Belgium

Health Care & Long-Term Care Systems

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Health care systems

1.2. BELGIUM

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

With EUR 393 billion (2013), the Belgian share in the EU economy is some 4%. GDP per capita is with 30,340 PPS in 2013 above the EU average of 27,900 PPS. Economic growth decelerated in 2015, and it is projected to remain stable at 1.3% in 2016 to then increase to 1.7% in 2017 ([34]).

The population of the constitutional monarchy has increased during the past decade, from 10.4 million in 2003 to 11.2 in 2013. Over the decades to come, the Belgian population is projected to continue to increase significantly, from 11.2 million in 2013 to 15.4 million in 2060 ([35]). This projected increase in population is much higher than that of the EU (37.7% vs 3.1%).

Total and public expenditure on health as % of GDP

Total expenditure on health, as a percentage of GDP, has steadily increased during the past decade, from 9.7% in 2003 to 11.2% of GDP in 2013 ([36]). Total expenditure in PPS is with 3549 higher than the EU average (2988 PPS per capita). Public expenditure, after reaching a plateau at around 8.0% from 2009 to 2012, displays in 2013 a slightly wider gap with respect to the EU average than the past years (0.7% in 2013 vs 0.4% in 2011 and less than 0.1% in 2009).

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care expenditure is projected to increase by 0.1 pps of GDP, below the average growth level expected for the EU of 0.9 pp of GDP, according to the AWG reference scenario ([37]). When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 0.5 pps of GDP from now until 2060, still lower than the average (EU level: 1.6).

From a sustainability point of view, the country faces both medium and short term challenges, driven by the high initial debt-to-GDP ratio and, especially over the long term, by projected cost of ageing ([38]).

Health status

With 83.2 and 78.1 years for women and men respectively, life expectancy at birth is in Belgium similar to the EU average in 2013 (83.3 and 77.8 respectively). The years spent healthy are, with 63.7 for women and 64 and for men, higher than the EU average (61.5 and 61.4, respectively). Infant mortality, which represents the ratio of the number of child deaths under one year of age per 1000 live births, has declined to 3.5. This declining trend is noted throughout the whole of the EU, which averages around 3.9 in 2013.

System characteristics

System financing, revenue collection mechanism, coverage and role of private insurance and out of pocket co-payments

The responsibility for the regulation and financing of the compulsory health insurance lies with the federal government. It also creates the programmes and normative framework for the hospitals. In addition it governs the rules for recognition of providers and organises the registration of pharmaceuticals and their price and determines the rules for financing of healthcare infrastructure (such as costly medical equipment). At federal level, decisions are also made regarding which products and services can be benefitted from under the system.

The compulsory health insurance is combined with a mostly private system of health care delivery,

([34]) European Commission (2016), European Economic Forecast Winter 2016.

([35]) Eurostat 2013 Population Projections – Main Scenario. Note that this number is considerably higher than the current (March 2016) Belgian national projection of 13.0 million in 2060.

([36]) WHO Total Health Expenditure (Series 6710). Note that the AWG projection is based on Current Health Expenditures (10.2 % of GDP) as reported in the System of Health Accounts.

([37]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

([38]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.

based on independent medical practice, free choice of physician and predominantly fee-for-service payment.

Financing for the healthcare insurance is obtained through employee and employer contributions and through a contribution from the state budget from the general taxation, complemented with alternative financing by earmarked taxes 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. Between 2004 and 2012, the health care budget was allowed to grow by 4.5% per year (since 2004), after adjustment for inflation. However, the actual expenditures were growing slower on average, which, together with the aim of controlling public expenditure, has led to a downward revision of the growth norm in the wake of the financial crisis. The norm was set to 2% in 2012 and 3% in 2013 and 2014. After the change in government in 2014 and the austerity policy it set out to pursue, the growth norm was set to 1.5% from 2015 onward.

Citizens contribute financially to the healthcare system according to their employment situation, their statute (preferential reimbursement or not) ([39]), the type of service they request and on the basis of the amount of user charges they have already paid during that year. Users of healthcare services will participate in health-care financing by paying a certain fixed amount of the cost of a service, with the third-party payer covering the balance of the amount. In 2001, Belgium introduced a system of maximum billing. The system has been designed as a structural measure to find a compromise between social protection of the weakest groups in society on the one hand and individual responsibility on the other hand. Thanks to this scheme, each household (both with high and low incomes) has, according to the family's net taxable income, an annual out-of-pocket ceiling for all necessary health care expenses. The ceiling has a minimum and a maximum height.

Almost the whole population (> 99%) is covered for a very broad benefits package. Since January 2008, there is no longer any difference between health insurance coverage in the general scheme and the scheme for the self-employed, as the latter now includes the coverage of minor risks.

A large majority of the population hold voluntary health insurance (both complementary and supplementary), covering for example single room accommodation for hospitalised patients. These insurances are being provided by both the sickness funds and private for profit insurance companies. Private health insurance is relatively limited in importance, as it represents between 4 and 4.5% of total health expenditure in 2013 ([40]), and covers mostly inpatient expenditure, even when larger coverage (ambulatory care and dental care) also exist.

Private expenditure (patient co-financing and voluntary insurance) in Belgium is higher than the EU-average (around 24.2% of total expenditure). This share used to be higher, but the share of public expenditure in the total has increased from 2003 to 2013 from 73.1% to 75.8%, closer to the EU average of 77.4%. Out-of-pocket expenditure alone, however, displays at 19.9% in 2013, a wider gap with respect to EU.

