European Health Management Questionnaire

The purpose of the questionnaire is to identify the specificities of the various European countries in the following areas:

- ***Typology of the Health System***
- ***Level of resources and investment in Health System***
- ***Hospital management model(s)***
- ***Healthcare managers professionalization***

I. Typology of the Health System

Country identification:

Belgium

Number of inhabitants:

11.492.641 (legally registered residents as per 1 January 2020)

Health System Model characterization: Bismarck, Beveridge, Other?

Bismarck Model

Health System Funding:

The Belgian healthcare system is mainly organised on two levels: The federal and regional levels. Responsibility for healthcare policy is shared between the federal government, the Federal Public Service Social Security, the National Institute for Sickness and Disability Insurance (NIHDI), and the Dutch-, French-, and German-speaking community Ministries of Health. The federal government is responsible for regulating and financing the compulsory health insurance, determining accreditation criteria, financing hospitals and so-called 'heavy' medical care units, as well as legislation covering different professional qualifications, and registration of pharmaceuticals and their price control. The regional governments are responsible for health promotion, maternity and child health services, some aspects of elderly care, implementation of hospital accreditation standards, and financing of hospital investment.

Public healthcare in Belgium is funded by a combination of health insurance and social security contributions. All individuals entitled to health insurance must join or register with a sickness fund. Belgian sickness funds receive a prospective budget from the National Institute for Health and Disability Insurance (NIHDI) to finance the healthcare costs of their members. They are held financially accountable for a proportion of any discrepancy between their actual spending and their so-called normative, that is, risk-adjusted, healthcare expenditures. The reimbursement of services provided depends on the employment situation of the patient, the type of service provided, the statute of the person who is socially insured, as well as the accumulated amount of user charges already paid.

Patients in Belgium participate in healthcare financing via co-payments, for which the patient pays a certain fixed amount of the cost of a service, with the third-party-payer covering the balance of the amount, (i.e. the practice of an insurer (third party) paying providers (second party) directly for services rendered instead of the patient); and via co-insurance for which the patient pays a certain fixed proportion of the cost of a service and the third-party-payer covers the remaining proportion.

There are, respectively, two systems of payment:

1. A reimbursement system for which the patient pays the full costs of services and then obtains a refund for part of the expense from the sickness fund, which covers ambulatory care; and
2. A third-party-payer system for which the sickness fund directly pays the provider while the patient only pays the co-insurance or co-payment, which covers inpatient care and pharmaceuticals.

The basic feature of Belgian hospital financing is its dual remuneration structure according to the type of services provided: Accommodation, emergency admission, and nursing activities in the surgical department are financed via a fixed prospective budget system based on diagnosis- related groups; while medical and medico technical services such as consultations, laboratories, medical imaging, technical procedures, and paramedical services are remunerated via a fee for- service system to the service provider. Together, these two remuneration systems account for almost 80% of a hospital's revenue. Hospitals receive additional funding from:

- Outpatient and inpatient sale of pharmaceutical products (financed per unit or pack);
- A prospective budget for pharmaceuticals for inpatient care;
- Specific ambulatory activities, such as day care, dialysis and rehabilitation, which are mainly reimbursed per patient via lump sums;
- Subsidies for investments from the federated authorities (communities);
- Supplements charged to patients;
- Non-hospital activities, such as commercial operations and homes for the elderly, nursing homes, cafeteria, newspaper shop, etc.;
- Private legacy or corporate grants.

II. Level of resources and investment in Health System

GDP per capita:

36.615 € / per capita in 2019

Average Life Expectancy:

In 2019, the life expectancy at birth in Belgium was 81,8 years.
Men: 79,6 years / Women: 84,0 years

Doctors per 1.000 inhabitants:

Per 31 December 2019:
Total number of physicians in Belgium: 54.533
Physicians / 1.000 inhabitants: 4,74

Nurses per 1.000 inhabitants:

Per 31 December 2019:
Total number of nurses in Belgium: 199.178
Nurses / 1.000 inhabitants: 17,33

Level of allocation of family doctor:

Per 31 December 2019:
Total number of general practitioners in Belgium: 16.097
Physicians / 1.000 inhabitants: 1,4

