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**BELGIUM: ENHANCING THE COST EFFICIENCY AND FLEXIBILITY OF THE HEALTH
SECTOR TO ADJUST TO POPULATION AGEING**

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By Stéphane Sorbe

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ABSTRACT/RÉSUMÉ

Belgium: enhancing the cost efficiency and flexibility of the health sector to adjust to population ageing

Belgium has a good record in delivering accessible care, but adaptation to population ageing will be complicated by the fragmentation of responsibilities in the healthcare system and a strong reliance on government regulations. The organisation of the system could be rationalised by giving sickness funds a more active role as promoters of cost-efficiency, better aligning the incentives of the different levels of government and focussing on medium-term budgeting. At the level of care providers, better information flows and incentive structures could facilitate addressing practice and efficiency variations and supplier-induced demand. This notably involves completing the shift to pathology-based budgets in hospitals, more capitation in the remuneration of doctors and measures to tackle the high spending on drugs. Once incentives for cost-efficiency are in place, a shift towards a more demand-driven system could be encouraged by phasing out over-prescriptive hospital regulations. In addition, relative remunerations of doctors should be revised regularly to ensure an adequate supply per specialty. In long-term care, home care, which is generally cost-efficient, could be further encouraged by giving more autonomy to patients to organise their care. This Working Paper relates to the 2013 *OECD Economic Survey of Belgium* (www.oecd.org/eco/surveys/belgium).

JEL classification: H51, I11, I13, I18

Keywords: Belgium, health, long-term care, population ageing, hospitals, sickness funds, pharmaceuticals

Belgique : améliorer l'efficacité et la flexibilité du secteur de la santé pour s'adapter au vieillissement de la population

La Belgique a su se doter de services de santé accessibles, mais le morcellement des responsabilités au sein du système et le poids de la réglementation risquent de rendre l'adaptation au vieillissement de la population difficile. Le système pourrait être organisé plus simplement en donnant aux caisses d'assurance maladie (mutualités) un rôle plus actif dans l'amélioration de l'efficacité, en alignant mieux les incitations des différents niveaux d'administration et en mettant l'accent sur la budgétisation à moyen terme. Au niveau des prestataires de santé, une meilleure circulation de l'information et de meilleures structures incitatives pourraient contribuer à atténuer les variations en termes de pratiques et d'efficacité, ainsi qu'à lutter contre la demande induite par les prestataires eux-mêmes. Pour ce faire, il s'agit notamment d'achever la transition vers des budgets hospitaliers fondés sur les pathologies, d'augmenter la part de la rémunération forfaitaire des médecins et de mettre en place des mesures visant à diminuer le niveau élevé des dépenses en médicaments. Une fois que des mesures destinées à améliorer l'efficacité seront en place, l'adoption d'un système davantage axé sur la demande pourrait être encouragée en supprimant progressivement les règles hospitalières excessivement normatives. En outre, les rémunérations relatives des médecins devraient être révisées régulièrement afin d'obtenir une offre adaptée dans chaque domaine de spécialité. S'agissant des soins de longue durée, la prise en charge à domicile, qui est globalement efficace au regard de son coût, pourrait être encore plus encouragée en laissant les patients organiser plus librement les soins dont ils bénéficient. Ce Document de travail se rapporte à l'*Étude économique de l'OCDE de la Belgique, 2013* (www.oecd.org/eco/etudes/belgique).

Classification JEL : H51, I11, I13, I18

Mots clés : Belgique, santé, soins de longue durée, vieillissement de la population, hôpitaux, caisses d'assurance maladie (mutualités), médicaments

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TABLE OF CONTENTS

BELGIUM: ENHANCING THE COST EFFICIENCY AND FLEXIBILITY OF THE HEALTH SECTOR TO ADJUST TO POPULATION AGEING.....	5
Population ageing poses considerable challenges	5
Performance of the health system	7
Improving the organisation of the health system to enhance cost-efficiency.....	12
Improving information flows and incentives at the level of care providers and patients.....	16
Enabling adaptation to changing demand patterns in an ageing society	21
BIBLIOGRAPHY.....	29

Tables

1. Projected increase in public health spending, 2010-60	7
2. Mortality rates of infants and mortality by leading causes.....	8
3. Specialist remuneration, as ratio to GP wage in each country	23
4. Majority settings for general practice per country.....	24

Figures

1. Population ageing	6
2. Current expenditure on health	7
3. Life expectancy	8
4. The Belgian diet is caloric.....	9
5. Health and activity.....	10
6. Alcohol consumption and taxation.....	10
7. Health care resources and their use	11
8. The gap below the spending ceiling has been reduced.....	12
9. Health administrative costs and preventive care spending	14
10. Pharmaceuticals.....	18
11. The GP population is ageing	22
12. Long-term care	26

Boxes

Box 1. Future health and long-term care demand is difficult to anticipate	6
Box 2. Physical activity and health	10
Box 3. The “claw-back” tax on pharmaceutical companies.....	18
Box 4. The Belgian long-term care system	25
Box 5. Main recommendations to give an ageing population an efficient health sector.....	28

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Belgium: enhancing the cost efficiency and flexibility of the health sector to adjust to population ageing

By

Stéphane Sorbe¹

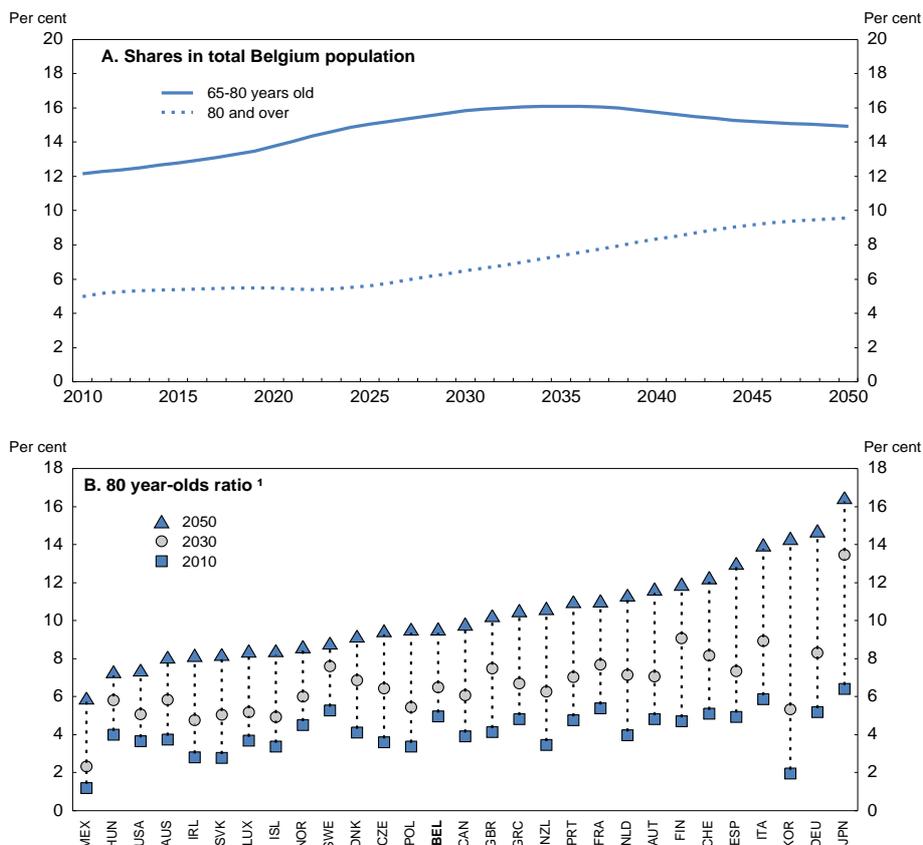
Population ageing poses considerable challenges

Population ageing has started and will accelerate in the mid-2020s. The number of people over 80 - the biggest recipients of health and long-term care - will double to 10% of the population in 2050 (Figure 1). This leaves little time to prepare the health system. The main challenge will be to contain the upward pressure on public spending while maintaining accessible and quality care. This will be complicated by future changes in demand being difficult to anticipate, requiring a sufficiently flexible health supply to adapt timely (Box 1).

The health system delivers accessible care. Health supply is ample, as illustrated by the absence of waiting lists in hospitals, but there are risks of future shortages as the workforce of general practitioners (GPs) is ageing and there are already waiting lists in nursing homes in certain areas. The rapid spending increases of the past decade have brought Belgium into the group of high health spenders (Figure 2). Cost-containment and adaptation to change are complicated by tasks being distributed across many stakeholders: the federal, regional and community governments, the sickness funds in charge of the public health insurance and non-profit hospitals with diverse historical backgrounds. These stakeholders sometimes have conflicting incentives, which complicates coordination and the establishment of good financing mechanisms and information flows to promote cost-efficient behaviours by care providers and tackle the high spending on pharmaceuticals. The fragmentation of responsibility may also slow adaptation to changes in demand, especially as health supply is largely shaped by government regulation.

1. This paper originally appeared as chapter 1 in the OECD Economic Survey of Belgium 2013, published in May 2013 under the authority of the Economic and Development Review Committee. Stéphane Sorbe is an economist in the OECD Economics Department. The author is grateful to Pierre Beynet, Andrew Dean, Marion Devaux, Robert Ford, Jens Høj and Mark Pearson for valuable comments and suggestions on earlier drafts as well as for discussions with Belgian government officials and independent experts. Special thanks go to Sylvie Foucher-Hantala for statistical assistance and Sylvie Ricordeau for editorial assistance.

Figure 1. Population ageing



1. Population 80 years and over divided by total population.

Source: OECD (2012), Historical population data and projections database (1950-2050).

