KEY DATA IN HEALTHCARE

# Healthcare professionals

Edition 2022

.be

# Colophon

## SUBJECT

This report provides a picture, based on key figures, of the activities of the FPS Public Health, Food Chain Safety and Environment in the healthcare professions. Some trends are highlighted in four chapters on 'Organisation', 'Activity', 'Funding' and 'Quality'.

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**www.health.belgium.be**
and **www.healthybelgium.be**

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# PREFACE

Dear reader,

Since 2020, our daily lives have been turned upside down on more than one level. The impact of the health crisis continues to be felt as we redefine what it means to "get back to normal."

At the heart of these challenging times are the people who work on the ground every day to provide quality health care. In this fifth edition of "Key data in healthcare" we want to honour them.

They have been called "heroes", but behind this grandiose word are real human beings who have chosen to use their knowledge, skills and investment to serve others.

We would like to invite you to meet the healthcare practitioners. In the following pages, we will explore how the various departments, within the Directorate General for Healthcare (DGGS), support them throughout their career, and the different measures put in place to ensure the quality of the care.

We have highlighted three professions to better illustrate their activities: nurses, midwives and speech therapists. We will have the opportunity to feature other professions in future editions dedicated to healthcare professionals.

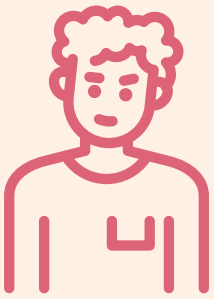
I hope you enjoy reading this edition.

**Annick Poncé,**
Acting Director General, DG Healthcare

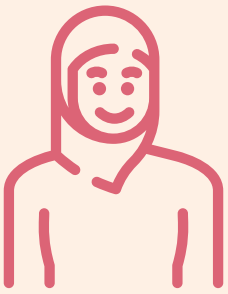
# INTRODUCTION

**To better illustrate what we are covering in this issue, we invite you to embark on this adventure with three young students, who have just graduated from secondary school.**

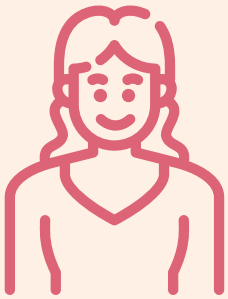
They are inspired by the thousands of students who, each year, out of curiosity or vocation, embark on studies in healthcare and who will one day join the ranks of health practitioners.



**Joël** has always dreamed of working in the medical world. Even as a child, he walked around with a stethoscope in one hand and plasters in the other, ready to treat any injury.



**Nora** found her calling during the pandemic. Inspired by the resilience of the health care professionals on the front lines during the crisis, she too wants to help people.



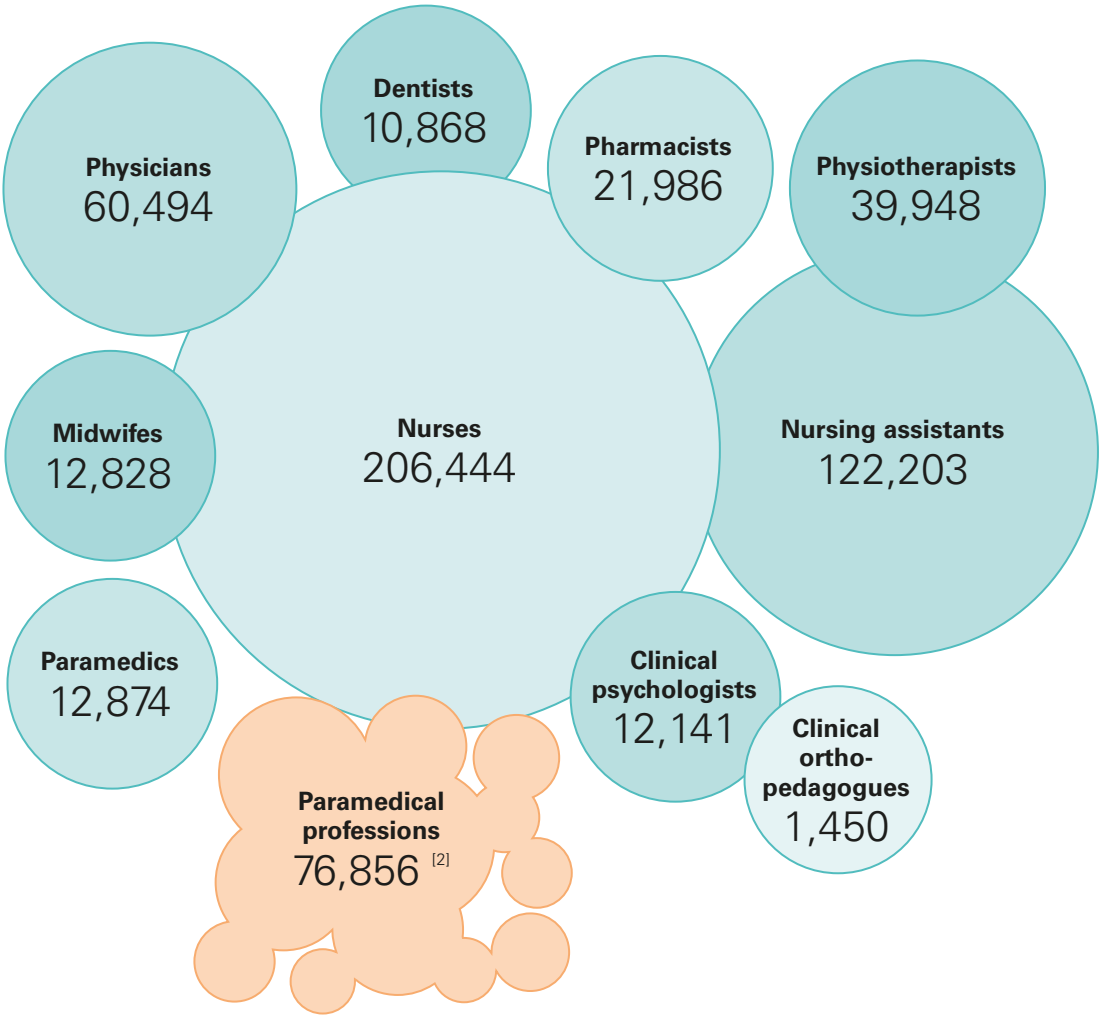
**Deborah**, like many young people her age, was not sure what path to take after secondary school. Recently, her family has grown. While visiting her nephew in hospital, Deborah was very impressed by the calm and the competence of the medical staff working around this newborn.

Our three friends are determined to work in the health field. So what is the next step for them?

First of all, they will have to narrow down their choice.

The medical world is vast and offers a range of choices. In Belgium today, we have **more than 670,000 healthcare professionals**. They are distributed among more than 20 professions recognised by Belgian law. Some have existed for decades, others for just a few years. After all, the field of health is constantly evolving and the legislation is adapted accordingly. Each of these professions[1], as well as the professional titles and qualifications, are included in the Coordinated Law of 10 May 2015, on the practice of healthcare professions.

