



**World Health
Organization**

A low-angle photograph of the Atomium structure in Brussels, Belgium, showing several of its iconic spherical nodes connected by white tubes against a clear blue sky. The spheres are highly reflective, mirroring the surrounding environment.

Country Cooperation Strategy

**WHO - BELGIUM
2016-2022**

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Introduction

It is the first time that Belgium and the World Health Organization (WHO) sign a Country Cooperation Strategy (CCS). The CCS is a medium-term strategic framework for cooperation among both partners and outlines a shared agenda with priority areas of work for six years.

The CCS will guide WHO in its work with Belgium in line with WHO's global health priorities, core functions and comparative advantages. The formulation of a strategic agenda ensures that the main priorities continue to be addressed irrespective of changes of government and ministry officials and ensures continuity in the programme of technical assistance delivered by the Organization. Furthermore, this CCS highlights Belgium's contribution to the global health agenda in general and to WHO in specific.

In the past, Belgium has had a relationship with WHO through Biennial Collaborative Agreements (BCAs), which mainly focused on the contributions of Belgium to WHO. This is the first time that the two parties also define a strategic agenda for joint work. This CCS covers the period from 2016 to 2022.

The CCS for Belgium was elaborated over a number of months. The process involved internal and external consultations and provided an opportunity for Belgium to evaluate the aims, objectives, targets and priorities in its various active policies, strategies and action plans. It provided an opportunity to ensure that actions taken are in line with the principles enunciated in the following WHO framework documents:

- The 2030 Agenda for Sustainable Development¹
- The WHO Twelfth General Programme of Work 2014 - 2019 which provides the high level strategic vision for the work of WHO
- The WHO Regional Office for Europe Health 2020 – European policy framework and strategy for the 21st century

The CCS is structured around 5 chapters: After the introduction, chapter 2 makes an assessment of the public health status and health system in Belgium, while chapter 3 describes the development cooperation and contribution of Belgium to global health, as well as the collaboration between Belgium and WHO in the past years. Chapter 4 outlines the strategic agenda for cooperation between Belgium and WHO, and provides details on the areas of collaboration between both partners. Finally, chapter 6 describes the monitoring and evaluation process for the implementation of the strategy.

1. Both Belgium and WHO have the intention to use the CCS as a contributing element when implementing the Sustainable Development Goals (SDGs), which were adopted by the United Nations General Assembly in September 2015. This CCS already indicates linkages between the priorities defined in the CCS and the SDGs.

This chapter presents an overview of Belgium's health situation. After a brief introduction about Belgium's socio-economic and institutional context, the chapter analyses the health system and health status of its population. Subsequently, the country's health system's outcomes, main challenges and government's response to these are described.

2.1. Belgium's socio-economic and institutional context

The population in Belgium has steadily increased over the past decades, from 10 million inhabitants in 1991 to about 11 million (11.150.516 inhabitants) on 1 January 2014. Forecasts predict a population of 13,5 million inhabitants by 2060. This population is also an ageing population: while in 2012 the group aged 65+ compared to the group aged 15-64 was 26,6%, it is predicted that this ratio will evolve to 44,4% by 2060 (FOD Economie, 2014a, 2014b).

Belgium is a constitutional monarchy with a parliamentary system of governance and a federal state which is divided into a federal governing level, three regions and three communities. The three regions are the Flemish region, the Walloon region and the region of Brussels-Capital. The three communities are the Flemish community, the French community and the German community. Responsibilities are divided between the national level, the communities and the regions. Largely, the federal state is responsible for foreign affairs, defence, justice, fiscal policy, domestic affairs, social security, and a share of public health. The regions are responsible for territorial matters, such as policy on the economy, energy, agriculture, and environment. The three communities are responsible for so-called person-related matters, such as education, cultural affairs, language, and health and welfare, insofar as they are not part of the social security system. The Belgian federated entities also have responsibilities for international aspects related to their competences (Belgium Federal Portal, 2016).

Belgium has an open market and mainly service-oriented economy (about 70% of the GDP) (FOD Economie, 2014). The capital of Belgium, Brussels, hosts numerous headquarters of international organizations, including the EU and the NATO, and several multinational corporations. Belgium also has a considerable pharmaceutical industry, as for example Belgian export of pharmaceuticals is 15% of the total European export of pharmaceuticals. The GDP per capita in Belgium is slightly above 36.000 Euros in 2014, which is higher than the EU average (Eurostat, 2014). The unemployment rate has been slowly increasing since 2011 and was around 8.6% in 2014. However, rates vary across socio-economic groups with more vulnerable populations, including settled migrants, having higher unemployment rates of 19% national average. In Brussels, 51% of the total unemployed are settled migrants (OECD, 2015b).

In line with many other EU member countries, Belgium has experienced major changes in the labor market with an increase in the percentage of workers on temporary and part time contracts. Young workers aged 18-24 years have higher exposure to precarious employment conditions including temporary contracts, no contracts and frequent periods of unemployment. Women represent more than 60% of all workers in nonstandard employment in Belgium (OECD, 2015b).

2.2. The health system

Organization and governance

Health policy is a shared responsibility of the federal and federated authorities in Belgium. The federal authorities are responsible for the regulation and financing of the compulsory health insurance, the financing of hospital budgets, the legislation covering professional qualifications, and the registration and price control of pharmaceuticals. The federated entities are responsible for the financing of health infrastructure and medico-technical services, the definition of recognition norms for hospitals, health promotion and prevention, health workforce planning, maternity and child health care, social services, coordination in primary care, elderly care, mental health care, and long-term care (OBS-HSPM, 2016).

Since governing the health system and health policies requires a tight collaboration between the federal and the regional health ministers, the Interministerial Conference for Health meets on a regular basis to discuss and agree on issues with shared competences.