Box 1. Future health and long-term care demand is difficult to anticipate

There is great uncertainty about future health and long-term care needs, as illustrated in the large differences in projected spending under different sets of assumptions (Table 1). In addition to demographic and economic trends, health spending will depend on:

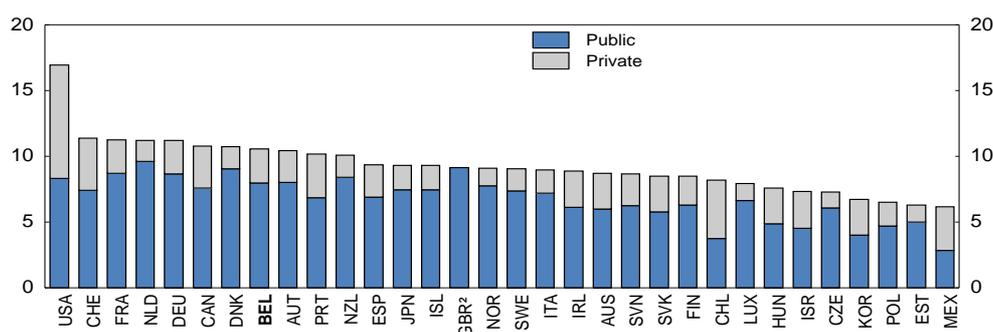
- More or less healthy ageing, *i.e.* how much of the life expectancy gains will be spent in good health, which will notably depend on the nature of medical progress. OECD projections in Table 1.1 assume fully healthy ageing, while the European Commission (in its “reference” scenario) assumes only “half healthy” ageing.
- The effect of technological progress on the cost of health care services, both in terms of lowering the price of existing services and creating new (costly) services. The latter has been predominant over the past decades, contributing to higher spending. The European Commission leaves aside this effect in its projections, explaining its relatively lower projected spending increases on health care.
- The elasticity of health demand to rising incomes, *i.e.* by how much an extra 1% of income will increase health spending. There is no consensus in the literature (Box 2 of European Commission, 2012) and OECD projections assume a lower elasticity (0.8) than the European Commission (1.05 on average over the projection period).
- The tendency of wages in the health sector, as in other service sectors, to grow as fast as in the rest of the economy despite slower productivity gains, leading to relative price increases for health care services (the so-called Baumol effect).
- Societal changes, such as evolutions in the willingness of family members to provide informal long-term care to their relatives.

Table1. Projected increase in public health spending, 2010-60¹

		% of GDP	
		Health care	Long-term care
OECD	“cost-containment” scenario	1.9	0.8
	“cost-pressure” scenario	5.8	1.3
European Commission	“reference” scenario	0.4	2.7
	“risk” scenario	0.8	3.5
Belgian High Council of Finance		3.0 (total)	

1. For OECD, increase between the average of 2006-10 and 2060; For Belgian High Council of Finance, increase between 2011 and 2060.

Source: De La Maisonneuve C. and J. Oliveira Martins (2013), "Public spending on health and long-term care, a new set of projections"; (OECD Economics Department, Working Papers forthcoming), European Commission (2012), "Ageing report"; Conseil Supérieur des Finances (2012), "Comité d'Études sur le Vieillissement, Rapport Annuel".

Figure 2. Current expenditure on healthAs a percentage of GDP, 2010¹

1. 2009 for Australia, Chile, Israel, Japan, Luxembourg and Mexico.

2. No breakdown available for United Kingdom, for which public expenditure includes private expenditure.

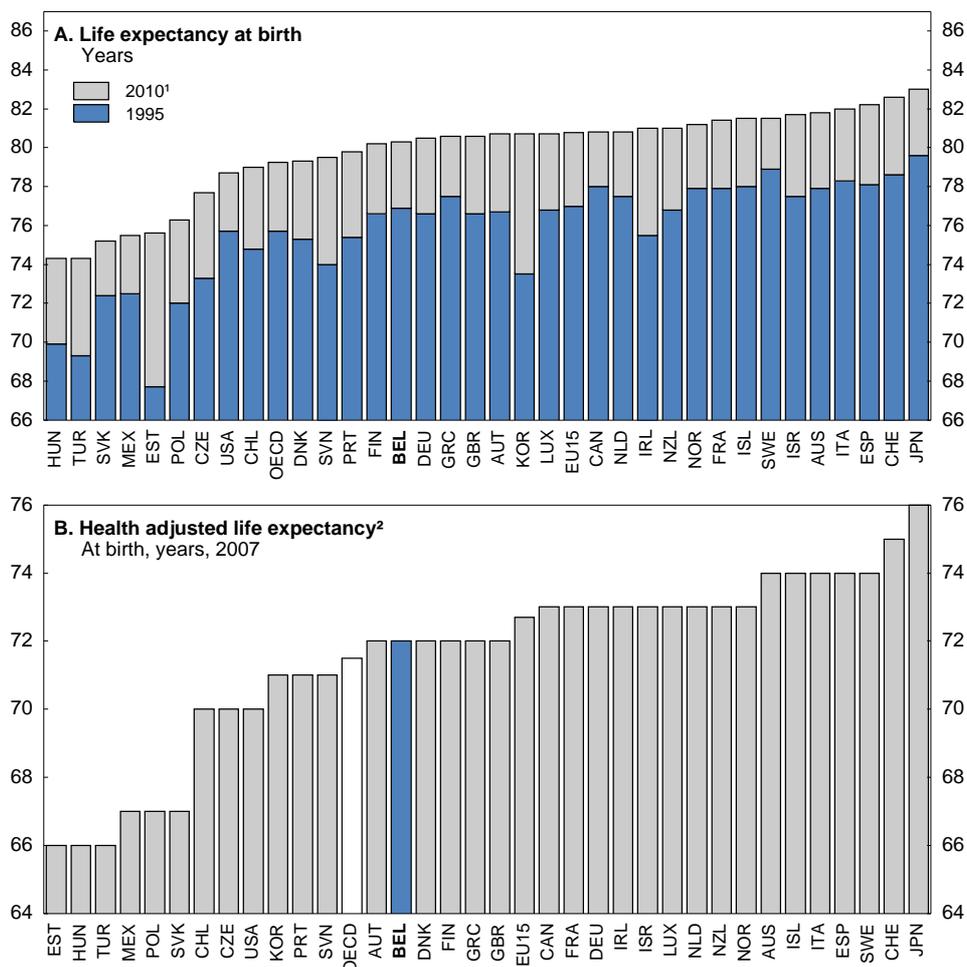
Source: OECD (2013), "OECD Health Data: Health expenditure and financing", OECD Health Statistics (database), April.

Performance of the health system

Health outcomes are broadly satisfactory

Life expectancy is above OECD average but slightly below Western Europe average (Figure 3), although more detailed indicators, such as survival rates after five years for certain cancers, are relatively good (Vrijens *et al.*, 2013). In the same manner, (self-reported) morbidity rates are relatively low, and rates of mortality by main non-communicable diseases and infant mortality are lower than OECD average (Table 2). Also positive is the indication that health inequalities are lower than in other European countries, although they may have increased, possibly reflecting increasing inequalities in lifestyle and relatively high patient payments (Mackenbach *et al.*, 2008; van Oyen *et al.*, 2010). Leaving affordability aside, public satisfaction with the health and long-term care system is internationally high, in terms of the quality and accessibility of care (Eurobarometer, 2007; Eurobarometer, 2012). According to another survey, 95% of Belgians are satisfied with their GP, which may notably reflect that patients value their large freedom to choose their care provider (Meeus and van Aubel, 2012).

Figure 3. Life expectancy



1. Or latest year of data available (2006-10); see source database for detail of country coverage.
2. Number of years expected to be lived in what might be termed the equivalent of "full health".

Source: OECD (2013), "OECD Health Data: Health Status", OECD Health Statistics (database), April and WHO (2011), Global Health Observatory Data Repository, World Health Organisation, May.

Table 2. Mortality rates of infants and mortality by leading causes

2010 or latest year available¹

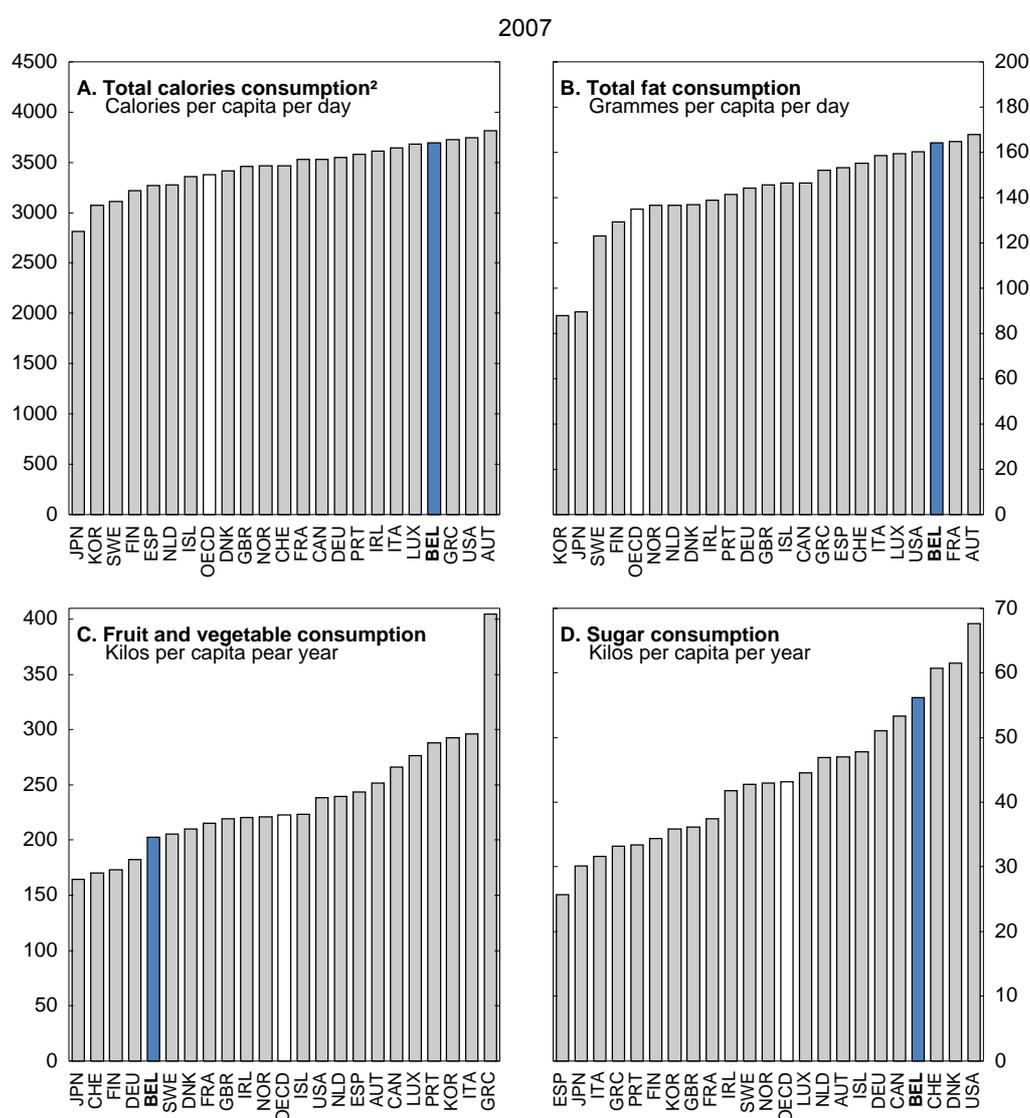
	Infant mortality (deaths per 1 000 live births)	Leading causes of mortality (deaths per 100 000 population)				
		Ischemic heart disease	Cerebrovascular disease (stroke)	Lung, trachea, bronchus cancer	Other types of cancer	Liver diseases and cirrhosis
Belgium	3.5	88	64	54	167	10
OECD average ²	4.1	128	74	44	171	14
OECD highest	14.1 (MEX)	404 (SVK)	137 (SVK)	76(HUN)	220 (HUN)	44 (HUN)
OECD lowest	2.2 (ISL)	39 (JPN)	41 (ISR)	13 (MEX)	108 (MEX)	2(ISL)

1. The latest year varies from 2007 to 2010 for infant mortality and from 2006 to 2010 for causes of mortality.
2. Unweighted average of latest year of data available. See source database for detail of country coverage.

