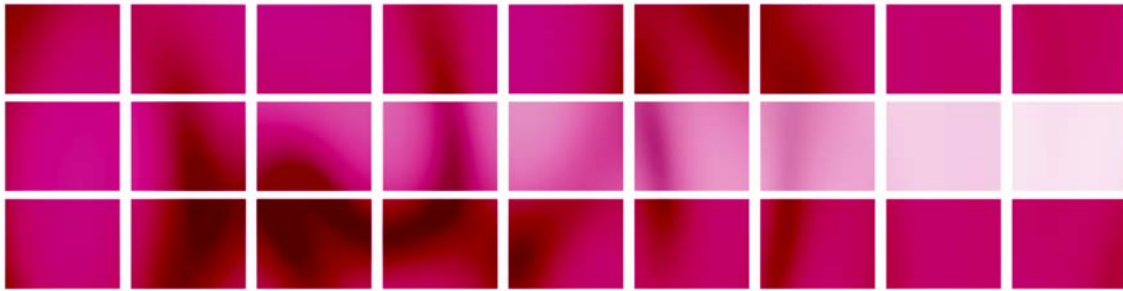


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**PRIVATISATION OF PUBLIC SERVICES AND THE IMPACT ON
QUALITY, EMPLOYMENT AND PRODUCTIVITY (PIQUE)**

Liberalisation, privatisation and regulation in the Belgian healthcare sector/hospitals

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Country report on liberalisation and privatisation processes and forms of regulation

The project “Privatisation of Public Services and the Impact on Quality, Employment and Productivity” (CIT5-2006-028478) is funded by the European Commission’s 6th Framework programme.



November 2006

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1. *INTRODUCTION TO THE SECTOR*

The principal characteristics of Belgium's health care system result from decisions taken after the Second World War to create a public, compulsory health insurance system, based on: independent medical practice, free choice of doctor and hospital by the patient and fee-for-service payments of providers, with reimbursement (European Observatory on Health Care Systems, 2000, p. 5). The system rests on the solidarity principle, since, as a rule, contributions are proportional to participants' revenues – with no reference to the health risk – while reimbursements are equal for everyone – except for especially vulnerable social groups (OECD, 1995, p. 75).

A striking feature of Belgian health care is that it combines a predominantly public funding system with a predominantly private system of health care provision (Kesenne, 2004, p. 36). The following kind of health care activities can be found in Belgium: independent health professionals (both generalists and specialists) providing ambulatory care and services, public health services, hospitals, the pharmaceutical industry and social care facilities for the elderly and other groups with special needs (European Observatory on Health Care Systems, 2000, p. 33).

Medicine, dentistry and pharmacy can be practised only by persons in possession of an official medical doctor's, dentist's or pharmacist's license. Doctors also have to be registered with the Order of Physicians and pharmacists with the Pharmacists' Council (European Observatory on Health Care Systems, 2000, p. 50). The Order of Physicians has the power to withdraw the registration and thus suspend a doctor (Van Gompel, 2006, p. 60).

The vast majority of the holders of official licences work as independent self-employed health professionals. Medical specialists can work in institutions (mostly hospitals) and/or on ambulatory basis, in private practice. Because there is no referral system between general practitioners and specialists, every citizen has free access to medical specialists and hospital care, even as the first point of contact with the health care system (European Observatory on Health Care Systems, 2000, p. 50). In other words, there is no gatekeeper (OECD, 1999, p. 75).

The systems is not only characterised by a nearly unlimited freedom of patients to choose their preferred providers, but also by the equally broad therapeutic freedom of the providers. Furthermore, there has been a tradition of abundant supply (Schokkaert, 2003, p. 5).

Most physicians are paid on a fee-for-service basis (OECD, 1999, p. 77). In the case of ambulatory care, patients usually pay the complete fee to the providers and are reimbursed partially by their sickness fund on submission of the bill. In the case of hospital care and pharmaceuticals, financing is mainly through third-payer arrangements, in which the sickness funds pay the providers and the patients are only responsible for

the co-payment. Own payments are relatively high by international standards, and cover at least 15% of total health expenditures (Schokkaert, 2003, p. 3).

The federal government has the final responsibility for the level of contributions and reimbursement rates, as well as for the rules governing the relationship between the mutual funds and the providers. Moreover, it has veto power over the levels of fees, and plays a central role in negotiating the drug prices. It is also responsible for the accreditation of doctors and nurses, and regulates the hospital sector (OECD, 1999, p. 75). The responsibility for some other aspects of health care has been shifted to the Communities and Regions. These aspects include: preventive care, health education, and the implementation of various decisions initiated at the federal level – such as initiatives concerning the number and size of hospitals (OECD, 1999, p. 74).

Downward price competition on the provider markets is forbidden but there is intense quality competition. Providers are very responsive to the subjective needs of the patients (Schokkaert, 2003, p. 5). For instance, Belgian general practitioners deliver a high proportion of their services at the home of the patient, in comparison to other western European countries (European Observatory on Health Care, 2000, p. 53).

