building programme can be paid for from the hospital budget provided by the federal government. The federal government managed to reach an agreement with the communities for a building programme just as the merging of hospitals threatened to greatly multiply the level of federal expenditure for hospital building. Hospitals were obliged to merge to work on a larger scale to improve their productivity.

Regulations of other health institutions, such as homes for the elderly and nursing homes, are described in Chapter 5.

Health professionals

The practice of most health care professionals is regulated by the Practice of Health Care Professions Act. This law regulates access to professions such as physicians, dentists, physiotherapists, pharmacists, nurses, midwives and practitioners of a paramedical profession (see also Section 4.2.2 Registration/licensing and planning of health care personnel).

In 1996, the federal government set up the Committee for Medical Supply Planning. The original remit of this Committee was to ascertain medical supply needs with regard to physicians and dentists, and to take account of the evolving needs of medical care, the quality of care provision, and the demographic and sociological development of the professions concerned. Later, the remit of this committee was extended to cover physiotherapists (1997), nurses, midwives and logopaedists (1999) as well (see also Section 4.2.2 Registration/licensing and planning of health care personnel).

National agreement between physicians and sickness funds 2016-2017

By Sophie Gerkens

On 27 January 2016, a new agreement was published, for the 2016-2017 period, between the representatives of physicians and sickness funds. The objectives of this agreement were to promote: access to care and financial transparency; the role of GPs in prevention and patient management; care integration for chronic disease patients; continuity of care with a more effective use of emergency services and organized duty centres (i.e. well-equipped practices providing out-of-hours primary care services for people in specific geographical areas); and the use of innovative treatments/techniques.


National agreement between representatives of physicians and sickness funds 2012

By Sophie Gerkens

The agreement has the following objectives:
• Strengthening primary care by implementing the IMPULSEO III fund, consisting in an enlargement of impulseo funds for solo practice (financial support for administrative assistance)
• Increasing the attractiveness of conventionnement
• Reducing health care expenditures by:
  o A limitation of the indexation in January 2012
  o The proposal of structural measures by a working group for June 2012
The limitation of the indexation could be removed later, when the structural measures will be executed and that, no later than for December 1, 2012.

More details on this agreement can be found on the following link: http://www.riziv.fgov.be/care/fr/doctors/general-information/agreements/2012/index.htm
2.8.3 Mechanisms to ensure the quality of care

Health institutions

Hospital regulations

The Hospital Act contains several provisions promoting quality of care. Architectural, organizational and functional accreditation standards aim to guarantee a minimal level of quality for inpatient care. However, because of their static character, accreditation standards can guarantee quality only to a limited extent (Callens and Peers 2003).

Besides accreditation standards, the Hospital Act contains several requirements which can promote quality of care, such as those concerning the organization of medical and nursing activity, the description of the tasks of the medical manager, the obligation to maintain a medical file, the tasks of the Medical Council, the establishment of an ethical committee, a committee for hospital hygiene, a medical pharmaceutical committee, a committee for medical material, a committee for blood transfusions, as well as other specialized committees.

Since 1999, the medical manager of each hospital must compile a report concerning the internal evaluation of the quality of the medical activity. This report must be sent to the colleges of physicians, established at the FPS Public Health. The objective of these colleges is to promote quality of care by consensually developing indicators of quality and ways of evaluating good medical practice; recording and reporting activities; giving information to the multipartite consultation structure for hospital policy; and giving feedback to the hospitals and physicians concerned. These colleges of physicians were established in several fields: cardiac pathology, specialized emergency care, intensive care, renal dialysis, mother and neonate, radiology and nuclear medicine, radiotherapy, reproductive medicine and oncology. The appointment of the members of the colleges is generally based on the advice of the scientific associations of the respective disciplines.

Since 1999, the regulation and accreditation of medical hospital services and functions have also gradually been replaced by the accreditation of “care programmes”. A care programme is the collection of several hospital activities which are organized around certain pathologies or patient groups (e.g. paediatric patients). For each care programme, legal criteria are set related to the target group, nature and content of care, minimum activity level, necessary infrastructure, required medical and nonmedical staff and their required expertise, standards concerning quality and quality monitoring, economic standards and geographical accessibility criteria. At present, there are care programmes for reproductive medicine, cardiac pathology, oncology, and geriatric and paediatric activities (see also Section 5.4 Secondary care).

