GATEWAY TO GLOBAL AGING DATA

g2aging.org

Gateway Policy Explorer: Retirement Series

Belgium

Public Old-Age Health Insurance Plan Details

1992-2023

Authors
Qinyi Ouyang
David Knapp

Contributors
Alain Jousten
Jérôme Schoenmaeckers
Jinkook Lee
Maciej Lis†
Rachel Lobo
Drystan Phillips
Kanghong Shao
Alejandra Tantamango
Michael Upchurch
Yeeun Lee Yoo

Version: 1.0 (August 2023)

This project is funded by the National Institutes of Health, National Institute of Aging, R01 AG030153.

Please cite as "Gateway to Global Aging Data (2024). *Gateway Policy Explorer: Belgium, Public Old-Age Health Insurance Plan Details, 1992-2023*, Version: 1.0 (August 2023), University of Southern California, Los Angeles. https://doi.org/10.25553/gpe.ret.hi.bel"

Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Retirement Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Retirement Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Retirement Series* are country and time. We prioritize data collection for each country based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country and each broad category of policies covered in the *Gateway Policy Explorer: Retirement Series*.

Author and Contributor Disclaimers

† The opinions expressed here are those of authors and do not necessarily reflect the views of the OECD or of its member countries.

Belgium

Old-Age Health Insurance
Plan details 1992-2023 * †

The Belgian public health care system provides universal health care largely financed by taxes and social contributions paid by the insured and their employers. It covers all Belgian citizens and some non-citizens residing in Belgium through the compulsory health insurance (assurance obligatoire).

The Belgium compulsory health insurance provides full or partial reimbursement for a wide range of services. All services eligible for reimbursement are included in the nationally established fee schedule known as the Nomenclature, where reimbursement amounts are specified.

Since 1992, there have been several reforms regarding covered services and out-of-pocket payment.

Key Dates
First law: 1894
Major changes since 1992: 1994

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-1993

Overview

The Belgian public health care system provides universal health care. It covers all Belgian citizens and non-citizens residing in Belgium through the compulsory health insurance (assurance obligatoire). It is provided on a fee-for-service basis and reimburses individuals for a wide range of services. A person is entitled to compulsory health care if they continue to pay contributions unless the requirement is waived. All beneficiaries must join or register with a health insurance institution. Insured people may also choose to contract with private (for and not-for profit) health insurance to cover out-of-pocket payments, herein referred to as the complementary health insurance.

The Health Insurance Act and the Hospital Act form the legal basis of the Belgian compulsory health insurance. Additionally, the Royal Decree establishing the personal contribution of beneficiaries to the cost of pharmaceutical supplies reimbursable under compulsory health care and compensation insurance (Moniteur Belge, 1991, as amended), effective January 1, 1992, determines the reimbursement policy of pharmaceuticals.

The National Institute for Health and Disability Insurance (Institut national d'assurance maladie-invalidité, INAMI) is responsible for the general organization and financial management of compulsory health insurance, and monitors all aspects of medical services. The National Social Security Office (Office National de Sécurité Sociale, ONSS) collects social security contributions from employees and employers.

Other reforms during this period include:

- Law of June 26, 1992, effective July 1, 1992, made the following changes:
  - Increased employee's contribution to compulsory health insurance from 2.55% of earned income to 3.55%
  - Increased pensioner's contribution to compulsory health insurance from 2.55% of gross pension benefit to 3.55%, effective October 1, 1992

Eligibility

- **Qualifications**

  Compulsory Health Insurance (Assurance Obligatoire)

  A person must register with a health insurance fund and continue to contribute to compulsory health insurance to be covered. Funds are known as mutualities (mutualité) and the fee to join a mutuality for compulsory health insurance is nominal and uniform. The contribution rate varies by employment type:
  - For employees: 2.55% of earned income paid by themselves, which was increased to 3.55% (effective July 1, 1992). 3.8% paid by employers.
  - For self-employed: Rates of personal contribution before 1998 have not been identified yet.
  - For pensioners: 2.55% of gross pension amount, which was increased to 3.55% (effective October 1, 1992) —see Formula 1 for more information.

  In addition to normal mutualities, a person can join the Auxiliary Health and Disability Insurance Fund (Caisse Auxiliaire d'Assurance Maladie-Invalidité, CAAMI). It is a public social security institution and has no contribution requirements.

  Complementary Health Insurance (CHI)

  All mutualities except for CAAMI provide complementary health insurance. A person can contract with any of them to cover out-of-pocket payments. Some mutualities require a 6-month waiting period before the insurance coverage becomes valid if a person is becoming insured for the first time.
- **To receive health benefits, does an individual have to claim them?** Answer: Yes
- **To continue to receive health benefits, does an individual have to remain qualified?** Answer: Yes

Coverage

Compulsory Health Insurance (Assurance Obligatoire)

All services eligible for partial or full reimbursement are included in the nationally established fee schedule, which is known as the Nomenclature (Nomenclature des Prestations de Santé). It specifies the official fees and reimbursement amounts, and is regulated by the Royal Decree of September 14, 1984, as amended. Covered services include:

- Routine care:

  - Visits and consultations with general practitioners (GPs) and specialists
  - Care from physiotherapists
  - Diagnostic and treatment services
  - Dental care (including dentures)
- Birth delivery
- Specialist care
- Medical aids
- Pharmaceuticals
- Hospitalization
- Rehabilitative care
- Travel costs
- Care at nursing homes for the elderly
- Integrated home care services

Outpatient Care
Patients have direct access and freedom of choice regarding health care providers. They also have direct access to specialists. However, GP remains a preferred entry point for health services, and patients with referrals may receive higher reimbursements.

Inpatient Care
Compulsory health insurance covers inpatient care. Patients usually need a doctor's referral for inpatient care. Inpatient care is provided at public and private hospitals and patients can choose by themselves.

Pharmaceuticals
Compulsory health insurance reimburses certain pharmaceuticals, which are sorted into 5 different categories depending on their medical or therapeutic importance and level of necessity:

- Category A: Specialties of vital importance. For example, drugs for the treatment of diabetes or cancer
- Category B: Therapeutically important pharmaceutical specialties. For example, antibiotics, antiasthmatics, antihypertensives
- Category C: Medicinal products intended for symptomatic treatment. For example, substances used to thin mucus for the treatment of chronic bronchitis
- Category Cs: Drugs used in certain chronic illnesses (e.g. drugs used in coronary heart disease), antihistamines and vaccines
- Category Cx: Contraceptives and antispasmodics

The list of reimbursable pharmaceuticals is published every month at INAMI, Reimbursable pharmaceutical specialties: lists and reference files. Drugs that are not included in any of these 5 categories are not eligible for reimbursement. For example, tranquilizers or sleeping pills.

Complementary Health Insurance (CHI)
If the insured contracts with complementary health insurance, the medical expenses not reimbursed by the compulsory health insurance can be reimbursed in whole or in part, depending on the contracted insurance plan.

Long-Term Care (LTC)
For details about long-term care benefits, please refer to the policy document *Belgium Long-Term Care In-Kind Benefit Plan Details, 1994-2022* (Global Aging Data, 2023).

Costs

Compulsory Health Insurance (Assurance Obligatoire)
All services eligible for partial or full reimbursement are included in the Nomenclature. Health care providers who follow the official fees in the Nomenclature are called conventioned practitioners. Partially conventioned or non-conventioned practitioners may charge extra.

Out-of-pocket payments consist of two parts during this period:

- Coinsurance (ticket modérateur): A certain amount payable by the patients due to partial reimbursement by the compulsory health insurance. The coinsurance amounts vary across services.
- Extra billing (supplement d'honoraire): The difference between the actual costs and the official rates that are set by the Nomenclature. Extra billing occurs for various services such as dental and vision services.