III. Hospital Management Model(s)

Describe the hospital management model in your country:
Describe the model of hiring / appointment of Healthcare managers / Hospital directors / CEOs:
Composition and model of appointment of the Board of Directors:

Of the 103 hospitals in Belgium, 28% are public as of 01.01.2020, i.e. managed by a public authority (municipality, inter-municipal, province, region, etc.), and 72% are private and run as non-profit organizations. Historically, the latter were the result of religious congregations, mutual societies (sickness funds), free universities or former company hospitals. Given the large number of hospital mergers in recent decades, many institutions are now a legacy of both the public and private sectors. However, the Hospital Act Law, that defines the hospital governance structure, applies in equal measure to both the public and private sectors.

The Hospital Act provides for the following governance structures (see figure below):

The General Assembly:
Each hospital that is organised as a not-for-profit association has a general assembly that is composed of the members of the not-for-profit association. The general assembly has some reserved powers such as the amendment of the statutes of the hospital, the appointment and discharge of the board members and the approval of the budget and financial statements.
Other similar structures exist, for instance in hospitals that are linked to Public Centres for Social Welfare ('OCMW'/'CPAS'), inter-communal collaborations or universities.

The Board:
At the highest hierarchical level, the hospital board governs a hospital. It fulfils the role of the 'administrator' as defined in the Hospital Act. The board is responsible for the organisation, functioning and financial flows of

hospital activity. In the hospital board experts in healthcare or in other fields, such as financial, legal or ethical, usually have a seat. In public hospitals, (local) politicians are also represented. An overall commitment and expertise of board members is important. Also the independence of the board is crucial. It is for example generally recommended that the board consist of a majority of non-executives. A common practice in Belgian hospitals consists of executives seating in each other's board. The underlying idea is that it leads to a win–win situation, as it yields reference material for both institutions. Until now, executives of neighbouring hospitals do not easily participate in each other's board. After all, this practice is not always free from any exercise of power and influence. Therefore, charters of good governance are now demanded by the government and are implemented by each hospital board.

The executive management:
Each hospital has a chief executive officer (CEO), who is appointed by the hospital board and is directly and exclusively accountable to it. His/her tasks include the management of the hospital. The CEO co-operates closely with those responsible for the medical, nursing, paramedical, administrative and technical departments. Together they constitute the executive management.

The role of the medical specialist in hospital governance:

Chief medical officer
The involvement of physicians in the decision-making structures is crucial. This is regulated via the function of chief medical officer (CMO), the medical council and other advisory bodies such as the 'permanent consultation committee'.

