Analytical support on
social protection reforms and
their socio-economic impact

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Pensions, health and long-term care

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1 Executive Summary

The nomination of the Di Rupo-government in December 2011 could not set aside the climate of political hypertension in Belgium. Eager to show that good policies were possible without the involvement of the main opposition party, the new coalition swiftly adopted a policy course of highly visible changes, including in the sectors under scrutiny in this report. While these do not amount to fundamental reform, they do constitute a welcome change from previous years characterised mainly by inaction.

Among the important and long-standing issues at stake, one can find the abolishment of the legal differences between blue-collar and white-collar workers, as well as the transformation of the so-called "bridging pensions" into a system of unemployment with an additional benefit paid by the employer.

Regarding pensions, pathways to early retirement are blocked or made narrower, and new calculations value periods of professional activity more than the periods of inactivity even if those are also taken into account. The lowest benefits are further adapted to offer better replacement rates.

Important as these initiatives may be, they are insufficiently matched by an elaborate and encompassing policy to encourage and enable older employees to stay at work. While such "positive" measures are difficult to conceive and will be more difficult to implement than restrictions on early retirement, they would also yield a higher reward in terms of curbing the budgetary cost of ageing and of bringing about a better replacement rate once retirement is due.

The increase of the cost of the health care system is slowed down by a lowering of the "growth norm", a legally set percentage by which the health care budget is allowed to expand on top of inflation. In this sector, few budget cuts or more fundamental reforms that could lead to efficiency gains are apparent. As financial accessibility and the resulting social inequality are still something to worry about, further measures help to keep the cost for the patient in check.

In order to cope with a future increase in demand, which is certain but which exact scope is difficult to predict, more diverse and integrated long-term care services are being developed. More and better cooperation should allow dependent persons to stay at home longer and to only move to residential care when absolutely necessary. Organising the move of patients between care facilities remains a difficult challenge.

At the same time, the sixth round of state reform in Belgium is taking shape. Important responsibilities in the field of health care and long-term care will be transferred to the regions. As practical arrangements are still being discussed, the exact impact of this transfer is difficult to assess. Moreover, once the competences are handed over, it is up to the regions to use them to further develop and enhance their policies. Federal powers came with federal policy. The challenge of deciding whether or not to continue that policy at the regional level will be met by the new government taking office after the upcoming elections in spring 2014.

This report covers events from February 2012 to October 2013.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

Policy evolution and reform in the Belgian pension system is characterised by an incremental approach, rather than by big changes. The emphasis is on evolution, not revolution, and on changes in the parameters of the system rather than on a re-thinking of its fundamental underlying principles. In recent years, the system has further evolved mainly through the continuation of changes set in motion through earlier measures.

The changes made to the pension system by the Di Rupo government since December 2011, while certainly significant and important, can not be characterised as a major reform, as the underlying principles of the system are not affected. They are further described in section 2.1.3.

Four important initiatives (prior to 2012) deserve explanation.

The first important text is the 1996 Act on the sustainability of pensions,[1] which introduced:

a) the equalisation of the pension age for men and women (by gradually raising the pension age for women from 60 to 65, by 2009),

b) the introduction of changes in the calculation of pension amounts which benefit women in particular, and

c) an increase in the replacement rate by linking the capped wage that is considered for the pension calculation to the evolution of wages, and through a re-evaluation of the minimum pension and the residual social assistance scheme (guaranteed income for the elderly).

Secondly, the 2001 Act on the institution of the "Silver Fund" (*Zilverfonds*)[2] is to be mentioned. This Fund was created to build financial reserves that can be used to finance the extra obligations of the legal pension system when the "baby boom generation" will reach the legal pension age (between 2010 and 2030), and was meant to be financed by surpluses on the state budget, investments, non-fiscal income and – primarily – savings made through reducing the public debt. However, sovereign debt was expected to fall below 60% of GDP for the system to work; a goal that was never achieved.[3]

By the same Act, a "Study Committee on Ageing" (*Studiecommissie vergrijzing*) was created and commissioned to deliver yearly reports on the long-term budgetary impact of ageing where it concerns social security and social assistance (not limited to pensions). These yearly

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1 Wet van 26 juli 1996 tot modernisering van de sociale zekerheid en tot vrijwaring van de leefbaarheid van de wettelijke pensioenstelsels, *Belgisch Staatsblad*, 1 August 1996.

2 Wet van 5 September 2001 tot waarborging van een voortdurende vermindering van de overheidsschuld en tot oprichting van een Zilverfonds, *Belgisch Staatsblad*, 14 September 2001.

3 The Silver Fund, long proclaimed to be an instrument to safeguard sustainability, is today often characterised as "an empty box". Meant to be funded by surpluses on the running state budget, the only income for the Silver Fund today (and since 2007) is from interest gained through investments in national government bonds. In other words, not only has the government not realised the budget surpluses needed to invest in the Fund, but the money that was put in has been used to borrow to itself. See also: ZILVERFONDS, "Jaarverslag over de werking van het Zilverfonds in 2012" (*Year Report concerning the functioning of the Silver Fund in 2012*), May 2013; http://www.zilverfonds.be/pdf/rpt_2012_NL.pdf.

findings are important, as they form the basis on which the High Council of Finance[4] (an entity within the Federal Public Service Finance) formulates its own recommendations. The two reports together then form the basis for an appendix to the budget (the "Silver Note" or *Zilvernota*), in which the Government outlines the policy concerning the challenges encountered. The activities of the Study Committee on Ageing are thus institutionalised.

Thirdly, the 2003 Act on Supplementary Pensions regulates the second pillar pension system.

Lastly, the 2005 Generation Pact[5] encompasses measures to activate older workers (such as stricter rules for the system of "bridging pensions" and the emergence of a "pension bonus" which encourage a reintegration of the labour market), and changes to the level of the benefits according to the evolution of wages (the so-called "prosperity bonus" or *welvaartsbonus*). Concerning early retirement (from the age of 60 onwards), the Generation Pact of 2005 raised the minimum career requirement from 30 years to 35 years.[6]

Until December 2011, Belgian pension policy did not move outside the framework of these four policy initiatives and their implementation. With the new government Di Rupo I, swift action was undertaken to adapt the pension system to the budgetary reality. The actual changes to the system are commented below. In sum, the 2011 reforms are neither systemic nor revolutionary. They do however represent a shift towards concrete action, however more inspired by budgetary concerns than by consensus based policy. The 2011 adaptations also seem to form the prelude to other, more fundamental, changes. The intent to bring the different pension systems closer together, for example, has already been announced.

2.1.2 System characteristics

The **first pillar** of the Belgian pension system (the statutory system, organised by public institutions) encompasses three provisions: the retirement pension, the survivor's pension, and a scheme called "Guaranteed Income for the Elderly" (*Inkomensgarantie Ouderen* or *IGO*).[7]

The provisions concerning the **retirement pension** and survivor's pension are different for employees, for self-employed and for civil servants.

The legal *retirement age* is 65, both for men and women.

Where early retirement was possible from the age of 60 before the year 2013, this will be brought to 62 by 2016 (in increments of six months per year). Employees and the self-employed need to be able to prove payment of contributions for at least 35 years in order to enter early retirement. This career requirement will be brought to 40 years by 2016. These conditions for early retirement will apply in all pension systems – the current rule whereby civil servants can enter early retirement from the age of 60 provided they have been in service for at least five years, disappears.

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4 See http://docufin.fgov.be/intersalgen/hrfcsf/onzedienst/Onzedienst.htm.

5 Wet van 23 December 2005 betreffende het generatiepact, *Belgisch Staatsblad*, 30 December 2005. For a detailed overview of all the measures contained in this law, see http://www.sd.be/site/NR/rdonlyres/DCCB3D2D-0991-4F8B-BDD1-6E2A854C6F32/0/GPwetoverzichtsartikel_NL_060131.pdf.

6 While the Generation Pact itself contained the promise of a thorough assessment of its measures in the first quarter of 2012, disagreement on the data that was to be used postponed this evaluation. To date, only a limited evaluation of the non-implented measures of the Pact (and not of the impact of those that were implemented) has been made. Hoge Raad voor de Werkgelegenheid: Verslag 2012, Brussels, June 2012, 249-283; http://www.werk.belgie.be/WorkArea/DownloadAsset.aspx?id=36946

7 The "Guaranteed Income for the Elderly" is, strictly speaking, not a social security benefit, as it is financed from general taxation instead of contributions. The system is a non-contributory benefit in the sense of the European Social Security Coordination Regulations.

Year	***Minimum Age***	***Career***	***Exception for long careers***
2012	60	35 years	n.a.
2013	60.5	38 years	60, when a career of 40 years
2014	61	39 years	60, when a career of 40 years
2015	61.5	40 years	60, when a career of 41 years
2016	62	40 years	60, when a career of 42 years; 61, when a career of 41 years

In response to the protest and discussion these measures provoked, further transitional procedures were called into life. As a result, early retirement will remain possible in the years between now and 2016 for those who fulfil the conditions today (meaning for example that a worker who was 60 in 2012 and had a career of 35 years will be allowed to enter early retirement in 2014, even if the condition of a 39-year career has not been met). Moreover, for those aged 57 or older and having a career of at least 32 years by the end of 2012, early retirement is reported by a maximum of two years.[8]

For employees, the *amount of the benefit* is calculated as a percentage of the (capped) average individual wage over the period between 20 years of age and the normal pension age. This percentage is 75% for retired employees who have dependents without other income; 60% for all other employees.

The benefit for self-employed persons is determined differently, on the basis of a low, flat-rate business income per year for the years prior to 1984 or of the (capped) business income for the subsequent years. Again, 75% is paid as a family pension, while 60% is paid for individuals. An actuarial reduction in the pension calculation in case of early retirement is only implemented in the scheme for the self-employed, not in the employee scheme.

In other words, the calculation of employee and self-employed pensions presumes a full career to be 45 years of work.

For civil servants, benefits are not based on the wages over the whole career, but on the average wage in the last ten years of service – up from five years before the new reform measures. While different provisions may apply in general, that amount is then divided by 60,[9] and multiplied by the total number of service years taken into account. This calculation results in a maximum pension equalling to 3/4^{ths} of the wage used for the calculation, explaining why the pension replacement rate is the highest for civil servants.[10] Conceptually, pensions for civil servants are seen as a form of "delayed wages", rather than insurance-based benefits. Seen as an individual right, the benefit is not adapted to the family situation.

[8] See, for more details, http://www.dirupo1.be/announcements/nieuwe-overgangsmaatregelen-rond-de-pensioenhervorming

[9] To some categories of civil servants, more generous calculation rules apply, resulting in less years needed to reach a full pension benefit. These exceptional arrangements will continue to exist up to a fraction of 1/48 (for example 1/55 for teachers, 1/50 for firefighters, 1/48 for train drivers, …); the lower fractions (up to 1/12) disappear for any work performed after 1 January 2012. For more details, see http://pdos.fgov.be/pdos/pdf/publications/pdos_rustpensioen.pdf.

[10] In addition, an absolute maximum of € 6 283.85 per month applies.

Ceilings apply to the amounts taken into account to calculate the benefit (except for civil servants), but not to the amount on which contributions are paid.

Survivor's pensions are paid to the surviving spouse of an employee, self-employed or civil servant, when himself or herself is at least 45 years of age. The amount of the survivor's pension is 80% of the pension benefit of the deceased. Further specific conditions and modalities apply: in the system for civil servants, orphans benefit from an additional and separate pension. Following the 2011 reforms, the survivor's pension is set to be transformed to take into account the age, the number of children and the years of marriage or lawful cohabitation. This change has however not yet been enacted.

The statutory pension system in Belgium contains several arrangements to ensure that the amount of the pension benefit reaches and maintains a certain level.

An important mechanism to ensure adequate benefit levels is that of the minimum entitlement per year of work. Because pensions are calculated as a percentage of previously earned (capped and re-evaluated) wages, low wages can lead to low pension rights. The mechanism compares the re-evaluated wage in a particular year with the minimum wage, and takes into account the highest amount. The mechanism of minimum entitlement per year of work was introduced in 1996. The national minimum was raised by 17% in the framework of the "Generation Pact" (2005). Both the original setup and its increase benefit women, due to generally lower wage levels.

A minimum pension is granted to persons who have worked at least 30 years (for at least half of a full-time employment). Before the Generation Pact of 2005, the minimum pension was only granted to those with a minimum of 30 years of work with a full-time contract. The adaptation in the mechanism of minimum pensions also benefits women, as the percentage of women working part-time is significantly higher than that of men (41.5% versus 8.6% in 2009 and 43.6% versus 9.7% in 2012[11]).

Once the right to a minimum pension is established, the amount is then calculated on the basis of the career. This calculation is complex, and can lead to different amounts depending on the exact composition and placement of working periods and the possible combination of different periods of insurance in different schemes.

When pension rights are not sufficient, a person has the right to a means-tested ***Guaranteed Income for the Elderly (IGO)***. This *IGO*, paid on top of whatever pension entitlement is acquired, is slightly more generous than normal social assistance benefits. Furthermore, conditions for pensioners who live together with other family members (for example, their children) are changed favourably, meaning that the income of these other family members is no longer taken into account when the level of the *IGO* is determined. However, the benefit offered remains under the relative poverty line.

Once established, first-pillar pension benefits are adapted to the evolution of consumer prices (through the mechanism of indexation) and to the evolution of wages (through the mechanisms of the "prosperity bonus" (*welvaartsbonus*) and "perequatie"[12]).

