STRATEGIC REPORT ON SOCIAL PROTECTION AND INCLUSION 2006-2008

Belgium

STRATEGIC REPORT ON SOCIAL PROTECTION AND INCLUSION 2006-2008

Belgium

CONTENT

Foreword

As underlined in the conclusions of the European councils of March 2005 and March 2006, the revamped **Lisbon Strategy** with a stronger focus on economic growth and employment offers a framework in which the economic, employment and social policies reinforce each other.

In the social field, the **Open Method of Coordination** (fixing of common objectives, follow-up and evaluation of their implementation and mutual learning) covers three fields: social inclusion, pensions and health care and long-term care. Since this year, these three fields are joined in a rationalised and integrated social process.

It is in this context that the Council asked the 25 Member States, in September 2006, to present **«national reports on social protection and social inclusion for the period 2006-2008»**. On the basis of these national strategic reports, the European Commission will present a draft joint report on social protection and social inclusion in view of the Council of March 2007.

The Belgian strategic report presented in this brochure comprises four chapters: a general introduction, a chapter on social inclusion, a chapter on pensions and a chapter on health care and long-term care.

Chapter I, the **general introduction**, comprises two sections. The first section gives a state of affairs of the social situation in Belgium. It gives information (illustrated with statistics) on welfare, social protection, poverty, health, employment, activation, training, the social security and social assistance benefits, housing and the financial viability of the social protection systems. This information situates Belgium at European level and sometimes, details per category are given (employed/unemployed persons, young/elderly persons, men/women, etc.). All these data make it possible to list the Belgian strengths and weaknesses in the social field and thus to identify the main challenges that may orientate the Belgian policies for the period 2006-2008. The second section summarises the Belgian general strategic approach in the social field. It mentions the will to maintain a strong, viable, just and solidarity-based social security, namely via job creation. It puts the solidarity contract between generations forward as a very important tool.

Chapter II on the **«National Action Plan for Inclusion»** was drawn up on the basis of three key challenges: guarantee correct and affordable housing for everyone; develop activation and diversity more in the field of employment and social integration; fight against child poverty. For each challenge, the report gives quantified objectives, the main political measures (general outlines) aimed at reaching these objectives, indicators and the follow-up methods (i.e. monitoring tools) and the means allocated to the realisation of these objectives.

Chapter III on **pensions** is mainly an update of the «Belgian national strategic report on pensions 2005». The three sections of this chapter respectively deal with the three common European objectives, namely: sufficient pensions; the financial viability of the pension schemes (namely in order to face the budgetary consequences of the ageing of the population) and the modernising of the pension schemes. Special attention is paid to the measures taken in the framework of the solidarity contract between generations in order to reach these objectives.

Chapter IV concerns **health care and long-term care**. The first section gives an overview of the main challenges the country is confronted with regarding health care and long-term care. The second section deals with health care, while the third section deals with long-term care. For these two main sections, after a brief description of the present systems, the report focuses on the three common objectives defined at European level: ensuring access to health care (an long-term care), promoting the quality of care and ensuring the financial viability of the health care and long-term care systems.

Chapter I:
General Introduction

SECTION 1.1. INVENTORY OF THE SOCIAL SITUATION

1.1.1. Welfare, social protection and poverty

Belgium has a high general level of welfare and a highly developed system of social protection. Mean available income of Belgian households in 2003 was among the highest in the EU-25 zone (7th place). That same year, 29.7% of GDP was devoted to social protection (5th place in EU-25). Social benefits (without pensions) reduce the risk of poverty by 46%, a result higher than the average for EU-25, although certain Member States show a better score.

In this context, Belgium has a relative risk of poverty (15%) that is close to the average for EU-25 (16%). In Belgium, as concerns the risk of poverty, and also as compared to other Member States, there is a very large difference between those who work (4%), on one hand, and the unemployed (28%) and other inactive persons (27%), on the other. The elderly (65+) clearly have a higher risk of poverty. As compared to the younger age category (0-64 years old), the elderly have a risk of poverty 1.5 times higher (21% versus 14%). On the whole, there is no difference between the risk of poverty for elderly men and elderly women. Conversely, clear differences can be seen between isolated elderly women (24%) and isolated elderly men (19%). This difference is greater still for persons over 75. These differences are probably explained by different career profiles, as women's careers are characterized by career breaks at lower pay schedules, among other reasons due to more frequent part-time work (see below). Unskilled persons have a risk of poverty three times higher than highly qualified persons (23% versus 7%). The percentage of risk of poverty of children (0-15 years) and young adults (16-24 years), respectively 17% and 16%, is close to the average for the total population. Single parents and people living in a household with no paid employment and with dependent children, and persons of non-EU-25 nationality, run the highest risk of poverty.

1.1.2. Health and long-term care

Certain important indicators testify to continual improvement in the overall health of the population. Both life expectancy and life expectancy in good health continue to rise. The latter is increasing faster than overall life expectancy. In these two fields, Belgium has a good score at European level, also as concerns trends. Infant mortality has decreased sharply in the last 10 years and continues to fall (12.1/1000 in 1980, 4.3/1000 in 2004).

The rate of health care cover is essentially total as concerns major medical interventions (99%) and is now improving for minor medical interventions (current cover 94%), particularly by means of mandatory insurance for self-employed workers. As compared to 12 other EU Member States for which EU-SILC data were collected in 2004, the percentage of people (16+) who declared that they postponed or gave up a medical examination or treatment for financial reasons is limited in Belgium: 1.8%. When dental examinations are also taken into account, this figure increases to 4%. With this score, Belgium is among the best of the Member States. However, other sources, for which other types of questions were used, give higher figures. The development of indicators for this aspect and for others in the field of health care and long-term care constitutes a special challenge. Most health indicators show large gaps between well-to-do categories of the population and the less wealthy. In this context, affordability of preventive and curative health care, among others, is an important concern.

In the field of long-term care, viability is considered a major challenge from the social and personal standpoint, given the perspective of the aging of the population.

1.1.3. Work, activation and training

In 2005, the rate of employment of 61.1% is below the average for EU-25. Differences as compared to the European average pertain to young people (15-24) and the elder working age category (55-64 years old) exclusively. In fact, these categories are given priority attention in employment policy. Long-term unemployment exceeds the European average, particularly for adults living in a household with no remunerated employment. «Non-EU-25» nationals, unskilled persons and disabled persons have a considerably lower rate of employment than the overall active population. Among employees, part-time work is rising. In 1995, 15.4% of workers on salary were working part-time. In 2005, this percentage rose to 24.1%: 43.5% of women and 8.1% of men. This rate of activity is characterized by large regional differences, moreover. From the standpoint of social inclusion, a major challenge consists of stimulating employment for a series of target groups, without increasing the percentage of working poor, which is relatively low in Belgium.

Education and training are crucial factors in determining opportunities in the employment market and optimal fulfilment of personal capacities. From this standpoint, it must be observed that as concerns the percentage of young people who leave school early, there is no tendency towards a reduction that could meet the objective of 10% by 2010. In 2005, young people who stopped studying prematurely represented

13% in Belgium, as compared to an average of 15% for EU-25. Participation in continuing education has clearly increased since the beginning of the 90s. With a percentage of 10%, Belgium is still below the EU-25 average however (10.8%). Like in other countries, participation is higher for persons who already have a good basic education than for those whose basic education is weaker.

1.1.4. Social Security benefits and social assistance

Social benefits are a necessary complement of a labour market activation policy and a strategic factor for the policy in the fight against poverty and for the promotion of social cohesion. After observing the lag between (minimum) benefits and the development of general welfare in the 1980s and 1990s, maintenance of a standard of living by means of pensions and other social benefits has been recognized as a governmental priority in recent years. As from 2008, the solidarity pact between generations provides that the government will take a decision every two years on the financial resources it allocates to adjusting all or certain income-replacement benefits to the evolution of general welfare.

As concerns the income of the elderly, various indicators show that the incomes of persons over 65, which consist of pensions for 85%, are not high on the average in Belgium, nor from the international standpoint. For example, they refer to a median rate of net income; the ratio of the median income equivalent of the population age 65 and over, to the median income equivalent of the population of the complementary younger category, from 0 to 64, is 76% in Belgium. The average for EU-25 is 87%. Greater attention given to adjustment of welfare, to atypical careers mainly of women, and to pensions of self-employed workers, represents an effort in recent years to improve the level of current and future pensions. The government has recently decided (1/12/2006) to increase the base for protection of the elderly (GRAPA) to the level of the threshold of the risk of poverty.

The policy for social benefits for persons who do not have access to the labour market targets guaranteeing an adequate minimum on one hand, given budgetary possibilities and, on the other, eliminating the financial traps of unemployment and inactivity. A series of recent measures have helped eliminate these unemployment traps to a large extent. Nevertheless, it must be observed that the level of certain minimum benefits is still below the threshold of the risk of poverty. These are mainly unemployment, invalidity and assistance benefits for couples (with and without children) and unemployment and assistance benefits for isolated persons (with and without children).

1.1.5. Housing

The income situation of a fair number of tenants is very precarious. The percentage of the risk of poverty is twice as high as for homeowners; 27% versus 11%. Although there is no good indicator for affordable housing, because of previous surveys, there is reason to believe in the existence of a major financial problem for access to housing on the private rental market for low income households. Since 1995, the number of

units of social housing as a percentage of the total number of households has remained constant at about 6%, in all three Regions. For disadvantaged social categories, the quality of housing seems less good in many cases. Improving the housing situation to obtain affordable, quality housing in the private rental market for disadvantaged social categories constitutes an important challenge.

1.1.6. Demography – information

The current measures and challenges must be seen in relation to demographic trends. According to forecasts, the ratio of the population 65 and over to the active population (15-65 years old) will rise from 26% in 2004 to 46% in 2050. The budgetary cost of aging, defined as the increase in all social expenditures of the authorities, will represent 5.8% of GDP according to the most recent forecasts. Maintaining a high level of general welfare and ensuring an adequate standard of living and health care for all citizens presupposes preparing for this evolution in all fields concern.

SECTION 1.2. GENERAL STRATEGIC APPROACH

1.2.1. Strong, viable, fair Social Security for solidarity

The government is convinced that strong, viable, fair Social Security for solidarity is a development tool for a dynamic economy and constitutes an indispensable instrument for creating jobs, improving the rate of activity and welfare. Its objective is to reinforce that rate.

Job creation is the best guarantee, par excellence, to ensure the future of Social Security.

In this spirit, the government is promoting ambitious actions to support and boost the economy while, at the same time, preventing the creation of a gap between the level of social protection and the evolution of national wealth.

The progress report on the national reform programme for 2005-2008 (PNR) describes the implementation of the strategy.

To a large extent it reflects the measures taken and announces the execution of the solidarity contract between generations which is an integral part of the governmental declaration for 2006.

The social partners will negotiate an inter-professional agreement in the next few weeks which could make it possible to continue the programme as defined.

The question of financing social protection is not considered in the work covered by the open coordination method for social questions, but it is nevertheless central and it would be illogical not to mention this in a report on the social strategy.

The government's *first priority* in the field of social protection is to ensure the financial balance of Social Security in a structural way; without increasing the cost of labour, while maintaining a high level of social protection.

Fiscal and related pressure on labour is very high and could influence our competitive position in the world. Belgium would like to see this problematic treated in the framework of economic and social convergence in the European scale.

To favour job creation, complementary measures have been introduced reducing contributions for young people and elderly workers and promoting the development of research. New reductions of the contributions are under consideration. These measures are described in the section on employment of the Belgian National Reform Programme (PNR) progress report.

The reduction in Social Security receipts resulting from these decreased contributions has been compensated by alternative financing. This alternative financing is increasingly diversified – first it was derived exclusively from a percentage of VAT receipts, but today it also comes from excise taxes and a percentage of property tax among others.

The new social protection measures to promote employment (employment bonus, service vouchers, outplacement…) are financed by allocations drawn from alternative financing.

In order to control receipts, the government has decided to reinforce the fight against undeclared labour and social fraud. It feels that a concerted action at European level or by means of cooperation between certain Member States would be appropriate to ensure an effective fight against fraud.

Control of expenditures, particularly for health care is part of the problematic of healthy financing. The government is determined to ensure adequate financing of health care, while implementing mechanisms to control costs and improve responsible attitudes of those involved (health-care providers, hospitals, insurance organizations…). This policy is showing results, as described in Chapter 4 of the report.

The government's *second priority* in the field of social protection is linking welfare and social allowances to cost-of-living. This mechanism guarantees maintenance of a decent level of social protection.

Chapter 3 of the report describes this strategy for pensions and the structural mechanism of the link to wealth developed by the social partners.

This strategy is also applicable to social benefits not considered in this report.

In addition to these priorities, Belgian strategy in the social field is also based on:

– rigorous management of public finance and decreasing public debt (which has reached the lowest level in a quarter of a century), which frees resources to cope with the budgetary cost of aging;
– a policy targeting reform of the labor market (shifting from job security to security of an activity or career);
– fighting poverty and social exclusion using a multidimensional approach;
– raising the level of minimum income to make work more attractive.

1.2.2. The Lisbon strategy and mutual strengthening of employment, social and economics policies

Close relations exist between the national reform programme and the strategic social report.

As concerns *employment*, we refer to the second key challenge identified in Chapter 2 on social inclusion: *activation and diversity* whose priority objective is to *increase the rate of activity of groups at risk* (women, the under-educated, population of foreign nationality or origin, disabled persons). By concentrating on continuing education of the least educated and the fight against school dropouts and by focusing particularly on the path to employment of the target groups.

Chapter 3 on retirement gives a broader description of the question of *active aging* and the measures taken in the context of the solidarity contract between generations.

Finally, the importance of health care and long-term care tends to show that the service sector can be a source of jobs.

As concerns the *macro economic* part of the National Reform Programme (PNR), a link can be made with the – public finance and cost control issues considered in Chapter 3 – pensions, that recalls the Belgian strategy related to the aging fund, and considers the question of the balance between quality-accessibility/cost in the section on health.

The social report also deals with the question of **income** and social benefits, a central issue in the fight against poverty.

The first key challenge identified in the section on inclusion: *correct, affordable housing for everyone* – completes the description of the income problematic. The Belgian authorities thus respond to the observations consistently made for Belgium in the related reports on social inclusion (2004, 2005) and on «Social inclusion in Europe 2006».

The Belgian sustainable development plan also retains the question of housing as one of its priority actions.

Finally, the chapter on inclusion stresses *child poverty*. To meet this challenge, a mainstreaming approach is indispensable covering education, income, employment, health, transport… The responsibility of the authorities in offering equal opportunities for all (and therefore correcting inequalities) is found in this strongly emphasized challenge.

1.2.3. Health: a new challenge

The **health** part is new in the European process – in subsequent versions of social strategy reports, there will be better articulation between the various sections. This section describes the Belgian strategy that targets offering quality health care to all, at affordable cost, while mastering the overall increase in costs in the system.

To break the vicious circle affecting persons suffering from mental illness whereby illness leads to exclusion and exclusion to illness, concerted actions and in-depth thinking are required. This must also include the question of the social status of the persons concerned.