Since co-payments by patients represents only around 15 per cent of total costs, the main source of financing health care covered by compulsory insurance is public revenues, with social security contributions and general taxation accounting each for a little over 40 per cent, and some other minor sources – such as contributions from old-age pensions and taxes on car insurance – accounting for the remainder. With effect from 1995, however, the global management of social security system abolished the distinction between contributions and tax revenues for each branch of the social security taken separately. There are no longer, therefore, any specific contributions for health insurance, since this scheme is an integral part of the social security system (OECD, 1999, p. 75).

The already mentioned mutual funds are nongovernmental non-profit organisations, which are responsible for the management and administration of the statutory health insurance programme (van Doorslaer, 2000, p. 881). They are given a monopoly position in the compulsory health insurance market (European Observatory on Health Care Systems, 2000, p. 13). The mutual funds also offer voluntary health insurance to cover additional services for all of their affiliated members. This last segment of the insurance market has grown steadily over the past few years. Risk-based private health insurance offered by private for-profit companies is still very small compared with the public health insurance but, like complementary insurance offered by the mutual funds, it has grown steadily, especially for hospital costs, apparently reflecting some reduction in coverage and reimbursement in the compulsory scheme. Unlike mutual funds, which are prevented by law from doing so, private insurance companies can offer cover for the proportion of medical expenses which the individual must pay under the compulsory insurance. But apart from special situations or market niches, the possibility for private-for-profit insurance companies to compete with mutual funds on the market for complementary health insurance seems limited, given the tax-exempted status of the mutual funds and their possibility of relying on economies of scale, and private for-

profit insurance companies are excluded by law from the compulsory health insurance market (OECD, 1999, p. 75-76).

2. *MARKET STRUCTURE OF THE HOSPITAL SECTOR*

2.1. *Market structure before liberalisation (question 1.1)*

Until 1982, the Belgian hospital structure was characterised by the great number of small hospitals. A steady increase of the number of beds was witnessed. In 1981, Belgium counted 531 hospitals (BIGE, 2001, p. 84).

There was and still is competition between these hospitals. Despite the fact that the patient is not fully able to evaluate the quality of the hospitals due to the information asymmetry, he or she is free to choose where he/she wants to receive treatment (Van Gompel, 2006, p. 95). Moreover, hospitals have to accept all patients (European Observatory on Health Care Systems, 2000, p. 41).

2.2. *Steps and processes of liberalisation*

The Belgian hospital sector did not undergo a process of liberalisation. Although it was subjected to a number of reforms over these last years, the aim was not to open up the market further for competitors. On the contrary, as we will see, the number of competitors on the market decreases as a result of these reforms.

Health care reforms implemented during the last 20 years have been aimed at containing the system's costs without forsaking its more positive characteristics. The reforms of the Belgian health care system, which arose from the need to contain spiralling costs, have been twofold. Firstly, by adapting the financial mechanisms of the system, the reforms have been aimed at devolving responsibility for Belgian health care to the system's various stakeholders. Secondly, the Belgian government has implemented reforms which focus on the supply-side of the system (Crainich, 1999, p. 247-248). The aim is to limit the supply of medical services (Crainich, 1999, p. 259). (**question 1.2.ii**)

These reforms had also consequences for the hospital sector. First of all, a policy of bed reduction has been applied since the introduction of the moratorium stating that the number of beds counted on 1 July 1982 could not be exceeded from that date. The government intended to reduce the number of in-patient days through these cuts. Financial incentives have also been introduced to promote the policy of bed-reduction, in the form of compensation being granted for the non-execution of building projects already authorized, and for the closure or failure to open hospitals and geriatric departments (Crainich, 1999, p. 260).

Moreover, incentives to reduce investments have also been introduced. Communities now have the option of reducing their contributions from 60 per cent to 30 per cent for investments that cut the number of beds in a hospital by at least 25 per cent (the remaining 30 per cent being paid by health insurance) (Crainich, 1999, p. 260).

Secondly, the Belgian government has also implemented a policy of bed concentration. Under this policy, a hospital must contain a minimum number of 150 beds, spread across at least three departments. The Ministry for Social Affairs, Public Health and the Environment has forced hospitals that do not contain the requisite number of beds to either merge with other hospitals or to close altogether. Until the 1980s, the Belgian hospital structure was characterized by the existence of a considerable number of small hospitals. However, these measures have led to an increase in the average size of hospitals and a concomitant reduction in the number of small institutions (Crainich, 1999, p. 260-261).