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[11] Eurostat: http://epp.eurostat.ec.europa.eu/tgm/refreshTableAction.do?tab=table&plugin=1&init=1&pcode=tps00159&language=en.

[12] *Perequatie* is a mechanism that ensures that the pension amount of a retired civil servant goes up, every time the maximum of the remuneration scale that is applied to the last level he or she was on, goes up also. In practice, the pension amount is re-calculated every other year according to a *perequatiecoëfficiënt*. This coefficient expresses the relation between the pension amount and the maximum wage applied to the last

Second pillar pensions in Belgium encompass all forms of supplementary pension rights financed by employers. These are the pension arrangements (other than the first pillar system) in which one can or must participate on the grounds of his or her professional activity.

The second pillar pension system is regulated by the 2003 Act on Supplementary Pensions[13] which creates socio-economic protection for supplementary pensions that are agreed on the level of the company or the sector of industry, and which determines the rules under which a second pillar system can be constituted. It further introduces fiscal measures to encourage take-up of the second pillar system, having observed that second pillar systems were until then almost exclusively joined by high wage earners – those for whom the replacement rate of the statutory system is the lowest.[14] Second pillar pensions can be paid out either as a periodic payment, or in the form of a lump sum. An individual has always the choice to opt for periodic payments.

For employed persons, these are:

- "group company pensions" (financed through group insurance or a pension fund);
- "individual company pensions" (benefiting an individual employee, and subject to strict conditions to ensure its occasional rather than systematic character)[15];
- "sectoral pensions" (created on the basis of a collective agreement within a joint committee or sub-committee, obliging the employers in the respective sectors of industry to provide pensions for all employees who fall within the scope of the collective agreement[16]).

While the first two types of arrangements are created on the basis of a unilateral decision by the employer, the sectoral pensions are based on collective bargaining.

For self-employed persons, the provisions of the second pillar contain:

- the free supplementary pension for the self-employed, which operates as an individual life insurance policy and is accessible to all self-employed;

function classification of the pensioner on the date on which the pension starts. This coefficient is then applied to the new maximum wage of his or her last position.

[13] Wet van 28 april 2003 betreffende de aanvullende pensioenen en het belastingstelsel van die pensioenen en van somige aanvullende voordelen inzake sociale zekerheid, *Belgisch Staatsblad*, 15 May 2003.

[14] Figures on participation illustrate this policy concern: in 1999, a maximum of 30% of employees participated in a group company pension or a sector pension. Fiscal data for the same year shows that 80% of the total volume of benefits paid went out to 20% of the recipients. For a more detailed analysis of data prior to 2003, see Gieselink, Peeters, Van Gestel et al., 2003.

[15] Individual company pensions are only permissible when awarded in rare cases. This restriction is put in place to avoid an obvious "work-around" in order not to have to establish group company pensions. Even if the employer is free regarding categories of staff to include in group company pensions, unlawful distinctions cannot be made.

[16] The 2003 Act put the sectoral pension arrangements under the same legislative framework as the other second pillar arrangements, and entrusted the Banking, Finance and Insurance Commission (later reformed to the Financial Services and Markets Authority) to issue biennial reports. In its 2013 report, the Commission observes that the majority of beneficiaries (63%) of these types of second pillar pensions are blue-collar workers, and mostly males (66%). The Commission also reports that sectoral pensions are common in some sectors, but almost completely absent in others. In those sectors of the economy where sectoral pensions are agreed upon, the vast majority of workers participate. For a detailed analysis, see Financial Services and Markets Authority, "Tweejaarlijks verslag betreffende de sectorale pensioenstelsels" (*Biennial Report concerning Supplementary Pensions*), June 2013. Note that this report deals with sectoral pensions only, and not with group company pensions or individual company pensions.
http://www.fsma.be/~/media/Files/publications/ver/apwn/nl/fsma_sp_2013.ashx

- the supplementary pension for certain liberal professions (an opportunity given to members of certain professions through recognised pension funds, set up by the group of professionals concerned[17]);
- the supplementary pension for self-employed managers (some self-employed managers can participate in a group company scheme or benefit from an individual company pension).

At the end of 2011, 45% of those with a self-employed activity as their main economic activity contributed to the system, up from 43% in 2009.[18]

The **third pillar** of the pension system includes different saving schemes with different fiscal treatment. In this respect, individual life insurance is to be distinguished from saving-based pension schemes. While the concept is similar, tax treatment of both arrangements is quite different.

The pension reforms announced at the end of 2011 also touch second- and third-pillar pensions. The fiscal advantage given to contributions made to second and third pillar systems will be reduced, and pensions taken up before the age of 62 will be taxed at a higher rate. Through these measures, second and third pillar pensions are made less attractive, but do not seem to be severely discouraged.

2.1.3 Details on recent reforms

The challenges and difficulties of maintaining a Bismarckian pension system in a demographic situation for which it was never designed or intended are well known and not unique to Belgium. Due to political strife, but also (and probably more so) because of the strength of societal groups with vested interests in a status quo, the problems have for a long time remained unaddressed. After years of studying, debating, and stumbling along, the swift changes introduced by the Belgian government in December 2011 surprised many. While they do not amount to any radical shifts (for which in any case there was, or is, no consensus), these changes are however very significant. Through smaller, balanced, less critical decisions, the pension system is adapted to better cope with an ageing population.

The impact of such incremental reform is probably less visible and certainly less predictable compared to large systemic reforms. There also is no apparent agenda or game plan that would allow to say with any certainty what other measures are still to be enacted by this or the following government. Nevertheless, the changes to the system seem to have brought about an increased awareness of the problem and of possible solutions, and a more focused debate.

With the goal of wanting to encourage longer careers, avenues to early retirement are closed and special pension schemes are curbed. A clear message rings through a set of important measures that were enacted almost immediately after the inauguration of the new government: everyone will have to work two years longer.

The reforms, promised at the start of the Di Rupo government and (partially) implemented up to October 2013, can be summarised in seven points:

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[17] The Provident Fund for Doctors, Dentists and Pharmacists (Dutch: Voorzorgskas voor Geneesheren, Tandartsen en Apothekers - VKG), the Provident Fund for Pharmacists (Dutch: Voorzorgskas voor Apothekers - VKA), the Supplementary Pension Fund for Notaries (Dutch: aanvullend pensioenfonds voor het Notariaat) and the Provident Fund for Lawyers and Process Servers (Dutch: Voorzorgskas voor Advocaten en Gerechtsdeurwaarders).

[18] Financial Services and Markets Authority, "Tweejaarlijks verslag over het vrij aanvullend pensioen voor zelfstandigen" (*Biennial Report on the Free Supplementary Pension for Self-Employed*), June 2013; http://www.fsma.be/~/media/Files/publications/ver/apzs/nl/fsma_wapz_2013.ashx.

(a) Working longer is the norm. The minimum age and minimum length of career required to gain access to the pension system are increased (see above). By the year 2016, nobody under the age of 62 will be allowed to retire, and a minimum career of 40 years will be required.[19] The legal pension age remains at 65, and one still needs a career of 45 years in order to reach a full pension benefit.

(b) Those who can retire are encouraged to postpone doing so, and are granted additional pension rights in return (the "pension bonus"). The "pension bonus" was already introduced in 2005, and has been adapted into an extended system that will enter into force in 2014. The system rewards those who postpone their pension by at least one year, by offering additional pension rights from the second year onwards[20].

(c) Combining a pension with an income becomes easier. At present, a retirement pension cannot be combined with income derived from professional activity, with the exception of a low yearly amount. Those who earn more than this amount see their pension benefits suspended. Recent changes to the legislation remove this restriction for those who can show a career of 42 years in 2013. Working while receiving a pension before the age of 65 will still be restricted, be it that the limits will be adapted to the evolution of consumer prices.

(d) Putting more value on work. In the calculation of pension benefits, periods for which no contributions have been paid can be taken into account (so-called "equalised periods"), using rules that differ according to the scheme. The 2011 pension reform measures have changed many of these rules from 1 January 2012 onwards. Generally speaking, new calculation rules still confer more importance to periods of work than to periods of inactivity, such as for example unemployment or career interruption.

(e) Second-pillar pensions for everyone. Government plans call for a generalisation of second pillar pensions, but leaves the decision on how to accomplish this to the social partners. As of now, little progress has been made towards this goal.

(f) Increasing savings for third pillar pensions, by improving the fiscal regime. This change has yet to be enacted.

(g) Abolishing special schemes for certain professional groups. As of 1 January 2012, special schemes by which miners, seafarers, civilian flight staff and professional journalists could retire earlier and could benefit from a more beneficial calculation of pension benefits, have - in principle – disappeared. However, the government does not interfere in schemes where additional benefits are funded by additional contributions and organised by a specific professional group.

While Belgium still has separate pension systems for civil servants, employees and self-employed, the recent reforms seem to erode the differences between these categories and other special groups with a separate or specific system. Even if the creation of one single system for all professional groups is not planned, an approximation is nevertheless being achieved.

[19] This now also applies to civil servants.

[20] The net effect of the changes in the rules concerning the "pension bonus" is debated. While official communications state that the new system results in more benefits and more encouragement, calculations using more realistic scenario's reveal that the new system is actually less generous than it used to be.

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

It is generally acknowledged that Belgian pensions are rather low. Data and projections on the adequacy of pensions are incorporated in the annual reports of the Study Committee on Ageing.[21]

In 2010, 19.4% of those over the age of 65 live on an income of less than 60% of the median; a rather high percentage compared to the EU average of 15.9%. Nevertheless, the indicators show a gradual improvement of the economic situation of pensioners. This evolution can be traced back to 2007, when the means-tested Guaranteed Income for the Elderly was raised by almost 14% and a set of adaptations was enforced in order to let pension benefits keep track of the evolution of wages.[22]

Several mechanisms help social benefits keep track of the evolution of consumer prices and wages. The adaptation of benefits to consumer prices through indexation is automatic, where the adjustment to the evolution of wages differs between pension systems. For employees and self-employed, the mechanism of the "prosperity bonus" (*welvaartsbonus*) applies. This structural mechanism creates the obligation for the government to decide every second year on a budget for adapting social security benefits, to better match the evolution of wages. What benefits are adapted as priority relies on political decision-making and on agreement with the social partners. The pension benefit of civil servants is not affected by the "prosperity bonus", but instead keeps track of wage increases granted to those still in the same service position, through a system called "*perequatie*". The mechanism ensures that the pension amount of a civil servant is revised once every other year, based on the salary he or she would have received had he or she still been in service.[23]

The mechanism of "*perequatie*" allows for pensions of civil servants to keep better track of the evolution of wages than the pension benefits in the employee or self-employed scheme, as the adaptation is linear and automatic, and thus not dependent on budget or political priority. While some perceive this as an unjust advantage, it is also argued that the system is preferable and more fair than the adaptations through the mechanism of the "prosperity bonus".

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[21] Hard data on the poverty risk of elderly persons is derived from the 2011 EU-SILC survey data, which reflects the situation in 2010. The numbers in this section summarise the information described in the ASISP Annual National Report 2012 (18 to 19).

More detailed and comparative information can be found in the report "Pension Adequacy in the European Union 2010-2050", prepared jointly by the Directorate-General for Employment, Social Affairs and Inclusion of the European Commission and the Social Protection Committee, May 2012; http://ec.europa.eu/social/BlobServlet?docId=7805&langId=en

For information on gender-specific consequences of the recent reforms, see Dekkers, G., Desmet, R., Fasquelle, N., Festjens, M-J., Joyeux, C., Scholtus, B., Weemaes, S., Mesures prises en 2012 dans les branches chômage et pension: évaluation des effets selon le genre, Federal Planning Bureau Working paper 3-13, February 2013, Brussels, 26, http://www.plan.be/publications/Publication_det.php?lang=en&TM=63&IS=63&KeyPub=1209

[22] See also: De Vil, Greet, Fasquelle, Nicole, Festjens, Marie-Jeanne and JOYEUX, Christophe (2011), Welvaartsbinding van sociale en bijstandsuitkeringen, Federal Planning Bureau Working Paper 4-11, March 2011, Brussels.

[23] The mechanism at its conception was meant to offset the fact that wages in the public sector historically were lower than in the private sector, a reasoning which no longer holds true as the net hourly wage of the average civil servant today is 1.7% higher than that of his private sector colleague. See Eugène, B., Public sector wages, Nationale Bank van Belgie, Economisch Tijdschrift december 2011, 21-33.

In February and December 2012, first pillar pensions and the Guaranteed Income for the Elderly were raised by 2% through the mechanism of indexation. In addition, on 1 September 2012, minimum pensions for employees and self-employed and the Guaranteed Income for the Elderly were adapted through the mechanism of "prosperity bonus". On 1 January 2013, the system of "perequatie" brought an increase of the pension amount for civil servants of on average 0.57%.

Taking into account factors other than income (such as property, capital and benefits in kind), the poverty risk of elderly persons (65+), at 11.3%, is lower than that of the rest of the population (13.6%). Poverty in this age group is apparently also less severe.