1.2.4. Improving governance

• The process of drafting strategic reports

With regard to political coordination, because of its constitutional structure, Belgium has developed a practice of mutual consultation among all levels of the competent legislative authorities: the Federal Government, the Regions and the Communities. The

National Reform Programme (PNR), drafted in the context of the Lisbon strategy, has been the subject of coordination between these authorities. New structures have been put in place for the drafting of strategic report to ensure coordination even at the drafting stage.

This report, which for the first time integrates the three elements of the OCM, has also given rise to the creation of an ad hoc drafting and mutual consultation structure, that draws on the networks put in place for the previous reports.

The competent administrations for their part, were at times partners, at times they did the drafting and they were even the bodies behind certain choices made in the report (such as the NAPincl for example).

The report was submitted to the social partners for opinion.

Ad hoc preparatory and monitoring processes and structures already existed for the NAP-incl. A number of different players, including associations of people experiencing poverty and social exclusion situations were involved in these structures that have been further reinforced to improve participation and transparency of the processes. So the «action group» was considerably enlarged and, it is important to stress that this was the group that made the proposal for strategic objectives. This «bottom-up» process was also reinforced by taking more account of the many recommendations included in the report on «abolishing poverty» published in December 2005 by the department for the fight against poverty, precariousness and social exclusion, issued by the concertation groups that met for two years as part of the «dialogue method».

• Inclusion: pilot experiment: mediators in the field

The federal government launched an experiment in 2004 to reduce the gap between the poor and society, and to better sensitize society to the problematic of social exclusion. People who had an actual experience of poverty and social exclusion were given specific training so that they could use their experience of poverty in a professional way within the government services. Currently, 18 mediators in the field are working on poverty and social exclusion in 10 different public services.

• Health

The existing structures for concertation between the Communities and Regions and the Federal Government were put to use to coordinate the drafting of the report. This coordination is an example of good governance and was particularly effective as concerns long-term care.

Like what was done for inclusion, activating an indicator group and an action group is under consideration to monitor the evolution of the health aspect of the report.

With regard to monitoring actions and objectives, an annual, cross-sector assessment will be planned in concertation with the officials responsible for the National Reform Programme, for the sustainable development plan and the social partners.

Part I will be monitored by means of a set of overall indicators of the social OCM (Open Coordination Method). This monitoring will be done by the Belgian delegation to the Indicator subgroup in concertation with the officials in charge of the employment strategy.

Part II is monitored by the groups referred to above in concertation with the department for the fight against poverty.

Part III is mainly monitored by the committee for the study of aging mentioned above. Pension indicators will also be monitored by the Belgian delegation to ISG in concertation with the officials for pension policy.

Part IV is monitored in various groups:

The health survey using interviews is the first source of data in Belgium. The survey for 2004 focuses more particularly on the situation of the elderly.

The centre of expertise (KCE) more fully described in the report has an important assessment role.

Concertation must still be done to ensure coherence of actions undertaken with the aid of the European Structural Fund related to the implementation of the Lisbon strategy for social strands.

Chapter 2 : The National Action Plan for Inclusion

SECTION 2.1.: KEY CHALLENGES, PRIORITY OBJECTIVES AND TARGETED RESULTS

2.1.1. Correct, affordable housing for everyone

Guaranteeing acceptable housing at an affordable price is still one of the major political challenges in Belgium. The Belgian housing market is characterized by a high number of homeowners and a limited rental market, which does not offer a sufficient number of social housing units to meet needs. Since 1995, the ratio of the number of social housing units to the total number of households has remained constant at about 6%. Long waiting lists exist in all three Regions. This is one of the indicators of the need for housing, but not the only one. The private rental market is characterized by a deficit in the lower segment, with housing that is often too expensive and of mediocre quality. Some constitute real exploitation whose main victims are persons residing illegally in Belgium.

Research has shown a sharp increase in the cost of housing in the 90s. Consequently, a large group of tenants suffer both from a weak position in the income scale and relatively high housing costs. The NAP Inclusion indicator on the cost of housing indicates that, in 2003, 33% of tenants with incomes below the median devote more than one third of their family budget to housing. Past research also shows that problems of financial affordability of housing pertain essentially to persons renting housing in the private rental sector.

It seems that the quality of housing is often lower for persons who do not come from EU-25, and for households with low labour intensity that have children. These categories more frequently live in housing that has at least two structural problems or where there is insufficient room. Persons in vulnerable social categories (single parents, unemployed, ill/incapacitated) more frequently live in housing that has two or more shortages as is the case for occupants of a rented housing unit. Households in Brussels, considerably more than households in the other Regions, are confronted with a lack of space (17% as compared to about 4% for the other Regions). More households in Wallonia and Brussels (23%) live in housing with a structural shortage than those in Flanders (14%).

To ensure correct, affordable housing for everyone, it is imperative for the Regions to develop a global and coherent housing policy, in harmonization with the federal level, integrating various possibilities.

TARGET 1: Increasing the percentage of social housing in the rental sector as compared to the total number of private households.

	2003	2004	2008	2010
Belgium	6,2%	6,3%	7%	8%

2.1.2. Activation and diversity: More workers in the groups at risk

Starting with the observation that work is a decisive barricade against poverty and social exclusion, activation of jobs was already pinpointed as a major priority in the NAP Inclusion 2001-2003. Activation measures to promote professional integration of groups at risk by means of financial stimuli, by eliminating unemployment traps and the development of the social and economy are a constant factor of the NAP Inclusion that have been implemented in the past.

The National Reform Programme stresses a broad labour market policy targeting a valid job for everyone, young or old, and emphasizing an increase in the rate of employment and the creation of new jobs.

In 2005, with 61.1%, the rate of employment in Belgium was lower than the average of the EU-25 (63.8%). A large portion of this gap is due to limited participation of elderly workers. Nevertheless, in the context of this chapter, objectives centred on certain groups at risk, aspects related to older workers will be considered in Chapter 3. Indicators confirm the importance of under-participation of certain specific groups in work. The rates of employment of persons who do not have the nationality of one of the Member States of EU-25, under-educated persons and persons with a disability are still well below that of the total active population. Persons living alone, persons with a poor education, and particularly single parents and persons of nationalities outside EU-25 run a much higher risk of long-term unemployment. In 2005, the proportion of persons in Belgium living in a household without any remunerated employment was one of the highest in EU-25 (13.5% versus 10% for EU-25). It is observed that a significant increase in the rate of employment of women (from 44.6% in 1992 to 53.8% in 2005) was not accompanied by a reduction in the percentage of households without remunerated work. It therefore seems that this increase particularly affected households where remunerated work was already present. Certain groups clearly need specific measures for accompaniment to employment. Given the high percentage of risk of poverty for persons living in a household without work, attentiveness to protection of income remains crucial.

Based on these observations, and as a complement of the general labour policy, the theme «activation and diversity» will be put forward in this NAP Inclusion as a basic political challenge. To increase the rate of employment of groups at risk, specific, differentiated measures must be taken for persons concerned in order to put them on the path to employment, and efforts must be developed to make the labour market more accessible to them.

TARGET 1: Increasing the rate of employment of a specific target group, that being persons with nationalities outside EU-25, persons with poor education, and persons with a disability.

	2005	2008	2010
Total active population	61,1%	66%	70%
Women	53,8%	55%	60%
Under-educated	32,6%	40%	50%
Persons with a disability	35,6%	40%	50%

TARGET 2: Reducing the rate of unemployment of persons of foreign nationality or origin to the level of that of Belgian workers.

	2005		Ratio EU/No EU		
	No EU	EU	Indice 2005	Target 2008	Target 2010
Belgium	32,2%	7,9%	24,53	70	100
Brussels	34,6%	14,0%	40,46	76	100
Flanders	25,6%	5,2%	20,31	68	100
Wallonia	39,4%	11,6%	29,44	72	100

TARGET 3: Increasing participation in lifelong learning, particularly for persons with a low level of basic training. The idea here is the percentage of the population between 25 and 64 who took part in training or education for at least four weeks prior to the survey on the Labour Force.

	2003	2004	2008	2010
Belgium	8,5%	9,5%	11,5%	12,5%
Under educated	2,6%	3,2%	4,5%	6,25%

TARGET 4 : Reducing school dropouts, or more specifically, the percentage of young people between 18 and 24 who do not have a higher secondary school degree and are no longer attending any education or training programme.

	2005	2008	2010
Belgium	13%	11%	10%

2.1.3. Child Poverty: Breaking the vicious circle of poverty

Observing poverty and social exclusion from the standpoint of children is quite new in Belgium. In the General Report on Poverty (1994), the importance of the family and measures to protect the family life of persons living in poverty was put forward as an essential aspect of the fight against poverty. Focusing on the components of the family, and more particularly on children, and observing things from their standpoint, identifies new paths to terminate the vicious circle of poverty, whereby poverty goes from one generation to the next.

The rate of child poverty in Belgium is lower than the average for EU-25 (17% versus 19%). But, like for the majority of the Member States, the risk of poverty of children (less than 16 years old) is slightly higher than the percentage for the risk of poverty of the total population. Children of single parents, and particularly, children living in jobless households, are confronted with an even higher risk of poverty, respectively 36% and 70%. For these categories, the figures are higher than the European average. The difficult situation of these families can also be seen in other fields, such as the (im)possibility of leaving on holiday. With nearly 13%, the percentage of children living in a household without remunerated work is among the highest in Europe.

Despite the role played by education, the tendency to reproduce poverty from one generation to the next persists. The PISA survey – which shows that children whose parents have a high social-professional status (upper quartile) obtain sharply higher scores in aptitude tests for reading than children whose parents have a low social-professional status (lower quartile) – is a good illustration of this phenomenon.

Children live in defective housing slightly more frequently than the total population, and significantly more frequently they live in housing with too little room. As concerns basic comfort (bath or shower, running hot water, indoor toilet), on the average children are also less comfortable than the total population.

The crucial factor to break the inter-generation cycle of poverty is the reinforcement of possibilities for persons living in poverty to construct an independent, quality family life in which children get support for their development and benefit from a maximum chance to shape their futures without the disadvantage of the accumulation of problems and difficulties associated with poverty. To put it briefly, this means an income corresponding to dignity, a quality job, quality housing, good educational opportunities, and the possibility of leisure.

TARGET 1: Reducing the percentage of children under 16 at risk of poverty, in other words living in a household whose total income is lower than 60% of the national median income equivalent.

	2003	2008	2010
Belgium	17%	15%	12%

TARGET 2: Reducing the proportion of children (0-17 years) living in households with no remunerated employment.

	2004	2005	2008	2010
Belgium	13,2%	12,9%	10%	7%

SECTION 2.2.: GUARANTEEING AFFORDABLE QUALITY HOUSING FOR EVERYONE BY INTERVENING IN THE RENTAL MARKET

2.2.1. Policy measures

Guideline 1: Acting on supply, both quantitatively and qualitatively

Access to housing and the quality of housing are priorities for the policies implemented. For example, Flanders is updating the regime of rental aid by focusing on quality control and compliance with minimum quality standards, and is studying the possibility of creating a fund for guarantees, stimulating the service of social real estate agencies, and continuing to develop tenants' unions. The supply of modest housing is being enlarged, moreover, and the combination of social and private housing is encouraged. Along the same lines, the Walloon Region will be giving concrete form to the housing strand of its «HP» plan. «HP», will mobilize private real estate and improve the quality of modest rentals, including by partnerships with private sector and promoting the creation of «community» housing. For its part, the Brussels-Capital Region has scheduled the construction of 5000 new housing units, stimulating transformation of abandoned offices into housing and encouraging occupancy of empty units above shops, and will be reducing property tax in neighbourhoods targeted for positive discrimination.

Guideline 2: Reducing the threshold of access to housing by acting both on costs and on income

At federal level, indicative rental grids will be determined in the context of joint landlord/tenant committees. The creation of a fund to pay guarantees is under consideration. In Flanders, the procedures for the rental aid scheme will be simplified. In addition,

a study will be done on the possibility of using available income, after taking account of debts, for the registration and allocation of housing. Rental aid will also be reformed in Brussels, where access will be facilitated. Among other things, an experiment is going forward for specific target groups, and a regional tax on abandoned buildings will be set up, a Housing Information Centre will be created, and administrative simplification will be applied.

Guideline 3: Access to energy and water

Various social measures in the energy field came into force in Flanders as soon as the energy market was liberalized in July 2003. After an in-depth evaluation, the principle of a proposal for a decree and a proposal for a regional order were approved on 20 July 2006 by the Flemish government. These notably provide for an increase in net minimum supply of electricity and an increasingly strict regulation on cutting off the supply of electricity. In the meantime, a pilot project marketing the implementation of social energy assessments was done in East Flanders. In the Walloon region, the development of a social fund for water is a major step toward setting up a real right to energy. In addition, the Walloon Region will provide better access to gas and electricity for all and better protection of the poorest. In all Brussels social housing units, individual meters will gradually be installed within budgetary limits and, in the case of renovation, an effort will be made to promote energy-savings and the use of renewable energy.

Guideline 4: Reinforcing the position of tenants and stimulating participation

The federal policy for large towns is financing pilot projects in Charleroi, Ghent and Brussels in fields covered by the joint landlord/tenant committee. Registration of leases, which must consequently necessarily be in writing, will be made mandatory to reinforce the tenant's position and rights. A priority rule for residents in housing units declared unfit for habitation will be included in the new Flemish decree on social housing, whereas, in the context of the new Flemish rent allowance scheme, occupants of unsanitary and/or unfit housing units will receive support in the form of a rent allowance if they move into complying housing. The tax on abandoned housing introduced in Flanders in 1995 was amended in 2004 with the introduction of a more consistent and more objective method for determining the amount of the tax. The Walloon Region is trying to improve accompaniment of social tenants and to promote the quality of their environment. In private housing, landlords in the Walloon Region who continue to rent housing that has been prohibited will be sanctioned. In Brussels, social housing will be provided with professional social services, and tenant advisory boards will be extended to all social housing developments.

Guideline 5: «Socializing» Private housing

In Flanders, the budget of social real estate agencies will be increased again. They will have new possibilities to take action and benefit from a promotional campaign. The Walloon Region also plans on refinancing a social real estate agency and work in unoccupied buildings, essentially by means of an aid for renovation/rehabilitation,

where they take over the management. In Brussels, the number of units managed by social real estate agencies will be increased by 2000, and the Habitat Network will offer various social services to residents who do not benefit from social housing via the implementation of its multiyear plan: advice on renovation, social accompaniment and house hunting.

Guideline 6: Reinforcing accompaniment of the homeless

The federal authorities will remove the obstacles preventing a homeless person from taking a reference address. To promote integration of the homeless, the Walloon Region will stimulate professionalization of the sector. In the Brussels Region, several measures are also planned: concertation organized on the priority missions of insertion by housing and intensification of social cohesion programmes, the organization of an overnight shelter, increasing the number of shelters for women, creating a place for expression, increasing the resources devoted to work in the street, financial support of accompanied housing and the creation of a reference centre. The French Community, for its part, will develop an awareness project for the homeless emphasizing their health. The German-speaking Community is now assessing the decree of 9 May 1994 on the approval of institutions for temporary lodging and counselling of persons in distress, and including award of subsidies for the purchase, construction, rental, renovation and equipment of housing intended for emergency shelter.