Formula 2 illustrates how out-of-pocket costs without complementary health insurance are calculated.

Outpatient Care

Compulsory health insurance typically partially reimburses outpatient care such as visits to GPs or specialists. The coinsurance rates for health care services vary by type of service. Coinsurance rates for certain services are listed as follows:

- Visits to GPs: A coinsurance rate of 30% applies
- Visits to specialists: A coinsurance rate of 40% applies

Inpatient Care

Inpatient care is charged per day of hospitalization. Its price varies by type of hospital, duration of stay, and patient's own status (e.g., whether they have dependents, etc.). The Federal Public Service Health, Food Chain Safety and Environment (Service public fédéral Santé publique, Sécurité de la chaîne alimentaire et Environnement) sets the price and updates the amounts every January 1 and July 1. The coinsurance rate is typically 20%. This hospitalization stay price covers all the costs of the stay except for the following:

- Pharmaceuticals: A flat-rate of 25 F (= 0.63 €) per day applies
- Clinical biology services: A flat-rate applies —the exact amount varies by hospital [1]
- Medical imaging: A flat-rate applies —the exact amount varies by hospital [2]

Pharmaceuticals

The patient's copayment depends on the reimbursement category of the pharmaceuticals and whether the drugs are dispensed in public pharmacies or in hospitals. See the following tables for more information:

- Table 1: Coinsurance rates for pharmaceuticals (January 1, 1992 - March 31, 2010)
- Table 2: Maximum out-of-pocket payment for pharmaceuticals in Category B (patients with Preferential Reimbursement, 1992 - present)
- Table 3: Maximum out-of-pocket payment for pharmaceuticals in Category B (patients without Preferential Reimbursement, 1992 - present)
- Table 4: Maximum Out-of-Pocket Payment for Pharmaceuticals in Category C (1992 - present)

Additionally, the insured must pay for health care that is not among the listed services in the Nomenclature. These services may be partially or fully reimbursed by the insured's complementary health insurance policy, depending on individual contract.

Long-Term Care (LTC)

For details about long-term care costs, please refer to the policy document *Belgium Long-Term Care In-Kind Benefit Plan Details, 1994-2022* (Global Aging Data, 2023).

Notes

[1] The price of clinical biology services is linked to code 592001 in the Nomenclature

[2] The price of medical imaging is linked to code 460784 in the Nomenclature

Chapter 2: Policy enacted 1994-2023

Policy change in 1994

Law on Compulsory Health Care and Compensation Insurance, coordinated on July 14, 1994, which is also known as the Health Insurance Reform Act, effective September 6, 1994, made the following changes to the compulsory health insurance:

- Extended the coverage of the compulsory health insurance
- Introduced the Preferential Reimbursement classification to reduce out-of-pocket payments for patients satisfying certain conditions
- Created a system of maximum out-of-pocket payments for better accessibility to health care

Other reforms during this period include:

- Royal Decree of July 14, 1997, effective July 1, 1997, extended the Preferential Reimbursement to people who are receiving certain benefits
- Law of February 22, 1998, effective March 13, 1998, extended the coverage of compulsory health insurance to palliative care at home
- Law of January 25, 1999, effective February 16, 1999, extended the coverage of compulsory health insurance to home nursing care
- Royal Decree of July 10, 2001, effective May 1, 2001, introduced the Global Medical Record, which reduces the copayment rates for patients who opt-in with the Global Medical Record
- Law of June 5, 2002, effective January 1, 2002, updated the system of annual maximum out-of-pocket payments, which lowered the annual caps for people satisfying certain conditions
- Royal Decree of September 17, 2005, effective September 1, 2005, introduced a higher maximum out-of-pocket payment for pharmaceuticals applicable to large packaging medicines (i.e., with more than 60 units)
- Royal Decree of August 26, 2010, effective October 1, 2010, introduced a maximum out-of-pocket payment for visits to specialists
- Royal Decree of October 3, 2011, effective December 1, 2011, replaced the coinsurance for visits to GPs with copayments
- Royal Decree of March 5, 2012, effective March 29, 2012, introduced two new categories of reimbursable pharmaceuticals
- National Dental-Mutualist Agreement, effective January 1, 2016, introduced the oral care pathway (trajet de soins buccaux), which requires a person to visit dentists regularly (i.e., at least one reimbursed visit during the previous calendar year) to receive normal reimbursement amounts during the current year

Overview

The Belgian public health care system provides universal health care. It covers all Belgian citizens and non-citizens residing in Belgium through the compulsory health insurance (assurance obligatoire). It is provided on a fee-for-service basis and reimburses individuals for a wide range of services. A person is entitled to compulsory health care if they continue to pay contributions unless the requirement is waived. All beneficiaries must join or register with a health insurance institution. Insured people may also choose to contract with private (for and not-for profit) health insurance to cover out-of-pocket payments.

The Health Insurance Act, the Hospital Act, and the Health Insurance Reform Act form the legal basis of the Belgian compulsory health insurance. Additionally, the Royal Decree establishing the personal contribution of beneficiaries to the cost of pharmaceutical supplies reimbursable under compulsory health care and compensation insurance (Moniteur Belge, 1991, as amended), effective January 1, 1992, determines the reimbursement policy of pharmaceuticals.

The National Institute for Health and Disability Insurance (Institut national d'assurance maladie-invalidité, INAMI) is responsible for the general organization and financial management of compulsory health insurance, and monitors all aspects of medical services. The National Social Security Office (Office National de Sécurité Sociale, ONSS) collects social security contributions from employees and employers.

Eligibility

- **Qualifications**

  Compulsory Health Insurance (Assurance Obligatoire)

  A person must register with a health insurance and be insured with the compulsory health insurance to be covered. Funds are known as mutualities (mutualité) and the fee to join a mutuality for compulsory health insurance is nominal and uniform. The contribution rules vary by employment type:
  - For employees: 3.55% of earned income paid by themselves. 3.8% paid by employers.
  - For self-employed: 881.42 € per quarter (values of 2023) —see Table 5 for rates from 1998-2023. Reduced by half, i.e., 440.70 € per quarter, if their income is lower than an annual ceiling —see Table 6 for income ceilings from 2002-2023, or reduced to 74.72 € per quarter if their income is lower than the annual income ceiling of the Preferential Reimbursement —see Table 7 for the income threshold. Personal contribution is waived if a person is entitled to the Preferential Reimbursement.
  - For pensioners: 3.55% of gross monthly own old-age benefit amount if it exceeds 1,990.87 € (values of 2023). Reduced if the monthly pension benefit is lower than or equal to 1,990.87 € —see Formula 1 for more information.

  In addition to normal mutualities, a person can join the Auxiliary Health and Disability Insurance Fund (Caisse Auxiliaire d'Assurance Maladie-Invalidité, CAAMI). It is a public social security institution and has no contribution requirements.