These figures however hide important differences between separate categories of persons. Not every recipient of social benefits is equally well off, and even within the overall scope of pensions there are important differences between the different professional schemes. In general, first pillar pensions for civil servants are more generous than in the other schemes. Minimum pensions in the employee scheme are situated just above the relative poverty line, and minimum pensions in the system for self-employed fall between the legal and the relative poverty line. Moreover, the current setting in which some categories of workers benefit from second pillar arrangements and others do not, tends to increase internal inequalities.[24]

2.2.2 Sustainability

In Belgium, the effective retirement age is low. In the period 2006 to 2011, men retired on average at the age of 59.6, and women at the age of 59; compared to a legal retirement age of 65 for both.[25] By the end of 2011, 1 845 642 employees and self-employed persons received a pension; an increase of almost 2% compared to December 2010. At the same time, the number of retired civil servants stands at more than 440 000. Some 65 000 more received the guaranteed income for the elderly. The costs of pension benefits in the private sector (excluding civil servants) increased by 5.7%, to € 22.8 billion.

Early exit from the labour market is caused by a variety of reasons. In some instances, it is more attractive to stop early than to continue working; as certain forms of labour become too arduous at a later age while there is no culture of transferring older workers into less demanding job, those can chose to exit paid labour. The reforms implemented in 2011 through 2013 mainly aim at making it more difficult to retire before the legal pension age, by tightening conditions and closing exit pathways.

One such arrangement was the system of "bridging pensions". The Belgian "bridging pension" (*brugpensioen; prépension*) is not a pension as such, but an unemployment benefit granted to older workers who lose their job and who are some years away from the official retirement age. The unemployment benefit is supplemented by an additional benefit paid by the employer, and the worker is no longer expected to take up a new position. The system is meant to "bridge the gap" between the last employment and retirement and is popular as it softens the social consequences of important lay-offs. Attempts made over the years to limit the use of the system have proved inconsequential,[26] creating tension between the goal to keep

[24] Berghman, J., Debels, A., Vandenplas, H., Verleden, F., Mutsaerts, A., Peeters, H. And Verpoorten, R. (2010), De Belgische pensioenatlas 2010, FOD Sociale Zekerheid, Brussels, 2010.

[25] In the neighbouring countries, the effective retirement age is much closer to the legal standard, see http://www.oecd.org/els/emp/ageingandemploymentpolicies-statisticsonaverageeffectiveageofretirement.htm

[26] In April 2010, the system became more expensive for employers. Before the change, employers were required to pay a fixed-sum contribution on the additional benefit paid to the employee, with no regard to the amount of this benefit. This fixed-sum contribution is now replaced by a percentage which varies according to the age of the employee for which the system is implemented – the younger the employee, the higher the

people at work longer and the desire to maintain this exception especially in constituencies where big lay-offs and company closures are expected. To trade unions, the system of "bridging pensions" is a necessary mechanism to aid workers in tough professions, for whom long careers are not or less feasible.

With the implementation of the government plans, the system was renamed to better reflect its true nature and is now called "unemployment with employer supplement" (*werkloosheid met bedrijfstoeslag; chômage avec complément d'entreprise*). The conditions under which the system can be accessed are tightened[27] and – perhaps more importantly – the way in which periods under the system are taken into account for the calculation of pensions is made much less advantageous. Moreover, the contribution to be paid by the employers is doubled.

In essence, the changes aim to make employers less keen on using the system and to make it more attractive for laid off workers to seek new employment than to enter *de facto* retirement.

While certainly a necessary and highly symbolic change, abolishing the "bridging pension" will not solve the sustainability question. Indeed, the budgetary effect of the recent reforms in the pension system, leading to a higher effective retirement age, can only be expressed in fractions of a percentage of GDP. Already in 2011, the gain from the changes in the system of "bridging pensions", expressed as a reduction in the increase of expenditures, was calculated at a mere 0.1 percentage point.[28] Likewise, the changes in the pension bonus (rewarding postponing retirement by awarding additional pension benefits), are projected to lower expenditures by no more than 0.3% of GDP.[29]

On the other hand, the same data from 2011 shows that increasing the global employment rate would have a much more significant effect.

At the same time, it has become clear that ageing will weigh much heavier on the budget than previously anticipated. In total, social expenditure is projected to amount to 31.2% of GDP in 2060, 5.4 percentage points higher than in 2012. More than half of this increase in expenditure (3.3 points out of 5.4) will materialise by the year 2030.[30]

From this, one could derive: a) that many more reforms are needed to make a real difference in terms of spending related to ageing; b) that measures aimed at keeping older individuals at work can be expected to have a much bigger impact than measures that simply deny an early exit from the labour market.

2.2.3 Private pensions

Information on the evolution of sectoral pension schemes and other second pillar arrangements can be found in the biennial reports published by the Financial Services and

percentage. The goal of this measure was to discourage the use of the "bridging pension" system. However, the benefit for the employee and the conditions under which the system could be used remained untouched.

[27] For details, see http://rva.be/frames/Frameset.aspx?Path=D_opdracht_BP/Regl/Reglementering/&Language=NL&Items=1/1/2.

[28] Study Committee On Ageing, "Jaarlijks Verslag 2011" (*annual report 2011*), June 2011, 84. Instead of an increase in expenditure of 5.6% of GDP, the reform would bring the increase to 5.5% of GDP; http://www.plan.be/publications/Publication_det.php?lang=en&TM=63&IS=63&KeyPub=1057

[29] Study Committee On Ageing, "Jaarlijks Verslag 2013" (*annual report 2013*), July 2013, 89; http://www.plan.be/publications/Publication_det.php?lang=nl&TM=63&IS=63&KeyPub=1237

[30] *Ibidem.*

Markets Authority.[31] In its 2013 report, the Commission observes that the majority of beneficiaries of these types of second pillar pensions are blue-collar workers (63%), and mostly males (66%). There is an important evolution in these figures (in the 2009 report, the values were 81% and 83% respectively), mainly because of the expansion of the sectors in which a scheme exists.

On 31 December 2011, 1 327 081 employees[32] could benefit from a sectoral pension scheme, up from some 757 000 in 2009 (+ 75%). Many of these new employees are active in healthcare and in the Flemish non-profit sector, explaining why the percentage of white-collar workers and women in particular has changed so dramatically.

In those sectors of the economy where sectoral pensions are agreed upon, the vast majority of workers participate. One should however also note that sectoral pensions are almost completely absent in some sectors of the economy – such as distribution, business-to-business services, textiles and the hotel and catering industry.

With this information in mind, a few remarks can be made.

Expanding second pillar pension schemes to the whole of the working population is often mentioned as one of the important elements in keeping the pension system sustainable and just. It is however clear that there is still a long way to go until everyone would be able to benefit from such a scheme.

Moreover, recent developments in the move towards abolishing the distinction between blue-collar and white-collar workers may influence the evolution towards a general application of second pillar schemes.

The distinction between both categories runs throughout Belgian labour and social security laws. Belonging to one group or the other makes a real difference in terms of applicable collective agreements, wage elements and social (security) provisions, and responsibilities for both employers and employees. Moreover, different labour law provisions result in different procedures and compensations in the case of termination of contract. The dichotomy is embedded in the Belgian system in which social consultation and a co-ownership of the social system by government, employers and employees play an important role.

In a ruling dated 7 July 2011, the Constitutional Court found that the differences between white-collar workers and blue-collar workers are no longer valid and amount to an unconstitutional inequality, insofar as the legal arrangements foresee different rules for redundancy pay (white-collar workers receive more redundancy pay in case of a layoff) and for the payment of sick leave (the first day of sick leave of a blue-collar worker is called the *carenzdag* and is not covered by the employer or by the social security system).

In response, the 2011-2012 Inter-Professional Agreement contained a plan to gradually introduce a single statute for both types of workers, with concrete measures concerning holiday pay, redundancy compensation, collective bargaining, temporary unemployment, and

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[31] Financial Services and Markets Authority, "Tweejaarlijks verslag betreffende de sectorale pensioenstelsels" (*Biennial Report concerning Supplementary Pensions*), June 2013. Note that this report deals with sectoral pensions only, and not with group company pensions or individual company pensions. http://www.fsma.be/~/media/Files/publications/ver/apwn/nl/fsma_sp_2013.ashx. The evolution described above is apparent from a comparison with the 2011 report of the same organisation.

[32] Out of an estimated total of 3 809 274 wage earners. See Instituut voor de nationale rekeningen, Regionale Rekeningen 2003-2011, Nationale Bank van België, Brussel, Februari 2013; http://www.nbb.be/doc/dq/n/dq3/nnr.pdf. The publication contains statistical economic information, specified by region.

sick leave cost for the employer. This compromise between negotiators was however rejected by a majority of trade union members.

In July 2013, the government, under pressure from the threat of law suits based on the ruling by the Constitutional Court, finally brokered an agreement to rid the legal system of any discrimination and to reach a unified statute for all employees (*eenheidsstatuut*). A new law to implement these changes will take effect on 1 January 2014. Amongst other measures, redundancy arrangements will become the same for all workers, and the first day of sick leave will now be covered by wages for everyone.

As the distinction between blue-collar and white-collar workers has existed for so long and is so deeply rooted in the social system, the long-term consequences of this rather fundamental change are however not all easy to foresee. It is for example not clear how all this will change the organisation of second-pillar pension arrangements.

Currently, sectoral second-pillar pension schemes have mostly been set up for blue-collar workers, while white-collar workers typically enjoy individual supplementary pension plans or plans at the level of the enterprise. The contributions employers make towards supplementary pension plans for blue-collar workers are typically lower than those for the pension plans for white-collar workers (on average 1.35% versus 3.20% of gross yearly wages). While the easiest way to reach the same level of coverage for both categories would be to allow blue-collar workers to join the schemes for white-collar workers, this would also be the most expensive option.

According to the agreement, convergence should be reached by the year 2025. Discussions about the cost of convergence might however stand in the way of a solution that expands sectoral arrangements, which leaves the issue to be solved at the level of the enterprise.

It is also doubtful whether or not the general application of second pillar pension schemes would offer a solution at all in terms of pension adequacy and sustainability. While employees are entitled to a yield of at least 3.25% on contributions paid by employers and 3.75% on contributions paid by employees, the fall-out of the financial and economic crisis leads many insurers to only offer a yield of 2.25% for new contracts, leaving employers to pay the difference between the legally guaranteed yield and what is paid by the insurers. As this situation is not likely to improve, the net result will be that employers will either hesitate to offer second pillar pension schemes, or that the legally guaranteed yield at some point will have to be lowered.

In its 2011 annual report, the Advisory Committee for the Pension Sector[33] points out that second and third pillar pensions are not likely to guarantee an increase of the income of pensioners to a satisfactory level. While second pillar arrangements originally tended to provide additional benefits in the form of annuities, only few schemes today do so. Instead, many schemes seem to constitute no more than a savings account with minimal yield.

To be effective, second pillar pensions should apply to everyone, contain an element of solidarity both between economic sectors and between participants, favour annuities instead of payments as a capital, and benefit from a fair fiscal treatment. In this final annual report, the Advisory Committee further suggests raising the replacement rate of first pillar pensions from 60% to 75% by 2022, introducing a guaranteed minimum pension equal to the minimum wage, and an automatic (not *ad hoc*) adaptation of pensions to the evolution of wages.

[33] The Advisory Committee for the Pension Sector formulates opinions to the benefit of the Minister of pensions. Raadgevend Comité voor de Pensioensector, Jaarverslag 2011, Brussels, July 2012; http://www.socialsecurity.fgov.be/docs/nl/compens/rapport-2011-nl.pdf. The Committee has recently been replaced by the Federal Advisory Committee for the Elderly (established 21 November 2012).

2.2.4 Summary

Despite the high cost of the pension system, benefits in Belgium are generally low. Too many people leave the labour market before the legal pension age, and policy is directed towards bridging that gap. Whether or not a system in which everyone would effectively retire at the age of 65 would then be viable and deliver the desired results is a hypothetical question as long as not enough people pay contributions over the course of a sufficient amount of years. Or, to paraphrase a saying that has become popular of late, it is not how old the car is that matters, but how many miles it has on the milometer. Belgium is putting more emphasis on the length of a career (i.e. the mileage) than at the age on which retirement should follow (number of years).

While the recent measures to discourage or prevent an early exit from the labour market offer a welcome change from the overall inaction of recent years, they are insufficiently matched by employment support measures for older workers. These questions, while linked to labour policy, can not (as confirmed by the data cited above) be separated from "the pension problem". The idea that the experience of an older worker should translate into higher wages still persists, as does the perception that older workers are less productive than younger ones. Set-ups whereby an older worker is given more appropriate tasks, and perhaps takes home a smaller pay check, are not at all common in Belgium.

Changing minds and expectations will require both soft and hard measures, and a concerted effort by all involved. Government has as of yet not formulated such an elaborate and coordinated plan.

2.3 Reform debates

In 2012, the Council of the European Union recommended that Belgium should implement the reform of pre-retirement and pension schemes and should take further steps to ensure an increase in the effective retirement age, including through linking the statutory retirement age to life expectancy.

In 2013, the country specific recommendations included a call to step up efforts to i) close the gap between the effective and statutory retirement age, also by pursuing the ongoing reforms to reduce the early-exit possibilities, and to ii) increase the effective retirement age by aligning retirement age *or pension benefits* to changes in life expectancy. In addition, Belgium is asked to underpin its reforms of the social security systems dealing with old age with measures that support employment and labour market reforms conducive to active ageing.

The difference between the two sets of recommendations, intended or not, matches both the evolution of policies and the political debate in Belgium in 2012 and 2013.

