Joint 5th Joint AEMH-FEMS General Assembly
10-11 May 2024, Berlin, Germany

Members reports

Please name 3 main current concerns of the healthcare system in your country :
1. As the legislature draws to a close, the main reforms initiated by the Minister for Health are still in progress. 2. The decree implementing the law passed by Parliament in December 2022 to ban supplements for consultations with BIM patients was published in the Monitor at the beginning of 2024. In addition to its perverse effects, this law short-circuits the medical-mutualist agreements, rendering them meaningless. 3. In the run-up to the elections, the proposals put forward by the political parties give rise to fears that the healthcare system will be completely dismantled, leading to a decline in the quality of care and a further loss of quality of life for doctors, particularly those working outside hospital.

ABSYM-BVAS report (Belgium)
AEMH-FEMS Congress (Berlin 10-11 May 2024)

1. The major projects initiated by the Minister for Health, which we have already mentioned in the 2022 and 2023 reports, have still not been completed:

A) the revision of the nomenclature of medical acts is still in progress (phase II and, for certain specialities, phase I) and will not result in concrete proposals for many months. At this stage, it is difficult to form a clear idea of the major trends and, even more so, of the practical consequences that this overhaul of the nomenclature will have both in everyday practice and in financial terms.

B) Hospital refinancing is also still a work in progress. The various lobbies and pressure groups are still at work, which does not simplify decision-making. The current impression is that the objective of transparency and above all simplification is unlikely to be achieved. More than ever, the system resembles a gigantic black box, with only a handful of civil

servants and insiders able to understand the inner workings and consequences. Furthermore, the role of medical fees in hospital financing has still not been clearly defined. Admittedly, guarantees have been given to limit deductions and ensure transparency, but they are still insufficient to provide the protection that is so vital in the face of the risk of uncontrolled or forced deductions, particularly when hospitals are in financial difficulty.

C) In an attempt to resolve the shortage of nursing staff in our country and throughout Europe, Belgium has invested more than €1 billion since 2020 to refinance the nursing sector:
- 500 million has been devoted to raising salaries;
- 400 million to the « white coats fund » ;
- 100 million to liquidate leave entitlements.
A "White Coats Fund" was created in December 2019 to tackle the nursing shortage. This fund, financed by the federal government, has two main objectives:

1. it is intended primarily to finance full-time equivalent nursing staff and secondarily to hire care and support staff enabling nurses to free up time to increase bedside and ward care.

2. The second objective is to improve working conditions and the quality of care. This fund has enabled the creation of 4,862 full-time equivalents, 75% of whom are nurses and care assistants. The remainder is made up of staff intended to help and relieve the nursing staff (stretcher-bearers, logistical assistance, direct administrative support, etc.). Despite these substantial financial resources, it is clear that the jobs created are not enough to satisfy hospital demand. At present, virtually all university and non-university hospitals in Belgium have one or two care units that are closed for lack of staff. In surgery, the shortage of nursing staff is forcing the closure of certain operating rooms and limiting accessibility, including for the management of certain emergencies. The fundamental problem remains the lack of qualified staff. It is worrying to note that enrolments in nursing schools in the French-speaking part of the country have been falling since 2014 (2014: 3,325 enrolments, 2023: 2,491). This clearly shows that the solution is not only financial. The main problems and pitfalls include :
- the extension of the lenght of studies from three to four years to comply with European standards. As well as resulting in a year without a graduate, the lengthening of the course, with no real benefit for students, has discouraged many candidates.
- the public's general lack of appreciation of the profession and the healthcare professions;
- the lack of recognition of know-how;
- the administrative burden and the weight of responsibilities in the face of increasingly demanding and intolerant patients, also explain the persistent lack of interest in this profession.
We should also add that a reform of the profession is under way, in particular to allow certain under-qualified people to carry out tasks currently reserved for qualified nurses.

D) From a budgetary point of view, it can be seen that the 2% growth norm intended to finance the care of a population whose longevity continues to increase (+4 years according to the latest study) has been scaled back. Initially set at 2.5% in 2021, it has been reduced to 2% and part of this money has been confiscated by the government. We can also see

that the share of medical care in the total healthcare budget is constantly falling: 33.8% in 2013 and 28.5% in 2024. What's more, government funding in recent years has tended to go to areas other than direct healthcare, especially medical care:
- Cybersecurity: 67 million the last 2 years and 39,5 million in 2024 ;
- Energy: 100 million;
- White Coats Fund: 400 million;
- Salary increases for non-medical staff: 600 million;
- EMS nurses: €100 million.
- Reductions in social security contributions on salaries, which combined with support for energy, amount to some 262 million euros.
Lastly, although there has been a 9% increase in financial resources between 2019 and 2024 (excluding indexation and after deducting the increase in GNP), these resources have been allocated exclusively to financing hospitals.

