MONOGRAPH ON THE ORGANISATION OF MEDICAL CARE WITHIN THE FRAMEWORK OF SOCIAL SECURITY IN BELGIUM

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This series of monographs, which was prepared in connection with a study of the organisation of medical care within the framework of social security, undertaken by the International Labour Office, with the assistance of external collaborators, covers the following countries:

Belgium	(Soc. Sec. 1968/D.5)
Canada	(Soc. Sec. 1968/D.8)
Ecuador	(Soc. Sec. 1968/D.6)
Federal Republic of Germany	(Soc. Sec. 1968/D.7)
India	(Soc. Sec. 1968/D.1)
Poland	(Soc. Sec. 1968/D.2)
Tunisia	(Soc. Sec. 1968/D.4)
United Kingdom	(Soc. Sec. 1968/D.3)

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A. Methods by Which Categories of the Population May Obtain Medical Care

1. General

In Belgium, medical care within social security is organised, in essence, within the framework of sickness and invalidity insurance.

Such insurance was made compulsory for employees from 1 January 1945, and was extended by the Act of 9 August 1963 to cover self-employed persons and public servants: today, more than 90 per cent. of the population are covered by the scheme.

It should be pointed out in this preamble that a voluntary insurance scheme organised by mutual benefit societies continues to operate, partly to ensure the provision of medical care for persons who do not benefit under the compulsory insurance, and partly to enable certain of those who are compulsorily insured to be provided with additional benefits, particularly in the matter of costs of children's holidays, transport by ambulance and convalescent cures.

Furthermore, legislation based on employers' liability for employment accidents and occupational diseases replaces the provisions concerning sickness and invalidity insurance, when such liability is established, in bearing the cost of the medical care required for the injury in question.

Finally, it is guaranteed by law that the entire population shall receive, without charge, specific benefits in the sphere of preventive measures against contagious diseases: vaccination against smallpox and poliomyelitis, and free consultations at anti-tuberculosis centres.

Similarly, permanent free advisory centres operate throughout the country for advice in pre- and post-natal care.

2. Number of Persons Protected by the Sickness and Invalidity Insurance Scheme

The complete table of statistics given below shows the state of manpower on 31 December 1965. This table was drawn up taking into account the "Scheme for the Practical Application of a Minimum Programme of Social Statistics".

Given the features which characterise the Belgian system, as regards the persons protected a distinction is made between employees and public servants, on the one hand, and self-employed persons on the other hand. A further distinction is made between economically active workers and inactive insured persons such as pensioners and widows, together with members of the family (spouses, children, ascendants).

Domestic workers are not at present covered by the compulsory sickness insurance scheme, principally because of the special nature of the contract which binds them individually to an "employer" who

is himself in another connection under a contract of employment or under a contract of work because of the occupation.

1. Contributors on 31.12.65 (Table A I, 1)

(a) General Scheme

Wage earners	1,628,568	
Salaried employees	585,637	
Miners	95,754	
Public services	359,821	2,669,780

(b) Scheme for Self-Employed Persons

Self-employed	564,083	
Others	63,337	627,420
		3,297,200

2. Dependent Persons at 31.12.65 (Table A I, 2)

(a) General Scheme

Spouses	1,257,858	
Ascendants	61,311	
Descendants	1,859,867	
Various	2,827	3,181,863

(b) Scheme for Self-Employed Persons

Spouses	391,858	
Ascendants	15,360	
Descendants	541,655	
Various	360	949,233
		4,131,096

3. Pensioners, Widows and Dependent Persons at 31.12.65 (Table A I, 3)

A. PENSIONERS

(a) General Scheme

Beneficiaries; general scheme	462,677	
Beneficiaries; public services	66,693	
	529,370	
Spouses	272,604	
Ascendants	1,959	
Descendants	66,166	870,099

(b) Scheme for Self-Employed Persons			
Self-employed pensioners	87,266		
Other pensioners	7,357		
	94,623		
Spouses	43,840		
Ascendants	62		
Descendants	1,681		
		140,206	
Pensioners: Total			1,010,305
B. WIDOWS			
(a) General Scheme			
Beneficiaries; general scheme	251,661		
Beneficiaries; public services	38,545		
	290,206		
Ascendants	1,353		
Descendants	36,455		
		328,014	
(b) Scheme for Self-Employed Persons			
Self-employed widows	41,266		
Other widows	5,612		
	46,878		
Ascendants	97		
Descendants	2,300		
		49,275	
Widows: Total			377,289
General total (pensioners + widows)			1,387,594

Summary of Persons Protected

	General Scheme	Self-Employed	Total
(1) Contributors	2,669,780	627,420	3,297,200
(2) Dependants	3,181,863	949,233	4,131,096
(3) Pensioners, widows, dependants	1,198,113	189,481	1,387,594
	7,049,756	1,766,134	8,815,890

B. Summary of the Provisions under Which the Granting of Medical Care is Organised

1. Contingencies

Sickness and invalidity insurance is subdivided into two different sectors, that of health care and that of cash benefits.

Wage earners and salaried employees receive benefits under both sectors; public servants, who have their own rules to cover remuneration in the event of incapacity for work, enjoy health care only.

For both these groups of workers, contributions to the scheme are borne jointly by the workers themselves and by their employers.

Self-employed persons come under health care branch only, but as they pay the whole contribution themselves, the cost of the scheme applying to them has been kept low by limiting the care covered by compulsory insurance.

For all categories of workers, the State makes up the funds required for the scheme by adding to the payments made by contributors, subsidies which vary with the level of expenditure: the working of this is set out in the chapter on financing.

Benefits granted to self-employed persons are at present limited to surgical operations, board and lodging in hospital - whatever the nature of the complaint or the treatment - cost of medicaments during hospitalisation, medical and obstetrical care in cases of confinement, costs of specific treatment of mental diseases, tuberculosis, cancer, poliomyelitis, congenital complaints and malformations: whilst it is true that they are limited, these items indubitably cover the major part of the expenses in health care insurance; even so, however, studies are currently being made to enable these items to be extended, particularly in the field of diagnosis, radiology and biology.

Aside from these restrictive provisions which apply to self-employed persons, entitlement is given by statutory provision to Health Service care in all cases which imply the need for medical benefits, whether such benefits are related to preventive or to curative medicine or to techniques of retraining; whether they consist of home treatment or treatment at the doctor's surgery, or whether they necessitate hospitalisation; whether they are given by a doctor, a dentist, a chemist, a midwife, a nurse, a physiotherapist, or, as regards artificial limbs, seeing and hearing aids, or rupture appliances, by an authorised technical supplier recognised by the Health Service. Maternity benefits form an integral part of this scheme.

Article 23 of the Act of 9 August 1963 is worded as follows:

"Health benefits shall relate both to preventive and to curative care. They shall include:

(1) General medical care, that is:

(a) visits from and consultations with general practitioners and specialists;

(b) medical care by nurses and auxiliary staff;

(c) medical care by physiotherapists;

(d) technical services of diagnosis and treatment which do not require a specialist;

(e) dental care, both preservative and corrective, including dental prosthesis.

(2) Confinements.

(3) Services which require a specially qualified medical specialist, chemist or licentiate in science.

(4) The provision of spectacles or other visual aids, hearing aids, orthopaedic appliances and other prosthesis.

(5) The provision of pharmaceutical products, including:

(a) made-up prescriptions;

(b) proprietary preparations.

(6) Treatment of mental diseases and of tuberculosis, cancer, poliomyelitis, and congenital complaints and malformations.

(7) Hospitalisation for observation and treatment.

(8) The necessary treatment for functional retraining.

(9) The necessary benefits for vocational retraining.

(10) Placing:

(a) in the context of tuberculosis prevention, in a preventorium or a colony for delicate children;

(b) in the context of protection of children against tubercular infection, in nurseries, protective institutions or families.

(11) Costs of travel for sick persons going for hospitalisation in a sanitorium for pulmonary tuberculosis, or receiving ambulatory treatment in anti-cancer centres."

Article 70 of the Act also provides, however, for the possibility of care being required as a result of an injury covered by common law (third party liability) or by other legislation.

In these cases, health care benefits are not granted in full together with the compensation arising out of such other legislation, in particular as regards employment accidents and occupational diseases: the Health Service is liable for benefits only in so far as the injury covered by other legislation is not effectively made good.

In all cases, Health Service insurance guarantees to beneficiaries a total intervention of not less than the equivalent of its own benefits: to this end, it has the right to subrogate for the beneficiary, and may itself proceed for recovery against the person liable for the injury.

The law specifies, furthermore, that benefits shall not be granted when they are provided outside the national territory: however, it gives the Crown power to derogate from this rule which, moreover, is without prejudice to the provisions of international Conventions or Regulations; for instance, in particular, E.E.C. Regulations Nos. 3 and 4 have laid down the right of migrant workers to receive health benefits provided in any one of the six countries of the Community.

Aside from such international regulations, a Royal Decree specifies the conditions under which beneficiaries may be reimbursed for benefits provided outside the national territory; this covers, in particular:

(1) beneficiaries in a period of incapacity for work, who have previously been authorised by the advisory medical officer to take up temporary residence abroad, while continuing to have their domicile in Belgium;

(2) beneficiaries the restoration of whose health requires hospitalisation which can best be provided abroad, where this is previously decided by the advisory medical officer to be indispensable;

(3) beneficiaries who, during a sojourn abroad, require urgent hospitalisation;

(4) beneficiaries suffering from pulmonary tuberculosis and for whom the advisory medical officer agrees that a cure in a foreign sanatorium is necessary;

(5) beneficiaries whose functional or vocational retraining is carried out abroad;

(6) beneficiaries who are injured in an accident in national territory, whose condition requires urgent treatment and who by reason of such urgency are transported to a hospital abroad which is closer or more accessible than any similar establishment situated in Belgium.

2. Scope

The following are entitled to medical care as defined above:

(a) active workers who belong to one of the following categories:

- wage earners and salaried employees in industry, commerce, agriculture and mining who are subject to social security legislation in toto;

- established public servants employed by the State, public bodies, the provinces, communes and provincial and communal statutory bodies;

- lay members of the teaching or administrative staff of private pre-school, primary, intermediate, teachers' training, technical and artistic educational establishments and the lay members of the teaching or administrative staff of advanced public or private educational establishments;

- self-employed persons who are subject to the legislation concerning retirement and survivors' pensions for the self-employed, i.e. tradesmen, craftsmen, farmers, lawyers, doctors and the other liberal professions.

(b) persons referred to under (a) who have to cease their occupational activity temporarily or definitively because of disease, accident or invalidity causing a loss of earning capacity of not less than 66 per cent.

(c) persons referred to under (a), during a period of inactivity caused by their hospitalisation in an establishment for medical care, whether they are so hospitalised for observation or for treatment, whatever the duration of hospitalisation and whatever the degree of incapacity for work;

(d) persons referred to under (a), during a period of inactivity before, during and after confinement: during such a period, no minimum degree of incapacity for work is required, provided that the cessation of occupational activity begins after the fourth month of pregnancy and ends not more than 12 weeks after the confinement;

(e) persons referred to under (a) who are entitled to unemployment benefits, provided that during their period of inactivity they submit themselves to the controls imposed by the unemployment insurance scheme;

(f) persons referred to under (a) who, in order to end a period of involuntary unemployment, undertake domestic work: it should be noted that domestic workers as such are not yet included within the scope of health care insurance, this provision therefore enables such workers, nevertheless, to benefit from health care insurance if, being unemployed former employees, they choose to become domestic workers;

(g) persons referred to under (a) who cease their occupational activity on becoming entitled to a retirement pension, either by virtue of the relevant legislation or by virtue of the

staff rules of a particular undertaking: i.e. the group covered by the general term, "pensioners";

(h) widows of persons referred to under (a) to (g);

(i) orphans who have lost both parents, if one of the latter was, during his or her lifetime a titular beneficiary under (a) to (h), and for as long as such orphans continue to be entitled to family allowances. Adoptive parents are assimilated to the father or mother on the terms set out below to define the concept of "child";

(j) persons belonging to the household of insured persons under (a) to (h), who are dependent on the latter: this includes in effect, three main groups of beneficiaries:

(i) spouses: husband, wife, or housekeeper taking the wife's place;

(ii) children;

(iii) ascendants.

Such persons enjoy the same rights as the insured persons provided that they belong to their household: they are considered as meeting this requirement if they have the same habitual residence as the insured person, save in the event of husband and wife being separated.

(i) Spouses and persons assimilated to spouses:

(1) Wife of the insured person:

a wife who is living apart from her husband, but who is not divorced or is legally separated from him, may be considered as a dependant in one of the following circumstances:

(a) where she supports at least one child who is considered as a dependant. The qualification of such a child to be considered as a dependant person is assessed as if the legally separated wife were herself the insured person;

(b) where she has obtained a legal ruling obliging her husband to pay her alimony;

(c) where she is authorised to collect sums owed to her husband by third parties, pursuant to the Civil Code;

(d) where she receives a pension as allowed to separated wives pursuant to provision in law. A divorced wife or a wife who is living apart from her husband cannot qualify as a dependant.

(2) The husband of the insured person, provided that he is neither

divorced, nor living apart from his wife nor legally separated from her if because of his physical or mental condition he has been unable for at least one year regularly to engage in gainful employment.

A husband who is neither divorced nor legally separated from his wife but who is living apart from her may, however, be considered as a dependant of his wife if, in addition to being unable as above-described regularly to engage in gainful employment, under the following circumstances:

(a) he supports at least one child who is considered as a dependant. The qualification of such a child to be considered as a dependent person is assessed as if the legally separated husband were himself the insured person;

(b) he has obtained a legal ruling obliging his wife to pay him alimony.

(3) The housekeeper of the insured person, provided that she receives no remuneration, and if she has belonged for more than six months to the household of the insured person. The six-month waiting period is not required for a housekeeper who was already entitled to health benefits, on whatever grounds, prior to registration. A housekeeper may not be registered as a dependant if the wife of the insured person is herself entitled to be so registered or if, being herself the insured person and being entitled to health benefits on these grounds, she lives under her husband's roof.

(ii) Children:

(a) legitimate children, legitimised children, adopted children, natural children recognised by the insured person and children on whose birth certificate the name of the insured person is entered;

(b) children not born jointly of the insured person and his or her spouse who are legitimate, legitimised, adopted or natural children recognised by the insured person, and children on whose birth certificate the name of the said spouse is entered, where that spouse undertakes their support;

(c) children not born jointly of the insured person and his dependent housekeeper who are legitimate, legitimised, adopted or natural children recognised by the said housekeeper, and children on whose birth certificate the name of the said housekeeper is entered, where the latter undertakes their support;

(d) the grandchildren of the insured person or of his or her spouse or housekeeper, where the said insured person undertakes the support of such children;

(e) the children and grandchildren of the spouse or housekeeper of the insured person within the meaning of the

provisions set out under (b), (c) and (d), where the insured person supports such children after the decease of such spouse or housekeeper;

(f) children supported by the insured person for and instead of the father, mother or other person who would normally be responsible for them, where the latter are deceased, in prison, 66 per cent. incapable for work and not receiving compensation for such incapacity, or where they have abandoned the said children, or where, through the intervention of a national or international welfare organisation, they have entrusted the said children to the insured person.