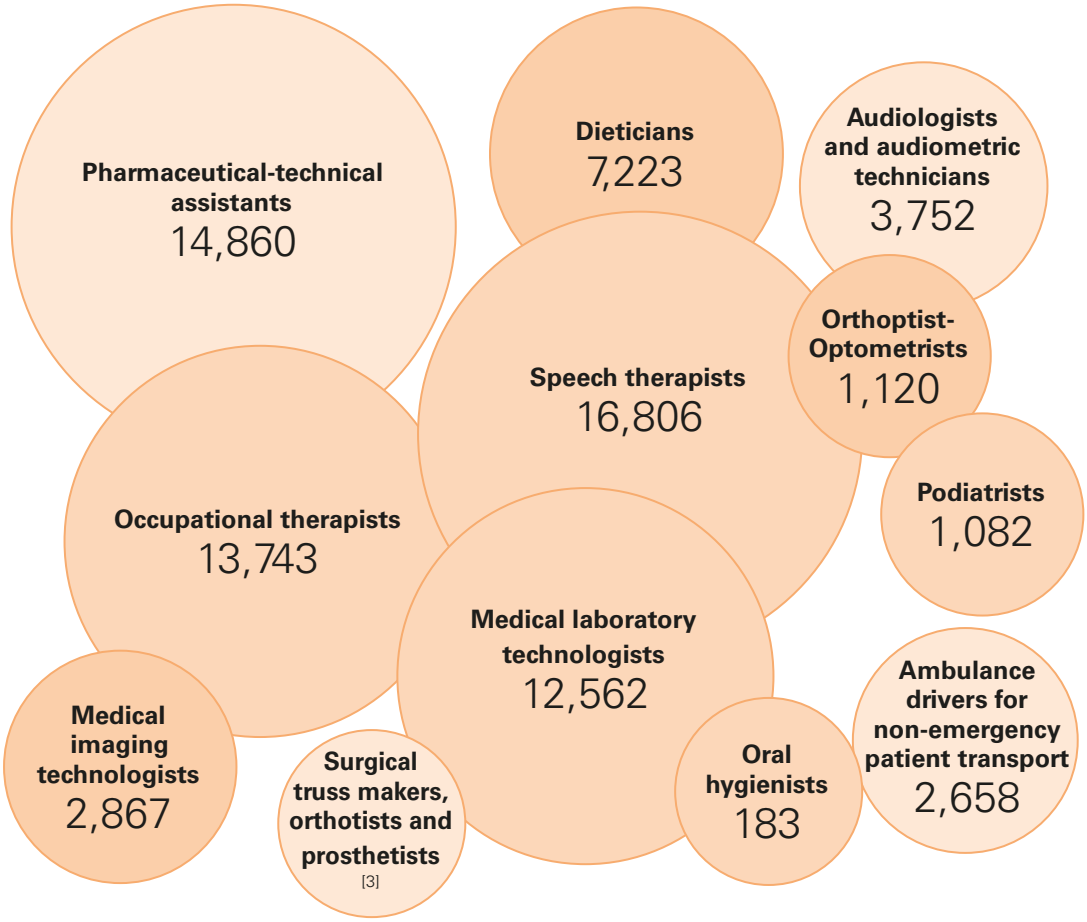

OVERVIEW OF THE HEALTH CARE PROFESSIONS AND THE NUMBER OF PEOPLE ENTITLED TO PRACTICE IN EACH OF THEM.




1 The graphs below show the different professions and the number of professionals authorised to practise in Belgium.

2 The professions of surgical truss makers, orthotists and prosthetists are not registered in the FPS Public Health database. Their figures are therefore not included in this publication.

THE NAME "PARAMEDICAL PROFESSIONS"
COMPRISES AROUND TEN DISTINCT PROFESSIONS.




Each of these paramedical professions is governed by its own decree.

**Find out more:**

**www.health.belgium.be**

All professionals authorised to practise in Belgium are registered in a federal database of health professionals. This database, called the **"register"** or **"e-CAD"**, has three objectives: to collect the data needed to carry out the missions of the Planning Commission, to enable the execution of the missions of the administration and public agencies, and to improve communication among health professionals[4].

3 The professions of surgical truss makers, orthotists and prosthetists are not registered in the FPS Public Health database. Their figures are therefore not included in this publication.

4 Law of 10 May 2015, Articles 97 to 101: https://www.ejustice.just.fgov.be/eli/loi/2015/05/10/2015A24141/justel#LNKR0016

The register[5] contains personal data (first name, surname, address, age, nationality), professional data and data on the academic background of professionals (diploma, institution that issued it, any internship plan, specialisations and skills, accreditation, visa, etc.).

This register therefore provides a summary of every person who has applied to a licensed professional activity. The information contained in this database provides a picture of the profession at a given time and allows trends to be extracted.

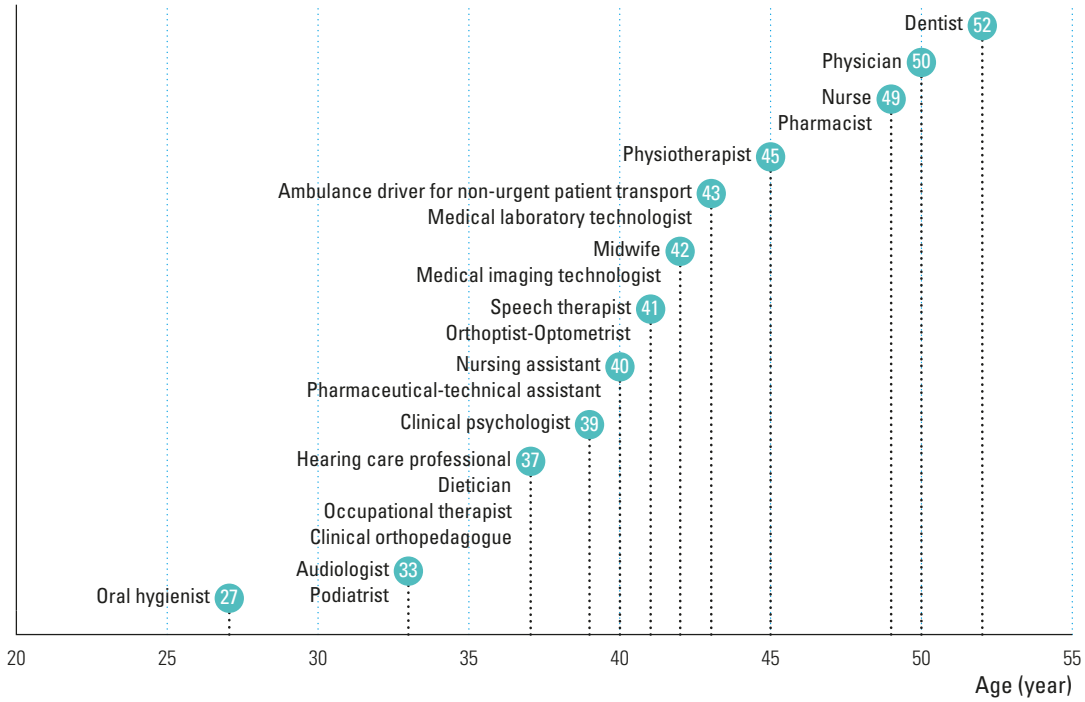
**Find a healthcare professional:**

**apps.health.belgium.be**

## TRENDS OBSERVED AMONG PROFESSIONALS ENTITLED TO PRACTISE IN BELGIUM.

It is interesting to note the correlation between the age of the profession and the average age of its practitioners. Long-established professions, such as physicians and dentists, have the highest average age. However, the very recently established professions, such as podiatrists and oral hygienists, tend to have much younger practitioners.

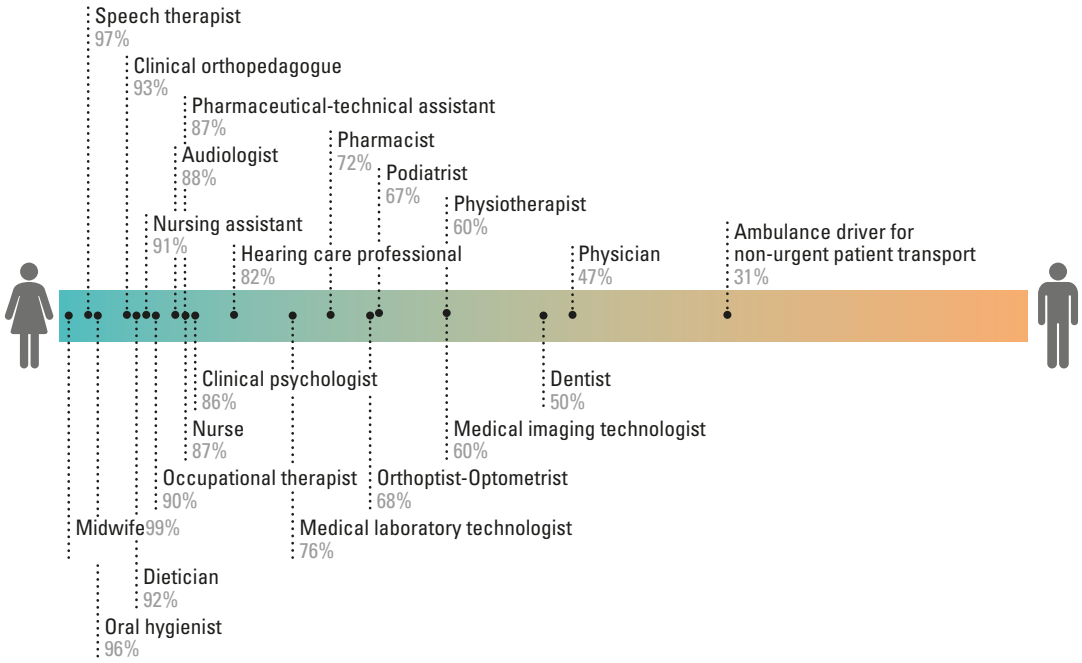
AVERAGE AGE BY HEALTHCARE PROFESSIONAL




5 Federal data bank of professionals entitled to provide services | FPS Public Health (belgium.be)

Many professions comprise a majority of women.