Financing

In 2013, Belgium's total health expenditure was 10.2% of the GDP, which is 6th highest among the EU-15 (OECD, 2015). Health care services are mainly financed through a broad and mandatory social insurance system. The health insurance budget is distributed among (non-profit) sickness funds which reimburse the health care costs of their members. The reimbursed tariffs are negotiated among the sickness insurance funds and the physician representatives under the supervision of the federal government. For people in a vulnerable socio-economic situation as well as for patients with chronic diseases, measures are taken to ensure their access to high-quality care like the system of the 'maximum bill', which limits the amount of co-payments to a pre-specified threshold (OBS-HSPM, 2016).

Physicians are generally paid on a fee-for-service basis, while hospitals are partially financed by the federal government through accommodation costs, mainly based on the justified bed occupancy rate of each hospital, and partially through contributions from medical specialists working in the hospital. Prevention is mainly financed by the federated entities.

Service delivery

Belgium has a liberal system of service provision with a large therapeutic freedom for physicians and freedom of choice for patients. Physicians are mainly independent (self-employed) and are remunerated based on fee-for-service payments. Hospital care is provided by either private non-profit-making or public hospitals (OBS-HSPM, 2016).

The acute health care sector in Belgium is well developed, both in primary and hospital care settings. For example, compared to the EU-15, Belgium is ranked 4th for its number of hospital beds (6,3 beds/1000 inhabitants), and 2nd for its number of doctor consultations (7,4 consultations per capita) (OECD, 2015). Com-

pared to the acute care services, preventive services are less well-established in Belgium. For example, the coverage of breast cancer screening for women aged 50-69 years within the last 2 years is only at 63%, which is a bit below the EU-15 average (64.3%) and considerably below the WHO target of 75% (KCE, 2016).

The focus on acute care is challenged due to the increasing number of patients with chronic diseases, and need for integrated care services. The Belgian health ministers initiated a common reflection in 2012 on the organization of integrated care services, which will result in a reorientation of the health system (KCE, 2012, Federal coalition agreement, 2014). In the area of mental health services, there is a shift from residential-based towards community-based care services. To this end, several innovative services were developed and/or strengthened, such as home support for the elderly to allow them to live longer in their homes (OBS-HSPM, 2016).

Physical and human resources

The number of health care professionals has been relatively stable since 2000, mainly by planning and limiting the number of students admitted to the education curriculum. In 2012, Belgium had 2,9 practicing physicians per 1000 inhabitants. The number of practicing nurses is estimated at 9,9 per 1000 inhabitants. The average age of GPs in Belgium in 2000 was 46.6 years and increased rapidly to 52.8 years in 2013. Furthermore, only 28 % of the medical graduates become GPs while the recommended share according to the planning commission, should be around 40%, which might create a shortage of GPs in the (near) future (KCE, 2016). Noteworthy is that the number of foreign physicians licensed to practice in Belgium has sharply increased since 2004: new visas granted to foreign medical doctors rose from 78 before 2004 to 430 in 2008. A similar trend is observed for nurses (OBS-HSPM, 2016).

Information

In the past years, Belgium has made improvements in the field of health information, partially due to the development of a Belgian eHealth platform and a regular evaluation of the performance of the Belgian health system. However while many health data are being collected and published in Belgium, some data are collected but are not used (e.g. morbidity indicators), while for other areas such as nursing, primary care, psychiatry, elderly and nursing homes, and non-reimbursed payments only limited data are available. In addition, the coordination to integrate the data available for policy decision should be strengthened (KCE, 2016).

Medical products

Pharmaceuticals are provided through community and hospital pharmacies, and about 2500 pharmaceutical products are partly or fully reimbursable. Recently, important efforts have been made to control pharmaceutical expenditures while at the same time guaranteeing an equitable accessibility and rewarding innovation (OBS-HSPM, 2016).

The usage of pharmaceuticals in Belgium is generally high and this is not without risks, especially regarding the increasing resistance to antibiotics. For example, the use of antibiotics (total daily dose/1000 population per day) is at 28.7, while the EU-15 average is at 21.8. Outpatient antibiotic consumption, expressed in number of packages, has declined by more than 36% compared to the period 1999-2000 but remains high compared to other European countries (e.g. 2,5 times higher than in the Netherlands). Also the antibiotic consumption in hospitals is high as it rose by 5.6% between 2007 and 2013. In addition, the use of

antibiotics in veterinary medicine is higher in Belgium than in the neighbouring countries. For example, consumption in veterinary medicine of antibiotics declined by 23.3% between 2007 and 2014, while in the Netherlands it was reduced by 58% between 2009 and 2014. Furthermore, a recent study has shown that 7.2 % of patients in acute care hospitals and 3.1% in residential care facilities had a healthcare-associated infection on the day of the survey. In 1999, Belgium created a Commission for the Coordination of Policy on Antibiotic Consumption (BAPCOC), which adopted a work plan on AMR, including both the human and veterinary aspects (BAPCOC, 2014).

2.3. Health status

Life expectancy at birth in Belgium in 2013 is 77.8 years for men, compared to an EU-15 average of 78.6, and 83.2 years for women, compared to an EU-15 average of 83.7 (KCE, 2016). In the latest Health Interview Survey (2014), 76.8% of the Belgian inhabitants report to be in good or very good health, which is above the EU-15 average. 20% of the inhabitants of 15 years and older indicate to be in bad health.

According to the most recent statistics on causes of death (2013), cardiovascular diseases (28,6%) and cancer (26,3%) are by far the most important causes of death for the Belgian population. While the share of cardiovascular diseases has decreased over the past years (36.0% in 1998), mortality from cancer has remained relatively stable (ADSEI, 2016).

Persistent health inequalities remain for overall health outcomes: people in higher socio-economic groups have almost 20 additional healthy life years compared to people belonging to the lower socio-economic groups. This is also reflected in major lifestyle differences: e.g. people in lower socio-economic groups have a 3 times higher chance to be obese, and a 2,6 times higher chance to smoke (KCE, 2016).

Non-communicable diseases (NCDs)

NCDs represent a big challenge to Belgium: more than one-fourth of the citizens of 15 years and older (28.5%) reported in 2013 to have at least one chronic condition. This prevalence also increased over the years (24.6% in 1997). Among the elderly, more than one-third of the 65+ is suffering from at least two serious chronic conditions.