Overall, there seems to be a broad consensus on the need for Belgians to work longer in order to receive a full pension benefit, and that that this is a pre-requisite to ensure sustainability and adequacy of the pension system. None of the participants in the debate have so far come up with an elaborated and comprehensive plan that would amount to a complete re-thinking of the pension system, and increasing the legal pension age beyond the age of 65 is explicitly not on the table. Rather, discussions seem to focus on the scope, speed and style of the current reforms, rather than on their necessity.

Further changes to the pension scheme are imminent, although it is not yet clear what these changes will entail. As mentioned before, much could be gained from facilitating and motivating different working careers, where older workers find it easier to work longer. This labour market policy aspect aside, debate on the pension system as a social security provision

will in the near future likely focus on the interplay between first pillar and second pillar pension provisions, and on the question if and how to generalise the latter.

Looking further, policy is expected to be guided by the activities of a commission of 12 experts, called upon to formulate proposals to keep the Belgian pension system sustainable and adequate. The work of this commission should result in academic consensus and in technically elaborated recommendations intended to guide policy for the years 2020 to 2040. Its report is due by the spring of 2014, just before the next federal elections. Perhaps the results will help to find the necessary consensus on difficult questions: what is a fair pension amount; how long can someone be expected to work; should there be a differentiation between different jobs; how much do we wish to contribute to a common system, or do we rather want to build on personal responsibility? Such issues must be considered, and require answers that are plausible and acceptable for a supporting majority.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

The Belgian health care system is characterised by continuous evolutions that mainly focus on quality, (financial) accessibility and sustainability.

While many of these changes are important and far-reaching for the aspects they touch, none amount to a systemic change in the organisation of the health care system. They are identified and incorporated in the description below.

3.1.2 System characteristics

The organisation of health care, as part of the social security system, is a Federal competence. After several rounds of state reform, the overall picture is however more complicated. Gradually, the Communities have become responsible for prevention and health promotion, and for organising health care in hospitals, nursing homes and other institutions, and outside these institutions (such as primary health care and home care).

The framework within which the Communities undertake these tasks is set out at the Federal level. In summary, the Federal authorities are responsible for the regulation and financing of the compulsory health insurance, create the programmes and normative framework for the hospitals, govern the rules for recognition of providers, organise the registration of pharmaceuticals and their price control, determine the rules for financing of infrastructure (including costly medical equipment), and arrange for the benefits under the system.[34]

Cooperation between the different levels is organised through inter-ministerial conferences, where protocol agreements are formulated.

The main administrator of the system is the National Institute for Health and Disability Insurance (*RIZIV-INAMI*; hereafter: *NIHDI*). Decisions are made with the involvement of the various stakeholders in the system.

[34] As the different Communities develop different policies which are impossible to summarise in the scope of this report, and as the Federal level is responsible for what is understood under the social security concept of health care, we necessarily limit ourselves to the evolutions at the Federal level.

Financing is obtained through employee and employer contributions and through intervention from the state budget with alternative financing derived from VAT income. The budget for the system is fixed and is adjusted to inflation and, on top of that, according to a legally inscribed real growth norm (*groeinorm*, *norme de croissance*). Between 2004 and 2012, the health care budget was allowed to grow by 4.5% per year (since 2004), after adjustment for inflation. The most recent austerity measures have set the growth norm to 2% in 2012 and 3% in 2013 and 2014.

Total spending on health care (aside from investments) stood at 10.5% of GDP in 2011 (compared to an OECD average of 9.3%). The share of government spending as opposed to private insurance and out-of-pocket payments is calculated at 76% (compared to an OECD average of 72%).[35]

Adequate access to health care is ensured by the wide personal scope of the system which also includes persons dependent on insured individuals, by cost-controlling protection for certain vulnerable groups, by measures to maintain high-quality and high-quantity supply, and by measures aimed at prevention meant to combat inequality. Coverage through the statutory system is compulsory and stands at a nearly universal rate of 99.5%.

An important development in this respect was the extension of compulsory coverage for self-employed persons from January 2008 onwards. Before this change, the compulsory health insurance for self-employed persons only encompassed what was known as "major risks". Other health care services – the "minor risks"[36] – were not included in the package, but a self-employed person could purchase additional protection on the insurance market. The distinction between these categories of risk is now abolished, meaning that self-employed persons are, under the compulsory scheme, indemnified for the same risks as civil servants or employed persons. This of course also means that the contribution to the health care system made by self-employed persons has increased, from 19.65% to 22%.

In most cases, insured persons pay for medical services themselves and are reimbursed afterwards for the amount paid, minus a personal contribution (*remgeld*).[37] Reimbursement is arranged through sickness funds which are fully embedded in the overall administration of the system.[38] What is reimbursed is determined on the basis of an official list containing the amount that can officially be charged for the medical service. These official scales consist of a list of treatments and prices agreed between the government services (via the mutual funds), representatives of health care workers and the social partners. In some cases, the real amount

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[35] OECD Health Data 2013, http://www.oecd.org/belgium/Briefing-Note-BELGIUM-2013.pdf; for variables and comparisons, see http://www.oecd.org/health/health-systems/oecd-health-data-2013-list-of-variables.htm

[36] Minor risks included family doctor interventions, dental care, small surgical interventions (such as stitches etc.), ambulant nursery care, orthopaedic aids, many common laboratory tests, prescription medicine, etc.

[37] The out-of-pocket payment depends on the specific service according to a set nomenclatura (for medical dispensations) or list of pharmaceutical specialities, and typically amounts up to 25%. The share of out-of-pocket payment as part of total health expenditure per household is estimated to be 20%, compared to a total of private sector expenditures of 24% - meaning that out-of-pocket payments by families directly finances 20% of health care, while private insurance finances another 4% (OECD Health Data; Statistics and Indicators: http://www.oecd.org/health/healthdata; Assuralia Kerncijfers Gezondheid: http://www.assuralia.be/fileadmin/content/stats/03_Cijfers_per_tak/05_Gezondheid/06_Nationale_uitgaven_gezondheidszorg/NL/01_Uitgaven_per_financier%2001.htm).

[38] From a practical and administrative point of view, the existence of these sickness funds, or "mutual funds", with a network of offices and agents, means that access to information, administration and further advice is straightforward. Mutual funds arrange payments through the system and offer further services that are widely taken up, including voluntary additional insurance. Individuals are required to register with a sickness fund of their choice.

paid by the patient may however be higher than the official amount that is taken into account for reimbursement.

In a certain number of cases (for example that of hospital care), the patient is only required to pay the amount of the personal contribution, after which the balance is paid directly to the provider by the health care system (*derde-betaler systeem*). This mechanism is also used to improve access to primary care for certain vulnerable groups.[39]

Additional voluntary private insurance covers health care expenditure that is not covered by the system and reimburses the personal contributions made in case of serious health problems that necessitate hospitalisation. The percentage of people covered by private insurance rose from 37.9% in 2001 to 49.8% in 2007 and at least 70% in 2010.[40] All private insurance schemes taken together, the percentage was reported to be 70% in 2010.

Patients have the right to choose and change their family doctor and have direct access to specialised medical care. Health care workers are remunerated mainly per treatment.

To discourage "medical shopping", a system called the "Global Medical File" was introduced in 2002 (*Globaal Medisch Dossier*). This mechanism collects all health information for an individual in one place, kept by the patient's primary health care provider. Patients however have to request this for themselves. To motivate patients to do so, a reduction in out-of-pocket payments is awarded both for primary health care and for referred specialist care. The system is however used by less than half of all insured persons.[41]

3.1.3 Details on recent reforms

One of the key policy intentions of the Di Rupo government which took office in December 2011 was to lower the cost of the health care system, both for society as a whole as for the individual citizen.

The growth of the general health care budget has been curbed by lowering the previously mentioned "growth norm" – a percentage by which the budget is raised each year on top of inflation – from 4.5% per year (which was the norm between 2004 and 2011) to 2% in 2013 and 3% in 2014 and the following years. The amount to which these percentages are applied is € 25.63 billion, which was the budget for 2012.[42] This represents important savings if

[39] Persons with a low pension, persons benefiting from social assistance and long-term unemployed can thus visit a family doctor and pay € 1 personal contribution.

[40] The 2001 and 2007 data is obtained from the Belgian federation of insurance companies (Assuralia) and cited in Vlayen, J., Vanthomme, K., Camberlin, C., Piérart, J., Walckiers, D., Kohn, L., Vinck, I., Denis, A., Meeus, P., Van Oyen, H. and Léonard, C., "A first step towards measuring the performance of the Belgian health care system", KCE Reports 128, 2010.

The same federation reported a 70% figure in 2010. See "Bijna 8 miljoen Belgen hebben hospitalisatieverzekering", De Morgen (newspaper), 17 March 2010; reporting that Assuralia puts the number of persons benefiting from an additional insurance at 7.8 million. 4 million of those are covered by a group insurance policy (mostly organised through employers), 2.5 million by a contract with their mutual fund, and 1.3 million by a contract with a private insurer.

[41] Vrijens, F., Renard, F., Jonckheer, P., Van Den Heede, K., Van De Voorde, C., Walckiers, D., Dubois, C., Camberlin, C., Vlayen, J., Van Oyen, H., Meeus, P., Performance of the Belgian Health System, Report 2012, Health Services Research (HSR), Brussels, Belgian Health Care Knowledge Centre (KCE), 2012, KCE Report 196C, 84; https://kce.fgov.be/publication/report/performance-of-the-belgian-health-system-report-2012

[42] Note that the percentage is applied to the budgetted amount, not to the actual costs.

compared to what status quo would have been,[43] however it does not constitute a break from the past. Budgets will still be allowed to structurally increase, even if by a lesser amount.[44]

A second instrument to limit costs is the policy concerning pharmaceuticals, where several existing cost-curbing mechanisms are further developed and extended. In short, the structural policy towards cheaper pharmaceuticals started in 2001 with the introduction of a "Reference Price System", meant to lower the price of brand name medication and to encourage the use of generic products with the same active ingredients. Through this system, original "brand" pharmaceuticals for which a "generic" alternative exists are reimbursed at a much reduced rate, meaning that the patient pays more for the branded pharmaceuticals than for the cheaper alternative and is therefore encouraged to make a choice for the latter.

In 2005, prescription quota were introduced, forcing general practitioners to prescribe a certain volume of cheaper, generic alternatives. As of 5 November 2012, indicators have been set to allow a more objective monitoring of prescription behaviour.

Also in 2005, the possibility to prescribe medication by active ingredient (*Voorschrift Op Stofnaam*) was introduced, legally allowing doctors to leave the choice of the precise product to the pharmacist and the patient. Before this, doctors were obliged to prescribe named medication and pharmacists were allowed to only deliver exactly what was prescribed. While doctors became required to prescribe generic medication to a set minimum percentage of their total volume of prescriptions, the prescription by active ingredient had always been voluntary. As of 1 April 2012 however, the prescription of antibiotics, antimycotics and pyrosis medication is always considered to be a prescription by active ingredient for which the chemist is compelled to offer the cheaper alternative. This measure thus effectively introduces a forced substitution, irrespective of what the doctor has actually prescribed.

Other measures include an extension of the possibility to conclude contracts with providers of pharmaceuticals to get better prices through purchasing larger volumes and an imposed price cut on some 2 500 pharmaceuticals, rendering different types of medication up to 70% cheaper as of 1 April 2013. The downside of this policy is that shortages of certain pharmaceuticals become more common. Taking advantage of the internal European market where pharmaceuticals can be traded just like other goods and products, distributors prefer to sell stock, originally planned for the Belgian market, to other markets (such as Germany) where prices are higher.

Curbing the cost for the users of the system has been a priority in recent years, and is also at the forefront of policy action during the reporting period. While patients in general of course also benefit from cheaper pharmaceuticals, other recent changes are relevant mostly to specific vulnerable groups and aim to limit out-of-pocket payments.

As a rule, patients seeking medical care have to pay a personal contribution towards the system (*remgeld, ticket modérateur*) in the form of a percentage of the total bill. Because of the way the system is organised, patients also play a role in its administration – they are

[43] The mechanism was intended to limit the growth of the health care budget, but has instead lead to an automatic and important increase, from € 18 billion in 2006 to nearly € 26 billion in 2011. Moreover, this growth path has lead to surpluses in the system, demonstrating that the original goal of cost control has not been reached. These surpluses were channelled to a „future fund" in 2008, 2009 and 2010, and were returned to the social security system in 2011. In 2011, the surplus amounted to € 1.1 billion – money that was budgeted for the health care system, but eventually ended up financing other branches of social security.

[44] The 2011 baseline budget amounted to 25.87 billion euro. If the growth norm would have been applied without change, the 2012 budget would have added 4.5% and some 3% indexation to that amount.

All figures derived from the budget as published on the website of the National Institute for Health and Disability Insurance - http://riziv.fgov.be/information/nl/accounting/budgets/index2.htm

required to pay the service provider in full and can then claim the part paid by the health insurance system back from a mutual insurance fund. This refund therefore consists of the total bill minus the personal contribution of the patient.

In some cases, patients are only required to pay the amount of the personal contribution to the service provider, who then has to claim the rest directly from the health insurance system. This is called the "third-payer" mechanism (*derde betaler, tiers-payant*). This arrangement is extended and now applies to more patients – some 2.5 million individuals.