Guideline 7: Acting across sectors and promoting coordination of the various levels of authority

At federal level, additional resources for housing of low income persons will be granted in 15 towns and municipal districts that already benefit from support under the town contracts, as well as Mechelen and Sint-Niklaas. This housing must notably benefit persons with a low income. The Interministerial Conference on the policy for large towns and housing provides for the organization of a dialogue between the Federal State and the federated authorities in both urban questions and housing. In this context, ten working groups have been set up. At the level of the Brussels Region, organizing a roundtable to fight exploitation of unsanitary and overcrowded housing, and an inter-Regional meeting on social accompaniment are scheduled.

Guideline 8: Developing knowledge of the problematic

In 2006, the federal administration in charge of the Policy for large towns will continue to develop the data bank on towns that it started in 2005. In Flanders, an Information Centre for the Sustainable Development of Housing has set up a research project on the quality of housing and desires of inhabitants in the field. Research on the supply policy in the private rental sector is also going forward, as well as a research project on possibilities and procedures for creating a rental guarantee fund. Several instruments are also being developed in the Brussels Region: an assessment of tools to improve the effectiveness of existing schemes, to ensure fair accessibility to the poorest persons, setting up an observatory for housing, a structural and prospective study of housing, a Neighbourhood Atlas and, finally, constituting a land registry of public property.

2.2.2. Indicators and monitoring procedures

The indicators that will be used to monitor each of the actions are described in the monetary data sheets. The results will be progressively added to an interactive monitoring file. Adjustments of the targets as described in section 2.1.1. will then be monitored in an indicator working group.

2.2.3. Resources allocated to achieving the objective

The resources allocated to each of the guidelines are described in the monitoring data sheets. But achieving the objective of providing appropriate housing for everyone, also and above all, entails mobilization of large investments in structural policies already being implemented, for both housing and related fields, including employment, taxation, social aid, urban renewal, justice and even health. This diversity of approaches, which of course comes with a comparable diversity of the people responsible for the sources of financing, requires a continual effort in terms of cooperation. The inter-ministerial conference on the Policy for Large Towns and Housing is an essential instrument.

SECTION 2.3. DEVELOPING ACTIVATION AND DIVERSITY IN EMPLOYMENT AND SOCIAL INTEGRATION

2.3.1. Political measures

Guideline 1: Promoting equal opportunities in (access to) employment and managing diversity

The major objective is to have a labour market that reflects social reality. For this reason, everyone should have equal access to public and private jobs and discrimination must be fought. The federal level has set up an inter-ministerial working group on discrimination and launched awareness actions in the business world. The National Labour Council has the assignment of taking an inventory of all employment measures, in order to ensure good harmonization of the various measures that give a central place to optimizing labour market opportunities and providing a lasting job for groups at risk. On various points, the policy focuses special attention on the diversity aspect: separate budgets for projects in the framework of diversity, promotion of management of diversity in companies by means of the bonus +, as well as particular attention to the «gender» theme. The Federal State has decided to support diversity and fight discrimination in employment by launching a certification project for efforts made by companies in this field. Flanders will launch diversity plans to increase participation of the poor and ex-convicts. A revised diversity policy should help prevent exclusion of the elderly, persons of another ethnic-cultural origin and persons with a disability from the labour market. A Flemish authority devotes more than 8 million euros per year to a certain number of initiatives, and also provides an employment bonus on hiring people over 50. In Wallonia, equal opportunity is central in the question of access to employment. In addition to structural methods that target these groups in priority – including the integrated scheme for social-professional Insertion – the Walloon Region is developing several specific measures in the context of its strategic cross-sector plan for Social Conclusion: reinforcement of job coaching in the Regional Employment Missions, reinforcement of prequalification in the On-the-job training companies (*Entreprises de Formation par le Travail – EFT*) and socio-professional organizations (*Organismes d'insertion socioprofessionnelle – OISP*), reinforcement of the insertion of people suffering from a disability in enterprises, reinforcement of the insertion of beneficiaries of the right to social integration by hiring, within the CPAS, additional insertion advisers, and reinforcement of the integration of unskilled persons by promoting the existing Insertion Enterprises and by creating new structures. In Brussels, the policy of diversity will be implemented by organizing awareness seminars in enterprises, by a Diversity Charter, by a Diversity Plan, and by using specialized consultants. An equal opportunities management plan will also be implemented within the Brussels housing administration.

Guideline 2: Removing obstacles that reduce access to employment of parents

The federal authority has completed the extension of parental leave and the improvement of maternity leave. It now targets aligning the public sector to what has been done in the private sector. In addition, by developing a new status for teleworkers at home, it is also contributing to promoting better reconciliation of working life and private life. This status will be improved still further by adapting the law on welfare at work to this particular working procedure. The Flemish action plan to extend the supply of flexible and occasional childcare will take effect in 2007. The French Community will be implementing the Plan Cigogne (Stork Plan) II, targeting the creation of additional childcare capacity for 8000 children between 0 and 3, and the Walloon Government has budgeted additional resources to support the policy enacted in the field by the French Community to achieve the objectives of the European Barcelona Summit (a rate of cover of 33% by 2010). In Brussels, a capacity increase for 2,600 infants will be created in its childcare centres, whereas the Flemish Community Committee will increase capacity for occasional and flexible childcare in existing infrastructures and will provide for starting up new initiatives. It will also increase the number of slots reserved for children of new arrivals, and will organize training courses for the personnel in day care structures stressing accessibility. Finally, child care for children of job seekers will be reinforced by opening a second «*Maison d'enfants*» in the «vulnerable» zone in the Region and by intensifying partnerships with day care centres in the Region.

Guideline 3: Promoting employment of the least qualified by supporting them in their integration efforts, by developing and recognizing their skills

To achieve durable social-professional integration in the labour market of the CPAS' beneficiaries registered for their first employment path, the federal authority has set up several instruments, including conventions with the CPAS in large towns, the «Social Inclusion» guideline of the European Social Fund (ESF) federal planning, and a promotional measure for the integration of CPAS beneficiaries in the business world. As concerns the paths for integration, the efforts of CPAS for diversification of employment will be taken into greater account. The Flemish strategic plan «lettrisme» defines clear priorities and stipulates the implementation of a series of actions. With the Decree on obtaining a recognized professional skill, the Flemish authorities want to give everyone the right to obtain that for which she/he has the necessary skills. In Wallonia, the Integrated Professional Integration Scheme (*Dispositif intégré d'Insertion professionnelle*) provides for individual accompaniment of priority target groups: jobseekers who are very far from employment, including the unskilled, long-term unemployed, beneficiaries of integration income, disabled persons and persons of foreign origin. The action of the CPAS in favour of integration of beneficiaries of an integration income will also be reinforced. In addition, the professional integration strand of the HP plan provides for accompaniment of those whose permanent residence is in a campground. In addition, the Walloon Region will act on professional orientation and a literacy programme will

be enacted jointly with the French Community. For the French Community, the objective of the cooperation agreement with the Walloon Region and with the COCOF is to increase the overall capacity of literacy courses for adults by 50%. The Walloon programme also contains a coherent strategy for fighting the digital fracture. Finally, the validation of skills that will be organized by the Walloon Region, the French Community and, in Brussels, the COCOF, will contribute to offering more training possibilities at the workplace and to increasing the volume and level of qualifications. A partnership will be created between ORBEM and the 19 CPAS in Brussels for the implementation of a common social-professional integration programme for welfare or equivalent beneficiaries, while the regional administration will hire persons under a «first employment contract».

Guideline 4: Supporting social integration upstream of professional integration for groups at risk, and promoting activation by means of activities that are not necessarily professional

Activation must not be limited to a paying job. The diversity of social exclusion must also be taken into account, calling for stimulation of every possibility leading to integration in society. Flanders will be investing in the development of a social service economy. The framework defined by the decree organizing the social service economy should be implemented in 2006. In the context of the Flemish plan for increasing jobs, actions are planned mainly for jobseekers who are confronted with a problem not related to the labour market: reinforcing specialized screening, developing a pilot activation path combining work and care, qualitatively and quantitatively increasing sheltered jobs in the social economy. For its part, the Walloon Region will favour the creation of social relays and integrated health relays. From the same viewpoint, the French Community will organize a preventive service by setting up mobile teams with the associative and medical milieus. To promote access to culture, the first Sunday of every month, access to museums with which it has a contract will be free of charge.

Guideline 5: Stimulating expansion of the social economy, proximity services and sustainable development as a lever for activation and diversity of employment

To promote sustainability of public supply contracts, a support service for sustainable public supply contracts will be created at the federal level. The regions have made a commitment, in the context of the cooperation agreements for a plural economy, to support cooperative activities, whereas the CIDD (Interdepartmental commission for sustainable development) has developed a reference framework for corporate social responsibility. In Flanders, urban and municipal action plans to fight unemployment of young people will be implemented. Alongside activation of young people, the measures essentially pertain to job hunting, intensive job coaching and a supply of adjusted jobs. Within the integration economy, the Flemish government will create additional quality jobs, and will be more attentive to supervision and the quality of work. In the Walloon Region, Activity Cooperatives will be prolonged, and integration enterprises will be reinforced and jobs will be created in proximity services. In addition, a new

Proximity Services decree will be drafted in 2006. Finally, the rural development strand of the HP Plan will contribute to ensuring balanced territorial development. In Brussels too, new proximity jobs will be created, whereas a regional platform will be set up to support the creation of economic activities and social economy counters.

Guideline 6: Developing knowledge of the problem

As concerns knowledge of activation, several research projects will be launched on federal level, including a study of paths aimed at assessing the rates of maintenance in activity of groups benefiting from CPAS aid, as well as the study of transfers that will analyse the real impact of activation on job-hunting behaviour further to the plan for reinforcing accompaniment of job-seekers. In the Brussels Region, all employment measures will be listed, and the set of measures will be assessed in order to simplify the schemes and maintain only those that allow for the creation of acceptable, normally paid jobs. As concerns knowledge of diversity, ethnic registration – or monitoring – will help identify where problems lie, in which sectors, which regions and which professions. The social partners have been asked to take an «unequivocal positio » on this. Ethnic minorities will be asked as broadly as possible about their ideas concerning monitoring. In Flanders, the various initiatives concerning the non-native population will be harmonized, and a few paths will be explored to measure the target group of non-native residents. In Brussels, a round table on the statistics based on origin will be organized.

2.3.2. Indicators and procedures for monitoring

The indicators that will be used to monitor each of the actions are given in detail in the monitoring data sheets. The results will be added gradually to the interactive monitoring file. Evolution of targets as described in section 2.1.2. will be followed in the indicator working group.

2.3.3. Resources allocated to achieving the objective

The resources allocated to each of the actions are defined explicitly in the monitoring data sheets. But the achievement of the objective of developing activation and diversity in employment, and social integration also, and above all, entails mobilizing considerable investments in structural policies already implemented, such as employment and related fields like education, vocational training, social security, social aid, childcare, justice, the fight against racism and even health. This diversity of approaches, which of course goes hand-in-hand with comparable diversity of responsible persons and sources of finance, requires a continual effort in intensive cooperation. This is why the various cross-sector policies put in place are so important.

SECTION 2.4. FIGHTING POVERTY AFFECTING CHILDREN

2.4.1. Policy measures

Guideline 1: Acting on family income and the cost of housing

Several measures presented in sections 2.2. and 2.3. correspond to the guideline. There is no need to recall them here to emphasize their importance. Other measures are particularly addressed to households with children, with an anticipated impact on the improvement of material conditions in which the children live. Consequently, linking social welfare allowances is a priority of the federal government. The employment bonus system also contributes to this objective, as does the new family allowance for the beginning of this school year scheduled for August 2006 for children from 6 to 18.

Guideline 2: Stimulating social participation of all children at as early an age as possible

Early participation in society, among other things via childcare structures for very young children and preschool education, increases the chance of success in subsequent education. The Federal government has recently taken initiatives to develop a project in which intercultural mediators will be hired to increase attendance at school of begging children. Flanders has undertaken efforts to increase the supply of childcare and to improve accessibility based on existing exclusion mechanisms. In addition, participation in preschool education will be increased by improving awareness of the importance of early participation. The French Community has provided for an evolution in supervision capacity of preschool education at any time in the year in case of increase in the number of children. For primary school, teaching staff will be reinforced in the first two years of school by hiring more teachers. The Walloon Region stresses the fight against dropping out of school and to promote access to new technologies for young people. In the Brussels Region, the French Community Commission has stabilized financing of *«écoles de devoirs»* (institutions providing supervision and assistance with classwork after school) and other services offering care for young people in difficulty, and has also provided for subsidies to ensure better access to sports for the poorest groups. As from the beginning of the 2006 school year, museums in Wallonia and Brussels that have a contract with the French Community will be free of charge for school groups and groups of young people, and collaboration will be reinforced between Culture and Education to give culture a central place in schools. Initiatives will also be taken in the sports field to promote integration, membership and participation of socially and economically vulnerable young people.

Guideline 3: Reducing the cost of education and promoting equal opportunities

In Flanders, fundamental education will be made free of charge for everything needed to get through school. As concerns cost control and secondary education, a maximum amount will be established. A new system of financing based on the

characteristics of the school and the students will be introduced for all mandatory education for Dutch speakers. Educational courses geared to technologically sophisticated professions will benefit from an additional bonus per student, to reduce the contribution of the parents. Education free of charge or at reduced cost is also a particularly concern for the LOP (local inter-school consultation platforms). In addition, Flanders has also made considerable efforts to reach target groups that are entitled to a scholarship. The new regulation simplifying administrative procedures for educational allowances introduces higher income ceilings and higher allowances. Administrative simplification means that citizens need only provide minimum information to fill out forms. The reform of mainstream and special education is currently subject to social concertation. Since the 2005-2006 school year, schools can implement priority rules and apply an active recruitment policy to diversify their students. Flanders is also studying how education can be adapted to new non-native arrivals (referred to as «OKAN»). Other projects are also being developed, for example as concerns aid with homework for socially disadvantaged families. In the French Community, a circular has clearly combined its goals of legislation concerning school expenses while presenting new measures that will enter into force in the near future notably concerning the expenses that can be charged to students and their families. Finally, a whole series of actions target revalorization of qualifying vocational training.

Guideline 4: supporting parents in their educational role

In the Flemish action plan «garden path» and in all of the management agreements with the federations of parents associations, there are a whole series of actions targeting increasing involvement of parents of groups that are hard to reach. Specifically for the target groups, as from September 2006, there is a plan to have the CLB (centres for pupil coaching) include mediators in the field of poverty and social exclusion and intercultural mediators as part of the structural training programme of their personnel. In Flanders, work is also being done to reinforce educational support policy. Alongside that, Flanders will support the implementation of the «triple P» programme, and will continue to give subsidies to foster families. To improve relations between school and families, the French Community will launch various initiatives targeting reinforcing their relations between families and schools. In Brussels, the VGC (Flemish Community Commission) will develop education centres plus a potential supply for support to families. Moreover, preventive actions carried out with young people by Brussels CPAS will be encouraged.

