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The Perspective of the Provider

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1. Introduction

In order to understand the provider's point of view, in this case the physicians', I think it useful and necessary to briefly sketch the history of the Belgian health care system. It is striking that the great controversies between physicians and the Belgian Authorities over a period of about 60 years of social security and sickness and invalidity insurance, remain almost unchanged.

2. Short history of organized interest groups

2.1. Creation of sickness funds and medical trade unions

The wave of industrialization not only led to the rising of a proletariat among the working class in the 19th century, but also resulted in the creation of the precursors of the present sickness funds.

The societies of mutual assistance were recognized by the law of 03.04.1851 and they were allowed to join in unions or associations with legal personality by the law of 23.06.1894. This law remained in application till 31.12.1990.
The law of 19.03.1898 implemented the subsidy or grant scheme by the public authorities.

At the end of world war II, by the law of 18.12.1944, the Flemish socialist Achiel VAN ACKER introduced social security for workers with, amongst other items, compulsory sickness and invalidity insurance. The practical implementation was regulated by the decree of the Regent of 21.03.1945. A national fund for sickness and invalidity insurance was created, run by a National Committee of directors.

That committee was composed of 8 representatives from the employees trade unions, 8 representatives from the employers associations, 5 representatives from the recognized sickness fund organizations and 3 government commissioners (labour and social security, public health and finance). Physicians and other health care providers were absent.

The Minister of Labour and Social Affairs laid down a tariff list, the forerunner of the current nomenclature of medical services. The first temporary list of tariffs was published together with the ministerial decree of 19.04.1945. But it was impossible to

impose the obligation to observe the fixed tariffs upon the health care providers, since a proper structure for physicians was lacking. Much to the annoyance of the government, which was unable to guarantee the implementation of tariffs for the insured.
In this context one has to understand the development of the medical trade unions.

Medical syndicalism started in the second half of the twentieth century. Until then, syndicalism was a characteristic of the labour class and the employees in general. The independent and intellectual professions held the unions in abhorrence. Half a century later, the term "medical union" still has a negative connotation.

Till the mid-fifties of the previous century, there was a variety of professional unions, which worked separately from one another but which, sometimes, at local level, and/or within a certain professional group, decided on agreements negotiated with some sickness fund organizations.

On 15.07.1954, the co-ordinating body was created which grouped the existing professional unions of medical specialists of the time in an association: the Association of Belgian Professional Societies of Medical Specialists (VBS-GBS: Verbond der Belgische Beroepsverenigingen van Geneesheren-specialisten – Groupement des Unions professionelles belges de médecins spécialistes).

On 03.10.1954 the General Syndicate of Belgian Medical Doctors (ASGB: Algemeen Syndicaat van Geneesheren van België) was created involving specialists as well as general practitioners. Its aim was to develop, together with the Government, a system of co-participation and co-responsibility in the management of sickness and invalidity insurance. Dr. Marcel DE BRABANTER, a Dutch speaking anaesthetist and founder member, soon became its chairman.
Many physicians were afraid that such a responsibility would lead towards a rationing of health care and that the State would interfere in the relation between patient and doctor.

From 1955 and later on several efforts were made to conclude an agreement between sickness funds and the VBS, the ASGB and other medical associations, such as the General association of Belgian physicians (AVGB: Algemeen Verbond van Geneesheren van België). But they remained unsuccessful.

A wide majority of physicians did not agree with the ideas of the A.S.G.B, in respect of the financial co-responsibility, nor with their proposal to introduce a global system of compulsory third party payment.

At the beginning of 1961, Belgium had to face a pre-revolutionary situation.
There was a general strike together with violent demonstrations all over the country caused by the "Law of union of 14.02.1961" which Gaston EYSKENS, Prime minister at that time, had had approved in the Chamber on 13.01.1961 and in the Senate on 14.02.1961.

That law also contained, amongst other items, two important articles related to health insurance. Article 33 changed medical inspection into an independent body called "Institution for Medical Control" and article 52 authorised the King to impose tariffs if

no convention is concluded. This article is still in application in the current coordinated law on Medical Care and Allowances of 14.07.1994 (Wet betreffende de verplichte verzekering voor geneeskundige verzorging en uitkeringen, GVU-wet, art. 50, §11), however somewhat modified. The current Minister of Social Affairs and Pensions, Frank VANDENBROUCKE, used it recently as a means of pressure upon dentists as well as upon medical practitioners in order to force them – at the end of 2002 – to conclude an agreement with the sickness funds.