The children as described above must fulfil one of the following conditions.

They must:

(1) be entitled to family allowances: those entitled to such allowances are all children up to the age of 14 years, and up to the age of 21 years if they are students;

(2) be more than 21 years and less than 25 years old, and regularly attend courses in intermediate, advanced, professional or technical education, such courses to be given during the day-time and not to be restricted to a part of the year only. These provisions apply to diocesan priests pursuing their studies in so far as they are not appointed to any paid post, and to members of religious orders pursuing their studies in so far as they have not taken their first vows.

A child ceases to qualify as a dependant if his or her studies are interrupted unless the advisory medical officer considers that the interruption is justified on grounds of sickness. In the latter case, the child continues to qualify as a dependant until the date of recovery, if this occurs before the child's 25th birthday and, where appropriate, during the period in which the studies are resumed before the child reaches the age of 25;

(3) be bound by a contract of apprenticeship the concluding of which is registered and the implementation supervised by an officially recognised apprenticeship bureau;

(4) be an unmarried child of more than 14 years of age who either takes the place in the home of the deceased spouse or housekeeper, or who helps the spouse or housekeeper in the work of a household which must include not less than four children of whom not less than three are entitled to family allowances. In these two cases, neither the child, the spouse nor the housekeeper may engage in an occupation other than that referred to in this provision;

(5) be an unmarried child of more than 14 years of age who is taking the place of the wife, housekeeper or widow in the

work of the household, where the latter has been for at least one month totally unable, for reasons of health, to carry out such work herself. The fact that the wife, housekeeper or widow is unable for health reasons to run her household must be vouched for by a medical certificate, and must be noted and checked by the advisory medical officer.

Where the child is himself or herself an insured person and entirely ceases his or her work on the terms defined in this provision, the child is immediately considered as a beneficiary;

(6) be an unmarried child of more than 14 years of age with no profession who runs the household in place of his or her mother if the latter is widowed, separated or abandoned, and if she is covered by social security and has a full-time professional occupation;

(7) be, whatever his or her age, a child who is dependent on the insured person and who is unable, because of his or her physical or mental condition, to undertake any occupation whatsoever - including domestic service - provided that he or she agrees to undergo any functional or vocational training or retraining treatment judged to be appropriate.

A child cannot qualify as a dependant if he or she has annual resources, derived either from gainful employment or from welfare allowances, which are more than 600 times the amount of the minimum invalidity allowance laid down for the insured person as being a regular worker with no dependants.

(iii) Ascendants:

Ascendants of the insured person and of his or her spouse and, where appropriate, their fathers-in-law and mothers-in-law if the latter qualify as follows.

They must:

(a) either be more than 55 years of age, or be no longer able because of their physical or mental state to undertake any work whatsoever;

(b) not be in possession of annual resources, derived either from gainful employment or from welfare allowances, which in respect of each party concerned are more than 300 times the amount of the minimum invalidity allowance laid down for the insured person as being a regular worker with no dependants;

(c) have been registered for not less than six months as belonging to the household of an insured person.

This waiting period is not required if the parties concerned were already entitled to health care, on

any grounds, when they were registered as ascendants.

The rights of dependants are exactly the same as those of the insured person on whom they depend; and entitlement begins, continues and expires to the extent that the insured person's entitlement begins, continues and expires. Entitlement cannot, therefore, exist for dependants unless it exists similarly for the insured person, but the converse can obtain; parties may remain dependent on an insured person within a household but their entitlement to medical care may cease; this is so in particular for children of more than 14 years of age who stop attending regular educational classes and thus lose their entitlement to family allowances; it is also the case for ascendants whose resources exceed the maximum rates laid down by law.

Of the causes which bring about cessation of entitlement to medical care, some are definitive and others temporary. Definitive causes include, in particular, those which are linked to a child's age: in such cases, the law specifies that if the child ceases to qualify as a dependant at the moment when he or she is hospitalised, he or she may continue to receive medical care for not more than six months if he or she is hospitalised in a sanatorium, hospital or clinic, or until the end of the current quarter if he or she is staying in a preventorium clinic or in a colony for delicate children.

Similarly, children who have finished their studies or their apprenticeship continue to qualify as dependants and as being entitled to medical care during the period immediately following the end of the academic or the apprenticeship year, such period to end not later than 1 November following the end of such academic year as regards the former, and not later than three months after the end of the apprenticeship as regards the latter.

Temporary causes include, in particular, changes of residence of dependants: in such cases, a change of residence is considered to be temporary if it does not exceed three months, and there is no limitation of duration for a period of hospitalisation in a medical care establishment: such temporary breaks in belonging to the household of the insured person do not give rise to cessation of the status of dependant nor of entitlement to medical care. In one eventuality, however, entitlement of dependants to medical care is dissociated from the entitlement of the insured person: in the event of the latter's decease, if he or she dies at the time when dependants are hospitalised, the dependants continue for a period of not more than six months to be entitled to medical care.

Two further categories must be added to the number of those entitled to medical care. These categories cover persons who are legally guaranteed to entitlement on special terms enabling members of a household to be protected to the

exclusion of the head of the household, the latter having lost his status as insured person. The two categories include:

(k) persons dependant on employees who have had one of the qualifications referred to in (a) to (g) above and who are doing their military service: medical care for the military does not in fact come within the competence of the Health Service, and is given by the Ministry of National Defence; but this provision makes it possible for members of their families to continue receiving medical care under the Health Service;

(l) persons dependent on employees of Belgian nationality who are subject to the social security legislation of another country, if the dependants are in or return to Belgium while such employees are doing their military service: this provision is based, in essence, on the same grounds as the foregoing one; but this case concerns employees who, before doing their military service, were not insured under the Belgian medical care insurance scheme.

3. Qualifying Conditions for Benefit

(a) Registration of insured persons with an insurance carrier

Beneficiaries' rights as defined above become effective only as from the date on which the insured person applies for registration with an insurance carrier.

As will be seen in the chapter dealing with administration of insurance, health care insurance in Belgium is administered by the former mutual benefit societies, federated at regional level and grouped, at national level, into five national confederations with regard to the political or philosophical affinities of their members. Thus a distinction can be made between the Christian, socialist, liberal, professional and neutral benefit societies.

To these traditional mutual benefit societies - some of them 100 years old - officially recognised for implementation of the law, must be added an Auxiliary Sickness and Invalidity Insurance Fund, set up in 1945 to enable compulsorily insured persons to choose a non-mutual benefit body, with no political or philosophic choice attached to it. The five national confederations of mutual benefit societies and the Auxiliary Fund together form the six insurance carriers officially appointed to ensure the working of the health care scheme. These insurance carriers are highly decentralised: they have administrative and social services operating not only in all regions of the country, but also in all towns of major or secondary importance, offices, services and agents of the various carriers are at the disposal of insured persons in the majority of Belgian communes. The titular beneficiary

is free to choose his insurance carrier: his choice implies, however, that all persons dependent on him are registered with the same carrier.

Any change in the insured person's household, or any change of domicile or of residence must be notified to the insurance carrier within a period of 30 days.

If the insured person omits to apply within this period for a dependant to be registered, entitlement to benefit for such new beneficiary begins only as from the time when application is made.

The insured person may, however, alter his choice of insurance carrier, provided that not less than 12 months elapse between the date of registration with the former carrier and that of transferring to the new one.

Such is the case in the event of an individual transfer.

Collective transfers make it possible, in particular for whole mutual benefit societies to transfer from one national confederation to another: such decisions must be taken at a duly convened General Assembly.

(b) Qualifying Period

In order that the insured person and the members of his household may, after he is formally registered, receive medical care, it is further necessary for the insured person to have fulfilled the qualifying conditions required by law.

This qualifying condition consists of a period during which contributions are due without the party concerned being thereby entitled actually to receive benefits: over a six-month period, the insured person must have completed 120 working days.

The following, however, are assimilated to the working days taken into consideration for completion of the qualifying period:

- days of inactivity caused by an employment accident or occupational disease causing a loss of earning capacity of not less than 66 per cent.;
- days of legal yearly holiday;
- days of certified involuntary unemployment;
- days of strike recognised by trade union organisations;
- days when work is interrupted due to lock-out;

- days of non-attendance for which the employer is liable for payment of remuneration;
- compensatory rest-days designed to reduce the working week to an average of less than 48 hours;
- days on which the insured person is forbidden to attend work because he or she has been in contact with a contagious disease: a maximum period is laid down in respect of each infection which corresponds in principle to the incubation period of the relevant contagious disease.

The number of working days thus totalled during the six-month qualifying period is nominally increased by 20 per cent. if the employee's weekly activity is normally spread over five days: this provision takes account of the standard five-day week in undertakings.

Beside this qualifying condition as linked to the frequency of working days, it is also required that the total contribution related to those working days, charged on remuneration, must reach a minimum figure: the minimum contribution figure varies according to workers' age and sex, and corresponds in practice to the figure which would be arrived at by multiplying the contribution rate (per cent. of remuneration), which is the same for all insured persons, by the minimum remuneration for the category of employee in question. Should the minimum contribution figures not be achieved, the employee must make it up by paying directly to his insurance carrier the difference between such minimum figure and the contribution which has been charged on his remuneration.

Until he has paid this supplementary contribution, neither the insured person nor the members of his household are entitled to medical care.

The following are exempted from these qualifying conditions, and are therefore entitled to receive immediate medical care:

- persons who again become entitled to Health Service treatment after having lost their status as entitled persons, provided that when they were formerly covered by health insurance they completed the prescribed qualifying period and that during the interim they have continuously been voluntarily affiliated, for medical care services, to a mutual benefit society whose rules allow the same rights to compulsorily insured persons who become voluntarily insured;
- persons who become insured persons under medical care insurance after having received medical care as dependants of an insured person, provided that the interval between ceasing to be a dependant and becoming an insured person is not more than one month;

- dependent children who become insured persons not later than 1 November following the end of the academic year which they finished;

- persons doing military service who were insured persons when they were called up, to the extent that they become insured persons within 30 days after completion of their military service.

Qualifying conditions for self-employed persons are in principle the same as the general conditions just described. But in view of the particular characteristics of the occupation of self-employed persons and especially the impossibility of imposing or controlling the frequency of occupation in terms of working days, qualifying conditions for such persons consist basically of a six-month waiting period during which the required contributions must be paid without any benefit being received in return.

(c) Maintenance of Entitlement to Benefit

When the qualifying conditions as described under (b) above are satisfied, the insured person and the members of his household become effectively entitled to medical care. Entitlement continues, subject always to the condition that in the two quarters immediately preceding that in which he or a member of his household has recourse to medical care, the insured person has continued for at least 120 days, on whatever grounds, to be entitled under one of the conditions listed under B.2 (a) to (i) above; and that, in the case of an active worker, his contributions have not fallen below the minimum figure referred to above or, if they have, that he has paid the supplementary contribution.

The result of this is that aside from employees who regularly complete not less than 120 working days per six months, the following continue always to be covered: the involuntarily unemployed, the sick, the disabled, pensioners and widows: in effect, certified involuntary unemployment, incapacity for work and invalidity, whatever, their origin and in so far as they amount to not less than 66 per cent. of the retirement or widow's pension, are considered as insurance periods giving entitlement to benefit and not implying any contribution payment from the parties concerned.

Consequently, therefore, except for the conditions linked on the one hand to retention of status as an active worker or to the grounds which made it necessary to cease work, and on the other hand, to the minimum contribution figure, there is no limit of duration to the granting of medical care, whatever the nature of the care or of the disease.

(d) Continued Insurance

In principle, continuing entitlement to Health Service benefits is dependent on the extent to which the status of insured person is maintained; and as explained above, employees maintain their status as insured persons both by means of a minimum frequency of working days or of days assimilated to working days, and by means of minimum contributions. Furthermore, for a large proportion of employees, entitlement to benefits under the medical care insurance is linked to the existence of coverage under the whole scheme of social security.

There are cases, however, where social security coverage stops because before a retirement or widow's pension can be granted, there ceases to be a contract for hire of services, or a period of certified unemployment or of incapacity for work. The law is designed to deal with deserving cases in which people cease temporarily to be covered by Belgian legislation on social security for employees, by enabling them to on receiving medical care on payment of contributions for a limited period described as the continued insurance period.

This solution enables such people on the one hand to continue to receive, both personally and as regards their dependants, medical benefits at a reduced rate of contribution, and on the other hand, to be exempted from the possible need to undergo a new qualifying period when their situation - essentially a precarious one from the point of view of social legislation - is again regularised.

There are covered, in particular:

- persons who, although they are involuntarily unemployed, cannot receive unemployment benefits, in particular because they have not completed the qualifying conditions required under the unemployment insurance scheme, or because their former employer has paid them compensation for breach of contract which covers such unemployment period: in the latter event, continued insurance may apply to the whole of the period covered by the compensation for breach of contract, while in other cases the period is limited to between 3 and 12 months, according to the circumstances;
- persons at the end of a period of invalidity or of incapacity for work whom rehabilitation measures have enabled to follow an occupation, which they follow and which is not covered by any social legislation: i.e. in essence, persons formerly disabled who have been rehabilitated and who, having been unable to get work in industry, follow their new occupation as self-employed person; although they may thereby achieve the status of self-employed persons, they may continue to benefit, not under the limited health care scheme specifically for this category

of workers, but under the general scheme which covers all benefits.

Continued insurance in such case is given for a period of two years, which may be renewed.

- Nursing mothers: as from the sixth week after her confinement, a woman who did not go back to work would lose her entitlement if "continued insurance" did not enable her to go on receiving medical care; in such case, the period of continued insurance may not exceed the end of the fifth month following confinement;

- former insured persons incarcerated in prison or remanded in custody or committed to a workhouse. Where such circumstances arise at a time when the party concerned is in a condition of incapacity for work, this fact automatically maintains entitlement to medical care as regards the party concerned and the members of his household.

  But where such circumstances arise at a time when the party concerned is not in a condition of incapacity for work, or where such incapacity comes to an end, he would lose his entitlement (and in consequence the members of the household of persons imprisoned, detained or committed to a workhouse would no longer be entitled to medical care) if "continued insurance" did not enable such entitlement to be maintained throughout the period in which the head of the household was imprisoned, detained or committed;

- former insured persons who are temporarily employed abroad in the same occupation as that which they followed in Belgium and who are not entitled, in the new place of work, to benefit under a social security scheme: in such case, continued insurance is granted throughout the period of work abroad.

4. Provisions for Cost Sharing by the Beneficiary

Chapter B.1 above quotes Article 23 of the Act of 9 August 1963, and sets out those benefits which are covered by medical care insurance.