Patients with a lower income pay a lower personal contribution if they qualify for a preferential status named OMNIO. For any patient, the amount of personal contributions is in any case limited through the "Maximum Billing System" (*maximumfactuur, maximum à facturer*), which puts maximum cap depending on income and socio-economic status, per year. This system is maintained.

Not yet implemented but already decided upon is a new preferential status for patients with a chronic condition. As of 1 January 2014, an estimated 840 000 patients will benefit from lower out-of-pocket payments through the "Maximum Billing System" and will be able to make use of the "third-payer" mechanism.

3.2 Assessment of strengths and weaknesses

3.2.1 Coverage and access to services

The goal to provide universal access to quality care is a constant concern for Belgian health care policy. Just about every Belgian is insured under the system, and physical access to health care services is not a real concern.

Financial access – or ensuring that all patients are able to afford health care services – has been improved both by the extension of coverage for self-employed persons and the gradual widening of the OMNIO system. Several other measures and initiatives focus on this goal and work to limit the total amount of personal contributions a patient actually has to pay without encouraging overconsumption and excessive use.

Specific categories of insured persons receive preferential treatment and are required to pay lower patient fees (before application of the Maximum Billing System). Originally, the system of preferential treatment was restricted to persons of specific social status (pensioners, widow(er)s, persons with disabilities and orphans) for which the gross taxable income of the family did not exceed a yearly-revised limit. In 1997 and 1998, the benefit of the preferential tariff system was extended to specific groups,[45] still conditional on the income limit.

In 2007, this system was further expanded. The newly introduced OMNIO-status, which however has to be applied for, benefits a larger group of people and guarantees preferential treatment to all households below a certain income level.[46] The necessity for application

[45] Long-term unemployed, aged 50 and older with at least one year of full unemployment (according to the definition of the employment regulations), and persons entitled to one of the following allowances: Integration allowance for handicapped persons, Income replacement allowance for handicapped persons, Allowance for assistance for the elderly, Income guarantee for the elderly, Subsistence level income (*leefloon; revenu d'intégration)*, Support from the public municipal welfare centres (OCMW, CPAS).

[46] The Omnio statute also allows claiming for derived rights, such as reduced public transport fees, and a reduction in the contribution for the Flemish Care Insurance (see further). See "Het nieuwe Omnio-statuut en de hervorming van de verhoogde tegemoetkoming", RIZIV, 2008.

however causes low take-up, with only 25% of potential beneficiaries requesting the measure in 2009.[47]

Having general applicability, the "Maximum Billing System" (*maximumfactuur*), introduced in 2002, sets a maximum amount of patient fees to be paid, determined per income bracket. Once this amount is reached, health care is reimbursed fully. The maximum billing system (MBS) takes effect per family unit – not per individual. The maximum amounts one has to pay, the composition of the family taken into account, and the specific rules that are applied depend on what type of maximum billing system is used – the social MBS, the income-based MBS or the MBS based on personal entitlement.[48] Although this system is fairly complicated, it bears no difficulty for the patient as it is applied automatically with no additional paperwork involved. With respect to the extended coverage of self-employed persons, it can be noted that they now also fully benefit from the MBS. Previously, only the patient fees for "major risks" were reimbursed fully when the limits were reached.

3.2.2 Quality and performance indicators

Quality of care and patient safety receive ample attention and are increasingly monitored through the establishment of information systems and feed-back mechanisms.

Two years after the first health system performance assessment,[49] the Belgian Health Care Knowledge Centre has published a more elaborate 2012 report on the performance of the Belgian health system.[50] The report contains conclusions on the basis of 74 indicators covering quality and performance, sustainability and efficiency.

With regards to coverage and access to services, it points to a high level of out-of-pocket expenditures and some level of delayed contacts with health services due to financial reasons. In other words, despite universal insurance coverage and the existence of social mechanisms to limit personal spending, especially for vulnerable groups, *financial* accessibility to the system does not seem guaranteed.

Another matter of concern is that people with fewer socio-economic means often experience worse health. When looking at health determinants and health care utilisation by socio-economic position, strong inequalities were observed in the health and lifestyle indicators. Individuals in a weaker social and economic position do not live as long, are more inclined to suffer from obesity and even infant mortality, and adopt a less healthy lifestyle. At a macro level, the progressivity of health care financing is decreasing, which is an evolution towards less equity.

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47 Steunpunt tot bestrijding van armoede, bestaansonzekerheid en sociale uitsluiting, "Verslag Armoedebestrijding 2008-2009 – Deel 1", 2010. While the Di Rupo government has planned to grant the status without application, the application procedure remains unchanged to date.

48 Patient fees are limited to a maximum between € 450 and € 1,800, depending on the family income. The income brackets are adapted each year, while the maximum amounts remain the same. Personal contributions that exceed the maximum amount are reimbursed automatically and in full.

49 Vlayen J, Vanthomme K, Camberlin C, Piérart J, Walckiers D, Kohn L, Vinck I, Denis A, Meeus P, Van Oyen H, Leonard C., Een eerste stap naar het meten van de performantie van het Belgische gezondheidszorgsysteem. Health Services Research (HSR). Brussel, Federaal Kenniscentrum voor de Gezondheidszorg (KCE). 2010. KCE Reports 128A. D/2010/10.273/25; https://kce.fgov.be/publication/report/a-first-step-towards-measuring-the-performance-of-the-belgian-healthcare-system

50 Vrijens, F., Renard, F., Jonckheer, P., Van Den Heede, K., Van De Voorde, C., Walckiers, D., Dubois, C., Camberlin, C., Vlayen, J., Van Oyen, H., Meeus, P., Performance of the Belgian Health System, Report 2012, Health Services Research (HSR), Brussels, Belgian Health Care Knowledge Centre (KCE), 2012, KCE Report 196C, https://kce.fgov.be/publication/report/performance-of-the-belgian-health-system-report-2012

Research on the basis of patients billing information collected in 2010 and 2011 by mutual insurance funds confirms this picture.[51] Patients who receive social assistance are deemed less likely to visit the general practitioner and more likely to visit a hospital, and in particular an emergency room. This limits the likelihood of problems being detected at an early stage and therefore easier to remedy.

Despite the fact that preventive dental care is offered free of charge to persons benefitting from social assistance, they only visit the dentist half as much as others. Here too, the problem seems to be one of information and communication. Reducing inequalities therefore seems to be also an issue rooted in better preventive health care.

While the policy regarding pharmaceuticals seems to be successful, research shows that the cost for the patient and for the system could still be reduced significantly.[52] Cheaper pharmaceuticals now occupy over 50% of the market (compared to 10% ten years ago). Prescriptions based on the active component of the medication however only represent 8% of the total volume.

3.2.3 Sustainability

While the quality of the health care system is generally high, the cost is equally important. In 2010, 10.5% of GDP was spent on health care (8% public and 2.6% private spending). Spending per capita was € 2 052, while the National Institute for Health and Disability Insurance calculated that the average cost for the health insurance system was € 2 186.[53]

As of 2005, the size of the budget of the compulsory health insurance is determined by a set mechanism: the yearly budget cannot surpass the budget of the previous year, complemented by a fixed percentage (the "growth norm"), the expected inflation, and (if applicable) extra-ordinary expenses. This mechanism was intended to limit the growth of the health care budget, but has instead lead to an automatic and important increase of the health care budget, from € 18 billion in 2006 to nearly € 26 billion in 2011. Moreover, this growth path has led to surpluses in the system, demonstrating that the original goal of cost control has not been met.[54]

During the negotiations preceding the government formation, it was suggested to lower the growth norm to 2% (instead of 4.5%) and to determine the amount on the basis of actual spending (instead of on the budget of the previous year). The final compromise does not go quite that far. While the percentage is indeed lowered to 2%, this only applies in 2013. In 2014, the norm will again be set to 3% and will remain at that level for the years to follow unless new legislation changes it. Moreover, the growth norm will be applied to the budgeted expenditures and not to actual costs, and the baseline budget for 2012 is set at € 25.63 billion.

Still, this means that the budget for health care will still be allowed to rise to an important extent in the years to come, without taking into account the real growth in expenses.

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[51] Henin, E., Rechthebbenden op het leefloon: vinden zij hun weg in het gezondheidssysteem?, September 2013. This publication can be accessed via http://www.cm.be/actueel/onderzoeken/leefloon.jsp

[52] Cornelis, K., Het geneesmiddelenbeleid inzake goedkopere geneesmiddelen in België, Brussels, September 2013; http://www.cm.be/binaries/CM-253-Geneesmiddelen_tcm375-130001.pdf

[53] OECD, Health at a Glance: Europe 2012, November 2012; http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe_23056088 and RIZIV, Jaarverslag 2012; http://www.riziv.be/presentation/nl/publications/annual-report/2012/index.htm

[54] Surpluses in the system were channelled to a „future fund" in 2008, 2009 and 2010, and were returned to the social security system in 2011. In 2011, the surplus amounted to € 1.1 billion – money that was budgeted for the health care system, but eventually ended up financing other branches of social security.

However, what is on the table now also represents an important savings when compared to what would have been the budget if no measures had been taken.[55]

Reducing the growth norm percentage to a more reasonable size is an easy and straightforward measure, but might not be sufficient to curb expenditures in the long run. A 2011 report by the Court of Audit reveals that the problem is not so much the growth norm, but the opaque and diverse way in which indexation (adaptation to inflation) is applied throughout the sector.[56] Even though the categories of expenditure are adapted to inflation according to different rules and mechanisms, the money needed for indexation is budgeted following another formula. As a result, the budget more than covers the sum of the actual funds needed. In other words, the budget obtained for indexation is never fully used, creating a structural and hidden surplus that amounted to € 300 million in 2011.

Further contributing to the high cost of the system is the relatively high amount of hospital beds (6.4 per 1000 population in 2011, compared to an OECD average of 4.8). To keep the numbers in check and to achieve a more balanced geographic spread of the supply, the government intended to lower the exisiting legal and financial barriers to cooperation between hospitals. While no legislation to this effect has been enacted, the opinion of the National Council for hospital supplies[57] (a specialist governmental council which advises the federal government on the policy regarding hospitals) has been asked on how to approach the issue. The Council has formulated concrete proposals and has identified the necessary changes in the legislative framework.[58]

Sustainability may also be affected by the lack of replacement of the current cohort of general practitioners. The average age of doctors continues to rise and they are insufficiently replaced by younger colleagues. The issue is only partly due to the fact that there is a limited number of doctors available,[59] but rather that those available are unevenly distributed amongst municipalities. Thus, 206 out of 589 municipalities reported a shortage of family doctors in 2010, 65% more than in 2008. Also, the problem seems to be more pronounced in the French-speaking part of the country.[60]

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55 The 2011 baseline budget amounted to 25.87 billion euro. If no measures would have been taken, the 2012 budget would have added 4.5% (growth norm) and some 3% indexation to that amount.

All figures derived from the budget as published on the website of the National Institute for Health and Disability Insurance - http://riziv.fgov.be/information/nl/accounting/budgets/index2.htm

56 Rekenhof, "Begroten en beheersen van de uitgaven voor geneeskundige verzorging – opvolgingsaudit" (*Report to the Federal Parliament: Estimate and monitoring of health care expenditure.*), 29 June 2011.

57 *Nationale Raad voor Ziekenhuisvoorzieningen (NRZV), Conseil national des établissements hospitaliers (CNEH)*. For more information, visit http://www.health.belgium.be/eportal/Healthcare/Consultativebodies/Nationalcouncilforhospitalfaci/658222_NL?ie2Term=nationale%20raad%20voor%20ziekenhuisvoorzieningen&ie2section=83&&fodnlang=nl#ancre5

58 Recommendation of 14 June 2012 on measures to promote cooperation between hospitals, and an Addendum to this recommendation of 8 November 2012. See http://www.health.belgium.be/eportal/Healthcare/Consultativebodies/Nationalcouncilforhospitalfaci/adviesprogramming2012/19076512_NL?fodnlang=nl#.UmQvdXC2bey

59 The limited number of doctors is the result of an active policy meant to prevent an oversupply. In essence, a quota system allows only a limited number of trained doctors to access medical practice. This is achieved by limiting the number of recognitions through the health care administration. Now however it seems that the number of doctors who effectively practice medicine is overestimated and that the profession of specialist is more attractive than that of family doctor, with over a quarter of the family doctor positions not taken up.

60 "Steeds meer gemeenten kampen met tekort aan huisartsen", Het Nieuwsblad (newspaper), 26 August 2010.

Mechanisms to ensure an adequate supply of health care professionals in general are described in detail in the "Belgium: Health System Review".[61] They include extra compensation for nurses working long hours and incentives for general practitioners to take up practice in under-serviced areas, amongst others. Notable in this respect is the plan to raise the effectiveness of some of these measures by transferring them to the Community level, so that efforts can be better fitted to local needs.

The question whether migration could be the answer to possible shortages of health care professionals is discussed in a report by the University of Leuven.[62] The study starts by the observation that current and projected scarcity of health care staff seems to be due not to a lack in the quantity of health care workers, but rather to the fact that many work part-time and that some tasks and positions are unappealing and undervalued. As such, it is not surprising that policy so far has focused on increasing the job appeal for health care workers and on actively recruiting domestically. Recruitment from abroad is still very limited in Belgium, with only a few dozen nurses per year attracted from countries such as Poland, Romania, Lebanon and The Philippines. As a conclusion, migration is not seen as the answer to possible shortages, and active recruitment abroad is in any case not part of government policy.