As a consequence of the "Law of union" and while the law on sickness and invalidity insurance of 09.08.1963 was being prepared by the socialist minister of Social Affairs, Edmond LEBURTON, the Belgian Association of Medical Unions (BVAS-ABSyM) was created in 1963, grouping five chambers: the syndicalist chamber of Liege and Luxembourg (created on 17.05.1962), the syndicalist chamber of Walloon Brabant, Hainaut and Namur (created on 22.03.1963), the syndicalist chamber of the Brussels metropolitan area (created 31.05.1963), the syndicalist chamber of Antwerp, Limburg and Flemish Brabant (created 23.08.1963) and the syndicalist chamber of East and West Flanders (created 29.08.1963). The French speaking surgeon, Dr. André WYNEN, became the flamboyant leader and dominated the medical and health insurers scene in Belgium for almost three decades.

As a result of the second state reform of 1980, which divided Belgium into regions and communities and which installed in Flanders one Flemish Parliament and one Flemish government, the two Flemish "chambers" were reformed into divisions and regrouped in the Flemish union of physicians, the Vlaams Artsensyndicaat (VAS), created on June 14, 1981.

2.2. Resistance and strike by the physicians

The physicians' opposition to the "Law LEBURTON" of August 8,1963 was very heavy. Physicians wanted another form of co-management and less interference from the state in their practices. They refused to be hold financial responsible for the medical care they provide. They also refused the possibility of an Authority imposing tariffs upon physicians who had rejected the agreement with the sickness funds. They claimed the elaboration of a social statute for physicians who acceeded to the convention between physicians and sickness funds.

The physicians' opposition to the Government led to a strike of 18 days under the leadership of Dr. André WYNEN (from 01 till 18.04.1964).

On 25.06.1964, the St.-John's agreement was negotiated between representatives of the physicians, the sickness fund agents, the employers, the employees trade unions and the Government. The St.-John's agreement is the basis of the system that is still currently existing but which has meanwhile been modified by several dozens of amendments.
As socialist ministers have been in power at the ministry of Social Affairs without interruption since 1988, and last but not at least with minister Frank VANDENBROUCKE from 1999-2003, the present system reclines more and more towards the original one of LEBURTON.

3. Elements of the law of 09.08.1963 on sickness and invalidity Insurance

3.1. The system of conventions

3.1.1. Basic principles

With the implementation of the St.-John's agreement into the law of 09.08.1963, some important principles were added, by way of the law of 08.04.1965. It concerns, amongst other items, the systems of conventions. The National Commission of Physicians and Sickness Funds is given the task to conclude agreements between medical doctors and health insurance organizations.
To acceed to the convention is a free and individual decision of the physician. The convention is negotiated between the representatives of the representative medical organisations and of the sickness funds.

The amendment of the law of 15.02.1993 reinforced the role of the Government and the social partners.
The convention between physicians and sickness funds has to be approved by the Insurance Committee of the National Sickness and Invalidity Insurance Institute (NSIII) and the NSIII General Council has to check whether the concluded convention is in conformity with the budget. To this end, the General Council receives advice from the Commission for Budget control. At last, the convention needs the approval of the competent minister.

3.1.2. The Medical Technical Council

The law of 09.08.1963 charged the Medical Technical Council (MTC) with the elaboration of the nomenclature for medical services. The council is composed of 27 members and a president. There are 9 seats for the representatives of the sickness funds, 7 for the university representatives and 11 for the representative organisations of physicians of which 4 for the general practitioners and 7 for the medical specialists.

At its start, the MTC could all by itself advise the minister about modifications in the nomenclature and the King could only approve or reject the proposals of the MTC, after having received recommendation of the Committee of Management. With the introduction of the law of 15.02.1993, the role of the MTC became less prominent with respect to the modification system for the nomenclature. Today the MTC merely acts as an organ involved with technical recommendations for the National Commission of Physicians and Sickness Funds.

3.1.3. Erosion of free choice in the course of the years

Patients who are under treatment by a physician who has refused to acceed to the convention physicians-sickness fund get the same reimbursement as those receiving the same medical treatment by physicians who have not refused the convention. This is an important difference in regard with other conventions (e.g. for the physiotherapists) and it was a main point of contest in 1963-1964. It is a decisive element in the guarantee for the patients' free choice of his physician.