  Complementary Health Insurance (CHI)

  All mutualities except for CAAMI provide complementary health insurance. A person can contract with any of them to cover out-of-pocket payments. Some mutualities require a 6-month waiting period before the insurance coverage becomes valid if a person is becoming insured for the first time.
- **To receive health benefits, does an individual have to claim them?** Answer: Yes
- **To continue to receive health benefits, does an individual have to remain qualified?** Answer: Yes

Coverage

Compulsory Health Insurance (Assurance Obligatoire)

Compulsory health insurance covers both preventive and curative care, including a wide range of services. All services eligible for partial or full reimbursement are included in the nationally established fee schedule, which is known as the Nomenclature (Nomenclature des Prestations de Santé). It specifies the official fees and reimbursement amounts, and is regulated by the Royal Decree of September 14, 1984, as amended. NomenSoft is an online database of the Nomenclature, where the insured can find the description, official fee and reimbursement amount of every health care service. Covered services include:

- Routine care:
  - Visits and consultations with general practitioners (GPs) and specialists
  - Nursing care and home nursing care, effective February 16, 1999
  - Care from physiotherapists
  - Diagnostic and treatment services
  - Dental care
- Birth delivery
- Specialist care
- Medical aids
- Pharmaceuticals
- Hospitalization
- Rehabilitative care
- Travel costs
- Care at residential homes, effective September 6, 1994
- Care at nursing homes for the elderly or short-stay centers, effective September 6, 1994
- Integrated home care services
- Palliative care at home, effective March 13, 1998

Outpatient Care

Patients have direct access and freedom of choice regarding health care providers. They also have direct access to specialists. However, GP remains a preferred entry point for health services, and patients with referrals may receive higher reimbursements.

Inpatient Care
Compulsory health insurance covers inpatient care. Patients usually need a doctor's referral for inpatient care. Inpatient care is provided at public and private hospitals and patients can choose by themselves.

Pharmaceuticals
Compulsory health insurance reimburses certain pharmaceuticals, which are sorted into 7 different categories depending on their medical or therapeutic importance and level of necessity:

- Category A: Specialties of vital importance. For example, drugs for the treatment of diabetes or cancer
- Category B: Therapeutically important pharmaceutical specialties. For example, antibiotics, antiasthmatics, antihypertensives
- Category C: Medicinal products intended for symptomatic treatment. For example, substances used to thin mucus for the treatment of chronic bronchitis
- Category Cs: Drugs used in certain chronic illnesses (e.g. drugs used in coronary heart disease), antihistamines and vaccines
- Category Cx: Contraceptives and antispasmodics
- Category Fa: Life-saving specialties, effective March 29, 2012. For example, erythropoiesis-stimulating hormones
- Category Fb: Therapeutically important specialties, effective March 29, 2012. For example, drugs used in the case of macular degeneration

The list of reimbursable pharmaceuticals is published every month at INAMI, Reimbursable pharmaceutical specialties: lists and reference files. Drugs that are not included in any of these 7 categories are not eligible for reimbursement. For example, tranquilizers or sleeping pills.

Complementary Health Insurance (CHI)
If the insured contracts with complementary health insurance, the medical expenses not reimbursed by the compulsory health insurance can be reimbursed in whole or in part, depending on the contracted insurance plan.

Long-Term Care (LTC)
For details about long-term care benefits, please refer to the policy document *Belgium Long-Term Care In-Kind Benefit Plan Details, 1994-2022* (Global Aging Data, 2023).

Costs

Compulsory Health Insurance (Assurance Obligatoire)
All services eligible for partial or full reimbursement are included in the Nomenclature. Health care providers who follow the official fees in the Nomenclature are called conventioned practitioners. Partially conventioned or non-conventioned practitioners may charge extra.

Out-of-pocket payments consist of three parts:

- Copayment: A flat-rate amount payable by patients. It applies to pharmaceuticals and GP consultations:
  - Table 8: Copayment amounts for visit to GPs for different types of patients (effective from May 1, 2013). There is no copayment for GP consultations before May 1, 2013
  - Table 9: Copayment for pharmaceuticals dispensed by public pharmacy (effective from April 1, 2010). There is no copayment for pharmaceuticals before April 1, 2010
- Coinsurance (ticket modérateur): A certain amount payable by the patients due to partial reimbursement by the compulsory health insurance. The coinsurance amounts vary across services.
- Extra billing (supplement d'honoraire): The difference between the actual costs and the official rates that are set by the Nomenclature. Extra billing occurs for various services such as dental and vision services.

Certain patients are offered higher reimbursement amounts, which is known as the Preferential Reimbursement. Patients can submit a request to their registered health insurance fund. They will be granted the Preferential Reimbursement rate if they satisfy certain conditions —see Box 1 for the requirement and tables regarding income thresholds and exempted amounts:

- Table 7: Income threshold of earnings from current year
- Table 10: Income threshold of earnings from previous year
- Table 11: Amounts exempted from cadastral income

Effective July 1, 1997, people who are receiving one of the following benefits are automatically entitled to the Preferential Reimbursement:

- Subsistence Minimum, or Integration Income (for at least 3 months)
- Guaranteed Income for the Elderly (GRAPA)
- Disability Allowance

- Allowance for help to the elderly

To further expand access to compulsory health insurance services, the Health Insurance Reform Act introduced an annual maximum for out-of-pocket payment:

- From 1994-2001: 200 F (= 5 €) per medical service for hospitalized patients, or 350 F (= 8.75 €) per medical service for non-hospitalized patients
- From 2002: The maximum out-of-pocket payment varies by household income, patient category, and whether they have long-term illnesses —see Formula 3 for further details regarding the out-of-pocket payment cap and the following tables regarding general maximum out-of-pocket payment:
  - Table 12: General maximum out-of-pocket payment (2002-2004)
  - Table 13: General maximum out-of-pocket payment (2005-2021)
  - Table 14: General maximum out-of-pocket payment (2022-present)
  - Table 15: General maximum out-of-pocket payment (values as of 2023)

Formula 2 illustrates how out-of-pocket payments per service without complementary health insurance are calculated from 1994-2001. Formula 3 illustrates how out-of-pocket payments per year without complementary health insurance are calculated since 2002.

Outpatient Care

Compulsory health insurance typically partially reimburses outpatient care such as visits to GPs or specialists. The copayment amounts and coinsurance rates vary by type of service and patient's own circumstances. Patients entitled to the Preferential Reimbursement have lower copayments and coinsurance rates. Since 2001, with the introduction of the Global Medical Record (GMR), patients who opt-in for a GMR allow a single GP to manage their medical information and have reduced copayments and coinsurance rates. Coinsurance rates and copayments for certain services are listed as follows:

- Visits to GPs:
  - From 1994 to 2011, the coinsurance rate was 30%
  - Effective December 1, 2011, a flat-rate applies —see Table 8 for copayment amounts for different types of patients
- Visits to specialists: A coinsurance rate of 40% applies —a maximum of 15.50 € per service starts to apply from October 1, 2010

Inpatient Care

Inpatient care is charged per day of hospitalization. Its price varies by type of hospital, duration of stay, and patient's own status (e.g., whether they are entitled to the Preferential Reimbursement, whether they have dependents, etc.). The Federal Public Service Health, Food Chain Safety and Environment (Service public fédéral Santé publique, Sécurité de la chaîne alimentaire et Environnement) sets the price and updates the amounts every January 1 and July 1. The coinsurance rate is typically 20%. This hospitalization stay prices covers all the costs of the stay except for the following:

- Pharmaceuticals: A flat-rate of 0.62 € per day applies
- Clinical biology services: A flat-rate applies. The exact amount varies by hospital [1]
- Medical imaging: A flat-rate applies. The exact amount varies by hospital [2]

Pharmaceuticals

The patient's copayment depends on the reimbursement category of the pharmaceuticals and whether the drugs are dispensed in public pharmacies or in hospitals. See the following tables for more information:

- Table 1: Coinsurance rates for pharmaceuticals (January 1, 1992 - March 31, 2010)
- Table 2: Maximum out-of-pocket payment for pharmaceuticals in Category B (patients with Preferential Reimbursement, 1992 - present)
- Table 3: Maximum out-of-pocket payment for pharmaceuticals in Category B (patients without Preferential Reimbursement, 1992 - present)
- Table 4: Maximum Out-of-Pocket Payment for Pharmaceuticals in Category C (1992 - present)
- Table 9: Copayment and coinsurance rates for pharmaceuticals dispensed by public pharmacy (effective from April 1, 2010)
- Table 16: Coinsurance rates for pharmaceuticals dispensed by hospitals (effective from April 1, 2010)

Dental Care

Effective January 1, 2016, the oral care pathway (trajet de soins buccaux) requires a person to visit dentists regularly (i.e., at least one reimbursed visit during the previous calendar year) to receive normal reimbursement amounts during the current year. Failure to do so will lead to a reduced reimbursement rate for certain dental services:

- Fillings, root treatments, extractions, emergency supplements and prosthetic services: The reimbursement amount is reduced by 1/2
- X-rays and other additional services: The reimbursement amount is reduced by 1/3

- Removable prostheses and oral implants: The reimbursement amount is reduced by 40.50 €

Additionally, the insured must pay for health care that is not among the listed services in the Nomenclature. These services may be partially or fully reimbursed by the insured's complementary health insurance policy, depending on individual contract.

Long-Term Care (LTC)

For details about long-term care costs, please refer to the policy document *Belgium Long-Term Care In-Kind Benefit Plan Details, 1994-2022* (Global Aging Data, 2023).

Notes

[1] The price of clinical biology services is linked to code 592001 in the Nomenclature. Current and historical amounts are available through the NomenSoft database.

[2] The price of medical imaging is linked to code 460784 in the Nomenclature. Current and historical amounts are available through the NomenSoft database.

Tables and Formulas

Formula 1: Pensioner's Contribution (Assurance Maladie-Invalidité, AMI) to Compulsory Health Insurance and Invalidity Insurance (1992-2023)

$$AMI_{i,t} \begin{cases} C_{i,t} \times (B_{OA,i,t} - T_t^{higher}) & \text{if} \quad B_{OA,i,t} > T_t^{higher} \\ \min\{B_{OA,i,t} - T_{i,t}^{lower}, 0\} & \text{if} \quad B_{OA,i,t} \leq T_t^{higher} \end{cases}$$

- $AMI_{i,t}$ = Pensioner i's contribution (assurance maladie-invalidité, AMI) to compulsory health insurance and invalidity insurance at time t
- C_t = Contribution rate at time t, which was 2.55% and increased to 3.55% (effective October 1, 1992)
- $B_{OA,i,t}$ = Pensioner i's monthly pension benefit amount at time t
- T_t^{higher} = The higher threshold for calculating contribution amount at time t, which is 1,920.21 € in 2023
- $T_{i,t}^{lower}$ = The lower threshold for calculating contribution amount at time t, which is 1,990.87 € in 2023

Source: The National Institute for Sickness and Invalidity Insurance (2023), Moniteur Belge, 1994, as amended
Note: Historical values have not yet been identified.

Formula 2: Out-of-Pocket Payment per Service without Complementary Health Insurance (1992-2001)

$$OOP_{i,s,t} = \min\left\{ \min\{Cost_{i,s,t}, MAX_{i,s,t}^{Pharma}\} - Reimbursement_{i,s,t},\ MAX_{i,s,t}^{OOP} \right\}$$

- $OOP_{i,s,t}$ = Out-of-pocket payment of a medical service for individual i at time t if i is not insured with any complementary health insurance
- $Cost_{i,s,t}$ = The cost of the service or care that individual i receives at time t
- $MAX_{i,s,t}^{Pharma}$ = The maximum out-of-pocket payment for pharmaceuticals for individual i at time t:
  - Table 2: Maximum out-of-pocket payment for pharmaceuticals in Category B (patients with Preferential Reimbursement, 1992 - present)
  - Table 3: Maximum out-of-pocket payment for pharmaceuticals in Category B (patients without Preferential Reimbursement, 1992 - present)
  - Table 4: Maximum out-of-pocket payment for pharmaceuticals in Category C (1992 - present)

  For pharmaceuticals that do not have a maximum out-of-pocket payment and other services, $MAX_{i,s,t}^{Pharma} = +\infty$
- $Reimbursement_{i,s,t}$ = The reimbursement amount applicable to the service that individual i receives at time t, which is defined in the Nomenclature and publicly available through the NomenSoft
- $MAX_{i,s,t}^{OOP}$ = A maximum amount of out-of-pocket payment per service for individual i at time t:
  - From 1992-1993: There is no maximum out-of-pocket payment (i.e., $MAX_{i,s,t}^{OOP} = +\infty$)
  - From 1994-2001: 200 F per medical service for hospitalized patients, or 350 F per medical service for non-hospitalized patients

Source: Moniteur Belge, 1994, as amended

Table 1: Coinsurance Rates for Pharmaceuticals (Jan 1, 1992 - Mar 31, 2010)

Time Period	Category A	Category B	Category C	Category Cs	Category Cx
June, 2001 - March, 2010	0%	15% with Preferential Reimbursement; 25% otherwise	50%	60%	80%
April, 2000 - May, 2001	0%	10% with Preferential Reimbursement; 20% otherwise	50%	60%	80%
October, 1992 - March, 2000	0%	15% with Preferential Reimbursement; 25% otherwise	50%	60%	80%
January, 1992 - September, 1992	0%	15% with Preferential Reimbursement; 25% otherwise	50%	60%	75%

Source: Moniteur Belge, 1991, as amended

Note: For hospitalized patients, a flat rate of 0.62 € per day applies. This amount is independent of reimbursement category.

Table 2: Maximum Out-of-Pocket Payment for Pharmaceuticals in Category B (Patients with Preferential Reimbursement, 1992 - present)

Time Period	Normal Packaging	Large Packaging
From April, 2010	7.2 €	8.9 €
July, 2009 - March, 2010	6.2 €	7.7 €
May 1, 2008 - June, 2009	7.1 € when there are generics/ copies; 6.2 € otherwise	10.55 € when there are generics/ copies; 7.7 € otherwise
April, 2007 - April, 2008	9.3 € when there are generics/ copies; 6.2 € otherwise	13.95 € when there are generics/ copies; 7.7 € otherwise
September, 2005 - June, 2006	6.2 €	9.3 €
June, 2001 - August, 2005	6.2 € (= 250 F)	-
April, 2000 - May, 2001	210 F	-
October, 1992 - March, 2000	230 F	-
January, 1992 - September, 1992	200 F	-

Source: Moniteur Belge, 1991, as amended

Note: Effective September 1, 2005, a higher maximum out-of-pocket payment apply to large packaging medicines (i.e., with more than 60 units).

Table 3: Maximum Out-of-Pocket Payment for Pharmaceuticals in Category B (Patients without Preferential Reimbursement, 1992 - present)

Time Period	Normal Packaging	Large Packaging
From April, 2010	10.8 €	13.5 €
July, 2009 - March, 2010	9.3 €	11.65 €
May 1, 2008 - June, 2009	10.55 € when there are generics/ copies; 9.3 € otherwise	16.00 € when there are generics/ copies; 11.65 € otherwise
April, 2007 - April, 2008	13.95 € when there are generics/ copies; 9.3 € otherwise	20.90 € when there are generics/ copies; 11.65 € otherwise
September, 2005 - June, 2006	9.3 €	13.95 €
June, 2001 - August, 2005	9.3 € (= 375 F)	-
April, 2000 - May, 2001	315 F	-
October, 1992 - March, 2000	345 F	-
January, 1992 - September, 1992	300F	-

Source: Moniteur Belge, 1991, as amended

Note: Effective September 1, 2005, a higher maximum out-of-pocket payment apply to large packaging medicines (i.e., with more than 60 units).