Source: OECD (2012), "OECD Health Data: Health Status", OECD Health Statistics (database), October.

An insufficiently healthy lifestyle is likely to reduce life expectancy, suggesting room for better health promotion. The Belgian diet is rather caloric, with a relatively high consumption of sugar and fat and a still relatively low consumption of fruits and vegetables (Figure 4). As in other countries, self-reported levels of obesity have increased. Given the diet, a significant share of the population would benefit from more frequent physical activity (Box 2). Taxing sugar (or fat) could be a complementary way to tackle obesity, although recent international experience suggests that implementing such taxes can be complex and have side effects on equity (OECD, 2012a). Another negative lifestyle factor is the still substantial consumption of alcohol, notably beer, on which excise taxes are low in international comparison (Figure 6). Tobacco consumption is only slightly below OECD average and the significant air pollution may also contribute to the relatively high incidence of lung cancer (Kozłuk, 2011, Chapter 2). Finally, suicide rates are 50% higher than the OECD average and mortality by transport accidents is also high (OECD, 2012b).

Figure 4. The Belgian diet is caloric¹



1. The OECD aggregate is an un-weighted average.
2. Data from Belgian national sources (2004 Belgian Food Consumption Survey), based on another methodology, indicate a much lower calories intake.

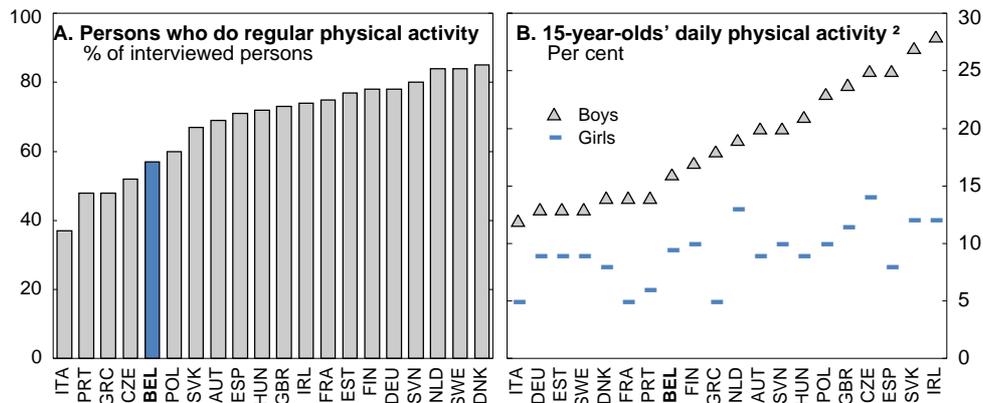
Source: OECD (2013), "OECD Health Data: Non-Medical Determinants of Health", April.

Box 2. Physical activity and health

Physical activity tends to improve people’s physical and mental health by reducing the risks of many non-communicable diseases and increasing social interaction (Cavill *et al.*, 2006). In addition, the fact that poorer people generally practice less physical activity than richer ones contributes to health inequalities. Relatively few Belgians regularly engage in any physical activities in a large sense, such as walking or gardening (Figure 5). According to another study, only 25% of the population practices sufficient activity, a rate 6 percentage points lower than the average of European countries considered (Sjöström *et al.*, 2006). Activity levels among teenagers are also lower than in many other European countries (Figure 5).

Figure 5. Health and activity

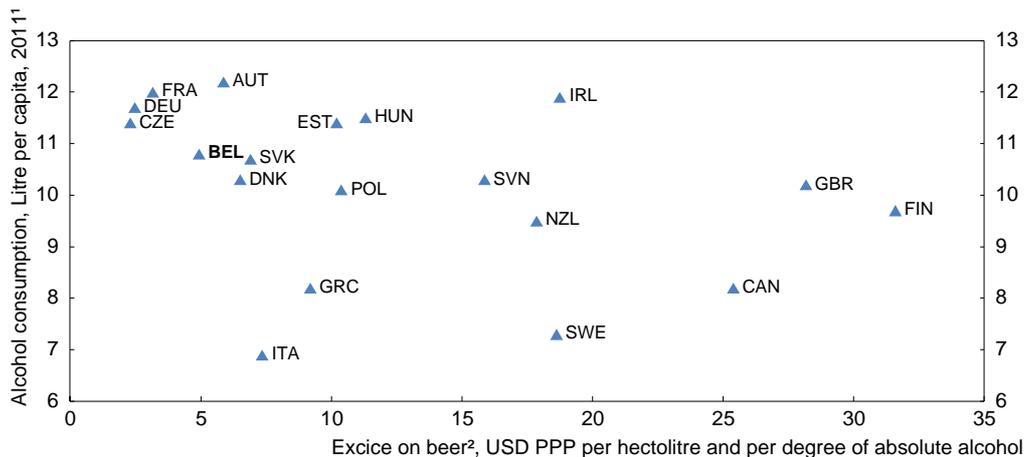
2010 or latest year available¹



1. The latest year varies from 2006 to 2010; see source database for detail of country coverage.
2. Daily moderate-to-vigorous activity, reported for 2009-2010 years. Moderate-to-vigorous physical activity refers to exercise undertaken for at least an hour each day, which increases the heart rate and leaves the child out of breath sometimes.

Source: OECD (2013), "OECD Health Data: Non-Medical Determinants of Health", April and Health at a glance: Europe 2012.

Figure 6. Alcohol consumption and taxation



1. 2011 or latest year available. Per capita refers to over 15 year-olds.
2. Position as at 1st January 2012.

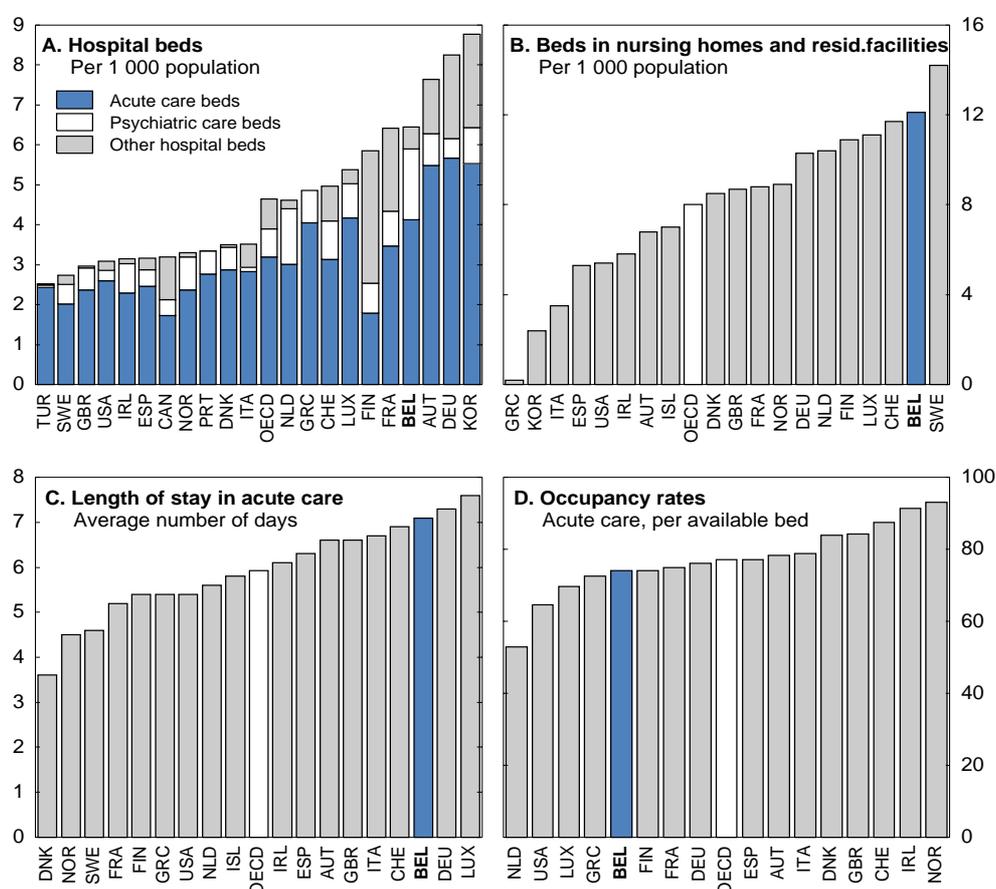
Source: OECD (2012), Consumption Tax Trends 2012: VAT/GST and Excise Rates, Trends and Administration Issues and OECD (2013), "OECD Health Data: Non-Medical Determinants of Health", February.

There is a large potential for cost-efficiency gains

There is an abundance of health resources. The number of hospital beds is high, especially in psychiatric care, and the combination of slightly below average occupancy rates and long stays (Figure 7) suggests potential for cost-efficiency gains (HOPE, 2011; Joumard *et al.*, 2010). There are also many long-term care beds in institutions (nursing homes and homes for the elderly), suggesting room to further develop nursing care at home. The number of practising doctors per inhabitant is in line with OECD average, but Belgian doctors are more active than their peers, a tendency encouraged by their essentially fee-for-service remuneration. Indeed, the Belgians consult a doctor on average 8 times per year, among the highest in the OECD. In addition, the density of practising pharmacists is 50% higher than OECD average and the density of nurses is relatively high (OECD, 2011).

Figure 7. Health care resources and their use

2010 or latest year available¹



1. The latest year varies from 2005 to 2010. The OECD aggregate is an un-weighted average of data available.

Source: OECD (2013), "OECD Health Data: Health Care Resources and use databases, April" and OECD (2013), "OECD Health Data: Long-Term Care Resources and Utilisation database, April".

Empirical analysis suggests that bringing the efficiency of the Belgian system to the level of the OECD top performers could generate life expectancy gains of 3 years with no budget costs (Joumard *et al.*, 2010). This number should be treated with caution, however, as life expectancy, on which the analysis is based, is only one aspect of health outcomes and can be influenced by factors external to the health system. Nevertheless, the figure possibly underestimates potential gains as the analysis leaves aside within-country

efficiency variations, which in many cases are greater than cross-country variations. Important variations in medical practice exist within Belgium, notably in terms of drug prescriptions, preventive care and non-urgent surgical operations. Practice and efficiency variations across hospitals are also important (Mertens *et al.*, 2005; Jacques *et al.*, 2006; van De Sande *et al.*, 2010).