The therapeutic freedom was confirmed in the St.-Johns agreement, but with the years the legislator curtailed it more and more. The latest government with minister Frank VANDENBROUCKE, went quite very far in this matter. The "law of 22.08.2002 regulating medical care" introduced "reference prices" for 14 surgical acts and for 12 treatments in internal medicine. If more than the average amount is spent on the treatment of one of these 26 pathologies, selected from the *All Patients Refined Diagnosis Related Group)*-system *(APR-DRG*, the hospital and its physicians have to reimburse the difference.

APR-DGR's Internal medicine : number and description

045 Cva w infarct
046 Nonspecific cva & precerebral occlusion w/o infarct
047 Transient ischemia
134 Pulmonary embolism
136 Respiratory malignancy
139 Simple pneumonia
190 Circulatory disorders w AMI
202 Angina pectoris
204 Syncope & collapse
244 Diverticulitis & diverticulosis
464 Urinary stones w esw lithotripsy
465 Urinary stones w/o esw lithotripsy

APR-DGR's SURGERY : number and description

073 Lens procedures w or w/o vitrectomy
097 Tonsillectomy & adenoidectomy procedures
179 Vein ligation & stripping
225 Appendectomy
228 Inguinal & femoral hernia procedures
263 Laparoscopic cholecystectomy
302 Major joint & limb reattach proc of lower extrem exc for trauma
313 Knee & lower leg procedures except foot
318 Removal of internal fixation device
482 Transurethral prostatectomy
513 Uterine & adnexa procedures for ca in situ & nonmalignancy
516 Laparoscopy & tubal interruption
540 Cesarean delivery
560 Vaginal delivery

The Programme law II of 24.12.2002 issued a series of measures which brought the health care providers to assume individual responsibility, when they deviate from a kind of "guidelines" or "indicators". To this end, the proceeding of the Control commission was adapted and its name changed into "Department of medical evaluation and control"

3.1.4. From “fee for service” to “agreed lump sum payments”

The system of conventions between physicians and sickness funds, as conceived in the St.-John's convention of 25.06.1964, concerned the fees, the term of validity of the convention, the time and the conditions to which the convention refers and the guarantees related to the implementation of the system. The basis for the remuneration is still payment per act ("fee for service") except for laboratory medicine (clinical biology) and radiology where the payment exists of an agreed lump sum respectively for 75% and +/- 31%. The remaining part is paid per act.

Over the last 10 years, other elements were also adopted in the convention such as the accreditation system with a, partly fixed fee and a partly remuneration per act (or service), the introduction of the Global Medical Record (GMR) for general practitioners, the introduction of a fixed fee for disposability for general practitioners, subsidies for software programmes for general practitioners, financial assistance for the local circles of general practitioners which organize, among other things, the local guard duty. For the moment, a draft of Royal Decree is on the desk of the State Council for advice which aims to subsidize certain forms of general medical practices. The BVAS-ABSyM is fully opposed to this idea.

3.1.5. The acceptance of the conventions between physicians and sickness funds

A convention between physicians and sickness funds cannot come into effect when more than 40% of the physicians refuse the convention (by registered letter) or when more than 50% of the general practitioners or more than 50% of the specialists refuse to acceed to it.
The counting is elaborated by each legal district.

Regarding the convention for the year 2003, closed on 19.12.2002, 7.243 physicians out of 40.666 or 17,81% refused to acceed to the convention. From the 17.913 general practitioners, 2.804 or 15,65% refused and from the 22.753 specialists 4.439 or 19,51% refused it (table 1).

Refusals to acceed to the convention concluded on 19.12.2002

	Number	Number refusals	
		absolute	in %
General practitioner	17.913	2.804	15,65
Medical specialists	22.753	4.439	19,51
Total	40.666	7.243	17,81

Table 1

Table 2 gives an overview of the percentages refusals since 1990. The convention of 18.12.1992 brought an exceptional situation, as stipulated in article 51 § 1, sub-section 6, 2° of the GVU-law of 14.07.1994. As the representative medical unions did not succeed in concluding a convention with the sickness funds, minister Philippe MOUREAUX imposed himself provisional tariffs for individual physicians. But they were rejected by 51,5% of the physicians, 37,8% of the general practitioners and 63,73% of the medical specialists (table 2).

A concluded convention can be cancelled by one of the contracting partners – the sickness funds or the medical trade unions.
The convention of 11.12.1995 was cancelled by the BVAS on 16.01.1997 because of the Governments'linear economy measures (- 3%) (° in table 2).
The convention of 03.11.1997 was cancelled by the BVAS on 01.14.1998 because of the legal restrictions on the fee supplements in hospitals (△ in table 2).