Also the risk factors associated with non-communicable diseases are an issue in Belgium: Despite some gains over the last years, many risk factors are on the rise. Overweight and obesity are increasingly prevalent among both adults and children, as the average BMI in Belgium is 25,4, while 25 is regarded as the threshold for 'overweight'. Almost half of the adult population (+18 years) is overweight, from which 14% is obese. 14% of the Belgian (15 years and over) drink alcohol on a daily basis, a number that is increasing over the years (in 1997, only 8% consumed alcohol on a daily basis). The rate of daily and occasional smokers is slowly decreasing, from 30% in 1997 to 23% in 2013, and this also among adolescents (32% in 1997, compared to 22% in 2013). This decrease is higher among men than women. Further, Belgians have a sedentary lifestyle: only 36% of the population (15 years or older) has daily activity of at least 30 minutes of (at least) average physical activity. Overall, there did not seem to be a significant improvement in the last years (WIV, 2015).

Regarding mental health, figures show a clear deterioration of the psycho-emotional state of the Belgian population aged 15 year and over in the past five

years. One out of three persons (32%) aged 15 year and older said to have psychological problems which could be described as 'feeling bad'. This trend is also rising as in 2008 only one in four indicated such problems. The National Health Survey (2014) reported that emotional problems (anxiety disorders, depressed feelings and sleeping problems) increased in the past 5 years (10% anxiety disorders, 15% depressed feelings, and 30% sleeping problems), especially among adolescents and young adults (15-24 years old). 7% of the populations reported they suffered from a depression in the year prior to this survey. In the population aged 15 years and older, 20% of women reported to use psychotropic drugs, compared to 12% among men (this includes sedatives, tranquillizers and antidepressants). Especially worrying is the increasing amount of users of antidepressants in Belgium in the last 15 years: from 3.9 % in 1997 to 7.6 % in 2013 (WIV, 2015). The number of suicides, although it decreased from 2.143 in 2000 to 1.893 deaths in 2013 (ADSEI, 2016), is considerably higher compared to other countries: 18.3/100.000 in Belgium compared to 10.6 for EU-15 countries (KCE, 2016).

In the past years, both the federal and regional health ministers developed and implemented several action plans to tackle the NCD pandemic: plans were developed for obesity and physical activity in the Flemish and French community (Flemish action plan for food and physical activity and the French operational plan for health promotion), and currently the health ministers are together preparing a new National Food and Nutrition Plan (2015). Further, there are also policy initiatives on consumption of tobacco, alcohol and drugs (e.g. the Flemish action plan on tobacco, alcohol and drugs and the Walloon action plan on tobacco).

Communicable diseases

Communicable diseases are not a challenge of the past, but are returning to the health policy agenda in new forms and with new challenges.

For vaccination coverage for example, although vaccination rates of children for polio, diphtheria, tetanus, pertussis and Hepatitis B is generally high (> 90%) and meet the WHO targets (90%), some areas require continued attention: Vaccination of measles in children (%of the population receiving the 2nd dose) does not meet the target (85% in Belgium compared to a target of 95%), especially if one takes into account that the incidence of new cases (6,1/1 million) of measles, compared to the target (1/1 million). Also influenza vaccination among elderly is low (56,4% of the population aged 65+) and does not meet the WHO target of 75% (KCE, 2016).

Belgium has among the highest HIV incidence rates of the EU per 100,000 head of population: Estonia (27.3), Latvia (13.4), Belgium (10.7) and the United Kingdom (10.0) (figures from 2011). In Europe as a whole the incidence is 5.7%. Belgium has about 2.4 new cases diagnosed each day and has 14.719 HIV- infected patients medically followed up. Belgium adopted a national plan on AIDS in September 2013 with four strategic pillars: (1) prevention; (2) screening and early detection; (3) treatment of people with HIV and finally (4) quality of life of persons with HIV.

Also tuberculosis remains an important public health issue in Belgium: although incidence has been declining steadily in the last decade with 959 new cases in 2014 (mostly among people in poverty, prisoners, and migrant refugees from high incidence countries), Belgium has a higher incidence than its neighbouring countries.

Health and environment

Belgium is confronted with a high level of air pollution, mainly caused by intense traffic, which poses a serious public health risk, as air pollution is amongst others a leading environmental cause of cancer deaths. The estimated economic cost of health effects related to air pollution in Belgium are 17,7 billion euro yearly (OECD, 2015) of which at least 50% due to transport related air pollution. A 2016 report shows 12.000 premature deaths a year are caused by air pollution and Belgium ranks 2nd last on the list of air quality in Europe (Hsu, 2016). At regional level, policy plans have been developed to tackle this problem, like the Flemish regional plan on air quality and the Walloon regional plan 'Air Climate Energy'.

2.4. Belgium's preparedness for emergency response: implementation of the IHR

Health security in Belgium is shaped by the International Health Regulations (IHR) and the EU Decision 1082/2013 on serious cross-border health threats. The purpose of the IHR are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks and which avoid unnecessary interference with international traffic and trade (Art. 2 of IHR) (WHO, 2005).

To ensure health security for its citizens, Belgium promotes a cross-sectoral and coordinated approach, both internally and with external partners, drawing on independent scientific risk assessment. During the last years, various plans and procedures have been developed in order to be prepared for an emergency response. In accordance with the IHR, a Risk Management Group and Risk Assessment Group have been established to manage the medical and scientific aspects of health crises. These groups consist of representatives of federal entities, federated entities, scientific institutions and other experts. A National Focal Point, an Early Warning Response System and a Central Government Crisis-Coordinating Centre further coordinate health security in Belgium.

While the Ebola crisis and the A/H1N1 pandemic have demonstrated that Belgium is overall well prepared to respond to sudden and large health crises. Nevertheless, there is room for improvement, as for example Belgium scored rather low in its self-assessment of the implementation of the IHR for the areas of coordination, preparedness and human resources (WHO, 2015).