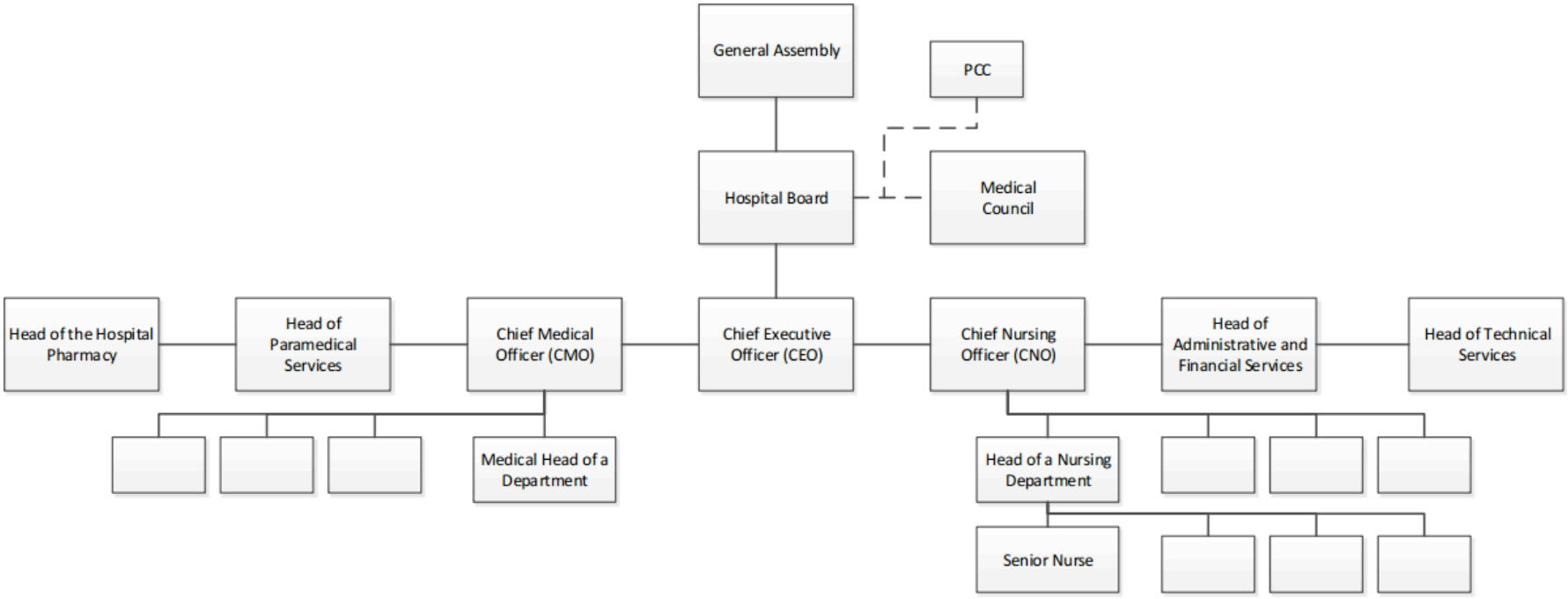
The CMO is appointed by the board (after a so-called reinforced advice of the medical council) and has the responsibility to involve physicians in the hospital activities in an integrated way. Physicians have professional medical autonomy. Consequently, regulations imposed on physicians by means of the Hospital Act concern the working conditions (e.g. organisation of working hours and on-call availability) and not the therapeutic and intellectual activities. In addition, the degree of the say of the hospital management in the working conditions of the hospital physicians varies according to their employment status. In the vast majority of hospitals physicians are self-employed while only in university and some public hospitals physicians are employees or civil servants.

Medical council and permanent consultation committee

The hospital board is obliged to ask for advice from the medical council (an elected body) on 18 matters (e.g. yearly budget estimates; changes in medical departments; modification of the destination of service that has an influence on the medical activity). The hospital board is not obliged to follow this advice except for six matters with so-called 'reinforced advice', for example concerning the general regulation; determination of staff that is financed via deductions on physician fees; decisions about medical equipment financed by physician fees. In case the hospital board disagrees with the reinforced advice and fails to achieve consensus, a quite cumbersome arbitration process, including the appointment of a mediator, is started.26

Via the permanent consultation committee (PCC) of physicians and board members a legal possibility was created to replace the procedure of advices from the medical council by a procedure with direct deliberation between both parties (that subsequently needs to be ratified by the respective committees of the participating organisations). However, if the medical council or the hospital board disagrees or the permanent consultation committee fails to find a consensus, there is a fall back on the normal procedure.

Figure: Institutional hospital governance in Belgium



Source: Organisational chart in a Belgian context, p138, Eeckloo (2008) Eeckloo K. Hospital Governance in Vlaanderen: Exploratieve studie in internationaal perspectief. Leuven: 2008. Doctoral Dissertation.

IV. Healthcare managers professionalization

Do you have a formal recognition of the hospital/healthcare manager profession in your country?

General practitioners, specialist physicians, dentists, hospital pharmacists, nurses, nursing auxiliaries, physiotherapists, allied health professionals, (paramedical staff) must obtain a specific professional diploma, which must be stamped and recognized by the authorities before they are authorised to practice.

Some Belgian educational institutes, as far example Vlerick Business School offers courses on ' Management for Hospital Professionals'. Specialist doctors in training are required to follow a hospital management-training module before they can obtain their specialist recognition. Also most universities offer a Master of Science degree in Health Care Management and Policy. Nowadays, universities even joined forces and are offering an interuniversity hospital management & leadership courses.

But unfortunately, we do not have a formal recognition of the hospital nor healthcare *manager* profession in Belgium.

Do you have a certification competency model in your country?

We do not have a certification competency model in Belgium.

Do you have a mandatory training model in your country?

No, we do not have a mandatory training model in Belgium.