Percentage refusals to acceed to the convention physicians-sickness funds

	All physicians	General practitioners	Medical specialists
10.12.1990	12,57	9,78	16,35
18.12.1992 (*)	51,50	37,80	63,73
13.12.1993	19,27	18,42	20,02
11.12.1995 (°)	16,50	16,18	16,77
03.11.1997 (△)	15,60	14,28	16,71
18.12.2000	14,77	11,85	17,16
19.12.2002	17,81	15,65	19,51

Table 2

* Document Moureaux

There are, in general, some quite important differences in the number of refusals between general practitioners and specialists and between the Dutch- (Flemish region) and the French-speaking communities (Walloon region and the majority of the Brussels agglomeration). For example, table 3 shows the percentages of refusals for the convention concluded on 19.12.2002.

Refusal of the convention physicians-sickness funds of 19.12.2002

	All physicians	General practitioners	Medical specialists
Flemish region	13,87	7,23	19,25
Walloon region	21,04	24,58	18,12
Brussels region	24,20	25,94	23,08
Total	17,81	15,65	19,51

Table 3

Physicians who acceed to the convention are granted a financial participation in their social security contribution by the NSIII. In 2002 the amount of the participation was € 2.612,70 for those who fully acceeded and € 1.749,79 for those who used the convention tariffs only during part of their practice.

3.2. Representativity of medical associations

The law of 08.04.1965, which materialises the St.-John's Agreement of 25.06.1964 introduced a procedure aiming at measuring the representativity of medical associations through the counting of their members. This system never worked and it is only with Article 122 of the law of 29.04.1996 (Belgian Official journal dated

30.04.1996) concerning social provisions that the principle of elections of representative medical associations at four years intervals was incorporated as article 211 § 1 of the Law on Medical Care and Allowances. Article 211 § 1 was further amended by the law of 22.02.1998 (Belgian Official Journal of 03.02.1998).

The Royal Decree of 08.08.1997 (Belgian Official Journal of 11.09.1997) carrying that law into effect and amended by the Royal Decrees of 02.12.1997 (Official Journal dated 13.12.1997) and of 02.03.1998 (Official Journal dated 05.03.1998) determined the rules applicable to medical elections.

In order to be representative, an organization must include in its ranks both medical specialists and general practitioners; have members in at least two of the three regions; exist at least since twelve months and count at least 1.500 affiliated individual members who are health care providers registered with the NSIII.

Only two organizations fulfil these criteria: on the one hand the BVAS-ABSyM with two Dutch-speaking sections and three French-speaking Chambers and, on the other hand, the Cartel constituted by the Syndicate of Flemish General Practitioners (Syndicaat van Vlaams Huisartsen - SVH) and the Confederation of Belgian Doctors composed in its turn of three smaller associations; namely the Belgian Grouping of General Practitioners (Groupement Belge des Omnipraticiens - GBO), the Belgian Syndicate of Medical Specialists (Syndicaat der Belgische Geneesheren-Specialisten - SMS) – which is no more active – and the General Syndicate of Belgian Medical Professions (Algemeen Syndicaat der Geneeskundigen van België - ASGB).

The results of elections determine the number of seats in the various councils, committees and commissions of the NSIII. The body that has the greatest symbolic value is the National Commission Physicians-Sickness Funds in the frame of which agreements are concluded between medical doctors and mutual insurance companies. The new rules grant 12 seats to the representatives of sickness funds and 12 seats to physicians including 6 for general practitioners and 6 for medical specialists.

It results that the voices of general practitioners have a greater weight than those of medical specialists since circa 45 % of physicians are registered as general practitioners to the NSIII, while circa 55 % of physicians are medical specialists.

Since the publication of the Royal Decree of 08.08.1997 two medical elections have been organized respectively in June 1998 and June 2002. Until then, BVAS-ABSyM had always obtained an absolute majority in the representation of medical doctors in all the bodies of the NSIII. BVAS-ABSyM had 9 of the 11 seats, at that time, in the National Commission Physicians-Sickness Funds.

Participation in medical elections is not compulsory. In June 1998, 70.66 % participated. In June 2002, participation decreased to only 56.33 % (see table 4).

Participation in medical elections.