Some of these benefits are reimbursed in toto while as regards others, it is specified that a part of the cost of benefit shall be payable by the beneficiary: such personal intervention by the beneficiary is generally referred to as the "ticket modérateur".

Benefits in respect of which cost-sharing by the beneficiary is specified are firstly, medicaments, and secondly, what is known as "general" care, i.e. consultations with and visits from

doctors, care given by physiotherapists, nurses and auxiliary staff, dental care and technical services performed by general medical practitioners.

Numerous discussions have been held both at parliamentary level and in the context of negotiations between the medical profession and the Medical Care Insurance authorities as to the effect of the ticket modérateur, and more especially as to whether it should really be required from the beneficiary.

While it is true that in general, professional medical associations consider that it should be compulsory, in all cases where cost-sharing by the beneficiary is specified, for the ticket modérateur to be paid, parliamentary studies and in particular the statements of various successive ministers of social welfare have indicated that the concept of cost-sharing by the beneficiary in certain items of medical care should be interpreted as meaning that the health insurance does not intervene as regards the whole of the expenditure involved in these benefits, but that the person responsible for treatment (doctor, dentist, midwife, etc.) may abstain from charging that part of the fee which corresponds to the ticket modérateur.

At all events, the law specifies that pensioners, disabled persons, widows and orphans are in no case liable for such cost-sharing in respect of general care as set out in Chapter B.1 above, nor in respect of medicaments which are prescribed and delivered in the form of made-up prescriptions, by contrast with proprietary preparations, in respect of which all categories of beneficiaries, without exception, are obliged to bear a part of the cost.

Cost-sharing for which the beneficiary is liable is fixed for general care at a standard rate of 25 per cent. of the cost of benefit; so that in such cases, the insurance reimburses beneficiaries in respect of 75 per cent. of the cost of benefit.

As regards medicaments, the cost borne by the beneficiary is differently fixed according to whether these consist of made-up prescriptions or of proprietary preparations.

The cost of making up a prescription varies according to the actual contents of the prescription; it was thought undesirable that the cost borne by the beneficiary should vary equally with the cost of the prescription since this would mean that a sick person for whom a relatively expensive product was prescribed would be at a disadvantage as compared with another sick person who was treated with a cheaper medicament; to this end, it was decided that the average cost of made-up prescriptions over a given period should be established, and that the beneficiary's share should be fixed at a standard 25 per cent. of such average cost.

The average cost being currently established at 80 Belgian francs, the beneficiary personally pays 20 Belgian francs for any made-up prescription, and the insurance pays the whole of the difference between the actual cost of the prescription and the 20 francs paid directly by the beneficiary.

As regards proprietary preparations, the insurance bears a comparatively low proportion of the cost of medicaments which retail fairly cheaply, and a very high proportion of the cost of the dearer products: the insurance does not pay any part of the cost of medicaments if the retail price is equal to or less than 50 francs but, on the other hand, the beneficiary never himself pays more than 50 Belgian francs per proprietary product.

There is, however, a restricted list, which is open to extension in appropriate cases, of proprietary preparations which are largely for chronic diseases - especially tonicardiac diseases - and in respect of which the maximum proportion of the cost borne by beneficiaries is reduced from 50 to 25 francs.

The maximum charge for proprietary preparations is always reduced to 22 francs in the case of pensioners, disabled persons, widows and orphans; and in special cases such as insulin (for diabetics) beneficiaries bear no part of the cost, the whole of which is paid by the insurance.

Moreover, as regards all other benefits - i.e. those which are neither medicaments nor benefits considered as general care - insurance covers the entire cost of the service provided, whether this is a matter of technical diagnosis and/or treatment by specialists (surgery, anaesthesia, radiology, laboratory analysis, physiotherapy, radiotherapy, electro-cardiography, electro-encephalography, etc.), hospital costs, functional or vocational retraining, or confinement costs.

It must, however, be added that in referring to total intervention by the insurance or to an intervention expressed as a percentage of the cost of medical care, the costs referred to are either the rates of charges fixed by agreement and charged accordingly in practice, or the rates of charges which, in the absence of any agreement, can be imposed on practitioners in respect of all or part of the medical care given; in such cases, beneficiaries may in fact be personally liable for the extra cost as made up of the difference between the fees actually charged and the rates of charges taken into consideration by the medical care insurance scheme in determining the amount to be refunded.

We shall see, when we get to describing the machinery for agreements, how these various circumstances may arise and how they have actually been dealt with in practice.

As regards medicaments, whether in the form of made-up prescriptions or of proprietary preparations, the level of insurance intervention is in all cases decided on actual selling prices, including that part of such prices which covers the chemists' fees for the responsibility of preparation.

5. Administration of Medical Care Insurance

We have already seen that the working of medical care insurance is dealt with under five national confederations of mutual benefit societies and an Auxiliary Sickness and Invalidity Insurance Fund,

each of which run decentralised services grouped in regional and local offices so as to permit of easy and continuous contact with the population: these insurance carriers are bound to apply identical rules for accountancy and statistics, and to observe the rulings drawn up by the Health Care Service of the National Institute for Sickness and Invalidity Insurance concerning eligibility for entitlement to and dispensation of benefits.

The Health Care Service is administered by a Managing Committee made up of representatives of the insurance carriers, the workers' organisations, the employers' organisations, the self-employed persons' organisations, the medical and dental professional organisations, the hospital establishments, the para-medical professional organisations (chemists, midwives, nurses, physiotherapists, opticians, truss-makers, orthopaedists, makers of artificial hearing aids).

Government Commissioners appointed by the Ministers of Social Welfare, Public Health and Finance sit on the Managing Committee, with power to veto any decision which they consider to be contrary to law or public interest. Such veto suspends implementation of decisions; and the suspension becomes definitive if, within 15 days, the Minister confirms his Commissioner's veto. Should the veto not be confirmed, the Managing Committee's decision stands.

All members of the Managing Committee are entitled to vote except representatives of the medical and dental professions; and in a monograph dealing with the problems of medical care, it would perhaps be appropriate to elucidate this apparently paradoxical situation.

The criticism and lack of interest formerly shown by doctors and dentists towards the working of sickness insurance could be said to have been justified by the evident impotence of latter to adjust its intervention to new developments in medicine and to changes in costs, and in its refusal to allow the medical profession to take part in drawing up rules and regulations which were directly or indirectly concerned with medicine; it was, moreover, obvious that sickness insurance could not aspire to negotiate any ruling on reciprocal duties with the medical profession while its own financial resources did not enable it both to guarantee practitioners' rights and to affirm its own right to subrogate for sick persons in the matter of their material interests.

It was clear on any grounds that the reform arising out of the Act of 9 August 1963 must supply the basic equipment to embark on such a dialogue with the medical profession, to arouse its interest and answer its criticisms: such a condition should have been achieved by the new concept of financing adjusted to the requirements and organisational measures implied in the Act. But paradoxically, these were the very aspects which provoked the initial and major hostility of doctors.

In order effectively to give the necessary guarantees that all factors liable to affect the cost of medicine would be taken into consideration, and more especially in order that the Managing

Committee should not be influenced, by its anxiety to avoid increases in contributions, into underestimating the normal rise in costs of medical care, the Act specified that representatives of the medical profession should be members of the Managing Committee, entitled to vote and entitled also to suspend implementation of Committee decisions in which the voting went against them. This right, referred to as the "qualified majority", could be exercised as regards all decisions of the Managing Committee, and in particular as regards those concerning approval of budget estimates; and its use would create either a revision of the decision by the Committee itself or, in the event of continued lack of agreement, a decision by government arbitration.

In opposing the Act in 1964, doctors seized on only one aspect of this evident promotion of the medical profession to the level of institutions and responsibility for financing the cost of sickness - namely the obligation imposed on them by the Act to bind themselves to "association with the executive", and the danger that this might involve them in liability for any deficit, the material cost of which they might have to bear themselves.

It should be made clear, however, that the Act, which makes it compulsory that income and expenditure should balance in the budget estimate and thus excludes the possibility of deficit at the estimate stage, also lays down provisions for methods of covering administrative deficits, which always remain within the bounds of possibility no matter how carefully budgetary estimates have been drawn up: those organisations which show a deficit in their yearly balance sheets are solely responsible for making up the deficit, either by mobilising their reserves or, if they have no reserves available, by claiming a supplementary contribution direct from their members.

It should be noted that such unforeseen increases in expenditure are to be taken into consideration in drawing up subsequent budgetary estimates; so that in no case can the medical profession be obliged, even indirectly or in part, to cover any deficit.

Although the medical profession had for years been demanding firstly, that they should attend the Managing Committee, and secondly, that they should take part in its work, when the Act was published they announced their categorical refusal to take part in the institutions responsible for medical care insurance.

Discussions were held between the Government and representatives of the Medical Council and the Academy of Medicine, following which the latter bodies agreed, in the absence of representatives of the medical associations, to send observers to the Managing Committee; the Government tabled a supplementary draft Act to incorporate this amendment into the main Act of 9 August 1963: the draft Act was passed, but in the meantime the medical associations had succeeded in persuading the members of the Medical Council and the Academy of Medicine not to appoint observers to the Managing Committee. Consequently, the new provision of the supplementary Act of 24 December 1963 cannot be implemented.

Everything therefore went back to square one. The medical association boards, having rallied the great majority of the country's medical profession to their support, continued their opposition movement.

A strike was threatened, followed by further negotiations which broke down; and in March-April 1964 the medical profession embarked on a stoppage of medical care which came to an end on the promise of renewed discussions, which was obtained through the intervention of the Belgian University rectors.

The renewed discussions led to the agreement of 25 June 1964, of which the most notable feature was that the medical profession not only agreed to appoint representatives to attend the Managing Committee in a consultative capacity, but also to sit on the technical councils empowered to prepare and keep up to date a new nomenclature for benefits.

It was clear that these negotiations had led the medical profession to adopt an appreciably more realistic position.

However, the paradox still remains that the doctors have spontaneously given up their right to vote, together with their right to suspend the decisions of the Managing Committee.

The profession's concurrence, however, in attending the institution responsible for medical care insurance, would seem to show a real trend towards collaboration in the new system; and the experience opened up by its presence at discussions and by its confrontation with the realities of insurance administration must of its nature bring the two standpoints even closer.

The explanation of such a volte-face in the attitude of the medical profession would seem to lie in its realisation, during the discussions held with government representatives, that its presence within the managing bodies of medical care insurance forms precisely the means by which, under the Act, it can ensure observance of the values to which by tradition the profession is attached: professional secrecy, liberty to prescribe treatment, free choice of doctor by sick persons.

It is indeed indisputable that the presence of doctors at discussions on the drawing up of regulations to organise the dispensation of care creates the best possible guarantee against any excess in this field.

True, the medical association boards present their entry into the Managing Committee as a victory brought about by their perseverance of action; and to demonstrate this, they lean heavily on the fact that the Act no longer "constrains" them to have a vote or to associate themselves with liability for any deficit. They have succeeded in having the Act amended in this sense, and it is here that their victory lies. Psychologically, it is important because it gives them a sense of collaboration in an achievement which, although far from perfect, has been improved by their suggestions. But the importance of the psychological victory is

nugatory as compared with the concrete fact of the doctors' presence within an institution whose job is to implement an Act which the medical profession initially wanted to see repealed in its entirety.

6. Financing

The basic fault of the previous sickness and invalidity insurance scheme lay in a permanent and constantly widening imbalance between income and expenditure: the spectre of this deficit first made itself felt in 1947, and its first result was to create a psychological climate which was unfavourable to any extension of the scheme to other categories of the population; its second effect was to render sterile - because not materially susceptible of achievement - any initiative designed to increase the effectiveness of the existing scheme, under which heavier and heavier charges devolved upon the beneficiaries themselves in order to make up costs of treatment. These personal charges were especially onerous in the case of sick or disabled persons unable to work (whose needs in terms of care had increased because of their condition, and whose compensation, however, for the same financial reasons, could not be adjusted to the rising cost of living), or of retired persons and widows, whose incomes are essentially and definitively made up of pensions or allowances usually amounting to less than the wage of an active worker.

The correction of this financial imbalance, while it was not the essential part of the reform under the Act of 9 August 1963, was nevertheless one of its principal features.

Furthermore, it was necessary as a preliminary to establish that the chronic deficit in sickness and invalidity insurance had been due not to bad management or excessive hand-outs, but the mathematical result of the total inadequacy of its financial resources faced with the new and developing needs created by social progress and in particular with the considerable expansion of resources made available by modern medicine, both in accurate diagnosis of disease and in adequate therapy for treatment.

The financial requirements for sickness insurance had been calculated, in 1944, in direct ratio with the level of expenditure of the mutual benefit societies which, up to the outbreak of the World War in 1940 and for several decades previously had set up and elaborated a considerable free insurance organisation, which to some extent made it possible to postpone the advent of compulsory insurance and which was why, when compulsory insurance was introduced in 1945, the mutual benefit societies with their wide experience and their network of socio-medical services throughout the country were given such an important part to play.

And while it is true that compulsory insurance, with comparable financing terms, failed after 1944 to achieve the balance that free insurance had maintained before 1940, it could not be the quality of management which should be called into question, since this was in most places essentially in the hands of the same bodies and even of the same people; nor, clearly, was it because of alterations in benefit reimbursement rates, since these were adjusted

to the rates charged before the war, on the same basis as the rates for contribution.

Where there was a fundamental change was in the quality and quantity of services to which doctors had recourse, reimbursement for which was claimed from the insurance by the beneficiaries; and this trend was the result, not of the transfer from free insurance to compulsory insurance, but of the simultaneous and considerable advances in medicine. This is a matter for emphasis because medical techniques are continuing to advance, and so, by implication, is the need to adjust methods of financing and of calculating the needs of sickness insurance schemes.

The various governments which have succeeded each other since 1947 have indeed attempted to reform sickness and invalidity insurance; but they have all, obsessed by the negative financial balance, made the mistake of failing to examine the causes, and of trying to solve the problem by inventing various forms of insurance organisation which have been a continuing attempt to contain expenditure within the framework of a budget manifestly inadequate to meet developments in medicine and in population trends.

In the context of a budget which was not adapted to the new requirements, and which was limited by inadequate resources, the long out-of-date nomenclature for benefits could not be altered without the risk of further exacerbating the growing deficit; reimbursement rates could not be altered, although in many cases they were disproportionate to the importance, medically, of the action taken; it was frequently necessary to refuse intervention in the cost of certain benefits, or to have recourse to ambiguous correlations, which inaccurately corresponded to actions not expressly provided for in the scale of charges. The very inadequacy of reimbursement meant that conscientious doctors who still took the time to practise efficiently found themselves in competition with those who got round the disadvantages of underpayment by practising on the basis of the easy answer and the immediate solution, more influenced by the economic viability of nomenclature than by any concern for accurate diagnosis or adequate treatment.