3.2.4 Summary

Health care in Belgium is accessible and of good quality, which translates in good scores concerning population health and life expectancy.[63] Patients are free to choose their provider, and the system does not limit the amount of provisions made available.

Access to health care services proves too expensive for some, even to the point that socio-economic inequalities become visible in the general health of the population. This occurs in spite of important efforts to limit the costs for vulnerable groups. Lower co-payments through the OMNIO-status reduce the cost for lower income households from the start, while the maximum billing system tops the bill for others (but only after a certain amount has been spent). While the maximum billing system is automatic, the OMNIO-status still needs to be applied for. An automatic granting of such rights could already make a big difference for the individuals concerned.

Progress could also be made in strengthening the role of the general practitioner as a gatekeeper to the system. The existing "global medical file" helps to better coordinate the provision of care, and to follow up on its results. Despite promises to generalise this instrument, nothing has so far been done to lift its use to higher levels.

3.3 Reform debates

Important changes are expected concerning the division of responsibilities between the different State entities (the Federal level, the Regions and the Communities). Out of concern to not allow regional policies to affect the basic rules and financing of the system, the Communities were only granted limited authority in the field of health care. The resulting division has long produced undesirable consequences. There is for example no direct link

[61] Gerkens, S. And Merkur, S., "Belgium: Health system review", Health Systems in Transition, European Observatory on Health Systems and Policies, 2010, 12(5).

[62] Wets, J. And De Bruyn, T., "Migratie: de oplossing voor het personeelstekort in de zorg-en gezondheidssector?", HIVA, December 2011.

[63] In 2010, life expectancy at birth for the whole population in Belgium stood at 81 years, a year above the OECD average of 80. When asked „how is your health in general", 73% of Belgians reported to be in good health, higher than the OECD average of 69% (but lower than the score of 77% in 2009). For a quick overview comparing all OECD countries, see http://oecdbetterlifeindex.org/topics/health/.

between efforts concerning prevention and efficient organisation, and financing. Regional prevention campaigns that result in a reduction of costly curative care bring financial benefit to Federal level only, and not to the authorities that invested in the measure. Vice versa, inefficiency at the Community level is not translated into fewer resources. This does not offer incentives for cost-effective practices, and in many ways hampers the development of comprehensive policies. The effects of structural incoherencies are felt in many fields, such as the provision of long-term care, the development of an efficient gatekeeper system, or even the implementation of the "National Cancer Plan" where the current division of powers hampered an integrated approach and halted the timely implementation of some of the measures planned.[64]

In October 2011, an agreement on institutional issues was reached which in turn opened the door to consensus about social and economic issues and to the formation of the Di Rupo government in December. This institutional agreement amounts to a 6th reform of the Belgian state and marks a new move in the transformation to a federal system in which most responsibilities would go to the hands of the regional entities, rather than at the federal level. In health care, the reform will result mostly in the transfer of supporting and organisational competences. The main changes are found in the normative framework for hospitals, subsidising infrastructure, consultation concerning psychiatric health, the recognition of health care professions, and the organisation of primary health care.[65]

Describing the exact impact of this reform on the organisation of social protection is as of yet however not easy. Not only is the wording of the political agreement in many places less than clear, the real impact of changes and initiatives will depend on how their financing will be arranged and on how practical agreements will be reached between the different federal entities.[66]

The discussion concerning the implementation of this planned transfer of powers can be expected to take place on three levels. First, on the precise extent and timing of the hand-over. Second, on the budgets and costs connected to these powers. As has happened in other

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[64] More details on the evaluation and state-of-affairs concerning the National Cancer Plan can be found here: https://www.wiv-isp.be/cancer/

[65] The communities, who are now already responsible for recognising and inspecting hospitals, will become competent for setting the recognition criteria as well. Programming (deciding for example how many beds should be available) and financing however remain the responsibility of the federal government. Furthermore, it is agreed by the partners in the federal government that the recognition criteria should not have a negative impact on the federal budgets and that the reference norms set by the European Union relating to quality will continue to apply. The text of the agreement does not elaborate on this point.

The agreements include the creation of an institution that should provide answers, in consultation, on wider (financial and other) challenges concerning the future of healthcare. The institution will be the permanent and inter-federal platform for deliberation between the different ministers responsible for health care policy and will be tasked with defining a common and future-oriented vision for a durable health care. This institute will however not replace other existing cooperation and coordination platforms.

The text of the agreement explicitly states that this new "Inter-Federal Health Care Institute" will take over the current Cancer Centre. This Cancer Centre, which currently operates under the Belgian Scientific Institute for Public Health (a federal institution), gathers, assesses, integrates and disseminates knowledge on cancer policy in Belgium. https://www.wiv-isp.be/Programs/Public-health-surveillance/Pages/EN-CancerCentre.aspx?pflg=1033

[66] A detailed analysis of the changes and the resulting policy options can be found in the "Sixth State Reform Green Paper", a 635-page document prepared by the Flemish government to serve as the basis for the choices the next Flemish government will have to make. As regional and community competencies are dealt with within one organisational framework in Flanders, the green paper offers a concise overview of what is handed over from the federal to the regional level. See http://www.vlaanderen.be/nl/overheid/vlaamse-regering/beleidsdocumenten/groenboek-voor-de-implementatie-van-de-zesde-staatshervorming

matters, it is conceivable that the Federal government will cut funding in matters related to regional competences, leaving the regional governments to decide whether or not to respond to the unbudgeted bill. And, finally, it is of course yet to be decided what the regions will do with the new responsibility and how much this will deviate from current policies – a debate that will gain importance in the run-up to the elections in the spring of 2014.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

The Belgian long-term care system did not undergo any major reforms in recent years. Nevertheless, some developments in the health care system have had an important effect on the provision of long-term care.

The "Maximum Billing System" (*Maximumfactuur*, introduced in 2001) limits the amount of out-of-pocket payments an individual has to pay, and various (mostly means-tested) allowances help people cope with the financial burden of non-medical expenses. Some special measures are directed specifically towards long-term care patients, such as a yearly allowance for the use of incontinence material.

An important recent development is the extension of compulsory coverage for self-employed persons from January 2008 onwards. Before this change, the compulsory health insurance for self-employed persons only encompassed what was known as "major risks". Other health care services – the "minor risks"[67] – were not included in the package, but a self-employed person could purchase additional protection on the insurance market. The distinction between these categories of risk is now abolished, meaning that self-employed persons are, under the compulsory scheme, indemnified for the same risks as civil servants or employed persons. This also means that former self-employed elderly are now covered for nursing care in homes for the elderly.

4.1.2 System characteristics

Long-term care is part of an integrated system of health care, complemented by social service provision. Institutional arrangements reflect a "medical model" of care delivery (as opposed to a "welfare model").[68] Not unique to Belgium, long-term care is approached as a mix of different services and measures, funded through different sources and organised at different levels.

The organisational landscape of long-term care provisions is fragmented because of a division of competencies between the Federal Government (responsible for medical care through the health care system) and the Communities[69] (responsible for non-medical care). Cities and

[67] Minor risks included family doctor interventions, dental care, small surgical interventions (such as stitches etc.), ambulant nursery care, orthopaedic aids, many common laboratory tests, prescription medicine, etc.

[68] Detailed information on the long-term care system and provisions can be found in WILLEMĖ, Peter, The Belgian long-term care system, March 2010, Federal Planning Bureau Working paper 7-10.

For another view on long-term care in Belgium, see OECD, "Belgium. Long-term care", country notes and highlights, May 2011.

[69] While it is often stated that long-term care is a "regional" matter, the actual division of powers is more complicated. The Flemish, French and German-speaking Communities are responsible for „person-related matters", including some that affect health care and long-term care. The Flemish and German-speaking

municipalities further intervene in financing the construction of residential structures. Medical care represents the bulk of long-term care provisions.

There is no specific federal legislation concerning long-term care – rules concerning the services provided are the same as under the general health care system. On the Community level, separate decrees regulate a wide range of aspects concerning the provision of long-term care services such as the recognition of providers, integration of services and quality monitoring.

Policy is aimed at supporting dependent older persons in their home environment for as long as possible. Should limitations in activities of daily living become too severe and adequate informal or professional support at home is unavailable or insufficient, dependent persons should have access to suitable and affordable residential care facilities.

There are many different long-term care **benefits in kind**. Medical services are organised and paid for by the federal health insurance system, while personal care is organised on a regional level. How these services are provided depends on the specific care setting.

Home care includes medical care and non-medical services. Medical home nursing care, which consists of services such as wound dressing and drug administration, is provided as part of the social security scheme and is currently reimbursed at the Belgian Federal level through the National Institute for Health and Disability Insurance (NIHDI).[70] Non-medical home care services are regulated and organised by the Communities. These services include help with personal care tasks (e.g. help with eating or moving around, hygienic help) along with instrumental help (e.g. light housework, preparing meals). The services offered under the health insurance scheme and those provided for by the Communities partially overlap.

In 2002, the Federal Government introduced the "Integrated Home Care Services" (*Geintegreerde Diensten Thuiszorg (GDT)/Service Intégré de Soins à Domicile (SISD)*), which are financed by the statutory health insurance system. This structure coordinates all disciplines involved in the care for patients for a specific geographical area.[71]

In the Flemish community, it is coordinated by "Cooperation Initiatives Primary Care" (*SamenwerkingsInitiatieven Eerstelijnsgezondheidszorg* or *SELs*), officially recognised and subsidised by the Flemish Government.[72] In the French community, home care is coordinated by the "Coordination Centres for Home Care and Services" (*Centres de Coordination de Soins et Services a Domicile* or *CSSDs*). Their main task is to guarantee the quality of care and the cooperation between home care workers. Care support and coordination is geared towards keeping patients at home for as long as possible.

Communities assume these responsibilities themselves, while the French-speaking Community has devolved its competence to the Walloon Region. In Brussels, matters are arranged by three community commissions - the French Community Commission (Commission Communautaire française, COCOF), the Joint Community Commission (Commission Communautaire Commune, COCOM) and the Flemish Community Commission (Vlaamse Gemeenschapscommissie, VGC).

[70] For more information on the organisation and financing of home care and, specifically, home nursing care, see Sermeus, W., Pirson, M., Paquay, L., Pacolet, J., Falez, F., Stordeur, S. and Leys, M., "Financing of home nursing in Belgium", Belgian Health Care Knowledge Centre, Report 122C, February 2010.

[71] To stimulate multidisciplinary cooperation instead of competition, each geographical area can have only one GDT-SISD, with the exception of the Brussels region where both the Flemish and the French communities can accredit GDT-SISDs. The GDT-SISDs main task is to oversee the practical organisation and to support care providers and their activities within the framework of home care. In Flanders, the overlap is now addressed through the emergence in 2010 of "Cooperation Initiatives Primary Care" (SEL), which are the only ones who can gain recognition as GDT.

[72] Before 1 January 2010, home care was coordinated through "*Samenwerkingsinitiatieven Thuiszorg*" (SIT) – or "Cooperation Initiatives Home Care".

In centres for **day care** and "short-stay" care, nursing care and personal care are provided to elderly persons for whom home care is temporarily unavailable. This is meant for people who do not need intensive medical care but who require care or supervision and aid in the activities of daily living. A fixed daily compensation is paid by the compulsory health insurance.

Elder persons who do not require much care can also be serviced in a semi-residential setting, where individual living arrangements are combined with collective facilities such as meal services or home help services. These arrangements are commonly known as "service flats".

A residential **home for the elderly** is a home-replacing environment where the medical responsibility rests with a general practitioner. The cost of stay is paid by the occupant, while medical costs and the cost of care are taken by the compulsory health insurance scheme based on an objectively assessed degree of care needed.

Patients with moderate to severe limitations but who do not need permanent hospital treatment are admitted in **nursing homes** (*Rust- en verzorgingstehuis* (*RVT); maison de repos et de soins (MRS)*). Each nursing home must have a coordinating and advisory physician who is responsible for the coordination of pharmaceutical care, wound care and physiotherapy. Each rest and nursing home must always have a functional link with a hospital. They must cooperate with the geriatric service of the hospital and a specialised service of palliative care. While residents must finance the cost of stay themselves, nursing care is reimbursed by the compulsory health insurance.

As the costs for medical care are reimbursed to the individual by the health insurance system, out-of-pocket payments are subject to the system of the "maximum billing system" (described above, chapter 2.3). Moreover, co-payments for some home nursing services were reduced from 15% to 10% as of February 2010.

Expenses related to non-medical long-term care are borne by the individual, but offset by several **cash benefits**. On the federal level, a monthly allowance for disabled persons and the elderly (*Tegemoetkoming voor hulp aan bejaarden; Allocation pour l'aide aux personnes âgées*) is granted to persons aged 65 and older for whom a severe need for care is ascertained. This allowance is means-tested. Several other topical allowances exist, aimed at specific costs (e.g. incontinence material) or circumstances (e.g. for palliative care at home).

Flanders has introduced an additional "Flemish Care Insurance" (*Zorgverzekering*) in 1999, covering the costs of non-medical help and services borne by people with reduced self-sufficiency. The system is organised as a residence-based compulsory insurance-type scheme: every person residing in Flanders is obligatorily covered; persons residing in Brussels are allowed, but not obliged, to join. Note that the *zorgverzekering* only provides financial benefits; insurance under the scheme is not a requirement for receiving long-term care *services.*[73]

Patients in residential care who do not have the means to pay for board and lodging are helped through social assistance services which are provided for by the municipalities.