The quality requirements for nursing staff were also upgraded and the hospital nursing department was defined. To improve the functioning of nurses, a nursing record was designed and recommendations were formulated for an electronic record, which fits with the new registration of the nursing activity in hospitals. Furthermore, a new statute for midwives was established, as well as for nursing assistants in hospitals, in nursing and homes for the elderly and in home care.

Furthermore, with regard to the organization of hospital hygiene, the integration of the hygienist physician and nurse team has been emphasized. Additional measures are in place to improve staff compliance and to generalize registration with an obligation to register methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile. Special attention has been given to hand hygiene through three national campaigns (in 2005, 2006 and 2009).

In addition, a committee for antibiotherapy was set up in the hospitals in order to promote a better use of antibiotics and to reduce resistance (Royal Decree of 12 February 2008).

In 2007, the first contract for the coordination of quality and patient safety in Belgian hospitals was approved. An annual budget of €6.8 million was allocated for this project and a total of 164 hospitals (80% of all hospitals) agreed to participate (including acute psychiatric and long-term care hospitals) (Borgermans et al. 2009). The hospitals had to provide information on the six different parts of the contract including: (1) hospital mission and objectives with regard to quality and patient safety; (2) overview of existing structures regarding quality and safety of care; (3) organizing a survey on patient safety culture; (4) reporting and analysing incidents and near incidents; (5) introducing “quality” projects concerning three
out of four topics (i.e. economic performance, capacity and innovation, clinical performance and patient safety); and (6) selecting indicators from the “multidimensional feedback” (only for acute hospitals) and answering specific questions with regard to the selected indicators. These multidimensional indicators are based on administrative data and were used as benchmarking measures among acute care hospitals.

The first contract allowed hospitals to formulate recommendations concerning (among others) information and ICT needs, financial support and harmonization of policies at the federal and federated level. Between 2008 and 2012, hospitals must follow a pluri-annual plan focused on three pillars including: (1) structure: development of safety management systems; (2) process: analysis of processes; and (3) results: the development of multidimensional set of indicators. For psychiatric hospitals, specific settings on quality and safety were established. Indeed, the pillar-process mentions that internal transfers as well as vigilance regarding aggression are important issues for these institutions (FPS Health, Food Chain Safety and Environment 2008c). The participation of hospitals has increased constantly and reached 90% for the 2009–2010 contract, which is a clear indicator for the success of the pluri-annual programme.

Integration of care and multidisciplinary collaboration

Since 2000, the reform and modernization of hospital services have been tackled again. The new objectives of policy-makers were to integrate care between organizations by improving multidisciplinary collaboration between health professionals and facilities in order to rationalize supply and improve quality of care. Incentives were created for hospitals within the hospital financing system to rationalize supply, to create complementarities between different hospital sites or to reduce their number of beds. Hospitals were encouraged to adhere to “care areas”, which could lead to more complementarities within a region. At the same time, powerful incentives were created to modernize hospital infrastructure by covering, within the hospital financing system, a greater part of the construction cost, by increasing the tariffs of construction ceilings and by facilitating renovations. Additional measures to foster quality of care were through the increased interest in clinical pathways (see Section 5.2 Patient pathways). In particular, for certain disease groups, such as diabetes and renal failure, quality of care could be improved through better coordination of multidisciplinary teams and a tool for establishing more integrated care, also linking the hospital with the primary care level.

Feedback and reference amounts

Also hospitals receive feedback on the activities of their practising physicians, compared with other hospitals. Systems of peer review were set up to compare practices and outcomes between physicians in Belgium and against internationally accepted standards. Feedback on pre-operative examinations (2005) and on prenatal care (2007) was also provided (see also the following section).

In order to address significant differences in medical practice between hospitals which can not be explained medically, a system of reference amounts for standard interventions was introduced. This recuperation system has been applied to admissions since 1 October 2002. For standard interventions, a significantly divergent consumption profile is compared to a national reference amount (the average of national expenditures increased by 10%). This recuperation system is only applied for 34 APR-DRGs (see Table2.2), two severity levels of the disorder (levels 1 and 2), and three services groups (see below). Severity should be taken into account because average consumption per patient increases systematically with the degree of severity. Recuperation will only be applied for severity classes 1 and 2. The number of cases that fall under severity classes 3 and 4 is limited for most pathology groups. It may for example involve a (rare) serious complication or a patient with significant co-morbidity.

In the selection of APR-DRGs, the starting point was that medically homogeneous and simple pathologies that occur frequently had to be included. Table2.2 shows the APR-DRGs that were ultimately included in the system of reference amounts, and that qualify for recuperation.