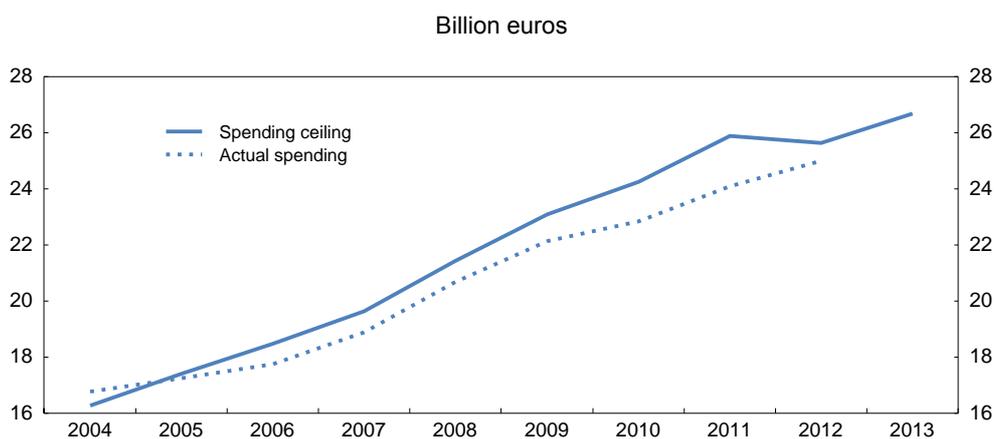
Improving the organisation of the health system to enhance cost-efficiency

International experience suggests that no specific organisation of health care provision and financing performs systematically better in delivering cost-efficient services (Joumard *et al.*, 2010). Nevertheless, there is generally scope for improvement within each kind of health system to reach the efficiency level of the best performers. This is the case for Belgium, which is identified as the worst performer in terms of cost-efficiency in the group of countries having the most comparable institutional settings: Australia, Canada and France – these countries share with Belgium a public insurance system and a heavy reliance on market mechanisms at the provider level (Joumard *et al.*, 2010).

There is room to further improve the health budgeting system

A well functioning health budgeting system is a first condition for securing a cost-efficient provision of health services. The current system is based on an annual ceiling for total federal spending on health and sub-ceilings for some subcategories of spending. The government and the sickness funds have to ensure that spending is kept within the ceiling, if necessary by jointly negotiating changes in tariffs with providers. Until recently, the main issue was too rapid increases in the ceiling, giving insufficient pressure for cost-efficiency. Over 2005-11, the ceiling was allowed to grow by 4 ½ per cent per year in real terms to a level of 7.0% of GDP, up by 1 ½ percentage point in only half a decade. Actual spending grew substantially more slowly, resulting in a widening gap below the ceiling and in overspending of the budget of subsectors no longer being restrained by the overall ceiling (Court of Auditors, 2011). To address this issue, the ceiling was lowered in 2012 to a level close to actual spending, while lower real growth rates were chosen for the following years, of 2% in 2013 and 3% in 2014 and thereafter (Figure 8).

Figure 8. The gap below the spending ceiling has been reduced



Source: Belgian authorities.

Two further steps are needed to enhance the effectiveness of the spending ceiling: putting more focus on the medium-term and closing potential escape routes. The current system is focused on annual budgets. Introducing a detailed medium-term budget framework would encourage the strategic reflexion over the desired level of spending and the balance between cost-control and accessibility concerns. A medium-term framework would also be particularly useful to reflect transparently the effect of new measures, which can

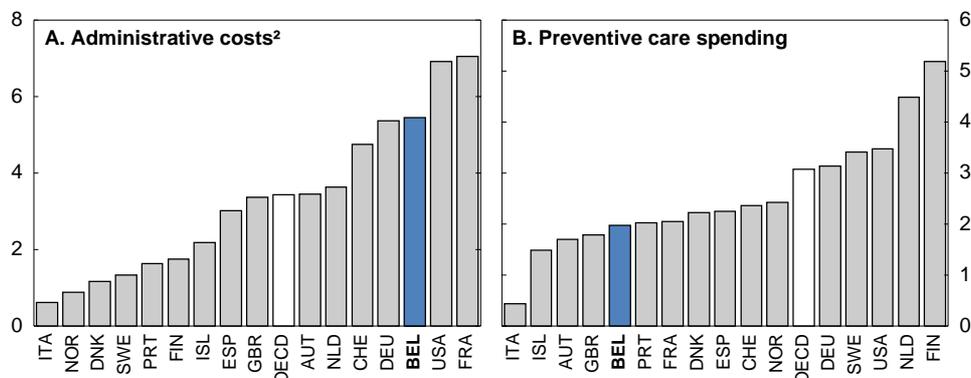
take several years to materialise. It would replace the current awkward system where all measures are assumed to take full effect on the first day of the budget year, even when the actual date of effect is planned to be different, sometimes by more than a year (Court of Auditors, 2011).

In the current context of tighter budget ceilings, political pressure risks increasing to bypass the ceilings, for example through “exceptional expenses”. These expenses were a common budget escape route in the late 1990s (Court of Auditors, 2006), a period of tight ceilings in the run up to the euro, and they have not been used in the last few years only because of the rapid growth in the ceiling. They regroup heterogeneous spending posts that are excluded from the ceiling, such as innovative drugs and services, vaccination and screening programmes and subsidies to the supplementary pensions of doctors. In addition, there are few obstacles to the creation of new exceptional expenses by the government. For example, in the 2013 budget, an additional envelope of EUR 40 million was created outside of the ceiling to finance a higher remuneration of nurses. To enhance the respect of budget ceilings, the legal base for exceptional expenses should be limited to really exceptional cases, such as large unforeseen epidemics.

Better aligning the incentives of the different government levels is possible

The complex distribution of tasks across government levels, which results from successive decentralisations since the 1980s, is a potential source of inefficiencies. Broadly speaking, acute care remains primarily a federal responsibility, while preventive care and long-term care are increasingly a responsibility of the three linguistic communities. Regional and local authorities also have smaller roles. Along these broad lines, responsibilities are complexly intertwined. For example, long-term care is partly organised by communities, but nursing long-term care services are federally financed. Similarly, communities are responsible for preventive care, but federal authorities also run or co-finance vaccination and screening campaigns. Hospital financing is another area of overlap as most day-to-day financing is federal, while regions subsidise hospital investment, although with possible federal top ups.

This distribution of tasks poses several problems. *First*, its complexity generates administrative and coordination costs that are notably reflected in the abundance of committees meant to facilitate coordination (Figure 9). Complexity is particularly high in the Brussels region, where two communities are jointly responsible for organising services. *Second*, the distribution of tasks entails responsibility overlaps but may also leave certain areas insufficiently covered (De Maeseneer, 2011). *Third*, the incentives of the different government levels may not always be aligned because decisions by communities and regions can have significant externalities on federal care costs, despite procedures to encourage coordination between government levels. For example, regions may have excessive incentives to subsidise investment in hospital beds, as they do not bear the associated running costs. Similarly, communities lack incentives to invest in preventive care as they do not enjoy the associated benefits in terms of lower acute care costs (Figure 9). Another related issue is the conflict of interest created by local public authorities owning some hospitals (around one third, the remainder being traditionally related to religious orders and universities). As they are liable for potential deficits, local authorities have incentives to maximise (federal) care costs in these hospitals.

Figure 9. Health administrative costs and preventive care spendingAs a% of total health spending, 2010 or latest year available¹

1. The latest year varies from 2006 to 2011; The OECD aggregate is an unweighted average of data available.

2. Health administration and health insurance, public and private.

Source: OECD (2013), "OECD Health Data: Health expenditure and financing", OECD Health Statistics (database), April.

The ongoing fiscal federalism reform (the so-called sixth State reform) gives communities more responsibilities in preventive and long-term care and in the "Impulseo" subsidies to attract GPs in low-density areas. The reform may contribute to some extent to a more rational distribution of tasks by concentrating more preventive and long-term care responsibilities at a single government level. However, it does not address the issue of conflicting incentives between government levels, as the federal government will continue to finance curative care costs as well as some long-term care costs, notably in the area of nursing services at home. In this area, an implication of the reform is that communities will get incentives for shifting costs by moving patients from community-funded institutions to federally-funded nursing care at home, independently of the optimal solution for the patient. Another issue is that communities will have the full responsibility over new initiatives in preventive care, leaving less scope to the federal government to offset potential underinvestment. To mitigate these risks, the reform foresees the creation of an "Institute for the Future" to facilitate strategic coordination between the different government levels.

In the short term, better aligning the incentives of the different government levels could be achieved by giving communities (and possibly regions) a stake in federal care costs to avoid cost shifting. This would help them internalise the broader impact of their decisions. For example, a community running a successful prevention campaign or promoting efficient long-term care for elderly people would reap the associated benefits in terms of lower medical care costs. Similarly, a community providing insufficient supply of nursing homes, leading elderly people to stay unnecessarily long in geriatric hospital care, would pay the price for it. In practice, communities could be made financially responsible for a share of any deviation between the federal cost of care in their community and prospective budgets reflecting the risk profile of their inhabitants, as proposed by Schokkaert and van de Voorde (2011). Although potentially complex, such a mechanism would also present the benefit of better associating communities to the fiscal risks of population ageing, leading to a more balanced distribution of ageing risks across government levels.

In the longer term, another possibility would be to concentrate tasks fully at a single government level. This level (federal, regional or community) should be chosen consistently with potential reforms of the sickness funds discussed below. In particular, the combination of active and competing sickness funds with decentralised health care responsibilities should be avoided as it would risk giving certain sickness funds a dominant position on the relatively small regional or community markets (Schokkaert and van de Voorde, 2011).

Sickness funds should be more active in promoting cost efficiency

For historical reasons, the health system is centred around sickness funds, which originate from the progressive merger of the corporatist worker funds created in the 19th century (Companje *et al.*, 2009). There are six sickness funds, but the three largest ones – respectively Christian, Socialist and Independent – control most of the market. Their main role is to deliver the broad public health and long-term care insurance package that now covers virtually all the population. They receive budgets from the federal government to reimburse the medical expenses of their members. However, their role is largely administrative, as they are all required by law to offer the same basic insurance package at the same price, paid to the government in the form of social contributions and taxes. They slightly differentiate themselves on their offer for complementary insurance, which covers services such as optic and dental care and alternative medicines, and supplementary insurance, which covers certain copayments, mainly in hospital. Patients seldom change fund (Thomson *et al.*, 2013).