Table 4: Maximum Out-of-Pocket Payment for Pharmaceuticals in Category C (1992 - present)

Time Period	Patients Entitled to Preferential Reimbursement	Other Patients
From April, 2010	8.9 €	13.5 €
July, 2009 - March, 2010	7.7 €	11.65 €
May, 2008 - June, 2009	10.55 € when there are generics/ copies; 7.7 € otherwise	26.00 € when there are generics/ copies; 11.65 € otherwise
April, 2007 - April, 2008	13.95 € when there are generics/ copies; 7.7 € otherwise	20.90 € when there are generics/ copies; 11.65 € otherwise
September, 2005 - June, 2006	13.95 € when there are generics/ copies; 9.3 € otherwise	23.24 € when there are generics/ copies; 15.49 € otherwise
June, 2001 - August, 2005	9.3 € (= 375 F)	15.49 € (= 625 F)
April, 2000 - May, 2001	375 F when there are generics/ copies; 315 F otherwise	625 F when there are generics/ copies; 525 F otherwise
October, 1992 - March, 2000	345 F	575 F
January, 1992 - September, 1992	300 F	500 F

Source: Moniteur Belge, 1991, as amended

Table 5: Personal Contribution to Compulsory Health Insurance for the Self-Employed (1998-2023)

Time Period	Contribution Amount
From January, 2002	508.53 €/quarter
January, 1998 - December, 2001	19,818 F/quarter

Source: Moniteur Belge (1996)

Note:

1. Effective January 1, 1998, the amount was linked to the consumer price index 123.38 on October 31, 1996. Starting January 1, 2002, the amount is linked to consumer price index 104.06 (base 1996 = 100).
2. Historical values before 1998 have not yet been identified.

Table 6: Annual Income Ceiling for Reduced Self Contribution to Compulsory Health Insurance (2002-2023)

Effective Date	Annual Income Ceiling	Extra Allowance per Dependent
January 1, 2023	42,312.15 €	4,682.19 €
December 1, 2022	42,312.15	4,561.31
November 1, 2022	41,482.80	4,471.78
August 1, 2022	40,668.62	4,383.98
May 1, 2022	39,872.14	4,298.25
March 1, 2022	39,090.83	4,213.90
January 1, 2022	38,324.69	4,131.28
September 1, 2021	37,571.19	3,843.96
July 1, 2021	36,835.39	3,768.51
March 1, 2020	36,835.39	3,694.61
July 1, 2019	36,112.24	3,622.24
September 1, 2018	36,112.24	3,536.95
September 1, 2017	35,404.25	3,467.55
June 1, 2017	35,404.25	3,399.56
June 1, 2016	34,711.44	3,332.74
January 1, 2016	34,031.27	3,267.47
September 1, 2015	34,031.27	3,225.83
July 1, 2015	34,031.27	3,203.40
September 1, 2013	33,363.74	3,140.77
December 1, 2012	33,363.74	3,079.19
February 1, 2012	32,708.86	3,018.74
May 1, 2011	32,066.61	2,901.44
September 1, 2010	31,437.01	2,844.47
January 1, 2010	30,820.06	2,788.65
June 1, 2009	30,820.06	2,756.15
September 1, 2008	30,820.06	2,707.42
May 1, 2008	30,215.74	2,654.33
January 1, 2008	29,624.07	2,602.36
September 1, 2007	29,042.51	2,518.75
October 1, 2006	29,042.51	2,501.25
August 1, 2005	28,473.60	2,452.25
October 1, 2004	27,914.79	2,404.13
June 1, 2003	27,368.64	2,357.09
February 1, 2002	26,832.59	2,310.92
January 1, 2002	26,306.66	2,265.63

Source: The National Institute for Sickness and Invalidity Insurance (2023)

Table 7: Income Threshold of Earnings from Current Year

Effective Date	Family of one person	Increase per additional person in the family
January 1, 2023	25,291.73 €/year	4,682.19 €/year
December 1, 2022	24,638.79	4,561.31
November 1, 2022	24,155.16	4,471.78
August 1, 2022	23,680.87	4,383.98
May 1, 2022	23,217.78	4,298.25
March 1, 2022	22,762.17	4,213.90
January 1, 2022	22,315.89	4,131.28
September 1, 2021	20,763.88	3,843.96
July 1, 2021	20,356.30	3,768.51
March 1, 2021	19,957.16	3,694.61
July 1, 2019	19,566.25	3,622.24
September 1, 2018	19,105.58	3,536.95
September 1, 2017	18,730.66	3,467.55
June 1, 2017	18,363.39	3,399.56
June 1, 2016	18,002.48	3,332.74
January 1, 2016	17,649.88	3,267.47
September 1, 2015	17,424.93	3,225.83
July 1, 2015	17,303.80	3,203.40
September 1, 2013	16,965.47	3,140.77
December 1, 2012	16,632.81	3,079.19
February 1, 2012	16,306.33	3,018.74
January 1, 2012	15,986.16	2,959.47
September 1, 2011	15,782.42	2,921.74
May 1, 2011	15,672.71	2,901.44
September 1, 2010	15,364.99	2,844.47
January 1, 2010	15,063.45	2,788.65
June 1, 2009	14,887.95	2,756.15
September 1, 2008	14,624.70	2,707.42
May 1, 2008	14,337.94	2,654.33
January 1, 2008	14,057.18	2,602.36
September 1, 2007	13,606.77	2,518.97
October 1, 2006	13,512.18	2,501.47
August 1, 2005	13,246.34	2,452.25
October 1, 2004	12,986.37	2,404.13
June 1, 2003	12,732.29	2,357.09
February 1, 2002	12,482.92	2,310.92
January 1, 2002	12,238.25	2,265.63

Source: The National Institute for Sickness and Invalidity Insurance (2023)
Note: Historical values before 2002 have not yet been identified.

Table 8: Copayment for Visit to GPs (effective May 1, 2013)

Type of Patient	Copayment Amount
Patients with Preferential Reimbursement and Global Medical Record	1.00 €
Patients with Preferential Reimbursement	1.50
Patients without Preferential Reimbursement but with Global Medical Record	4.00
Patients without Preferential Reimbursement or Global Medical Record	6.00

Source: Moniteur Belge, 1994, as amended

Table 9: Copayment and Coinsurance Rates for Pharmaceuticals Dispensed by Public Pharmacy (effective from April 1, 2010)

Reimbursement Category	Price < 14.38 €	Price ≥14.38 €
Category A/Fa	0%	0%
Category B/Fb	26.52% with Preferential Reimbursement; 44.20% otherwise	1.50 € + 16% with Preferential Reimbursement; 2.50 € + 27% otherwise
Category C	88.39%	5.00 € + 54%
Category Cs	106.07%	6.00 € + 65%
Category Cx	141.43%	8.00 € + 86%

Source: Moniteur Belge, 1991, as amended

Note:

1. These amounts also apply to patients residing in a nursing home
2. For hospitalized patients, a flat rate of 0.62 € per day applies. This amount is independent of reimbursement category.