Moreover, only the following groups of services are taken into account:

- clinical biology, with the exception of lump sum payments;
- medical imaging, with the exception of lump sum payments and nuclear MRI; and
- internal medicine, physiotherapy and various technical medical services.

The first stage of the system consists of identifying hospitals which should be taken into account for
reimbursement. For this, the difference between the real expenditure of the hospital and the expenditure of the reference (= number of stays concerned in the hospital x reference amount) are calculated for each selected APR-DRG (after the elimination of outliers), severity levels and services groups (i.e. 204 differences: 34 x 2 x 3). These differences are then added and only hospitals with a positive result are selected. In 2009 (based on 2006 data), 34 of the 125 hospitals were selected (NIHDI 2009i).

The second stage consists of the determination of the amount that should be reimbursed. For this, the difference between the real expenditure of the hospital and the median national expenditure is calculated for each selected APR-DRG (after the elimination of outliers), severity levels and services groups. Then, all positive differences are added. If this total amount is greater than €1000, this amount must be reimbursed by the hospital. In 2009 (based on 2006 data), a total of €5 982 577 had to be reimbursed (NIHDI 2009i) (see Table 2.3).

The first reference amounts were for 2003, but the system was abrogated for the years 2003–2005 by the Health Law (Act of 31 December 2008). The first reference amounts were then determined for 2006 with a new methodology based on recommendations from a KCE report (Van de Sande et al. 2005). Then, a new methodology was applied for hospital stays ending after 31 December 2008. This 2009 methodology provides reference amounts in advance in order to allow hospitals to adapt their behaviour accordingly and to use mechanisms in order to avoid a downward spiral of the average national amounts. More details on these methodologies can be found on the NIHDI website (NIHDI 2009i).

Quality policy and plan in Flanders

Initiatives have also been taken by the Flemish community. In 1997, the Flemish community created a framework to improve quality of care in health care institutions. The decree concerning quality of health and welfare stipulated that the aim of the health care system is to supply health care to each patient without distinction with regard to age or gender, ideological, philosophical or religious conviction, race or nature and financial situation of the person concerned. When developing an integrated quality policy, attention must be given to justified care which meets the requirements of effectiveness, efficiency, continuity, social acceptability and user orientation.

Each health care institution in Flanders (general hospital, psychiatric hospital, home for the elderly, nursing home and centre for mental health care) must implement a quality policy by means of a quality manual and quality plan. The quality manual describes the vision and the objective of the internal quality policy. This manual is translated into a quality plan that includes a description of the existing situation and the operational objectives concerning specific fields imposed by the government. Every care institution is expected to set up improvement schemes and to evaluate them periodically. The imposed topics by the government are:

- clinical performance concerning hospital mortality, unplanned readmissions, obstetric care, average length of stay, day care and transfusion reactions;
- operational performance defined as a permanent monitoring and improving the general organization;
- satisfaction of patients;
- satisfaction of employees.

The quality plan also provides details concerning timing and evaluation. Also, a quality coordinator is selected to carry out the policy. Care institutions can only obtain, preserve and extend their accreditation if they fulfil the requirements of the quality decree.

Along with the implementation of quality legislation, Flemish health care institutions began to address the issue of quality in a more structured way. A dialogue began between the health care institutions themselves and between the government and the health care institutions. From this dialogue, the focus on quality took the direction of specific, systematic and integrated bottom-up quality control (Valepyn 2005).

Health professionals

Several measures to increase the quality of the health system were undertaken for health professionals, including establishing an accreditation system, strengthening primary care and making health care providers more accountable. The measures undertaken after 2007 are described in Chapter 6.
**Accreditation of physicians**

To further increase quality of care, a system of physician accreditation has been developed. Two national laws define the conditions of accreditation in Belgium. The law of 14 July 1994 (*Moniteur Belge* 1994) describes the accreditation scheme for GPs that refers to the certification of doctors who fulfill specific criteria. There are four domains: medical practice criteria (especially the minimal threshold of patient contacts), continuing medical education (learning activities with accumulation of a minimum number of points), an evaluation of medical practice (participation in meetings with a local quality evaluation group (LOK-GLEM)) and rational prescribing. Accreditation is not mandatory, but it is encouraged through financial incentives for accredited physicians: increased consultation fees and an annual contractual indemnity (Van der Brempt 2007).