Reflecting this administrative role, sickness funds have only marginal instruments to control their spending and promote cost-efficiency. This is because patients enjoy a free choice of care providers, while sickness funds negotiate tariffs of medical services only collectively and alongside the government. Sickness funds can question the reimbursement of care services only in cases of fraud, and thus can only marginally tackle issues such as excessive drug prescription. In addition to fighting fraud, sickness funds can run their own preventive campaigns (in addition to government-run campaigns) and reduce their operational expenses. However, this can only have a small influence on total spending. Consequently, sickness funds' financial incentives to contain costs – a bonus/malus system introduced in 1995 that rewards spending control – are unlikely to have a significant effect (Schut and van Doorslaer, 1999).

To promote cost-efficiency, sickness funds should be given more instruments. They should be allowed to benchmark the performance of hospitals and long-term care institutions in terms of costs and the quality of care. To enhance the performance of these institutions, sickness funds should be given power, in the most problematic cases and alongside the government, to force institutions to change organisation or practices.

In addition, sickness funds should be allowed, on a limited scale, to experiment with selective contracting of care providers. This would enable funds to select cost-efficient providers, to which they should be allowed to orient their members through reduced copayments. In the same manner, funds could experiment with vertical integration with providers, as is the case with US “health management organisations” (HMOs), which appear to have reduced costs. A possible application of selective contracting and integration is the treatment of chronically ill patients, where sickness funds could organise “care paths” integrating efficiently the different care providers involved in the treatment - pilot projects have illustrated the potential gains from such care paths. In Germany, selective contracting has recently been introduced in specific areas, such as care paths. A potential risk of selective contracting and vertical integration, though, is that the different funds could end up offering different services and coverage, undermining the system's philosophy of universal and egalitarian coverage. This would justify starting with pilot projects on a limited scale and monitoring carefully the results to secure an evidence-based successful implementation.

To enhance the effectiveness of these measures, sickness funds' own incentives for cost-control should be reinforced. The share of their budget that is determined by their historical spending, currently two thirds, should be further reduced. Their large reserves of bonuses, accumulated in the period of generalised budget underspending in the late 2000s, could also undermine funds incentives for cost-control as funds could use them to offset future overspending (Court of Auditors, 2011). A potential downside is that reinforced financial incentives could increase funds' incentives to "select" members to lower costs, which are currently low because of the low level of financial risk borne by the sickness funds (Thomson *et al.*, 2013). This should be countered by reinforcing the risk-equalisation scheme that adjusts funds' budgets for the risk profile of their members (for example, funds with older members receive larger budgets) but which only covers one third of their budget.

In the much longer term, an option to be considered could be to move further in the direction of "regulated competition" between sickness funds, as Switzerland and the Netherlands have been doing over the past decade (OECD/WHO, 2006; Hurst, 2010; Schut, 2011; Schut *et al.*, 2013). This would mean generalising the selective contracting of care providers and possibly making sickness funds compete on the price of a basic insurance package. Such a reform may increase the overall quality and flexibility of health supply, but its success requires many preconditions, notably in terms of information flows (van de Ven *et al.*, 2013) and it could also lead to higher costs. Before taking further steps, the lessons from the Swiss and Dutch reforms should be monitored in this respect. In the Belgian case, such a reform would also require encouraging new entries on the insurance market as the current situation where only three funds control most of the market would favour oligopolistic behaviours.

Improving information flows and incentives at the level of care providers and patients

To be fully effective, these institutional changes should be combined with improved information flows and stronger incentive structures at the level of care providers and patients. Measures should notably aim to tackle the information advantage of doctors which may allow them to generate additional demand or to overcharge for their services. Such "supplier-induced" demand is difficult to measure, although the internationally high volume of doctor consultations is an indication of it. One empirical study finds no clear evidence of supplier-induced demand (Léonard *et al.*, 2009). Another study finds evidence of it in all specialties, but not in general practice (Roberfroid *et al.*, 2008). A third study suggests that even GPs may be concerned (Schaumans, 2007). A related issue is practice variation, *i.e.* the fact that similar illnesses are treated differently (and at a different cost) in different geographic areas. For example, there is empirical evidence of large and persistent variations for the handling of different non-emergency surgical operations (Jacques *et al.*, 2006). Supplier-induced demand and practice variation probably contribute to the important cost-efficiency discrepancies across hospitals.

Making better use of data

Data on the quality, effectiveness and costs of care are collected and analysed at different levels: sickness funds, several federal government bodies, regional and community governments, hospitals and doctors' associations. This fragmentation is reflected in the existence of as many as 131 health-related databases in 2009 (Gerkens and Merkur, 2010). The joint exploitation of these databases is hampered by the lack of consistency in their design and quality, the lack of a unique patient identification and burdensome administrative procedures. Despite the abundance of databases, there is also a lack of good quality data in a number of areas, such as outpatient care, chronic care, psychiatric care, long-term care institutions, complementary insurance and the quality of care in general (van de Sande *et al.*, 2006; Paulus *et al.*, 2012). Nevertheless, some progress in centralising data has been made in the past few years, in the form of more pooling of data by sickness funds, developing the databases of the social security administration (NIHDI) and the creation of an "E-health" platform that facilitates access and sets common standards (Devlies *et al.*, 2010).

Further centralising and coordinating management into a single platform would enable a better use of these data. This platform should be made responsible for developing adequate indicators and setting common standards to harmonise existing databases. It should also ensure that the relevant data is accessible for users, such as public authorities, sickness funds, independent researchers, patients, and care providers themselves to stimulate benchmarking. Rather than creating a new institution, such tasks could be given to the “intermutualistic” agency regrouping the sickness funds, or to the Belgian Health Care Knowledge Centre (KCE), an independent public institute created in 2002, with a staff of around 30 experts, which already has a pivotal role in data analysis.

The KCE produces reports and non-prescriptive recommendations aimed to improve the health care system. Recommendations are endorsed by the main healthcare stakeholders, which are represented on the institute’s board of directors. To enhance their impact, the good practice initiated by this government that the Minister of Health reports yearly in front of the Parliament on the follow-up on KCE recommendations should be continued by formalising the practice into law.

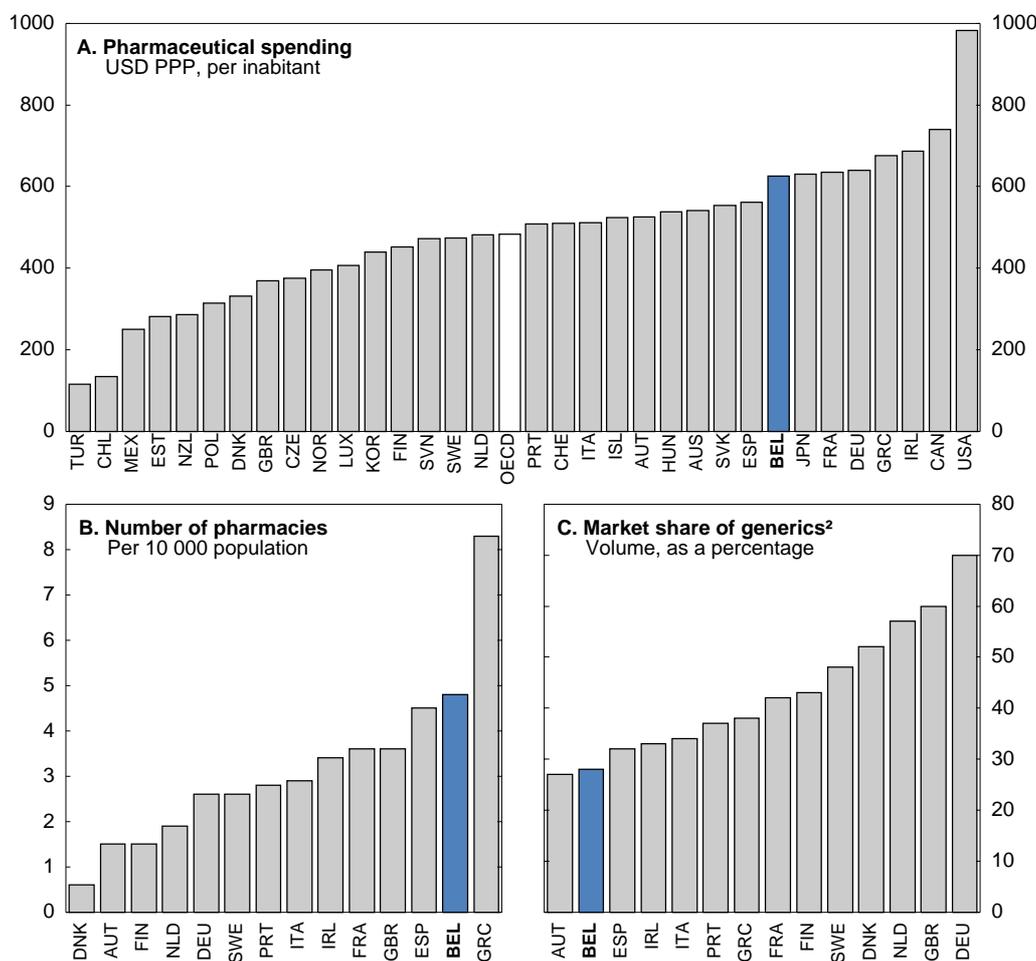
An area where information could be used more effectively is the statistical monitoring of doctor practices. A framework has been in place for several years to identify inappropriate practices such as excessive prescription of drugs (which contributes to excessive consumption). If identified, providers are placed under monitoring and may ultimately incur sanctions, such as administrative fines. The framework covers a very broad field, both in terms of care providers (hospitals, GPs, specialists and nurses) and services (drug prescriptions, medical biology, medical imaging and surgical procedures). However, its effectiveness remains limited because of insufficient clinical guidelines and long lags in procedures that make sanctions insufficiently dissuasive. Sanctioning procedures can last up to three years, notably because of insufficient cooperation between the government and the sickness funds, while doctors’ associations have been little inclined to sanction their members. To enhance the effectiveness of the framework, clinical guidelines should be reinforced and procedures should be shortened, for example by establishing clearer deadlines and clarifying the distribution of tasks between the government and the sickness funds.

Reducing the high spending on pharmaceuticals

A more effective monitoring framework would contribute to reduce the high spending on pharmaceuticals. The high spending reflects excessive consumption, notably of antibiotics and antidepressants, and to a smaller extent relatively high prices as the penetration of generic drugs remains lower than in most countries (Figure 10, Panels A and C). It may also be an indirect consequence of the “claw-back” tax on pharmaceutical companies, a tax that is automatically levied to offset (part of) budget overruns on pharmaceuticals, facilitating budget control in the short-term but potentially discouraging more structural measures by the authorities to control spending and entailing a risk of strategic behaviour by pharmaceutical companies to increase profit, potentially to the detriment of patients (Box 3).