2. In Belgium, doctors and mutual insurance companies (regional or federal insurance organisations) have been meeting for many years to discuss and sign a national agreement. This agreement "... is concluded for a period of 1 or 2 years and sets, among other things, the rates that doctors covered by the agreement may charge. It therefore provides security for patients and stability for the healthcare system. The agreement also sets out concrete commitments to improve the quality and organisation of care.
The number of memberships determines whether an agreement comes into force in the country or by district". (Institut National d'Assurance Maladie Invalidité-INAMI)
Under the terms of this agreement, doctors covered by the convention must comply with the tariff agreement. Only doctors who have refused the agreement may charge extra for consultations. The agreement rate of around 85% (90% of GPs and 80% of specialists), which has been constant for many years, guarantees patients access to affordable, high-quality medicine. What's more, most hospitals, particularly those in the public network and university hospitals, require doctors working in their practices to be fully or partially contracted. The agreement is accompanied by a social status that gives doctors financial compensation for agreeing to comply with INAMI tariffs.
To fully understand the situation, I would add that in Belgium most doctors are self-employed (or bogus self-employed) and that salaried doctors are in the minority, including in hospitals.
As the last agreement expires on 31 December 2023, new negotiations have opened at the end of 2023.
Let's take a step back in time to understand what happens next: "On 29 November 2022, Parliament enacted a law containing various provisions relating to health which [inter alia] prohibits healthcare providers from charging extra fees for outpatient care provided to patients who benefit from the INAMI's increased contribution. (These patients are commonly referred to as "BIM" for Beneficiaries of the Increased Intervention). The aim of this provision is to guarantee access to healthcare for the most financially vulnerable patients". [Cambier Avocats -18 April 2024] This restriction concern around 2.2 million patients, or 20% of the population, who currently have this status. With this ban, Parliament is short-circuiting the medical-mutualist agreement, since it prohibits doctors not covered by the agreement from charging extra fees. Howwever this right to opt out is one of the pillars of these agreements and, more fundamentally, of medical freedom in the broadest sense.

As a result, ABSYM-BVAS and the Chamber of Dentistry lodged a number of appeals with the Constitutional Court to overturn the decision. However, in its ruling of 11 April 2024, the Constitutional Court rejected these appeals. The reasons given are similar to those used to dismiss the appeal lodged a few years ago against the ban on hospital surcharges in shared rooms. It is absolutely astounding that, on the pretext of accessibility to healthcare, which in fact already exists in view of the rate of contracting in, consultation and the signing of agreements that have been renewed for decades are being circumvented. At the end of the day, these "agreements" are now completely devoid of meaning, since unilateral political decisions can bypass them and the commitments signed are not respected.

At the end of 2023, when the last medical-mutualist agreements were being discussed, ABSYM-BVAS managed to postpone the entry into force of this law until 1 January 2025 and to limit it to BIM patients with a financial income that could justify it. This provision temporarily reduces the number of patients affected by the ban to around 1 million. A €10 million fund has also been set up to 'compensate' for the loss of revenue resulting from this law, but given that the estimated loss is €200 million, it is hard to see how this 'handout' will restore the balance. Doctors are not asking for charity, but that their rights are respected just as much as those of their patients.

A more detailed analysis of the situation shows that :
a) Up until now, 85% of doctors practising in Belgium were under agreement. As a result, there was genuine accessibility for patients. This law is therefore purely demagogic. It is designed to give the public the impression that we have taken a huge step forward, when in fact it does nothing to improve accessibility and may, on the contrary, be accompanied by perverse effects. « Despite its laudable aim of ensuring access to care, this measure could have perverse effects for patients. In fact, it is possible that certain healthcare providers will refuse to provide care to BIM patients because of the impossibility of charging the surcharges they usually do. » [Cambier Avocats - April 18, 2024]. Will the political world finally understand that if we want to improve the quality of care and patient accessibility, we need to invest in the healthcare system and not impose restrictive rules on a sector that has heard nothing but talk of economics for many years and is constantly being discredited while the vast majority of them try to serve the public while trying to make a decent living. The shortage of nurses and the thousands of people leaving the medical profession throughout Europe should be a wake-up call to the general public and to politicians in particular about the failure of the strategies developed in recent years and their negative short, medium and long-term consequences for public health.
b) This law and ban are a direct attack on out-of-hospital medicine, which is largely not under agreement in Belgium and operates on a self-employed basis. Yet this type of medicine accounts for a large proportion of overall consultation activity. These restrictions will particularly affect specialist medicine, which has already borne the brunt of the Covid-19 pandemic. With consultation fees for some specialities reimbursed at between €25 and €30, it's clear that without a supplement we're below the break-even point. Under these conditions, we're heading either for the disappearance of this sector, or for a two-tier medical system.The shortage of nurses and the thousands of people leaving the medical profession throughout Europe should be a wake-up call to the general public and to

