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BELGIAN HEALTH CARE: A SYSTEM WORTH STUDYING

by

DOUGLAS JOHN MARAGAS*

INTRODUCTION

One of the fundamental differences between Belgian and American health care systems is the goal of the systems. In Belgium, the most important health care goal is *access* to medical care.¹ Whereas, in the United States, access is secondary to providing the best, most innovative, health care for the *paying consumer*. To myself, and many others,² access *should* be paramount in America.

Although access is a secondary goal in America, there are programs to support access to health care. To assist the American health care consumer, there is a piecemeal network between public and private health care providers; ie. Medicare and Medicaid alongside private health insurers. It is no secret that the current American system is inadequate because it fails to ensure access to health care at a manageable price.³ It is also no secret that the unspoken catastrophic insurance is had by bankrupting or by depleting the elderly persons' assets. By "spending down" their assets,⁴ the elderly persons' medical bills are paid through the Medicaid program while their individual families retain their assets.⁵ In effect, the *only* "insurance" available against truly catastrophic illness is the degrading of one's economic status to the poverty level. This is not an attractive health insurance policy.

A comprehensive plan guaranteeing access could solve America's health care problems. I recommend developing a comprehensive plan similar to the Belgian health care system. I advocate the Belgian system because it is a comprehensive system guaranteeing access, using both private and public resources.

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¹ Interview with J. Hermesse, Chef du Service d'etudes, Alliance des Mutualites Chretiennes, in Brussels, Belgium (Summer 1991).

² In this past presidential election, access to health care was a principle issue.

³ JANET KLINE, CONGRESSIONAL RESEARCH SERVICE, THE LIBRARY OF CONGRESS NO. IB90005, HEALTH INSURANCE, 11 (June 27, 1990). For truly catastrophic ailments, private insurance is, for all intents and purposes, unavailable.

⁴ Elderly persons give their assets to their families, thereby making their estate bankrupt. As a result, their assets are insulated from exorbitant medical bill deductibles.

⁵ *Catastrophic Health Insurance: Filling the Long-term Care Gap*, Before the Subcomm. on Health and Long-term Care of the House Comm. on Aging, 101st Cong., 1st sess. (July 2, 1987).

This article will focus on basic information pertinent to the Belgian system. A more extensive explanation of the Belgian system, and a proposed American health care plan adapted from the Belgian system, can be found in my report: "A Comprehensive Health Care System Incorporating Public and Private Enterprise: With the Belgian system as a Base, America can Develop a Cost Efficient Comprehensive Health Care System."⁶

BELGIAN MUTUALITIES

All Belgians, including the poor, are covered by compulsory health, sickness and invalidity insurance.⁷ And, all Belgians are given the opportunity to choose their insurance carrier.⁸

There are only six health insurance carriers in Belgium. Five are private health insurance companies, called "mutualities." The sixth is a public health insurance company called the "auxiliary fund."⁹ The auxiliary fund is available for people who don't wish to join one of the five mutualities.¹⁰

The five mutualities are Christian, Socialist, Liberal, Professional, and Neutral. The Christian and Socialist Mutualities are the largest insurers and the auxiliary fund is, by far, the smallest.

All mutualities must be insurance providers for the state mandated health insurance program. And, along with the compulsory policies, all offer their own variation of private insurance policies. For example, when a person joins the Christian mutuality, the person is automatically inscribed in the mutuality's "complimentary" insurance program.¹¹ This insurance is not state mandated, but, to join the Christian mutuality, you must subscribe to "complimentary" insurance.¹² Aside from this, the Christian Mutuality also offers voluntary

⁶ Douglas John Maragas, A Comprehensive Health Care System Incorporating Public and Private Enterprise: With the Belgian System as a Base, America can Develop a Cost Efficient Comprehensive Health Care System (unpublished report, on file with author).

⁷ J. HERMESSE ET AL., THE NATIONAL ALLIANCE OF CHRISTIAN MUTUALITIES RES. DEPT., THE REFORM OF HEALTH CARE IN BELGIUM 5 (Brussels, Belgium, 1990). See also JEROME DEJARDIN, NATIONAL SICKNESS AND INVALIDITY INS. INST., OUTLINE OF THE BELGIAN COMPULSORY SICKNESS AND INVALIDITY INSURANCE 7-14 (12th ed. 1982).

⁸ Interview with J. Massion, Professor and Director of Administration at Universitaire St. Luc Hospital, in Brussels, Belgium (1991). See HERMESSE ET AL., *supra* note 7, at 5.

⁹ See DEJARDIN *supra* note 7, at 15. Mutualities are historical institutions that pre-existed the national health care system and were incorporated into the national health care structure at its inception. Belgium has had a compulsory health insurance system since 1945. In 1963, the mandatory health insurance system was reconstructed to what is basically the systems present form.

¹⁰ DEJARDIN *supra* note 7, at 31.