Administrative organisation

The compulsory health insurance is executed through six private, not-for-profit national associations of sickness funds and one public sickness fund. It is their major responsibility to reimburse health service benefits. The sickness funds are members of the National Institute for Health and Disability Insurance (NIHDI-RIZIV-INAMI). Since 1995 a trend has started to make Belgian sickness funds more financially accountable for their expenses made. They act collectively in their negotiations with health care providers.

The public expenditure in 2013 on healthcare administration and health insurance is in Belgium with 0.3% close to the EU average of 0.27% of GDP.

([39]) To qualify for preferential reimbursement the patient has to belong to a socioeconomically vulnerable group and have an income below a certain limit. In addition, patients with certain medical conditions or chronic diseases are exempted from cost-sharing.

([40]) http://ec.europa.eu/eurostat/web/health/health-care/data/database (SHA).

Treatment options, covered health services

The services that are covered by compulsory health insurance, which is characterised as a fee-for-service system, are described in the nationally established fee schedule (more than 8000 services), the so called 'nomenclature'.

Types of providers, referral systems and patient choice

National planning sets various targets and accreditation norms that institutions must follow. Access to professions is regulated by law. The Belgian health system is mainly based on the principles of equal access and freedom of choice. All residents have to register to a Bismarckian-type of public compulsory health insurance (sickness funds) which offers a very broad benefits package (a positive list of goods and services is defined at the central level).

Belgium has a well-developed system of primary care. The service is provided through independent general practitioners (GPs, or "family doctors"). Some GPs provide their services in group practices. There are relatively many GPs in Belgium, compared to other EU Member States (112 vs 78.3 in the EU respectively per 100,000 inhabitants). The Belgian government aims at a strengthening of the role of the GP, for example in the treatment of chronic diseases. The current apparent over capacity could facilitate that shift.

Specialist outpatient care is provided predominantly in hospital outpatient departments and at times in private group practices.

Day care and inpatient treatment is provided in hospitals. Two thirds of the hospital acute beds are owned by private not-for-profit hospitals. The rest of the hospitals are publicly owned. The number of acute care beds per 100 000 inhabitants (396 in 2013), while showing a reduction, is still above the even faster decreasing EU average (356). Overall there are compared to the EU average not so many physicians per inhabitant in Belgium (295 per 100,000 compared to 344) ([41]). The amount of practising nurses per 100,000 inhabitants in Belgium on the other hand is higher than in the average EU level (932 in BE and 812 in the EU in 2011).

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Two systems of payment are implemented, the first one is a reimbursement system (for outpatient/ ambulatory care) and the second one is a third-party payer system where the patient pays only the co-insurance or the co-payment (for inpatient care and pharmaceuticals). The third-party payer system is gradually being further enlarged and implemented also in ambulatory care.

Most health care professionals are self-employed and are paid on a fee-for-service basis (publicly and readily available), with the patient partly reimbursed (generally at a rate of 75%) afterwards. Indeed, less than 1% of the physicians working in hospitals are employees. Nurses are mainly salaried in comparison. To avoid competition between services from hospitals or from office-based specialists, the same national negotiated fee is imposed. However, when working in hospitals, the specialists allow the institutions to retain a proportion of the fees as compensation for the space, equipment, staff and additional services. The government sets the fees for GPs and specialists every two years following a bargaining process with all the concerned parties. Only non-contracted physicians can set their fees freely even if the contracted can, in some specific cases like activity outside core time for example, charge higher fees. The same principle applies to dentists, pharmacists and self-employed nurses. In Belgium the remuneration gap is particularly large between GPs and specialists with GPs earning three times less than specialists even if some efforts have been made recently to decrease this gap. A possibility has been created for GPs to receive compensation/pay for the management of chronic diseases.

Inpatient care is covered by the third-party payer system. The patient pays a co-payment while the bulk of the cost is directly paid by the sickness fund to the hospitals. For the hospitals' running

([41]) Note that the actual figures may be underestimated as Belgium limits the count to physicians with a minimum amount of activity, whereas other countries count all physicians who have had at least one patient contact per year.

costs, a national budget ([42]) is set annually and paid to the hospitals via the sickness funds with an aim to make the hospitals accountable for their operations by means of financial rewards or fines. Hospitals are paid on a combination of ([43]): "common services" (about 25%) based on surface area, number of cases, number of patient days etc., "clinical services" (about 47%) based on volume and type of activity, intensity of nursing services and other activity indicators, and "legally required services" (general surgeon, hospital hygiene, registry keeping, quality policy and monitoring, hospital pharmacy) (about 14%) and other smaller items. Hospital activity is very high, with hospital inpatient discharges slightly below the EU average (15.8 vs. 16.4 per 100 inhabitants in 2011) but more than compensated by substantially higher than average (more than double) number of day case discharges (15,149 vs. 6,530 in 2011). Day case surgery has increased significantly in the last decade and the percentage of surgical procedures conducted as day cases in 2011 (48.9%) is much above the EU average during the same year (28.7%). From 1982, the "number of days" for an inpatient stay is subject to restrictions (pathology weighted) to discourage hospitals to extend stays for financial reasons. Despite that kind of control procedure, Belgium had for long time a hospital average length of stay above the EU average, though having decreased through the past decade. The average is currently 7.1 vs 6.3 days in the EU in 2011.

One of the key advantages of the Belgian system is that the precise price setting (flat rate) avoids unexpected fees for the patient. However, in hospitals, the patient's out-of-pocket contribution per day of hospitalisation may vary if there are additional costs for a single room, non-reimbursable products or non-publicly contracted physicians. Recent legislation however, obliges hospitals to provide a cost estimate of the treatment to the patient at the admission.

([42]) This budget only covers about 50% of the hospitals' operational costs. The other half is financed by fee-for-service payments by the NIHDI and patient out-of-pocket (or private insurance) payments (mainly physicians' fees and drugs).