2.5. Assessment of the health system

The following text, describing the performance of the Belgian health system, is based on a recent official assessment of the Belgian health system (KCE, 2016). The performance of the health system is evaluated according to five dimensions: quality, accessibility, efficiency, sustainability and equity.

Quality

Quality of care is here divided into five sub-dimensions: appropriateness, patient-centeredness, continuity of care, safety and effectiveness:

Appropriateness is defined as 'the degree to which provided healthcare is relevant to the needs, given the current best evidence'. Several indicators illustrate that appropriateness of care is not optimal in Belgium and even rather bad compared to international benchmarks. One example is the high prescription rate of antibiotics.



Patient-centeredness, defined as “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that the patient’s values guide all clinical decisions”, is assessed by how patients evaluate their contacts with their general practitioner and specialist in terms of time spent with them, explanation, openness to questions and shared decision-making. Patients generally evaluate this as very positive, with satisfaction rates of 90% and more. The existing indicators show a mixed picture: within one setting, being in general practice or within hospitals, continuity of care could be better but results are improving over time. However, when looking at continuity of care between the hospital and the general practitioner, results are disappointing. One useful indicator is the number of patients having contact with a GP within one week after their hospital discharge, a practice that presents many advantages. However, this was the case for only 58% of hospitalizations in elderly patients (65+) in Belgium in 2013. This proportion has slightly decreased since 2006. To conclude, it should be noted that several issues hamper the measurement of continuity of care in the Belgian healthcare system. Better and more internationally comparable indicators are needed in this area. Also health literacy is a crucial factor to improve health and essential to have a good continuity of care, but requires attention in Belgium as a recent survey (2012) showed that more than 40% of the Belgian population has insufficient health literacy (KCE, 2016).

With regard to patient safety, a report by the Belgian Health Care Knowledge Centre (KCE, 2009) estimates that yearly 2625 people die prematurely in a Belgian hospital due to a healthcare-associated infection (HAI). KCE estimates the yearly surplus for society at 384 million euro, caused by an average extension of the hospital stay of 6,7 days per HAI. Other countries have similar problems but seem to succeed better in reducing bacterial resistance.

Belgium is situated around the EU-15 average for all effectiveness indicators, except for colon and rectal cancer where results are better than in other countries. There are also positive trends for several indicators, for example for avoidable hospital admissions for asthma and diabetes, or for the case-fatality rates after an acute myocardial infarction, which have both decreased. However, it should be noted that the measurement of effectiveness of care is not complete, as there is no information on how patients evaluate the outcome of medical procedures, also known as ‘patient-reported outcome measures’ (e.g. after a hip or knee replacement) (KCE, 2016).

Accessibility

The definition of accessibility is based on physical access, costs, waiting time, and availability of qualified personnel.

Nearly the entire population (98.9%) is covered by the compulsory public health insurance system. Despite this, an average of 8% of Belgian households declared in 2013 that they had to postpone healthcare for financial reasons. The share of out-of-pocket payments in total healthcare expenditure remained rather constant in the last decade and amounted to 17.9% in 2013 (KCE, 2016).

Availability of workforce is an important aspect of access to healthcare. Physician density in Belgium is lower than the EU-12 mean (2.96 vs. 3.48 per 1000 inhabitants), just as is the density of practicing nurses in comparison with the EU-9 mean (9.51 vs. 10.77 per 1000 population). However, due to the self-employed status of physicians working on a fee-for-service basis resulting in a high productivity, there are in general few waiting lists for acute care.

Availability of health professionals is also related to health professionals with the right profiles. The current curricula of health workers and their professional responsibilities as defined by law, are becoming increasingly inadequate to respond to the future health needs. Many health professionals are carrying out tasks below or beside their level of competence (e.g. a pediatrician performing vaccinations) (Robert & Swennen, 2012).

Efficiency

As in other European countries, the trend in Belgium is towards an improving efficiency of health care services. Indicators show positive evolutions over time: an increase in the use of low-cost medication, and in the shift from classic (at least one night) to one-day surgical hospitalizations, and a decrease in the length of stay for a normal delivery. However, geographic variation in the quantity of care or in healthcare costs remain which may indicate an inefficient use of resources.

Sustainability

Sustainability is defined as the system's capacity to stay durably financed; to provide and maintain infrastructure and workforce; to be innovative and to be responsive to emerging needs.

Expressed as a percentage of GDP, total health expenditures represented 10.2% in 2013. In absolute terms, this amounts to € 40.6 billion, which represents € 3104 per capita. 78% of these expenditures are financed by the public sector.

Regarding workforce, the challenge in Belgium is to maintain a sufficient number of qualified nurses and to maintain a well working primary care to develop integrated care.

Belgium scores poorly for two "access-to-medicine" indicators, which illustrate the capacity to integrate innovation: the % of medicines available (63%) is lower than the EU-8 average (79%) and the delay to access these new medicines is longer than the EU average (368 days compared to 273 days). This delay has, however, decreased since the first measures of this indicator (2005-2007). Another indicator of an innovative system is the use of new technologies. In 2014, three quarter (76.7%) of the practicing GPs used an electronic filing system with recommended software to maintain their patient's medical record (S-13). This represents a slight increase since 2008 (KCE, 2016).

Equity

People in Belgium with a lower socio-economic status have, compared to the highest socio-economic group, a worse health status, an unhealthier lifestyle behavior, a lower health literacy, less participation in cancer screening and poorer follow-up of patients suffering from diabetes. The healthy life years expectancy differs by almost 20 years between people in the lowest and highest socio-economic group. People in the highest socio-economic group also reported only 3% delayed contacts with health services for financial reasons, compared to 19% in the lowest socio-economic group. Further, 9,5% of the highest socio-economic group smokes, compared to 25% in the lowest socio-economic group. So despite the several measures in the Belgian health system to improve health equity, there still are considerable differences (KCE, 2016).