Guideline 5: Avoid placing children and promoting alternative solutions

On the basis of an opinion of the interministerial commission, discussions should continue between the federal government and the Communities to reach a cooperation agreement for the reception of unaccompanied foreign children. In Flanders, the Global Action Plan for special aid to youth allows for an increase of 14% in the supply of special aid to youth. Prevention, such as risk assessment, early detection at home, etc. are all covered by this. An improvement of the policy for aid to youth has also been adopted in the French Community with a whole series of measures. Finally, the Walloon Region will create emergency structures for housing families and accompanying them to find a durable housing solution.

Guideline 6: Developing knowledge of the problem

A research project is being done at federal level on the relation between poverty and placement. In Flanders, poverty in education is monitored using GOK (Equal Education Opportunities) indicators and comparative international surveys (PISA, …), while the LOP (local inter-school consultation platforms) are trying to map how general policies for education on equal opportunities are implemented locally, in order to fine tune the policy on the basis of local needs. Kind en Gezin also monitors poor families continually. In the French Community, the measures to fight ghetto schools and to ensure equal chances of social emancipation for all students are being assessed and studied. The objective is to envisage additional/complementary courses of action. In Brussels, a map of childcare needs will be drafted. The social report of the German-speaking Community will stress the theme of «poverty-children». This report is expected for the fall of 2006.

2.4.2. Indicators and follow-up procedures

The indicators that will be used to monitor each of the actions are explained in the monitoring data sheets. The results will be added gradually in the interactive monitoring file. Evolution in targets as described in section 2.1.3. will be monitored in the indicator working group.

2.4.3. Resources allocated to achieving the objective

The resources allocated to each of the actions are described in detail in the monitoring data sheets. But the achievement of the objective of fighting against poverty of children also, and above all entails mobilization of considerable costs invested in the structural policies already implemented in the field of education and related fields such as Social Security, social aid, childcare, employment, housing, health, sports and culture. This diversity of approaches, which of course comes with a comparable diversity of the people responsible for the sources of financing, requires a continual effort in terms of cooperation, which is why the various cross-sector policies put in place are so important.

SECTION 2.5. PROVISIONS MADE FOR BETTER GOVERNANCE

2.5.1. Preparatory process

Like the previous NAP Inclusion, the Chapter NAP Inclusion of this Strategic Report was done under the coordination of the Federal Public Service for Social Integration, which falls under the authority of the Minister of Social Integration. To insure coherence with the other chapters, the Federal Public Service is represented in the drafting committee of the Strategic Report by its president. The Federal Public Service for Social Integration is behind the creation of the actions working group that intervened in July 2005 with the objective of reinforcing participation of all stakeholders. This new action group, enlarged to concerned representatives from all sectors of civil society, has met five times during the preparatory period for the NAP Inclusion. The actions group works in collaboration with the indicator working group, which continued its deliberations on a parallel, focusing on developing the most appropriate indicators in order to determine the targets and an optimal monitoring for the three key objectives retained.

2.5.2. Political coordination

The Federal Minister for Social Integration was appointed by the interministerial conference on Integration in Society to carry out the process of developing the NAP Inclusion. In addition to competent federal ministers for the fields associated with social inclusion, and ministers of the Communities and Regions responsible for coordinating social inclusion, take part in this conference. This conference is notably what decided to broaden the actions working group and to choose its new working method. The conference is also the body that approved the choice of the three key priorities and the timetable proposed by the federal and regional administrations for implementing NAP Inclusion 2006-2008. The interministerial conference also validated the final document.

Political coordination had to be organized at Regional level. In Flanders, very structured coordination was set up to carry out the Regional Action Plan for fighting poverty (see the section devoted to good practices). In Wallonia, there are of course action plans coordinated regionally as well, including the Strategic Plan No. 3 (PST 3) which specifically targets social inclusion, but also deals with times and measures that are different from those of the National Action Plan.

The measures set down in the NAP must first be the subject of an agreement at the level of the Walloon Government. To simplify coordination, in 2003 the government decided to create the monitoring committee for the Walloon strand of the NAP Inclusion that it decided in July 2006 to transform into the permanent inter-Cabinet working group on «Social Inclusion» in July 2006. In Brussels, administrative coordination is done by the JCC (Joint Community Committee) and its two ministers. Although this administration is legally responsible for coordinating the various political institutions in Brussels territory, the fields considered in the fight against poverty depend respectively on different institutions (Region, Community Committee or Community). This means

that the ministers involved in concertation are not competent for all of the fields considered. On the other hand, a new decree on poverty has just been adopted by the Brussels Parliament in July 2006 coordinating synergies both for the report on the condition of poverty, and in coordination between Brussels governments, collaboration in the NAP, and drafting a plan for Brussels in the fight against poverty.

2.5.3. Mobilization and involvement of the players

As mentioned above, participation of the players has been greatly stimulated by the enlargement of the actions group and its new means of operation. The NAP Inclusion 2006-2008 was not developed on the basis of the actions working group only. Other sources were of course used, particularly the report entitled *«Abolir la Pauvreté»* (Abolishing Poverty) (2005) from the *Service de Lutte contre la Pauvreté, la Précarité et l'Exclusion sociale* (Department for fighting Poverty, Precariousness and Social exclusion) (http://www.luttepauvrete.be). This «contribution to the discussion and to political actions» is the outcome of two years of discussions and a think tank by the concertation groups, including associations where the poor can speak out, working with the Fight against Poverty works. The report also includes contributions from the public discussions organized in 2005 in the context of the 10 years of the General Report on Poverty.
Involvement has also been reinforced in the indicator group, which has particularly stressed taking consideration of the results of a research-action-vocational training project called «another approach to poverty indicators» (*une autre approche des indicateurs de pauvreté*).
(http://www.luttepauvrete.be/publicationsserviceindicateurs.htm)

2.5.4. Mainstreaming

In Belgium, different channels are used to height attention for questions of inclusion in various departments. The involvement of all levels of authorities in drafting the National Action Plan for Inclusion is one of these, as is the Federal Plan for sustainable development and the processes associated with it (www.cidd.fgov.be). Social welfare and the fight against poverty are included as fundamental pillars of sustainable development, and all federal administrations are regularly invited to report on the actions undertaken in this context, both internally (human and material resource management) and externally (political measures and targeted communication). At regional level, all departments of the Flemish administration include a reference person in charge of drawing attention to the question of poverty.

2.5.5. Monitoring and provisions adopted for assessment

While the indicator group will monitor the evolution of targets and draw attention of the authorities concerned to cases where indicators do not progress as expected, the various administrations responsible in the field will have the possibility of introducing the elements that allow monitoring the implementation of their respective actions in the

Internet site of the Federal Public Service for Social Integration. Like the Federal government (http://www.statbel.fgov.be), the Regions have statistics institutes that have developed methods and instruments to monitor indicators to follow the social-economic evolution of their population. Both the Flemish planning and statistics administration (http://aps.vlaanderen.be) and the Walloon Institute for Evaluation, Prospective and Statistics (http://statistiques.wallonie.be) as well as the Brussels Observatory of Health and Social Welfare (http://www.observatbru.be/fr/Publications/barometre.asp) are indispensable partners in very active in the indicators working group. Since 2005, the Brussels Observatory has published a social barometer which looks into demography, income, employment, housing, health, level of education and social integration and participation (http://www.observatbru.be/documents/Barometre_Social_20051(1).pdf).

In the beginning of 2007, a new public conference will be held on the NAP Inclusion, and will be an excellent opportunity to make recommendations for the future. The material needed to draft an assessment report by the end of 2008 will therefore be progressively available.

Chapter 3:
National Strategic Report

Updating the Belgian National Strategic Report on pensions 2005

The Belgian national pension system, and a comparison of this system with those of other EU Member States, have already been presented in detail in the National Strategic Report on pensions 2005. Net challenges of the Belgian pensions scheme were also discussed. Maintaining the standard of living of pensioners, sustainable financing of pension expenditures in the context of increasing demographic aging, and reduction of Belgium's lag in employment are considered as current major challenges. To meet them, the Federal Government developed the *Solidarity pact between generations* with the help of the social partners. This Pact targets maintaining viability of Social Security. A series of measures have been taken for this purpose in order to increase the rate of activity and to give material form to the new social contract for a strong social security with solidarity.

For the field of pension policy, the report has a short description of the measures taken under the *Solidarity Pact* between Generations to reach the three joint objectives described above.

SECTION 3.1. SUFFICIENT PENSIONS

3.1.1.Policy objective and data on the context

Policy objective g): A sufficient pension income for all and pension rights enabling pensioners to reasonably maintain their standard of living after retirement, in a spirit of equity, and inter-generational and intra-generational solidarity

The percentage of risk of poverty for the total population, for a poverty threshold of the equivalent of 60% of median income is 15% in Belgium for the income year 2003 (EU-Silc 2004), whereas the average for EU-25 is 16%. For the higher age category (65+) in Belgium, the percentage of the risk of poverty increases to 21%. This percentage is significantly higher than the average in UE-25 (18%). Given that in Belgium, the share of pension income represents about 84% of total income for the higher age category (65+), a sufficient pension constitutes a major instrument for reducing the percentage of risk of poverty for this age group.

A detailed description of the income situation of elderly pensioners is attached in the Annex to Part One: Analysis of the social situation and an Overview of this national report. The indicator of «theoretical replacement rate» can provide an answer to the question of whether pension benefits are sufficient in shifting from economic activity to retirement. The results of this indicator for various typical cases of a wage earner with a career of 40 years are attached in the annex to Part 3 of this report. For 2004-2050, a slight increase in total net replacements (1st and 2nd pillar) is observed for the different typical cases, due to the increasing importance of the second pillar.

3.1.2. Measures

A. Measures to ensure a sufficient pension income

– Adaptation of minimum pensions to welfare using a legal adjustment mechanism for welfare social benefits (workers in salary and self-employed workers)

In recent years, minimum pension benefits have followed the evolution of welfare. As from 2008, the Solidarity Pact between Generations provides that the government must make a decision every two years in the subject of the allocation of financial resources made available for the adjustment of all Social Security income-replacement benefits in view of the evolution of general welfare. Minimum pensions are part of this. The implementation of this kind of structural mechanism should not mean that the level of protection of Social Security maintains a gap with regard to the evolution of general welfare and pay schedules of the active population. The procedure designed for this purpose will be set up in the fall of 2006 in consultation with the social partners. The government can found its decisions among other things on the reports by the Study Committee on Aging (see point 3.1.2.).

– The minimum guaranteed pension and minimum right per year of career: adjustment of procedures (workers on salary)

Based on administrative data on current pensioners, it is observed that women, more than men, have had a career considered as atypical. Consequently, because they worked part-time for more years, among other things, they are not taken into consideration to benefit from the minimum guaranteed pension after 30 years on the job. In this context, an adjustment has been made so that these years of part time employment are now also taken into account in the right to a minimum pension. Their pension is calculated in proportion to the duration of activity.

On Saturday, for a career of less than 15 years of employment during which there was at least one year an activity equivalent to one third full-time employment, a *'minimum right per year of career'* is awarded. In this case, the pension is calculated for each year at least on the basis of minimum monthly guaranteed remuneration. The amount used as a basis for the calculation of the minimum right will be increased by 17%. Consequently, the pension rights acquired for these years will be aligned on the minimum guaranteed pension, in proportion to the duration of employment. This target group consists mainly of women.

– Maxi status for aiding spouses (self-employed workers)

Aiding spouses born after 31 December 1955 are automatically covered by the Maxi status as from 1 July 2005 that, among other things, enables them to constitute personal pension. For aiding spouses who could not envisage a minimum pension because of the insufficient number of years of career for a pension, transitory measures have been provided, so that aiding spouses can claim a minimum pension.

– Increase in the guaranteed income for the elderly (social assistance)

In recent years, the amounts of the guaranteed income for the elderly have followed the evolution of welfare. On 1/12/2005, the base amount was again increased by 10 € per month. Despite this increase, the current amount is below the threshold for the poverty risk. Thanks to an increase of 60 € of the base amount on 1.12.2006, the minimum income of isolated persons over 65 is now at the level of this risk threshold.

B. Measures to guarantee an acceptable standard of living for pensioners

– Adjustment of wage and income ceilings to welfare in the context of the calculation of the pension (workers on salary and self-employed workers)

The ceiling for salaries and income in the context of the calculation of the pension is adjusted every other year (first adjustment in 1999), in order to follow the evolution of welfare.
As from 2008, the adjustment of wage and income ceilings for workers on salary and for self-employed workers will be subject to its own mechanisms stipulated by law for the adjustment of social benefits to welfare (see above).

– Adjustment of pensions to welfare during retirement (workers on salary and self-employed workers)

Selective adjustments to welfare of old pensions will continue until 2007 with the objective of reducing the historical difference that appeared between the average amount of old pensions and those of new pensions. As from 2008, the adaptation of old pensions will be subject to the legally stipulated mechanisms as concerns the adaptation of Social Security income-replacement benefits to general welfare (see above).

– Adjustment of the condition of the career for a non-reduced early-retirement pension (self-employed workers)

A self-employed worker can obtain an early non-reduced retirement pension if he can demonstrate a «full professional career». As for 1 January 2003, a full professional career amounts to 45 calendar years; at this time demonstration must be given for 44 calendar years. The measure applies to pensions that have actually taken effect, and for the first time at the earliest in 1 January 2006, for both men and women.

– Greater flexibility for the negative pension bonus for self-employed workers

The 'negative bonus' applied for retirement before 65 is reduced slightly for self-employed workers. The percentage of reduction – 5% per year of early retirement to date – decreases with the age for which retirement took effect. The measure is applicable to pensions that took effect for the first time on 2 January 2007 at the earliest.

SECTION 3.2. FINANCIAL VIABILITY OF PENSION SCHEMES

3.2.1. Policy objective and data on the context

Policy objective h): Financial viability of public and private pension schemes, given pressure on public finance of the aging of the population, and in the context of the triple strategy, to deal with the consequences of aging on the budget, particularly by: maintaining people on the job longer, encouraging active old-age, ensuring an adequate, socially justified balance between premiums and benefits, and by encouraging financial viability and security of systems covering the capital and of special regimes.

In its annual report for 2006, the Study Committee on Aging is updating its recent assessments of the budgetary cost of aging. In the most recent assessments, account has been taken of the implementation of the measures of the Solidarity Pact between Generations that have an impact on the supply of work and on social expenditures. The table given in annex to Part 3 shows that the budgetary cost of aging for the period 2005-2050 is estimated at 5.8% of GDP. For the same period, the cost of pensions is estimated at 3.9% of GDP. For the period 2005-2011, the budgetary cost of aging, estimated at 0.4% of GDP, will be rather limited. The Study Committee, which has not taken account in its assessments of all of the measures of the Solidarity Pact between generations, however, concluded that the estimated budgetary cost of aging will have a rather limited impact. For the period 2005-2011, the measures taken into consideration will increase the budgetary cost by 0.2 % points. For the subsequent period of 2011-2030, the measures taken into consideration should reduce the budgetary costs by 0.1 % points.