¹¹ Interview with J. Huybrechs, Director of Reserach at Christian Mutuality, in Brussels, Belgium (summer and autumn 1991).

¹² *Id.*

insurance. the voluntary insurance policy is optional and, in most cases, the coverage is limited due to the comprehensiveness of the standard policy.¹³

THE HEALTH INSURANCE PROCESS

As the mutualities exemplify, the system is a combination of public and private initiatives. The administration of the national system is assigned to the five private mutualities and the "auxiliary fund."¹⁴ For coverage information and filing claims, persons must use either one of the five mutualities or the auxiliary fund.

Everyone must join either a mutuality or the auxiliary fund. And, with the exception of the poor, every person with an income pays into the health insurance system.¹⁵ The state pays the premiums and deductibles for the poor on all standard fee services.¹⁶

All Belgians, including the poor, can choose either one of the private mutualities or the auxiliary fund as their care provided.¹⁷ Consistently, more than 99% of all Belgian people, including the poor, choose to be covered by the private mutualities as opposed to the auxiliary fund.¹⁸

To join an insurance carrier, a membership application must be submitted to one of the mutualities or the auxiliary fund.¹⁹ Being private organizations, the mutualities may refuse membership to an applicant.²⁰ The public fund, however, may not refuse membership to an applicant.²¹ This guarantees the availability of health insurance to all Belgians.

A person is bound by his choice of mutuality or auxiliary fund for a one year period.²² Further, dependent children are bound by the parent subscribers' choice.²³

¹³ *Id.* See MINISTRY OF SOCIAL AFFAIRS, SECURITE SOCIALE EN BELGIQUE (Brussels, Belgium, 1989). 9.8% of the Christian Mutuality's members are voluntary insurance subscribers.

¹⁴ HERMESSE ET AL., *supra* note 7, at 14-15.

¹⁵ DEJARDIN *supra* note 7, at 31-34.

¹⁶ HERMESSE ET AL., *supra* note 7, at 5.

¹⁷ DEJARDIN *supra* note 7, at 32.

¹⁸ Interview with Paul Quathoven, Professor at Catholic University of Leuven, Centrum Voor Ziekenhuiswetenschap, in Leuven, Belgium (Autumn 1991).

¹⁹ HERMESSE ET AL., *supra* note 7, at 4.

²⁰ Interview with J. Huybrechs, *supra* note 11.

²¹ DEJARDIN *supra* note 7, at 31.

²² *Id.*

²³ *Id.*; Interview with J. Huybrechs, *supra* note 11. Your dependents are automatically covered under the same mutuality program. For the supplementary insurance between the mutuality and the subscriber, the premiums may be higher according to the number of your dependents.

THE TWO PARTS OF MANDATORY INSURANCE

There are two types of benefits under the mandatory insurance program: health care benefits and cash benefits. Health care benefits are for health services. Cash benefits are payments given to the sick who are unable to work.

Cash Benefits

The purpose of the program is to protect workers against the temporary pecuniary consequences of accidents, sickness, pregnancy, and confinement.²⁴ Those covered include employed persons, apprentices, handicapped persons, domestic servants, and some persons in public service.²⁵

When an employed person is ill and unable to work, the beneficiary is entitled to an allowance amounting to as much as 60% of the limited daily remuneration.²⁶ Employers often pay the difference between the 60% allotment and the normal salary.²⁷ Allowances are paid for up to one year.²⁸ In cases of pregnancy or confinement, the allowance period is limited to 14 weeks.²⁹

When the cash benefit period has elapsed, "Invalidity Insurance" insures the employed person against the pecuniary consequence of a long-term incapacity to work.³⁰ The right to an invalidity allowance is obtained when the initial incapacity for work has reached one year.³¹ The allowance is 65% of the salary for persons with dependents and 45% for persons without dependents.³²

Cash Benefits operate similarly to the worker's compensation programs in the United States. Except, Cash Benefits are given to workers when ailments are caused by something *other* than those incurred in the scope-of-employment. In Belgium, there is another insurance program to cover work related diseases and accidents.³³

²⁴ DEJARDIN, *supra* note 7, at 41. However, accidents at work, those involving the liability of a third party, and those resulting from a serious fault committed by the insured person are excluded.

²⁵ DEJARDIN, *supra* note 7, at 7-14.

²⁶ HERMAN NYS & PAUL QUATHOVEN, *COMPARATIVE HEALTH SYSTEMS: DESCRIPTIVE ANALYSES OF FOURTEEN NATIONAL HEALTH SYSTEMS, HEALTH SERVICES IN BELGIUM* 72 (Marshall W. Raffe ed., 1984).

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

³¹ *Id.* At the end of a year, "incapacity insurance" terminates. At this time, if the person is still incapacitated, "invalidity insurance" replaces "incapacity insurance."