([43]) CM 2013, De organisatie en financiering van de ziekenhuizen. CM Informatie nr. 253 (info fiche) [also available in French].

The market for pharmaceutical products

Pharmaceuticals are exclusively distributed through community pharmacies and hospital pharmacies and their establishment is strictly regulated since 1973.

Total expenditure in Belgium on pharmaceuticals as a percentage of GDP has over the last few years quite closely matched the EU average, going from 1.8 to 1.46% of GDP ([44]) (2013), with a EU average of 1.44 in 2013.

About 2500 pharmaceuticals are reimbursable in Belgium. The initial price of reimbursed drugs is based on clinical performance, economic evaluation and cost of existing treatments, and looking at the average EU price. The amount reimbursed is determined by the pharmaceutical category that reflects the social importance of the drug, pharmacotherapeutic criteria and price criteria. The patient pays only the non-reimbursable amount as a co-payment to the pharmacy. Authorities also use reference pricing whereby the reimbursement level of a drug is based on the prices of drugs that have the same active ingredient.

The sickness funds negotiate as a cartel with the drug companies on reimbursement rates under the supervision of the central government. The central government can also as an extreme measure oblige pharmaceutical firms to pay a special tax when expenditures on pharmaceutics are too high (a sort of payback system). However, the main policy instruments to stem (public) cost increases during the last decade have been price regulation and increases in co-payments.

Since 2001, the use of generics has been stimulated by introducing lower co-payments for the users and lower reimbursement levels for branded drugs when generics are available. Generic drugs must be at least 30% cheaper than originators. Doctors are encouraged to prescribe generic medicines through prescription quotas. Pharmacists are encouraged to provide the generic drug when available, for some categories of drugs,

([44]) Expenditure on pharmaceuticals used here corresponds to category HC.5.1 in the OECD System of Health Accounts. Note that this SHA-based estimate only records pharmaceuticals in ambulatory care (pharmacies), not in hospitals.

the substitution is compulsory (providing the patient with the cheapest or generic variant with the same active molecule of a prescribed drug). Information on generics is provided to health professionals and to the public.

Authorities promote rational prescribing by physicians through compulsory guidelines and prescription quotas, complemented with monitoring of prescribing behaviour and education and information campaigns on the prescription and use of medicines. They also promote education and information campaigns for patients.

Despite the success of the measures introduced so far, research ([45]) suggests that there is scope for further cost savings, which suggests progress towards the wider adoption of more cost-effective solutions should be pursued.

Use of Health Technology Assessments and cost-benefit analysis

The Belgian Health Care Knowledge Centre has played a major role in conducting and gathering information on health technology assessment since 2003. Health technology assessment information has been used to define guidelines and determine coverage and level of reimbursement of new procedures, new medicines and new high-cost equipment.

eHealth (e-prescription, e-medical records)

Belgium has established a public institution for eHealth with the law of August 28 2008. The organisation's mission is 'to optimise the quality and continuity of health care provision and patient safety and to streamline administrative procedures by means of mutual electronic services and data exchange between all health care actors, while guaranteeing information security and respecting patient privacy ([46]).

The mission translates into a number of tasks, such as the development of software platforms for safe information exchange between health professionals and between care providers and administrative services (the Federal Public Service for Health, Food Chain Safety and the Environment, the National Institute for Health and Disability Insurance, etc.) and managing and coordinating the ICT-related, organisational, functional and technical aspects of data exchange related to electronic patient records and electronic prescriptions. The organisation also acts as a 'trusted third party' for coding, anonymising and linking data requested by academic or public or private sector researchers.

Health and health-system information and reporting mechanisms

Monitoring and data collection has been widely implemented in the Belgian health-care system. Dedicated databases like Pharmanet, NMDS ([47]) or HDS ([48]), allow the control of the medical practice of individual physicians (volume of activity, prescription activity) and whether it complies with treatment guidelines. It also enables among other things the monitoring of health problems and the epidemiological situation or the effectiveness and quality of hospital care. The global set of data is very wide even if the collection of data about voluntary private health insurance or about care and nursing homes could be improved. The performance of the Belgian health care system is monitored continuously and reported periodically ([49]).

Health promotion and disease prevention policies

In Belgium, the communities and partially the federal state are responsible for prevention, promotion and education on health. In 2013, public expenditure on prevention and public health services reached 0.32% of GDP, which is above the EU average (0.19%). The most recent health promotion campaigns included: healthy eating, organ donation, deadly accident prevention, abuse of antibiotics, promotion of vaccinations and breast and cervical cancer screening.

([45]) Cornelis, K., Het geneesmiddelenbeleid inzake goedkopere geneesmiddelen in België, Brussels, September 2013; http://www.cm.be/binaries/CM-253-Geneesmiddelen_tcm375-130001.pdf.
([46]) See https://www.ehealth.fgov.be/nl/over-het-ehealth-platform/wetgeving/wet (only available in Dutch and French).
([47]) Nursing Minimum Data Set.
([48]) Hospital Data Set.
([49]) See: Vrijens et al. 2016, De performantie van het Belgische gezondheidssysteem - Rapport 2015. KCE Rapport 259A (Dutch and French).

Transparency and corruption

In 2008 Belgium signed the 'Tallinn Charter' on 'Health Systems for Health and Wealth' at a ministerial conference in Estonia organised by the World Health Organisation European Office. One of the commitments of the signing member states was to 'promote transparency and be accountable for health system performance to achieve measurable results'. This commitment has fuelled an ongoing policy debate in Belgium regarding the best ways to improve the transparency of health care provision. This debate focuses mainly on using transparency to improve informed patient choice and quality of service. One example of this approach is to measure and publicise hospital performance indicators. The feasibility of this idea is currently being tested in Flanders as part of the 'Flemish Indicators Project'. Participating Flemish hospitals measure a number of performance or quality indicators on a voluntary basis and decide whether they publish the results online. Many of them also conduct patient satisfaction surveys on a regular basis ([50]).