Estimates of the budgetary costs by the Study Committee are lower than the long-term projections that Belgium transmitted in the spring of 2006 in the aging working group of the EU Economic Policy Committee (see annex, part 3).

In the context of the aging of the population, objectives for increasing the rate of activity and the rate of employment become crucial. They are analysed in annex, part I of the Overview of the national report.

3.2.2. Measures

A. Measures to promote financial viability of the pension regimes

– Continuing the reduction of public debt and constituting structural reserves in an Aging Fund

As from the budget year 2007, the reduction of public debt will be accelerated by means of annual budget surpluses that will be paid to the Aging Fund. The Aging Fund was created in 2001 to constitute a financial reserve so as to finance the additional expenditures of the various legal pension regimes due to aging during the period 2010-2030. At the end of 2005, the value of the portfolio of the Aging Fund was more than 13.5 billion euros, or about 4.53 % of GDP.

– Broadening the financial base of Social Security, among other things by allocating receipts drawn from property tax (précompte immobilier)

In the context of the Solidarity Pact between the Generations, the means of financing Social Security has been reinforced to insure a durable financial balance and to guarantee everyone, including the elderly, high level protection. In order to reach this objective, the base of financing is extended as from the budget year 2006, among other things by allocating 15% of property tax receipts to financing Social Security systems. In addition, the principle of transfer of tax receipts generated by the recovery of reductions of social contributions will be applied as in 2007.

B. Measures reinforcing the rising trend in the rate of activity

– Setting up a pension bonus as incentive to continue a career (employees on salary and self employed workers)

The retirement pension is increased by a «bonus», subject to the condition that the worker on salary or self-employed worker has reached at least 62 or proves a professional career of at least 44 calendar years, while continuing to exercise his/her professional activity. The measure is applicable to pensions that take effect for the first time in 1 January 2007 and only concerns periods of benefits after 2005. This creation of a pension bonus should encourage older workers on salary and self-employed workers to continue their professional career after 62 or at least to 44 years of career. This policy measure also has the additional effect of increasing the standard of living at the time of retirement (see point 3.1.1).

– Tax advantage for the benefit of a second pillar pension at legal retirement age (workers on salary and self-employed workers)

A tax advantage will be awarded for the benefit of a complementary pension at the end of effective occupation up to the legal age of retirement. For workers on salary who continued their activity up to legal retirement age, the rate of taxation on the part constituted by means of premiums paid by the employer will be reduced from 16.5% to 10%. For self-employed persons who continue to be active at least until legal retirement age, only 80% of the capital constituted for complementary pension will be taken into account in its conversion into a fiscal annuity.

– Award of pension rights to young workers working part-time and taking courses part-time (workers on salary)

As from January 1 following their 18th birthday, pension rights will be granted to young people doing on-the-job training, apprenticeship contracts, part-time work and part-time education in order to encourage more young people to accept a job. This measure takes effect retroactively to 1 January 2004.

– Setting up differentiated wage ceilings for the calculation of pension (workers on salary)

To improve the return of activity as compared to inactivity, the wage ceiling in the calculation of the pension is split into a ceiling applicable to effective remuneration and a ceiling applicable to active remuneration (of the following assimilated periods: full-time unemployment, full-time early pension, full-time career break, full-time employment hours credit (credit-temps). During a period that remains to be defined, only the ceiling for effective remuneration will be adjusted at least once every two years to the evolution of general welfare, so that a difference will gradually appear between the two ceilings in the future.

SECTION 3.3. MODERNIZATION OF PENSION SCHEMES

3.3.1 Policy objective and data on the context

Policy objective i): Transparent pension regimes corresponding to needs and expectations of men and women and to needs of modern societies, given aging and structural changes, good information so that people can plan their retirement and so that reforms based on as broad a consensus as possible can be implemented.

In the last few decades, women have arrived in the labour market massively. More than for man, their career is characterized by part-time work and career breaks, however. Consequently, in 2005, about 42.6% are women were working part-time, as compared to 7.8% of men (see annex to part 3). The Belgian pension system has not sufficiently followed this evolution of society. In the context of the Solidarity Pact between Generations, the «Women and Pension» initiative began at the end of 2005, among other things to identify the consequences of women's professional situation for their pension and to make any needed adjustments, given the needs of modern society.

In addition, particular attention has been given to vocational training of the population. Sociological studies have shown that both young people beginning their careers, and their elders, who are reaching the end of theirs, are insufficiently informed of the pension rights that they have constituted. Choices during a professional career must always be made in full knowledge of the financial consequences for both the short and long-term. It is therefore important to inform young people well about the con-

sequences of their career choice for their pensions. For categories of older workers, it should be possible to give them a correct estimate of their pension, in order to show them, for example, the financial consequence on the pension of continuing their career for one more year.

3.3.2. Measures

A. Measures corresponding to the needs of modern society

– Better access to guaranteed minimum pensions

Better access to the minimum pension as mentioned above is a measure that was decided in 2006 to take account of the specific situation of women at work (see point 3.1.1. Measures for sufficient pension income).

B. Informational measures

– Information intended for young women about their choice of a career and the consequences for pension: «Women and Pension» informational brochure

Deliberate career choices offering a good solution during a certain phase of life can subsequently have major consequences on the pension. An informational brochure «Women and pension» informs young women during the first phase of their career about their choice of career and its consequences on their pension.

– Tailor-made information on pensions

On the web site www.toutsurmapension.be, anyone can obtain a reliable calculation of his/her future gross retirement pension. In the context of another initiative, anyone age 55 will automatically receive an estimate of his/her future retirement pension as from 2006, plus an overview of the career. People 55 and over can obtain an adjusted calculation for this purpose on request. The objective is to enable everyone, whatever the pension regime, to have access to a simulation of pension online by 2010. A new organization, SIGeDIS, has been created for this purpose.

Chapter 4: Health care and long-term care

SECTION 4.1. THE MAIN CHALLENGES AND AN OVERVIEW OF RECENT EVOLUTION IN HEALTH CARE AND LONG-TERM CARE

The Belgian health care system is based on a mandatory health care insurance scheme which is an integral part of Social Security. This system has the following characteristics:

– Universal cover;
– good accessibility;
– financing based on Solidarity (additional contributions by interventions of the State and allocation of taxes);
– payments of health-care providers essentially at the time of the service (except for certain services, such as chemical biology or radiology);
– broad supply of health-care providers and health institutions without a waiting list;
– freedom of choice of health-care provider;
– management, concertation and agreements on prices by and with the social partners, mutual societies and health-care providers.

As concerns *interactions between the health-care system and long-term care services*, various formal services in long-term care are incorporated in the existing health-care system. In fact, many risks specific to long-term care are provided via the mandatory health care insurance. To achieve cooperation and coordination at local, regional and national levels resulting in an integrated supply of care (and assistance services), two types of coordination have been set up. First, there is coordination between the Federal, Community and Regional fields of competence by means of the *«Inter-ministerial Public Health Conference»* by which the various organizations make commitments in the fields of care for the elderly, home care and basic health care. Secondly, there is coordination between general care and long-term care services, for example by means of integrated home care services, allowing for the best complementary use of the various health-care providers and assistance services.

The main guidelines of Belgian policy, for the two or three years to come, as concerns health care, can be summarized as follows:

– although, in past years, efforts were made to lighten the financial cost for patients in order to reduce social inequality and favour affordability of care, complementary measures are still needed. Concretely speaking, the scope of the «maximum charge» (maximum à facturer) will be broadened. Better reimbursement for implants will also be established. Legislation on additional charges will be amended. Finally, the status of the beneficiaries of a higher intervention will be broadened. Alongside financial measures, initiatives will be taken to reduce inequality in consumption of care. This will notably be the case for dental care.

– In order to *continually increase the quality of care*, the authorities target guaranteeing *user-oriented services* (adapted to their needs) focusing on continuity of care, particularly by means of priority given to primary care, prevention policies, patients' freedom of choice and of availability of information. For long-term care, particular stress will be put on coordination to offer an integrated, continual, multidisciplinary supply of care, adapted to the person's needs. Future efforts will be devoted to developing and implementing care schemes for chronic patients, among other things.

– One of the challenges for future years consists of ensuring the deployment of human resources, given the aging of the population. Efforts will be made to reinforce the position of health-care providers working in primary care and ensuring sufficient assistance and health-care services with attractive status. Developing various potential forms of care will also be necessary, taking account of the decree of dependence of the persons (residential care, day care, night care, temporary residential care). A multi-annual protocol has been concluded in 2005 between the various authorities competent in these fields.

– *The Cost/effectiveness ratio must be improved*. With this in mind, «evidence medicine» techniques are developing increasingly in hospitals and in ambulatory care, targeting increased efficiency of health policies. Instruments such as the 'Health Technology Assessment' will be used more and more, along with indicators of good practices. At the same time, to ensure consolidation and sustainability of the health insurance, the authorities are trying to control costs (norms for growth) particularly by increasing awareness and responsibility of all those working in the field of health.

– Developing *health promotion policies and healthy lifestyles* is also a priority for all authorities.

SECTION 4.2. HEALTH CARE

4.2.1. Brief description of the health-care system

In opposition to section 4.3 which concerns long-term care[1], the health care covered by this section refers mainly to individual curative care, and to the related health policies, as well as collective health services enacted to implement prevention and public health policies.

The Belgian health-care system promotes *freedom of choice* (of the health-care provider) for the patients (both for ambulatory medical services and paramedical services at hospital) as well as the expertise of *liberal medicine*.

Without going into detail, we can say that the Federal State is exclusively competent for the «*mandatory health insurance scheme*» which is an integral part of the Belgian Social Security system and, as we will see in the next section, covers essentially the entire population for a large range of care. On the other hand, in the field of public health (supply of care, protection of public health), responsibilities are split between the Federal State and the Communities and Regions.

4.2.2. Ensuring access to health care: Universality, Equity, Solidarity

A) Mandatory public insurance covering essentially the entire population

The Mandatory public health-care insurance covers essentially the entire population. Consequently, on considering the rate of cover of health care such as the number of insured persons for health care as compared to the entire population (including children) we get a figure of 99% cover[2] for «major risks» (mainly hospitalization) and 94% for «minor risks» in Belgium. This difference results from a distinction made at this time between care under the regime for workers on salary and the regime for self-employed workers, which only provides for reimbursement of «major risks» at this time. However, this distinction will gradually be eliminated since *the government has decided to extend coverage of minor risks to self-employed persons, partially as for 1 July 2006 and completely as from 1 January 2008*.

Ensuring maintenance of persons benefiting from protection within the system and promoting the entry into the system of those who are excluded are important objectives for the Belgian authorities. Consequently, to further improve cover, the government has recently expressed its intention[3] to extend coverage to unaccompanied foreign children enrolled in primary or secondary education for at least three month or, for younger children, having been presented at a preventive institution for support to families.

1. See section 4.3.1. for the definition of long-term care.
2. Source: OECD (Health Data 2006).
3. Proposal for the law on health 2006, scheduled to take effect in 1 January 2007.

On the whole, this *cover* is *quite complete*. Within the possibilities offered by the budget, the authorities regularly try to extend this cover. We can mention, for example, an agreement reached at the end of June this year to reimburse the vaccine for pneumococcus for children under two, and under certain conditions, as from January 2007.

We recall that health-care insurance does not supply health services but grants financial intervention in the cost of care. The amount of this intervention varies mainly with the type of service and the beneficiary. Without going into details, we note simply that the personal contribution or «ticket modérateur» is in principle 25% but, depending on the type of services provided, can be higher or lower. We can state here that various mechanisms exist to improve affordability of care (we will come back to these in point C herebelow), to ease the personal contribution of certain patients, reducing the average effective participation that patients disburse for all services to 8.43%[4].

B) Good general affordability

On the basis of indicators such as «unmet needs»[5], Belgium obtains satisfactory results as compared to the European average. Nevertheless, these indicators show that, for certain services such as dental care, there is room for improvement.

C) Measures to reduce «financial obstacles»

Although mandatory health care insurance can be considered relatively broad, nevertheless the patient is confronted with costs (*ticket modérateur*, services not covered, various supplements) that can sometimes be significant for his budget. Without forgetting that the rule of «a posteriori reimbursement» means that the patient must put up the money before getting reimbursement.

The authorities are preoccupied with this problematic and various mechanisms exist to ease the personal contribution of certain patients.

- The mechanisms targeted for groups identified as the most vulnerable in terms of affordability include the *«Benefit of the Increased Intervention»* (BIM) and the Maximum Charge *«Maximum à facturer»* (MAF)

The *«BIM»* awards higher reimbursements for certain «social categories» or persons inactive on the labour market (such as incapacitated, pensioners, disabled, …) whose annual incomes do not exceed a certain amount (currently € 13,246 plus € 2,452 per dependent child). Note that the government has decided to extend the benefit of BIM in 2007 to ALL households whose income is below a certain ceiling to be determined.

4. For example, effective participation of the insured person is only 1.39% on the average for nursing care but is 22.88% on the average for physical therapy. (Source INAMI; figures for the year 2005).
5. Indicator expressing the percentage of the population that at times may have to postpone or give up certain types of care.

The *«MAF»* defines a maximum amount (that varies with the income of the household) of annual expenditures per family for reimbursable health care. *The «maximum charge» in fact constitutes a basic tool for affordable health care, thanks to its very broad scope* (slightly more than 500,000 Belgian households benefited from this measure in 2005). The maximum charge in fact puts a ceiling on total tickets *modérateurs* which lightens the cost borne by patients, mainly in the lowest categories of income. To further increase the scope of this mechanism, note that a decision has been taken to extend the personal contributions taken into account in the maximum charge to include, for example, prescription drugs and implants.

- Among general measures whose objective is to reduce the personal contribution of patients, we can mention, among others:
  - Reduction by 30% of the amount of the ticket *modérateur* in case of consultation of a family doctor for all persons who have a *«global medical file»* (DMG).
  - A consistent policy for decreasing the prices of medicines characterized by:
    - *Regular reductions of mandatory prices*. As from 1 July 2006, prices were reduced on no fewer than 1400 medicines, particularly old specialty drugs (average decrease of 2%, with significantly higher reductions in some cases);
    - More favourable reimbursements for the least expensive medicines in the market. This is what is called a *«reference reimbursement»*;
    - reimbursement since 2006 of several *truly innovating drugs*, despite their very high cost (particularly drugs to fight cancer such as Herceptine and Erbitux), thanks to an increase in the budget for drugs.
    - Awareness campaigns to encourage doctors to prescribe at least a minimum percentage of generic drugs (30% less expensive than patented drugs) subject to sanctions[6] asked for 1 April 2006.
    - Competition between pharmaceutical firms has been established for two molecules that have large market share, in order to obtain the lowest possible price by means of a tender system called *«Kiwi model»*. This system will be developed further.

As concerns the difficulties associated with the «a posteriori reimbursement» mechanism, various measures target enabling healthcare providers to apply the «third-party payer» principle[7] for persons in a precarious economic situation. With this in mind, a specific *«flat rate s»*[8] system exists in *«maisons médicales»*[9] (ambulatory care); 150,000 people benefit from this.