³² *Id.*

³³ *Id.*

Health Care Benefits

"Health Care Benefits" are intended to cover what could be termed traditional health care services. Some examples would be doctors' visits, hospital costs and medicines. Health care benefits under the compulsory policy are funded both by the government³⁴ and user deductibles.³⁵ Health care benefits under the private voluntary policies are paid directly by membership premiums.³⁶

The tax base supporting the health care system relies heavily on a 6.35% tax based on employees' gross income.³⁷ Both employees and employers contribute to comprise the 6.35% tax base.³⁸ Based on employees' salaries, employees contribute 2.55% and employers contribute 3.80%.³⁹

There are no contribution ceilings for employees.⁴⁰ The self-employed, however, do have a contribution ceiling.⁴¹ For the self-employed, the contribution represents 3.20% of their income, with a taxable ceiling set at an annual income of 2.1 million BF.⁴² Although the self-employed have a contribution ceiling, it is so high that, due to their higher average salaries, the self-employed actually pay more than the employed.⁴³

Pensioners pay a contribution of 2.55% of their pension, as long as their pension is above a certain minimal income;⁴⁴ taxing beyond the minimal income would activate aid from the state, merely circulating government money.⁴⁵

1. Two Different Health Care Policies

There are different mandatory policies depending on whether the person is an employee or self-employed. Employees receive a "general policy" covering major

³⁴ Government revenue is obtained through income and consumption tax bases.

³⁵ Interview with Paul Quaethoven, *supra* note 18. With the exception of the poor, the beneficiary must pay a deductible for every service under the mandatory policy.

There are special cases where mutualities, on their own initiative, will relieve patients of their deductible responsibilities. For example, a patient had to be transferred to a specialized hospital in Switzerland. The mutuality permitted the transfer and agreed to pay 100% rather than the normal 80%; the reason being, the patient's family could not afford to pay 20% of the medical costs and the patient's living expenses (ie.: for telephone, spending money, etc.). Most likely, this was the only way of maintaining the solvency of the patient's family, and therefore the full reimbursement of medical expenses was permitted.

³⁶ HERMESSE ET AL., *supra* note 7, at 2-3.

³⁷ *Id.* at 6.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.* at 7.

⁴² *Id.*

⁴³ *Id.*

⁴⁴ The minimum income is roughly 24,000 BF a month.

⁴⁵ Interview with Paul Quaethoven, *supra* note 18.

and minor risks; ie. from stroke to toothache.⁴⁶ The self-employed receive a "major risk policy" which doesn't cover less-serious risks such as dental problems.⁴⁷ Most self-employed persons voluntarily purchase a supplementary plan to cover minor risks,⁴⁸ including deductibles, luxury services, etc.⁴⁹

A supplementary plan is also available for employees.⁵⁰ However, since the employees' policy covers both major and minor risks, they have less need for additional coverage and are less likely to purchase the plan.⁵¹

2. The Categorization of Major and Minor Risks

There is a list of major and minor risks. One risk listed in the "major risk" category is an overnight stay in a hospital.⁵² As a consequence, all costs incurred during the overnight visit would be paid under either the employer or employees' standard compulsory policy.⁵³ However, once outside hospital confines, the list must be referenced to determine if the particular service falls under the major or minor risk category.⁵⁴ For example, a follow-up heart checkup at a physician's office would not be considered a major risk despite the prior overnight hospital treatment for the same heart condition.⁵⁵ Thus, a self-employed person with no supplemental coverage would *not* be covered for the follow-up visit.

In General, major risks involve inpatient care and special technical services. Minor risks include outpatient care, medicines, dental care, etc.⁵⁶ Of the total expenses incurred in health insurance, 41.6% are attributed to minor risks.⁵⁷

⁴⁶ HERMESSE ET AL., *supra* note 7, at 4-6. Working persons are always insured because employers are responsible for including employees in the system. Employers delete the portion of the employees' salaries prior to the employees' receipt of their salaries.

The "general policy" applies to employees, civil servants, retired persons, and handicapped persons. Their dependents are also covered under the "general policy." Eighty-five percent of the population is covered under the "general policy;" the "self-employed" policy accounts for the remaining fifteen percent.

⁴⁷ DEJARDIN, *supra* note 7, at 81.

⁴⁸ HERMESSE et al., *supra* note 7, at 6. Approximately 70% of the self-employed have chosen voluntary, supplemental coverage. *Id.*

⁴⁹ *Id.* In 1987, outlays for the voluntary health insurance for the self-employed amounted to 6.6 billion BF. *Id.*

⁵⁰ Interview with J. Hermesse, *supra* note 1.

⁵¹ *Id.*

⁵² DEJARDIN, *supra* note 7, at 82-83.

⁵³ Interview with L. Van Roye, Secretary of Administration, Association der Erablissements Public de Soins, in Brussels, Belgium (Summer 1991).