A recent government bill has been approved aimed at improving the transparency of medical costs charged to patients. The bill aims to improve the disclosure of the details of the medical interventions and the associated full costs, both for the patients (co-payments and supplements) and for the health insurance funds (reimbursements). Hospitals will have to provide patients with detailed information on expected costs before they are admitted.

Recently legislated and/or planned policy reforms

The main change in health care policy legislated in the recent years concerns the devolution of responsibilities (and shifts in associated budgets) for a number of health care tasks from the federal to the regional level (Flanders, Wallony and Brussels) as a consequence of the 6th Reform of the State. The reform was signed into law on January 31 2014 and became effective on July 1 2014. While the transferred responsibilities mainly concern care for the elderly (see country document on long-term care), some may be classified as acute care expenditures. A few notable examples are geriatric hospital services, revalidation, mobility aides, prevention and the maximum billing (MAB) payments. The total budget shift from the federal to the regional level is estimated to be approximately 3.4 billion euros in 2015, almost 12% (400 million euros) of which will be (acute) health care expenditures ([51]). At the time of writing there is no information available as to how the regional authorities will manage their new responsibilities, including if and how they may change the rules that govern the use of services and the associated public expenditures. Consequently, the current Belgian projections at the national level assume that the regionalised health care expenditures will evolve according to the same mechanisms that pertained at the federal level.

Ongoing efforts to improve the performance of the Belgian health care system are detailed in the annual Policy Notes of the Minister responsible for public health and health care. The most recent Policy Note, issued in November 2014 ([52]), discusses a government bill aimed at improving the accessibility of health care, the continuing integration of chronic care, the execution of the eHealth platform and the strengthening of primary care. Planned structural reforms envisage the reform of hospital financing, the expansion of mental health care services and a stronger focus on evidence-based medicine.

An important recent policy reform concerns the pharmaceutical industry. The Minister of Health and Social Affairs has signed a 'Pact for the Future' with the Belgian pharmaceutical sector, aimed at improving the accessibility to innovative therapies while containing pharmaceutical spending. The agreement provides a framework that combines cost containment with measures to stimulate innovation, especially in the area of orphan drugs. In order to achieve this, a multi-year budget aimed at providing perspective and

([50]) See https://www.zorg-en-gezondheid.be/Beleid/Kwaliteit/Welke-ziekenhuizen-meten-hun-kwaliteit-met-VIP%C2%B2/ (only available in Dutch).

([51]) RIZIV, Budget 2016. Technical estimates for 2015-2016 (internal document).

([52]) See http://www.deblock.belgium.be/sites/default/files/articles/2014_11_25_Beleidsnota%20Gezondheidszorg_54K0588007.pdf.

predictability of the revenues of the sector has been agreed.

Challenges

The analysis above shows that a number of reforms have been implemented over the years, aiming to improve the quality and efficiency of care delivery, and which Belgium should continue to pursue. The main challenges for the Belgian health system are as follows:

- To continue increasing the efficiency of health care spending, promoting quality and integrated care as well as a focusing on costs in view of the relatively high spending on health care as a share of GDP and increasing health care expenditure over the coming decades, which will accompany the high projected demographic growth;

- To ensure that the recent responsibilities of the regional governments and the management of the budgets they have acquired with the recent reform of the state are well coordinated horizontally, with other regions, and with decisions at the federal level to avoid duplications and inefficiencies;

- To further the efforts in the area of pharmaceuticals considering additional measures to improve the rational and cost-effective prescribing and usage of medicines, such as information and education campaigns, the monitoring of prescription of medicines and incentivising the uptake of generics, as already successfully implemented in the past years. The policies could help improving population health and improving access to cost-effective new medicines while generating savings to the public payer;

- To strengthen the role of primary care as a gatekeeper by expanding the current incentives in place, both for doctors and patients, to contain direct access to specialist care, for instance, by making referrals compulsory. To make use of high capacity of GPs to support patients in their management of chronic conditions as envisaged;

- To monitor the issue of financial access, in light of the high level of co-payment, while ensuring that enough incentives to discourage over-consumption of health care services are preserved;

- To continue to improve data collection and monitoring of inputs, processes, outputs and outcomes, focussing in the areas of voluntary private health insurance and on care and nursing homes, so that regular performance assessment can be conducted and used to continuously improve access, quality and sustainability of care;

- To further enhance health promotion and disease prevention activities, i.e. promoting healthy life styles and disease screening.