---

6. The nature of the sanction has not yet been determined.
7. Mandatory for hospitalization, critical biology and medicines. (See point F of Annex 4.1.2.)
8. In the context of a contract signed between the patient, his insurance organization and the *maison médicale,* the insurance organization pays a flat rate to the *«maison médicale»* every month for each subscriber whose mutual society contributions are in order. The amount of this flat rate is calculated on the basis of the average cost of reimbursements of INAMI. This system of payment for the medical act; the cost of any any ticket modérateur (personal contribution) is nevertheless borne by the patient.
9. *«Maisons médicales»* are self-managed associations providing basic health care. A team of general practitioners, physical therapists, nurses, paramedics, social workers, receptionists, mental health professionals work there.

In addition, we also note that many CPAS[10] offer the possibility of a «medical card»[11] for the reimbursement of basic care. In the Brussels Region, for example, the 19 CPAS in the Brussels municipal districts have come to an agreement to reimburse a list of basic medicines. As concerns the Brussels Region, as well as the Walloon Region, it might be helpful to mention that there is a difficult situation concerning accessibility to health care for people who have no legal residence. These people are entitled to Emergency Medical Aid, but the various parties involved are not always familiar with the procedure to obtain care (by means of a certificate filled in by the health-care provider to be presented to the CPAS) and the paperwork is relatively complicated, which sometimes restricts access to indispensable health care for these people. Various initiatives could be envisaged to increase visibility of the procedure[12].

Finally, a number of studies have recently shown a significant rise in the cost to be borne by the patient for stay in hospital. The authorities are concerned about the situation. Consequently, a recent proposal for a law (proposal for a law on health 2006) would prohibit hospitals from claiming additional fees and charges for rooms under certain circumstances (child accompanied by a parent, day hospitalization, emergency or intensive care…). In addition, in order to guarantee greater transparency for the patient, and to make him aware of the consequences of his choices, a «declaration of admission»[13] has been introduced.

D) Measures for reducing «non-financial obstacles»

Alongside these purely financial aspects, other obstacles reduce accessibility of health-care for all or part of the population.

Sufficiency of the supply of care, Belgium is not affected by the phenomena of shortages or waiting lists.

However, a more effective structure of the Belgian hospital landscape is gradually falling into place. It targets promoting an adjustment of the supply of hospital care in a given geographic zone called a «*health-care basin*», to the needs of the population. The purpose of this new structure is to provide an optimal supply[14] of aids and services in view of current and future needs of the population of each zone. This adequate geographic breakdown of operating sites should ensure access to specialized health care for the entire population in the long run.

---

10. *Centres publics d'Action Sociale* (Public Social Action Centres).
11. Under certain conditions, the CPAS can issue a card enabling patient to get free medical care with a family doctor approved by the CPAS or to get a free medical consultation in a hospital in a given network.
12. Particularly by means of the «Health relay», within the «Social relays» in the Walloon Region.
13. This is a document that explains what costs can be expected as a result of an admission to the hospital, which must be provided to every patient, at the latest of the time of admission.
14. By using the whole palette of regulatory instruments available to the federal, regional and community governments: planning, approval standards, financing rules…

As concerns the adequacy of the supply of health care, priority is given to primary care. The political authorities have thereby chosen to encourage health-care providers to optimize accessibility of primary health care (referring to first consultation health-care providers, consequently family doctors for the most part) because these doctors are in a better position to take advantage of the diversity of the persons, because of their position of first contact, and therefore they play an important role in determining the most adequate and optimal *«health-care path»* for the patient.

In fact, even if a free, responsible choice of the doctor must continue to be a basis of the system, a certain structure («Gate keeping») is sometimes needed in the supply of health care. Consequently, in order to encourage prior consultation of the family doctor before any consultation of a specialist the first reference consultation will soon benefit from a «preferential rate» of reimbursement at the end of 2006.

In addition, the geographic location of general practitioners is sometimes problematical, which results in an insufficient number of family doctors in certain neighbourhoods or certain regions. In order to partially solve this problem, an *«impetus fund»* granting interest-free loans and subsidies to general practitioners who set up in an area where there is a shortage of doctors will be launched in September 2006.

Finally, we know that this priority to primary care is also practiced by the Communities and the Regions. For example, a Flemish decree of March 2004, encourages all health-care providers to make special efforts to optimize accessibility of primary care, particularly by taking account of the «diversity» of the population in connection with the policy for equal opportunities.

4.2.3. Promoting the quality of care

A) Quality care for all!

All Belgian authorities competent for health are aware that the quality of care needs constant attention. In addition to compliance with the approval standards that are applicable, the authorities must ascertain that health care institutions give every user appropriate care, meeting the requirements of effectiveness, efficiency, continuity, social acceptability and user orientation, without distinction of any kind[15]. To meet this objective, particular attention is given, among other things, to primary care, prevention policies, involvement of patients, freedom of choice and availability of information.

15. Note that a Flemish decree of October 2003 on the quality of health care requires health providers to supply their services without distinction pertaining to the patient concerned (of age, sex, ideological, philosophical or religious conviction, race, economic situation).

As a support structure for taking decisions on health care policy, the *«Federal Healthcare Expertise Centre»* (KCE)[16] has been created to work for greater accessibility of high quality care, taking account of growing needs and the limited available budgets. KCE's activities can be broken down into four fields of investigation:

– An analysis of clinical practices in the development of recommendations for Good Clinical Practice;
– Health Technology Assessment;
– Health Services Research;
– Equity and study of patient behavior.

It should be noted that *«Good Practice»* is increasingly considered as an indispensable contribution to the achievements of an effective health care policy. So to reach higher quality of medical services, INAMI has organized *«feedback campaigns»* on various subjects. Individual feedback includes recent scientific information on certain themes on one hand, and, on the other, individual data concerning services of the doctor in this field. He or she is also compared with colleagues in the district and all over the country.

Finally, as pointed out in the section in Annex 4.1, the Communities are competent for health education, subject to the competence reserved to the federal authorities, and for activities or services in the field of *«preventive health care»*. These include other initiatives targeting improvement actions for the state of health of the population. For *vaccination policy*, free vaccines and vaccinations are part of the current health policy. Children and young people can be vaccinated free of charge by means of organized preventive services. Vaccines for polio, diphtheria, tetanus, whooping cough, hepatitis B, type B Haemophilus influenza, measles, mumps, German measles and meningococcus for serogroup C are free. By offering these preventive measures without stigmatization, we obtain good results for health in vulnerable groups, for example people living in a poverty situation[17].

As concerns *early detection policies*, a protocol has been concluded targeting collaboration between the Federal State and the Communities with regard to massive early detection of breast cancer by mammogram. Information campaigns have been launched on the early detection programme for cancer. A preventive mammogram is offered every two calendar years for women between 50 and 69 who have not been treated for breast cancer and do not regularly take control examinations.

16. http://www.kenniscentrum.be
17. Nevertheless, we should draw attention to the fact that accessibility of certain preventive healthcare measures is lower for the weakest social-economic groups and for people with little education.

B) Quality of treatment:

B1. Several «good evidence medicine» initiatives

Practices pertaining to the hospital environment:

«Good evidence medicine» is increasingly considered as an indispensable contribution for achieving an effective health policy. In hospitals, the following practices have seen the light:

– *«clinical itineraries»* (CI) are a set of methods and means to harmonize interventions of members of a multidisciplinary and interprofessional team and to conclude agreements on assignments for a «specific patient population». The organization of care between institutions (referral systems) and cooperation between basic care and stages of further care can be optimized by means of CI.

– *«Clinical risk management»* includes a series of concepts, methods and techniques to avoid undesirable or negative results in the health-care process, insofar as possible. The federal authorities supports two research projects. The first concerns errors in medications; 17 hospitals take part. The second research project considers the feasibility of extracting a set of security indicators based on existing administrative data banks.

– A multidisciplinary «medical-pharmaceutical committee» (CMP) is established in each hospital by legislation on hospitals to ensure effective, rational use of medicines in the institutions.

– Since 1999, «medical boards» have been created in various fields. These boards have a two-fold assignment: giving detailed explanations on quality, particularly to professional practitioners, and promoting a bilateral exchange of information on the medical practice between the authorities and the service providers. Concretely, their assignments consist, among other things, of establishing a consensus on quality indicators and assessment criteria for good medical practice, making visits if needed, controlling records, drafting reports, giving feedback to hospitals and doctors concerned…

Practices not specific to hospitals:

The concept of 'tailormade care' has developed for disorders such as mucoviscidosis, neuromuscular disease, cerebral palsy, spina bifida, hereditary monogenic conditions, … The concept works by a system of contracts with «reference centres» committed to providing a global, long-term care of these patients in view of their needs that can vary with the stage of the disease (for example diagnosis, a stage of dependence, palliative stage) and with the gravity and complexity of the condition.

At the same time, a system of «conditional reimbursement» has been set up for a certain number of excessively expensive health care services, the reimbursement of which is reserved for criteria under «Evidence Based Medecine». As this concerns highly specialized care (like for example defibrillating heart implants) the super specialists concerned are associated with the decisions on cost, with the objective of 'peer review' as well as social control/responsibilization.

B2. Quality treatment by optimal rationalization of the use of resources

The *«programming»* policy determines how many hospitals, hospital wards, sections, functions and beds are needed at federal level. If the calculation is done in terms of the needs of the population and future perspectives[18], it also takes account of geographic location and tries to maintain the conditions of healthy management, requiring a certain rationalization in the use of resources. Consequently, as indicated in point D, section 4.2.2., the structure in *«health basins»* targets optimal geographic location of assistance and services for each zone.

The same logic is used for planning technologies (Pet Scan for example).

C) Quality health-care providers

- The traditional way of reaching quality care is to impose *«standards of recognition»*

  To be recognized, a health-care institute[19] must meet recognition standards called, «Approval» (*agrément*), pertaining to, among others:

  - General Organization (minimal level of activity, minimum number of beds, types of health programmes, etc.);
  - the organization and operation of all types of services (technical equipment required, medical personnel, paramedics and nurses…).

  Over the years, recognition of institutions has evolved. Thus, with a view to protecting public health, alongside structural requirements, standards include a growing number of patient-oriented conditions.

  Similarly, medical and paramedical staff must also meet certain standards to be able to provide services. «Accreditation» is granted for any health-care provider who meets the minimum conditions decided for continuing education, assessment (by peers) and activity (minimum number of patients). This accreditation gives the right to an annual complementary flat rate «fee».

- In addition to the need to have adequate recognition standards, other quality criteria are important for health-care providers:
  - To ensure quality supply, health-care providers must be sufficiently numerous. As mentioned in point D of section 4.2.2, Belgium does not really have any shortage of health-care providers, nor waiting lists.
  - Peer review systems exist to maintain mutual motivation of health-care providers. The «*hospital performance*» concept, based on existing data banks, individual,

18. Using mathematical rules and formula based on figures pertaining to the population, the age pyramid, morbidity etc.
19. For hospitals, this applies to each service, function, ward, medical department, medical-technical service and health-care programme created within the hospital.

multidimensional feedback and integrated administrative data in hospitals, is now being developed for use in hospitals. The objective is to enable hospitals to determine their position in the Belgian hospital landscape, so that they can define objectives and improvement actions for themselves and manage quality from a prospective standpoint.

D) Respect of patients' rights

A precise definition of *«patients' rights»* in a clear and simple law is an important instrument for promoting the quality of health-care services, particularly for maintaining good relations between the patient and the health-care provider. According to the law, in his relation with a professional practitioner, the patient has several rights: the right to high quality care, the right to free choice of a professional practitioner, the right to all information concerning himself, the right to a carefully kept patient file, updated and maintained in a safe place, the right to protection of privacy, etc.

Note that to maintain respect of these rights in practice in hospitals, a «mediation» function has been created to moderate any differences between the patient and the health-care provider.

We also note, from a similar standpoint, that the Flemish Community supports various initiatives targeting reinforcement of the patient's position. For example, we can mention the *«Vlaams Patiëntenplatform»* (VPP – Flemish patient platform), the federation that represents patient associations and mutual assistance groups to improve quality of life for the patient and his entourage, in order to achieve accessible «tailor-made» care.

4.2.4. Ensuring financial viability of accessible, quality care

A) Evolution of expenditures: a trend under control given the cost of aging

In its most recent report in May 2006, the Study Committee for Aging (CEV) considers that public health expenditures will increase from 7.1%[20] of GDP in 2005, to 10.8% in 2050. These projections also take account of demographic factors (the volume effect and the aging effect of the population) and non-demographic factors. The projections make a distinction between evolution of acute care (which will rise from 6.2% to 8.6% of GDP from 2005 to 2050) and expenditures for long-term care (which will increase from 0.9% 2.2% of GDP from 2005 to 2050).

20. Using the OECD SHA methodology (System of Health Accounts), total health expenditures in Belgium were 9.9% of GDP in 2003 (about 10.1% in 2004 according to estimates) of which +/- 70% were public expenditures and 30% private expenditures.

Note that the Working Group on Aging (WGA) of the European Union Economic Policy Committee has made a slightly different estimate, since it anticipates slower growth in public expenditures in Belgium (which are expected to increase from 7.1% to 9.5% of GDP between 2005 and 2050)

In order to deal with growing expenditures, *an overall standard for growth of expenditures*, has been in force since the 1995 tax year for mandatory health insurance that is set at *4.5%* per year *before inflation*[21], for the years 2004 to 2007 (see B below).

B) Setting a standard for growth of public health expenditures

The principle consists of setting the maximum accepted amount, for one year to the next, of expenditures of the mandatory health-care system (reimbursement of health costs), given the growth standard that has been set (4.5% before inflation for 2004-2007). This amount is called the *«Overall Budget Objective»*[22]. In 2004, the objective was exceeded slightly (and therefore the «expenditures trend» was readjusted slightly below the 4.5% of real gross income. The first indications seem to show that the overall budget objective will be met in 2006.

INAMI is in charge of putting together the annual budget for mandatory health-care insurance. And as needs change from year to year, and are not the same for all sectors, this overall budget objective is broken down and subdivided every year into *«Partial Budget Objectives»* by large medical and paramedical headings.

To allocate these funds, the responsible organizations use several elements: the description and financial estimate of the cost of «new needs» (list of health-care services that are not yet covered (or are insufficiently covered) by health insurance); technical calculations done by the INAMI services that give the estimated amount of future expenditures; and possible savings on existing health-care services (elimination of obsolete services, reduction of fees, adjustment of personal contributions (*tickets modérateurs*), modification of rules of access and reimbursement of services, … etc.). For more detail on a budget procedure.