All physicians have to keep medical records of their patients, collect at least 20 credits of continuing medical education per year, have at least 1250 patient encounters per year, and not have an outlier prescription profile. GPs should attend LOK-GLEM meetings at least twice a year. Each LOK-GLEM strives for consensus about subjects chosen by the group concerning medical strategies, evaluates prescribing profiles and develops an annual evaluation report.

**Increasing accountability**

In 2001, the Belgian government felt that insufficient progress had been made towards the efficient use of health care resources. Significant differences were noted in the practice of physicians, without medical explanations for these differences. For the same problem or the same group of patients, considerable differences were observed in the choice of pharmaceuticals, treatments, and techniques of medical imaging and clinical biology.

The government therefore asked physicians, sickness funds and managers of hospitals to: (1) formulate proposals for reducing individual differences in practice to an acceptable level of variation with respect to scientifically based objective standards; and (2) develop techniques as a result of which prescribers and providers would be held individually accountable for the resources they use and the costs they generate.

Drawing from the consultation conclusions, the government devised a policy to make providers more accountable, from 2003 onwards, upon the following principles:

- promoting quality by encouraging good medical practice on the basis of recommendations and feedback that gives physicians the opportunity to compare their medical practice with respect to other physicians; and
- preventing and (if necessary) sanctioning divergences from good medical practice and the correct application of the stipulations provided for in the compulsory health insurance system.

The National Council for Quality Promotion, set up in 2002, is responsible for quality promotion. It is composed of representatives of the physicians, the universities, the scientific medical associations, the sickness funds and the Minister of Social Affairs and Public Health. Data on prescribing behaviour, together with recommendations on good medical practice, are first checked for their relevance in a limited number of local quality evaluation groups (LOK-GLEM). After this evaluation and any modification, all physicians (GPs and specialists) receive feedback. Then, in Local Medical Evaluation Groups, physicians test their own individual behaviour against that of their colleagues with the aim of improving quality of care. Reviews are not compulsory. The recommendations on good medical practice are provided to offer physicians a frame of reference. Health providers or health care institutions have received feedback on the following areas: antibiotics (2001, 2003, 2007, 2010), hypertensive prescriptions (2002, 2003), pre-operative examinations (2005), extreme outliers (amoxiclav, quinolones, sartan, 2005), the prescription of a minimum percentage of cheap medicines (2006, 2007, 2008, 2009), prenatal care (2007) and breast cancer screening (2002, 2004, 2005, 2006, 2007, 2009) (see also Chapter 6).

The Department for Medical Control of the NIHDI was reformed in 2003 to tackle the issue of divergences with respect to good medical practice. Since 1989, this office already had the task of controlling the misuse of diagnostic and therapeutic freedom, related in particular to over-consumption. However, the existing legislation for combating over-consumption was considered inadequate due to unrealistic penalties, legal
uncertainty and the unwieldy structure. As a result of the reforms introduced to make health care providers more individually accountable, the Department for Medical Control became the Department for Medical Evaluation and Inspection (DGEC-SECM) and received two new assignments:

- evaluating the reimbursement of medical care consumption in light of the measures taken to prevent and detect misuse; and
- providing information to health care providers, such as recommendations on good medical practice and indicators of over-consumption.

As a logical result of the recommendations of good medical practice, the National Council for Quality Promotion was given the task of establishing indicators of divergence with respect to normal medical practice. The Commission for the Reimbursement of Pharmaceuticals (CRP-CTG-CRM) formulates recommendations in connection with the prescribing behaviour of certain proprietary pharmaceuticals. The DGEC-SECM can also submit a proposal of indicators to the National Council for Quality Promotion or the Committee for the Evaluation of Medical Practices for Drugs on the basis of a scientifically underpinned dossier.

As soon as an indicator of divergence is definitely established, the DGEC-SECM provides information, on an individual anonymous basis, about the relevant services. Any divergences are reported to the Committee of the DGEC-SECM. Subsequently, all health care providers that score more than the set indicator value are requested to account for their behaviour and to justify the divergence in medical practice. If it appears after investigation that the explanation received is a satisfactory clarification for their divergence from the norm, this is communicated to the care provider in question. If the explanation is unsatisfactory or the request for additional information was not complied with, the care provider is placed under monitoring for six months.