	1998				2002			
	Number of ballots sent		Number of ballots received		Number of ballots sent		Number of ballots received	
	Absolute number	% of total	Absolute number	% of total	Absolute number	% of total	Absolute number	% of total
General practitioners	16.919	45,26	11.755	69,48	17.872	44,58	10.341	57,86
Medical Specialists	20.464	54,74	14.659	71,63	22.218	55,42	12.241	55,09
Total	37.383	100,0	26.414	70,66	40.090	100,00	22.582	56,33

Table 4

Table 5 shows the results of the two medical elections.
In 1998, BVAS-ABSyM obtained 67.1 % of the total of votes cast including 39.7 % from general practitioners and 89.2 % from specialists.
In 2002, BVAS-ABSyM lost 7 % of votes, by obtaining 60.1 % of votes mainly due to a loss of votes from general practitioners, for whom the decrease amounting to 11.6 %. A *status quo* was observed as far as specialists were concerned.

Results of the medical elections of 30.06.1998 and 25.06.2002 (percentage)

		1998	2002
BVAS	General practitioners	39,7	28,1
	Medical specialists	89,2	87,1
	total	**67,1**	**60,1**
Cartel	General practitioners	59,0	69,1
	Medical specialists	9,9	9,7
	total	**31,7**	**36,9**
Invalid/blank	General practitioners	0,6	1,3
	Medical specialists	0,6	1,7
	total	1,2	3,0
		100	100

Table 5

ABSyM kept its majority in all the bodies of the NSIII both in 1998 and 2002. This was also the case in the National Commission Physicians-Sickness Funds : 7 seats were given to BVAS-ABSyM among which 5 for specialists and 2 for general practitioners while 5 went to the Cartel including 4 for general practitioners and 1 for medical specialists (see table 6).

Composition National Commission Physicians-Sickness Funds

Physicians		Sickness Funds
BVAS General practitioners	2	
BVAS Medical specialists	5	
Total BVAS-ABSyM	7	
Cartel General practitioners	4	
Cartel Medical specialists	1	
Total Cartel	5	
General total	12	12

Table 6

The numerous other medical associations are not considered as representative according to the law on health care and allowances. This is also the case as regards the Grouping of Belgian Professional Societies of Medical Specialists (VBS-GBS).

Given the fact that only specialized doctors may be affiliated to it, this organization which counts the greatest number of members among all the Belgian medical organizations (7.313) is not considered as representative by the NSIII. The VBS-GBS is a "cupola" organization regrouping 24 professional associations, that is one per medical speciality recognized by the law, and 4 associate professional unions. Since many years, VBS-GBS works in close co-operation with BVAS-ABSyM without going as far as to constitute a cartel or another form of structured co-operation. The different professional associations offer their know-how, such as the support given to BVAS-ABSyM in the Technical Medical Council of the NSIII during the preparation of the nomenclature of health care services specific to each discipline.

In addition to the professional associations of specialists, there are dozens of specialized scientific societies working on the basis of disciplines or sub-disciplines and either French or Dutch-speaking or Federal.

Associations that group only general practitioners - which by definition cannot be "representative" - are strongly dispersed and regionalized. In Flanders local circles of general practitioners are grouped in the *"Unie van huisartsenkringen (UHAK)"*. On the Francophone part of the country there exist identical groupings. Local associations of general practitioners are united inside the Forum of General Practitioners' Associations (FAG).

There exist two scientific societies of general practitioners subsidized by the State : one in Flanders - the *Wetenschappelijke Vereniging van Vlaamse Huisartsen* (WWVH) - and the other in the French-speaking region, the Societé Scientifique de Médecins Spécialistes (SSMG).

In Flanders, there is also a Parliament of Flemish general practitioners : the *Vlaams Huisartsen Parlement (VHP)* to which three benches are elected : one for the representatives of general practitioners' unions; one for the scientific society and universities and one for the representatives of general practitioners' circles. This *Vlaams Huisartsen Parlement* has no legal competence but works as an informal lobby group.

A certain number of general practitioners who are not members of BVAS-ABSyM wish to secede from specialists, in the structures of the NSIII, and to have a distinct budget as well as a separate convention for general practitioners. Recently, voices arose to request that the convention for general practitioners ceased to be concluded with traditional sickness funds, but be negotiated with the Government. To the extent that in the organization of general medicine, there exist very important differences between Flanders and the francophone part of the country, political leaders fear that a splitting between general practitioners and specialists may directly result in a division of health care and of the whole field of social security. French-speaking political parties are fiercely opposed to such a development

4. Representation of medical associations in official bodies

The two representative medical organizations, BVAS-ABSyM and the Cartel, are both represented in several official bodies belonging to the Federal Public Service (FPS) Social Security and of the FPS Public Health, Safety of the Food-Chain and Environment. In the National Sickness and Invalidity Insurance Institute (NSIII), which pertains to the competence of the Minister of Social Affairs and the SPF Social Security, the number of seats in the different bodies is allocated as a function of the number of votes obtained during medical elections.