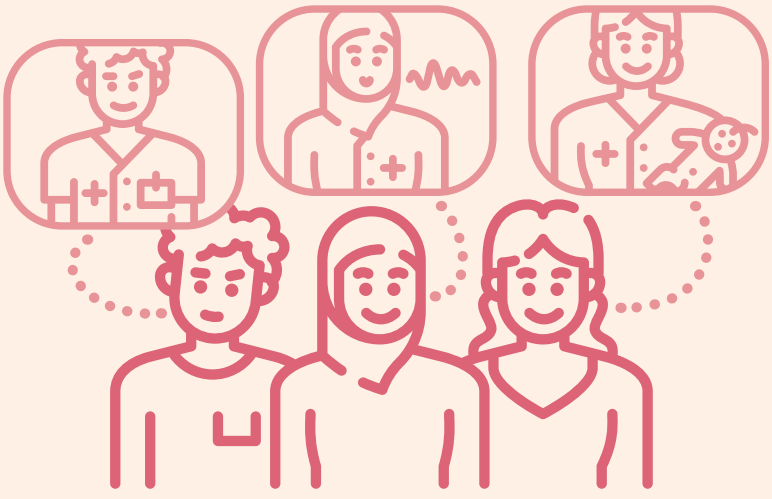
PROPORTION OF WOMEN BY HEALTHCARE PROFESSIONAL




**More data about healthcare professionals:**

**consultativebodies.health.belgium.be**

After taking many factors into consideration, the die was cast: **Joël** would become a **nurse**, **Nora** wants to become a **speech therapist** and **Déborah** was won over by **midwifery**.



This is where their career path begins.

# ORGANISATION

## 1. Monitoring and planning of the health care workforce

It is important to note that the supervision of healthcare professionals begins even before their training.

This supervision includes the monitoring and planning of the medical offer. The general idea is to ensure that the health needs of the population are met by avoiding both excesses and shortages of professionals in any given field.

### 1.1. What is planning?

Planning the health care professional workforce is critical to ensuring the health of the population, in order to:

- guarantee that the supply and demand for care match
- avoid shortages
- anticipate abundance

All of these are essential to ensure quality of care, the well-being of our professionals, budgetary sustainability and the efficiency of social security. The Medical Offer Planning Commission was established in 1996 for this purpose. It is composed of representatives from universities, mutual health funds (Collège Intermutualiste), healthcare professions (professional organisations), the relevant ministries, the Communities, NIHDI and the FPS HFCSE.

Today, the information available to the planning commission is complex. The data is extracted from different databases, anonymised and analysed to provide the most detailed and realistic picture of the activity of health professionals in Belgium.

Planning was initially limited to doctors and dentists. Now, it extends to an ever-growing number of professionals. Like the needs of the population, planning is a dynamic and constantly improving process.

**Medical Offer Planning Commission:**

**consultativebodies.health.belgium.be**

## 1.2. The planning stages

The figure below summarises the different steps taken by the Planning Commission for each profession, from the completion of the PlanCad to the writing of the recommendations.

THE PLANNING STAGES

**CURRENT WORKFORCE**

description of the activity of a profession in the Belgian employment market

**BASIC SCENARIO**

evolution of the workforce (stock + in-out); no break with the historical trend: continuity scenario

**ALTERNATIVE SCENARIOS**

according to the vision of future care developed by the Planning Commission, e.g. delegation of tasks, change in length of studies, work/life balance, etc.

**FORMAL RECOMMENDATION**

on the quotas for physicians and dentists, and on the planning of the other non-quota professions represented (nurses, nursing assistants, midwives, physiotherapists and speech therapists)

### DESCRIPTION OF THE ACTIVITY OF A PROFESSION IN THE BELGIAN EMPLOYMENT MARKET

While the register is very useful for the Planning Commission, providing a summary of everyone who has applied to a licensed professional activity, it is not sufficient for it to carry out its tasks.

This database does not show us the proportion of certified persons who are actually working, the extent to which this activity is carried out, in which sectors and in which geographical area.

However, the Planning Commission needs information on the activity of health professionals and on the level of this activity, so it can accurately monitor this workforce, prepare forecasts of its evolution and plan the supply of professionals, in particular by determining the quota of physicians and dentists. This is why Art. 99 of the law of 10 May 2015 provides for the possibility of linking register data with a series of other databases.

The "PlanCad" project, on this basis, links data from various sources to supplement e-CAD. These sources include:

- the National Institute for Health and Disability Insurance **(NIHDI)**,
- the National Social Security Office **(NSSO)** for employee data,
- the National Institute of Social Insurance for the Self-Employed **(NISISE)** for data on the self-employed.

The identification of individuals is made impossible by anonymisation. This linking allows relevant answers to be provided to questions related to the **workforce of the professions**.

For example:

- **how many people are active** in a profession in Belgium?
- what is the **age pyramid** of the professional group?
- what is the **length of time** that healthcare providers work as **employees** or as **freelancers**?
- what is the **distribution** of these individuals across the **different healthcare sub-sectors**?
- what is the respective proportion of **full-time** and **part-time** work?
- what is the distribution according to the **district of residence**?
- how did the composition of a given profession change **over the years**?

The data used covers several years. This makes it possible to identify developments and estimate trends in future workforce development projections.

## BASIC SCENARIO

The health professions planning work involves reviewing available data to develop a numerical "forecast". Several workforce evolution scenarios are developed for each profession.

The **workforce projection model** is the working tool on which the forecast is based. It is of the "stock and flow" type. It starts with the premise that for each healthcare profession, there is **demand** and **supply**.

The demand comes from the population that requires healthcare. The supply is determined by the people in the healthcare sector who practise the profession in question.

The projection model has a number of parameters and takes account of international mobility, both at the beginning of studies and at the start of specialisations and professional practice. The scenarios anticipate the active professional population in Belgium, placed in a **European and international context**.

Several **scenarios for the evolution** of the workforce are developed, based on the current situation of a specific group of professionals and various assumptions about future developments.

In the baseline scenario, observed historical trends are used as a starting point and projections for the evolution of the number of active professionals are made "under unchanged conditions and policies". In these predictions, the number of active professionals is taken into account, minus exits (deaths, retirements), plus new graduates in Belgium, plus the flow of practitioners who have graduated abroad.

The evolution of the demand for care is estimated on the basis of the number of individuals, the structure of the population, according to age and sex, as well as the consumption of care.

## ALTERNATIVE SCENARIOS

**Alternative scenarios** are then developed. The parameters of the baseline model are adapted according to a series of hypotheses relating to the future evolution of the workforce, the context, the activity, the demand for care, etc. These hypotheses are developed by the various Planning Commission working groups.