During the monitoring period, the provider’s entire practice and/or prescribing behaviour is evaluated for a minimum of six months on the basis of all useful indicators with variation from the normal medical practice or, in their absence, on the basis of a comparison with the practice of a normally prudent and diligent care provider in similar circumstances. After the monitoring period, the practice is re-evaluated. If it appears that the care providers in question have not modified their behaviour to normal medical practice, they are requested to provide a written explanation. This explanation is either accepted or considered unsatisfactory. If unsatisfactory, the case will be heard by two members of the Committee of the DGEC-SECM. A decision will then be taken and a sanction may be imposed.

Through the reform, it is possible to sanction all establishments or people that organize health care provision, such as hospitals and their managers, for carrying out or having carried out unnecessarily costly or unnecessary services, at the expense of the statutory medical insurance, with the sole aim of increasing their incomes.

Prior to the reform of 2003, the sanctions against over-consumption consisted of suspension of both the third-party payer arrangement and the reimbursement of unnecessary or unnecessarily expensive services. The problem with the suspension of the third-party payer arrangement was that it affected not only the physician but also the patient, since the latter had to change physician or pay the full fee. Furthermore, such a sanction was discriminatory. The third-party payer arrangement is mainly applicable in the case of specialists and only for a limited proportion of GP activities.

Consequently, sanctions now consist of administrative fines and withdrawal of accreditation of the care provider in question. However, the first aim of this reform remains to prevent divergent behaviour by providing information and by monitoring medical practice. If these measures are not successful in bringing the provider’s medical practice in line with the guidelines, then fines are imposed. After a first evaluation of this reform at the end of 2006, some changes were introduced to clarify and improve the procedure and the rights of the prescribers. Divergent prescription profiles are not examined case by case, and they are to be evaluated in the light of the doctor’s overall practice.

**Strengthening primary care**

Although GPs do not have a gatekeeping role in Belgium, a number of decisions were taken in past years to reassess and strengthen primary care, as well as to reappraise and promote the profession. The most important of these are listed below.
In 1999, the Global Medical File (GMD) was established to increase the availability of medical, social and administrative patient information and access to such information. This measure was introduced with the aim of optimizing the quality of primary care provided and avoiding unnecessary or duplicated care and contradictory prescriptions. The GP holds the GMD with the patient’s consent and shares relevant information with other providers responsible for the patient. The GMD was initially only implemented for those 60 years old and over, from 1999 to 2000. Its use was eventually extended for those over 50 on 1 May 2001 and, finally, since 1 May 2002, the entire population was eligible. Only one GP can hold the patient’s file. GPs charge a fixed amount per year, fully reimbursed by compulsory health insurance, to keep the patient’s GMD. Consequently, for each consultation in that year with the GP holding the GMD, co-insurance by the patient is reduced by 30%. Similar patient contribution reductions for home visits apply to vulnerable groups, such as the chronically ill or patients over 75 years old.

An additional incentive for patients to use their GP as a preferential entry point is the increased reimbursement (up to the preferential reimbursement rate) for the first visit to a specialist if referred by a GP.

To discourage ambulatory patients with problems that can be solved by the front-line system from directly accessing the accident and emergency (A&E) services in hospitals, different measures have been tested. First, as of 1 March 2003, hospitals were allowed to charge patients a fixed amount of €12.50 for using a hospital A&E unit (no co-payment for some exceptions). On 1 July 2005, this user charge had become compulsory for all hospitals and had been reduced to €9.50 (€4.75 for patients who are beneficiaries of preferential treatment). The list of co-payment exceptions has also been enlarged. Since 1 July 2007, fixed co-payments have been replaced by modulated ones. The amount of co-payment depends on the status of the patients, and is reduced if patients are brought to the A&E unit via emergency medical aid or if they are referred by a physician.

From 2003, GP circles were established. Within a GP circle, local GPs work in collaboration to reach an agreement with local authorities to organize out-of-hours shifts, improve emergency care, arrange locums for GPs who are ill or on holiday, take measures for GP safety, conclude agreements with domiciliary care providers, inform the population and set up local care programmes in the context of preventive medicine. Funding for GP circles is mainly based on the number of inhabitants in the GP area where the circle operates. Additional funds support GP circles with the organization and operation of a central telephone line for out-of-hours calls.

Another more recent initiative taken to promote the use of front-line medical assistance is the creation of primary care outposts, which are permanently organized on-call services for GPs, with the necessary infrastructure to treat minor urgencies. These new primary care outposts are established under the form of pilot projects.

Because of the varied geographical distribution of GPs, an impulse fund was created in 2006 to grant interest-free loans and subsidies to doctors starting a GP practice in an area with a shortage of GPs (see also Chapter 6).