Box 1: Eligibility Requirements for Preferential Reimbursement

Patients are granted the Preferential Reimbursement Rate if they satisfy one of the following conditions:

- Their current year's household income does not exceed an annual ceiling —see Table 7 for values over time, and they satisfy the following conditions:
  - They are receiving a disability pension
  - They have disabilities
  - They are unemployed for at least 3 months
  - They are self-employed and they have been receiving the right-bridging benefit for at least a quarter
  - They are single parents
  - They are recognized by the proactive flow
- They do not satisfy any of the aforementioned conditions but their previous year's income does not exceed an annual ceiling —see Table 10 for values over time

The income taken into account is the gross taxable income (i.e., before any deduction, reduction, exemption), including:

- Professional income
- Property income
- Capital income
- Cadastral Income with certain amounts exempted —see Table 11 for values over time

Source: The National Institute for Sickness and Invalidity Insurance (2023), Moniteur Belge, 1994, as amended

Table 10: Income Threshold of Earnings from Last Year (2008-2023)

Year	Family of one person	Increase per additional person in the family
2023	23,303.84 €	4,314.18 €
2022	20,292.59	3,756.71
2021	19,892.01	3,682.55
2020	19,335.92	3,579.60
2019	18,855.63	3,490.68
2018	18,335.43	3,394.38
2017	17,855.56	3,305.54
2016	17,175.01	3,179.56
2015	16,965.47	3,140.77
2014	16,743.70	3,099.72
2013	16,306.86	3,018.84
2012	15,606.71	2,889.22
2011	15,163.96	2,807.26
2010	14,778.26	2,735.85
2009	14,339.94	2,654.70
2008	13,543.71	2,507.30

Source: The National Institute for Sickness and Invalidity Insurance (2023)
Note: Historical values before 2008 have not yet been identified.

Table 11: Amounts Exempted from Cadastral Income (2013-2022)

Year	Family of one person	Increase per additional person in the family
2022	1,419.00 €	237.00 €
2021	1,385.00	231.00
2020	1,375.00	229.00
2019	1,356.00	226.00
2018	1,328.00	221.00
2017	1,301.00	217.00
2016	1,276.00	213.00
2015	1,268.00	211.00
2014	1,264.00	211.00
2013	1,250.00	208.00

Source: The National Institute for Sickness and Invalidity Insurance (2023)
Note: Historical values before 2013 have not yet been identified.

Formula 3: Out-of-Pocket Payment per Year without Complementary Health Insurance (2002-present)

$$OOP_{i,t} = \min\left\{Copayment_{i,t} + \min\{Cost_{i,t}, MAX_{i,t}^{Pharma}\} - Reimbursement_{i,t},\ MAX_{i,t}^{OOP}\right\}$$

- $OOP_{i,t}$ = Out-of-pocket payment that individual i needs to pay at time t for services received in a year if i is not insured with any complementary health insurance
- $Copayment_{i,t}$ = Total copayment that individual i needs to pay at time t for services received in a year, which applies to GP consultations and pharmaceuticals:
  - Table 8: Copayment amounts for visit to GPs for different types of patients (effective from May 1, 2013). There is no copayment for GP consultations before May 1, 2013 (i.e., $Copayment_{i,t} = 0$)
  - Table 9: Copayment for pharmaceuticals dispensed by public pharmacy (effective from April 1, 2010). There is no copayment for pharmaceuticals before April 1, 2010 (i.e., $Copayment_{i,t} = 0$)
- $Cost_{i,t}$ = The total cost that individual i needs to pay at time t for services received in a year
- $MAX_{i,t}^{Pharma}$ = The maximum out-of-pocket payment that individual i needs to pay at time t for pharmaceuticals prescribed in a year:
  - Table 2: Maximum out-of-pocket payment for pharmaceuticals in Category B (patients with Preferential Reimbursement, 1992 - present)
  - Table 3: Maximum out-of-pocket payment for pharmaceuticals in Category B (patients without Preferential Reimbursement, 1992 - present)
  - Table 4: Maximum out-of-pocket payment for pharmaceuticals in Category C (1992 - present)

  For pharmaceuticals that do not have a maximum out-of-pocket payment and other services, $MAX_{i,t}^{Pharma} = +\infty$
- $Reimbursement_{i,t}$ = The total reimbursement amount applicable to services that individual i receives in a year at time t, which is defined in the Nomenclature and publicly available through the NomenSoft
- $MAX_{i,t}^{OOP}$ = A maximum amount of out-of-pocket payment that individual i needs to pay at time t for services received in a year. A household's out-of-pocket payment in a year is capped by a maximum amount (maximum à facturer, MàF). The MàF amount varies by household income, patient category, and whether they have long-term illnesses:
  - MàF income: A general out-of-pocket payment maximum that applies to all patients, which varies by household net income —
    - Table 12: General maximum out-of-pocket payment (2002-2004)
    - Table 13: General maximum out-of-pocket payment (2005-2021)
    - Table 14: General maximum out-of-pocket payment (2022-present)
    - Table 15: General maximum out-of-pocket payment (indexed values as of 2023)
  - MàF social: An out-of-pocket payment maximum that applies to patients eligible for the Preferential Reimbursement, which is a fixed at 450 € (indexed to 506.79 € as of 2023)
  - MàF for children under age 19: An out-of-pocket payment maximum that applies to children under age 19, which is a fixed at 650 € effective January 1, 2004 (indexed to 732.03 € as of 2023)
  - MàF for people with long-term illnesses: An out-of-pocket payment maximum that applies to households that have patients with long-term illnesses, whose amount is any type of MàF reduced by 100 € (indexed to 112.62 € as of 2023)

Source: The National Institute for Sickness and Invalidity Insurance (2023), Moniteur Belge, 1994, as amended

Table 12: General Maximum Out-of-Pocket Payment (2002-2004)

Income Range	Maximum Out-of-Pocket Payment
≤13,400.00 €	450.00 €/year
≤20,600.00 €	650.00

Source: Moniteur Belge, 1994, as amended

Note: Effective January 1, 2004, a maximum out-of-pocket payment of 650 € applies to children under age 19, regardless of their household's income.

Table 13: General Maximum Out-of-Pocket Payment (2005-2021)

Income Range	Maximum Out-of-Pocket Payment
≤13,400.00 €	450.00 €/year
≤20,600.00 €	650.00
≤27,800.00 €	1,000.00
≤34,700.00 €	1,400.00
≥34,700.01 €	1,800.00

Source: Moniteur Belge, 1994, as amended
Note: Effective January 1, 2016, the amounts are linked to the pivot index 101.02 (base 2013 = 100) and varies in accordance with the provisions of the Law of August 2, 1971, as amended.

Table 14: General Maximum Out-of-Pocket Payment (2022-present)

Income Range	Maximum Out-of-Pocket Payment
≤11,120.00 €	250.00 €/year
≤13,400.00 €	450.00
≤20,600.00 €	650.00
≤27,800.00 €	1,000.00
≤34,700.00 €	1,400.00
≥34,700.01 €	1,800.00

Source: Moniteur Belge, 1994, as amended
Note: Effective January 1, 2016, the amounts are linked to the pivot index 101.02 (base 2013 = 100) and varies in accordance with the provisions of the Law of August 2, as amended. The amount 250.00 € is linked from January 1, 2023.

Table 15: General Maximum Out-of-Pocket Payment (values indexed as of 2023)

Income Range	Maximum Out-of-Pocket Payment
≤12,186.41 €	250.00 €/year
≤21,801.89 €	506.79
≤33,516,33 €	732.03
≤45,230.81 €	1,126.20
≤56,457.17 €	1,576.68
≥56,457.18 €	2,027.16

Source: The National Institute for Sickness and Invalidity Insurance (2023)
Note: For historical figures, see https://www.inami.fgov.be/fr/themes/cout-remboursement/facilite-financiere/Pages/types-maximum-facturer-(MAF)-.aspx.