## NOTICE TO THE FEDERAL MINISTER OF PUBLIC HEALTH

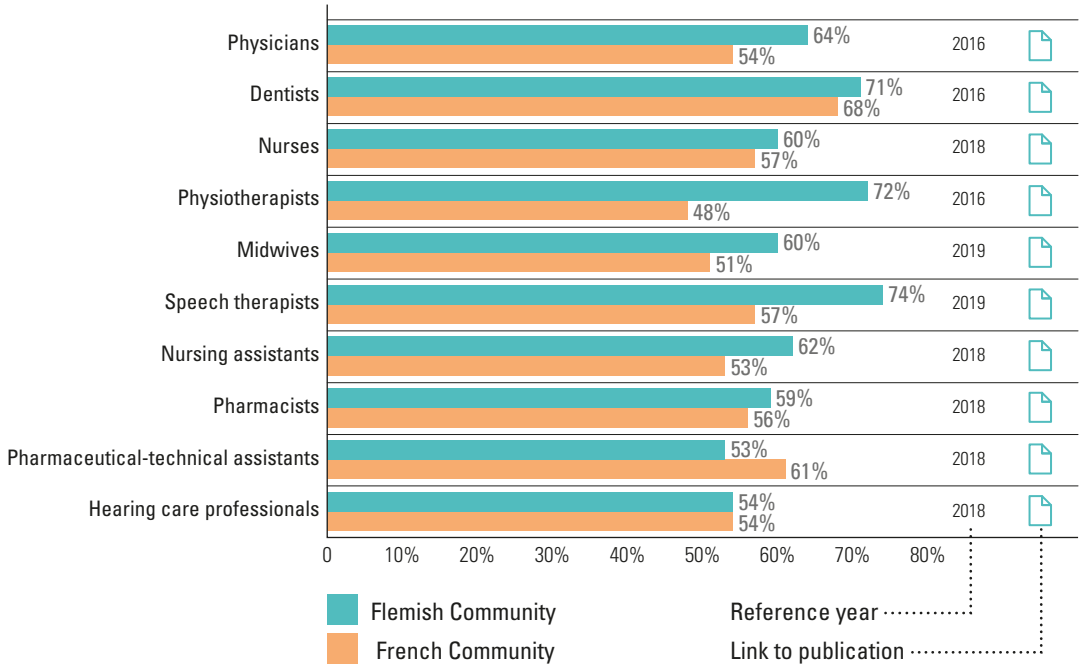
Once the future scenarios have been completed, the Planning Commission prepares a recommendation. This recommendation reflects the evolution of the profession, the relationship between supply and demand, and any related issues and concerns. For professions subject to a quota, the Commission also drafts a notice setting the **federal quota**. This quota will be used to determine the number of physicians and dentists with a Belgian diploma who qualify to apply for an internship to obtain a professional title in a specialty in Belgium. To date, only physicians and dentists are subject to such a quota.

## ACTIVE PROFESSIONALS IN RELATION TO ALL REGISTERED HEALTH CARE PROFESSIONALS

Firstly, we have the number of professionals entitled to provide services. This is the number registered as of 31 December 2021 in the annual statistics of professionals entitled to provide services. It includes all professionals domiciled in and outside Belgium.

Secondly, we have the number of professionals actually working in healthcare. The rate used to estimate active practitioners is that observed in the latest available publication on the activity of the profession (published or in progress).

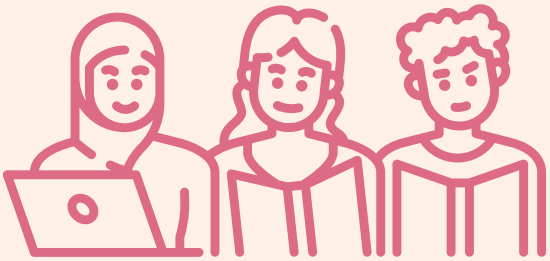
ESTIMATED NUMBER OF ACTIVE WORKERS AS A PERCENTAGE OF ALL HEALTHCARE PROFESSIONALS LICENSED TO PRACTISE



The difference in rates observed between the two communities for the health care workforce is mainly explained by the significant presence of foreign students in French Community education. Many foreign students come to train in French-speaking education and then return to practise in their country of origin without strengthening the workforce in Belgium. The French Community has issued a decree to limit this number.

# 2. The training of professionals

None of the professions chosen by **Nora**, **Déborah** and **Joël** is subject to a quota. They can begin their studies without being concerned by quotas. Thus begins their higher education experience. But how is their curriculum defined? On what basis is the length of their studies determined? Will they have to complete an internship or not?



All this data is determined within the federal healthcare professions advisory bodies.

## 2.1. The advisory bodies

There are different advisory bodies for the healthcare professions, each with advisory powers. Their mission is to give the Minister of Public Health, at the Minister's request or on its own initiative, advice on the practice of the profession(s) they represent and, if necessary, advice on the accreditation criteria for these practitioners and the internship supervisors and internship centres for the disciplines concerned.

There are currently **eight advisory boards** and **two technical commissions**:

- the Superior Council of **Specialist Physicians and General Practitioners**
- the **Dental** Council
- the Federal Council of **Pharmacists**[6]
- the Federal Council of **Physiotherapy**
- the Federal Council of **Nursing**
- the Technical Commission of **Nursing**
- the Federal Council of **Midwifery**
- the Federal Council of **Mental Health Professions**
- the Federal Council of the **Paramedical Professions**
- the Technical Commission for the **Paramedical Professions**

6 The Federal Council of Pharmacists is currently being instaured.

Generally speaking, these advisory bodies are mainly composed of representatives of the profession from professional associations or the academic world. Physicians sit on most of them. The exact composition of these advisory bodies differs, however, depending on the profession represented.

To prepare these recommendations, each advisory body can create working groups with a specific mission. These working groups are composed of members of the board or commission concerned and possibly external experts. Fixed working groups may also be established, depending on the specific competencies assigned to the advisory body.

When the profession requires an internship, these working groups are responsible for analysing individual cases and preparing recommendations within the framework of legal procedures (granting or renewal of approval as an internship supervisor, etc.). This is the case for physicians, dentists, hospital pharmacists and the mental health professions.

## RECOMMENDATIONS

The recommendations may concern a series of measures affecting the training that students in the various medical professions will undergo.

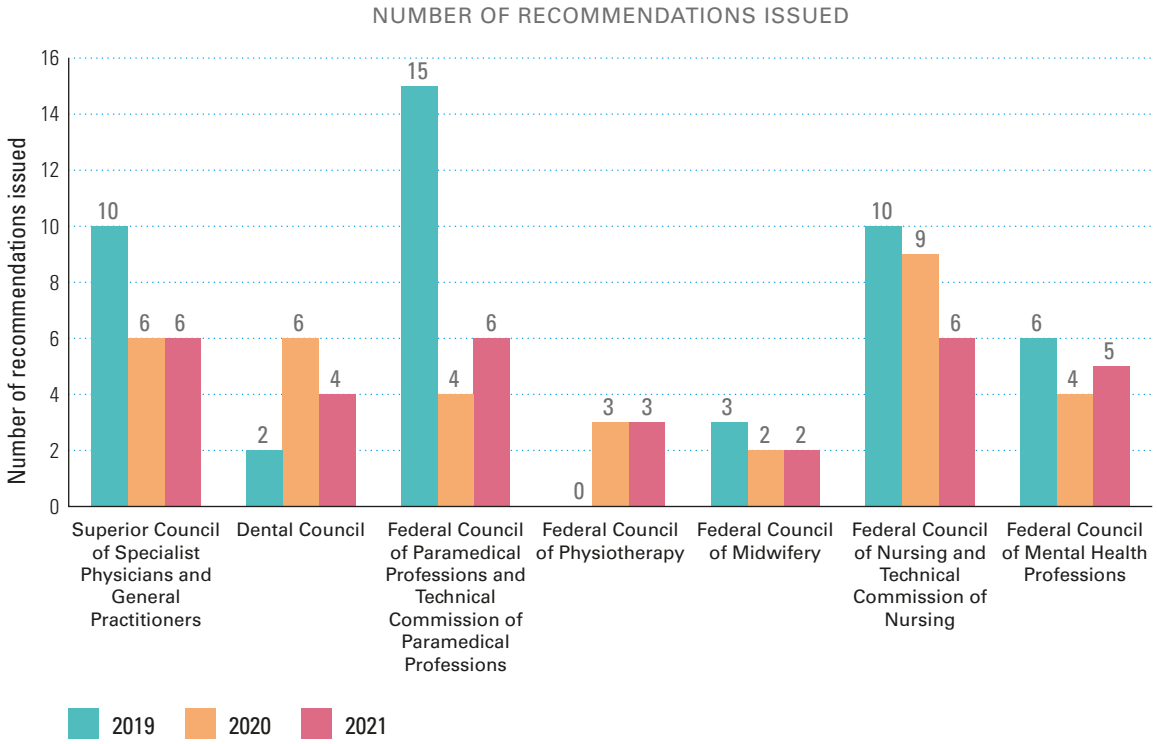
The following is a non-exhaustive list of the topics that may be the subject of a recommendation:

- the opportunity to create regulated titles or professions
- the revision of existing criteria
- the duration and level of training
- the final skills to be acquired
- the reserved acts, which can be exercised independently, which can be delegated, etc.
- the topics presenting new challenges, such as artificial intelligence, telemedicine, etc.
- if applicable, the number of training hours to be completed
- etc.

**Consult the recommendations issued by the Minister's advisory bodies:**

**consultativebodies.health.belgium.be**

In 2021, a total of 32 recommendations were issued.