With the increase of chronic conditions, the primary care level will be required to play an increasingly important role in guiding patients through the health system and coordinating and managing home care. Along with the GP, who is a vital link in this context, Integrated Services for Home Care (ISHC-GDT-SISD) have been created and funded since 2003 by compulsory health insurance to support a multidisciplinary approach within primary care (see also Section 5.8 Long-term care for the elderly). These ISHC-GDT-SISDs are to support in a care zone the practical organization and coordination of home care provided by professionals of various disciplines. In particular, the role of the ISHC-GDT-SISD is to evaluate the autonomy of the patient, draw up and follow up on a care plan, divide the tasks between the different care providers and organize a multidisciplinary consultation, which, since 1 January 2006, is reimbursed for patients at home or institutionalized patients who will be returning home.
### Table 22: APR-DRGs in the system of reference amounts

<table>
<thead>
<tr>
<th>APR-DRG</th>
<th>Description</th>
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<tbody>
<tr>
<td>024</td>
<td>Extracranial vascular procedures</td>
</tr>
<tr>
<td>045</td>
<td>CVA with infarct</td>
</tr>
<tr>
<td>046</td>
<td>Non-specific CVA and pre- and postoperative occlusion without infarct</td>
</tr>
<tr>
<td>047</td>
<td>Transient ischaemia</td>
</tr>
<tr>
<td>072</td>
<td>Extracranial procedures except orbit</td>
</tr>
<tr>
<td>073</td>
<td>Lens procedures with or without vitrectomy</td>
</tr>
<tr>
<td>097</td>
<td>Tonsillectomy and adenoidectomy procedures</td>
</tr>
<tr>
<td>134</td>
<td>Pulmonary embolism</td>
</tr>
<tr>
<td>136</td>
<td>Respiratory malignancy</td>
</tr>
<tr>
<td>139</td>
<td>Simple pneumonia</td>
</tr>
<tr>
<td>171</td>
<td>Permanent cardiac pacemaker implant without AMI, heart failure or shock</td>
</tr>
<tr>
<td>176</td>
<td>Cardiac pacemaker and defibrillator device replacement</td>
</tr>
<tr>
<td>179</td>
<td>Vein ligation and stripping</td>
</tr>
<tr>
<td>190</td>
<td>Circulatory disorders with AMI</td>
</tr>
<tr>
<td>202</td>
<td>Angina pectoris</td>
</tr>
<tr>
<td>204</td>
<td>Syncope and collapse</td>
</tr>
<tr>
<td>225</td>
<td>Appendectomy</td>
</tr>
<tr>
<td>226</td>
<td>Inguinal and femoral hernia procedures</td>
</tr>
<tr>
<td>244</td>
<td>Diverticulitis and diverticulosis</td>
</tr>
<tr>
<td>263</td>
<td>Laparoscopic cholecystectomy</td>
</tr>
<tr>
<td>302a</td>
<td>Major joint and limb reattachment procedure of lower extremity except for trauma if nomenclature code 289085 – arthroplasty of the hip with total prosthesis (acetabulum and femur head) were charged</td>
</tr>
<tr>
<td>302b</td>
<td>Major joint and limb reattachment procedure of lower extremity except for trauma if nomenclature code 290285 – femorotibial arthroplasty with sectional prosthesis was charged</td>
</tr>
<tr>
<td>313</td>
<td>Knee and lower leg procedures except foot if nomenclature code 300344 – therapeutic arthroscopy (partial or total meniscectomy) was charged</td>
</tr>
<tr>
<td>318</td>
<td>Removal of internal fixation device</td>
</tr>
<tr>
<td>445</td>
<td>Minor bladder procedures</td>
</tr>
<tr>
<td>464</td>
<td>Urinary stones with ESW lithotripsy</td>
</tr>
<tr>
<td>465</td>
<td>Urinary stones without ESW lithotripsy</td>
</tr>
<tr>
<td>482</td>
<td>Transurethral prostatectomy</td>
</tr>
<tr>
<td>513a</td>
<td>Uterine and adnexa procedures for malignant or nonmalignant if nomenclature code 431281 – total hysterectomy by abdominal route was charged</td>
</tr>
<tr>
<td>513b</td>
<td>Uterine and adnexa procedures for malignant or nonmalignant if nomenclature code 431325 – total hysterectomy by vaginal route including posterior colpotomyhysteraphy was charged</td>
</tr>
<tr>
<td>516</td>
<td>Laparoscopy and tubal interruption</td>
</tr>
<tr>
<td>517</td>
<td>Dilation, curetteage and conization</td>
</tr>
<tr>
<td>540</td>
<td>Caesarean delivery</td>
</tr>
<tr>
<td>560</td>
<td>Vaginal delivery</td>
</tr>
</tbody>
</table>