The federal government has taken several initiatives to stimulate the expansion of hospitals. It issued a decree on 14 July 1998 that offered instruments to anticipate the tendency of increase in scale and to stimulate cooperation between private and public hospitals (Schoonjans, 1999). (**question 1.2.iv**)

The process of reforming this sector is not yet finished. Containing the cost of health care remains a challenge. The policy of bed reduction and bed concentration will be continued. It is therefore likely that in the future the number of hospitals will continue to decrease. The result will be a smaller number of bigger hospitals. (**question 1.2.i**)

Table 1: Market structure

Before reforms	After reforms
Many small hospitals	Policy of bed reduction Policy of bed concentration ⇒ mergers and cooperation ⇒ Decrease of number of hospitals

2.3. *Current market structure and remaining challenges*

Over the last years, there has been a trend towards reduction of the number of hospitals. In 1981, Belgium counted 531 hospitals. This number dropped to 274 in 1996 (BIGE, 2001, p. 84). In 1999, there were still 174 hospitals and by 2003 this number was further reduced to 149 institutions (Nationaal Instituut voor de Statistiek, 2002, p. 12-13; Nationaal Instituut voor de Statistiek, 2005, p. 12-13). In other words, there was a reduction of 382 hospitals in a little more than 20 years time.

Nowadays, patient care is more and more organised in a network of care provision. There is a trend towards integrated intramural care. This trend is not only caused by the policy of bed concentration. The cost price of medical equipment, the increasing

tendency towards sub specialisation and the scarcity of certain professionals also help to explain the trend towards more cooperation between and even mergers of hospitals. Care providers aim at a higher penetration of the market of programs directed at small groups of patients. By choosing for cooperation and mergers, they also aim at economies of scale for auxiliary services, such as ICT, labs, and medical imaging (Degadt, 2003, p. 124). Furthermore, the provision that hospitals should at least count 150 beds, on the other hand, resulted in a reduction of the number of small hospitals. Many of those hospitals merged with another hospital or they simply disappeared (BIGE, 2001, p. 82). (**question 1.3**)

The trend towards concentration has consequences for the competition between the hospitals. Even though it was necessary to reduce the supply of medical services, such as hospital care, it remains to be seen how this will impact on the level of competition between hospitals. After all, competition has positive consequences for the quality and productivity of companies. (**question 1.4**)

3. *REGULATION OF THE HOSPITAL SECTOR*

3.1. *Instruments*

Hospitals are strictly regulated in Belgium (Van Gompel, p. 61). First of all, hospitals are subjected to quality and quantity regulation. The programming that was foreseen in the Hospital law of 23 December 1963 originally used economic instruments to regulate the quantity of hospitals. Only hospitals that were allowed by the programming were to receive subsidies from the government. However, hospitals not falling under the programming would also be approved. The only difference was that these hospitals would not receive any money from the government. As a result, the aim of the programming, a good geographical dispersion, was not achieved (Callens, 2003, p. 105).

In 1973, a new law was passed that replaced the systems of subsidies by a system of building licenses that would only be issued to hospitals falling under the programming. This way, the quantity of hospitals could be controlled (Callens, 2003, p. 105). However, this system was not perfect either.

The decade of the 80s therefore witnessed a tendency towards closer regulation and supply restrictions in the hospital sector (Schokkaert, 2003, p. 6). In 1982, a KB established a moratorium. The number of beds that was recognized was blocked at the level of 1 July 1982. Measures were taken to encourage and even impose the reduction of the number of beds (Callens, 2003, p.106). This moratorium is still in force today: its effect is that the number of beds reached on 1 July 1982 cannot be exceeded. This means that the addition of any new bed must be compensated for by the closure of a bed somewhere else in the hospital system. Alongside the moratorium, a compensation

scheme was introduced to recompense hospitals for closure or non-use of beds. However, the number of hospital beds decreased less than was foreseen by the Government when it first introduced the above measures (European Observatory on Health Care Systems, 2000, p. 42). Another piece of legislation passed in this area was the royal decree of 1 January 1989, which fixed the minimum bed capacity at 150 beds for general hospitals (European Observatory on Health Care Systems, 2000, p. 42). **(question 2.1 & 2.2)**

Table 2: Instruments of regulation

Before reforms	After reforms
Building licenses	Price regulation
Economic instruments	Licenses for heavy equipment
Moratorium	Licenses for construction and renovation
Minimum bed capacity	Licenses for exploitation
	Moratorium
	Accreditation
	Regulation regarding the financing of hospitals
	Minimum bed capacity
	Economic instruments

Entry into the market for hospital services is nowadays still restricted by government regulation (OECD, 1999, p. 78). A hospital needs several licenses. The granting of some of these licenses depends on the programming established at federal level (Callens, 2003, p. 106). The programming determines the number of hospitals, the number of wards and hospital beds a hospital should have. Rules and formulas have been developed to calculate these numbers based on the needs of the population, which depend on the size of the population, the age structure, the morbidity, and the geographical dispersion. Furthermore, the demands of a good management of health care and the prospects of the future are also taken into account when making these calculations. This programming is of crucial importance if a division or a whole hospital wants to get a license (Van Gompel, 2006, p. 61). Programming usually takes the form of target figures: 2, 9 beds per 100 inhabitants for general inpatient services, 32 beds per 1 000 births for maternity services, and so on (European Observatory on Health Care Systems, 2000, p. 15).