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ DEJARDIN, *supra* note 7, at 82-83. The following are services covered under "major" and "minor" risk categories:

Major risk

-treatment of mental diseases, tuberculosis, cancer poliomyelitis, congenital disorders and malformations

3. *The Reimbursement System*

The form of reimbursement depends on whether the ailment is categorized under major or minor risk.⁵⁸ For minor risks, insureds are reimbursed by their insurance companies after they've paid the health care provider.⁵⁹ For example: A patient visits his physician, pays his physician, and then is reimbursed by the insurance company after having a form signed by the physician and returning it to the insurance company.⁶⁰

For major risks, the patient is treated and then pays only his deductible share to the care provider. The care provider bills the insurance company for the remainder.⁶¹ This method of payment is used primarily in conjunction with hospital use.⁶²

Unless a person falls into VIPO status, the insurance reimbursement for ordinary medical care amounts to 75% of the fees.⁶³ For VIPOs, a category including widow, orphans, pensioners and invalids with an annual household income not exceeding 356,113 BF,⁶⁴ the reimbursement is 90%.⁶⁵

Administration of the Mandatory Insurance

Since the Belgian health insurance system operates on the intermingling of

-
- medical and obstetric care for confinements
 - hospitalization for observation and treatment
 - medication administered during a stay in a hospital establishment
 - surgery of relative value (for example, plastic surgery is normally not considered to have relative value and is not reimbursed under the major (or minor risk) category)
 - anesthesiological services during surgery of relative value
 - the therapy associated with regaining bodily movement after a surgery of relative value
 - radiodiagnosis
 - radiotherapy and radium therapy
 - clinical biology
 - the emergency room supplementary fees (the regular fees, if not listed above, are not covered. Only the supplements added on to the normal fees for use of an emergency room during the night, weekend, or holiday)
 - implants, prostheses, miscellaneous apparatus, wheelchairs and accessories that are necessary due to any of the above procedures
 - hemodialysis
 - traveling expenses for patients who have to be hospitalized in a sanitarium for pulmonary tuberculosis or who are treated as out-patients in a cancer center.

⁵⁷ J. HUYBRECHS, CHRISTIAN MUTUALITY, RAMING VAN DE VITGAVEN VOOR KLEINE RISICOIS. IN DE ALGEMENE REGELING (1991).

⁵⁸ Interview with J. Huybrechs, *supra* note 11.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ NYS & QUAETHOVEN, *supra* note 26, at 71.

⁶² *Id.*

⁶³ *Id.*

⁶⁴ About \$10,000.

⁶⁵ NYS & QUAETHOVEN, *supra* note 26, at 71.

public and private institutions, responsibilities and costs are shared. Along with the voluntary health insurance policies, the mutualities are responsible for policing and administering the nationally mandated health care policies.⁶⁶

Monetary compensation for administering the mandatory policies is fixed at around 5% of all member claims for a given mutuality.⁶⁷ In other words, the government contribution to mutualities for administrative expenses is based on a percentage of the mutuality's total claims paid to its members for the previous fiscal year. In 1991, the administrative allotment to mutualities was 4.64% of a particular mutuality's previous year's total reimbursement expenses.⁶⁸ Once the administrative contribution is established, the contribution is distributed to the mutualities in monthly payments.⁶⁹

In 1991, for all mutualities, the total amount allocated for expenses associated with administering the mandatory part of the national health care program was 16,177,902,000 BF.⁷⁰ Converted into dollars, roughly \$462,225,000 was paid to administer the mandatory insurance to a population of roughly 10 million people. This amounts to approximately \$46 per person per year.

1. Profit Making Ability

Mutualities, being private institutions, are permitted to maintain profits from their voluntary insurance policies and from any administrative savings they realize through efficient administration of the mandatory policy.⁷¹

However, mutualities may not profit from the contribution and claims portion of the mandatory policy. For the mandatory policy, the mutualities are government employed to merely administer the mandatory policy. As such, the mutualities do not share in any profits or losses on the government mandated

⁶⁶ Interview with Herman NYS, Professor of Medical Law at Catholic University of Leuven, in Ghent, Belgium (Summer 1991).

⁶⁷ Interview with J. Hermesse, *supra* note 1. This amount can change every year, but in practice stays around 5%.

⁶⁸ DE STUDIEDIENST VAN DE CHRISTELIJKE MUTUALIEITEN, DE Z.I.V. IN CIJFERS (Brussels, Belgium, 1990).

⁶⁹ Interview with J. Huybrechs, *supra* note 11. A simplified example: Mutuality X paid out 1 million BF worth of reimbursements in 1990. The 1991 administrative expense budget would be 4.64% of 1 million which is 46,400 BF, annually, distributed at 3,867 BF per month.

⁷⁰ MINISTRY OF SOCIAL AFFAIRS, CONTROLE BUDGETAIRE, STATUT SOCIAL INDEPENDENTS - BUDGET 1991 - PREVISIONS PRIX COURANTS (Brussels, Belgium, 1991). *See also* MINISTRY OF SOCIAL AFFAIRS, CONTROLE BUDGETAIRE, TRAVAILLEURS SALARIES - BUDGET 1991 - PREVISIONS DE FINANCEMENT PRIX COURANTS (Brussels, Belgium, 1991). 1990 total claims paid 348,661,700,000 BF, multiplied by 4.64% = 16,777,902,000 BF = approximately \$462,225,000.