### Table 23: Amounts to be reimbursed in 2009 (based on 2006 data)

<table>
<thead>
<tr>
<th></th>
<th>Total expenditures €</th>
<th>Amounts to be reimbursed €</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical imaging</td>
<td>15 936 099</td>
<td>1 908 862</td>
<td>12.4</td>
</tr>
<tr>
<td>Clinical biology</td>
<td>6 289 410</td>
<td>780 569</td>
<td>12.4</td>
</tr>
<tr>
<td>Technical medical services</td>
<td>23 197 377</td>
<td>3 293 146</td>
<td>14.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>44 822 866</strong></td>
<td><strong>5 982 577</strong></td>
<td><strong>13.3</strong></td>
</tr>
</tbody>
</table>

Source: NIHDI 2009i.
Campaign on the responsible use of antibiotics

By Sophie Gerkens

A new campaign on the responsible use of antibiotics was launched in December 2014 as well as a new strategic plan for 2014-2019 to fight against bacterial resistance. For details see:
http://health.belgium.be/eportal/Myhealth/Properuse/Antibiotics/BAPCOC/index.htm?

2015 National agreement between physicians and sickness funds

By Sophie Gerkens

On 22 December 2014, a new agreement was concluded, for a one year period, between the representatives of physicians and sickness funds. The objectives of this agreement concerned: the development of eHealth, the rational use of pharmaceuticals and the reduction of polypharmacy, the correct use of duty and emergency services, and the promotion of the global medical file and evidence-based practice. This agreement also foresees the enlargement of care pathways, based on a generic model (a pre-trajectory will be established and financial incentives will be increased) as well as the obligation of the social third-party-payer-system for people with preferential reimbursement who consult their GP.
For details see:

New law for implants and medical devices

By Sophie Gerkens

On 1 July 2014, a Royal Decree reforming the system of reimbursement of implants and invasive medical devices entered into force. The main objectives were: administrative simplification, greater transparency, faster decision-making, and pricing security for patients. In 2015, the Minister of Social Affairs and Public Health undertook further objectives - to reduce the price and volume of implants and to promote the use of implants only when it is totally indispensable. For details see:
http://www.inami.fgov.be/fr/professionnels/sante/fournisseurs-implants/Pages/remboursement-implants-dispositifs.aspx (French) /
http://www.inami.fgov.be/nl/professionals/individuelezorgverleners/verstrekkers-van-implantaten/Paginas/terugbetalinq-implantaten.aspx (Dutch)

New norms in medical imaging

By Sophie Gerkens

In Belgium, new norms for the installation and running of heavy medical equipment in hospitals have been approved (August 2014). To limit patient exposition and promote MRI instead of scans, the number of MRI units allowed has been increased. Moreover, because of the increasing demand for PET scans and to ensure patient accessibility, the number of PET units allowed has also been increased. For more details: http://www.syndicat-medecins.be/scanners.html
Substitution rights for radiologists

By Sophie Gerkens

To improve quality of care, avoid unnecessary exposure of the population to ionizing radiation, and optimize the use of resources, radiologists have been given substitution right as of April 2014. They can replace the test proposed by the prescriber by a more appropriate examination (X-rays, CT scans, MRI or ultrasound) by taking into account the demand of diagnosis, the clinical context and previous examination history. Since March 2013, prescriptions for medical imaging have been standardized and include more information. For more details:

Creation of EBMPacticeNet

By Sophie Gerkens

EBMPracticeNet was created in 2011 to offer an easy and reliable access to good clinical practice guidelines. EBMPracticeNet makes the link between the various producers of Belgian guidelines and aims to improve accessibility, coherence and consistency of evidence-based medicine (EBM) information for all health care providers in Belgium in order to optimize the quality of care. Current guidelines temporarily target general practitioners but in the long term, guidelines will also target specialists, nurses, physiotherapists, and pharmacists. Patients can also have access to this free EBM information. For more details: http://www.ebmpricenct.net/Pages/default.aspx

Support of general medicine

By Sophie Gerkens

The Council of Ministers of 13 December 2012 approved a proposal of royal decree allowing to grant subsidy to some scientific organizations in general medicine. Their aim is to provide logistic and scientific support, to improve guidelines coordination, to support projects aiming at providing a unique call number for out-of-hours services, and to support practice group.