A first license that a hospital needs is a license to build or renovate a part of the hospital. It will only get a license if the project falls under the programming (Callens, 2003, p. 109). Secondly, a hospital will need another license (exploitation license) once it wants to start using the newly build or renovated parts (Callens, 2003, p. 107-109). If the opening of a new hospital or department entails an increase in the number of beds, then it will only get a license if it can prove that the increase of beds is compensated by a reduction of beds in another department of the hospital in question or in another hospital (Callens, 2003, p. 107-109). The proposal (for hospital opening, extension or

alteration) has to respect national programming (European Observatory on Health Care Systems, 2000, p. 15).

Thirdly, hospitals also need the approval of the Minister if they want to use heavy medical equipment (Callens, 2003, p. 109). The programming determines where and how many of certain medical equipment are needed (e.g. PET-scans). Only if it is stipulated by the Programming that certain equipment is needed, can a hospital have it. The aim of this kind of regulation is to prevent overconsumption (Van Gompel, 2006, p. 90).

A hospital does not only have to fit into the programming. It also needs an accreditation for which it has to meet a number of accreditation norms. Accreditation allows a hospital service to operate a certain number of beds for each service category (e.g. acute care, surgery, maternity) and gives a hospital the right to be subsidized and to be reimbursed by the mutual funds. It is considered as a guarantee to the patient of the safety, quality and hygiene of the hospital. (European Observatory on Health Care Systems, 2000, p. 15 & 41).

The norms which have to be met are comprehensive. First of all, hospitals are subjected to norms with regard to its organisation and management. For instance, hospitals are obligated to establish a 'Medical Council' (Van Gompel, 2006, p. 91). Other organizational norms relate to staff requirement and responsibilities, hygiene, ethical requirements and so on. Secondly, hospitals need to meet some architectural criteria concerning the number, size, comfort, and hygiene of hospital rooms. Thirdly, government imposes also functional standards that refer to convenience, accessibility, etc. Additional norms relate to minimum activity, e.g. they stipulate that hospitals should have no fewer than 150 beds, diagnosis/surgical units no fewer than 30 beds, intensive neonatal units no fewer than 15 beds, and they set minimum facility standards and expected staff numbers (European Observatory on Health Care Systems, 2000, p. 15). The length of stay of patients is also monitored and penalized if necessary (Van Gompel, 2006, p. 89). With this regulation, the Belgian government tries to raise the quality of hospital care (Van Gompel, 2006, p. 91).

In theory, accreditation can be granted to run a hospital facility even if accreditation criteria are not met, but in practice, a facility which did not meet the criteria would not be reimbursed (European Observatory on Health Care Systems, 2000, p. 15). If a hospital can no longer guarantee a certain level of quality then it will lose its accreditation. The accreditations are granted by the responsible Minister at the level of the Communities. The Minister is therefore also responsible for supervising the accreditation norms. It is, however, at the federal level that the accreditation norms are determined (Callens, 2003, p. 112-113). Hospitals will only receive financing if they meet all criteria with regard to the programming and accreditation (Van Gompel, 60-61).

Hospitals are not only subjected to quantity and quality regulation. Price regulation is yet another regulatory instrument that is used in this sector. Binding agreements are made with regard to prices and tariffs at two-yearly national conventions (Callens, 2003, p. 41). Negotiations are held between representatives of the sickness funds and the health care providers (including the hospital sector) (Schokkaert, 2003, p. 3). The

result of these negotiations is then laid down in the nomenclature of medical provisions. These agreements stipulate the tariffs for the honorariums and for the cost price of medical provisions. The reimbursement/compensation by the insurance companies for medical care is then calculated based on these tariffs. Once there is an agreement, the care suppliers can choose if they want to become part of these agreements. If they choose to do so, they have to respect the fixed honorarium and cost price tariffs. If there is no agreement, then the government can impose an honorarium tariff for the doctors and dentists (Callens, 2003, p. 41).

Finally, the financing of hospitals is also subjected to regulation. Hospitals rely on different sources for the financing of their investments, personnel and other working costs. First of all, they get a prospective budget based on a standard cost per day. Secondly, hospitals have fee-splitting arrangements with staff physicians (OECD, 1999, p. 78). Finally, hospitals also get subsidies (Callens, 2003, p. 125).

The financing of hospitals has undergone quite some changes over the last two decades. The central thrust of the reforms in hospital financing has been to build a new financial structure based on a hospital's function, needs and performance, rather than one based solely on medical treatments provided and costs incurred (Crainich, 1999, p. 248).

The result has been a continuous evolution from a cost-based to a prospective financing system since the 1980s. Before the 1980s the hospitals received a fixed standard cost per day for each patient instead of the prospective budget of financial means. This, however, created incentives to increase the length of stay because the marginal cost of an additional patient day was lower than the standard cost per day rate. To counter this evolution, there has been a gradual move towards prospective financing (Schokkaert, 2003, p. 8).