Table 1.2.1: **Statistical Annex – Belgium**

General context												**EU- latest national data**		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	283	299	311	327	345	354	349	365	379	387	393	9289	9800	9934
GDP per capita PPS (thousands)	29.8	30.1	30.3	30.5	31.1	30.4	28.9	30.2	30.5	30.7	30.3	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	0.4	2.8	1.2	2.0	2.1	0.2	-3.5	1.5	0.9	-0.8	-0.3	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	4.2	3.1	0.9	1.3	2.5	3.5	3.4	0.6	1.4	1.8	2.4	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	9.7	9.7	9.7	9.6	9.6	9.9	10.7	10.6	10.6	10.9	11.2	10.4	10.1	10.1
Total current as % of GDP	9.7	9.1	9.0	8.9	9.0	9.4	10.1	9.9	10.1	10.2	10.2	9.8	9.6	9.7
Total capital investment as % of GDP	0.0	0.6	0.6	0.7	0.6	0.6	0.5	0.7	0.5	0.7	0.9	0.6	0.5	0.5
Total per capita PPS	2365	2507	2594	2684	2825	2975	3114	3207	3296	3428	3549	2828	2911	2995
Public as % of GDP	7.1	7.2	7.1	7.0	7.0	7.4	8.1	7.9	8.0	8.2	8.5	8.1	7.8	7.8
Public current as % of GDP	7.1	7.0	6.9	6.8	6.8	7.2	7.8	7.7	7.8	7.9	8.0	7.9	7.7	7.7
Public per capita PPS	1688	1807	1869	1911	1995	2172	2304	2343	2495	2578	2690	2079	2218	2208
Public capital investment as % of GDP	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.5	0.2	0.2	0.1
Public as % total expenditure on health	73.1	73.9	74.0	73.0	72.5	74.6	75.8	75.0	75.7	75.2	75.8	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	13.7	14.0	13.3	13.8	14.1	14.5	14.5	14.6	14.8	14.7	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	99.0	99.0	99.0	99.0	99.0	99.5	100.5	101.5	98.8	99.0	99.0	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	21.8	20.9	20.8	21.9	22.3	21.1	20.0	20.8	20.0	20.4	19.9	14.1	14.4	14.1

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status												**2009**	**2011**	**2013**
Population, current (millions)	10.4	10.4	10.4	10.5	10.6	10.7	10.8	10.8	11.0	11.1	11.2	502.1	504.5	506.6
Life expectancy at birth for females	81.1	81.9	81.9	82.3	82.6	82.6	82.8	83.0	83.3	83.1	83.2	82.6	83.1	83.3
Life expectancy at birth for males	75.3	76.0	76.2	76.6	77.1	76.9	77.3	77.5	78.0	77.8	78.1	76.6	77.3	77.8
Healthy life years at birth females	69.2	58.4	62.3	63.2	63.9	64.1	63.7	62.6	63.6	65.0	63.7	:	62.1	61.5
Healthy life years at birth males	67.4	58.9	62.4	63.0	63.5	63.4	63.9	64.0	63.4	64.2	64.0	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	63	60	58	54	53	52	50	:	100	99	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	4.1	3.9	3.7	4.0	3.9	3.8	3.5	3.6	3.4	3.8	3.5	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												**EU- latest national data**		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	2.68	2.60	2.47	2.49	2.53	2.66	2.87	2.81	2.86	2.94	2.93	3.13	2.99	3.01
Day cases curative and rehabilitative care	0.05	0.05	0.05	0.02	0.02	0.04	0.05	0.07	0.07	0.07	0.07	0.18	0.18	0.19
Out-patient curative and rehabilitative care	1.64	1.66	1.69	1.29	1.31	1.24	1.40	1.38	1.41	1.44	1.49	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.80	1.56	1.55	1.48	1.51	1.53	1.61	1.55	1.56	1.49	1.46	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.15	0.16	0.15	0.15	0.15	0.17	0.21	0.21	0.21	0.21	0.23	0.31	0.31	0.32
Prevention and public health services	0.19	0.08	0.14	0.09	0.10	0.16	0.16	0.11	0.11	0.12	0.32	0.25	0.25	0.24
Health administration and health insurance	0.56	0.54	0.56	0.56	0.51	0.52	0.55	0.54	0.55	0.54	0.37	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	2.24	2.18	2.09	2.02	1.99	2.10	2.24	2.18	2.23	2.27	2.28	2.73	2.61	2.62
Day cases curative and rehabilitative care	0.05	0.05	0.05	0.02	0.02	0.04	0.05	0.07	0.07	0.07	0.07	0.16	0.16	0.18
Out-patient curative and rehabilitative care	1.44	1.47	1.51	1.14	1.16	1.12	1.27	1.23	1.25	1.28	1.32	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	0.90	0.93	0.92	0.86	0.88	0.97	1.04	1.03	1.03	1.01	0.97	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.09	0.09	0.09	0.09	0.09	0.10	0.10	0.10	0.10	0.11	0.11	0.13	0.12	0.13
Prevention and public health services	0.19	0.08	0.14	0.09	0.10	0.16	0.16	0.11	0.11	0.12	0.32	0.25	0.20	0.19
Health administration and health insurance	0.45	0.44	0.46	0.46	0.41	0.42	0.45	0.44	0.44	0.42	0.30	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.2.2: **Statistical Annex - continued – Belgium**

Composition of total as % of total current health expenditure	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
Inpatient curative and rehabilitative care	27.8%	28.6%	27.4%	27.9%	28.1%	28.4%	28.3%	28.4%	28.2%	28.8%	28.6%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	0.5%	0.6%	0.5%	0.2%	0.2%	0.5%	0.5%	0.7%	0.7%	0.7%	0.7%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	17.0%	18.2%	18.7%	14.4%	14.6%	13.2%	13.8%	14.0%	13.9%	14.1%	14.6%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	18.7%	17.1%	17.2%	16.6%	16.8%	16.3%	15.9%	15.7%	15.4%	14.6%	14.3%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	1.5%	1.7%	1.7%	1.7%	1.7%	1.8%	2.1%	2.1%	2.1%	2.1%	2.2%	3.2%	3.3%	3.3%
Prevention and public health services	2.0%	0.9%	1.6%	1.0%	1.1%	1.7%	1.6%	1.1%	1.1%	1.2%	3.2%	2.6%	2.6%	2.5%
Health administration and health insurance	5.8%	5.9%	6.2%	6.3%	5.7%	5.6%	5.4%	5.5%	5.4%	5.3%	3.6%	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	31.8%	31.3%	30.1%	29.8%	29.4%	29.1%	28.6%	28.4%	28.7%	28.6%	28.6%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	0.7%	0.7%	0.7%	0.3%	0.3%	0.6%	0.6%	0.9%	1.0%	0.9%	0.9%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	20.4%	21.1%	21.8%	16.8%	17.1%	15.5%	16.2%	16.0%	16.1%	16.1%	16.6%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	12.8%	13.4%	13.3%	12.7%	13.0%	13.4%	13.3%	13.4%	13.2%	12.7%	12.2%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	1.2%	1.3%	1.3%	1.3%	1.4%	1.3%	1.3%	1.3%	1.3%	1.3%	1.4%	1.6%	1.6%	1.6%
Prevention and public health services	2.7%	1.1%	2.0%	1.3%	1.5%	2.2%	2.0%	1.4%	1.4%	1.5%	4.1%	3.2%	2.7%	2.5%
Health administration and health insurance	6.4%	6.3%	6.6%	6.8%	6.0%	5.8%	5.7%	5.7%	5.6%	5.3%	3.8%	1.4%	3.5%	3.5%