C) Monitoring public health expenditures

Once the partial budget objectives have been set (during the second half of the previous year), monitoring procedures are set up to verify the achievement of these objectives and also to ensure compliance with the standard. During the year in consideration, the health-care insurance expenditures are analysed regularly. The first

21. Note that this standard concerns only health-care expenditures reimbursed by the health insurance scheme. Personal contributions (tickets modérateurs) borne by insured parties, and services (or equipment or drugs) which are not included on the list (nomenclature) of reimbursed care, etc. are not included in this amount.
22. This supposes that financing of «controlled» expenditures is possible. However, as this maximum rate allowed for the growth of expenditures is higher than the growth rate of GDP, this could cause financing problems in the medium term…

goal of this analysis is to detect any (risk of) overspending as compared to the partial budget objective set (for each partial budget objective) and to take adequate measures as quickly as possible to maintain compliance with budgets. During the year in consideration, on a monthly basis INAMI receives health-care insurance expenditures from the financing organizations (with a lag of three months)[23]. On this basis, a detailed analysis is done every quarter and communicated to the various management bodies that ensure a *«continual audit»* and analyse the evolution expenditures. If there is an objective risk of overspending, corrections are requested and implemented.

D) Estimates for controlling norms on the rate of growth of public health expenditures

Alongside the indispensable corrective measures mentioned in C, the State sets up various cost control policies (control of volume and price) for health-care services. The most important of these are listed below:

1°) Policies to promote responsibility of the various players

Several provisions in the mandatory health-insurance scheme encourage all players to «moderate» health-care expenditures. Examples are:

– The «*ticket modérateur*» and a posteriori reimbursement promotes patient responsibility;
– Requiring a flat rate charge for certain services mainly in hospitals promotes responsibility of health-care providers. Since the principle of «payment for the act provided» sometimes leads to overconsumption, in certain fields, it is now stipulated that a flat rate reimbursement will be used partially (for clinical biology, medical imagery, …) to better control expenditures;
– The «continual audit of expenditures» mechanism promotes responsibility of service providers and managers;
– Responsibility of the organizing bodies is also promoted by the allocation of the INAMI budget between the mutual societies. Without going into detail, 30% of the interventions of mutual societies is reimbursed by INAMI by calculating the «theoretical expenditures» for each of the mutual societies. These theoretical expenditures correspond to «health risk» profiles of the insured persons.

2°) Rationalization and efficiency in controlling the volume of health services and prescriptions

The promotion of primary care, campaigns against the abuse of antibiotics, «evidence based medicine» techniques, the global medical dossier (GMD) … all of these «incentives», described in the previous sections, whose first objective is affordability and/or quality of care, are also «incentives» for efficiency and rationalization in services

23. These are expenditures « entered in account » (as opposed to the concept of «services provided» or «paid»).

provided which, if they are successful, will inevitably lead to reduction in the volume of health-care services, all other things being equal.

From the same viewpoint, it can be hoped that the increasingly frequent use of the flat rate mechanism (see 1° in this section) will act as a discouragement of overconsumption. It should be noted on this subject that as from 1 July 2006, a flat rate will be used for 3/4 of the medicines used in hospitals.

Finally, note that the continued development of data bases within the *«Banque Carrefour de sécurité sociale»* and the generalization of the SIS card (as well as the increasing use of the European card) all promote increased efficiency and more particularly, save time.

3°) Measures targeting cost control of services provided

Various measures target moderating the evolution of the cost of goods and services in health. As we have seen in point C of the section 4.2.2, prices of the series of medicines dropped considerably on 1 July 2006. The future application of the *«kiwi model»*, could confirm this tendency for the reduction of the price of drugs in months to come.

E) Other policies for sustainability

As concerns policies to promote health and healthy lifestyles, the Communities each have their own policy.

In 1998, the Flemish Government had already officially recognized five health targets, in full compliance with the recommendations of the European section of the World Health Organization (WHO). During the 2006-2008 period, these objectives were systematically updated[24]. In 2007, additional attention will be given to developing a plan for the consumption of stimulants (tobacco, alcohol and drugs). In 2008, the Flemish Authority will organize a health conference on the subject of food and physical exercise.

The French Community, for its part, has developed an Operational Community Plan defining priorities for health promotion and prevention: prevention of cancer, prevention of AIDS-HIV, cardiovascular health, vaccination, prevention of household accidents and prevention of drug abuse. In the context of the cardiovascular health priority, a

24. The objectives are as follows: decreasing the number of smokers by 10%, specifically among young people; reducing fatty foods and replacing them with foods that have little fat but are rich in fibres; more preventive examinations for breast cancer (by means of a mammogram for women from 50 to 69 years old); decrease (by 20%) of the number of fatal accidents in private life and in traffic; better prevention of infectious diseases (particularly by increasing the rate of vaccination for diseases such as polio, whooping cough, tetanus, diphtheria, measles, mumps and German measles, the objective being to reach a percentage of vaccination of at least 95%, recommended by WHO. These were the Regions' objective in 2005. Prevention of suicide and depression is now a sixth health objective.

«Healthy attitudes plan» to improve awareness of children and adolescents by means of an information campaign, to encourage them to change their eating habits and to get more exercise!

In addition, we should recall that, since 1 January 2006, a federal law prohibits any worker from smoking in any area where he is employed in the context of his work.

Finally, we note that to promote the responsible use of antibiotics, and particularly to fight an increase in microbic resistance, awareness campaigns[25] are organized to reduce the current overconsumption of antibiotics in Belgium.

F) Additional financing (or private financing) of health-care expenditures

The mandatory public health care insurance is a branch of Social Security, financed by the overall management of Social Security. This organization is not questioned, and all efforts are being made to consolidate and to ensure its sustainability.

However, some services are not covered, or are only partially covered by mandatory insurance. To increase their cover, citizens can decide to subscribe to a «complementary health-care insurance policy» offered by the insuring organizations (in this case they are managed in the spirit of a nonprofit mutual society, with solidarity) with which enrolment is mandatory, or by private insurance companies.

We also note that some employers take out «group complementary insurance» for their employees.

It seems that the use of complementary insurance policies has grown in recent years[26].

25. Particularly the creation of a committee called BAPCOP (Belgian Antibiotic Policy Coordination Committee).
26. The number of people covered by a private health insurance policy has increased respectively by 18% and 21% from 2000 to 2004 for individual policies (rising from 959,000 to 1,136,000) and for group policies (increasing from 2,849,000 to 3,459,000). The amounts reimbursed by private health-care insurance grew sharply in 2000 to 2004 from 77,576,000 to 141,570,000 for individual contracts (an increase of 82.5%) and from 180,667,000 to 314,993,000 for group policies (+ 74,3%). (Source: Assuralia, l'Union professionnelle des entreprises d'assurances)

SECTION 4.3. LONG-TERM CARE

4.3.1. Brief description of the system of long-term care

Defining long-term care» (or «long duration care») is not an easy thing to do. This care is not limited to the elderly. We have chosen to include in this category all rehabilitation, mental health care, care for chronic illnesses and palliative care. In addition, we also mention certain assistance services that are not really health care but that provide indispensable services complementary to long-term care. By and large, these services are complementary to the «informal care» provided by the family.

For long-term care, and particularly for care for the elderly, the Communities and Regions are competent to a large extent. Consequently, the range of services offered vary from one Region and one Community to another. Note that these differences may increase in the future, particularly as concerns the policy for «seniors», given that the different regions have different age pyramids and, consequently, aging will not be felt in the same way at the same time, nor to the same extent.

As concerns the organization, in each the Community/Region, long-term care can be provided in a hospital environment or in specialized services, as the case may be, or even take the form of care at home. As will be seen in the various sections in this part, collaboration has developed between the various service providers, emphasizing a multidisciplinary, integrated approach to long-term care.

Finally, to coordinate the policies at the highest levels of authority as best possible specialized committees called *«Inter-ministerial Conferences»* (consisting of members of the Federal Government and the executive governments of the Communities and Regions) have been created, and target determining common objectives, on the basis of which each authority establishes its own objectives in view of its own diversity. There is a working group for «Chronic care policy», a working group for the «Health policy for the elderly», and a working group on «Mental health».

4.3.2. Assuring access to long-term care

A) The supply of care to the elderly is growing constantly to meet evolving needs

The aging of the population, and more particularly, the group of persons over 80, which will be growing the fastest (see annex 4.3. for live expectancy) will have a considerable effect on demand and needs for care that necessitate a constant adaptation of the type and quality of care structures offered.

To meet these needs, there are various possibilities of services intended specifically for the elderly.

1°) Non-hospital residence

In Belgium, the supply of *«non-hospital residence for the elderly»* include several types of definitive host structures that differ in the types of services they propose and in the health care they supply. Homes for the elderly (*Maisons de repos pour personnes âgées*) (MRPA) provide traditional residential care for people over 60, Nursing homes (*Maisons de repos et de soins*) (MRS) are more medically-oriented, and – for elderly persons who are still independent – residences with services (*Résidences-services*) propose individual housing units associated with services on demand.

Alongside these structures for permanent residence, and often in the same facilities, the supply of occasional or temporary residence facilities has developed. There are day/night care centres (*centres de soins (ou d'accueil) de jour/de nuit*), and temporary residence facilities (*centres de court-séjour*). A day care centre (*centre de soins de jour*) is associated with a nursing home. During the day/night, it offers more limited services for elderly persons who, for the rest, are sufficiently independent to stay at home. A temporary residence facility offers residential care for the elderly who stay for only short periods, for a maximum of 60 days successively, or 90 days annually.

«Programming» of needs for resident structures for the elderly is done taking account of the number of elderly persons who need care, and the demographic evolution of the various age groups as from 60, in the different Communities and Regions[27].

In October 2005, the working group on «health policy for the elderly» (*Politique de la Santé à mener à l'égard des personnes âgées*) concluded a protocol of agreement (n°3), with a scope of six years, developing a coherent policy in favour of the elderly and providing a coordinated response to the need for residential facilities, accompaniment and care for this target group, respecting the competence of each level of authority. By means of this protocol, the initial programming of MRPA and MRS has been broadened and transformed into programming of «types of care» integrating alternative or innovating types of care and support for staying at home, using a key for conversion to equivalence with a MRS. Concretely speaking, each level of government has an additional budget (expressed in MRS equivalents[28]) to increase its residential capacity, continue the conversion of MRPA beds into MRS beds, and diversify supply of care[29].

27. Despite a relatively high price per day of this type of institution (see point B), Belgium is among the countries with the highest rate of institutionalization, with 6 to 7 persons institutionalized per 100 persons of 65 and older.
28. This is equivalent to an additional budget of € 174 million for the period of the protocol (2005-2011) allocated by the Federal State to the Communities and Regions .
29. Protocol n°3 specifies that the MRS equivalents must be used for 20% to encourage innovating projects, referring to forms of programmed, non-definitive residential care (day care centers, temporary facilities, etc.), or programmed residential care, to support home care, or a collaboration agreement between one or several of these structures and residential structures.

While leaving considerable latitude to the levels of government in the way they use the MRS equivalents, *the federal authority asks the Communities and Regions to take account in their programming of the priority that should be given to maintaining people at home*.

2°) Priority for keeping people at home

Home care offers an ideal alternative to residential care, as it is the best framework for organizing «tailormade care».

With this in mind, and in order to obtain the best possible framework, as well as a reduction of the workload, social agreements were concluded in 2005[30] providing for 2,613 full-time equivalents, of which 70 are reserved for home care, in order to develop a supply of care that avoids or postpones placement of elderly persons in need of care who are living at home, as part of collaboration between primary care and institutions providing care.

In addition, alongside provisions for home care, each Community also finances various subsidized associations such as: services for family care («Gezinszorg» in Flanders), local and regional service centres («Lokale en Regionale» dienstcentra in Flanders), services for «oppashulp» (in Flanders), associations for users of informal care (in Flanders), services for logistic aid for home care (in Flanders).

As can be seen, the Flemish Community has clearly affirmed the development of home care as a priority for its health policy, in order to respect the desires of patients who prefer to stay at home as long as possible[31]. The Brussels Region has also decided to give priority to home care, particularly by creating a platform for concertation for the health of the elderly at home. The Walloon Region also supports aid at home, particularly by subsidizing a considerable increase in the hours of family assistance for dependent persons from 2004 to 2006.

Note also that the German-speaking Community has reinforced contacts between host structures supplying care outside the home, and structures for aid at home by extending the concept of *«case management»*[32] to the entire sector of elderly persons.

30. In the context of the conversion of an equivalent of 28,000 beds in MRPA into MRS using the «MRS equivalent principle».
31. Note that, in the same spirit, the Federal State wants to support care and aid provided by the entourage of senior citizens by professional leave or specific career breaks…
32. An elderly person is taken in charge on first application (either for residence in MR-MRS or at home); a multidisciplinary team establishes a plan for aid and care with the person, taking account of the family environment and the habitat; in case of need, links are established with social aid structures. Currently in the form of a pilot project, this concept has avoided institutionalization in MR-MRS for 50% of applicants.

3°) Hospital care for the elderly: promoting a continuum of care

A programme of geriatric care has been developed. The development of this programme targets guaranteeing a specialized approach to geriatric patients, including five aspects: geriatric ward (index G), consultation in geriatrics, geriatric hospital for day care, internal liaison and external liaison. The objective of these new liaisons is to ensure a «*continuum of care*» for the elderly between hospitalization and long-term care. For example, the internal liaison assists hospitalization of patients with a geriatric profile who are not admitted in geriatrics, and the external liaison allows for easy transfers without discontinuity from the hospital to nursing homes or to coordination of home care.

In addition, one-day hospitalization represents a significant step forward in geriatrics and allows for an ambulatory diagnosis programme, for example as part of a global assessment of problems specific to the very old, or a pre-operation evaluation. 46 day hospitals have been created as pilot projects on 1 January 2006.

B) Cost and other problems of access to care for elderly

1°) The problem of waiting lists in facilities for occasional or temporary residence

Programming resident structures, based on needs for care and on demographic evolution, adapted to the various Communities and Regions (see point A), helps reduce global[33] problems associated with a lack of room to meet needs for definitive or long-term institutionalization. Conversely, some shortages are observed in occasional or temporary residential structures allowing for continuity of care before the return home. For this reason, the creation of new day care or short-stay facilities is encouraged by financial incentives to make them more attractive, as large fixed costs are involved in creating this kind of institution.

2°) The costs of services to the elderly

Health care provided as services to the elderly (residential or home care) are covered at a flat rate, by the mandatory health care insurance, in view of the degree of dependence of the beneficiaries[34].

33. However, in certain provinces there are shortages, particularly for «urgent» applications for institutionalization, mainly in MRS.
34. This dependence is currently assessed on the Katz scale.

On the other hand, the cost of residence in non-hospital host structures in the form of a *«price per day»*, are borne by the residents. The price, controlled by the Federal State, varies with the institutions in terms of the services offered. Moreover, for «day care centres» and for «temporary residence», one mustn't forget that in addition to the price of the stay in an institution, the elderly person must continue to cover costs at home[35].

To increase transparency and to enable the resident and his family to get sufficient information to be able to make a reliable comparison of the supply proposed by various institutions, and to prevent double invoicing, the authorities have agreed to take the necessary measures to restrict the breakdown of costs in addition to the price per day insofar as possible. (These costs for example are supplements, advance payments to authorized third parties…).

3°) The problem of transport for «day care centres»

It should also be pointed out that using *«day care centres»* is more complicated since many elderly persons cannot take advantage of them for lack of suitable transport, particularly since day care centres do not benefit from a specific subsidy for transport and, consequently, many day care centres must invoice additional costs to the elderly person. Because of this observation, the federal authority has recently submitted a proposal for financing to the Communities and Regions, to provide for a social worker and accompanying person for transport, in order to optimize the operation of the centres and increase the number of beneficiaries.