The health crisis has heavily impacted the work of the advisory bodies since March 2020. They have been asked to provide emergency recommendations on matters specific to this pandemic. In addition, the professionals who sit on these boards and commissions have been heavily involved in the field. For these reasons, non-pandemic work slowed down during the first part of the crisis, although the impact was felt differently by each Council.

The advisory bodies have since resumed their activities at a more usual pace. However, some Councils are in the process of changing or have been very recently changed. This also plays a role in their activities.

## PROPORTIONALITY

The Legislation on proportionality has impacted the work of advisory bodies since 2021. In accordance with the 2018 European Directive, the legislator must justify the proportionality of measures when they have a restrictive impact on access to or the exercise of any profession.

Many recommendations from the Councils and other bodies fall into one or both of these categories. Where this is the case, the body now has to demonstrate that they have an objective of general interest and are well justified.

A proportionality test must therefore be carried out when the measure adds restrictive measures to the access to or practice of a profession. This can be, for example:

- extending the number of years of study
- adding or extending the number of training hours
- introducing continuing education to practise a profession
- making the practice of a profession conditional on membership in a professional body
- etc.

In addition, the directive also includes a **disclosure requirement**. The regulations allow any person to be informed of the envisaged measures before they are established. Stakeholders can then react to them if they wish. This right of reaction is granted to practitioners themselves, as well as to students, patients, associations, etc.

**For more information on proportionality:**

**www.health.belgium.be**

## INTERNSHIP SUPERVISOR AND CONTINUING EDUCATION

As mentioned above, for certain professions a decision may be made that training must be organised for interns. This is the case for physicians, dentists, hospital pharmacists, clinical psychologists and clinical orthopedagogues[7], who are referred to as "interns" for the duration of their internship. These interns are trained by a practising practitioner, called a "internship supervisor". There is an approval process for these supervisors and internship centres. The Minister of Public Health is competent to issue these approvals. According to the legislation, **the Minister bases the decision on the recommendations given by the relevant advisory bodies**, in particular the Higher Council of Specialist Physicians and General Practitioners, the Dental Council, the Federal Council of Mental Health Professions and the Commission for the Accreditation of Hospital Pharmacists.

To ensure the quality of training, criteria for the approval of supervisors and internship centres have been established for each profession and speciality. These concern both the future supervisor and the activity and supervision that the internship centres can offer.

Criteria adapted to each type of practice guarantee the quality of the training for both a future general physician who trains in general practice and a clinical psychologist who trains in a hospital institution.

These internship supervisor approvals represent a fairly large annual volume of applications. The dossiers are analysed by the administration, then presented to working groups, and the recommendations are confirmed by the competent board before being sent to the Minister, who makes the final decision.

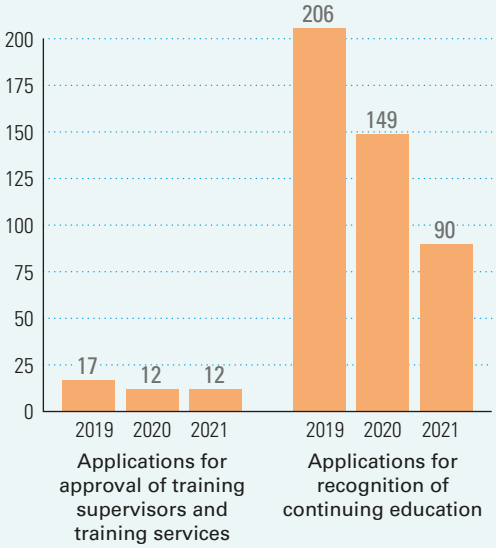
Here are some figures[8] to illustrate the volume of applications and recommendations issued concerning the approval of internship supervisors and continuing education according to the different professions.

7 Internship is in place for the last two professions but it has not yet been made mandatory.

8 These are the numbers of dossiers finalised during year X, i.e. that received a recommendation from the board and a ministerial decision. This is not a volume of activity, since each dossier is counted only once, regardless of the number of intermediate recommendations that the council has issued.

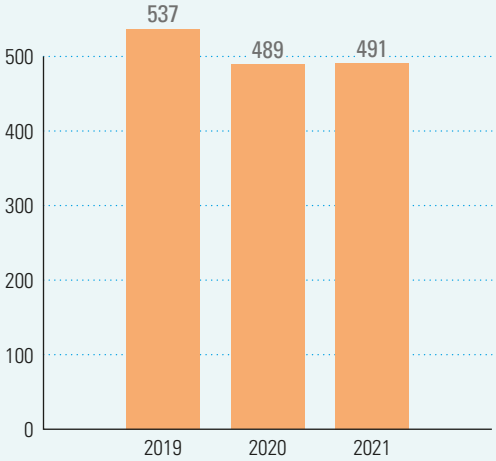
### HOSPITAL PHARMACISTS

Applications for the approval of internship supervisors and centres for hospital pharmacists are processed by the Approval Commission, pending the establishment of the Federal Council of Pharmacists. This commission also decides on applications for the recognition of continuing education for hospital pharmacists. To apply for the renewal of their hospital pharmacist approval, the professionals concerned must submit a dossier to the communities every five years. One of the elements in this dossier is proof of **continuing education**[9].




### DENTISTS

For dentists, the legal basis is the Royal Decree of 10 November 1996, which establishes the modalities for the approval of dental practitioners with a specific professional title. An ongoing working group processes applications for the approval of internship supervisors and services in general and specialised dentistry.




### MENTAL HEALTH PROFESSIONALS

The approval process for mental health internship supervisors and services began in 2021.

A total of 184 applications for the approval of internship supervisors and centres have been submitted. Two professions were involved: **clinical psychology and clinical orthopedagogue**.

In the future, we will have the opportunity to compare the data with subsequent years to obtain a better picture of the evolution of mental health training.

9 2020 and 2021 were impacted by the health crisis. The organisation of continuing education was particularly disrupted.

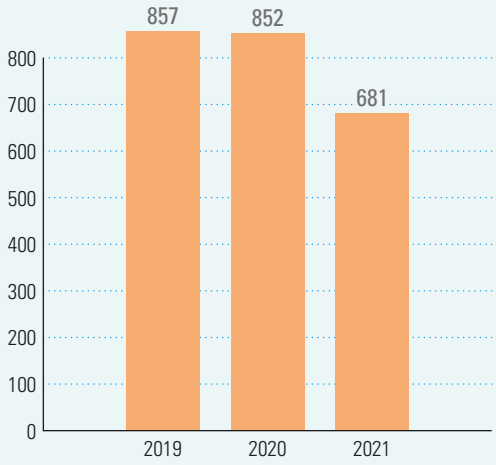
## PHYSICIANS

As far as Physicians are concerned, the legal basis is the Royal Decree of 21 April 1983, which establishes the modalities for the approval of specialists and general practitioners.

**Two permanent working groups** have been set up: "General Practitioners" and "Specialists". Their roles are to:

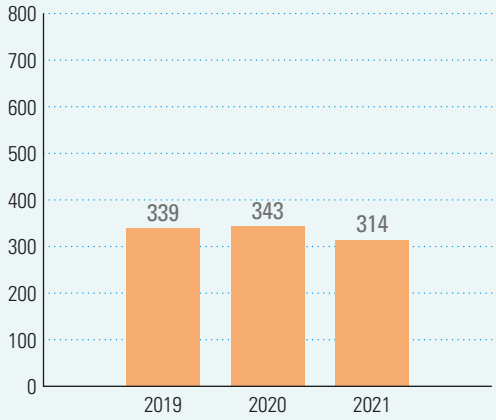
- provide the Superior Council with a recommendation on the applications for approval submitted by general practitioners and specialists as internship supervisors or services. This recommendation is validated by the Council
- issue a recommendation on matters referred to them by the Council

GENERAL PRACTITIONERS
(POSITIVE REVIEWS)

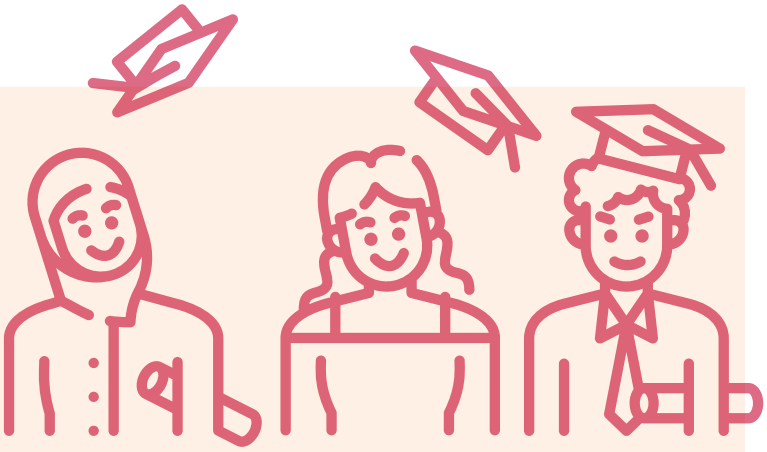



Applications for approval of training supervisors and training services

SPECIALIST PRACTITIONERS
(POSITIVE REVIEWS)




Applications for approval of training supervisors and training services

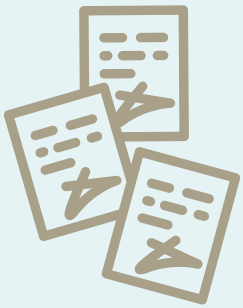


**Nora**, **Déborah** and **Joël** have completed their higher education training partially based on the advice of the federal councils of their respective professions, and their efforts have paid off.