However, this system was not perfect either. Therefore the new system has been reformed in 2002. At first, the budget of financial means was determined based on the number of accredited beds and the number of realized nursing days. Currently, different criteria, such as the social profile of patients, normal length of stay and the pathology, are used to determine the budget of financial means. Hospitals cannot exceed this budget. As a result, the budget of financial means is a dynamic system of financing based on activity instead of a static system based on the number of beds. (Kegelaers, 2006, p. 43-44).

The costs of a hospital can be divided into different categories: the non-medical costs (nursing care, the so-called hotel costs (laundry, food, heating, etc.) and infrastructure for hospitalized patients), investment costs and medical costs (Van Gompel, 2006, p. 61; European Observatory on Health Care Systems, 2000, p. 66).

Different income sources are used to finance these different categories of costs. First of all, the most important sources for financing the non-medical costs are the prospective budget of financial means on the one hand and the honoraria that are determined for each provision of medical care. The prospective budget of financial means is determined for each hospital separately by the minister responsible for public health (Callens, 2003, p. 125). The budget of financial means is used to pay the costs of a stay

in a common room and the provision of care to patients in a hospital (Callens, 2003, p. 126). 25% of the financial means are paid by the State. The other 75% are paid by the mutual funds (Callens, 2003, p. 130). Secondly, the medical services are covered by a fee-for-service system paid by the patients or by a third party. Fee revenue finances medical acts (e.g. consultations, surgical operations, diagnostic tests) and technical and paramedical acts (e.g. physiotherapy) (European Observatory on Health Care Systems, 2000, p. 66; (Callens, 2003, p. 132). Finally, hospitals have investment costs. Part of these costs is paid by yet another income source, notably state subsidies¹ (Callens, 2003, p. 138-139). These subsidies come from the Flemish region and the Federal Government (Van Gompel, 2006, p. 93). The part of the investment not covered by the subsidies will be financed by the budget of financial means (Callens, 2003, p. 138-139). The government – in co-operation with regional and local authorities – controls overall hospital capacity through the financing of investment in this sector. The rules applying to the financing of investment are broadly the same for private and public hospitals. In both cases, construction and renovation work has to be agreed by the Regional Ministry of Health, in which case the regional government, through a public subsidy, funds 60 per cent of the investment cost of public and private hospitals, with the remainder being funded by government-guaranteed loans. Over the years, the government has used this control over the hospital sector, among other goals, to try and reduce the number of hospital beds, transforming some of them into less expensive nursing home beds (OECD, 1999, p. 78). **(question 2.2 & 2.3)**

3.2. *Actors*

The federal authorities are responsible for the enacting of hospital law. They deal with the criteria for granting accreditation to hospitals and heavy medical care units (which allows them to be reimbursed by the mutual funds), with the programming and financing of hospitals and the granting of university hospital status (European Observatory on health care systems, 2000, p. 11). The communities are responsible for ensuring the implementation of hospital norms and standards which have been set at federal level, for granting and supervising accreditation and for the authorization of construction and renovation work (European Observatory on health care systems, 2000, p. 13).

Presently, Belgium has one minister for health affairs at the federal level, the Minister of Social Affairs, Public Health and the Environment (Kesenne, 2004, p. 77). The newly

¹ Not all investment projects proposed by hospitals are accepted for public subsidy. Programming and approval rules for capital investment projects have been established by the Ministry for Social Affairs, Public Health and the Environment, based on advice given by the 'National Board of Hospital Establishments'. The application of these rules, however, is the responsibility of the Communities since it is they who determine which investment projects meet the criteria. These programming and approval standards are designed to meet the needs of the population through improved efficiency and quality. Factors that are considered are: the type of specialisation within a hospital, a department's capacity, equipment, geographical distribution, co-ordination in the use of equipment and so on (Crainich, 1999, p. 238-239).

created Minister of Social Affairs, Public Health and the Environment is in charge of the department Public Health, which is responsible for the programming, accreditation criteria and financing of hospitals and other care institutions. Furthermore, the department Public Health also defines the laws concerning hospitals (Van Gompel, 2006, p. 50-51).

In the Flemish region, it is the Department of Welfare, Health Care and Family that is the responsible department. It is not only responsible for prevention and health care education, but also for the implementation of regulation and standards and the supervision thereof. Furthermore, it will hand out the necessary licenses for the construction and renovation of hospitals (Van Gompel, 2006, p. 51). (**question 2.4 & 2.5**)

3.3. Problems

Some of the complaints that have been heard with regard to the regulation of hospitals are the lack of transparency, of clear objectives and even of equality between hospitals. This hinders the sound management of the hospitals (Degadt, 2003, p. 120). The hospital regulations are not always understandable, clear, consistent, or based on objective criteria. As a result, hospital managers do not always know why they did or did not get the budget they applied for (Degadt, 2003, p. 127).