⁷¹ Interview with J. Huybrechs, *supra* note 1.

portion of their policies. In other words, mutualities are *not* affected by differences in the total amount of money taken in and paid out under the mandatory policy.⁷²

In addition, the use of mutuality profits is restricted. Although mutualities are private profit-making entities, they technically are *non*profit corporations. If a mutuality realizes a profit, the mutuality must abide by profit spending parameters listed in each mutuality's by-laws.⁷³ And, Belgian law mandates that mutuality profits be spent only in a manner which comports with the purpose of the mutuality.⁷⁴ Thus, the money must be put back into the mutuality. For example, a permissible expense of a mutuality's profit would be giving its employees a bonus for processing claims in a timely manner.

2. Subrogation of Other Insurances

Fault oriented insurance policies which cover health care expenses subrogate mutuality health care policies.⁷⁵ Auto accident insurance, and workers' compensation are examples of Belgian fault oriented insurance policies.⁷⁶

It should be noted, however, that even if a person's injuries are covered under a fault based insurance policy, the person's mutuality will pay for the health-care, and *then* seek reimbursement through the fault oriented insurance company.⁷⁷

COST CONTAINMENT

Belgian health care is much more cost effective than American health care. Total Belgian health care expenditures account for roughly 7.5% of the Belgian gross national product.⁷⁸ Whereas, total American health care expenditures account for roughly 11.5% of the American gross national product.⁷⁹

In Belgium, the government earmarked 9.3% of its total 1991 tax revenue for its health care system.⁸⁰ The United States spent an estimated 11% of its 1990

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ DEJARDIN, *supra* note 7, at 83-85.

⁷⁶ Interview with L. Van Roye, *supra* note 53. Workers' compensation is paid via a fund completely separate from the general social security fund.

⁷⁷ Interview with J. Peers, President of the National Committee on Hospital Infrastructure, Chairman of the Organizing Committee for INAMI, Personal Advisor to the Minister of Social Affairs, Administrative Director of Universitaire Ziekenhuizen Leuven University Hospitals, in Leuven, Belgium (Autumn 1991).

⁷⁸ Interview with J. Hermesse, *supra* note 1. Using the 1987 O.E.C.D. report on Health Care.

⁷⁹ *Id.*

⁸⁰ DE STUDIEDIENST VAN DE CHRISTELIJKE MUTUALITEITEN, DE Z.I.V. IN CIJFERS (Brussels, Belgium, 1990). See also J. ROUSSEAU & E.J. DEWOLF, FISCAL ZAKBOEKJE (Kulwer Rechtswetenschappen Pub., Antwerpen, Belgium, 1991).

Appropriation of Belgian Tax Revenues in 1991:

government revenue on health care programs.⁸¹ The Belgian system is substantially less expensive *and* comprehensive.

Preventing Overuse of the Health Care System

Deductibles prevent overuse in the Belgian system. Although the deductible is not an excessive amount, it is enough to curb the use of medical facilities for minor ailments such as cuts, scrapes, colds, and minor aches.⁸² To help ensure that deductibles serve as a disincentive to seek service for *only* minor ailments, those persons of retirement age bear a lesser deductible per service.⁸³

1. Conferences

Through "conferences," communication and negotiation is made between the government, mutualities, and health services industries. The most important function of the conferences is establishing fee schedules for different clinician activities.

As a secondary function, the conferences serve as a governmental sounding board to field the successes and failures of the health care system.⁸⁴

The conferences also serve to inform clinicians about the current legal status concerning health care matters.⁸⁵ It is not uncommon for the medical system to change every year in some respects.⁸⁶

Regarding setting clinician fee schedules, the conferences resemble collective bargaining sessions. The bargaining is done at a national level.⁸⁷ The result of the bargaining is a set of rules that regulate the financial and administrative relations between the beneficiaries, mutualities, and health care providers.⁸⁸ The final item

-39.9% interest & principle on debt
 -31.6% social affairs
 -10.0% economic infrastructure, eg. roads, etc.
 -17.8% authority (military & police)
 -0.7% others

Id.

⁸¹ UNITED STATE GOVERNMENT, UNITED STATE BUDGET BRIEF 105-122 (1990). Both figures exclude state matching funds for Medicaid. Thus, the actual percentage, when including state government revenue, is higher.

⁸² DEJARDIN, *supra* note 7, at 82-83. Impoverished persons would be the only persons exempt from the deductible.

⁸³ DEJARDIN, *supra* note 7, at 83.

⁸⁴ Interview with G. Geest, Principle Advisor, Association des Etabissements Public de Soins, in Ghent, Belgium (Summer, Autumn 1991).