Hospitals of the Flemish region will start with quality indicators

By Sophie Gerkens

A core set of indicators has been developed to measure objectively the quality of care in hospitals of the Flemish region. The final methodological framework of the indicators will be delivered to hospitals in the coming months. Hospitals are encouraged to participate on a voluntary basis. After a content validation, the results will be sent to participating hospitals that will be able to compare their own results with data from other anonymous hospitals. They are also encouraged to publish their results, e.g. via their website. More details can be found via the following link: http://www.zorg-en-gezondheid.be/kwaliteitsindicatoren/

Launch of a campaign to increase accountability for medical imaging

By Sophie Gerkens

In 2010, recommendations for prescribing medical imaging have been created by a platform for
medical imaging including members of the FPS Public Health, the Federal Agency for Nuclear Control, the National Institute for Health and disability Insurance (NIHDI) and representatives of the medical imaging sectors. These recommendations were published on the website of the FPS Public Health and in October 2010, the NIHDI sent a brochure listing these recommendations to all prescribers.

On June 14, 2012, a new campaign addressed to general population has been launched: "Medical imaging is not family picture. No rays without reasons." The goal of this campaign is to inform and educate the public on the proper use of medical imaging, encourage patients to discuss medical imaging with their doctors, and support doctors in their work.

Other measures (implemented or planed) in this field concerns the creation of a quality system for radiology, the sent of feedback on prescriptions and the sent of folders with up to date information, the development of standardised prescriptions for radiology and nuclear medicine, the creation of a register on medical imaging, the limitation of CT units and the priority given in "eHealth" for applications stimulating a rational use of medical imaging.


Launch of the campaign “A drug is not a candy”

By Sophie Gerkens

The Federal Agency for Medicines and Health Products launched its second campaign with the support of the Minister of Public Health: “A drug is not a candy ! “, designed to educate the general public to the proper use of drugs. This new campaign proposes twelve keys for drug use and reminds the public that a drug may be ineffective, inappropriate or even dangerous if used improperly, without the advice of the physician or pharmacist and without complying with the instruction leaflet.

More information can be found on the following link: www.unmedicamentnestpasunbonbon.be

Launch of a campaign to rational clinical biology prescriptions

By Sophie Gerkens

A brochure was sent to all physicians in July 2011 to promote the rational use of clinical laboratory tests.

More information can be found on the following link:

Strengthening of the GMD-DMG and inclusion of the prevention module

By Sophie Gerkens

From April 2011, the global medical file (GMD-DMG) includes a prevention module and the third party payer system can be applied for GMD-DMG opening/prolongation and for the prevention module on the patient demand. More details are given in the health policy update on the strengthening of the global medical file.

April 2011 - Strenghtening of the global medical file

By Sophie Gerkens

To optimize the quality of primary care provided (continuity and coordination of care), the use of the
The global medical file (GMD-DMG) was strengthening these last years. The GMD-DMG is free for all and allows an additional reimbursement up to 30% for GP visits or GP consultations (depending on the patient’s category: under 10 years, between 10-75 years, over 75 years, chronically ill or palliative patients). From 1 April 2011, news initiatives entered into forces:

- Each GMD-DMG must include a prevention module, composed of a checklist containing the themes to be monitored for a patient. For patients aged 45 to 75 years with a GMD-DMG, an additional annual fee is foreseen for the discussion with the patient and his monitoring using the checklist. They have to pay a certain amount to the GP (€28.15 for the GMD-DMG opening/prolongation and €10.14 for the prevention module in 2011), but they will be fully reimbursed by the sickness funds. This additional fee can not be asked to other patients (75 years).
- On the patient demand, the third party payer system can be applied for GMD-DMG opening/prolongation and for the prevention module. If the third party payer system is applied for these services, it must also be applied for the consultation or visit fees linked to these services (this will not anymore be the case in the future, new regulation in progress).


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e-birth

By Sophie Gerkens

eBirth is an online application developed to optimize data exchange between all actors involved in the process of birth notifications. Medical care providers can report births information via a web portal. The exchange of information between all institutions is then automated, reducing administrative tasks. Statistical data are also transferred to the Communities. With e-birth, the whole procedure can take about 10 days, whereas before it could take 10 weeks.