After years of study, they have reached the end of their academic career and have a diploma in their pocket. What is the next step for them to start their career?

# 3. Licence to practice

Once the diploma has been obtained, the next step is either the application for approval or the application for licence to practice. In the area of healthcare, access to the profession is conditional on holding a licence.



Each year, up to
30,000 **new licences to practice** are issued to healthcare professionals

Once it has been granted, it is still possible for some professions to obtain approval for a **particular professional title** or **qualification**, often after completing **additional professional internship**.

This is the case for the following professions:

- general practitioners and specialists
- general dentists and specialists
- hospital pharmacists
- nurses
- midwives
- mental health professions

For other professions, **approval** is obtained **before a licence to practice**.

This is the case for:

- physiotherapists
- the paramedical professions

As a result of the 6th State Reform in 2014, jurisdiction over approval was transferred to the communities. The federal government is only responsible for the approval of internship supervisors as mentioned above. This has therefore created a division, as **access to the profession through the granting of accreditations is a federal responsibility**, while **approval is the responsibility of the communities**.

Accreditations were previously issued by a decentralised procedure by the provincial medical commissions. Today, they are largely delivered automatically and centrally. Here is the process according to the different professions:

| Physicians, dentists, pharmacists, nurses and midwives | Physiotherapists, paramedics and care assistants | Clinical psychologists and clinical orthopedagogue |
|---|---|---|
| For professions without recognition of the basic qualifications: licence to practice is issued on the basis of an exchange with the universities, colleges and secondary schools through a portal developed specifically for this purpose. | The basic diploma for health care professionals is initially subject to approval by the Communities. | The issuance of accreditations was launched in 2019, with some issued on the basis of transitional measures. |
| Each proclamation period, institutions provide lists of students with a basic diploma. The Access to the Profession unit uses these lists to send licence to practice automatically (email or mail) shortly after the end of their studies. | The Communities use the same database for approvals as the FPS does for granting licence to practice; licence to practice can be issued automatically as soon as approval has been granted | However, the majority of applications (transitional measures) are still made on an individual basis. The college portal can also be used for new graduates |

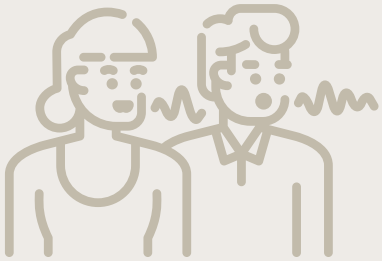
In addition to issuing accreditations for Belgian diplomas, they are also issued for foreign diplomas, in many cases, after prior recognition. The recognition procedure differs depending on whether the diploma was obtained in an EU or non-EU country.

| European diplomas | Non-European diplomas |
|---|---|
| Recognition in accordance with European Directive 2005/36/EC and therefore by the Communities.<br><br>Licence to practice is then automatically issued as it is for Belgian diplomas, with recognition of the basic qualification | Authorisation to practise a healthcare profession granted by the King, after the diploma has been declared equivalent by the Communities and after a recommendation of the competent federal council of the profession.<br><br>In addition to equivalence, approval is also required before a licence to practice can be granted for: physiotherapists, paramedics and nursing assistants |

Due to the reform mentioned earlier, the order of the post-graduation steps may vary from one profession to another. Here are the diagrams illustrating the steps for accessing and practising the chosen profession for Nora, Déborah and Joël.

## SPEECH THERAPIST

For speech therapists, we can see from the diagram that approval is the first formality to be completed upon graduation. A licence to practice is then granted and gives the right to practise in Belgium. For the rest, the practitioner can decide to affiliate and apply for an NIHDI number



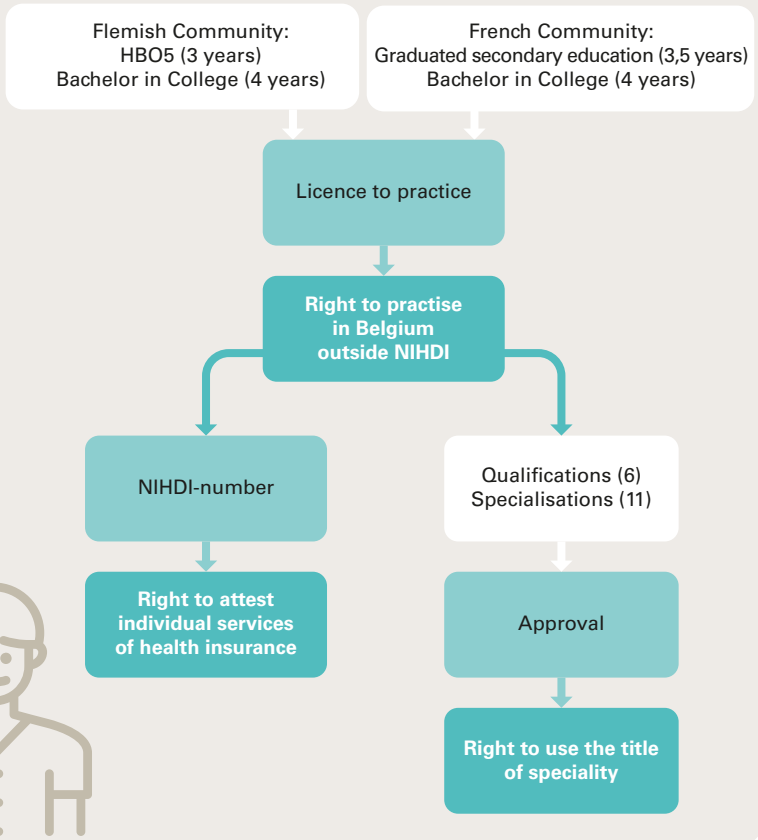


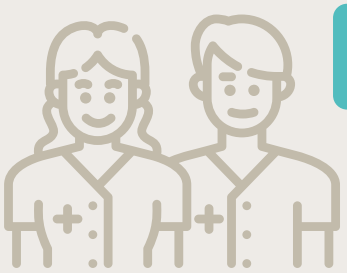

## MIDWIFE

The length of study is different, but the other steps do not change compared with the diagram of speech therapists.

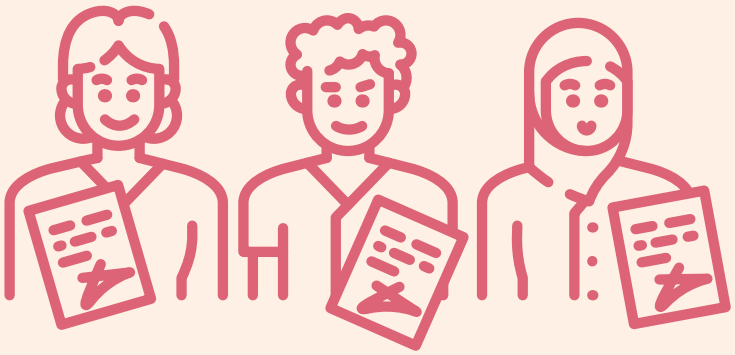
## NURSES

For nurses, however, accreditation is obtained first. The professional then has a choice: if they decide to obtain one of the possible qualifications or specialisations for the nursing profession, then approval will be given.