3.4. Conclusion

The way in which the hospital sector has been regulated over the years has not really changed all that much. There has, however, been a tendency to use even more regulatory instruments instead of reducing this number. The challenge to overcome spiralling health care cost will remain an important issue over the next years. New reforms will probably be introduced in the future. Regulation will therefore remain important as a way of guaranteeing a good level of quality, quantity and tariffs.

4. ACTORS/OWNERSHIP IN THE HOSPITAL SECTOR

Hospitals in Belgium are part of the third line care. They are situated at the local level and can be divided in several types. De facto it is possible to establish hospitals at the other levels. However, the local level is by far the most popular level. Private hospitals unite at the local level and public hospitals are situated at the level of the OCMW's, the public municipal welfare centres² (Aouraghe, 2003, p. 24).

² OCMW's have a range of different remits such as financial and educational guidance, financial assistance, affiliation of low-income patients to a mutual fund and so on (European Observatory on Health Care Systems, 2000, p. 40).

Different categories of hospitals can be distinguished. First of all, there are private hospitals, which are run by a private law legal body. These hospitals are usually non-profit organisations. A second category is the category of public hospitals which are exploited by a public law legal body. University hospitals³ are a third category of hospitals. They do not only have a care function, but also a research and education function. Finally, Belgium also counts a number of military hospitals. Unlike the other hospitals, military hospitals do not fall under the Hospital Law. This last category of hospitals falls under the Ministry of Defence (Aouraghe, 2003, p. 24). Some of these hospitals are subjected to specific rules. University hospitals are a good example (Callens, 2003, p. 64).

In terms of treatment a different distinction is made. According to this categorisation, there are only two categories of hospitals: general and psychiatric hospitals. The general category is itself divided into acute care hospitals (80%), geriatric hospitals (4%) and specialist hospitals (16%). Specialist hospitals specialize in cardiopulmonary diseases, locomotive diseases, neurological disorders, palliative care, chronic diseases and psycho-geriatric care. Some general hospitals have psychiatric departments but these can treat psychiatric cases for short stays only (European Observatory on Health Care Systems, 2000, p. 40). However, care is not only provided in hospitals, but also in rest homes, combined rest and nursing homes and psychiatric care houses. User-charges in these institutions are much higher than in hospitals, since patients must bear the total costs of board and lodging themselves (Crainich, 1999, p. 230).

About 60 per cent of all Belgian hospitals are non-profit **private** institutions, and the remainder are **public** institutions. Most of the private hospitals are owned by non-profit organisations which originally had links with religious charitable orders, some 5 per cent are owned by the mutual funds, and a small number by doctors (specialists) (OECD, 1999, p. 78). A public hospital, on the other hand, can be run by an OCMW, a public law association, an inter-municipal association,⁴ a province, a regional community or by the State. OCMW hospitals are the most common type of public law hospitals. OCMW hospitals are, however, not necessarily of public law nature (Callens, 2003, p. 55-56). Most hospitals are non-profit institutions. There are only a very limited number of for-profit hospitals (in 1999 there were two for-profit hospitals) (Crainich, 1999, p. 229).

³ There are seven university hospitals, which have special status due to their teaching and research functions. For instance, the standard cost per day for these hospitals is higher than for others. The university label does not mean that the hospital is owned by a university, but that a certain proportion of beds are registered as university beds. Each university has a certain number of beds, which are distributed among different hospitals. Hospitals are recognized as university institutions when more than 50% of their beds are university beds. University hospitals differ from other hospitals in that they do medical research and are responsible for both basic and specialist training of doctors (European Observatory on Health Care Systems, 2000, p. 40).

⁴ An inter-municipal association is a legal form of association which groups together local authorities, welfare centres and possibly provincial government or private stakeholders (European Observatory on Health Care Systems, 2000, p. 40).

One great advantage that private hospitals have over public hospitals is their flexible management system. Managers of public hospitals must work in a political and administrative context, which often limits their performance. Their options in policy-making and operational management are restricted by bureaucratic procedures and the need for political approval. Managers of private hospitals, on the other hand, can respond to internal and external developments with greater flexibility (Kesenne, 2004, p. 36).

The financing of hospitals comes from different sources and is in principle the same for public and private hospitals. However, the losses of public hospitals are according to the OCMW-legislation, to the account of local governments or the inter-municipal association depending on the level at which the hospitals have been set up (Van Gompel, 2006, p. 61).

Another important difference between public and private hospitals is the fact that public hospitals are usually required to admit all patients. As a consequence, their administrative rules tend to be more restrictive. Patients who depend on the OCMW's use public hospitals to receive health care. As a result public hospitals often have a higher proportion of low-income patients than private ones (Crainich, 1999, p. 230).