2.6. Principal health reforms

In the last years, Belgium's health policy mainly aimed at rationalizing the health-care services through hospital mergers and health workforce planning on the one hand, and at safeguarding and increasing financial accessibility through the introduction and broadening of the Maximum Bill on the other hand. Improving health equity and safeguarding equitable access to healthcare are and remain central objectives (Federal coalition agreement).

The current health authorities envisage a broad set of health reforms, aiming to:

- Develop a set of health targets together with the regional health ministers
- Involve a broader base of stakeholders in the negotiations of the healthcare budget
- Redistribute competences among health professionals
- Adapt the hospital financing system towards a more case-based system
- Improve care for patients with chronic diseases through integrated care
- Develop a strategy on health inequalities.
- Create a new Agency for Health, Social Protection, Handicap and Families in Wallonia after the Sixth State's Reform, contributing to an integrated vision.



Belgium's cooperation with WHO

3.1. Belgium's vision on development cooperation and cooperation with WHO

Belgium, with all its constituent parts, considers respect for human rights not only as a fundamental value, but also as the guarantee for fair and long-lasting social and economic development. Respect for universal human rights includes, among others, the right to the best possible state of health.

Belgium is convinced that the achievement of the Sustainable Development Goals (SDGs) requires an integrated and multi-sectorial approach based on clearly defined priorities. An integrated approach because SDGs relating to health should be achieved through coherent national plans based on an integrated health system meeting all health needs of a population. And a multi-sectorial approach, too, because social and economic factors having a major influence on populations' health status should be taken into account: e.g. education, employment, housing, equal opportunities for men and women, social protection, food and nutrition, a healthier environment and an appropriate supply of clean water. Besides, to achieve all SDGs, populations should be in a good state of health.

Belgian cooperation bases its health strategy on the recognition of the universal right to healthcare, on health-related problems in partner countries and on the experience acquired in the fields of efficiency, equity and solidarity in health matters through the policy document "Right to health and healthcare" (2008). Cooperation between Belgium and WHO contributes to support systems aiming at ensuring to all people, including the most destitute population groups, access to essential healthcare in accordance with the adopted principles:

- a sectorial approach based on an integrated national development plan requiring long-term funding
- a participative process stimulating the civil society, citizen control and national leadership
- a healthcare system integrating all services dealing with promotion, prevention, treatment and rehabilitation, with special emphasis on those relating to gender and reproductive health and to the fight against HIV/AIDS
- universal access to quality healthcare and the need for qualified staff and for adequate use of quality essential medicines

To strengthen the health sector, there should be, at international level, a maximization of the impact of support granted to international institutions (e. g. WHO). This requires that multilateral aid is offered in coherence and complementarily to bilateral and indirect aid, without neglecting strengthening the health system.

Among 15 multilateral organizations, WHO has been re-confirmed in 2015 as a partner organization for Belgium's multilateral cooperation, prolonging its long standing partnership that had been given form by the Royal Decrees of 27 April 2000 and 9 May 2008. Sharing the same values and the same approach based on human rights to achieve the Sustainable Development Goals (SDG), Belgium

considers WHO as a privileged partner. WHO possesses the necessary neutrality and the mandate to coordinate and direct the interventions during humanitarian health crises and the implementation of recommendations resulting from declarations on aid efficiency and effectiveness (Belgian development cooperation, 2014).

3.2. Past and current cooperation with WHO

In the last five years, Belgium has been a very active partner of WHO and its affiliated organizations.

Belgium held a mandate in the WHO Executive Board and in the Standing Committee at the European regional level from 2012 to 2015. Its main policy focus was guiding the WHO through their reform process towards greater internal coherence, especially with regard to financial planning.

Furthermore, Belgium is also a member of the WHO International Agency for Research on Cancer, the European Observatory for Health Systems and Policies, the Framework Convention on Tobacco Control, and the ministerial conference on the Environmental Health Action Plans.

In addition, Belgium provides a broad range of expertise to the WHO through 7 collaborating centers:

- WHO Collaborating Centre for HIV/AIDS Diagnostics and Laboratory Support
 - Centre collaborateur de l'OMS pour le Contrôle de Qualité des Pesticides
 - WHO Collaborating Centre for Research on Sexual and Reproductive Health
 - WHO Collaborating Centre for the monitoring of anthelmintic drug efficacy for soil-transmitted helminthiasis
 - WHO Collaborating Centre for Research and Training on human African trypanosomiasis diagnostics
 - WHO Collaborating Centre for the Prevention and Control of Infectious Diseases
 - WHO Collaborating Centre on Primary Health Care
- More specifically, there has been an active cooperation between Belgium and WHO in the following areas:

Health systems

Solid and well-financed health systems are indispensable to improve health and to conduct coherent and effective health policies. Belgium has always paid much attention to health systems in its general policy towards WHO. This vision was given weight throughout the voluntary funding, as 50 % is 'highly flexible earmarked' for the area of health systems. Belgium also supported WHO on the issue of international migration of health workers and on the development of the 'Framework for Action towards Coordinated/Integrated Health Services Delivery'.

Non-Communicable Diseases

Non-communicable diseases are one of the main priorities for Belgium both at national level as well as in its cooperation with WHO. Belgium has collaborated in different NCD-related WHO projects and programs over the past decade. The main areas of collaboration include: mental health, the Global Status Report on Violence Prevention, violence against women and children, NCD's and food safety. Belgium was amongst the first state parties to sign the WHO Framework Convention for Tobacco Control and its Protocol to Eliminate Illicit Trade in Tobacco Products.

Environment and health

During the last years, there has been a significant cooperation between WHO and Belgium in the area of Health and Environment through several projects, programmes and conventions. Belgium has been an active participant in follow-up meetings of the Parma Declaration related to biomonitoring indicators (coordination of DEMOCOPHES project at EU level) and until 2015, Belgium was one of the members of the Environment and Health Ministerial Board which was created by the Fifth Ministerial Conference on Environment and Health in 2010 in Parma.