At this level, the virtue of the Act of 9 August 1963 lies in that it first lists the new needs in medicine, and that it introduces a system of financing which no longer, as formerly, makes medical care expenditure dependent on an arbitrarily and empirically pre-established figure but on the contrary, specifies that the estimated expenditure for each financial year must be assessed beforehand, and resources allocated to cover such expenditure.

Such estimates are to be made for each year of a three-year period; on the one hand on the basis of the nomenclature as brought and kept continually up to date, and the scales for reimbursement as calculated on rates of fees agreed by convention, and on the other hand taking into account the cost increase coefficient as made up over the last three known financial years.

Estimated income must balance estimated expenditure in the budget; such income is made up of the following components:

(a) aggregate contributions by workers and employers fixed on 1.1.1964 at 5 per cent., and on 1.1.66 at 5.75 per cent. of a proportion of wages not to exceed a ceiling tied to the retail price index trend, and standing at 12.650 Fr. per month on 1 April 1966; workers pay 2.65 per cent. and employers 3.10 per cent. of wages;

(b) a state contribution designed to compensate for non-payment of contributions by unemployed persons, at a figure representing, per day of unemployment, the average contribution of an active worker;

(c) a state contribution to cover 95 per cent. of expenditure in respect of specific treatment for cancer, tuberculosis, mental diseases, poliomyelitis and congenital diseases;

(d) a state contribution to represent 27 per cent. of estimated expenditure in respect of all other medical and pharmaceutical services.

Any deficit in income estimates as compared with expenditure estimates is covered beforehand by a corresponding increase in contributions as due both from employees and from employers.

The amounts required to cover the Health Care Service administration costs of the National Institute for Sickness and Invalidity Insurance as assessed in the budget are withdrawn from the total resources as defined above.

The total figure remaining after such withdrawal is allocated amongst the six insurance carriers as follows:

(a) each insurance carrier receives, in respect of each active worker registered with it, the amount of contribution as deducted at source on such worker's wages, to include both his own contribution and that of the employer;

(b) each insurance carrier receives, in respect of every day of involuntary unemployment as regards an insured person registered with it, a sum corresponding to the average contribution of active workers;

(c) each insurance carrier receives, in respect of insured persons who are neither active workers nor unemployed - i.e. pensioners, widows, and invalids - a sum in direct ratio with the number of its members in these three social groups and with the actual charge they represent. The total of resources derived from state subsidies, corresponding to 27 per cent. of estimated expenditure, is therefore basically designed to offset non-contribution of payments by pensioners, widows and invalids: the proportion of such total allocated to each insurance carrier varies according to the number of its non-contributing members and to the proportion,

amongst the three groups of non-contributors, of persons belonging to the group which actually costs the most to support; the cost of medical care for invalids, on average, exceeds that for pensioners and widows by 50 per cent. In practice, the state subsidy makes it possible not only to cover the cost of medical care for non-contributing beneficiaries, but also to make up the difference between the amount paid in contributions and the actual cost of care for contributors: it can be seen that the number of invalids and widows is representative of the incidence of morbidity, and that the number of pensioners expresses with reasonable accuracy the increasing frequency of recourse to medical care as linked to advancing age: both are the expression of the essential characteristics of the categories of insured persons in the groups affiliated to each insurance carrier, wherein the average risks are the result, in particular, of the nature of occupation, regional population trends and local availability of medical care. Applying this formula of distribution as an experiment to completed financial years, it has been found that it enables the real expenditure of insurance carriers to be reconstructed with a margin of error of not more than 3 per cent.

This way of allocating funds, therefore, enables the national federations of mutual benefit societies and the Auxiliary Sickness and Invalidity Insurance Fund to dispose of funds which are in proportion to the actual charges they must meet.

These terms mean that each insurance carrier is responsible for the balancing of its annual costs;

(d) Each insurance carrier receives a state subsidy in respect of the total number of insured persons registered with it, amounting to 95 per cent. of the expenditure actually borne in the matter of social diseases (cancer, tuberculosis, poliomyelitis, mental diseases, congenital diseases and malformations). The balance of the expenditure on such diseases is covered, by each insurance carrier, by a part of the funds allocated to it in accordance with (a), (b) and (c) above.

The need thus to allocate medical care insurance funds between the insurance carriers is caused by the pluralism of the scheme's administrative structure: each insurance carrier must know beforehand the amount of funds available each year, so as to be able to fulfil its responsibility effectively.

This responsibility manifests itself especially in the event of a deficit at the end of the financial year; any deficit within one or more insurance carriers must be made up by charging a supplementary contribution, applicable only to the insured persons of the bodies having a deficit; the amount of such supplementary contribution varies, therefore, in ratio with the size of the deficit to be made up.

Insurance carriers concluding the financial year with a surplus, on the other hand, must set aside not less than 40 per cent. of such surplus for constituting a legal reserve fund: the balance of the surplus is paid into the ordinary reserve fund, and may be used to give additional advantages to beneficiaries which, however, may in no case take the form of increasing legal intervention by the insurance in benefits; such additional advantages may in particular concern certain transport costs for sick persons, or the organisation of holiday or convalescent homes.

In the event of a deficit, the legal reserve fund is first mobilised, and only when this is exhausted are the insured persons required to make a supplementary contribution to restore the balance.

The Act specifies, moreover, that if during a financial year decisions occur whose effect is to introduce fresh expenditure which was not provided for in the budget, such decisions must necessarily be accompanied by an estimate of the funds required for the new expenditure: in principle, such funds must be raised by an increase in contributions levied on remuneration, but the Government may, if appropriate in view of the political and economic aspects of such increases, decide to raise the requisite funds by other means.

7. Right of Appeal of Insured Persons

Disputes relating to the rights arising out of the laws and rules on medical care insurance are judged by disputes tribunals, which are made up of equal numbers of employers' and workers' representatives, presided over by a doctor of law appointed by the Crown from amongst magistrates, barristers or practitioners in social law, and assisted by secretary-rapporteurs. These tribunals are divided into claims commissions for first hearings, and an appeals commission. The seat and competence of claims commissions are so fixed that they may be accessible to all insured persons, without involving long journeys. All parties in a matter coming within the claims commission's competence may cause themselves to be represented by a duly authorised person: they may have counsel to assist them at the hearing. In the event of a natural person, such assistance may be rendered by counsel or by a delegate from a workers' organisation.

Any insured person or person claiming to be an insured person is entitled tc refer to the claims commission.

Appeal against a decision by the claims commissicn may be made by all parties concerned in the decision; provided that the beneficiary of a deceased person is empowered to exercise the latter's rights of appeal.

Should a disputes tribunal consider that it requires the information of an expert medical appraisal, this is stated by a decision: the tribunal appoints its expert from a list, drawn up by itself, of doctors who conform to the scales of fees and charges specified by Royal Decree.

The institution of disputes tribunals does not prejudice the competence of the courts and tribunals as laid down in the Belgian Constitution.

An action brought before one of these tribunals, however, implies recognition by the bringer of the action of the tribunal's competence: provided that a person summonsed by a tribunal may, exceptionally and before submitting any other defence, dispute that competence: should this occur, the matter is automatically referred to the common law judge.

C. Application of the Medical Care Insurance Scheme: Discussion of Experience and Problems

1. Ambulatory and Domiciliary General Practitioner Care

As has already been seen, consultations with doctors either at their private surgery, or in dispensaries or consultative services attached to hospitals, are reimbursed by the medical care insurace both as regards general practitioner and specialist care.

Similarly, the medical care insurance meets the cost of visits to beneficiaries' homes by general practitioners, pediatricians and specialists called in by the doctor in charge.

Beneficiaries have complete freedom of choice: the only pre-condition is that they should address themselves to a doctor who is qualified to practise in Belgium and who, pursuant thereto, is registered on the lists of the Medical Council.

No limit is laid down for intervention by the insurance either as to duration or as to frequency of application for benefit.

At present the patient may have free choice in consulting any doctor without affecting the intervention of the insurance scheme. He could on the same day consult several different doctors, whatever their qualifications and irrespective of the nature of his illness. A certificate may be issued indifferently by one or other of the doctors consulted.

Technical services carried out during consultations or visits are reimbursed on the same terms.

Fees - and consequently, the amounts for reimbursement - are higher for specialist consultations than for consultations with general practitioners: hence it has been necessary to draw up a list of recognised specialists. Recognition is given by credentials committees, operating within the Ministry of Public Health, the members of which are appointed on the one hand, by the various specialists' professional associations, and on the other hand, by the Belgian University Faculties of Medicine.

A doctor who is not a reccgnised specialist is ipso facto considered as a general practitioner.

Aside from normal technical services (e.g. radioscopic examinations, setting of simple fractures, normal laboratory examinations, treatment of wounds or minor cuts, etc.) which are considered as being within the competence of any doctor, the nomenclature includes a list, for each field of specialisation, of technical services which come solely within the competence of a specific field of specialisation: such services are reimbursed only to the extent that they have been performed by a recognised specialist in the relevant field.

Some of these services - surgery other than minor operations - are reimbursed only if they are carried out in a hospital establishment, since their performance under proper conditions requires equipment, assistance and a degree of asepsis which cannot be achieved in the doctor's surgery nor at the patient's home.

2. Care Given by Doctors at Hospitals

We have just seen that out-patient consultative services attached to hospitals are considered on the same footing as doctor's private surgeries; so that in consequence, consultations and all services provided therein are reimbursed by the medical care insurance.

Moreover, and a fortiori, the insurance reimburses all medical services provided during in-patient treatment of beneficiaries. The terms on which the medical care insurance pays for hospitalisation costs are described in a later section; meanwhile, suffice it to state that if hospitalisation is admitted, all services performed in the field of diagnosis or therapy are reimbursed without limit and without any authorisation being required beforehand.

The doctor in charge of in-patient treatment and supervision is solely responsible for the choice of treatment to be applied.

As regards choice of doctor by the sick person when the latter is hospitalised, the extent of such choice depends in essence on the organisation of the hospital itself - a sphere in which the medical care insurance does not intervene.

Some hospitals are open to all doctors, and where this is the case, the beneficiary can choose both his hospital and his doctor.

Other hospitals, as is generally the case in public-authority establishments, have their own medical staff to the exclusion of all other doctors: and where this is the case, the beneficiary's choice of hospital limits his choice of doctor to those attached to the establishment.

3. Pharmaceutical Supplies

Only medicaments prescribed by a doctor qualify for intervention by the medical care insurance.

Beneficiaries are moreover free to have prescriptions made up by any pharmacist, in so far as they choose a legally qualified pharmacist.

In the case of in-patients, however, in a hospital with a recognised pharmacy, medicaments can only be issued by the said service.

In practice, all medicaments which are prescribed and delivered in the form of made-up prescriptions are reimbursed by the medical care insurance save those which may be used as food or for hygienic or toilet purposes.

The same does not obtain for proprietary preparations: the medical care insurance, on a proposal of a technical council functioning under its aegis and made up of university professors, clinicians and pharmacologists, keeps up a list of patent medicines which is based on criteria as to the effectiveness and relative cost of such medicines; this selection cuts out, on the one hand, medicaments put up under a brand name but which can easily be made up as a chemist's prescription, and on the other hand, medicaments which may not necessarily be obtainable in prescription form but which are unduly expensive in view of their effectiveness in therapy.

This list, however, has the drawbacks of all selective lists in that it includes a number of patent medicines which qualify for reimbursement but which are obviously not justified in so doing, and in that by the same token, certain widely prescribed products which could well be included, are not.

It should, however, be added that the list is regularly amended so that developments and trends in therapy may be followed as closely as possible.

But reference to a restrictive list of patent medicines, whatever the relative value of the medicines selected, would create no great difficulty were it not that products which are excluded from the list continue to be sold in pharmacies and prescribed by doctors: such duality in practice creates a manifest contradiction, which it is proposed to end by co-ordinating the activity of the Ministry of Public Health (which is competent to authorise the marketing of patent medicines) with the decisions of the medical care insurance, which is competent to establish the lists of products qualifying for reimbursement.

In fact, procedures for registering medicines, which condition the right to market them, are based in essence on criteria as to conformity; while admission to reimbursement by the medical care insurance, on the other hand, is based on criteria as to efficacity. The co-ordination being sought for in this field is designed to introduce criteria as to therapeutic effectiveness into procedures for patenting medicines: once this is achieved, the medical care insurance can reimburse the cost of all recognised patent medicines which are put on the market, without having to make a further selection.

4. Costs of In-Patient Care in Hospital

Since 1 January 1964, an Act has been in force which lays down the daily maintenance cost which public and private hospitals are

entitled to claim from in-patients: this Act was drafted at the same time as the Act of 9 August 1963, reorganising health care insurance, and was designed to complete the latter's scope.

This daily maintenance charge varies according to the quality and nature of specialised care provided: it includes all costs relating to the patient's sojourn in a public ward, including amortisation costs and the cost of administrative, nursing and maintenance staff. It does not include fees for doctors, dentists, midwives or physiotherapists, nor the cost of prosthetic appliances or patent medicines.

No in-patient in a public ward in any hospital, therefore, can be asked to pay an amount greater than that laid down by law.

Hospitals are entitled to charge a supplement of not more than 50 per cent. for hospitalisation in a ward with two beds, and an unlimited supplement for hospitalisation in a private room.

The Act specifies, however, that where the patient has been placed in a ward with one or two beds not for reasons of personal convenience nor at his own request, but because his condition requires isolation, the establishment is only entitled to charge him the amount laid down for hospitalisation in a public ward.

In all cases, and whatever the allocation in a particular hospital as between private rooms and public wards, it is specified that half the total number of beds in an establishment at any given time must be available to patients at the charge for hospitalisation in a public ward.

Intervention by the medical care insurance in the costs of in-patient care has been determined with regard to these provisions as laid down in the Hospitals Act; such intervention covers the whole of the daily maintenance cost in a public ward, such that intervention is genuinely free for beneficiaries, not only when they are hospitalised in a public ward but also when, for medical reasons, they have to go into a private room; and this remains true whatever the type and category of service for which they are hospitalised.

In the matter of private rooms, however, it must be pointed out that it is not always easy in practice to determine whether the patient has been isolated because of the characteristics of his disease, or because of his own desire or even, merely, his passive agreement.

Moreover, it must be noted that although this absolute co-ordination between the daily maintenance costs as laid down for hospitals and the figure for intervention by the medical care insurance has succeeded in solving the problems created for beneficiaries by the ever-increasing costs of hospitalisation, it is also true that these fixed charges have set up new problems for some hospitals, who find their ability to meet administration and amortisation costs threatened thereby: indeed, although the fixed charges vary in relation to the degree of specialisation and the equipment provided by the various services, the average rates laid

down for each category may in some cases be slightly higher than is really necessary for establishments at the lower limit of minimum standards for hospital organisation, and may in other cases be well below what is needed to cover the costs of better equipped services. The solution to this problem is to be found in the context of an objective selection of hospital establishments.