In Belgium, the private sector is clearly larger than the public sector. However, it is important not to misinterpret this information. With the exception of one or two hospitals, all private hospitals operate on a not-for-profit basis. More important is the ongoing conversion of public hospitals into private not-for-profit hospitals. Increasingly, public hospitals are being converted into private organisations through the merger with or take-over by private hospitals (Kesenne, 2004, p. 36). A first reason for this conversion of public hospitals to private hospitals is the already mentioned flexible management system that private hospitals have. Secondly, the costs of public hospitals are higher since they a higher amount of patients with limited resources. If a hospital can no longer cover its own losses, then these will come to account of the municipalities. Therefore, the OCMW tried to solve this problem by giving their hospitals a new statute as autonomized private law agencies with non-profit status. Because these hospitals could work more flexible, they were able to solve part of the problems they had with their costs. However, some of the problems remained and therefore cooperation with private hospitals was in most cases the next step.

As a result, the number of public hospitals in Belgium has decreased considerably. In 1999, there were still 71 public hospitals. This number diminished to 54 in 2003 (Nationaal Instituut voor de Statistiek, 2002, p. 12-13; Nationaal Instituut voor de Statistiek, 2005, p. 12-13). Over a period of only 4 years, the number of public hospitals dropped with 17. In other words, the hospitals sector has witnessed a clear trend towards privatisation.

Table 3: Actors

Before reforms	After reforms
Public hospitals Private hospitals (majority)	Ongoing conversion to private hospitals through: ⇒ merger ⇒ take-over Reason: ⇒ flexible management system ⇒ financial deficits ⇒ co-funding

5. *ROLE OF GOVERNMENT AND OTHER STAKEHOLDERS*

5.1. *Role of Government*

The role of government as a policymaker is situated at the federal level. It is the Minister of Social Affairs, Public Health and the Environment together with the department of Public Health who elaborate the policy towards hospitals. It is also at this level that broad policy goals are translated into concrete objectives, such as the program for hospitals and the accreditation standards.

The responsibility for guarding the public interest is situated at the regional level. In the Flemish region it is the Department of Welfare, Health Care and Family falling under the Minister of Welfare, Health Care and Family that is responsible for this role of government. It is this department that grants the licences and accreditations and that supervises the quality standards and accreditation criteria.

The role of government as supervisor of the market is also situated at the regional level. This level is in the first place responsible for supervising the implementation of the different standards and criteria and not for supervising the competition between the hospitals as such. However, by assuring that all hospitals respect the norms, the Department of Welfare, Health Care and Family at the same time guarantees that there will not be any unfair competition between the different institutions. It is not possible for hospitals to lower price and quality below acceptable norms just to be in a better position to compete with other hospitals.

Finally, government can also in this sector act as an owner, since public hospitals can be owned by an OCMW, an inter-municipal association, a province, a regional community or by the State. However, most public hospitals are owned by the OCMW's. Only a very limited number of hospitals is in hands of the provinces and municipalities. Moreover, the provinces will have to hive off their hospitals within a couple of years. This means that the possibility of tensions and conflicts between the role of government

as a policymaker, government as a supervisor and government as an owner is very limited, since all these different roles are situated at different governmental levels. Moreover, the OCMW's who own the majority of public hospitals have no regulatory function. The conflicts that did occur at the level of the government were between the federal government and the regional governments. The cause has been the lack of a clear delineation of responsibilities between the two levels.

5.2. *Other stakeholders*

The bed concentration policy, even though it was supported by the government, has not always been that easy to translate into reality. Several attempts to merge hospitals have failed. One important factor that helps to explain these failures is the different corporate culture that exists in the different hospitals (SL, 2005). However, in other cases no significant problems were experienced. In other words, the hospitals did not take a uniform position in this whole reform position.

There are, however, a number of umbrella organisations that represent hospitals. A good example is 'Verbond der Verzorginstellingen' that is associated to Caritas, an association of Christian signature. Approximately 60 hospitals are member of the 'Verbond der Verzorginstellingen'. All its members are Dutch-speaking private non-profit hospitals of Christian signature (www.vvi.be).

The labour unions also play an important role in this sector. If hospitals would merge, then the labour unions would always be closely involved so that they could represent the employees in this whole operation. Once the merger was completed, labour unions continued to closely monitor the new situation (SPI, 2001; G.TEG., 2002; VKK, 2003).

Patients have also organised themselves in order to have a say in the health policy. One example of such patient organisations is the 'Vlaams patiëntenplatform', an umbrella organisation of 82 patient organisations (Aouraghe, 2006, p. 38). No evidence could be found, however, of their involvement in the reform of the hospital sector. In addition, the consumer organisation 'Test-Aankoop' also closely monitors the health care sector and hospitals (<http://www.test-aankoop.be>).