C) The supply of long-term care is becoming more specialized

Alongside specific services to the elderly, other types of long-term care are gradually becoming more specialized, both inside hospitals and in specialized institutions or at the patient's home.

As concerns *«services offered in a hospital environment»*, there are specialized services for treatment and adaptation called *«Sp service»*, in the following specialties: cardiopulmonary, neurological, locomotors, psychogeriatric, chronic and palliative treatments. These services can be set up inside a general hospital or have their own structure as required. Note that for Sp services with fewer than 80 beds, as is the case for geriatric services, financing is provided for the function of a *«hospital reference person»* to ensure continuity of care. This person takes the measures needed to prepare a quality return home, determines the processes for collaboration of a multidisciplinary team within the hospital, and between the hospital and the primary structures, as from admission in the hospital.

35. We recall that there are specific financial aids for elderly or dependent persons with low income, such as GRAPA (Guaranteed income for the elderly) and APA (Allocation of aid to the Elderly). They guarantee a minimum income to the elderly which, among other things, enables these people to call on residential or home services. In addition, if despite everything, an elderly person cannot meet the cost of indispensable residential care, under certain circumstances the CPAS can bear the cost of this.

As concerns the *«Home aid and care services»*, as mentioned in point A, various mechanisms and structures have also been put in place to help dependent persons, whatever their age. For example, home aid services include: delivery of meals, cleaning, family aids, etc.

Home nursing care is provided either by self-employed nurses, or by nurses employed by private or public organizations.

Similarly, for palliative care and accompaniment of people at the end of their lives, even if the palliative mission in hospitals has also been reinforced (by means of a palliative hospital function or by palliative Sps), particular attention is given to *«Palliative care at home»* for which a whole series of measures have also been taken, notably by officially setting up multidisciplinary palliative teams in 1998 to support palliative care of patients in the terminal phase who want to spend the end of their lives at home. Affordability of home palliative care has also been facilitated by a series of measures taken as part of the health care insurance scheme (see, among other things, the *«flat rate for palliative care»* in 1° of point D herebelow)

At Community and Regional level, many initiatives have been taken for palliative care. The Walloon Region grants subsidies to cover expenses incurred by associations active in the field of palliative care for expenditures not covered by INAMI. These primary services develop experimental actions in this field such as the «Palliative care platforms» and the «Walloon Federation of palliative care». In Flanders, the policy consists of stimulating palliative care at home by taking a number of measures to support informal care. The decree concerning primary care and cooperation between health-care providers sets the basis for recognition of «palliative networks».

Finally, with regard to «Mental Health», in addition to hospital services (psychiatric wards in general hospital and psychiatric hospitals), intended for patients requiring active treatment, ambulatory services called *«Mental health services»* (SSM) are becoming increasingly common. These are services that provide reception, and diagnosis and psychiatric, psychological and psychosocial treatment of persons, by means of a multidisciplinary approach and in collaboration with other services or persons concerned by mental health[36]. Alongside these, there are also psychiatric care institutions called *«Maisons de soins psychiatriques»* (MSP), that host patients whose condition is stable and who mainly require help with acts in everyday life, and *«sheltered housing»*, in other words residential services enabling patients who need help with social reintegration to live as independently as possible while maintaining a certain accompaniment. Many initiatives exist in the field of mental health. They try to contribute solutions to real problems of accessibility and adequacy that exist in this

36. Certain mental health services have developed initiatives targeting solutions for specific mental health problems in the fields of drug addiction, perpetrators of sexual offenses, the elderly, children and adolescents.

complex field. Thanks to these initiatives, in the framework of «therapeutic projects»[37], the existing structures, primary care – including care at home –, plus a whole set of specific services for mental health described above, receive the necessary incentives to work optimally on the issue of mental health, with the objective of ensuring continuity of care. (See also 3° of point D herebelow)

D) Costs and other problems of accessibility of long-term care

1°) The cost of long-term care

Several mechanisms exist to take account of the special situation of long-term patients who must cope with high costs.

First of all, long-term patients benefit from higher reimbursements from the mandatory health care insurance scheme under the *«BIM»* and *«MàF»*. (See point C of section 4.2.2.)

Secondly, various measures reduce the expenses of long-term patients, including:

- Interventions or flat-rate charges targeting long-term patients in special situations We can mention the *«flat rate for chronic diseases»*, the «intervention for incontinence material» and the *«palliative care flat rate»*. In each case, under certain conditions, patients can benefit from a monthly or annual flat-rate contribution to lighten the financial burden they face;
- *Allowance for the help of a third party:* a person who benefits from an incapacitation allowance who has one or several dependents and meets certain criteria can claim a flat-rate allowance for assistance from a third party. This allowance is equal to € 5.37 per day;
- *The integration allowance:* awarded by the Federal State to disabled persons between 21 and 65 whose lack of autonomy or reduced autonomy has been certified. We note that persons over 65 suffering from a lack of autonomy can apply for *an allowance for aid to the elderly (APA)*;
- A reduction of the ticket modérateur of 30% for home visits to the elderly over 75 and for persons who are not in a position to move because of a chronic illness, if the patient has a global medical dossier;
- *«Zorgverzekering»* from the Flemish Community; care insurance set up in October 2001 to reinforce aid to persons who suffer from prolonged and serious reduced autonomy, whatever their age. This insurance scheme[38] is intended to help cover the cost of non-medical aid and services. This is a monthly contribution: € 95 for proximity and home care; € 125 for residential care.

37. A joint declaration of the «mental health» working group (See section 4.3.1) has resulted, among other things, in the development of a sector «therapeutic projects» that will see the light at the end of 2006.
38. Financed by means of an allocation from the Community budget on one hand and, on the other, by collection of mandatory contributions (from € 10 to € 25 per year) of persons over 25 living in the Flemish Region.

2°) The problem of adequate supply

Although the supply is becoming increasingly specialized, there are still specific needs not covered for certain target groups, or more accurately needs for which specific costs are not covered, as they should be ideally.

The problem notably arises due to the fact that, except for hospitalization, Belgium does not have a system for bearing specific residential costs for people suffering from a serious pathology between childhood and old age. For example, this is the case for chronic care for people suffering from *«non-congenital brain damage»* for whom structural facilities are lacking or even nonexistent, particularly for long-term care. Since July 2004, however, a suitable care circuit for patients in persistent neurovegetative condition (PNVC) or in pauci-relational condition (PRC) has been put in place[39]. This network includes four components: a general hospital for the acute phase, transition hospitalization in an expertise centre, appropriate long-term care (institution or at home) and close cooperation (external liaison) between expertise centres and «long term» centres. The same kind of the approach is currently being studied to offer care to other, non-congenital chronic disorders of the nervous system.

3°) problems of accessibility and adequacy specific to mental health

There is no denying that there is a significant gap between the number of people who need financial assistance and treatment for mental or psychiatric problems, and the number of people whose needs are satisfied.

The problems of providing adequate care are associated with the complexity of mental suffering which often has various origins: medical, psychological, social. Under these circumstances, it is important for the supply of mental health care to be integrated, multidisciplinary and to ensure great continuity of care. For this purpose, the supply of mental health care is increasingly adjusted to target groups using the network principle (a principle recognized by a joint declaration of the «mental health» working group. For each target group (children, adults and the elderly), a supply of care or a specific care scheme should be defined. The network approach can take various forms, but in all cases, this is a form of collective action pooling all of the health-care providers concerned, with a view to improving coordination, complementarity, multi-discipline assistance, continuity and quality of their services and activities to better serve the user.

Problems of accessibility are obvious in mental health. There are also inequalities. The problem is doubly difficult. On one hand, poverty can cause problems in the mental health field. On the other, mental health problems can also be the cause of poverty. Moreover, people of foreign origin must also deal with specific difficulties associated with many precarious situations they encounter, particularly in large towns.

39. By the working group «Chronic care policy» (See section 4.3.1).

«Mental health services» (SSM) can provide advantageous solutions in the mental health field. By providing integrated healthcare by means of multi-discipline teams, they ensure a certain geographic, financial, cultural and psychological accessibility while developing a global approach that takes account of the patient's psycho-medical-social aspects.

Note that services are developing, particularly in Brussels but also in Wallonia, that try to facilitate access to aid in mental health for people in exile.

E) Necessary collaboration between the various long-term care services and services for the elderly

As is shown by the creation of the new liaison functions (internal and external) in hospitals (see point A 2°), ensuring a «continuum of care» for long-term patients (elderly and others) is a priority. This «continuum of care» must guarantee a multidisciplinary, integrated approach to long-term care and pursue the objective of returning or maintaining the person at home insofar as possible. For this purpose, we can mention among others:

– The role of the family doctor (and the coordinating doctor in MRS) should be reinforced and seen as an indispensable central link;

– *«Integrated home care services»* (SISD)[40] should provide an assessment of the patient's autonomy, establish and implement a care plan, assign the various tasks to the appropriate health-care providers and offer the multi-disciplinary concertation that goes with them. As from 1 January 2006, reimbursable multiple-disciplinary concertation is possible for a person living at home or who is admitted into an institution where a return to home is planned, for example, to prepare to return home of an elderly patient after a stay in hospital;

– Special palliative training has been created in nursing homes;

– The new geriatric programme (see B 1°) provides the solutions for fragmentation of care for the elderly.

4.3.3. Promoting the quality of long-term care

As explained in section 4.3.2., the traditional way of achieving quality is to impose *«standards of recognition»*. Concretely speaking, health care establishments are subject to many approval standards set by the Federal Public Service for public health and by the Communities and Regions; the local authorities also control compliance with standards. The flat rate contributions awarded to MRS and MRPA,

40. Integrated home care services (S.I.S.D.) are defined as a health-care institution which reinforces all types of care to patients provided within a certain zone, among others by organizing practical and supervisory services home care context, for care that requires the intervention of professional practitioners from different disciplines.

financed from the health and incapacitation insurance budget, are subject to compliance with these norms. Quality control is also based on different procedures to be met by medical, paramedical and other health-care providers (approval and/or accreditation).

Because of the aging of workers and the increase in demand for long-term health care services (and host facilities), mainly for elderly persons, there is the threat of a shortage of health-care providers. Consequently, to maintain quality and accessibility, attention must be given to drawing people to health professions, particularly by offering attractive working conditions.

There are approval criteria for claiming the special *professional qualification* of a nurse specialized in geriatrics or a nurse having particular expertise in geriatrics. Two ministerial decrees have been proposed that will define these criteria. Practitioners of nursing arts must take an additional training course in geriatrics including 150 hours of theory to obtain the professional qualification of a nurse with expertise in geriatrics. Another 450 hours of practice must be added to these 150 hours of theory to use the professional title of a nurse specialized in geriatrics.

Like for health care, there are various methods of peer review for long-term care that stimulate the quality of services. A *«medical board for geriatric services»* has been created. Like other medical boards, it has a variety of assignments (see section 4.2.3). Among these, we can particularly mention drafting the national annual report.

We also note that providing quality care to the elderly means more particularly having services that meet the real needs of our senior citizens. Consequently it is crucial to have an instrument to assess the needs for care and to develop the necessary care plan. For three years now, a university team has been doing research to find the most adequate instrument for Belgium. This study was completed in December 2005, and its conclusions show that the *«RAI/MDS»* is the tool that best meets the criteria and offers real added value for quality control of care and stimulation of work in collaboration for a patient. The study is now being done on the possibilities of generalizing the use of the RAI/MDS tool in the various health-care contexts.

In each Community/region, initiatives are being taken to increase the quality of long-term care.

The Flemish – Government emphasizes the need for «tailormade care». Thanks to good cooperation structures, this care should be flexible and adapted to the patients' real needs.

In the Walloon Region, consideration is being given to the optimal intervention model for inspection teams in nursing homes, in order to improve the quality of reception and housing of the elderly, particularly by means of a project for institutional life.

Finally, in the German-speaking Community, a «quality approach» is implemented in all nursing homes, resulting in the concept of care and housing anchoring the nursing home as a living environment where the structure should serve individual needs of the elderly residents.

4.3.4. Insuring financial viability of affordable, quality long-term care

Since most of the formal services for long-term care are incorporated in the existing health-care system, particularly by means of the mandatory insurance scheme, there are no policies specific to long-term care for the financial viability of the system. Consequently, we refer readers mainly to section 4.2.4.

We should specify, however, as concerns other services provided to long-term patients and to elderly persons that are not covered by the mandatory insurance scheme, political authorities at all levels are endeavouring to make these services as inexpensive as possible for the users and the community… while ensuring high-quality and making them as accessible as possible!

Finally, as mentioned in section 4.2.4, we recall that the projections of the CEV and the WGA make a distinction between the evolution of acute care and expenditures for long-term care. For the latter, they were 0.9% of GDP in 2005 and the CEV estimates that they will reach 2.2% of GDP in 2050 where as WGA puts them at 1.9% of GDP in 2005.

ANNEXES

On the enclosed CD, the reader will find a complete version of the report that was sent to the European Commission with several annexes, which have not been included in this brochure.

The annex to chapter I includes more information to clarify the report.

The annex to chapter II[41] includes analyses of 4 examples of «Good practice»[42].

The annex to chapter III includes a certain number of common indicators (and contextual data) with regard to the three common objectives in the strategic field of Pensions.

Finally, the annexes to chapter IV comprise more detailed information on the division of the competences in the field of health care in Belgium (between the Federal State, the Communities and the Regions), as well as on the compulsory health care insurance scheme, analyses of 5 examples of «Good practice»[43] and a set of statistical information (and indicators) in order to clarify this chapter of the report.

41. The set of indicators of the NAP on social inclusion is also included in a separate document.
42. For social inclusion, the following examples of «good practice» were chosen:
    - Ensuring affordable, quality housing for everyone: a cross sector experiment for integration of the homeless in the Brussels-Capital region (Direct access from the street to housing for homeless);
    - Developing activation and diversity of employment: managing diversity in the Walloon Region;
    - Fighting poverty affecting children: example in the French Community;
    - Measures taken for better governance: the integration of field mediators for the poverty and social exclusion issue, and, the Flemish Action Plan for fighting poverty.
43. For health care, the five following examples of «good practice» were chosen:
    - The «Maximum charge» as an instrument providing better affordability of health-care;
    - Early detection policies for breast cancer targeting detection of tumours as quickly as possible to increase the effectiveness of treatments;
    - The «Coma» projects as an adapted health-care scheme for patients in persistent neuro-vegetative condition (PNVC) or pauci-relational condition (PRC);
    - N° 3 inter-ministerial protocol for the elderly breaking down the budget and organization of health-care investments for the elderly over six years in the various Communities and Regions ;
    - Vaccination policies targeting reducing morbidity and mortality of avoidable infectious diseases by immunization of target groups.

Federal Public Service Social Security

Place Victor Horta 40, box 20 – B-1060 Brussels

http://www.socialsecurity.fgov.be

D/2006/9737/12

Responsible publisher: Frank Van Massenhove – Head of the FPS Social Security