Finally, it should be noted that the provisions as to the daily maintenance charge are the same for public hospitals and private clinics.

Some of these establishments were owned by the mutual benefit societies themselves, and are managed by them; these are in no way privileged, but it is self-evident that in their case, problems which may arise if the compulsory daily maintenance charge is too low can be easily solved by joint contributions freely paid by members of such mutual benefit societies.

Free hospitalisation, obviously, is guaranteed in mutual benefit clinics just as in other establishments, but free medical care is guaranteed in addition, since they have their own medical staff and since the insurance rates are always observed in their entirety, whether there is or is not an agreement scheme; this will be described hereinafter.

As regards the conditions for intervention by the medical care insurance in hospitalisation costs, it should be stated that all beneficiaries may be hospitalised at the expense of the insurance in cases where diagnosis or treatment cannot be given under ambulatory care or where isolation is necessary for an infectious patient.

Any beneficiary may be admitted to any hospital, without special formalities being required, for a period of seven to ten days; authorisation is only required in the event of hospitalisation being extended for a longer period than this, and must be given by the insurance carrier's advisory medical officer, on the basis of an explanatory report from the hospital. To the extent that such report is communicated within the prescribed period to the insurance carrier, the latter may not, in the event of delay in replying, dispute the justification for those days of hospitalisation which may have preceded the communication of a negative decision by it.

This provision is laid down both to encourage hospitals to submit applications for extension in due time, and also to make the insurance carriers give their reply to such applications with the least possible delay.

5. Dental Care

As has already been stated, care (both corrective and preservative) given by dental practitioners is considered as coming under normal care giving occasion for the beneficiary's personal participation in the cost: thus the medical care insurance reimburses 75 per cent. of the cost of dental care except in the case of widows, pensioners, invalids and orphans, for whom the reimbursement rate is

100 per cent. The conditions of free choice in dentistry are the same as in medicine.

There is in general, as for medical care, no limit to duration or frequency of care, save only as regards orthodontic care and dental prosthesis.

As regards orthodontia, treatment must have begun before the age of 12 years, and may be continued until the age of 16 years at most: this provision is designed to encourage early care, and to avoid treatments belatedly begun and thus becoming entirely ineffective.

Dental prosthesis, mcreover, is not given in principle until the age of 50 years; this provision equally is designed to encourage beneficiaries to have regular dental care before that age and to maintain their teeth in good condition; and to this end, preservative care is broadly speaking honoured and reimbursed with no limitation as to frequency.

However, certain special conditions may give entitlement to dental prosthesis before the age of 50 years; particularly in the case of persons with a local mouth complaint or with a general complaint where the restoration of normal masticatory functions is an essential factor in treatment.

6. Care Given by Members of the Para-Medical Professions

For nursing care given in the home, or for care given in physiotherapy clinics or by physiotherapists in patients' homes, or for confinements in the home or in maternity clinics under the care of midwives, beneficiaries have complete freedom of choice amongst the members of these professions provided that treatment is given by persons with established qualifications, who are recognised by the Medical Care Service of the National Institute for Sickness and Invalidity Insurance.

Beneficiaries have freedom of choice, equally, in the matter of obtaining spectacles, hearing aids, orthopaedic and rupture appliances, and may go to any authorised supplier of such aids to the extent that the said aids have been prescribed by a doctor, and that the technical qualifications of suppliers have been approved by specialised credentials committees, operating within the National Institute for Sickness and Invalidity Insurance, and made up in the main of representatives of the professional associations concerned.

The registration and/or approval of persons in para-medical occupations is based solely on the competence conferred on them by their statutory diploma or on their professional competence as recognised by the Credentials Committee; it does not automatically imply that they are bound to observe the medical care insurance rates of charges, but it does on the other hand bind them to transmit to beneficiaries all the statutory documents required in order to obtain the intervention of the medical care insurance, and in particular, the certificates stating the nature of services provided and the date on which they were provided.

Services performed by nurses at the patients' homes cover not only injections as prescribed by doctors, but also physical care for which disabled patients would otherwise have to go into hospital: these services, therefore, enable the cost of in-patient care to be avoided in numerous cases of bedridden patients suffering from chronic disability.

Orthopaedic appliances, prosthetic appliances and rupture appliances make up the whole range of articles which need to be supplied, either as being accessory or additional to certain surgical treatments, or as being prosthesis designed to replace or correct certain reduced or missing functions: prescribed periods are generally laid down for renewal of such articles, before the expiry of which insurance intervention is not authorised in the case of a further service of the same nature; but this provision is balanced by provision for intervention at a standard yearly rate to cover the costs of maintaining and repairing the relevant appliance.

7. Preventive Care

It should not be forgotten that the Act contains categorical provisions to put preventive care on the same footing as curative care in the context of benefits qualifying for reimbursement, on the same terms and for all covered persons.

These provisions genuinely apply in practice; and some insurance carriers, furthermore, organise regular examinations for the detection of tuberculosis and certain forms of cancer, which are free to covered persons, within the framework of their socio-medical services.

8. Social Services

All insurance carriers are in possession of a considerable socio-medical service made up of advisory medical officers, district nurses and social welfare officers; amongst its other duties, this service is responsible for social services to covered persons.

Such social service is especially directed towards assisting families in the event of tuberculosis, cancer, chronic disability or maternity, with a view to ensuring either proper prophylactic conditions, or else physical assistance with household chores; it is also directed towards dealings with pension or family allowance organisations, so as to facilitate and advance administrative formalities; and towards contacts with employers in seeking special employment conditions for certain maladjusted persons.

But in the main activity of the socio-medical services lies in discovering people who are liable to benefit from functional or vocational retraining, in drawing up programmes for retraining taking into account the personal aptitudes of the parties concerned, and in discovering the most suitable means of carrying out such programmes.

All costs relating to the achievement of such retraining programmes are met by the medical care insurance.

9. Maintenance and Notification of Medical Records

The Act of 9 August 1963 initially laid down that all doctors must keep a record for each beneficiary, which they should make available to the Medical Control Department of the medical care insurance; and also, that they must enter on a card to be retained by the beneficiary any technical services performed.

This measure was designed to enable all doctors successively consulted by a patient to be automatically informed of the import of previous examinations; and also, to avoid pointless repetition of certain benefits and to facilitate exchange of information amongst doctors.

But the energetic criticisms of the medical profession, who felt that such a procedure entailed the permanent divulging of professional secrets, led to the revoking of these provisions; this did not, however, imply denial of the need to ensure the exchange, between doctors on the one hand, and between doctors and the medical care insurance medical services on the other hand, of information which would be of use both to the patient and to control of the import and efficacity of care already given.

In practice, doctors usually do communicate any information they need to each other, particularly where a patient is referred by a general practitioner to a specialist or where a doctor applies for a patient to be admitted to hospital.

The medical care insurance, moreover, makes a payment for written reports synthesising the observations of one doctor and sent to another, to the extent that a copy of such reports is sent to the advisory medical officer of the insurance carrier: this compromise solution gives relative satisfaction to all parties and creates no particular difficulties.

Moreover, advisory medical officers have records in which are set out the main benefits in respect of which beneficiaries have applied for intervention by insurance carriers, and it is not unusual for doctors in charge of a case to ask the advisory medical officers to obtain a particular piece of information.

The advisory medical officers' records are completed, in addition, by the officers' knowledge of the various periods of incapacity for work of beneficiaries and of the medical causes thereof.

10. Certification of Incapacity for Work

Any period of incapacity for work must be supported by the evidence of a medical certificate containing a statement of reasons, made out by the doctor in charge and addressed to the advisory medical officer of the insurance carrier who decides as to whether this is well-founded, having recourse if necessary to examination of the patient.

On the basis of the data contained in the certificate, and also, where appropriate, his own examination, he decides on the period of

incapacity for work and decides, if necessary, to make a further examination after a given period.

11. Professional Secrecy in Handling of Records

The fact of records existing which list beneficiaries' illnesses, together with examinations and treatment given to them, raises the question of professional secrecy of agents of the insurance carriers who are appointed to handle records and general documentation containing medical information.

Both in the central administration of the medical care insurance and in the various geographical divisions of the insurance carriers, documents containing medical information are kept together under services for which the doctors are responsible; and the doctors as such are liable to come before the Medical Council to justify any breach of the rules on maintaining professional secrecy.

Nevertheless, it can be seen that the beneficiaries themselves - in whose interest the observance of medical secrecy is codified - transmit documents which may sometimes contain highly confidential information direct to non-medical staff: this occurs either voluntarily, or compulsorily, as for instance when beneficiaries submit statements of charges, which may give details enabling their complaint to be identified, to the offices of the insurance carriers.

Such contingencies cannot in practice be avoided, given the quantity of documents which are every day transmitted, processed and handled.

Consequently, all insurance officials who are appointed to duties liable to make them acquainted with medical information are compulsorily informed of this delicate aspect of their jobs, and are warned of the provisions laid down in the penal code on divulging of professional secrecy.

12. Internal Control of Benefits

(a) Control of qualifying conditions for entitlement to benefit. An administrative control service, operating within the National Institute for Sickness and Invalidity Insurance and managed by workers' and employers' representatives, is permanently responsible for keeping a check, by sampling, on whether beneficiaries receiving benefits from the insurance carriers fulfil the statutory conditions governing entitlement to benefit, in particular as regards completion of the qualifying period payment, where appropriate, of supplementary contributions, and the fact of genuinely belonging to the household of an insured person.

Benefits granted in error by insurance carriers may not be included in the accounts, imply the institution of procedure for recovery, and may give rise to financial sanctions for the body in default.

(b) Control of dispensation of care. It has already been explained that insurance carriers must provide themselves with the services of an advisory medical officer.

Within the scheme for insurance for medical care, the function of the advisory medical officer is to ensure the medical control of benefits. He may carry out this function in two ways:

(a) certain benefits, such as kinetotherapy and physiotherapy, may be started without the authorisation of the medical adviser, but may be continued beyond a given number of treatments only with his approval; in case of hospitalisation, the first seven days (ten in case of a confinement) are paid for without any formality other than a notice of admission given to the mutual benefit society by the establishment, but a further period is subject to the opinion of the advisory medical officer that it is not possible to make a diagnosis, or to apply an ambulatory therapy;

(b) any benefit for which an authorisation during its provision or an a posteriori opinion by the advisory medical officer is not legally required may nevertheless be subject to control on his part. This control is carried out by sampling and concerns both the efficacy of the therapy, notably in its relation to the re-establishment of capacity for work, and the frequency and necessity of the technical examinations.

Even though the insurance carriers at all times attach to themselves a sufficient number of advisory medical officers to ensure medical control throughout the country as a whole, the law specifies that in the event of a deficiency, the Central Medical Control Service which operates within the National Institute for Sickness and Invalidity Insurance may take the place of the insurance carrier for ensuring control. The said Central Medical Control Service is administered by a Committee made up exclusively of doctors representing the professional associations of the medical profession, the Medical Council, and the insurance carriers. The last named group is in the minority as against the two others.

The Chairman of the Committee is a magistrate; and its composition is completed by representatives of professional associations of the other medical and para-medical professions, when problems relating to these professions are under review.

The said control service has at its disposal supervisory medical officers, appointed to the various regions of the country.

The supervisory medical officer, an official of the medical control service, supervises the carrying out of the tasks devolving upon the advisory medical officer. He proceeds by sampling. He makes inquiries intended to control the existence of the

benefits reported to the insurance by the doctors, either by examining the documents sent to the mutual benefit societies, or by questioning the beneficiaries and the persons furnishing care. He reports on his investigations and the Committee of the Medical Control Service - which, it will be recalled, is exclusively composed of doctors - may impose sanctions when punishable facts have been brought to light. In a number of cases, however, a preliminary investigation of the records shows that the facts with which the doctors have been reproached are not of a sufficiently serious nature to warrant the application of sanctions. The doctor concerned is then invited to respect the regulations. The efficacy of this procedure is quite evident. In some cases, the medical control services refer the matter either to the tribunals or to the Medical Council.

The Medical Control Service Committee may itself impose penalties, in the form of prohibiting reimbursements of benefits provided by doctors who have been guilty of abuse: these periods of prohibition may run from one day to one year; and such decisions must be made known to beneficiaries.

In the course of the first three years of the operation of the present scheme, the bodies directing the Medical Control Service imposed 43 sanctions in 1964, 17 in 1965 and 11 in 1966. These sanctions concerned 73 doctors, one pharmacist, two dentists and one midwife.

The following table indicates the importance of the sanctions applied:

Duration of Sanction	1964	1965	1966
1 day	11		
2 days			1
3 days	4		
4 days			1 (dentist)
7-8 days	4	2	2
15 days	3	2	2
1 month	12	2	2 (1 pharm.) (1 dentist)
2 months	4	3	1
3 months	2	2	1
4 months	2	1	
6 months		1	
		1 (midwife)	
9 months	1		

The Medical Council, for its part, may impose penalties in the same matter, by forbidding doctors to practise during a given period or even, in some cases, striking them off the Roll.

13. Procedure to be Followed when Care Is Sought, and Registration of Insured Persons

Chapter B.3 - "Qualifying Conditions for Benefit" - gives the procedures for insured persons to register with an insurance carrier, and makes it clear that such registration is the pre-condition for entitlement to medical care.

Once the insured person has completed registration formalities, the continuation of the conditions giving him entitlement to benefit is automatically verified by a document entitled the "contribution voucher", which is issued by the employer and submitted quarterly, and which states the amount of contributions collected on remuneration, and the number of working days actually performed.

If, during that quarter, the employee has gone through periods of involuntary employment, he must furnish evidence of this by means of certificates issued by the official unemployment insurance services.

Moreover, it should not be forgotten that permanent verification of the insured person's status automatically gives rise to verification of entitlement as regards members of his household: additional verification is required for the latter, covering the actual residence of such persons or, as regards children, their regular attendance at an educational establishment; certificates to this effect are regularly issued by school governing boards.

D. Methods of Remunerating Members of Medical and Allied Professions and of Paying for Hospital Facilities and Pharmaceutical Products and Other Medical and Surgical Supplies

1. Methods of Remunerating Members of the Medical and Paramedical Professions

The rule for remuneration in general is based on payment for each service performed.

Payment is made on the basis of a nomenclature - which can at all times be altered on a proposal of a medical technical council - setting out a complete list of care of all kinds, by category of benefits, and giving the relative cost of each benefit.

The practitioner is bound by law to issue the beneficiary with a certificate in respect of each benefit allowed, stating the nature of the benefit.

Certificates follow a standard form for all members of any one medical or para-medical profession, which makes it easier for such documents to be made use of, read by officials of the insurance carriers, entered in the accounts, and analysed for statistical purposes.

In principle, the beneficiary pays the cost of the benefit to the practitioner, and obtains reimbursement from his insurance

carrier against the certificate with which he is issued, either by submitting it in person or by sending it through the post.