[73] More information on the Flemish care insurance can be found in the year reports of the Flemish Care Fund, accessible via http://www.zorg-en-gezondheid.be/Publicaties/Publicaties-Vlaamse-zorgverzekering/. Updated figures are posted on http://www.zorg-en-gezondheid.be/Cijfers/Cijfers-over-de-Vlaamse-zorgverzekering/.

4.1.3 Details on recent reforms in the past 2-3 years

In recent years, a wide range of new and more diversified services has been developed and implemented that allow the provision of long-term care for elderly persons in other settings than a residential one. More places for short-term stays are available, and there are new and better integrated services for home support and personal care (care attendance, temporary care, informal care and regional service centres). Likewise, the number of "assisted living residences" and "day-care centres" has substantially increased. These developments clearly underscore the focus on non-residential versus residential care.

At the same time, more places are created in residential care facilities. These extra beds are however mostly situated in nursing homes (rather than in homes for the elderly) and are intended for patients requiring a moderate to high level of care. The number of "classical" residential places for patients with lower care burden decreases, in favour of other forms of care provision at home or in a semi-residential setting.

In Flanders, the Decree on Residential and Home Care of 13 March 2009 (*Woonzorgdecreet*) and the Flemish Integrated Policy Plan for the Elderly 2010-2014 (*Vlaams Ouderenbeleidsplan 2010-2014*)[74] describe a policy of coordination and cooperation between residential and home care services. The legislative framework combines self-care, informal care and professional care in existing and new forms of home care, care that supports home care, and additional care and residential care. It paves the way to new care settings in which independent living is combined with the provision of care services, and takes into account a more diverse profile of care dependent persons.

While no such integrated legislative framework seems to exist in the Walloon region, policy focuses on the same issues and offers broadly the same solutions, offering a wider range of available services tailored to the various needs of the patients. There too, the goal is to improve the well-being of older people and to extend the time that they can keep living at home. Other topical measures are meant to bridge the digital divide, to encourage older people to exercise, etc.

At the federal level, specific actions have been initiated with regard to taking charge of old age dementia or with regard to the struggle against nosocomial infections in institutions for the elderly for instance. The idea of care trajectories that allow for better coordination and integration of different types of care in case of chronic diseases, according to the chronic care model, is increasingly gaining ground. Support for nursing and caring staff as well as informal carers is increased, for instance trough training programmes and enhanced financial support for existing training courses.

Recently decided but not yet implemented, a special statute for patients with chronic illnesses will result in lower out-of-pocket payments from 2014 onwards.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

As the medical aspects of long-term care are organised through the compulsory health care system, coverage and access to medical long-term care services are the same. Formal home care is widely available. While it is clear that there are more patients who want residential care than there are places available, the lack of a central register means that there are no

[74] Most of the media- and policy-attention in Flanders however goes to the organisation of long-term care for (non-elderly) handicapped persons. In this field, new funding and initiatives follow the lines set out in a "renewal plan 2020" (*vernieuwingsplan Perspectief 2020*).

accurate numbers concerning waiting periods. Moreover, the waiting lists kept at the level of the facilities themselves are not reliable because patients tend to register with multiple institutions at the same time, and because the actual need of those on the list is only checked when places become available.

The cost for the patient of a stay in a retirement home is estimated to be around € 1 500 per month, compared to the average monthly pension of around € 1 100. Moreover, inspections in retirement homes reveal that institutions sometimes charge extra costs that should be included in the normal price. If a care-dependent person is not able to pay the bill, children are required to contribute. If this proves impossible, the unpaid cost is covered via social assistance.

Home care services are organised locally. To pay for the part of the bill that is not subsidised, a federal means-tested monthly allowance for disabled persons and the elderly is complemented by, in the Walloon region, increased financial support for family assistance and, in Flanders, by a separate care insurance.

On 31 December 2012, the Flemish Care Insurance provided a benefit of € 130 per month to 222 798 individuals. As of 1 June 2013, the benefit is awarded automatically to users of home care, without the need for applying. This compensation is however not sufficient to cover the non-medical costs of many patients who receive care at home. For this reason, the Flemish government has planned to introduce a "Maximum Billing System" for home and residential care in Flanders. This measure, already enacted in 2011, has however not yet been implemented.

Many who make use of home care services pay for this by using "service coupons" (*dienstenchecques*). "Service coupons" were introduced in 2003 as a system of consumer subsidies for domestic services. It aimed to increase the employment of low-qualified labour, and at moving certain activities out of the black economy into the legal circuit. The system works by offering individuals a chance to buy vouchers which can be used to pay those who deliver domestic services such as cleaning, ironing and occasional child-care. From the supplier side, local work agencies co-ordinate those who deliver the service. A coupon can be used to pay a work hour at a reduced rate and offers an additional fiscal reduction.

While "service coupons" were never meant to be used for the provision of care, the reality is different: the system is especially popular in the provision of home care.[75] The number of vouchers used (counted per hour) per person for this purpose seems to level at around 110 per person per year, or 220 per family per year. The impact of budget measures rendering the system less attractive is thought to be limited.[76]

As a result of the sixth round of state reform, the system of service coupons will become the responsibility of the regions. Depending on the political choices made on that issue, there may be an impact on the usability of the system for the purchase of non-medical care; in any event conditions become less favourable to the recipients of home care.

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[75] An interesting study by Dr. Pacolet looks into the use of "service coupons" (*dienstenchecques*) in the provision of care: Pacolet, J, De Wispelaere, F, De Coninck, A, "De dienstencheque in Vlaanderen. Tot uw dienst of ten dienste van de zorg?" (*Service Coupons in Flanders. At your service, or at the service of care?*), Steunpunt Welzijn, Volksgezondheid en Gezin, April 2011.

[76] The number of "service coupons" is to be limited to 500 per person or 1,000 per family per year. The price of a service coupon for the user will also increase, from € 7.5 to € 8.5 in 2013 and to € 9 in 2014. The current fiscal reduction remains unchanged. Typically, one coupon is used per hour.

Another recent measure (of which the impact can not be assessed) reserves 60% of new employment paid through service coupons to fully unemployed persons or persons receiving social assistance.

4.2.2 Quality and performance indicators

The separate elements of long-term care provision are generally of good quality. In long-term care however, the biggest challenge is to tackle the strong increase of chronic conditions and of multi-morbidity. Patients are more likely to suffer from multiple (chronic) conditions and to be treated by different carers at different times. As patients move between care settings, the need for long-term care is difficult to assess or predict, which in turn means that it is not easy to get a clear picture of the quality or effectiveness of the care delivered.

Worryingly, existing social inequalities in health seem to persist into old age. In a recent study, the use of home care versus residential care is linked to data on those benefiting from a preferential status in the public health insurance system (because of social economic status). The study shows that those with a preferential status make more use of home care, and that there is a relation between socio-economic status and mortality at a younger age, and the prevalence of certain chronic conditions.[77]

4.2.3 Sustainability

While it is not easy to forecast the future need for long-term care in all its present and future forms, it is generally though that the number of dependent persons in need of care will double by the year 2060, when compared to the year 2007 (1 168 370 individuals in 2060 compared to 565 792 in 2007[78]). Provided that the proportion of older people in home care versus residential care remains the same, the number of users of residential care will increase from the current 125,000 to 166,000 already in 2025.[79]

The budgetary cost of long-term health care alone (not counting the cost of non-medical care) will increase from 1.2% of GDP in 2012 to 2.9% of GDP in 2060 – representing about 30% of the total increase in expenditures attributed to ageing.[80]

Nursing care, organised by the federal public health insurance system, is provided by qualified nurses, many of whom are self-employed. At the end of 2012, 174 849 qualified nurses were registered, of which 4 215 had a specific qualification in geriatric care. At over 87%, the profession is mostly taken up by women.[81] Care professionals (*zorgkundigen*) are persons who are authorised to help nurses within a structured team (for example in residential care). In 2012, 86 379 care professionals were registered.[82]

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77 Van Den Bosch, K., Geerts, J., Willemé, P., Long-term care use and socio-economic status in Belgium: a survival analysis using health care insurance data, Archives of Public Health (international online journal), January 2013; http://www.archpublichealth.com/content/71/1/1

78 Willemé, P., The Belgian long-term care system, Federal Planning Bureau Working Paper (7-10), March 2010. http://www.plan.be/admin/uploaded/201004230943350.wp2001007.pdf

79 Van Den Bosch, K, Willemé, P, Geerts, J, Breda, J, Peeters, S, Van De Sande, S, Vrijens, F, Van De Voorde, C, Stordeur, S., Toekomstige behoefte aan residentiële ouderenzorg in België: Projecties 2011-2025 (*Residential care for older persons in Belgium: Projections 2011 – 2025*), Belgian Health Care Knowledge Centre, Report 167A, November 2011.

80 Study Committee On Ageing, "Jaarlijks Verslag 2013", 6

81 http://www.gezondheid.belgie.be/eportal/Healthcare/Consultativebodies/Planningcommission/Statistiquesannuelles/index.htm#.UlvNldK2bew

82 A Dutch study of 2011 puts the number of nurses and care professionals in Belgium at 20.2 per 1000 inhabitants – higher than in other countries. The figures do however not reveal the number of full-time equivalents or the specific role of these carers in the provision of long-term care. See Mistiaen, P., Kroezen, P., Triemstra, M., Francke, A.L., Verpleegkundigen en verzorgenden in internationaal perspectief – Een literatuurstudie naar rollen en posities van beroepsbeoefenaren in de verpleging en verzorging, Utrecht, 2011, p. 53, http://www.nivel.nl/sites/default/files/bestanden/Rapport-Verpleging-Verzorging-internationaal-perspectief.pdf

Home care services (including meals service, help with domestic chores and basic personal help) are organised locally by staff employed by a public agency or by private non-profit firms. The number of persons engaged in the delivery of these services is not known. The subsidised home care sector produced about 25 million care hours in 2006; an equivalent of 17 000 full-time workers. While several measures and campaigns have succeeded in making a career in care more attractive, the number of future care recipients makes it clear that mobilising and "officialising" informal carers will have to be part of the solution.

Recent reliable statistics on the number of informal carers (versus the number of *recipients* of informal care) are not easy to find. WILLEMÉ cites estimates of approximately 668 000 informal caregivers aged 15 or older and 455 000 aged 45 or older – compared to the estimate of 400 000 informal caregivers aged 50 years of older provided by SHARE.[83]

Informal caregivers are currently supported through information provision, social and psychological services and by the existence of day centres and short-stay care centres which allow to temporarily alleviate the burden of informal caregivers. Combining care-giving with a career is to an extent facilitated by paid leave schemes (for employees and civil servants). These schemes allow taking time off to care for a needy person whilst receiving a replacement income provided for by the unemployment insurance scheme. Periods taken under these schemes count as contribution periods for other social security benefits, such as pensions.

As a result of measures meant to increase the effective retirement age and to prolong career durations (and therefore the periods during which a person contributes to the pension scheme), the use of these schemes is however becoming more restricted. This highlights the need for a specific recognition and social protection of informal carers.

While no special provisions yet exist, steps towards such a recognition are currently being taken. In March 2013, the government proposed a new Act towards a legal recognition of informal carers. The text seeks to define what constitutes an "informal carer" (*mantelzorgers*, *aidants proches*). Some elements in the definition are that informal carers provide help in a non-professional way and in cooperation with at least one professional care-giver, and that the time spent providing informal care must amount to at least 20 hours per week. The next steps will be to define specific categories and to attach (financial and other) consequences to the legal recognition as informal carer, meaning that "formalising informal care" may still take a while. This proposal follows earlier debate and a first parliamentary initiative dating from the summer of 2011. The main analytical basis for the current developments is a study concerning a legal recognition and social statute performed by the universities of Namur and Brussels.[84]

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83 Willemé, P., The Belgian long-term care system, 12. Several surveys and studies provide insight in who these carers are. In Belgium, the probability of giving care depends to an important extent on the gender and the occupational status of the potential caregiver. From this data, it is apparent that informal care is mostly provided by women aged 45 to 75.

For an analysis of census data with the goal to identify informal carers, see: DEBOOSERE, P. et al., Gezondheid en mantelzorg, FOD Economie, Sociaal-economische enquête 2001, Monografieën, 2006, nr. 1, 175 p, http://statbel.fgov.be/nl/binaries/mono_200101_nl%5B1%5D_tcm325-35806.pdf;

Masuy, A. J., How does elderly family care evolve over time? An analysis of the care provided to the elderly by their spouse and children in the Panel Study of Belgian Households 1992-2002, PhD dissertation, 2010-2011, https://lirias.kuleuven.be/handle/123456789/311889;

Riedel, M. And Kraus, M., Informal care provision in Europe: Regulation and profile of providers, ENEPRI Research Report No. 96, November 2011, http://www.ancien-longtermcare.eu/sites/default/files/RR%20No%2096%20_ANCIEN_%20Regulation%20and%20Profile%20of%20Providers%20of%20Informal%20Care.pdf

84 Flohimont, V, Van Limbergen, G, Tasiaux, A, Baeke, A-M And Versailles, P, "Reconnaissance légale et accès au droits sociaux pour les aidants proches" (*Legal recognition and access to social rights for*

4.2.4 Summary

Long-term care is available and accessible, but requires an important personal financial effort of the patient. The many initiatives taken to increase financial accessibility by limiting the cost for the patient, both of medical and non-medical care, do not seem to be sufficient to avoid social inequalities.