In the bodies of the Federal Public Service (SPF) Public Health, Safety of the Food-Chain and Environment, there is no legal basis enabling to take into account the results of medical elections.

4.1. At the National Sickness and Invalidity Insurance Institute (NSIII), representative organizations have a seat *inter alia* in the following bodies :

- ✓ **Service of Medical Care**
  - Insurance Committee
  - Budgetary Control Commission
  - National Commission Physicians-Sickness Funds
  - National Council for the Promotion of Quality
  - Accreditation system including
    - Accreditation Management Group
    - Joint Committee by Specialty
    - Working Group on Ethics and Economy
    - Technical Council for Accreditation
    - Appeal Commission
  - Commission of Profiles
  - Evaluation Committee on Medical Practice relating to Medication

- ✓ **Service of Medical Assessment and Control**
  - Service Unit
  - Committee
  - Appeal Board

4.2. In the Federal Public Service Public Health, Safety of the Food-chain and Environment, there are not only the two representative medical organizations but also the Grouping of Belgian Professional Societies of Medical Specialists (VBS-GBS). In any case, until the beginning of the 1960s the different professional associations of the GBS were responsible for giving medical doctors who requested it, their recognition as medical specialists.

In the field of certifications, representatives have seats
* in the Higher Council of Medical Specialists and General Practitioners.
* in the various certification commissions.

Concerning the legislation on hospitals, medical representatives have seats in

* the National Council for Hospitals
* the National Joint-Committee Medical Doctors Hospitals
* The Consensus-seeking structure between Hospital Managers, medical Doctors and Sickness Funds
* the Commission for the Supervision and Evaluation of Statistical Data concerning medical activities in Hospitals

There also exists a whole series of other bodies in which doctors-representatives have a seat

* National Council and technical Commission for Nursing Care
* National Council and technical Commission for Paramedical professions
* Commission on Clinical Biology

5. Principles - Objectives

At the end of this talk, we shall enunciate the basic principles and the objectives of the associations to which I adhere. We have ten basic rules :

1. The patient has a central position
2. The physician respects the Code of Medical Ethics and in particular Article 36: *"The physician is free as to his/her diagnosis and therapy. He/She will refrain from prescribing useless examinations or expensive therapies or to perform superfluous acts"*.
3. The patient is free to choose his medical doctor
4. The physician is free to decide between diagnostic and therapeutic alternatives
5. The protection of medical confidentiality is crucial
6. Physicians ensure the continuity of quality care
7. There is an equivalence between general practitioners and medical specialists
8. There is an equivalence between medical specialists as such
9. An identical pathology gives rise to identical fees, irrespective of the place
    * Academic or non academic institution
    * Region
    * Hospital care or out-patient care
10. In other words, the implementation of a just and objective legislation on the entire territory.

As an information for the new government to be appointed, we can but reiterate our vision :

- Stop the creation of costly and overlapping structures
- Give support to the co-operation agreements existing on a small scale between health care providers belonging to the same profession and between providers pertaining to several professions (general practitioners - medical specialists - physicians - nursing staff - paramedics - physiotherapists…)
- Restrict the interference of the State in health care
- Stop excessive standards and bureaucracy

- Leave health care first of all to practitioners, in consultation with their patients and avoid over-structuring.

6. Conclusion

During decades, the Belgian health care system enjoyed a considerable reputation at the international level. Health care is of high quality and easily accessible for almost all patients. Expenditures are under control even if this necessitates major efforts, mainly on the side of providers and also during recent years, but to a lesser extent, from patients themselves.

The origin of these positive results is to be found in a permanent system of negotiation between sickness funds and health care providers, under the supervision of the State. Physicians are definitely in favour of the pursuit of that concertation model. Neither a State medicine nor the hyper-liberal approach of a free market system applied to health care give better results.

In order to conclude and as a piece of information for the new Belgian government to be constituted, I repeat the words of the founding father of BVAS-ABSyM, Dr. André WYNEN, "Pas de médecine sans médecins" (No medecine without medical doctors).

I thank you for your attention.

Dr. M. MOENS