Expenditure drivers (technology, life style)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
MRI units per 100 000 inhabitants	0.68	0.70	0.70	0.71	0.75	:	:	:	:	:	:	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	1.5	1.4	1.4	1.4	1.3	:	:	:	:	:	:	0.9	0.9	0.8
CTS per 100 000 inhabitants	3.1	3.2	3.9	4.0	4.2	:	:	:	:	:	:	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	0.1	:	:	:	:	:	:	:	:	:	:	0.1	0.1	0.1
Proportion of the population that is obese	:	12.7	:	:	:	13.8	:	:	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	27.0	23.7	20.3	22.0	22.0	18.9	:	:	:	:	18.9	23.2	22.4	22.0
Alcohol consumption litres per capita	11.0	11.0	10.9	10.7	10.2	10.6	10.4	10.6	9.8	9.8	:	10.3	10.0	9.8

Providers	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Practising physicians per 100 000 inhabitants	286	287	287	289	291	292	292	291	291	293	295	329	335	344
Practising nurses per 100 000 inhabitants	:	854	865	878	885	895	905	910	932	951	:	840	812	837
General practitioners per 100 000 inhabitants	119	119	118	118	116	115	114	112	111	111	112	:	78	78.3
Acute hospital beds per 100 000 inhabitants	451	447	440	434	428	424	418	411	405	399	395	373	360	356

Outputs	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Doctors consultations per capita	7.8	7.2	7.2	7.1	7.2	7.5	7.6	7.4	7.4	:	:	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	16.0	15.9	16.1	15.8	15.7	15.9	15.9	:	15.8	15.9	:	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	9,335	9,979	10,497	10,773	11,359	12,554	12,832	:	15,149	15,546	:	6368	6530	7031
Acute care bed occupancy rates	76.0	75.0	75.0	74.0	74.0	74.0	78.1	78.2	78.0	78.4	:	72.0	73.1	70.2
Hospital curative average length of stay	7.5	7.4	7.7	7.2	7.1	7.1	7.2	7.2	7.1	7.0	:	6.5	6.3	6.3
Day cases as % of all hospital discharges	36.9	38.5	39.5	40.5	41.9	:	44.7	:	48.9	49.5	:	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	2013	2020	2030	2040	2050	2060	Change 2013 - 2060	EU Change 2013 - 2060
AWG reference scenario	6.0	5.9	5.9	6.1	6.1	6.1	0.1	0.9
AWG risk scenario	6.0	6.0	6.1	6.3	6.5	6.5	0.5	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	2013	2020	2030	2040	2050	2060	Change 2013 - 2060, in %	EU - Change 2013 - 2060, in %
Population projections until 2060 (millions)	11.2	11.9	12.9	14.0	14.8	15.4	37.7	3.1

Sources: EUROSTAT, OECD and WHO

Belgium

Long-term care systems

2.2. BELGIUM

General context: Expenditure, fiscal sustainability and demographic trends

Belgium has a population of just over 11 million inhabitants. According to the basic Eurostat scenario this number will grow to 15.4 million in 2060 ([348]), an increase of 38%, well above EU average (3%).

With a GDP of EUR 393 bn, or 30,300 PPS per capita in 2013, it scores well above the EU average of 27,900 PPS (2013). With public expenditure on long-term care of 2.1% of GDP (2013) ([349]), Belgium spends twice as big a share of GDP compared with EU average (1% in 2012).

Health status

Life expectancy at birth for both men and women is respectively 78.1 years and 83.2 years and is in line with the EU average (77.8 and 83.3 years respectively in 2013). On the other hand, the healthy life years at birth for both sexes are 63.7 years (women) and 64.0 years (men) higher than the EU-average (61.5 and 61.4 respectively). The percentage of the Belgian population having a long-standing illness or health problem is also significantly lower than in the Union as a whole (25.9% and 32.5% respectively in 2013). The percentage of the population indicating a self-perceived severe limitation in its daily activities has been fluctuating over the last few years, and is currently slightly lower than the EU-average (8.1% against 8.7%).