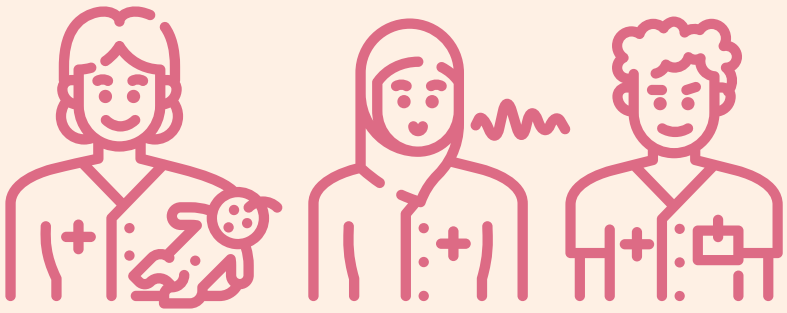
**Accreditation and approval have been obtained**. **Déborah**, **Joël** and **Nora** can now officially join the hundreds of thousands of people licensed to practise a healthcare profession in Belgium.



It's time for them to enter the workforce and begin the actual practice of their profession.

In the next section, we will use various figures to illustrate some characteristics of the three professions in which these three young people are going to work, namely **speech therapists**, **midwives** and **nurses**.

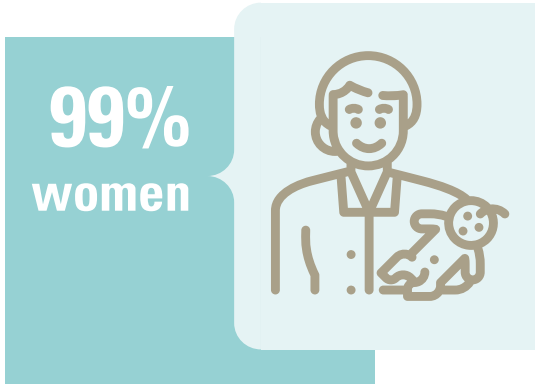
# ACTIVITY



**Déborah**, **Nora** and **Joël** are entering the workforce. They join the thousands of practitioners already working in their respective professions.

On this occasion, we will take a look at who these professionals are. Through various statistics, such as distribution by gender, age, occupational status, sector of activity and density by population, we will attempt to capture an image of the composition of these professions for a given year.

# 1. Midwives

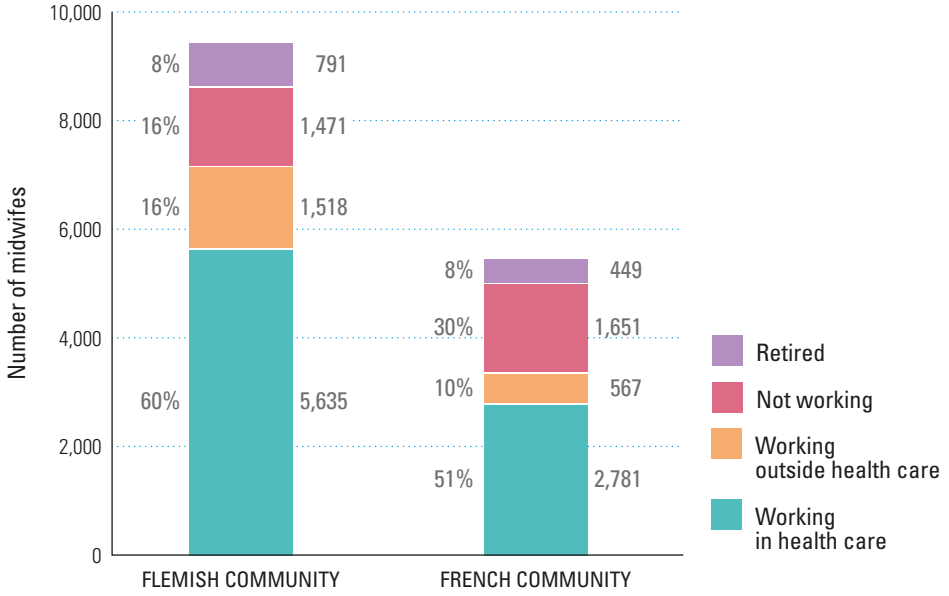



Midwifery is largely dominated by women, who make up 99% of the profession. In 2019, of the 8,416 active midwives, only 99 of them were male.

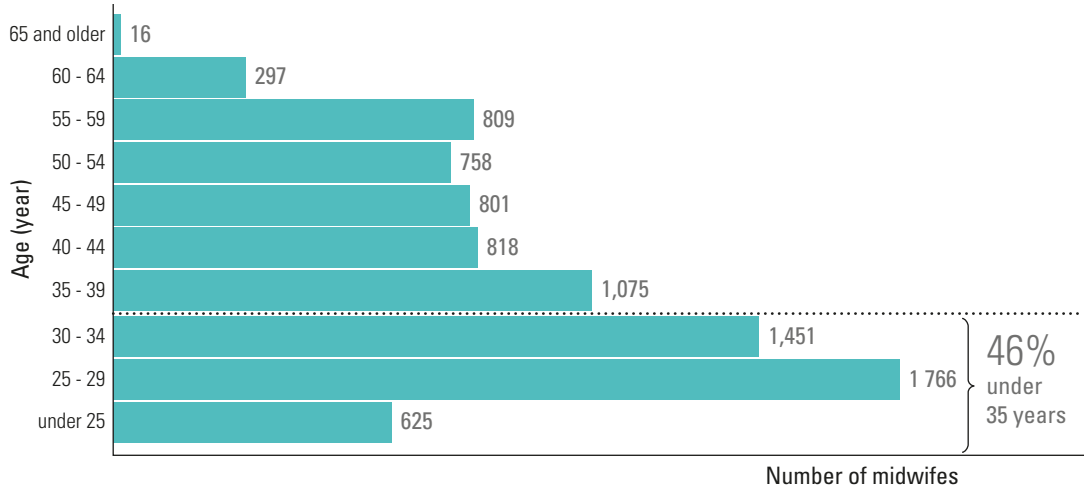
In 2019, **14,863 professionals were licensed to practise midwifery** in Belgium. Of these, 57% were working in health care (i.e. **8,416 practising midwives**), 14% were active outside the healthcare sector, 21% were not working in Belgium and 8% were retired.

Almost half of the midwives working in health care were **under 35 years old**.