Belgium has also actively engaged in intersectoral efforts to promote sustainable and healthy transport since over 10 years as a member of the Bureau of the Pan-European Programme on Transport, Health and Environment (PEP), jointly administered by WHO and UN Economic Commission for Europe.

Communicable diseases

Promoting health through the life course is another important area for cooperation between WHO and Belgium. Two WHO Collaborating Centers in Belgium contribute actively to this collaboration. An important area for cooperation within this category is reproductive, sexual, maternal, newborn, child and adolescent health. In the area of sexual and reproductive health and rights, Flanders collaborates actively with WHO and other multilateral organizations through the HRP Special Programme. Both maternal, newborn and child health as well as gender, HIV and equity-related issues are important priorities for Belgium's development cooperation in health.

A special mention can be made of the Belgian support towards the Institute of Tropical Medicine (Antwerp) in the fight against African Trypanosomiasis in the Democratic Republic of Congo.

3.3. Contributions of Belgium to the global health agenda

Belgium pays its annual assessed contributions to the regular budget of WHO and grants voluntary subsidies to WHO. These contributions are paid by several Belgian partners (Federal Public Service Health, Belgian Development Cooperation, Regions and Communities).

Considering the growing unbalance between the core funding and the highly earmarked contributions, and in order to enable WHO to maintain its essential functions and to fulfill its goals, the Belgian Development Cooperation has opted for a contribution to the general resources (fully flexible and highly flexible for strengthening health systems) and for a support to quality of care in fragile states by research for example through resources for the Tropical Disease Research (TDR) Programme for research in diseases of poverty.

Flanders targets its support to the Special Programme of Research, Development and Research Training for Human Reproduction, HRP, co-sponsored by WHO, UNDP, UNFPA, UNICEF and the World Bank. This Programme allows WHO to dedicate sufficient attention to the crucial component of all aspects of sexual and reproductive health and rights (SRHR).

The table hereunder shows the increasing financial contributions from Belgium to WHO from 2008 to 2015.



Contributions per authority (in EUR)	2008	2009	2010	2011	2012	2013	2014	2015
Assessed	4.035.627	3.585.309	4.166.370	3.506.306	3.783.134	3.765.445	3.468.685	4.105.592
Voluntary core	1.250.000	5.400.000	5.800.000	6.300.000	6.700.000	4.700.000	7.300.000	7.300.000
Voluntary non-core	2.857.273	1.834.625	1.700.000	2.205.910	1.565.906	1.157.226	1.741.280	1.500.000
Emergencies	0	250.000	0	0	0	0	0	0
FPS Health	300.000	76.000	273.000	313.000			45.000	NA
Flanders	448.800	1.185.267	378.024	3.560.570	1.043.273	1.841.169	2.655.948	NA
Total	8.891.700	12.331.201	12.317.394	15.885.266	13.092.313	11.463.840	15.210.914	12.905.592



The strategic agenda for WHO cooperation and focus areas

Based on the policy programs of the Belgian federal and federated governments, the 12th General Programme of Work of WHO, and the recently adopted Sustainable Development Goals for 2030 by the United Nations, Belgium and WHO identified the following list of key priorities for their collaboration:

- People-centered health systems and public health capacity
- Non-communicable diseases
- Preparedness, surveillance and response in case of health emergencies
- Environment and health
- Communicable diseases

Aiming at reinforcing the involvement and participation of all relevant partners working in and with Belgium on (inter)national health-related matters in the CCS, a broad stakeholder consultation was held on the CCS strategic priorities. The stakeholders consulted consisted of academic institutions, WHO collaborating centers, health insurance funds, professional associations, health-related public bodies like advisory committees or scientific institutions and NGOs. As a result of the consultation, stakeholders have indicated to support the strategic agenda of the CCS and showed clear interest in contributing to its implementation, in line with the expertise and activities of their specific organizations.

The following text details the rationale behind the selection of these priorities, and indicates to which (sub)targets of the Sustainable Development Goals the priority of collaboration is intended to contribute. For every priority, this chapter describes the focus areas that Belgium and WHO foresee to collaborate on for the period 2016-2022. The collaboration can take many different shapes: technical, political, scientific or financial, and may take place from the local to the global level.

Please note that an identified priority or ‘focus area’ for collaboration between Belgium and WHO does not imply that all Belgian competent health authorities are necessarily involved. For many of these areas, it will be further defined which authorities will participate.

Strategic Priority 1: People-centered health systems and public health capacity

As stated before, the Belgian health system is confronted with a series of challenges. For example, improving and safeguarding access, affordability and quality of health service remains high on the agenda.

The ageing population implies an increasing number of people living with chronic diseases and an increasing number of people confronted with disabilities. Tradition saw the development of health care programmes for specific diseases.

The actual epidemic of chronic diseases is pressing not only to integrate the medical care for more than one disease (multimorbidity), but also to include other types of care such as social or psychological support. Therefore, Belgium believes it is important to organize the health system as a continuum from health promotion and prevention to health support and care, including early diagnosis and treatment. It is aimed to shift from a 'disease-oriented' approach towards 'goal-oriented' care, focusing on the goals concerning the patient's life in terms of quantity and quality.

Linked to SDG 3.8 'Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all', Belgium and WHO will collaborate on strengthening health systems.

Under this strategic priority, there will be collaboration in the following action areas:

In the field of people-centered health systems:

People-Centered and Integrated care

Belgium is considered by WHO to be quite advanced in its preparations for its reform in integrated care. In line with its national Plan on chronic diseases: 'Integrated care for a better health', Belgium will continue to support WHO's work in its People-centered and Integrated Care Strategy, both at regional as well as global level.

Health inequalities

The federal and regional health ministers are developing together a national strategy to reduce health inequalities. Belgium will work with WHO to further develop, review and/or monitor this plan.

Access to care for vulnerable groups

Belgium, through a broad and bottom-up consultation, developed a green and a white paper providing recommendations to improve access for vulnerable groups (2014). Further work on implementation of the recommendation will be discussed with WHO.