Table 16: Coinsurance Rates for Pharmaceuticals Dispensed in Hospital (effective from April 1, 2010)

Reimbursement Category	Coinsurance Rate
Category A/Fa	0%
Category B/Fb	15% with Preferential Reimbursement; 25% otherwise
Category C	50%
Category Cs	60%
Category Cx	80%

Source: Moniteur Belge, 1991, as amended
Note: For hospitalized patients, a flat rate of 0.62 € per day applies. This amount is independent of reimbursement category.

Sources

This section records key sources consulted when we collected the institutional details reported in this document. Archived versions of these sources are available at the Gateway Policy Explorer website (http://g2aging.org/policy-explorer).

Belgian Statistical Office (2023). Available in English, French, and Dutch only. As of June 23, 2023. [Link]

Gateway to Global Aging Data (2023b). Gateway Policy Explorer: Belgium, Long-Term Care In-Kind Benefits Plan Details, 1994-2022, Version: 1.0 (June 2023), University of Southern California, Los Angeles. [Link]

Federal Pension Service (2022). Available in French, and Dutch only. As of October 4, 2022. [Link]

Institut national d'assurance maladie-invalidité [National Institute for Health and Disability Insurance] (2023). Available in French, and Dutch only. As of April 5, 2023. [Link]

Institut national d'assurance maladie-invalidité, Spécialités pharmaceutiques remboursables : listes et fichiers de référence [National Institute for Health and Disability Insurance, Reimbursable pharmaceutical specialties: lists and reference files] (2023). Available in French, and Dutch only. As of April 5, 2023. [Link]

Moniteur Belge (1963). Loi instituant et organisant un régime d'assurance obligatoire soins de santé et indemnités. [Law instituting and organizing a compulsory health care and compensation insurance scheme.], Belgian Official Gazette of November 1, 1963. Available in French and Dutch only. As of March 3, 2023. [Link]

Moniteur Belge (1967). Arrêté royal n° 50 relatif à la pension de retraite et de survie des travailleurs salariés. [Royal Decree n°50 on the retirement and survivor's pension for employees.], Belgian Official Gazette of October 24,1967. Available in French and Dutch only. As of September 20, 2022. [Link]

Moniteur Belge (1967). Arrêté royal portant règlement général du régime de pension de retraite et de survie des travailleurs salariés. [Royal Decree establishing the general regulations on the retirement and survivor's pension for employees.], Belgian Official Gazette of December 21, 1967. Available in French and Dutch only. As of September 20, 2022. [Link]

Moniteur Belge (1971). Loi organisant un régime de liaison à l'indice des prix à la consommation des traitements, salaires, pensions, allocations et subventions à charge du trésor public, de certaines prestations sociales, des limites de rémunération à prendre en considération pour le calcul de certaines cotisations de sécurité sociale des travailleurs, ainsi que des obligations imposées en matière sociale aux travailleurs indépendants. (Cette loi cesse d'être applicable aux dépenses , réglées par la loi du 1er mars 1977. [Law organizing a system linked to the consumer price index for salaries, wages, pensions, allowances and subsidies payable by the public treasury, certain social benefits, remuneration limits to be taken into consideration for the calculation of certain social security contributions for workers, as well as obligations imposed in social matters on self-employed workers. (This law ceases to be applicable to expenses, regulated by the law of March 1, 1977.], Belgian Official Gazette of August 30, 1971. Available in French and Dutch only. As of March 9, 2023. [Link]

Moniteur Belge (1974). Loi instituant le droit à un minimum de moyens d'existence. [Law establishing the right to a minimum means of subsistence.], Belgian Official Gazette of September 18, 1974. Available in French and Dutch only. As of January 9, 2023. [Link]

Moniteur Belge (1981). Loi établissant les principes généraux de la sécurité sociale des travailleurs salariés. [Law establishing the general principles of social security for salaried workers.], Belgian Official Gazette of July 2, 1981. Available in French and Dutch only. As of February 7, 2023. [Link]

Moniteur Belge (1984). Arrêté royal établissant la nomenclature des prestations de santé en matière d'assurance obligatoire soins de santé et indemnités. [Royal Decree establishing the nomenclature of health benefits in terms of compulsory health care insurance and allowances.], Belgian Official Gazette of September 29, 1984. Available in French and Dutch only. As of April 5, 2023. [Link]

Moniteur Belge (1987). Loi sur les hôpitaux, coordonnée le 7 août 1987. [Law on hospitals, coordinated on August 7 , 1987.], Belgian Official Gazette of October 7, 1987. Available in French and Dutch only. As of April 5, 2023. [Link]

Moniteur Belge (1991). Arrêté royal fixant l'intervention personnelle des bénéficiaires dans le coût des fournitures pharmaceutiques remboursables dans le cadre de l'assurance obligatoire soins de santé et indemnités. [Royal Decree establishing the personal contribution of beneficiaries to the cost of pharmaceutical supplies reimbursable under compulsory health care and compensation insurance.], Belgian Official Gazette of July 10, 1991. Available in French and Dutch only. As of March 28, 2023. [Link]

Moniteur Belge (1992). Loi portant des dispositions sociales et diverses. [Law on social and miscellaneous provisions.], Belgian Official Gazette of June 30, 1992. Available in French and Dutch only. As of April 5, 2023. [Link]

Moniteur Belge (1994). Loi relative à l'assurance obligatoire soins de santé et indemnités coordonnée le 14 juillet 1994. [Law relating to compulsory health care and compensation insurance coordinated on July 14, 1994.], Belgian Official Gazette of August 27, 1994. Available in French and Dutch only. As of February 27, 2023. [Link]

Moniteur Belge (1996). Arrêté royal portant exécution de la loi relative à l'assurance obligatoire soins de santé et indemnités, coordonnée le 14 juillet 1994. [Royal Decree implementing the law relating to compulsory health care and compensation insurance, coordinated on July 14, 1994.], Belgian Official Gazette of July 31, 1996. Available in French and Dutch only. As of June 6, 2023. [Link]

Moniteur Belge (1997). Arrêté royal portant des mesures visant à étendre le droit à une intervention majorée de l'assurance soins de santé à d'autres catégories d'ayants droit, en application des articles 11, 1° et 49, de la loi du 26 juillet 1996 portant modernisation de la sécurité sociale et assurant la viabilité des régimes légaux des pensions. [Royal Decree on measures aimed at extending the right to increased compensation for health care insurance to other categories of beneficiaries, pursuant to Articles 11, 1° and 49, of the law of 26 July 1996 modernizing social security and ensuring the viability of legal pension schemes.], Belgian Official Gazette of April 30, 1997. Available in French and Dutch only. As of April 5, 2023. [Link]

Moniteur Belge (1997). Arrêté royal portant des mesures visant à généraliser et assouplir l'accès au régime de l'assurance soins de santé en particulier pour les groupes socio-économiques défavorisés, en exécution des articles 11, 2°, 41 et 49 de la loi du 26 juillet 1996 portant modernisation de la sécurité sociale et assurant la viabilité des régimes légaux des pensions. [Royal Decree on measures aimed at generalizing and making more flexible access to the health care insurance scheme, in particular for disadvantaged socio-economic groups, in execution of Articles 11, 2°, 41 and 49 of the law of 26 July 1996 modernizing social security and ensuring the viability of legal pension schemes.], Belgian Official Gazette of June 19, 1997. Available in French and Dutch only. As of March 3, 2023. [Link]

Moniteur Belge (1998). Loi portant des dispositions sociales. [Law on social provisions.], Belgian Official Gazette of March 3, 1998. Available in French and Dutch only. As of April 5, 2023. [Link]

