World Health Organization

Country Cooperation Strategy at a glance

Belgium

http:// www.who.int/countries/en/

WHO region	Europe
World Bank income group	High-income
Child health	
Infants exclusively breastfed for the first six months of life (%) (2012)	12.0
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (2016)	98
Demographic and socioeconomic statistics	
Life expectancy at birth (years) (2015)	81.1 (Both sexes) 83.5 (Female) 78.6 (Male)
Population (in thousands) total (2015)	11299.2
% Population under 15 (2015)	16.9
% Population over 60 (2015)	24.1
Poverty headcount ratio at $1.25 a day (PPP) (% of population) ()	
Literacy rate among adults aged >= 15 years (%) ()	
Gender Inequality Index rank (2014)	8
Human Development Index rank (2014)	21
Health systems	
Total expenditure on health as a percentage of gross domestic product (2014)	10.59
Private expenditure on health as a percentage of total expenditure on health (2014)	22.13
General government expenditure on health as a percentage of total government expenditure (2014)	15.10
Physicians density (per 1000 population) (2015)	3.011
Nursing and midwifery personnel density (per 1000 population) (2016)	11.088
Mortality and global health estimates	
Neonatal mortality rate (per 1000 live births) (2016)	2.2 [1.9-2.5]
Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2016)	3.9 [3.6-4.4]
Maternal mortality ratio (per 100 000 live births) (2015)	7 [5 - 10]
Births attended by skilled health personnel (%) ()	
Public health and environment	
Population using safely managed sanitation services (%) (2015)	97 (Total)
Population using safely managed drinking water services (%) (2015)	98 (Total)

Sources of data:
Global Health Observatory May 2017
http://apps.who.int/gho/data/node.cco

HEALTH SITUATION

Life expectancy at birth (2015) in Belgium is 78.6 years for men, compared to an EU-15 average of 78.6, and 83.5 years for women, compared to an EU-15 average of 83.7. 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. 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. 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. 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). Environmental health concerns are also high, in particular regarding air pollution from traffic. Mental health statistics show a clear deterioration of the psycho-emotional state of the Belgian population aged 15 year and over in the past five years.

Communicable diseases are not a challenge of the past, but are returning to the health policy agenda in new forms and with new challenges. Belgium has one of the highest HIV incidence rates in the EU.

HEALTH POLICIES AND SYSTEMS

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.

In 2013, Belgium's total health expenditure was 10.2% of the GDP, which is among the highest in the EU-15. 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.

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.

In the last years, Belgium's health policy mainly aimed at rationalizing the healthcare 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).

In the past years, both the federal and regional health ministers developed and implemented several action plans to tackle the NCD pandemic.

COOPERATION FOR 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. Belgium is convinced that the achievement of the Sustainable Development Goals (SDGs) requires an integrated and multi-sectorial approach based on clearly defined priorities. As such, the CCS indicates linkages between priorities and the SDGs and is intended to be a contributing element when implementing the 2030 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 fulfil 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).

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Country Cooperation Strategy *at a glance*

WHO COUNTRY COOPERATION STRATEGIC AGENDA (2016–2022)	
Strategic Priorities	**Main Focus Areas for WHO Cooperation**
STRATEGIC PRIORITY 1: People-centered health systems and public health capacity	In the field of people-centered health systems: • People-Centered and Integrated care • Health inequalities • Access to care for vulnerable groups • Disabilities • Sexual and reproductive health • Medical products • Health system strengthening • Human resources - profile of the future health workforce In the field of public health capacities: • National health targets • Health systems performance assessment • Health information Public health workforce competencies and capacities
STRATEGIC PRIORITY 2: Non-communicable diseases (NCDs)	• Healthy lifestyle • Provision of norms and standards • Age-friendly cities
STRATEGIC PRIORITY 3: Emergency preparedness, surveillance and response	• Emergency preparedness, surveillance and response
STRATEGIC PRIORITY 4: Health and Environment	• Human Bio monitoring • Parma declaration
STRATEGIC PRIORITY 5: Communicable diseases	• Antibiotic consumption • HIV/AIDS • Tuberculosis • Communicable diseases