Dependency trends

The number of people depending on others to carry out activities of daily living is expected to increase significantly over the coming 50 years. From 860 thousand residents living with strong limitations due to health problems in 2013, an increase of 65% is projected until 2060 to around 1.42 million. That is a steeper increase than in the EU as a whole (40%). Also as a share of the population, the dependents are projected to become a bigger group, from 7.7% in 2013 to 9.2% in 2060. However, the increase is markedly less steep than EU average, at a projected 19% (EU: 36%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the AWG reference scenario, public long-term care expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 1.6 pps of GDP (75%) by 2060 (from 2.1% to 3.7% of GDP), above the EU average of 40%. ([350]) The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 2.6 pps (121%) of GDP by 2060, higher, but below the EU average of 149%. Overall, projected long-term care expenditure increase is expected to add to budgetary pressure. Sustainability risks appear over the long run due to the projected increase in age-related public spending, notably deriving from long-term care and pensions). ([351])

System Characteristics

Long-term care is part of an integrated system of health care, complemented by social service provision. 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 (responsible for non-medical care). One level further down in the organisational landscape, cities and municipalities

([348]) Eurostat 2013 Population Projections – Main Scenario. The increase in the number of dependents appears driven by the general population increase, rather than a change in the proportion of dependents, as supported by a moderate change when measured as a share of the population. Note that the Eurostat population projection is considerably higher than the current (March 2016) Belgian national projection of 13.0 million in 2060.

([349]) Eurostat SHA 2011, last update April 2016.

([350]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

([351]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.

have a responsibility as far as the financing of the construction of residential facilities are concerned (with financial support from the Communities in the form of investment subsidies).

At the same time it must be mentioned that there is no specific federal legislation relating to long-term care. The rules to be applied are the same as the ones that are dealing with the health care system. Regulations on community level deal with a wide range of aspects of provision of long-term care services, such as the recognition of providers, the integration of services and monitoring of quality.

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.

Types of care

There are many different long-term care benefits in kind. Although formally not part of long-term care, it can be mentioned that medical services are organised and paid for by the federal health insurance system, while more personal care is organised and paid for 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). 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.

Since 2002 service provision entities have been set up both in Flanders and in the French community to make sure that all disciplines involved in the care for patients for a specific geographical area are provided in a coordinated manner. Care support and coordination is geared towards keeping patients at home for as long as possible.

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 (depending on the severity of the limitations) is paid by the compulsory health insurance.

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 hospital treatment, are admitted in nursing homes. Legislation requires each nursing home to have a coordinating and advisory physician who is responsible for the coordination of pharmaceutical care, wound care and physiotherapy.

Each 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.

Role of the private sector

Many who make use of home care services pay for this by using "service coupons". "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 coordinate 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. 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.

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.

Eligibility criteria and user choices: dependency, care needs, income

Since nursing care is covered by the compulsory health insurance system, every elderly person with functional impairments is eligible to receive care. The level of care is determined by the severity of disability, determined by an assessment tool based on the Katz scale. This principle holds both in home and in residential care.

Eligibility criteria for personal care and family care differ slightly between regions. In principal, everyone in need of care is eligible to receive it. The type and amount of care as well as the co-payment to be paid depend on the severity of the problem and the social situation of the applicant (family composition, income, type of residence etc.).

Co-payments, out of the pocket expenses and private insurance

The costs for medical care are reimbursed to the individual by the health insurance organisation, out-of-pocket payments are never higher than what is allowed 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 are at least partially offset by several cash benefits. On the federal level, a monthly allowance for disabled older persons (*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 some of 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*. Patients in residential care who do not have the means to pay for board and lodging may receive help through social assistance services which are provided for by the municipalities. However, spouses, children and grandchildren have a legal maintenance obligation toward the person in residential care and as such they may be requested to bear (part of) the costs.

Prevention and rehabilitation measures

Prevention is a regional responsibility in Belgium. In Flanders, its goals have been defined in a 'Policy Plan for the Flemish Elderly 2010-2014'. They include initiatives to promote healthy dietary habits and physical activity/sports, fall prevention, increased vaccination (especially influenza), to reduce hospital-borne infectious diseases, to reduce medical overconsumption (especially in nursing homes) and to improve monitoring of mental well-being. In the French-speaking Community, fall prevention was explicitly stated as a target in the Communal Plan for Health Promotion 2008-2013. Particular attention has also been paid to malnutrition in residential care in the 'Plan Wallon nutrition Santé et bien-être des aînés'

('Walloon Nutrition and Well-Being Plan') which is part of a wider national nutrition plan launched in 2004.

Formal/informal caregiving

Belgium's elderly citizens use both formal and informal care rather frequently compared with most other European countries. Data from the 2004 Survey of Health Ageing and Retirement (SHARE) indicate that the share of users of professional nursing care and professional home care is among the highest in Europe (13.4 and 16.6 percent respectively) (see Geerts, 2009). Despite the high reliance on formal care there is also substantial use of informal care. For example, 45 percent of moderately or severely dependent elderly persons living at home receive informal care from someone outside the household (SHARE 2004 data, see Willemé et al. 2012). The caregivers are predominantly partners and adult children. The frequent combination of formal and informal care is rather exceptional, since in most other countries the two forms of care appear to be substitutes rather than complements.

Recently legislated and/or planned policy reforms

In recent years, the Belgian long-term care system did not undergo major reforms. Some developments in the health care system nevertheless have had an impact on the provision of long-term care.

The co-payments that an individual using care would need to pay, were limited through the so called "Maximum Billing System" (*Maximumfactuur*, introduced in 2001). In addition various allowances help people (in particular with lower incomes) cope with the financial burden of non-medical expenses. Also some yearly allowances were introduced, especially for long-term care patients, for example for the use of incontinence material.

The extension of compulsory coverage for self-employed persons from January 2008, can be recognised as an important development. Before 2008, the compulsory health insurance for self-employed persons consisted only of a minimal basic package, covering only "major risks". Since 2008, the self-employed have a compulsory health insurance with the same coverage as civil servants or employees, which means for example that former self-employed in need for nursing care in homes for the elderly are now covered for such services. However, the extension of insurance coverage for the self-employed mainly affects acute health care expenditures.

In order to cope with a future increase in demand for long-term care, which is certain but the exact magnitude of which is difficult to predict, more diverse and integrated long-term care services are being developed in Belgium. 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.