⁸⁵ Interview with Herman NYS, *supra* note 66.

⁸⁶ *Id.*

⁸⁷ See generally DEJARDIN, *supra* note 7.

⁸⁸ *Id.*

determined at each conference is the number of years their agreements will be binding. Current law mandates that agreements last at least two years.⁸⁹ At the end of the agreement period, another conference is scheduled to form a new agreement.⁹⁰

2. Specific Conferences

At the conferences, each mutuality has a representative; the government has a representative from the Ministry of Social Affairs; and, each type of clinician has its own representative body.⁹¹ The Ministry of Social Affairs oversees the conferences and ultimately has the power to accept or reject the agreements.

Each type of clinician has its own conference.⁹² And, matters agreed to within conferences are numerous and continually changing.⁹³ Common topics of agreement at conferences include fees, work hours per week, holidays, the number of clinicians per hospital bed, and the minimum amount of hospital compensation for salaried clinicians.⁹⁴

Once agreement is reached among the representative bodies within a conference, the proposal is submitted to the different representative "regions" within the country.⁹⁵ If the regional union or association accepts the proposed agreement, the block of clinicians represented in that region are counted as accepting the proposal.⁹⁶ If 60% of all clinicians agree to the proposal, the proposal is adopted. If the Ministry of Social Affairs accepts the agreement, the proposal is law until that particular type of clinician has its next conference.⁹⁷

If no agreement is reached in a particular conference, the government, by its own initiative, can make conference decisions.⁹⁸ However, the government has shown no desire to set rates without an agreement; principally because such a unitary government decision would inevitably bring excess political pressure from the various clinicians, mutualities, and beneficiaries.⁹⁹

⁸⁹ Interview with G. Geest, *supra* see note 84.

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.*

⁹³ Interview with J. Huybrechs, *supra* note 11.

⁹⁴ *Id.*

⁹⁵ Interview with J. Hemesse, *supra* note 1.

⁹⁶ Interview with J. Huybrechs, *supra* note 11.

⁹⁷ Interview with J. Hemesse, *supra* note 1. An individual clinician is not represented unless he or she belongs to one of the recognized unions or associations. And, a new union or association is not permitted into the conference unless it has been approved by the ministry.

⁹⁸ Interview with Paul Quaethoven, *supra* note 18.

⁹⁹ *Id.*

Among the different clinician conferences, there are some differences in procedure and allowable consequences. The most notable difference is the consequence of an individual clinician not signing the conference agreement.

By not signing the agreement, there are detrimental reimbursement consequences for the clinician's patients. The reimbursement consequences of an individual physician not agreeing to the conference agreement are more serious than other clinicians refusing to sign their respective conference agreements.¹⁰⁰ In all but the physicians' conference, the consequence of not signing a conference agreement results in the non-signers' patients' reimbursements being 25% less than normal reimbursement values for the services rendered.¹⁰¹ This is a strong incentive for agreement, but not as strong as the *total* reimbursement loss for physician services felt by patients who are treated by non-agreeing physicians.

As a consequence, physicians are very willing to sign their conference agreement. Due to the economic disincentive felt by patients when choosing non-agreeing physicians, many physicians sign their agreement for fear of losing their business.¹⁰² In fact, since the system was adopted in 1966, there has not been an instance where an agreement couldn't be reached.¹⁰³ Yet, based on excellent reputation or other reasons, some physicians do not agree and maintain ample patients to support successful practices.¹⁰⁴

3. *Escaping the Fee Schedule*

An important feature to all clinician fee schedules is the ability to escape the fee schedule. Apart from not signing the agreement, there are three ways for a clinician bound by an agreement to charge more than the agreed-on fees without penalty: First, if the patient desires a luxury service;¹⁰⁵ Second, when the clinician agrees to abide by the scheduled fees only during certain hours or days; and Third, if the patient has an income exceeding a certain level.¹⁰⁶

The Ministry of Health does not put a limit on the amount clinicians can additionally charge patients when patients opt for luxury services, hire non-

¹⁰⁰ *Id.* Interview with L. Van Roye, *supra* note 53.

¹⁰¹ Interview with J. Huybrechs, *supra* note 11.

¹⁰² Interview with Paul Quaethoven, *supra* note 18.

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ An example of the luxury service is the luxury hospital room. Luxury rooms are usually considered 1 or 2 person rooms (4 persons per room is normal room occupancy). If a patient hires a luxury room, all services given to the patient while in the hospital are exempt from the standard fee schedule. One luxury service triggers escape from the fee schedule for any service connected with the luxury service. For example, a physician's fees would no longer be subject to the standard fee schedule for treatment of a patient while staying in a luxury room.