Disabilities

The Walloon Region aims at i) developing a "dependence" plan incorporating an Autism Plan, ii) working to prevent and combat violence against girls and women with disabilities, and iii) continuing to develop an environmental approach to disability. The Region will share its best practices with WHO, and will work with WHO's support and advice on the deinstitutionalization of care to people with disabilities.

Sexual and reproductive health

Belgium, and especially Flanders, will continue their global efforts on sexual and reproductive health and supports WHO to advocate for universal access to all necessary sexual and reproductive services and to avoid endemic risks in hidden communities.

Medical products

Belgium continues to support QUAMED to ensure quality of non-prequalified medicines in its partner countries, and will work with WHO to expand progressively the prequalification of essential medicines to enhance the equitable access to quality essential medicines.

Health system strengthening

Finally, Belgium plans to continue to support health system strengthening through a yearly highly flexible funding to WHO and to support health systems internationally in the selected countries, and research on health technology by a yearly voluntary funding, while Flanders plans to continue to support Mozambique in this sense. International solidarity in R&D on health technology is stimulated by a yearly voluntary funding by Belgium, presently provided through TDR, the WHO Programme for Research and Training in Tropical Diseases (TDR). Flanders also plans to continue to support the Special Programme of research, development and research training in human reproduction (HRP).

Human resources - profile of the future health workforce

Belgium is currently revising its Royal Decree No 78 (1967) on the practice of healthcare professions. This issue is by no means limited to Belgium as many countries are facing similar situations. In, this reflection on the definition of profiles of the future health professionals, Belgium will work closely with WHO and will share its experience regarding the revision of the Royal Decree No78.

In the field of public health capacities:

National health targets

The federal and regional health ministers have initiated a process to develop national health targets, which is new in Belgium, although the Flemish government already adopted a list of health targets in 2000. Belgium will use WHO's expertise and best practices at different moments during this process, albeit during the definition and monitoring/evaluation of the national health targets.

Health systems performance assessment

Belgium aims at continuing its efforts in the field of health system performance. The Walloon Region is planning a reflection on health systems performance, with a special focus on primary care. The Region will collaborate with WHO, including technical support for the implementation of the targets defined in the context of primary health care reform.

Health information

Belgium will work with WHO in improving its health information system including the process of developing a coherent vision on which health information is needed. As WHO is responsible for developing the ICD-coding and ICF systems, presently in the 11th revision, Belgium will use WHO support for the integration of its hospital data based on the SNOMED CT system (a medical standard for documenting and coding medical data) with the ICD codes and ICF, which would facilitate the use of its hospital data for decision making.

Public health workforce competencies and capacities

Also the profile of people working for the ministry of health deserves reflection. A health ministry needs the adequate capacities and the right competences to be able to respond to changing health needs and new upcoming challenges. Belgium will work with WHO on public health capacities and competences needed for the public health workforce to respond to future challenges, and how health ministries in other countries develop these.

Strategic Priority 2: Non-communicable diseases (NCDs)

The NCD risk-factors (diet, smoking, alcohol, and physical activity) are an issue in Belgium as, regardless the several action plans on NCDs as developed by the federal and regional health ministers, the 'average Belgian' is still living a less healthy lifestyle than the 'average European' (cf. chapter 2). Therefore, Belgium and WHO wish to reinforce their collaboration to tackle NCDs and stimulate a healthy lifestyle, in line with SDG 3.4 'By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being' and the *Global Action Plan* for the Prevention and Control of NCDs (2013-2020).

Under this strategic priority, there will be collaboration in the following action areas:

Healthy lifestyle

The Walloon Region will work with WHO in the organization of a policy dialogue on the development of a healthy lifestyle putting special emphasis on health inequalities in nutrition.

Provision of norms and standards

In the field of combatting non-communicable diseases, countries strongly rely on international norms, standards and guidelines as developed by WHO (e.g. on tobacco control or sugar consumption). Belgium supports WHO in its role in the field of NCDs, including through a yearly voluntary fully flexible funding.

Age-friendly cities

In the Framework of the implementation of the study "WADA (Wallonie-Amie des aînés): pilot study for an integrated methodological approach in favour of 'Age-friendly municipalities'", researchers will participate in international exchanges around the 'Age-friendly cities and municipalities' through live exchanges with the WHO team in charge of the "WHO Global Network of Age-friendly Cities and Communities".

Regardless the collaboration among Belgium and WHO on these specific areas, Belgium will continue its implementation of several other important international agreements which it approved, like the Framework Convention on Tobacco Control and the Global plan of action to strengthen the role of the health system in addressing interpersonal violence, in particular against women and girls, and against children.

Strategic Priority 3: Emergency preparedness, surveillance and response

In the context of SDG 3.d 'Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks', Belgium and WHO will collaborate to improve IHR implementation.

The H1N1 influenza pandemic or more recently the Ebola crisis demonstrated that national health systems and (international) health threats cannot be separated. National health systems should be ready and able to respond to unpredicted large health crises as well. Belgium welcomes WHO to assess the implementation of the provisions of the IHR in Belgium, to review its generic crisis plan and other concrete crisis plans in case of health threats and invites WHO to share its expertise on capacity building, active crisis plan and coordinated communication. Belgium, will share its expertise to WHO, e.g. in the context of peer-assessments of IHR implementation in other countries.

Strategic Priority 4: Health and Environment

In line with SDG 3.9 ('By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination') and with SDG 11.6 ('By 2030, reduce the adverse per capita environmental impact of cities, including by paying special attention to air quality and municipal and other waste management'), and as Belgium is confronted with high degrees of air pollution, Belgium is actively trying to decrease the impact of environmental exposure on health, with special attention to the most vulnerable (health impact assessment studies, social cohesion plans, monitoring through its health observatory, surveillance of pollution inside the houses, radon detection, etc.).