To further tackle excessive consumption, drug reimbursement rules, which are almost never revised, should be reassessed regularly to reflect new evidence on their effectiveness as well as societal changes (Le Polain *et al.*, 2010). To reduce prices, several measures have been introduced over the last decade, such as a 31% to 41% reduction in drug reimbursement rates when cheaper alternatives exist and minimum quotas of low-cost drug prescriptions (about 50% for GPs). As a result, low-cost drugs, which include both generics and “cheap” original drugs, now represent more than half of the consumption, up from 17% in 2004. However, some of the associated savings may have been offset by the strategic reaction of pharmaceutical companies, in the form of new marketing strategies and oligopolistic behaviour that reduce price competition (Fraeyman *et al.*, 2012).

Figure 10. Pharmaceuticals
2010 or latest year available¹



1. The latest year varies from 2009 to 2010. The OECD aggregate is an un-weighted average of data available.
2. Does not include "low-cost" non generics drugs.

Source: OECD (2013), "OECD Health Data: Health Resources", OECD Health Statistics (database), April and European Commission (2012), "Cost-containment policies in public pharmaceutical spending in the EU", *Economic paper No. 461*, September.

Box 3. The "claw-back" tax on pharmaceutical companies

As a number of other European countries (e.g. Italy, France), Belgium has introduced a "claw-back" tax on pharmaceutical companies as a way to control the pharmaceutical budget. The tax is levied on the turnover of pharmaceutical companies to offset 75% of potential budget overruns on pharmaceuticals, up to a maximum of EUR 100 million per year. The tax presents clear short-term benefits in terms of budget control, but it may be detrimental in the longer term as it discourages structural reforms to tackle excessive drug consumption.

The tax also creates uncertainty for pharmaceutical companies, the more so as its design has changed several times in the past decade. Nevertheless, pharmaceutical companies across Europe tend to like such taxes, because they allow them to maintain relatively high drug prices where such taxes exist (indeed, abolishing the tax would allow governments to negotiate lower prices) and also – less justifiably – in neighbouring countries as price negotiations are frequently based on international price benchmarking (Carone *et al.*, 2012). Another issue with the tax is the risk of strategic reaction of pharmaceutical companies if they anticipate a budget overrun on pharmaceuticals. In such a case, companies would have incentives to reduce their tax base by reducing sales of products on which they make low profits, which could lead to rationing of cheaper drugs and penalise patients.

To further reduce drug prices, the reimbursement rate of pharmaceuticals for which cheaper alternatives exist should be systematically lowered down to the price of these alternatives, instead of the current minimum 31% reduction from the original price, which is unique in an international perspective (Vrijens *et al.*, 2010; Carone *et al.*, 2012). For example, Australia bases reimbursement rates on the price of the cheapest equivalent drug, and Denmark on the average of the two cheapest. This measure should be combined with allowing and encouraging pharmacists to substitute cheaper drugs to expensive ones unless explicitly prohibited by the prescriber, which is currently the case only for a few categories of drugs such as antibiotics.

More competition in the pharmacist sector would also put downward pressure on spending. Pharmacies have an exclusive right to distribute drugs (even non-prescription ones, such as aspirin) and a moratorium on new pharmacies has been imposed since 1994. This has left the sector fragmented, with a large number of pharmacies operating at an inefficiently small scale (Figure 10, Panel B). By preventing new entries on the market, the moratorium has in effect created rents, reflected in the high prices to buy existing pharmacies (Gerken and Merkur, 2010). These rents notably reflect the difference between the regulated selling price of drugs to patients and their actual cost for pharmacies, which is often lowered by discounts from pharmaceutical companies competing for market shares (Puig-Junoy, 2010; Carone *et al.*, 2012). To enable a rationalisation of the sector and the emergence of larger and more efficient pharmacies, the moratorium should be phased out and pharmacies should be allowed to compete on the currently regulated margin made on selling pharmaceuticals (a regulated fixed fee per box plus a regulated percentage of its price). To ensure that prices do not increase for patients, the current regulated margin should be kept as a maximum. In addition, other distributors, such as supermarkets, should be allowed to sell non-prescription drugs as a way to enhance accessibility and drive prices down.

Completing the shift to pathology-based hospital budgets

Better financial incentives would contribute to address efficiency discrepancies across hospitals. In 2002, a reform of hospital financing has shifted the focus from reimbursement of costs to reimbursement per pathology, basing hospital budgets on their pathology mix and on a normative average length of stay per pathology. This system, where only so-called “justified beds” are financed, gives hospitals incentives to contain costs. It has indeed lowered average lengths of stay, although they remain higher than in many other countries. However, the shift to reimbursement per pathology has been only partial and sometimes non-transparent as financing rules are complex and often changed (van de Sande *et al.*, 2010).

A large number of medical services, such as specialist consultations or medical imaging, are still reimbursed under a fee-for-service system. Consultation fees go directly to doctors, who redistribute a share of them to hospitals in exchange for using their facilities, meaning that hospitals have no incentive to tackle supplier-induced demand by their doctors. To address this shortcoming, a complementary mechanism was introduced in 2006 to identify and penalise hospitals where doctors’ total fees exceed the national average by more than 10% on 34 standard interventions. However, the scope of this mechanism, which the government envisages doubling, remains limited, as illustrated by the relatively small penalties collected from hospitals (INAMI, 2011).

To further tackle efficiency discrepancies, the shift towards reimbursement per pathology should be completed, including for doctors’ fees. This would push the less efficient hospitals to catch up with best performers and give hospital managers incentives to tackle supplier-induced demand. In such a system, hospitals and doctors would negotiate arrangements at the hospital level to share the new pathology-based budgets. To enhance the effectiveness of the reform, the budgets per pathology should also be updated. For example, there is no reason why the same treatment should be reimbursed differently depending on whether the patient stays overnight or not (van de Sande *et al.*, 2012). In addition, budgets should take into account international best practices and not just national averages (Koechlin *et al.*, 2010, Vrijens *et al.*,

2009). A downside of pathology-based budgets is the risk that care providers will overstate pathologies to receive more funding or cut costs at the expense of the quality of care. To counter such risks, better information management and more active sickness funds are needed to prevent pathology overstating, while indicators should be developed to monitor the quality of care. Preliminary simulations suggest that a shift towards full pathology budgets would result in substantial changes in the budget of numerous hospitals, confirming the diagnosis of large efficiency disparities and suggesting that a progressive transition may be required (van de Sande *et al.*, 2010).

The remuneration of doctors should be more capitation based

A full shift towards pathology-based budgets would change doctors' remuneration in hospital. In extramural care as well, doctors' remunerations should evolve further to reward activity less. Fee-for-service still represented 88% of GP revenues in 2010, although this share has declined over the past decade (Meeus and van Aubel, 2012). In this area, an increasing number of countries, such as Norway, Denmark, and the Netherlands, have adopted a mix of capitation payments (a fixed annual budget per patient whatever the number of consultations) and fee-for-service, at least for GPs. The idea is to balance the risks of excessive activity associated to fee-for-service and the risks of insufficient activity and "selecting" patients associated to capitation payments (Paris *et al.*, 2010). In Belgium, increasing the share of capitation payment would reduce incentives for supplier-induced demand and could also increase doctors' focus on preventive care. It may also make it easier for GPs to practice in groups, often a cost-efficient arrangement. Another benefit is that it would give doctors incentives to practise in low-density areas, mitigating potential shortages.

Improving incentives and information of patients

On patients' side as well, there is scope for better incentives without increasing the level of their out-of-pocket payments, which is relatively high. For example, the standard rate of patient copayment for GP consultations is 25% and it can reach 40% for specialist consultations. Payments can be much higher for doctors that do not adhere to the negotiated fee schedule, which represent a minority but an increasing share of doctors, notably in gynaecology, ophthalmology and dermatology. Out-of-pocket payments are particularly high in hospital, where patients have to pay an admission fee of EUR 31, a flat rate of EUR 14 per day of hospitalisation and copayments on the medical services they receive. Vulnerable groups, such as poorer households, enjoy lower copayment rates and, since 2002, total annual copayments on "necessary" care have an annual income dependent cap (for example, EUR 1 000 for a family with a net income of EUR 30 000). In addition, the government has recently prohibited doctors from charging more than the negotiated fees to patients in double hospital rooms – such supplements were already banned for patients in larger rooms and remain authorised in single rooms. Overall, private payments represent about a fifth of total care costs, a relatively high level that is justified by the need to control demand in a system where patients enjoy a free choice of care providers.

A number of chronically ill people face relatively high out-of-pocket payments. Knowing in advance that they will reach the annual cap on copayments may influence their behaviour and lead them to consume more care, although an empirical study finds only limited evidence for this phenomenon (Schokkaert *et al.*, 2008). These patients could be offered copayment-free treatment for certain services or up to a certain illness-specific limit, as a way to reduce the probability of reaching the cap. This would reduce their financial burden while also aligning their marginal copayment rate with that of other patients. The difficulty is in designing a well-targeted scheme for a sufficiently homogenous group of patients. The authorities intend to introduce elements of such a scheme in 2014 by offering copayment-free GP consultations to chronically ill patients, identified mainly on the basis of high past consumption of health services. After assessing the effect of the measure, the authorities should consider extending it to other services or refining it by identifying patients on the basis of pathologies.

GP gate-keeping in the access to specialist care is not in place as there is only a very small financial incentive to be referred by a GP. Being referred reduces the copayment on the specialist consultation by only EUR 5, while the GP visit needed to receive the reference implies a copayment of roughly that amount. This financial incentive should be strengthened to reinforce the role of GPs as the first line of treatment. Simulations suggest that such stronger gate-keeping would likely generate efficiency gains, especially in areas like psychiatrics, paediatrics and dermatology, where patients rely excessively on specialists for routine contacts (Schaumans, 2010). More generally, copayments should be more differentiated across medical services to better reflect their different societal value and to encourage good medical practices, such as care paths (Cleemput *et al.*, 2012). As discussed, sickness funds could be given a more active role in this area.

To promote a cost-efficient use of the system, patients should also be better informed. Patients are currently relatively well informed about the aim and nature of medical interventions and their degree of urgency, but less so in terms of the quality of care, related costs and potential alternatives, notably in hospital (Gerken and Merkur, 2010). Transparency of the price of extramural care could also be improved. In addition, patients could have a bigger role in informing care providers, the government and sickness funds about their experience of the system and how to improve it. In this area, the authorities have launched an interesting initiative to collect the feedback of chronically ill patients. In the same manner, sickness funds could experiment with gathering information from their members as a way to identify good practices or indications of supplier-induced demand.

Enabling adaptation to changing demand patterns in an ageing society

Population ageing will induce large changes in demand patterns, making it crucial that the healthcare supply can adapt rapidly. As discussed, a Dutch-like model of competing sickness funds could contribute to such an outcome, although with the risk of higher costs. In the current government-controlled system, several measures could also help enabling a more demand-oriented system where the supply of hospital care, doctors and long-term care would react more endogenously.