The main change in health care policy legislated in the recent years concerns the devolution of responsibilities (and shifts in associated budgets) for a number of health care tasks from the federal to the regional level (Flanders, Wallonia and Brussels) as a consequence of the 6th Reform of the State. The reform was signed into law on January 31 2014 and became effective on July 1 2014. While the transferred responsibilities mainly concern care for the elderly, some may be classified as acute care expenditures (see country fiche on health care). A few notable examples are geriatric hospital services, revalidation, mobility aides, prevention and the maximum billing (MAB) payments. The total budget shift from the federal to the regional level is estimated to be approximately 3.4 billion euros in 2015, almost 88% (3 billion euros) of which will be long-term care expenditures. At the time of writing there is no information available as to how the regional authorities will manage their new responsibilities, including if and how they may change the rules that govern the use of services and the associated public expenditures. Consequently, the current Belgian projections at the national level assume that the regionalised health care expenditures will evolve according to the same mechanisms that pertained at the federal level.

Challenges

Belgium has a relatively fragmented system of LTC. The main challenges towards the goal of a sustainable long-term care system appear to be:

- **Improving the governance framework**: to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state and regional authorities with respect to the provision of long-term care services; to use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing.

- **Encouraging independent living:** to provide effective home care, tele-care and information to recipients, as well as improving home and general living environment design.

- **Ensuring availability of formal carers: t**o determine current and future needs for qualified human resources and facilities for long-term care; to increase the retention of successfully recruited LTC workers, by improving the pay and working conditions of the LTC workforce, training opportunities, more responsibilities on-the-job, feedback support and supervision; to seek options to increase the productivity of LTC workers.

- **Supporting family carers:** to establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **Ensuring coordination and continuity of care:** to continue to promote coordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care coordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care coordination.

- **To facilitate appropriate utilisation across health and long-term care:** to create better rules, improving (and securing) safe care pathways and information delivered to chronically-ill people or circulated through the system; to steer LTC users towards appropriate settings.

- **Improving value for money:** to invest in assistive devices, which for example, facilitate self-care, patient centeredness, and coordination between health and care services.

- **To further the efforts in the area of prevention** and to improve administrative efficiency.

Table 2.2.1: **Statistical Annex – Belgium**

GENERAL CONTEXT

GDP and Population	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
GDP, in billion euro, current prices	283	299	311	327	345	354	349	365	379	387	393	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	29.8	30.1	30.3	30.5	31.1	30.4	28.9	30.2	30.5	30.7	30.3	26.8	27.6	28.0	28.1	27.9
Population, in millions	10.4	10.4	10.4	10.5	10.6	10.7	10.8	10.8	11.0	11.1	11.2	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	1.5	1.5	1.4	1.7	1.7	1.8	1.9	2.0	2.0	2.1	2.1	1.0	1.0	1.0	1.0	:
Per capita PPS	362.8	376.4	380.6	469.2	491.3	506.6	523.6	563.2	585.5	618.2	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	2.9	2.8	3.5	3.6	3.6	3.6	3.7	3.7	3.7	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	81.1	81.9	81.9	82.3	82.6	82.6	82.8	83.0	83.3	83.1	83.2	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	75.3	76.0	76.2	76.6	77.1	76.9	77.3	77.5	78.0	77.8	78.1	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	69.2	58.4	62.3	63.2	63.9	64.1	63.7	62.6	63.6	65.0	63.7	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	67.4	58.9	62.4	63.0	63.5	63.4	63.9	64.0	63.4	64.2	64.0	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	26.3	24.9	24.7	24.8	24.7	25.1	25.6	26.2	24.7	25.9	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	12.2	8.7	7.8	7.4	6.9	7.6	7.9	8.4	7.6	8.1	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
Number of people receiving care in an institution, in thousands	:	:	:	:	118	125	132	139	144	149	143	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	130	248	365	483	491	500	728	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	2.3	3.5	4.6	5.7	5.8	5.8	7.8	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	430	:	420	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.2.2: **Statistical Annex - continued – Belgium**

PROJECTIONS

Population	2013	2020	2030	2040	2050	2060	MS Change 2013-2060	EU Change 2013-2060
Population projection in millions	11.2	11.9	12.9	14.0	14.8	15.4	38%	3%
Dependency								
Number of dependents in millions	0.86	0.93	1.05	1.21	1.33	1.42	65%	40%
Share of dependents, in %	7.7	7.9	8.1	8.6	9.0	9.2	19%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	2.1	2.3	2.6	3.0	3.5	3.7	75%	40%
AWG risk scenario	2.1	2.4	2.8	3.5	4.2	4.7	121%	149%
Coverage								
Number of people receiving care in an institution	142,618	158,626	181,486	236,093	285,148	307,575	116%	79%
Number of people receiving care at home	727,933	784,738	889,888	1,042,053	1,159,292	1,225,738	68%	78%
Number of people receiving cash benefits	0	0	0	0	0	0	:	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	7.8	7.9	8.3	9.2	9.8	9.9	28%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	100.0	100.0	100.0	100.0	100.0	100.0	:	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	100.0	100.0	100.0	100.0	100.0	100.0	:	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	0.0	0.0	0.0	0.0	0.0	0.0	:	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	60.9	61.7	61.6	63.2	64.8	65.5	7%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	39.1	38.3	38.4	36.8	35.2	34.5	-12%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	101.3	107.5	112.5	113.8	116.7	121.6	20%	-2%
Unit costs of home care per recipient, as % of GDP per capita	12.7	13.5	14.3	15.0	15.6	16.1	26%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	:	:	:	:	:	:	:	-2%

(1) Cash benefits numbers not available as these benefits are recorded as benefits in-kind in the Belgian SHA.

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060).