Therefore, Belgium and WHO will collaborate especially on the following areas:

Human Biomonitoring

Belgium and WHO will collaborate on the translation of the technique of Human Biomonitoring into local action. This Biomonitoring technique will increase the knowledge of multi-factorial environmental pressure (environmental hotspots) on health. Refining this technique into a practical instrument at local level will help to identify and early detect health damage related to environmental pressure. To achieve real health gains, Flanders intends to set up (an) action plan(s) together with the local authorities on preventive health care. Belgium, and especially Flanders, has already knowledge and experience on identifying and addressing Environmental hotspots (use of Intego database) but would like to cooperate with WHO on refining the biomonitoring technique into a practical instrument and into action plans. Therefore, the exercise could result in sharing WHO scientific knowhow on health indicators, biomonitoring, risk assessment, environmental epidemiology (how to implement techniques at local level) as well as learning from other experienced countries with WHO experts participating in discussions.

Parma declaration

As a follow up of the Parma declaration on environment and health (article 6&8), Belgium is working on a better training in environmental health and medicine for health professionals. The Electromagnetic Fields Hotspots are a practical way of illustrating this need. Belgium will support the organization of the 20th meeting of the WHO International Advisory Committee for Electromagnetic Fields.

Strategic Priority 5: Communicable diseases

Communicable diseases have returned to the health policy agenda and pose serious challenges. In line with SDG 3.3 ('By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases') and SDG 5.6 ('Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences'), Belgium and WHO will collaborate especially in the areas of antimicrobial resistance, HIV/AIDS and tuberculosis (TB):

Antibiotic consumption

It has been explained in chapter 2 that antibiotic consumption is high in Belgium, both for the veterinary as for the human medicine. Belgium is determined to keep AMR high on the agenda as long as necessary and will examine with WHO which actions are needed to reduce the high consumption of antibiotics, both from a human and veterinary perspective (one-health strategy).

HIV/AIDS

It was mentioned that Belgium adopted a national plan on AIDS in September 2013. Belgium will work with WHO to review the effectiveness of Belgium in combatting HIV/AIDS.

Tuberculosis

Belgium will continue to work on TB control, as vigilance is required to improve TB control and to combat the multi-resistant form of TB in accordance with the European TB Action Plan 2016-2020.

Communicable diseases

As far as global efforts to combat communicable diseases are concerned, Belgium will continue to support WHO, UNAIDS and the Global Fund to fight HIV/AIDS, tuberculosis and malaria. Belgium will continue to work in order to fight against risky behaviour in the field of sexually transmitted diseases.

Evaluation of the CCS

This CCS is approved by all Belgian health ministers during the Interministerial Conference for Health in March 2016. The CCS is subsequently signed by the Belgian federal minister for Social Affairs and Public health, the WHO Director-General and the WHO Regional Director for Europe.

The current CCS will guide the strategic collaboration between the competent, federal and federated, health authorities in Belgium and WHO throughout the six years from 2016 to 2022. Belgium and WHO will work together to implement the strategic agenda described in the CCS, to achieve the mutually agreed goals and to reach a maximum of impact with their collaboration, using resources made available by both parties.

The competent health authorities of Belgium have agreed to focus their collaboration with WHO on the commonly defined priorities and to take the strategic agenda described in this CCS into account when dealing with international health policy issues. Besides, they have agreed to undertake the activities planned in the framework of the CCS. These activities will be built upon current practices and initiatives, and involvement of other key health stakeholders in the implementation of the strategic agenda will be encouraged.

The WHO Regional Office for Europe will assist Belgium in implementing the defined strategic priorities of collaboration in line with the Health 2020 framework. WHO, at global and regional level, will continue to promote Belgium's leadership in relevant health topics, and assist Belgium to further develop its national health expertise and capacity. WHO will also continue to assist Belgium with its contributions to the global and regional health and development agendas.

Dissemination of the CCS document

Successful implementation of the strategic priorities is dependent on the involvement and participation of both the Belgian health authorities and WHO, as well as other relevant stakeholders. Both Belgium and WHO will ensure a wide dissemination of the CCS document. Belgium will promote the strategy to the government and their relevant technical departments and units, as well as to other ministries and partners working in and with the country on (inter)national health-related matters, as only through combined efforts can some targets be reached. WHO Europe and Headquarters will disseminate the CCS document to all relevant WHO departments to ensure the document will serve as a framework for future discussions on activities with Belgium.

Evaluation of the CCS

The working group set up to develop the CCS, consisting of the competent health and development authorities in Belgium, and representatives of the WHO Regional Office for Europe and Headquarters, has committed to continue to meet for assessing the progress, facilitating and evaluating the implementation of the strategic agenda by all partners, to identify potential risks hindering the implementation, and to align the resources available.

The International Relations Unit of the Federal Public Service of Health, Food Chain Safety and Environment will coordinate the organization of the meetings of the working group. External stakeholders and experts may be invited to join the working group on relevant topics and as agreed upon by the working group. Also, representatives of WHO's technical units may be asked to join the meetings, when required for the strategic priorities being discussed by the group.

Mid-term review

Half-way into the CCS cycle, in 2019 or at a more convenient timing depending on other national policy processes in the country, the CCS will be reviewed by the established working group, coordinated by the International Relations Unit of the federal Public service of Public Health. The aim of the review is to ensure that the strategic priorities continue to be in coherence with the health policy framework of the country or whether there is a need to reformulate and/or change priorities, to evaluate whether all partners live up to their commitment to implement the CCS, and to assess whether the resources are adequate to ensure delivery of the defined outputs. If any changes are necessary, they should be discussed and if possible integrated into the final objectives.

End evaluation

A final evaluation of the CCS will be ensured by the established working group near the end of the CCS cycle in 2022. The evaluation will determine if and which outcomes have been achieved through the CCS implementation and which difference this has made at country level. Consequently, the working group will report back on the main achievements, and remaining gaps and challenges, and make appropriate recommendations for the following CCS cycle. Also, a list of lessons learned from the development, monitoring and evaluation process of the CCS will be prepared with WHO and shared, not only nationally but also with other countries, particularly within similar country groupings.



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