In terms of organisation, the policy focus both at the federal level as in the regions remains on the provision of services at home for as long as possible. The Country-specific Recommendation, issued in 2013, to "continue to improve the cost-efficiency of public spending on long term institutional care", does not cause concern. While the number of places in residential care indeed continues to increase, these places are meant for patients with a high need for care. As more patients move less quickly to residential care, this evolution will continue.

More diversified long-term care services are being developed, and better coordination and cooperation ensures that these services better correspond to the needs of the patients. Facilitating and organising the move of patients between care settings remains a challenge.

4.3 Reform debates

There is much agreement on policy and the direction in which the long-term care system should move. The overall goal is to enable older people to remain at home as long as possible and to ensure their autonomy. To that end, more and innovative care services need to be developed, and different types of care need to be better coordinated and integrated. The introduction of special provisions for chronic patients already implements this idea of care trajectories.

Keeping more people at home also requires more attention to the role of informal carers. As described above, first steps towards a "formalisation" of informal care are being taken, even if it is not yet clear what real difference it will make for informal carers.

At the same time, there is still a need for residential care. Here, problems arise because of the fact that planning, infrastructure and the actual provision of nursing care are governed by different entities. As a result of sixth package of state reorganisation measures in Belgium, the division of competencies between the different state entities is set to change in order to increase the homogeneity of competences, allowing policy to better meet local needs.

More aspects of long-term care will be handed over from the federal level to the communities, and many of these new competences involve direct service delivery to patients. The package includes competences concerning residential care (including setting the price charged to users), mental health care and psychiatric nursing homes, some care support allowances for people with a disability (including the monthly allowance for disabled persons and the elderly), rehabilitation, technical mobility aids, forms of sheltered living arrangements and psychiatric care, programmes for prevention and the organisation of primary care, etc.

At the same time, consultation between the Communities and the federal authorities will be strengthened by the creation of a new institute, which will be a permanent and inter-federal meeting place for policy-makers in the area of healthcare. The task of this institute will be to develop a common and future-oriented vision and to define a sustainable health policy. The planning of care supply will be done with the scientific support of the Federal Knowledge Centre for Health Care.

caregivers), May 2010. https://lirias.kuleuven.be/bitstream/123456789/269814/2/100604+-+reconnaissance+l%C3%A9gale+des+aidants+proches+-+version+d%C3%A9finitive.pdf

This represents a shift whereby not only home care but also intra-mural care will be more in the hands of the Communities, allowing for different regional policy accents and priorities to emerge and develop.

The shift in competencies is to take place in 2014. While the full extent of the reform is not yet clear, it is certain that the new competencies will influence current policies and current organisation of long-term care.

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DEKKERS, G., DESMET, R., FASQUELLE, N., FESTJENS, M-J., JOYEUX, C., SCHOLTUS, B., WEEMAES, S. (2013), "Mesures prises en 2012 dans les branches chômage et pension: évaluation des effets selon le genre" (*The measures taken in 2012 in the fields of unemployment and pensions: evaluation of their effects according to gender*), Federal Planning Bureau Working paper 3-13, February 2013, Brussels, 26, retrieved at http://www.plan.be/publications/Publication_det.php?lang=en&TM=63&IS=63&KeyPub=1209

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Annex – Key publications

[Pensions]

DEKKERS, G., DESMET, R., FASQUELLE, N., FESTJENS, M-J., JOYEUX, C., SCHOLTUS, B., WEEMAES, S., Mesures prises en 2012 dans les branches chômage et pension: évaluation des effets selon le genre, Federal Planning Bureau Working paper 3-13, February 2013, Brussels, 26p / retrieved from: http://www.plan.be/publications/Publication_det.php?lang=en&TM=63&IS=63&KeyPub=1209

"The measures taken in 2012 in the fields of unemployment and pensions: evaluation of their effects according to gender."

In the course of 2012, the Belgian government has introduced several changes in the pension system and the unemployment insurance system. While the microeconomic, budgetary and social effects are described in other publications (such as reports by the Study Committee for Ageing), this study looks at the impact according to gender. Because women, on average, have shorter careers, the new measures prompt then to delay retirement more than men. This delay is visible in a lower number of beneficiaries, but also an increase of the average pensions. The study also shows that the changes in the unemployment benefits increase the risk of poverty of the unemployed, and especially of men.

DE VIL, G., FASQUELLE, N., FESTJENS, M.-J. JOYEUX, C., Welvaartsbinding van sociale en bijstandsuitkeringen, Federal Planning Bureau Working Paper 4-11, March 2011, Brussels, xix + 74p / retrieved from: http://www.plan.be/admin/uploaded/201104071246330.wp201104.pdf.

"Prosperity-consistency of social benefits"

In this Working Paper by the Federal Planning Bureau, the effects of mechanisms on the adequacy of pensions is discussed. The paper concludes that the stabilising effect of the "prosperity bonus" is important and has a direct influence on poverty figures. The study also explains why the poverty risk amongst the elderly is set to diminish between 2030 and 2050 by pointing at the influence of repeated adaptations of the Minimum Income Guarantee for the Elderly and the general rise in pensions for women (due to longer careers).

DE VIL, G., VAN DEN BOSCK, K., De evolutie van de armoede bij ouderen nader bekeken, Federal Planning Bureau Working Paper 06-13, August 2013, Brussels, 38 p / retrieved from: http://www.plan.be/publications/Publication_det.php?lang=nl&TM=30&IS=63&KeyPub=1057

"A closer look at the evolution of poverty of elderly persons"

In spite of a strengthening of the minimum income protection for the elderly over the past decade, the risk of poverty amongst the elderly population does not seem to be much lower now. Only the situation of those living alone seems to have improved significantly, which can be connected to an important increase in the amount of the "guaranteed income for the elderly", a residual social assistance scheme. The EU-SILC research shows that the income of an important group of persons is lower than this guaranteed minimum. This is partly caused by different definitions of income, but also to an important extent by a high non-take-up of the benefit.

STUDY COMMITTEE ON AGEING, "Jaarlijks Verslag 2013", July 2013, Brussels, 89 p / retrieved from:
http://www.plan.be/publications/Publication_det.php?lang=nl&TM=63&IS=63&KeyPub=1237

"Annual Report"

The 2013 report of the Study Committee on Ageing contains projections on the evolution of the budgetary cost of ageing (defined as the variation of all social expenses over a given period) in different scenarios. In addition, the impact of some of the current reforms in the pension system is assessed and analysed. The report shows that the impact of these measures is rather limited.

[Health care]

DE GRAEVE, D., VAN MECHELEN, N., VANDELANNOOTE, D., DE WIDE, M., Measuring health care expenditures in Belgium: the at-risk-households approach, Flemosi discussion paper DP23, June 2013, 46 p, retrieved from:
http://www.flemosi.be/uploads/161/FLEMOSI%20DP23%20De%20Graeve%20et%20al.pdf

Using a simulation tool for ex ante evaluation of social economic policies in Flanders, this paper looks at the impact of illness and its related expenditures on the income position of specific households in Flanders. The simulation results show that their situation is often dramatic, but also that current protective policies for both medical and non-medical costs do improve the income situation of families with health care costs substantially.

OECD, "Health at a glance: Europe 2012", OECD Publishing, November 2012, 149 p / retrieved from:
http://www.oecd.org/health/healthataglance/europe

The sixth edition of "Health at a glance" is an excellent resource for the latest comparable data on different aspects of the performance of health systems in OECD countries. Key indicators provide information on health status, the determinants of health, health care activities and health expenditure and financing in OECD countries.

SORBE, S., Belgium: Enhancing the Cost Efficiency and Flexibility of the Health Sector to Adjust to Population Ageing, OECD Economics Department Working Papers nr. 1066, June 2013, 35 p / retrieved from:
http://www.oecd-ilibrary.org/economics/belgium-enhancing-the-cost-efficiency-and-flexibility-of-the-health-sector-in-belgium-to-adjust-to-population-ageing_5k44ssnfdnr7-en

Seen from an economic perspective, this paper proposes various topical strategic measures to adapt the Belgian healthcare system to population ageing. It offers an overview of possible efficiency gains, and interesting quantitative data and analysis.

VAN HERCK, P., ANNEMANS, L., VAN DE CLOOT, I., Het gouden ei van de geneesmiddelen in België: hervormen of vrijwaren?, Itinera Institute analyse, May 2012, Brussels, 27 p / retrieved from

http://www.itinerainstitute.org/upl/1/default/doc/20120510_analyse_generieken_PVH_NL.pdf

"The golden egg of pharmaceuticals in Belgium: remodel or protect?"

Itinera analyses the government policy targeting the price and volume of medicine use to cut healthcare spending and examines the need and potential for such reforms, the advantages and disadvantages, and how to proceed further. It concludes that the need for reform is substantial in short term, with a potential of € 444 million in yearly savings due to price competition after patent expiry. In the long run, a refocusing towards evidence-based medicine use is needed to partially address the issue of rising care expenditure. Itinera argues that the Belgian government should do both (and not just focus on price), without hurting the innovative capacity in pharmaceuticals, which is one of the main assets of the Belgian economy. The principles of current reforms, including obligatory substitution by pharmacists to give the most fair price across equivalent products, are supported. Yet, the practical set-up of a monthly based time pressure should be revised towards a longer period, preferably half a year. The prescription on active component should be generalised, with limited evidence-based exceptions. In addition, sickness funds and insurers should be enabled and stimulated to negotiate directly and individually with care providers, both on quality and prices of medicine use.

VRIJENS, F., RENARD, F., JONCKHEER, P., VAN DEN HEEDE, K., VAN DE VOORDE, C., WALCKIERS, D., DUBOIS, C., CAMBERLIN, C., VLAYEN, J., VAN OYEN, H., MEEUS, P., Performance of the Belgian Health System, Report 2012, Health Services Research (HSR), Brussels, Belgian Health Care Knowledge Centre (KCE), 2012, KCE Report 196C / retrieved from:
https://kce.fgov.be/publication/report/performance-of-the-belgian-health-system-report-2012

Health System Performance Assessment (HSPA) is a process that allows the health system to be assessed holistically. It uses measurable indicators to monitor the system and links health outcomes to the strategies and functions of the health system. A first Belgian Health System Performance Assessment was published in June 2010. The HSPA report 2012 builds on that and attempts to monitor the accessibility, quality, efficiency, sustainability and equity of the Belgian health system.

[Long term care]
PACOLET, J, DE WISPELAERE, F, DE CONINCK, A, De dienstencheque in Vlaanderen. Tot uw dienst of ten dienste van de zorg?, Steunpunt Welzijn, Volksgezondheid en Gezin, April 2011, 373 p / retrieved from:
http://www.steunpuntwvg.be/swvg/_docs/Publicaties/201103%20Rapport%2014%20Dienstencheques.pdf.

"Service Coupons in Flanders. At your service, or at the service of care?"

This report looks at the usage of the Belgian system of "service coupons" (*dienstencheques*) as a mechanism through which citizens can receive subsidised care. Through interviews with different stakeholders, a rather detailed picture is drawn of the situation in Flanders. In summary, it seems that the system is widely used for services in the field of home care – even if it was not meant for that. The use seems so widespread that abolishing or limiting the system would risk uprooting a practical ways in which people have organised themselves.

What is more, because the system has introduced private providers to the market of care provision and is also used by public providers who now also cater for the private market, adaptations would easily alter the way the supply side itself is organised.

VAN DEN BOSCH, K, WILLEMÉ, P, GEERTS, J, BREDA, J, PEETERS, S, VAN DE SANDE, S, VRIJENS, F, VAN DE VOORDE, C, STORDEUR, S., Toekomstige behoefte aan residentiële ouderenzorg in België: Projecties 2011-2025, November 2011, KCE Reports 167A, 136 p / retrieved from:
https://kce.fgov.be/nl/publication/report/toekomstige-behoefte-aan-residenti%C3%ABle-ouderenzorg-in-belgi%C3%AB-projecties-2011-2025

"Residential care for older persons in Belgium: Projections 2011 – 2025"

This study projects a strong rise of the number of users of residential care from about 125,000 currently to about 166,00 in 2025; an increase of some 40.000 places needed. Thus, more places need to be created to supplement the 129,732 places available in 2011. This increase is wholly due to population ageing; the prevalence of residential care among older persons is not expected to change significantly. Striking is the observation that, even if home care would be expanded by 50% (beyond the increase that is required to keep up with an ageing population), the need for residential care would still increase to 149,000 places and would thus require an annual increase of 1,600 beds – compared to the average yearly increase of about 790 beds between 200 and 2009. Beyond 2025, the growth in demand for residential care will most likely accelerate. The study employs a calculation model that can be used to test the impact of alternative policy, for example measures meant to lengthen the time one can remain at home. (This report is available in English.)

VAN DEN BOSCH, K., GEERTS, J., WILLEMÉ, P., Long-term care use and socio-economic status in Belgium: a survival analysis using health care insurance data, Brussels, archives of public health, January 2013 / retrieved from:
http://www.archpublichealth.com/content/71/1/1

The authors try to discover whether socio-economic inequality in morbidity among older persons also means that social inequalities in health persist into old age. They describe clear associations between an indicator of low income and home care use, some chronic conditions and death. The associations are stronger among men than among women, and decline with age for home care use and death, which might be explained by selective survival.

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