It is considered in certain quarters that such payment by the beneficiary constitutes a restraining element on over-consumption, and makes the beneficiary aware of the degree of intervention by social security.

In some cases, however - particularly in the case of expensive benefit such as, more specifically, surgical operations - the person giving care may submit certificates direct to the insurance carrier and be paid direct by the latter: this procedure for payment - known as "tiers payant" - obviates the expense of the benefit for the beneficiary, but it also makes it possible for the doctor or other practitioner to make out certificates for fictitious benefits; although it must be admitted that practically speaking, such abuse is the exception.

In addition to these payments of fees, which are the general rule, the Act gives the option of a flat-rate payment for benefits, either to individual doctors or to groups of doctors working in establishments for medical care: in practice, this flat-rate payment system has only been asked for by institutions, for the whole of the benefits as provided by the team of doctors working therein; the figures for flat-rate payments were established in 1964 and 1965, on the basis of the amount of benefits provided in each of these establishments during the three preceding years, adjusted in accordance with the recorded consumption increase coefficient.

As from 1966, these flat-rate amounts have to be calculated not, as formerly, in ratio to the amount of benefits provided in the immediate past, but in ratio to the actual running costs of the institution, after verification of the establishment's accounts.

These flat-rate payments would seem to constitute an administrative simplification, since they obviate the need for issuing certificates and for investigating the supporting documents for each benefit.

But only seven establishments for medical care in the whole country have applied for and obtained such flat-rate payment for the whole of the benefits provided by their doctors.

2. Methods of Fixing Rates of Remuneration and Charges

The Belgian medical care insurance scheme is based, as regards fixing rates of remuneration and charges, on the principle of agreement by convention between the parties.

Such conventions are negotiated at national level, by permanent committees whose chairman is the Director-General of the Medical Service, and which are made up in equal numbers of representatives of the insurance carriers on the one hand, and of representatives of the professional associations concerned on the other hand.

There is one committee for each medical and para-medical profession.

The negotiations are designed, in particular, to fix the value in francs of the multiplication factor to give the absolute value of benefits, which are worked out in the nomenclature in the form of relative values.

Proposals for agreement as made in the committees are submitted to the medical care insurance Managing Committee for its opinion, and more particularly, as regards the financial aspects of agreements concerning doctors and dentists, to representatives of employers' and workers' organisations.

Proposals for agreement are then submitted to the Minister of Social Welfare, whose approval is necessary before agreements can become definitive.

The text of agreements is then sent individually to each member of the profession concerned, to request his or her personal adherence: if not less than 60 per cent. of the members of the profession in the whole country agree personally to adherence, the scheme, as agreed by convention, may be put into effect throughout the entire realm. Should such quorum not be achieved, such scheme may be put into effect only in those regions where 60 per cent. adherence was obtained.

As from the date when the scheme as agreed by convention is put into effect as regards the whole country or as regards certain regions, this means that practitioners who have acceded to the convention shall respect the agreed scales of fees and charges, and that the minority who have remained outside the convention may charge different rates, on the understanding that the insurance carriers will repay the same amount for identical services as provided by one or the other group.

This legislation is based on the idea that if beneficiaries were to be guaranteed the option of obtaining care at the rates of fees and charges corresponding to intervention by the insurance, they must also be given an adequate degree of choice amongst all the practitioners competent to provide such care: and it was felt that by fixing the quorum required for the agreed scheme to come into effect at 60 per cent. of the total number of practitioners in a profession, beneficiaries' free choice was adequately ensured; and that hence, it was unnecessary to introduce a system of discrimination in the amount of reimbursement allowed in respect of benefits provided by the minority of practitioners who had not undertaken to observe the rates of fees.

In this context, it should be added that as regards doctors, the 60 per cent. quorum of individual adherents must include firstly, not less than 50 per cent. of the total number of general practitioners, and secondly, not less than 50 per cent. of the total number of specialists: this provision was designed to prevent the situation in which an agreed scheme might be accepted as valid, but in which the 60 per cent. quorum had been achieved through adherence by an appreciably larger proportion of one of these two groups of doctors than the other, such that beneficiaries would not have a sufficient degree of free choice in obtaining care, without payment, from doctors in the other group.

Agreements are valid for one year, but may be extended by tacit agreement from year to year.

Individual adherence is also valid for one year, and is also extended by tacit agreement from year to year, unless notice of withdrawal is given for the following year before the first of October in the current year.

Where agreements or national conventions are denounced within the specified period of notice, this gives rise to simultaneous denunciation of individual adherence for the following financial year.

The agreement recently concluded with doctors in respect of the year 1967 contains provisions laying down a social statute for doctors who adhere to it. The agreement lays down that, until definitive provisions can be drawn up in the national Medico-mutual Benefit Committee, the health insurance will pay all doctors who accede to the agreement a sum, provisionally fixed at 7,500 Fr. for 1967; such payment will be made to any insurance carrier named by the doctor concerned, provided that the latter personally pays the insurance carrier a contribution of at least an equivalent figure, to form either a retirement pension, or a survivor's pension, or an invalidity pension.

Where national convention committees have failed to reach agreement, or where agreement has been reached but the quorum for individual adherence either nationally or in certain regions has not been reached, the rates of fees and charges may be made compulsory by Royal Decree, either for the country as a whole or for those regions in which the quorum was not achieved.

In 1964, 1965 and 1966, in fact, agreements were concluded for nurses, physiotherapists, midwives, opticians, truss-makers, orthopaedists and makers of hearing aids, and the 60 per cent. quorum was reached in some cases with a considerable surplus margin. This situation will continue in respect of 1967.

As regards doctors, 1964 was a year of discussion, hesitation and disagreement which on 25 June 1964 led to an armistice and to the working out of an amendment to the Act which did not, however, infringe the basic principles thereof.

In 1965, on the basis of the agreement of 25 June 1964, more than 60 per cent. of doctors and dentists acceded to this agreement and effectively observed the terms of their undertaking.

In 1966, the agreement was not extended, so that the system agreed by convention could not be achieved during that year. Consequently, a Royal Decree was enacted which pegged doctors' fees at the level of fees charged as at 31 December 1965: a second Decree, to amend the first, laid down new compulsory rates for fees, and the amounts reimbursed were raised to the level of such rates: but compulsory observance of such fees only covered benefits granted to pensioners, invalids, widows and orphans. Fees remained free for other beneficiaries, thus creating the danger of a new imbalance between fees charged and sums reimbursed by the insurance.

Broadly speaking, fees actually charged for the majority of services provided in medical establishments and for costly services provided in private surgery by specialists corresponded in practice to the amounts reimbursed by the insurance; but the same did not hold good as regards fees for consultations and visits.

The agreement just established for 1967 tends precisely to adopt, as fees agreed by convention, the scales of fees freely charged by general practitioners for consultations and visits.

The text of this agreement has just been sent to all doctors and dentists in the country, and we are as yet unable to comment on the possibility of thus going back to the scheme as agreed by convention.

3. Payment for Hospital Facilities

The fixing of the daily maintenance charge in each hospital establishment has already been explained in Chapter C.4 - "Cost of in-patient care in hospital" - which makes clear that this system does not differ in its application to public hospitals, private clinics or institutions administered by the mutual benefit societies.

It will be remembered that in all cases, intervention by the medical care insurance covers costs of hospitalisation in a public ward, and in cases where the patient's condition requires him to be isolated, costs of hospitalisation in a private room.

Generally speaking, the costs of hospitalisation are paid under the system of "tiers payant", i.e., the hospital sends its bills for in-patient care direct to the insurance carrier.

A bipartite national convention Committee exists to deal with questions of hospital establishments, and operates on the same terms as those specified in Chapter D.2 above: it will be clear, however, that the primary object of this Committee is not to agree charges, since these are fixed by other means, but to regulate administrative dealings between hospitals and insurance carriers.

4. Payment for Pharmaceutical Products

In the passage on pharmaceutical supplies in Chapter C.3, it has been shown that, as regards proprietary preparations, interventions by the medical care insurance are calculated on the actual selling price for such products: these selling prices are fixed and controlled by the Ministry of Economic Affairs but it is quite common for pharmaceutical companies to agree reductions in such prices when application is made for patent medicines to be admitted to the list of medicaments which are reimbursed by the insurance.

Furthermore, as regards made-up prescriptions, prices are decided by a committee within the Ministry for Social Welfare; these prices are strictly observed by all pharmacists throughout the country.

Lastly, fees for preparations, which vary according to their pharmaceutical form, together with fees for responsibility, are laid down by the National Pharmaceutico-Mutual Benefit Committee, which operates on the general terms described in Chapter D.2 above: all pharmacists in the country, practically speaking, have adhered to the terms of the convention which was concluded, and charge strictly the agreed rates.

It should be pointed out, moreover, that the pharmacists themselves suggested and achieved a free scheme by which they bound themselves, even before the scheme as agreed by convention was set down in law.

Number of Adherents to Conventions in Respect of Hospital Establishments

GENERAL HOSPITALS AND SPECIALISED FACILITIES

Year	Number of Establishments	Number of Establishments which have Acceded to the Convention	%
1964	403	386	95.7
1965	409	398	97.3
1966	409	399	97.5
	SANATORIA FOR PULMONARY TUBERCULOSIS		
1964	20	20	100.0
1965	19	19	100.0
1966	19	19	100.0
	PSYCHIATRIC ESTABLISHMENTS: OPEN		
1964	30	19	63.3
1965	27	20	74.0
1966	27	20	74.0
	PSYCHIATRIC ESTABLISHMENTS: CLOSED		
1964	47	44	93.6
1965	47	44	93.6
1966	47	45	95.7

Number of Adherents to Conventions in Respect of Para-Medical Professions

DATE	1964			1965			1966		
CATEGORY	Total	Number of Adherents	%	Total	Number of Adherents	%	Total	Number of Adherents	%
Midwives	1,574	1,256	79.80	1,635	1,352	82.69	1,697	1,340	79.86
Nurses	8,630	5,250	60.83	9,939	5,243	52.75	10,836	6,375	58.83
Physio-theraptists	2,135	1,404	65.76	2,462	1,625	66.0	2,812	1,864	66.29
Orthopaedists	414	408	98.55	476	439	92.23	470	434	92.34
Truss-makers	1,808	1,782	98.56	1,961	1,819	92.76	1,951	1,812	92.87
Makers of hearing aids	351	343	97.72	351	342	97.44	326	319	97.85
Opticians	2,432	2,171	89.27	2,583	2,316	89.66	2,659	2,455	92.33

E. Attitudes of Parties Interested in the Scheme

1. Beneficiaries

It goes without saying that the adoption of schemes agreed by convention gives beneficiaries a guarantee, formerly lacking to them, that the charges will be observed.

Benefits in the field of care as given by nurses, midwives and physiotherapists, and of facilities supplied by opticians, truss-makers, orthopaedists, and makers of hearing aids, are practically free to beneficiaries; there can be no denying that in this sphere, the objectives of medical care insurance have been completely achieved.

As regards care given by doctors and dentists, a year's experience of the scheme as agreed by convention has done a great deal to close the gap between actual fees charged and the amount reimbursed by the insurance; this trend, moreover, continued beyond the period covered by convention and has been maintained to a notable degree for all beneficiaries, although compulsory rates were laid down only in respect of pensioners, invalids, widows and orphans.

The latest adjustment of fees, which was created by the recent agreement, has corrected the remaining disparities; and broadly speaking, beneficiaries appear to be satisfied with the situation, and this more especially because for those who, although having annual revenues less than 88,000 fr., to which may be added 7,500 fr. per dependant, belong to the privileged categories of pensioners, widows, invalids and orphans, the Act of 9 August 1963 suppressed the part of the intervention in the medical benefits and restricted to a considerable extent the portion for proprietary pharmaceutical preparations when the non-proprietory benefits are furnished free of charge. It must be stressed that the scheme introduced by the Act of 1963 fully applies the concept that there shall be no charge since respect for the rate of fees fixed by convention or undertaking is guaranteed and in many cases the intervention of the insurance is equal to 100 per cent. of these fees.

There is one situation, however, which continues to create difficulties: we have already seen that where in-patients are put into a private room at their own request, and not because their condition requires isolation, hospitals are free to fix the daily maintenance charge. Beneficiaries who have chosen this amenity for reasons of personal convenience do not criticise the additional charge; but it does occur that if a private room is freely chosen, the doctors are consequently free, pursuant to the agreement, to derogate from the fees as agreed by convention; and in such cases, patients are frequently asked to pay extremely high fees.

This is one cause of dissatisfaction; another lies in the limited number of patent medicines for which reimbursement is made: there are still too many cases in which doctors prescribe medicaments for their patients, which are not subject to reimbursement: this question hae already been raised in the section dealing with pharmaceutical products, and it is obvious that the solution we

suggested is the only one capable of doing away with this burden, sometimes a very heavy one, on beneficiaries; namely by restricting the registration of proprietary preparations as authorised to be put on the market in Belgium, no longer just on the basis of criteria as to chemical conformity, but also as to effectiveness, and by admitting all products to reimbursement which are registered on this basis.

2. The Medical and Para-Medical Professions

(a) In the para-medical professions, the success of the scheme as agreed by convention, together with the direct and positive support given by representatives of these professions to negotiations for agreement, would seem of itself to show that the scheme is satisfactory to them: at all events it provides them with a means of payment for the cost of benefits, which would still not exist if the medical care insurance scheme itself were not functioning, or if the scheme, although in existence, had not been so shaped by the conventions that reimbursements are at the level of fees and charges actually applied.

It should be pointed out that as regards nurses, midwives and physiotherapists, the great majority of those who have not acceded to the convention do nevertheless in effect observe the fees fixed thereby.

(b) As regards doctors and dentists, serious difficulties were created in 1964 by their opposition to the Act: some aspects of this opposition have already been described with reference to the presence of doctors and dentists within the Managing Committee of the health insurance, in Chapter B.5 - "Administration of Medical Care Insurance".

Under the banner of freedom and the traditional independence of their profession, the doctors initially and for a long time proclaimed that they would not even negotiate conditions for collaboration with the medical care insurance, and that the very principle of convention was incompatible with the requirements of good medicine, feeling as they did that the tie would by its mere existence, shackle their freedom in the exercise of their art.

Therefore, the medical association boards considered a further aspect of their victory to reside in the fact that the Act as amended on the basis of the agreement of 25 June 1964 no longer refers to a convention. This is true: but it does refer to an undertaking. It is a fact that neither the undertaking, nor the convention are ends in themselves but only a method for ensuring the observance of determined fees; but it must be remembered that both imply prior negotiation between representative associations of the medical profession and the insurance carriers, and subsequently, individual adherence by each doctor. The basic difference lies in the fact that on the basis of the agreement as made on 25 June 1964, the terms of the undertaking are no longer laid down by the amended Act, whereas in its primal form, the Act

specified very exactly both the object and the meaning of the component parts of the convention.