5.3. *Conflicts*

The trend toward the merger of public and private hospitals has caused some social conflicts, since some mergers were accompanied by restructuring of the hospitals and the dismissal of personnel (SPI, 2006). However, the merger or cooperation between hospitals also sometimes meant the end of conflicts between these hospitals. Some of these conflicts have been going on for a long time and were caused by competition for the best doctors or for medical equipment. Cooperation or merging often entailed the end of these conflicts since solutions had to be found for these problems (Tegenbos, 2003).

Next to the conflicts related specifically to the changes in the hospital sector, there have also been quite some social conflicts that were not limited to the hospitals but instead affected the whole health care sector. These conflicts resulted in several strikes. The objective of these strikes was to receive higher wages and more money for new personnel for the sector (BAVA, 2005).

CONCLUSIONS

The hospital sector did not undergo a liberalisation process like some other sectors did. On the contrary, the Belgian government actually introduced some measures that stimulated the concentration of hospitals. By doing so, competition was actually reduced in this sector. It remains to be seen if this evolution will have negative consequences for the productivity and quality of the hospitals.

The regulation of this sector, on the other hand, did undergo quite some changes. New regulatory instruments were adopted in the first place to contain costs. The result was an increase of the amount of regulatory instruments over the years. The containment of costs in the health sector remains an important issue in this sector, so it is unlikely that the number of regulatory instruments will decrease in the near future.

REFERENCES

- Aouraghe, E. H., Braeken, A., Bulens, E., Janssens, V., Vanherk, G., Van Aerschot, G., Van Gompel, L. & Willems, J. (2006). *Gezondheidszorg*. Leuven, unpublished paper, 83 p.
- BAVA (2005). 'Vlaamse Witte woede betoogt in Brussel'. In: *De Standaard*.
- BIGE (2001). *Compendium gezondheidsstatistiek 2001*. Zaventem, BIGE, 141 p.
- Callens, S. & Peers, J. (2003). *Organisatie van de gezondheidszorg*. Antwerpen, intersentia, 467 p.
- Crainich, D. & Closon, M.-C. (1999). 'Cost containment and health care reform in Belgium'. In: Mossialos, E. & Le Grand, J. (1999). *Health care and cost containment in the European Union*. Aldershot, Ashgate, pp. 219-266.
- Degadt, P. & Van Herck, G. (2003). 'Financiering van ziekenhuizen en het arenamodel'. In: *Tijdschrift voor economie en management*, 48(1), pp. 119-132.
- European Observatory on Health Care Systems (2000). *Health care systems in transition. Belgium*. Copenhagen, European Observatory on Health Care Systems, 85 p.
- G.TEG. (2002). 'Kommer en kwel in ziekenhuizen door herstructureren'. In: *De Standaard*.
- Kegelaers, E., Maes, P., Vander Aerschot, A., Vansintjan, P. & Vermeulen, B. (2006). *Het beleidsveld van de gezondheidszorg. Een verkennende analyse naar de actoren en hun onderlinge relaties binnen de gezondheidszorg in België*. Leuven, unpublished paper, 118 p.
- Kesenne, J., Alosse, H. & Leonard, Christian (2004). 'Implicit privatisation in Belgian health care'. In: Maarse, H. *Privatisation in European health care. A comparative analysis in eight countries*. Maarssen, Elsevier gezondheidszorg, pp. 33-48.
- Nationaal Instituut voor de Statistiek (2002). *Statistieken van volksgezondheid 2000*. Brussel, Nationaal Instituut voor de Statistiek, 70 p.
- Nationaal Instituut voor de Statistiek (2005). *Statistieken van volksgezondheid 2003*. Brussel, Nationaal Instituut voor de Statistiek, 80 p.
- OECD (1999). 'The health care system'. In: OECD. *Economic Surveys: Belgium/Luxembourg*. Paris, OECD, pp. 73-96.
- Schokkaert, E. & Van de Voorde, C. (2003) Health care reform in Belgium. 22 p.
- Schoonjans, M. & Chanterie, M. (1999). *Nieuwe accenten in het OCMW beleid vanaf 1 januari 1999*. 3 p. (www.binnenland.vlaanderen.be).
- Sénat de Belgique (2002). *Annales*. Bruxelles, Sénat de Belgique. (www.senate.be).
- SL (2005). 'Fusie ziekenhuizen feit tegen 2007'. In: *De Standaard*.
- SPI (2001). 'Vakbondspriest tegen ontslagen in ziekenhuis Tienen'. In: *De Standaard*.
- Tegenbos, Guy (2003). 'Elzenveldpact beëindigt concurrentieslag onder Antwerpse ziekenhuizen. Universitaire, openbare en vrije ziekenhuisgroepen sluiten vrede'. In: *De Standaard*.
- van Doorslaer, E. & Schut, Frederik T. (2000). 'Belgium and the Netherlands revisited'. In: *Journal of Health Politics, Policy and Law*, 25(5), pp. 875-887.
- VKK (2003). 'Personeel AZ Groeninge heel kritisch over fusie'. In: *De Standaard*.

Websites

<http://www.test-aankoop.be/>

<http://www.vvi.be>