The supply of hospital care is too dependent on government planning

The supply of hospital care largely reflects government planning. The government shapes hospital supply through a moratorium on the number of hospital beds and subsidies for hospital investment in infrastructure and heavy medical equipment. In addition, the hospital sector is tightly regulated with an aim to control costs as well as to promote the quality of care. For example, hospitals are required by law to have at least 150 beds per site and to offer at least three kinds of services plus emergency services, radiology and clinical biology, which in effect rules out specialised hospitals. Hospital equipment is also subject to strict regulations. The tight government control was necessary at a time when hospitals were directly reimbursed for their costs as there was no other mechanism to force them to be cost efficient. However, in a system increasingly based on budgets per pathology, such direct control is no longer needed and risks hampering the flexibility of hospitals to organise themselves efficiently (Joumard *et al.*, 2010). For example, it is possible that small specialised hospitals would provide more cost-efficient treatment for certain pathologies. Thus, once incentives for cost efficiency are fully in place (such as pathology-based budgets with mechanisms guaranteeing the quality of care) overly prescriptive hospital regulations should be eased.

In addition, the creation and closure of hospitals should be facilitated. On the creation side, the moratorium on hospital beds could be phased out – as above, once adequate financing mechanisms promoting cost-efficiency are fully in place to prevent an oversupply of beds. Also, agreement procedures for new hospitals should be shortened as a full agreement-construction cycle can now take up to a decade. Additionally, for-profit hospitals could be allowed to enter the market, although the gains in terms of a more competitive supply should be weighed against the risk that these hospitals “select” patients, leaving

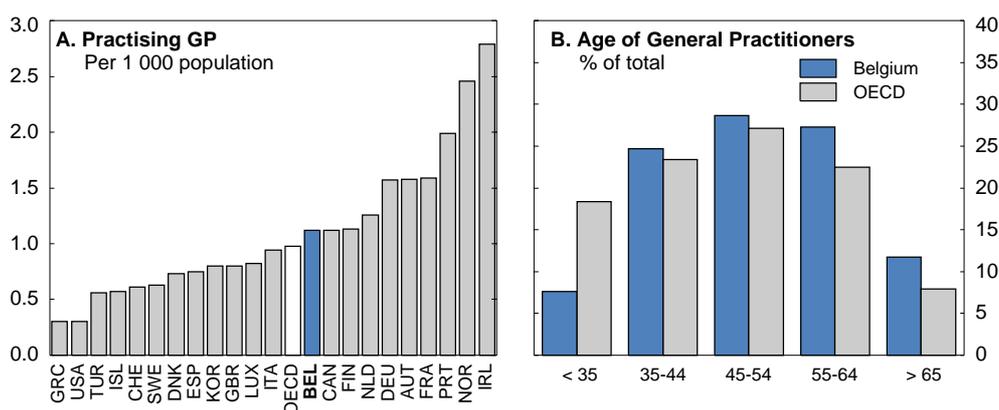
costly cases to non-profit hospitals. There is no legal barrier to the closure of inefficient hospitals, but it has happened only exceptionally in the past. In this area, more auditing of hospitals would be useful to identify potential financial difficulties early on. There should also be more transparency about the implicit federal subsidies involved in keeping costly hospitals open, for example in low-density areas. In such cases, the local authorities interested in keeping a hospital open could be made to participate to its financing.

An ageing GP population points to potential shortages

The ageing of the GP population and projected increases in demand risks leading to future shortages (Figure 11; Roberfroid *et al.*, 2008). These worries are compounded by quotas of new GP graduates generally not being filled over the past decade, in contrast to most specialties – with a few notable exceptions such as child psychiatry, acute medicine and emergency medicine. In addition, an increasing number of licensed GPs are leaving practice before retirement age (Lorant *et al.*, 2008). Potential shortages would also be aggravated by the uneven distribution of GPs across the country (Meeus and van Aubel, 2012).

Figure 11. The GP population is ageing

2011 or latest year available¹



1. The latest year varies from 2006 to 2011. The OECD aggregate is an un-weighted average of data available.

Source: OECD (2012), "OECD Health Data: Health Care Resources", OECD Health Statistics (database), October.

To address potential shortages, the authorities are raising the quotas of new medical graduates by 60% over 2011-15 and aim to make the GP profession more attractive in terms of working conditions, remuneration and image. Over the past decade, the remuneration of GPs aged 45-54 has risen by an average 8% per year, more rapidly than most other health professionals, although the remuneration gap with specialists remains internationally high (Table 3). In addition, financial incentives have been introduced to encourage GPs to move to low-density zones. For example, as part of the Impulseo I initiative, GPs moving to areas of low GP density can receive up to EUR 35 000 of direct subsidies and interest-free loans, as well as free administrative assistance for the first 18 months of activity. The subsequent Impulseo II initiative gives GPs financial incentives to practice in group in doctor houses and hire an administrative assistant.

Table 3. Specialist remuneration, as ratio to GP remuneration in each country

2011 ¹ (or latest year available)		
	Salaried	Self-employed
Australia (2009)		2.6
Austria (2007)		1.6
Belgium (2009)		2.6
Canada (2009)		1.5
Czech Republic (2008)		1.0
Denmark (2008)	1.0	
Estonia	1.3	
Finland (2010)	1.5	
France (2010)		1.7
Germany (2006/2007)	1.0	1.4
Hungary (2010)	1.2	
Iceland ²	1.0	
Ireland ³		
Italy		
Mexico (2010)	1.2	
Netherlands (2009)	1.7	2.1
New Zealand (2007)	1.4	
Slovak Republic		
Slovenia (2010)	1.1	
Spain (2010)	1.1	
Turkey (2010)	2.0	
United Kingdom (2009)	1.4	

1. No data means that either GP or specialists are mostly not salaried or not self-employed in this country.

2. Many specialists working in hospitals also earn incomes from private practices, which are not included.

3. Data for self-employed GPs include practice expenses resulting in an over-estimation.

Source: OECD (2012), Health at a Glance database, October.

Such group practice is increasingly popular, but remains less widespread than in other countries (Table 4). It should be further encouraged as it has the potential to improve the quality of services, working conditions and productivity by allowing GPs to offload some tasks to other professionals, such as nurses and administrative assistants (Bourgueil *et al.*, 2007; Lorant *et al.*, 2008). In Belgium, there is notably room for a bigger role of nurses in the follow-up of diabetic patients and in pain management (Delamaire and Lafortune, 2010). To facilitate this process, this “advanced” role of nurses in tasks so far reserved to doctors should be officially recognised, as in the United States, Canada and more recently Australia and Ireland. In turn, certain tasks of nurses could be delegated to nursing assistants, notably in long-term care, as a way to prevent a shortage of nurses.

Table 4. Majority settings for general practice per country

As a percentage of practitioners in the majority settings

Solo practice	
	Austria
	Belgium (69%)
	France (52%)
	Czech Republic (90%)
	Germany
	Greece (60% of spending)
	Korea (79.9%)
	Luxembourg
	Switzerland (63% of consultations)
Group practice	
Doctors only	Canada (47.7%) Italy (65%)
Doctors with other care practitioners (e.g. nurses) in private centres	Australia (92.2%) Denmark Ireland Netherlands (54%) New Zealand (52%) Norway Poland ¹ (76% of spending)
Doctors with other care practitioners in public centres	Chile (30.4% of spending) Finland (88% of spending) Iceland (95%) Israel Mexico (78% of consultations) Portugal (100% of institutions) Slovenia (67% of consultations) Spain (97% of institutions) Sweden United Kingdom (100%)

1. Non-public primary care clinics staffed by physicians and other health professionals in Poland.

Source: OECD Survey on Health system characteristics 2012 (forthcoming).

Giving a bigger role to price signals to allocate doctors across specialties

Quotas of new medical graduate, introduced in 1997, have been the government's preferred instrument to regulate the supply of doctors – both GPs and specialists. At that time, quotas were meant to address a perceived oversupply of doctors, identified as a source of supplier-induced demand. However, international experience shows that quotas are an imperfect tool that commonly under or overshoots its goals because of the large uncertainties about future demand and supply and the time lags in doctors' education (Roberfroid *et al.*, 2009; Stordeur and Léonard, 2010). The effectiveness of quotas is also undermined by the increasing cross-borders flows of doctors and students, especially since a European directive guarantees their free movement within the EU. An increasing number of foreign doctors, notably from Eastern Europe, practice in Belgium, with inflows representing 12% of new physicians in 2006. In the Belgian case, the functioning of quotas is also complicated by the Flemish- and French-speaking communities having implemented different and frequently evolving systems to select the right number of medical students.

A more promising approach to regulate the supply of doctors is to give a bigger role to price signals. Indeed, shortages in certain specialties (paediatrics, emergency medicine, geriatrics) and in general practice reflect to some extent the low remuneration vis-à-vis other specialties. The relative fee schedule (so-called “nomenclature”), first introduced in the 1960s, has not fully kept up with medical innovations and still gives excessive rewards to technical activities over consultations with patients, despite efforts to reduce the gap over the past decade (van der Oever and Volckaer, 2008; Stordeur and Léonard, 2010). This is because negotiations on doctors fees, which take place annually between doctors’ associations, sickness funds and the government, focus more on across-the-board tariff changes than on changing relative fees per service or per specialty. To enable a better allocation of doctor supply, the relative fee schedule should be adjusted regularly to reflect costs and the adequacy of supply per speciality.

Demand for long-term care will increase sharply

In long-term care, large increases in demand are looming as population ages. Under current policy, demand for care in institutions is projected to increase by 30% by 2025 and accelerate in subsequent years as ageing intensifies (van Den Bosch *et al.*, 2011). An issue in this respect is that the supply side is slow to adapt to changes, as reflected in the existence of substantial waiting lists in some areas (Willemé, 2010). This rigidity notably reflects strict government planning and lags created by the fragmentation of responsibilities across government levels (Box 4). Fragmentation is also an obstacle to an integrated and patient-centred approach to care, resulting in inefficiencies and welfare losses (Arnaert *et al.*, 2005). Measures are needed to enable a more endogenous reaction to changes in demand. This would enhance accessibility but may also increase costs, requiring significant measures to contain spending, such as better targeting and more focus on home care, which is often cheaper than institutional care (at least for the less severely dependent) and also more patient-centred.

Box 4. The Belgian long-term care system

The federal health insurance system covers long-term care in institutions and at home, while non-medical home services (e.g. help with domestic activities) are provided by communities. Institutions can be public or private and for-profit or not. They are financed by sickness funds according to their residents’ assessed dependency level in addition to payments from patients for accommodation and boarding, of an average EUR 1 200 per month (Colombo *et al.*, 2011). The latter are not covered by health insurance, but copayments for nursing services, both in institutions and at home, are relatively low and subject to the annual cap on health copayments.