Here is indubitably a considerable advance towards being able to widen both scope of discussions, and the ambit of the undertaking itself.

The original Act was drawn up and passed at a time when not only had no valid dialogue been established between doctors and the insurance authorities, but also when the lack of organisation in the medical profession would have rendered such contact impossible or useless; hence it was necessary to state the limitations to doctors' obligations in the Act itself, in order to enable a model convention to be drafted, in the absence of any negotiation, by the health insurance Managing Committee.

The main importance of the agreement of 25 June 1964, by contrast, lies in the fact that it puts into concrete form the possibility and the reality of negotiation: the dialogue is established, and thenceforward the negotiators who have agreed to discussion should be trusted to set up the bases for long-term collaboration. Moreover, the agreement itself lays down the essence of its ambit:

- to enable persons covered by social insurance to be effectively covered, as regards medical care, against the risk of illness;

- to set up conditions for direct and constructive co-operation between the medical profession and all parties concerned in the organisation, financing and functioning of sickness insurance;

- lastly, to enable an exact and fundamental study to be undertaken as regards our health policy, its objectives, its resources and its institutions.

The statements of intention thus given in the preamble might contain the risk of subsequent differences in interpretation, or of a superficial manifestation of goodwill with no other practical consequence save that of conveniently putting an end, for the time being, to conflict, were it not for the essential fact that the agreement contains specific conditions for such collaboration between the medical profession and the insurance, and contains also the actual form of undertaking to which each doctor will be asked to subscribe, at the request of the medical associations themselves, the importance of whose powers of persuasion and obviously representative character cannot in this context be over-estimated.

It is therefore worthy of note that, having obtained the withdrawal from the Act of the very passages which specify conditions in which conventions are to be negotiated and the areas on which such negotiations must of necessity bear, the medical profession has already conducted such a negotiation with the Government and the insurance carriers - as was specified in the Act - and that that

negotiation has led to an agreement which lays down very exactly the conditions for collaboration with the medical profession - conditions which do not differ in essence from those provided for by the Act. True, the concept of "undertaking" has been substituted for that of "convention". But this undertaking is guaranteed by the medical associations, who agree - and this demonstrates their good faith - that should less than 60 per cent. of doctors personally subscribe to such undertaking, the Crown shall impose compulsory scales of charges on all doctors.

The medical profession, indeed, has succeeded in protecting the principle of reserving "free time" for doctors who subscribe to the undertaking. According to the original text of the Act of 9 August 1963, the doctors who signed the convention or subscribed to the undertaking to respect the fees fixed in agreement between the medical corps and the bodies administering sickness insurance, could specify the hours when, and places for which, the fees for consultations could be increased, the maximum period of such free time being two half days per week. The text of the undertaking signed in July 1964 and of that which is in force for three years from the beginning of 1967 have set up another system, which in a different way embodies the same principle. The doctor in fact fixes the days and hours in respect of which the conventional fees will be compulsory for his consultations. As regards general practitioners the scale of fees under the engagement must apply to all their activities at the domicile of their patients. Furthermore, a minimum of 12 hours of consultation, distributed over three days per week, is required of all general practitioners; the minimum is 30 or 32 hours for specialists practising full or part-time at a hospital and 30 hours for those who practice at their own consulting rooms. Certain practitioners may be able to justify only a total of benefits less than the required minimum; in this case, however, the engagement is valid, provided it is established that the period concerned corresponds to three-quarters of their total activity. It was considered desirable to take account of the fact that certain doctors, notably the elderly, normally reduce their activity to an appreciable extent. The remaining quarter of their activity is composed of consultations given to non-insured persons, to independent workers who are not covered for small risks and to insured persons who wish to be able to fix the place where and hour when the doctor will receive them. Experience has shown that the latter category account for the greater part of the time devoted to consultations by doctors who have subscribed to the undertaking. Separate consulting rooms are not reserved for the practice of medicine under the undertaking and for free practice. When a non-insured person arrives during a consultation covered by the engagement he will be given care but the doctor will be free as regards his fee vis-à-vis this patient. It should be noted that the consultations which take place in hospitals or polyclinics are generally given for the insurance fee whether or not the doctors practising there are covered by the undertaking.

The Act itself, it must be added, contained a similar provision, which allowed doctors adhering to the convention to declare a limited number of private consultations for which they were not obliged to observe the fees as fixed by convention.

The medical profession also obtained the right to take the initiative with respect to drawing up and amending the nomenclature. The Technical Medical Council, set up within the National Institute for Sickness and Invalidity Insurance and made up for the majority of representatives of the medical associations, examines the nomenclature and makes proposals to the Crown through the Managing Committee. The Crown can approve or reject such proposals as they stand, but it cannot amend them without a fresh proposal from the Technical Medical Council.

The medical profession sees this right of initiative as ensuring that the nomenclature will be kept permanently up to date, while the medical care insurance scheme sees the need for approval by the Crown as ensuring moderation - voluntary or compulsory - on the part of the medical profession.

Furthermore, the medical profession had stood out fiercely against the penal and administrative penalties specified by the Act, particularly as regards cases of non-observance of the scales of charges, or cases where a doctor refused to issue an insured person with the prescribed documents concerning the nature of services performed.

These penalties have been retained, although on given points, more especially as regards evaluation of professional or deontological fault, it is specified that the Medical Council shall be exclusively competent. The Act of 9 August 1963 postulated the total coverage of costs for a major group of benefits, and in particular: hospitalisation; technical services performed by specialists in surgery, radio-diagnosis, clinical biology, physiotherapy, neuropsychiatry, cardiology, pneumology, etc.; and prosthesis, spectacles, hearing aids and other appliances.

It provided for personal participation by beneficiaries at the rate of 25 per cent. of costs in respect of a second group of benefits: visits from and consultations with doctors, pharmaceutical products and normal medical care as supplied by general practitioners, nurses and physiotherapists.

Although the medical profession, during the negotiations, frequently expressed its hostility to the concept of free medicine, it nevertheless agreed to collaborate in the scheme without implicating these provisions which, as regards practitioners who subscribe to the undertaking, result in free medicine for the first and major group of benefits, and medicine which is economically accessible for normal care benefits, with a maximum for personal participation by the beneficiary of 25 per cent.

It is difficult to give the true reasons for the opposition of the doctors to free medicine; however, it may be said that the principal reason that they invoke, but that the author does not share, is that free medicine is bad medicine and that without a doubt it entails over-consumption of benefits with, as a corollary, the danger, in view of the time devoted to each patient, of giving only superficial medical examinations.

The Act of 9 August 1963 also contained a special provision with regard to particularly noteworthy social categories, namely pensioners, widows, invalids and orphans, the relative slenderness of whose means as consisting only of the social pension or allowance cannot without compromising the essential needs of life cover costs arising out of sickness, the incidence of which is all the greater in that morbidity in such social groups is frequently increased by particular physiological or pathological factors.

The Act worked on the basis that in such cases, even the ticket modérateur required for normal care might act as a physical obstacle to access to medical care; and therefore specified that the ticket modérateur should not apply to these social categories.

Doctors criticised this provision on the hypothesis that by making treatment absolutely free, it might lead to abuse and to unnecessary recourse to the doctor, making it impossible for the latter to practise his profession unharried.

The provision was maintained in spite of all argument, and pensioners, widows, invalids and orphans remain entitled to free medical care if their means are less than 88,000 Fr. per year, a figure which is actually higher than the income of the lowest-paid employees. The medical profession moreover got it agreed that the insurance should allow the same reimbursements to doctors not subscribing to the undertaking, thus eliminating any discrimination vis-à-vis the patients, regardless of their choice of doctor.

It must, therefore, be observed that non-payment for care, or limitation of participation to 25 per cent. of the costs, is not in such case guaranteed to beneficiaries who choose a doctor who does not subscribe to the undertaking. But it must here be remembered that the agreement of 25 June 1964 specified - and the Act confirmed - that these provisions apply only provided that at least 60 per cent. of doctors in each region of the country undertake to observe the scales of charges: it was felt that such a minimum created adequate freedom of choice to enable all beneficiaries to obtain care on the most economic terms. If such free choice cannot be exercised because less than 60 per cent. of doctors subscribe to the undertaking, or if the agreement expired without being renewed, strictly applicable rates will be imposed on the medical profession by Royal Decree.

This statement of relations between the medical profession and the medical care insurance is undeniably positive on balance; but does it enable us to consider as definitive the effective collaboration of the doctors, or the terms of such collaboration?

Without question, it does not! Since the agreement of 25 June 1964, periodic difficulties have arisen; some have been attenuated, others have remained; the doctors did not renew their undertakings after 1 January 1966, and the Government had to have recourse to the imposition of compulsory scales of charges. But it should not be forgotten that the agreement itself provided for such an eventuality and for such a solution; and it would appear that the non-renewal by the doctors of their undertakings is the result not so much of

irreducible obstacles existing between the insurance and the medical profession, as of an uprush of solidarity in the latter, and the hesitation, by one section of the medical associations, in officially agreeing to terms which might immediately be laid open to criticism and outbid by the other section.

Amongst the paradoxical aspects of developments in the relations between doctors and the insurance to which we have already referred, mention must be made of the reaction by a great number of the sickness and invalidity insurance authorities who in 1964, saw with some anxiety the growth of a powerful federation of the medical professional organisations; but who now, faced with the discords which divide the federation, are forced to acknowledge that even if unity made the medical profession into a power which could not be ignored, it did have the immense virtue of producing spokesmen whose contributions were the more valid in that they were genuinely representative of a homogeneous body of opinion, thus ensuring that agreements made would be carried out.

It is true that it was easier for the medical profession to achieve unity in opposition to the Act than to maintain that unity when a constructive effort to collaborate was undertaken: dissension is not slow to arise in an organisation which represents a profession where individualism has for so long been traditional, and where the trend has been not to discourage such separatism, save where doctors are brought together in groups of general practitioners and in as many groups of specialists as there are medical disciplines: viewed from the standpoint of the profession, the problems for these various groups are not only different, but sometimes demand quite opposite solutions.

For many months, it was the unity of the professional medical associations which made it impossible to apply some of the provisions of the Act, and seriously affected relations between the insurance and the medical profession; but today, it is the break in that unity which is liable, from the medical side, to prevent the solidifying of an agreement to which there is, however, no obstacle as to fundamental principles.

If it is a fact that the future of medicine and doctors in the countries of Western Europe depends largely on the part played by sickness insurance schemes within a health policy, it is also a fact that the efficiency of such schemes and of such a policy postulates real collaboration by all doctors, together with availability, for those who are in need, of all the resources of modern medicine. To achieve this double postulate will require constant alertness in adapting sickness insurance.

The immense contribution made to both sides by the mere fact of negotiation and the organisation of a permanent dialogue is enough to show the value of direct free discussion, aimed in the first instance at an exchange of information and knowledge as regards the opinions of the other side, and at awareness that the patient's interests are in the last resort paramount, without ignoring the fact the immediate interests of the negotiators may be in direct opposition.

In spite of the difficulties, negotiations have just resulted in a new agreement being concluded for 1967.

The letter addressed to the medical profession on 23 January 1967 by Dr. WYNEN, head of the National Medical Federation (affiliated to the World Medical Association), is given below in full:

"Dear Colleague and Friend,

For the last two years, you have been subjected to an intensive propaganda which is hardly consistent with the critical spirit which in the normal course of events, should characterise our profession.

We now have pleasure in submitting for your consideration and decision concrete proposals which, in our opinion, will protect the practice of medicine against the two most dangerous pitfalls with which it is threatened.

The agreement which has been concluded protects us, in fact, from a fundamental revision of the scheme which would:

- either bring us close to nationalisation,

- or, as we suspect our opponents intend, bring us back to the 1963 scheme in which freedom was synonymous with undercutting, serving to benefit only those who are prepared to provide benefits without any sense of practical moderation.

The agreement of undertaking just concluded is, as you yourselves will observe, an improvement on that which was universally accepted by doctors in 1964. It gives better terms for indexing, programming, social status and fees; and lays down an exact timetable for drawing up the new nomenclature. The current nomenclature, as you are aware, was initially drafted without any control by the medical profession; whereas that to be established in 1967 will, by contrast, be made up in accordance with the structures laid down by agreement within the Medical Technical Council, which is composed exclusively of doctors.

We are aware that the undertaking we now submit to you is far from ideal, but it does nevertheless represent definite progress in the defence of the moral and material interests of the profession.

Its rejection by you implies no less responsibility than the act of acceptance.

Refusal will mean a return to the 1963 scheme, and implies, moreover, a continuation of the 52 V.I.P.O. system; (Editorial note: This is an elliptical reference to Article 52 of the Act, which, in the event of failure to reach agreement, specified compulsory scales of charges

for widows, invalids, pensioners and orphans: V.I.P.O.); in other words, it leaves the Minister free to alter reimbursement at will, on the pretext that scales of charges remain free as regards the non-V.I.P.O.

Such return to the 1963 situation can only benefit the small minority of colleagues who are in a position to ignore the nomenclature for reimbursement.

There is no danger, on the other hand, in signing the undertaking: it contains better terms than in 1964. For 30 days following publication of the revised nomenclature - due not later than 1 July - withdrawal is open to any signatory who considers the latter to be unacceptable.

A successful policy as regards acceptance of the undertaking will mean that we can stop the cart from being stuck in the mud and get it back on to the path marked out in 1964; and on these terms, we can renew discussion of the basic problems, namely free medical services, the future of general medicine, doctors in hospitals, etc. etc.

Your decision must be a 60 per cent. majority if the terms of the agreement are to be put into effect in any given region.

This puts you into a position of joint responsibility, since there will be no difference in effect as between those who do and those who do not subscribe.

(signed) Dr. A. WYNEN"

F. Distribution of Members of the Medical and Para-Medical Professions

Broadly speaking, the members of the medical and para-medical professions are adequate in number and reasonably well distributed throughout Belgium. The table showing the number of adherents to the convention per para-medical profession also reveals the number of members of each of these professions.

As regards doctors, more particularly, there are more than 15 doctors per 10,000 inhabitants; this is an average density, and varies between 7.8 per 10,000 and 22 per 10,000 according to the region.

Not surprisingly, the heaviest density is in the large urban centres.

The position is reasonably good, however, in more rural areas (the province of Luxembourg), and it is possible to satisfy the normal needs of the population, particularly in view of the fact that the distances separating these regions from the urban centres, with their specialists and medical establishments, are never such that the latter are not swiftly accessible in case of urgency.

The low population density in rural areas, however, creates a particular problem for general practitioners, for whom the distances to be traversed between the homes of two successive patients create a burden on the fees they charge, not only because of the cost of travel, which can be considerable, but also because of the time lost in such non-productive travelling.