Moniteur Belge (1999). Loi portant des dispositions sociales. [Law on social provisions.], Belgian Official Gazette of February 6, 1999. Available in French and Dutch only. As of April 5, 2023. [Link]

Moniteur Belge (2001). Arrêté royal modifiant l'arrêté royal du 14 septembre 1984 établissant la nomenclature des prestations de santé en matière d'assurance obligatoire soins de santé et indemnités. [Royal decree modifying the royal decree of September 14, 1984 establishing the nomenclature of health benefits with regard to compulsory health care insurance and allowances.], Belgian Official Gazette of July 31, 2001. Available in French and Dutch only. As of April 5, 2023. [Link]

Moniteur Belge (2002). Loi relative au maximum à facturer dans l'assurance soins de santé. [Law relating to the maximum to be invoiced in health care insurance.], Belgian Official Gazette of July 4, 2002. Available in French and Dutch only. As of April 5, 2023. [Link]

Moniteur Belge (2005). Arrêté royal modifiant l'arrêté royal du 7 mai 1991 fixant l'intervention personnelle des bénéficiaires dans le coût des fournitures pharmaceutiques remboursables dans le cadre de l'assurance obligatoire soins de santé et indemnités. [Royal decree amending the royal decree of 7 May 1991 establishing the personal contribution of beneficiaries to the cost of pharmaceutical supplies reimbursable under compulsory health care and allowances insurance.], Belgian Official Gazette of September 22, 2005. Available in French and Dutch only. As of April 5, 2023. [Link]

Moniteur Belge (2010). Arrêté royal modifiant l'article 37bis de la loi relative à l'assurance obligatoire soins de santé et indemnités, coordonnée le 14 juillet 1994. [Royal decree amending article 37bis of the law relating to compulsory health care and compensation insurance, coordinated on 14 July 1994.], Belgian Official Gazette of September 24, 2010. Available in French and Dutch only. As of April 5, 2023. [Link]

Moniteur Belge (2011). Arrêté royal modifiant l'article 37bis de la loi relative à l'assurance obligatoire soins de santé et indemnités, coordonnée le 14 juillet 1994. [Royal decree amending article 37bis of the law relating to compulsory health care and compensation insurance, coordinated on 14 July 1994.], Belgian Official Gazette of October 18, 2011. Available in French and Dutch only. As of April 5, 2023. [Link]

Moniteur Belge (2012). Arrêté royal modifiant l'arrêté royal 7 mai 1991 fixant l'intervention personnelle des bénéficiaires dans le coût des fournitures pharmaceutiques remboursables dans le cadre de l'assurance obligatoire soins de santé et indemnités. [Royal decree amending the royal decree of 7 May 1991 establishing the personal contribution of beneficiaries to the cost of pharmaceutical

supplies reimbursable under the compulsory health care and allowances insurance.], Belgian Official Gazette of March 19, 2012. Available in French and Dutch only. As of April 5, 2023. [Link]

Moniteur Belge (2014). Accord National Dento-Mutualiste. [National Dental-Mutualist Agreement], Belgian Official Gazette of January 20, 2015. Available in French and Dutch only. As of April 5, 2023. [Link]

Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Auxiliary Health and Disability Insurance Fund (Caisse Auxiliaire d'Assurance Maladie-Invalidité, CAAMI): A public social security institution as a health insurance fund. A person can join CAAMI without paying contributions.

Cadastral income: Cadastral income is the average normal net income that the property provides its owner in a year. It is the net average rental value in a year for the property at the reference date. This reference date has hitherto been January 1, 1975.

Claimable benefit: A benefit where the beneficiary must actively file a claim for benefits with the government's administering authority.

Coinsurance: A fixed proportion of the total cost of medical item or service.

Complementary health insurance: Supplementary insurance that can be purchased independent of the Federal Compulsory Health Insurance. It is a complementary health insurance scheme taken out by individuals to supplement the compulsory health insurance coverage and pay for out-of-pocket costs.

Compulsory Health Insurance (Assurance Obligatoire): The Belgian public health care system provides universal health care largely financed by taxes and social security contributions to all Belgian citizens and some non-citizens residing in Belgium through compulsory health insurance. Compulsory insurance reimburses a wide range of services, and people may take out complementary health insurance to cover out-of-pocket payments.

Copayment: A fixed fee (flat-rate) per medical item or service.

European Community (EC): An economic association formed by six European member countries in 1957, consisting of three communities that eventually were replaced by the European Union (EU) in 1993.

European Economic Community (EEC): A regional organization created by the Treaty of Rome of 1957, aiming to foster economic integration among its member states, which was later renamed the European Community (EC).

European Union (EU): European Union, an international organization comprising 27 European countries and governing common economic, social, and security policies.

Global Medical Record (Dossier Médical Global): The Global Medical Record was introduced in 2001 for better management of personal medical data (e.g., operations, chronic illnesses, current treatments, etc.). Patients who opt-in with GMR allow one single General Practitioner to manage their medical record, and have lower copayments for consultations.

Guaranteed Minimum Income for the Elderly (La Garantie de Revenus aux Personnes Âgées, GRAPA): A minimum level of income provided to the elderly if they satisfy certain age, citizenship and residency conditions.

National Institute for Health and Disability Insurance (Institut national d'assurance maladie-invalidité, INAMI): This organization is responsible for the general organisation and financial management of compulsory health insurance, and monitors all aspects of medical services.

Nomenclature (Nomenclature des Prestations de Santé): A nationally established fee schedule. It specifies the official fees, copayment and coinsurance rates for all services eligible for partial or full reimbursement. Conventioned practitioners fully adhere to the Nomenclature while partially conventioned or non-conventioned practitioners may charge extra.

NomenSoft: NomenSoft is a database and a search engine for the Nomenclature. It links each reimbursable health care service to its detailed description to its official fee through a unique code.

Preferential Reimbursement (Intervention Majorée): This classification provides certain categories of people with higher reimbursement by the compulsory health insurance.

Proactive flow (Flux Proactif): An exchange of data between administrations aimed at identifying the households that could potentially benefit from the Preferential Reimbursement. When a person is identified in this context, their health insurance fund informs them.

Public Center for Social Welfare (Centre public d'action sociale, CPAS): This organization administers the Integration Income (previously the Subsistence Minimum).

Qualified benefit: A benefit is qualified if an individual must continue to meet certain standards, such as a means test, to continue receipt of benefits.

Right-Bridging Benefit (Droit Passerelle): The right-bridging benefit is a financial benefit that a self-employed worker can receive for a maximum of twelve months. It is granted in certain situations of interruption or cessation of self-employed activity. It consists of a cash benefit and allows the continuation in terms of health care and allowances for incapacity for work, invalidity and maternity without having to pay social security contributions.

Subsistence Minimum (Minimum de Moyens d'Existence) or Integration Income (Revenu d'Intégration): A social assistance benefit provided to people with limited resources, which is not targeted at older people and was replaced by the Integration Income on October 1, 2002.

Version information

Current Version: 1.0 (August 2023)

Version History

- 1.0 (August 2023): First version

Additional resources

The following resources provide additional details for the interested reader:

European Commission, Employment, Social Affairs and Inclusion, Belgium - Health care.
Available at: https://ec.europa.eu/social/main.jsp?catId=1102&langId=en&intPageId=4416
Features: Provides summary and details of health care in Belgium.

Belgium: Health System Review Summary.
Available at: https://eurohealthobservatory.who.int/publications/i/belgium-health-system-summary
Features: Provides summary and details of current version of the Belgium health care system.