politicians in particular about the failure of the strategies developed in recent years and their negative short, medium and long-term consequences for public health.
c) The medical unions defended this agreement in particular for two reasons:
- the maintenance of social status. It only concerns doctors under agreement and therefore has no impact on doctors not under agreement, who are adversely affected by the new law.
- the indexation of fees (6.05%). On this subject, it is particularly surprising to note that doctors have to sign an agreement for their fees to be indexed when all Belgian employees have seen theirs automatically indexed by 18% in two years (and for many months) by virtue of the automatic indexation of salaries that exists in Belgium. Isn't this real discrimination and injustice?
Furthermore, if the medical-mutualist agreements now boil down to validating social status and indexing fees, do they still make sense? Shouldn't the money and energy spent in this agreement be invested elsewhere?
d) Lastly, although our Minister of Health boasts of an 85% rate of adhesion, we note that there is a high rate of contracting out in sectors where medical freedom and out-of-hospital practice are in the majority (dermatology, plastic surgery, ophthalmology, orthopaedics, etc.). Does this mean that the pressure in hospital disciplines and in general practice is such that most of these colleagues have no choice but to sign up to an agreement if they want to continue practising their profession, while the majority of those who have room for manoeuvre have opted out? Can we speak of an agreement if it is obtained under direct or indirect duress?

3. 2024 will be an important electoral year in Belgium, as federal and regional elections will be held on 09 June at the same time as the European elections. Health is a key concern for many Belgians, and all the political parties have put forward proposals in this area:
- Most agree on strengthening prevention, support for mental health and the well-being of care staff (nurses). The shortage and cost of medication is also on the agenda of most political parties. These sympathetic declarations of intent are obviously accompanied by very few practical proposals, and even more rarely by the means to fund them.
- As far as hospitals are concerned, virtually all the parties agree that they want to turn hospitals into high-performance technical platforms. Some of these hospitals would become national or regional centres of reference, the only ones approved to deal with certain pathologies such as paediatric oncology, breast cancer, traumatology, transplants, etc. What's more, everyone agrees that hospitals need to be refinanced, and half the parties agree that medical fees should be separated from this funding. Once again, no amount has been put forward and obviously no means of ensuring this funding.
- Much more worrying is the fact that all but one of the French-speaking parties also agree on the idea of limiting, and more often than not abolishing, hospital surcharges (currently authorised for private -1 bed rooms in Belgium). However, these supplements are financed by private insurance companies or by the patients themselves and are therefore not borne by the State. What's more, they represent modest sums (700 million euros) compared with the health budget of around 32 billion. This is a far cry from the exorbitant amount that is borne by the state and indigent patients, and from the two-tier medicine that is constantly being invoked. This begs the question as to the real motivation behind the political world's obsession with these hospital surcharges. Is it simply demagoguery,

particularly flourishing during election periods? Is it a desire to restrict the freedom of the medical profession so as to be able to impose certain constraints on doctors more easily? Or is it a form of jealousy at the financial independence and therefore autonomy of certain doctors who still have a choice in terms of health and quality of life? Whatever the case, this common desire is very worrying both in terms of individual freedom and in terms of income in a Belgian hospital landscape where the self-employed are in the majority compared with salaried employees.

- What is even more worrying is the unanimous desire to directly or indirectly reduce the funding and opportunities for out-of-hospital specialist practice. In our country, a large proportion of the population deliberately chooses to have recourse to private specialist medicine with full knowledge of the facts, particularly in financial terms, and with an excellent satisfaction rate. This desire to prohibit this practice, to reduce its funding or to encourage people to stop using it will undermine a whole area of local Belgian medicine, when it is clearly the opposite of what a large part of the population wants. This attitude is all the more incomprehensible given that the current trend towards hyper-specialisation in hospitals and the development of centres of reference, accompanied by a further reduction in the number of beds, can only be envisaged if part of the specialist activity is taken over by doctors outside hospitals, whether in private practice or in centres sponsored by hospitals.

In conclusion, the situation of medicine in Belgium today, whether hospital-based or not, general or specialist, remains difficult. No reform has substantially improved the financial situation of doctors or their quality of life, and trends in the quality of care are very worrying.

More and more often, politicians are imposing demagogic laws, thereby short-circuiting and undermining the consultations that have for years helped to ensure a balance within the medical profession and improve the quality of care.

The recent proposals put forward by the parties with a view to the forthcoming elections raise fears of the promulgation of decrees and laws limiting or prohibiting certain practices, both in and out of hospital, and further restricting financial resources and medical freedom. If this were to happen, it's a safe bet that a whole area of Belgian medicine would disappear and a real two-tier system of medicine would take hold, with all the consequences that this would entail in terms of discrimination and lower quality of care for patients.

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