The recent agreement concluded within the National Medico-Mutual Benefit Society Committee provides a viable solution to this problem: firstly, by increasing the fees charged by doctors in these areas, and secondly, by fixing rates for travelling expenses to cover time as well as actual costs. These charges are reimbursed to beneficiaries at the rate of 75 per cent.

DISTRIBUTION OF DOCTORS

PROVINCE	Population per Province as on 31.12.65	Area in Km^2	Number of Inhabitants per Km^2	Number of Doctors	Number of Doctors per Km^2	Number of Doctors per 1,000 Inhabitants
Antwerp	1,494,062	2,861	522.217	1,877	0.656	1.256
Brabant	2,108,296	3,369	625.793	4,762	1.413	2.259
West Flanders	1,029,165	3,132	328.597	1,197	0.382	1.163
East Flanders	1,294,695	2,977	434.899	1,563	0.525	1.207
Hainault	1,333,432	3,798	351.088	1,741	0.458	1.306
Liège	1,017,582	3,876	262.534	1,870	0.482	1.838
Limbourg	624,446	2,422	257.822	488	0.201	0.781
Luxembourg	219,450	4,418	49.672	242	0.055	1.103
Namur	378,106	3,660	103.308	590	0.161	1.560
TOTAL OF REALM	9,499,234	30,513	311.318	14,330	0.470	1.509

G. Statistical Data

The tables given below show an extract of statistics on the volume and cost of benefits, established in accordance with the "Scheme of Statistical Tables for the Practical Application of a Minimum Programme of Social Security Statistics".

We have separated the data as regards the general scheme (wage earners, salaried employees and public servants) and as regards the scheme for self-employed persons.

Statistics on the number of members of the medical and paramedical professions, moreover, are revealed in the tables already given.

SECTION 1 - Number of Consultations (General Scheme) - 1965 (Table A II, 1)

	Number of Cases	Amounts (in Million Francs)	Expenditure per Case (in Francs)
(a) Sickness			
Consultations: general medicine	14,019,000	710.5	50.68
Visits: general medicine	16,756,000	1,196.5	71.41
Consultations with specialists	8,136,000	977.5	120.15
Visits from specialists (pediatrics)	234,000	14.0	59.83
		2,898.5	
(b) Dental Care			
Consultations with dentists	416,000	20.8	50.0
Tooth extractions	2,563,000	221.5	86.42
Dental prosthesis	302,000	444.4	1,471.52
Orthodontic treatment	214,000	69.9	326.64
Preservative dental care	1,253,000	198.2	158.18
		954.8	

Belgium

The term "visits: general medicine" covers only home visits by general practitioners. In fact, since November 1964, aside from visits by specialists in pediatrics, home visits by specialists are not reimbursed by the insurance scheme. The expression home visit must be taken to refer to the benefit that the beneficiary claims at the place where he resides, normally, temporarily or incidentally, unless he is staying in a medical centre to which he has gone to receive care; the benefit provided by a doctor who is called to a home for old people or for children, or any establishment in which the beneficiary is staying for a purpose other than medical observation or treatment, or on the public roads in case of accident, is deemed to be a visit to the domicile of the beneficiary. On the other hand, an office consultation means a benefit to obtain which the beneficiary requesting care leaves his home, in particular, the benefit provided by a doctor consulted in the service of a clinic or polyclinic. Thus, the consultations given in undertakings, whether or not they have a medical service, to the workers occupied therein, must be considered as home visits. In these conditions the visits made by a specialist are not reimbursed by the insurance scheme. In the case of medical facilities within an undertaking which are available to persons other than the workers therein, the care given to the persons not connected with the undertaking must be deemed to be benefits provided in the doctor's surgery.

SECTION 2 - Miscellaneous Care (General Scheme) - 1965 (Table A II, 2)

	Number of Cases	Amounts (in Million Francs)	Expenditure per Case (in Francs)
Normal technical facilities	7,446,000	476.6	64.01
Doctors' travelling costs	15,607,000	315.6	20.22
Care by nurses	-	274.2	-
Medicaments (prescriptions + proprietary medicines)	66,691,000	4,642.3	69.61
Para-medical auxiliary personnel (physiotherapists, truss-makers, orthopaedists, opticians, makers of hearing aids)	6,400,000	810.3	126.61
Laboratory	4,389,000	579.9	132.13
Radiology, radiotherapy	2,029,000	920.9	453.87

SECTION 2 - Miscellaneous Care (General Scheme) - 1965
(Table A II, 2)

	Number of Cases	Amounts (in Million Francs)	Expenditure per Case (in Francs)
Miscellaneous (special benefits, stomatology, internal medicine, dermatology, physiotherapy, benefits in cases of urgency)	5,103,000	685.3	134.29
Surgery - anaesthesia	2,157,000	842.6	390.64
Special rehabilitation costs	-	27.8	-
Beneficiaries' travelling costs	-	120.0	-
Standard rate expenditure	1,566,000	255.2	162.96
		9,950.7	

SECTION 3 - Hospitalisation (General Scheme) - 1965
(Table A II, 3)

	Amounts (in Millions)	Number of Cases	Number of Days
A. Hospitalisation: General			
Hospitalisation - surgical	771.8	258,156	2,955,629
Hospitalisation - medical treatment and observation	1,295.3	277,031	5,034,913
Hospitalisation - confinements	269.3	114,681	987,320
Supervisory and standard charges: operating theatre	352.4	-	-
	2,688.8		
B. Social Diseases			
Mental illness	524.8	-	3,062,753
Tuberculosis	229.1	-	762,313
Cancer	138.5	-	294,230
Poliomyelitis	8.5	-	23,856
Congenital disease or malformation	37.3	-	102,586
	938.2		

Several considerations enter into the explanation of the total cost of medicaments indicated in section 2 of Table A II, 2. It is true that the unitary price of packaging proprietary pharmaceutical preparations is sometimes high, and it must be added that the margin of profit of the pharmacist is in the order of 30 per cent. of the sale price. On the latter point, it should be said that measures are envisaged to put a ceiling on this margin. On the other hand, the frequency of prescriptions is also an element to remember. It is customary that each consultation or visit is the occasion of a pharmaceutical prescription and that many patients do not understand that it should be otherwise and that their responsibility is at least as great as that of the doctors who might abuse prescriptions. Still another element is the charge accepted by the insurance in respect of the products in the composition of non-proprietary prescriptions and their preparation by the pharmacists. Recently certain products (alcohol, ether, for example) have been excluded from reimbursement by the insurance and, furthermore, the privileged categories of insured persons, for whom this reimbursement is higher, since non-proprietary prescriptions are supplied to them without their sharing in the cost and they pay less for proprietary preparations, will in the near future be given a book of prescriptions set out in such a way that it will be strictly reserved for their personal use (and that of their dependants) thus preventing the possibility of prescribing in their name pharmaceutical preparations for the use of the non-privileged categories of insured persons.

SECTION 4 - Confinements (General Scheme) - 1965
(Table A II, 4)

	Amounts (in Million Francs)	Number of Cases	Expenditure per Case (in Francs)
Fees: midwives	51.9	48,000	1,081.25
Fees: doctors	70.1	44,000	1,593.18
Fees: specialists	112.0	60,000	1,866.67
Fees: supervision: other benefits	71.1	-	-
	305.1		

General Summary
(expenditure in millions of francs)

Table A II, 1 :	2,898.5 + 954.8	=	3,853.3
Table A II, 2 :		=	9,950.7
Table A II, 3 :	2,688.8 + 938.2	=	3,627.0
Table A II, 4 :		=	305.1
Total, general scheme:			17,736.1

EXPENDITURE: SELF-EMPLOYED PERSONS

Section 2 (Table A II, 2):	miscellaneous care:	164.5 millions
Section 3 (Table A II, 3):	hospitalisation	343.5 millions
	social diseases :	92.4 millions
		435.9 millions
Section 4 (Table A II, 4):	confinements :	50.7 millions

General Summary
(expenditure in millions of francs)

Table A II, 2:	164.5 millions
Table A II, 3:	435.9 millions
Table A II, 4:	50.7 millions
Total, self-employed persons' scheme :	651.1 millions

ADDENDA

1. Cost of Administration

The cost of administration of the health care services includes, in addition to the cost of the National Institute for Sickness and Invalidity Insurance, the cost of the operation of the insurance carriers.

Recapitulation of the Cost of Administration of Sickness Insurance
1964 and 1965

	General Health Care Scheme	Independent Health Care	Cash Benefits	Total
(A) 1964				
F.N.A.M.I.[1]	145,297,637	3,782,779	82,565,584	231,646,000
O.A.[2]	1,069,744,136	27,880,522	585,540,218	1,683,164,876
Total:	1,215,041,773	31,663,301	668,105,802	1,914,810,876
% General Total	63%	2%	35%	100%
(B) 1965				
F.N.A.M.I.[1]	180,082,971	12,920,392	78,296,637	271,300,000
O.A.[2]	1,523,471,529	109,607,764	700,623,295	2,333,702,588
Total:	1,703,554,500	122,528,156	778,919,932	2,605,002,588
% General Total	65%	5%	30%	100%

[1] National Sickness and Invalidity Insurance Fund (Fonds national d'assurance maladie-invalidité).

[2] Insurance carriers (organismes assureurs).

2. At the present time Belgium has 14,330 doctors, of whom 8,384 are general practitioners and 5,946 doctors who have been recognised as specialists.

3. It is difficult to provide exact data on the remuneration of doctors. On the basis of the tables on page 58, however, it is possible to give an estimate that for doctors in general medicine will approach reality since almost all their earnings come to them from benefits provided to persons covered by social insurance. On the basis of the above figures the average annual earnings of a Belgian doctor would be 543,000 Belgian francs. However, it is not possible to make a distinction between the average earnings of a

doctor who has subscribed to the undertaking and those of a doctor who has not subscribed, although it is reasonable to suppose that the income of the latter is higher since his fees are not limited by contract or law, except as has already been indicated, for the privileged categories.

By dividing the expenditure - 2,769 millions - by the number of doctors in general medicine - 8,384 - one obtains average annual earnings in the order of 330,000 Belgian francs, to which must be added 75,000 Belgian francs representing the share of the insured persons in the fees for visits, consultations and current technical benefits, or a total of 405,000 Belgian francs for general practitioners per year. Proceeding in the same fashion for specialists one obtains the following results: 4,296 millions divided by 5,946 doctors equals 722,500 Belgian francs, to which must be added 25 per cent. of the thousand millions expended by the insurance scheme for consultations and home visits by pediatricians only, or 250 million, which makes the total of 764,500 Belgian francs per specialist per year.

It should be noted that private practice is more important for the surgical benefits than it is for the other specialities, that the fees are higher although it is not possible to calculate them with certitude. These averages do not take into account the fees in private medicine for non-insured patients or the supplementary fees claimed in certain cases. It is necessary, unfortunately, to add that part of the average income of specialists should be transferred to the average income of general practitioners by reason of the current practice of dichotomy, a practice which can be the source of the greatest overconsumption of health benefits.

4. (a) The fact that doctors receive a higher payment for home visits than for consultations does not, in the author's opinion, influence the number of visits: this difference in fees corresponds to the greater expenses for the doctor, particularly in respect of his travel and the time lost therein. It is believed that, in spite of the greater personal intervention required, the sick person has a material interest in saving the travelling expenses that he would have incurred if he had had to go to the doctor's office and in this fact may lie the reason for the increase in the number of home visits.

According to the original text of the Act of 9 August 1963, the expenses of travel which are included in the fees for home visits could be reimbursed only if the patient was unable to travel, the verification of this inability being made according to conditions to be determined by the executive authority. Quite naturally it had been thought that this impossibility should be certified by the doctor, but the medical profession did not wish to take responsibility for deciding if a patient whom one of its members visited was incapable of going to his office, since it was considered not appropriate that the doctor should possibly prejudice the position of his patient. Taking account of this, the Act of 8 April 1965 provided that the patient himself should attest that it was impossible for him to travel. It is certain that no one will attest the contrary, and furthermore, in practice this declaration

is ignored by the insurance bodies. From all evidence it will be necessary to find another solution to this problem.

(b) The direct access of patients to the consultation of a specialist is also the result of negotiations with the doctors, and in particular with the specialists themselves, who have maintained that in order not to lose a patient the general practitioners send a sick person to a specialist only in the last instance. Nevertheless, in the case of certain specialities (ophthalmology, otorhinolaryngology, gynaecology, pediatrics) the patients turn at once to a specialist without recourse to their attending physician.

(c) If any doctor were permitted to carry out all the technical acts figuring in the list, there would be a repetition of the acts carried out when a patient consults simultaneously or successively two or several doctors who may have different qualifications. On the other hand, it would be desirable to bring the sickness and invalidity legislation in respect of interventions for benefit into line with the provisions in respect of public health.

(d) Since sickness insurance covers almost the whole population of Belgium, it is necessary to avoid that another danger should continue to weaken its possibilities of a rational organisation and to increase its cost: the co-existence of two distinct ministerial departments - social insurance and public health - equally competent for dealing with the common if not identical problems, results in the permanent possibility of a duality of concepts, administrative clumsiness, unjustified cumulations of interventions, prejudicial contradictions which find an apparent solution only in the intertia and in the obligation to reject one or other authority and to improvise as many half truths in the margin of the laws and regulations as there are individuals and institutions which vainly await a valid reply.

The following examples, among numerous others, accentuate the lack of co-ordination and the ambiguity, which are incompatible with a rational organisation of public health: the interventions of the special assistance funds generally supplementary to those of the medical care insurance when the latter is supposed entirely to cover the expenses; the requests for the admission of pharmaceutical specialities by the National Institute of Sickness and Invalidity Insurance, which duplicates the formalities of registration of the same products by the Minister of Public Health without, however, necessarily reaching the same conclusions: the approval of specialists, which rests with the Minister of Public Health, when the Minister of Social Insurance establishes the list of technical benefits for which these doctors are recognised to be competent; the approval and the surveillance of hospital services by the Minister of Public Health, when the financial means required for the functioning of these services must be produced by the health insurance scheme; the subvention by the Minister of Public Health of certain preventive medical services, which for this reason are excluded from all possibility of the supplementary intervention of health insurance, when the same services guaranteed outside this approval, in the absence of any control, benefit from tariffs greatly exceeding the amount of the official subsidies.

It has become essential to entrust to a single ministerial department responsibility for all the problems concerning the organisation of medicine, pharmacies, para-medical activities and hospitals, as well as the rules for the exercise of the various professions, the functioning of the institutions, the conditions of financing and reimbursing the benefits which are provided.

It is essentially a question of uniting under a single responsible body the present powers of the Minister of Social Insurance in matters of health care insurance and those of the Minister of Public Health in matters of hygiene, the art of healing, hospitals and nursing. Thus, placed in a logical structure, all the problems concerning health could be envisaged simultaneously in a more harmonious and coherent conception without maintaining this anachronistic need to distinguish between the traditionally preventive aspects reserved to the public health administration and the curative aspects to which the preoccupations of sickness insurance have been limited.