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The Hospital System in Belgium:The Direction of Reforms

Authors:

Professor **Marie-Christine Closon**

Centre of the Socioeconomics of Health, School of Public Health,

Université Catholique de Louvain, Belgium

Email: marie-christine.closon@uclouvain.be

The Belgian healthcare system is a mix of mandatory national insurance and private medicine, a system of collective agreements between healthcare providers and insurance companies(national healthcare funds), and regulations issued by the public authorities. The Ministry of Public Health is responsible for defining laws on hospital programmes, number of beds and major equipment.

The healthcare system is extremely fragmented and the various levels of healthcare are not well coordinated. Patients have access to hospitals and specialists without having to obtain a referral from a general practitioner. Providers are generally self-employed, both in hospitals and for outpatient treatment, and paid on a fee-per-service basis.

Description of Hospital Service Provision

Belgium has a population of about 10 million and there are 146 general hospitals and approximately 60 psychiatric hospitals, 70% of which are private, non-profit organisations. Public and private hospitals are subject to the same financing rules. The number of hospital beds has decreased significantly since the beginning of the 1980s, from 92,436 to 70,795. This decrease is attributable to the conversion of hospital beds into retirement and nursing home beds for the elderly, as well as incentives for hospitals to merge, a reduction in the length of stay, an increase in hospital outpatient treatment and the development of alternatives to psychiatric hospitalisation. Since the 1980s, the length of stay has decreased (11.9 to 8.3 days) and the number of admissions has increased (13.6/100 to 17.4/100). The length of stay is higher and the number of admissions is lower than European averages.

Hospital Financing System Before Reforms

Financing of hospital care in Belgium can be broken down into two parts. The first, medical services and medication, are included under the heading of healthcare, paid mostly on a fee-per-service basis and retrospectively (according to the rates negotiated between the national health insurance companies and professional bodies). The second segment includes days of care, covering nursing services and accommodations. Until 1995, every day was reimbursed up to a certain quota based on the number of beds and a standard occupancy rate.

This type of financing system did not take into account the usefulness of the days or that of the services provided, nor did it encourage service providers or hospitals to find the most effective way to treat their patients.

In order to ensure that resources were used more efficiently, the development of need and performance indicators concerning both the use of resources and the quality of care had become critical. Financing-related incentives based on these indicators then had to be introduced. In other words, the general tendency was to introduce prospective elements into a reimbursement system, which until then was operating almost completely on a fee-for-service and retrospective basis. Advantages associated with a prospective financing system include better management of expenses and motivation to be efficient, but risks include decreasing quality of care and the selection of higher-yielding patients based on the expected financial structure.

Principal Reforms in the Hospital Sector

a) Prospective financing for in-patient hospital care

Belgian hospitals are financed for the number of justified days according to the activity measured and type of illnesses treated (taken into account by APRDRGs), age and the geriatric characteristic of the stay. Since 2007, the impact of social factors is also being taken into account. The number of justified days is determined by national averages in terms of the relevant characteristics.

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In addition, the number of days covered is reduced if the hospital has a lower percentage of hospital outpatient treatment than the national average, taking into account the treatment performed.

Medica 2007, Duesseldorf 14 – 17 November 2007 Hall 15 Booth C47
ADVANTECH Europe GmbH
Bijster 20A
NL 4817 HX Breda
The Netherlands
Phone: +31(0) 76 5231270
Contactperson: Brigitte Sebregts
eMail: brigitte.sebregts@advantech.nl
Trusted ePlatform Services
ADVANTECH

Initial studies conducted after this reform indicate that it has been somewhat effective in reducing lengths of stay and increasing the percentage of outpatient treatment.

b) Prospective funding for medication expenses

Prospective funding for medication in terms of APRDRGs and four severity levels has been established since 2006. This affects approximately 50% of medications used in hospitals. Exclusions apply to vital medications from a therapeutic and social point of view, which continue to be paid per medication. For medications included in the budget, each hospital receives a sum that theoretically covers 75% of its medication expenses based on the structure of the illnesses it treats. The remaining 25% continues to be financed on a fee-per-service basis.

c) Flat-sum billing of certain categories of fees based on “reference amounts”

Since physicians have always been paid on a fee-per-service basis in Belgium, the flat-sum billing of medical fees encounters significant resistance in medical circles. However, an initial attempt has been made. More flat-sum financing was decided upon for 28 frequently occurring illnesses which are uniform in terms of expenses, simple in terms of procedures (cataract, tonsillectomy, appendicitis, etc.), and for which patterns of consumption that deviate significantly from the national average can be easily identified.

For each group of illnesses, a reference amount has been determined by severity class (1 and 2) and by expense item (clinical biology, medical imaging and internal medicine). This amount corresponds to the national consumption average per patient increased by 20%. The hospital must reimburse expenses exceeding this amount. These 28 groups account for 22.7% of stays.

However, this reform excludes many stays, sanctioned by type of expense and by APRDRG, without allowing compensation between APRDRGs and expenses. In addition, it does not include positive incentives for hospitals.

Conclusion

In order to limit expenses and encourage efficiency, spending limits must be established for hospitals. However, it is unrealistic to think that it will be possible to take all clinical situations into account. Clinical situations are rarely specific and standardised enough to make it possible to precisely determine which services need to be provided for each patient based on guidelines. In order to take this inherent variability of medical practice into account, it must be possible to distribute risk. Efficient practices greatly reduce the probability of having expenses that exceed the expected budget, taking into account all patients, their illnesses and their severity.

Compensating for risks can then come completely into play. In conclusion, while it is useful to put a limit on expenses based on measurable needs (severity APRDRG, etc.), it is extremely important that physicians and managers realise that this limit only has meaning for an overall budget, and not per patient or group of illnesses, where the level of accuracy is too low.

Budget is a financial framework and not an indication of quality. The imposition of a budgetary framework must be accompanied by the development of quality care promotional programmes (development and evaluation of quality indicators, development of guidelines making more efficient practices possible).

To increase efficiency in the field of patient care in Belgium, it will also be crucial to increase coordination between the various levels of care (outpatient, specialised medicine, institutional, hospital), all the more so since an ageing population and increase in chronic illnesses will require more and more integrated medical services.

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