Long-term care responsibilities are complexly distributed across government levels, reflecting the position of long-term care at the intersection of personal care, a community responsibility, and health care, mainly a federal one. The federal government is in charge of the financing of care (with the exception of non-medical home services), the ceiling on the total number of institutional beds (until it expired in 2012) and negotiating fees with providers’ organisations. The federal government and the communities are co-responsible for certification, monitoring and quality control of care institutions. Communities are responsible for the organisation of home care, but both federal and community institutions coordinate the provision of home care between GPs, nurses and paramedical staff. Reflecting the complexity of the distribution of tasks, several working groups are necessary to coordinate policy objectives between the federal government and communities. The State reform will increase the responsibilities of the communities in organising care, but the financing of nursing care services at home is likely to remain federal.

Long-term care patients are eligible for several cash benefits independently of their use of “in-kind” care. Elderly people are entitled an “Allowance for Assistance to Elderly Persons” that can vary between EUR 900 and 6 100 per year depending on dependency level, income and assets. In addition, Flemish dependent people receive a non means-tested allowance of EUR 1 560 per year from their community. Disabled people can also benefit from a yearly allowance to employ a home helper. In addition, social and psychological support is increasingly in place for informal caregivers at the local level and facilities for temporary (respite) care as well.

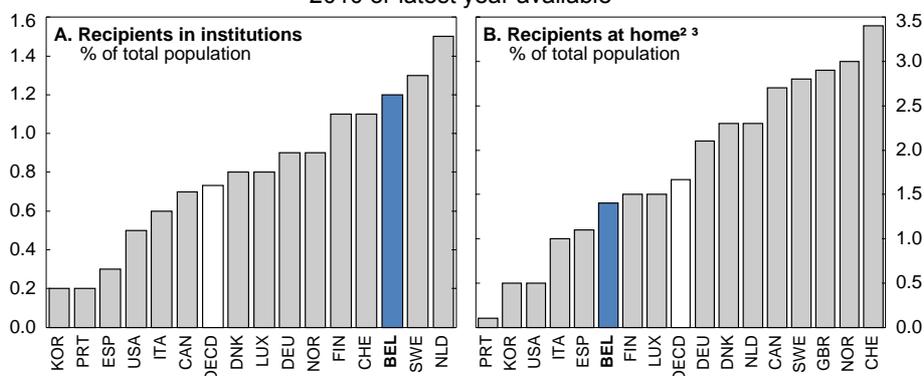
Source: Willemé (2010), “The Belgian long-term care system”, *Federal Planning Bureau*, Working paper 7-10.

Further encouraging home care by giving more autonomy to patients

Home care for elderly people has expanded rapidly over the past decade, especially in Flanders. However, the high institutionalisation rate suggests room for further development of home care (Figure 12). The recent development of home care reflects a number of initiatives by the authorities (*e.g.* more flexible and adaptive forms of long-term care provision, such as temporary care facilities), but also the rationing of institutional care induced by a moratorium on institutional beds - the moratorium expired at the end of 2012, but budget constraints at the level of communities will be the new method to limit the number of institutional beds. However, this rationing is a double-edged sword as people waiting for admission in a nursing home can either stay at home, which is cheaper as long as they need less than 2½ hours of care per day, or in geriatric hospital care, which is more expensive. The latter solution is apparently used to some extent as the average length of stay in hospital for dementia and Alzheimer’s disease is close to one month and exceeds OECD average by more than a half (Colombo *et al.*, 2011).

Figure 12. Long-term care

2010 or latest year available¹



1. The latest year varies from 2006 to 2010. The OECD aggregate is an un-weighted average of data available.
2. Data on the number of home care recipients only concern care for “Activities of Daily Living” (ADL), such as nursing care, but not “Instrumental Activities of Daily Living” (IADL), such as domestic support.
3. Survey data from another source (Survey of Health Ageing and Retirement in Europe) suggests an internationally higher proportion of formal home care use in Belgium.

Source: OECD (2013), “OECD Health Data: Long-term Resources and Utilisation”, OECD Health Statistics (database), April.

To further encourage home care, patients should be given more autonomy to organise their care, which would enable the emergence of more integrated care services. Currently, the nursing part of care is delivered by nurses contracted by the federal health insurance system. In contrast, help for domestic activities is organised by communities, which contract small non-profit companies, often local monopolies, to provide care. A good alternative would be to entitle patients with vouchers to purchase care from qualified professionals, which would give them the possibility to organise their own care, a system successfully adopted by Nordic countries (Colombo *et al.*, 2011). The free choice of provider would enhance patients’ welfare as well as competition across providers. In such a system, providers would be encouraged to develop integrated services for nursing and domestic activities, as patients would probably favour them. To enhance the effectiveness of the system, patients should receive information and counselling by actors with good knowledge of the local context, such as municipalities.

Updating the financing system for nursing interventions would also encourage a more efficient home care supply. Nursing interventions at home are financed under a dual system: fee-for-service for technical interventions and a lump-sum payment depending on the patient’s dependency level for less technical support (*e.g.* help with bathing). However, the fee schedule (“nomenclature”) is obsolete, complex and does not reflect relative costs of interventions (Sermeus *et al.*, 2010). For example, some common interventions are absent, while some interventions may be counted (and thus reimbursed) twice. Thus, the fee schedule should be updated.

In psychiatric care as well, there is still a tendency to rely excessively on too medicalised settings, such as psychiatric hospitals. Less medicalised facilities have been developed, such as psychiatric nursing homes and sheltered living initiatives, which have potential to enhance cost-efficiency and patient welfare. However, their supply remains too limited as reflected in long waiting lists (Eysen *et al.*, 2010). Another obstacle to a cost-efficient psychiatric care is the difficulty to provide care in an integrated way, *i.e.* to ensure good coordination between the different professionals involved. Several pilot projects have taken place since the early 2000s and a broader reform was launched in 2010, although progress remains hampered by a lack of information and the fragmentation of responsibilities across government levels. In addition, there is room to better promote the employment of the mentally-ill, notably through better integration of health and employment services and a more active role of the sickness funds (OECD, 2013).

Towards a more independent and integrated assessment of long-term care needs

Better targeting would also contribute to lower long-term care costs. This requires improving assessment procedures as well as toughening the relatively lenient criteria for access to institutional care (Paulus *et al.*, 2012). The assessment of care needs is generally performed by patients' regular GP or a local nurse. This creates a conflict of interest, as these professionals may be involved in delivering subsequent care. Indeed, when ex-post controls are performed, care needs are revised downwards 40% of the time, but overstatement of care needs is not sanctioned. Controls are complicated by the coexistence of as many as five different scales to qualify dependency levels, which also adds to administrative costs (Sermeus *et al.*, 2010). Several scales are in use for different purposes, such as in-kind care or cash allowances, both at the federal and community level. A project ("BelRAI") is underway to harmonise geriatric assessment, but will initially only concern care planning. As envisaged, the authorities should adapt and use the new harmonised assessment for financing purposes as well. In addition, dissuasive sanctions should be put in place for systematic overstatement of care needs. An alternative would be to delegate the assessment to a single dedicated independent authority.

Making long-term care supply more responsive to changes in demand

To control long-term care spending, the government has relied until the end of 2012 on a federal moratorium on the number of long-term care beds per community. Communities then decided on the allocation of beds. The end of the moratorium has made the communities responsible for the number of institutional beds. Despite the existence of waiting lists for admission in care institutions, permits to build new beds can take up to 10-15 years to be realised. This reflects long administrative procedures and the fact that care institutions are allowed, at least in the Flemish community, to store their permits for up to eight years and sell them to other institutions instead of building rapidly the associated beds. A consequence of waiting lists is that patients have less latitude to choose their institution as they generally enter the first one where they are accepted. In addition, admission policies of institutions do not always target the most in need for care (Paulus *et al.*, 2012).

The authorities should rely more on price signals to shape an efficient and reactive long-term care supply. To this end, the relative budgets per dependency level (similar to hospital pathology budgets) should be revised regularly to reflect the adequacy of supply in the different categories of beds (more or less care intensive). The moratorium on long-term care beds should not be reinstated and new institutions and initiatives should be allowed to respond to unmet demand, enhancing competition across institutions and facilitating the emergence of alternative solutions, such as day-care centres. Institutions could also be given more freedom to set the price of accommodation and boarding, which is currently controlled by the government. To ensure that such reforms do not generate unnecessary costs or affect the quality of care, the focus should be put on gathering information on the quality and cost of care, while encouraging sickness funds to benchmark the performance of institutions.

Box 5. Main recommendations to give an ageing population an efficient health sector

Improving the general organisation of the system to enhance cost-efficiency

- Improve the budgeting system by increasing the focus on the medium term and closing potential budget escape routes by limiting the scope of the “exceptional expenses”.
- Better align the incentives of the different government levels by giving communities (or regions) a stake in federal health care spending in their community to avoid cost shifting.
- Give sickness funds a more active role in promoting cost-efficient care by allowing them to identify underperforming hospitals and long-term care institutions and force corrective action when needed, and to experiment on a limited scale with selective contracting of providers.

Improving information flows and incentives at the level of care providers and patients

Data management and use

- Enhance data quality by greater centralisation and coordination of data management into a single platform.
- Reinforce the statistical framework to tackle inappropriate medical practices (such as excessive prescription of drugs) by improving clinical guidelines and shortening sanction procedures.

Pharmaceuticals

- Further tackle spending on pharmaceuticals by revising reimbursement rules regularly to reflect the relative effectiveness of drugs.
- Enhance competition on the pharmacist market by phasing out the moratorium on pharmacies, allowing pharmacies to compete on prices and allowing other distributors to sell non-prescription drugs.

Financing of care providers

- Complete the shift towards pathology-based budgets in hospital financing to address efficiency discrepancies across hospitals.
- Increase the share of capitation-based (as opposed to fee-for-service) remuneration of doctors.

Patients

- Offer copayment-free treatment to the chronically ill for certain services or up to a certain limit to reduce their financial burden and align their marginal copayment rate with other patients.
- Reinforce financial incentives to be referred by a GP when visiting a specialist to secure the role of GP as the first line of treatment.

Enabling adaptation to changing demand patterns in an ageing society

Hospitals and doctors

- Once adequate mechanisms to control costs are in place, ease overly prescriptive hospital regulations.
- Further encourage group practice by doctors by facilitating the offloading of tasks to qualified nurses.
- Update the relative fee schedule to let remuneration of GPs and specialists reflect adequacy of supply.

Long-term care

- Qualify care needs on a unified geriatric assessment and introduce dissuasive sanctions to deter overstatements of care needs.
- Further encourage home care by giving patients autonomy to organise their own care, possibly under a system of vouchers, to stimulate the emergence of competitive integrated care services.
- Update institutions' budgets per dependency level and allow new institutions and initiatives to respond to unmet demand.

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