¹⁰⁶ Interview with Paul Quaethoven, *supra* note 18.

agreeing physicians, or surpass the threshold income.¹⁰⁷ But, most hospitals, when they contract with clinicians, will set a limit on the additional amount that may be charged when patients are treated in the hospital.¹⁰⁸ At U.C.L.,¹⁰⁹ a university hospital in Brussels, physicians may charge four times the standard price for "intellectual services"¹¹⁰ and two times the standard price for "technical acts."¹¹¹

Clinicians, however, do not receive all of the extra charges. The clinician is expected to pay the hospital its portion of hospital "real costs" from this extra amount.¹¹² Real costs vary according to the service. For example, if the service is merely consultation, the hospital takes 20% of the physician's additional income.¹¹³ If the procedure is surgery, the hospital takes 50% of the physician's additional income.¹¹⁴ And, if the procedure involves a technical machine, the hospital takes 70% of the physician's additional income.¹¹⁵

It should also be noted that even under the standard fee schedule, apart from the extra fees for luxury services, etc., physicians must pay user-fees to their respective hospitals.¹¹⁶ Most hospitals take their user-fees before the physician is paid. The mutualities pay the hospital directly for the physicians' services and the hospital pays the physicians this amount *less* the cost to cover the use of the hospital.¹¹⁷

ANALYSIS AND POTENTIAL USE IN AMERICA

On the whole, the Belgian health insurance system is an excellent system. The use of private insurance companies (ie. mutualities) and bargaining conferences should work equally well in the United States. However, in adapting the system to the United States, I would suggest some changes; one area in particular is the scope of mandatory coverage.

¹⁰⁷ Interview with J. Massion, *supra* note 8.

¹⁰⁸ G. GEEST, A ASSOCIATION DES ETABLISSEMENTS PUBLIC DE SOINS, LEGISLATION IN REST HOMNES AND REST AND NURSING HOMES (Brussels, Belgium, 1991).

¹⁰⁹ U.C.L. is an abbreviation for Universite Catholique de Louvain. And in this case, the abbreviation specifically represents Cliniques Universitaires Saint-Luc at U.C.L.

¹¹⁰ Consultations.

¹¹¹ Interview with J. Massion, *supra* note 8. Technical acts are physician services such as surgery, or procedures requiring the use of a machine.

¹¹² *Id.* See also J. MASSION, MODALITES D'APPLICATION DU STATUT DECUNIAIRE DES DOCTEURS EN MEDECINE APPROUVEES PAR LE CONSEIL D'ADMINISTRATION DE L'UCL LE 30/11/1988 ET PAR LE COUNSEIL D'ADMINISTRATION DES CLINIQUES UNIVERSITAIRES ST-LUC LE 15/12/1977 7-14 (1988).

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ NYS & QUAETHOVEN, *supra* note 26, at 72.

¹¹⁷ *Id.*

Mandated insurance should be confined to what is truly necessary. Currently, in Belgium, as earlier stated, employees are completely covered for health care under the compulsory program. "Luxury services" and deductible reductions are the only existing voluntary options for employees under the current Belgian system. I propose that this is over-extensive.

What people truly require from a compulsory health insurance system is not a system where every health care problem, no matter how serious, is covered and controlled through a central body. What is publicly desired in mandatory health insurance is that people be insulated from economic ruin due to serious illness. Minor risks should not come close to causing economic ruin and should be excluded from the mandatory program. For this reason, and reasons of efficiency and maintaining a free market economy,¹¹⁸ I propose that only "major risks" be covered under the compulsory program and the remainder be covered under private programs at the individual person's request.

Each person can acquire voluntary insurance for minor risks. This will decrease the size of the mandatory program, lessening the financial and administrative strains on the government,¹¹⁹ and maintain substantial private enterprise involvement.

MEDICAL MALPRACTICE

Medical malpractice is formally outside the official Belgian health insurance system. But, its existence, or absence of existence, has an undeniable effect on the cost of health care.

The number of medical malpractice claims within Belgium are incredibly low. From 1980 to 1990, only 50 cases were reported.¹²⁰ This amounts to an extremely low number of cases: five, reported each year.¹²¹

Not only is the number of cases low, awards in the cases are also low. For example, a woman sued a physician for a failed sterilization which resulted in her

¹¹⁸ By strengthening the private sector's role in the health care system, the system becomes more efficient. Inherent to private enterprise is competition. Competition is no different in the health industry than any other industry; businesses compete to attract customers by offering a quality product at a comparatively lower price. Free enterprise is a natural, and to my knowledge, unequalled method of obtaining optimal efficiency. It is this reason that all public programs, health care being no exception, should be coupled with some sort of private industry aspect.

¹¹⁹ J. HUYBRECHTS, CHRISTIAN MUTUALITY, RAMING VAN DE UITGAVEN VOOR KLEIN RISICO'S, IN DE ALGEMERE REGELING (1991). In Belgium, for 1991, an estimated 41.13% of all medical expenses will be due to ailments categorized as minor risks.

¹²⁰ Interview with Herman NYS, *supra* note 66.

¹²¹ *Id.* The number of reported cases in the 1989 to 1990 period is five times more than the period from 1970 to 1979. However, much of the increase can be attributed to the publishing of a new reporter on health law.

pregnancy. After fault and cause were established, the woman was awarded the equivalent of roughly \$900 per year over eighteen years¹²² to help cover the cost of raising the child.¹²³ This amounts to a total award of only \$16,200.¹²⁴

In another case, a physician licensed as a dermatologist negligently performed facial plastic surgery on a young woman.¹²⁵ She was awarded the equivalent of 52 cents per day for the remainder of her life.¹²⁶

Due to guaranteed medical coverage, cash benefit compensation, the unavailability of contingent fee arrangements, and the unusual prospect of a substantial monetary recovery, Belgians are reluctant to bring malpractice suits.¹²⁷ Exemplifying the mind-set in regard to malpractice, a Belgian resident and professional soccer player was injured when tackled in a game. After negligent medical treatment, he was advised *not* to sue his physician because, even if he would win, the reward would be nominal.¹²⁸ He decided not to sue his physician.¹²⁹ It would be a rare day that a professional American athlete would be discouraged from suing a negligent physician for a career ending malpractice.

As a consequence of the low awards and fewer suits, malpractice insurance in Belgium is low in comparison to other nations.¹³⁰ For example, in Belgium, an anesthetist, in the highest risk category, pays, on average, 18,651 BF per year for malpractice insurance.¹³¹ A general practitioner pays 2,503 BF per year. Whereas, in France, for malpractice insurance, an anesthetist pays the equivalent of 75,000 BF per year and a general practitioner pays the equivalent of 5,000 BF per year.¹³² And, in New York, an anesthetist pays the equivalent of 850,000 BF per year, and a general practitioner pays the equivalent of 110,000 BF per year.¹³³ The difference in cost is dramatic between malpractice insurance in Belgium and the

¹²² In Belgium, eighteen years of age is the age of majority.

¹²³ HENRI LEW ALLE, *THE NATIONAL ALLIANCE OF CHRISTIAN MUTUALITIES, ITS HISTORY - ITS ORGANIZATION - ITS SERVICES* 1-48 (1990).

¹²⁴ Interview with Herman NYS, *supra* note 66.

¹²⁵ D. Hamann, *Erreurs Medicales En Belgique*, *L'INSTANT* June 6, 1991 at 4-15, 42-44, 56.

¹²⁶ *Id.* Her life expectancy was estimated at 32 additional years.

¹²⁷ Interview with Herman NYS, *supra* note 66.

¹²⁸ D. Hamann, *supra* note 125, at 4-15, 42-44, 56.

¹²⁹ *Id.*

¹³⁰ Interview with J. Peers, *supra* note 77. Also, as a product of a reasonable malpractice system, Belgian physicians are able to practice efficient methods of diagnosis and treatment. Rather than order duplicative, potentially unnecessary tests and treatments for fear of malpractice suits, physicians can diagnose patients, as physicians are trained. A diagnosis is made, and then, if a particular diagnosis or treatment was incorrect, the physician can order additional tests and treatments. Belgian inter-hospital studies have shown that using this diagnosis method, as opposed to the method of diagnosing only after ordering a battery of tests, can result in a tenfold savings in the costs associated with accurate diagnosis.

¹³¹ J. Zone, *Heurs et Malheurs de la responsabilité des professions médicales*, *RESPONSABILITE* June 1986 at 16-19.

¹³² *Id.*

¹³³ *Id.*

United States; for an anesthetist, it's the difference between paying \$533 per year in Belgium and \$24,286 per year in New York.¹³⁴

In summary, Belgian malpractice awards and malpractice insurance are comparatively non-existent by American standards. To control the malpractice acts and malpractice costs, it appears better to focus on physician accountability rather than victim compensation. It should not be forgotten that a physician is *licensed* to practice medicine. The medical practitioners' license is a *privilege*; just as a driver's license is a privilege. And, should malpractice occur, the privilege should be restricted or removed in the same manner as a state restricts or removes a driver's license.¹³⁵

Taken together, (although victims should be compensated for their losses and physicians should be made accountable through licensing) punitive, pain and suffering damages should be substantially curtailed. If curtailed, the cost of medical malpractice insurance will be contained and reduced, resulting in lower overall health care costs.

CONCLUSION

The Belgian health care system, by directly incorporating private insurers and conference bargaining, and indirectly incorporating limited malpractice recovery, is a success. America should take a serious look at the Belgian system. It is possible to provide a comprehensive health care system that is excellent, accessible, and efficient.

¹³⁴ *Id.*

¹³⁵ It should be noted that medical malpractice in Belgium is not limited to negligence. Malpractice also includes impermissibly charging beyond standard fees, and denying service to indigent patients due to their economic status. Malpractice in the United States should be similarly broad in definition. However, malpractice in the United States should not be defined so broadly that it includes instances where procedures do not render the best possible result. In other words, if the physician's work falls within the reasonable physician standard, the physician's acts should not be classified as malpractice..