DISTRIBUTION OF MIDWIVES BY ACTIVITY STATUS AND COMMUNITY, 2019




DISTRIBUTION OF ACTIVE MIDWIVES IN HEALTH CARE BY AGE, 2019

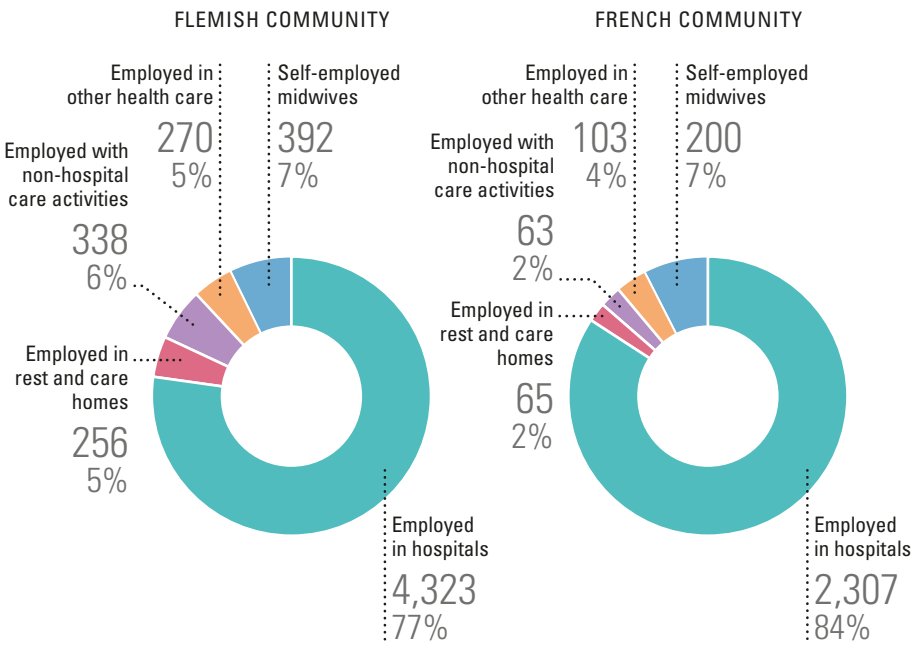


# Midwives

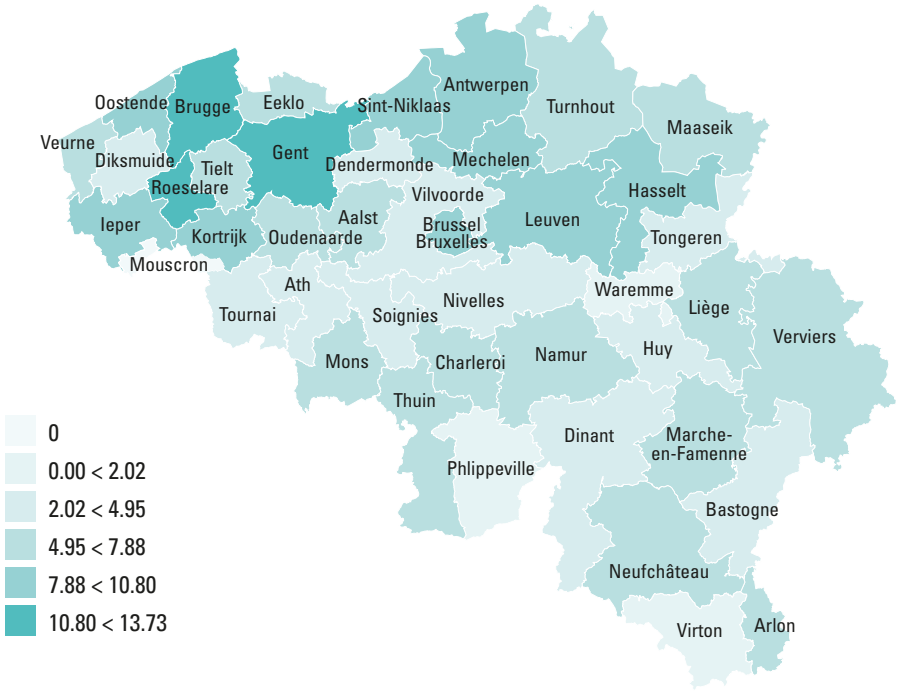
Two thirds of them were active in the Flemish Community and one third in the French Community. Most of them were **working as employees in hospitals**.

The density of midwives working in health care in Belgium was higher in the Flemish and Brussels-Capital Regions than in the Walloon Region (8.1 and 9.7 versus 5.2 respectively).

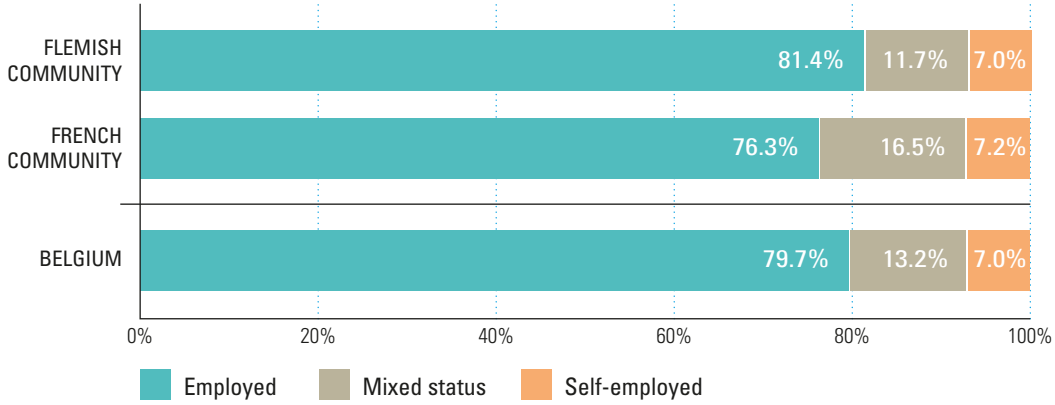
SECTOR OF ACTIVITY OF MIDWIVES WORKING IN HEALTH CARE IN 2019




NUMBER OF MIDWIVES WORKING IN HEALTH CARE PER 10,000 INHABITANTS BY ACTIVITY DISTRICT (31/12/2019)



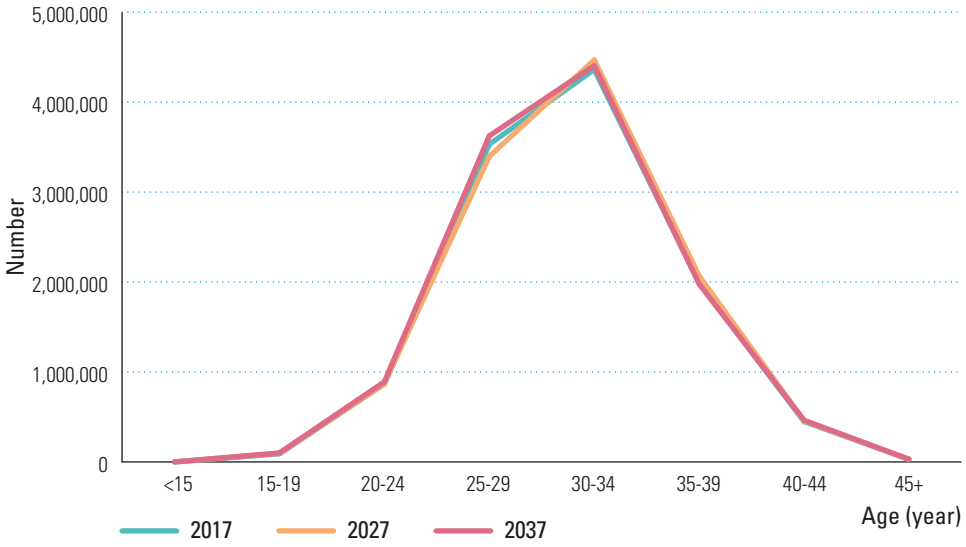

PROFESSIONAL STATUS OF MIDWIVES WORKING IN HEALTH CARE IN 2019



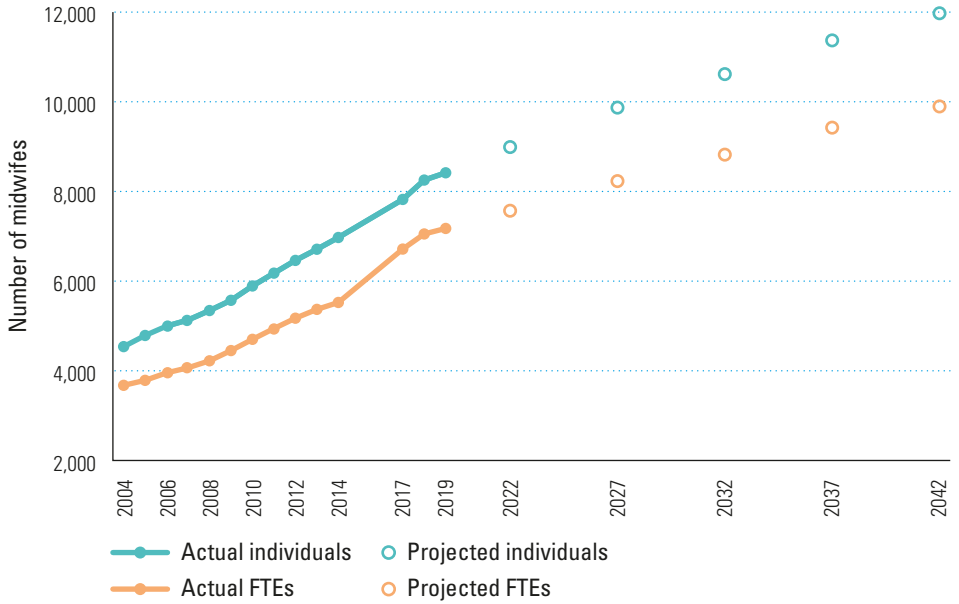
# Midwives

In the midwifery supply and demand projection exercise, we find that the need for midwifery care by 2037 is expected to remain stable while the number of midwives active in health care is projected to increase by just over 30% between 2020 and 2037 (in individuals and full-time equivalents).

SIZE OF EACH SEGMENT OF THE FEMALE POPULATION IN CURRENT AND FUTURE MIDWIFERY CARE IN RELATION TO ITS DEMOGRAPHIC CHANGE[10]

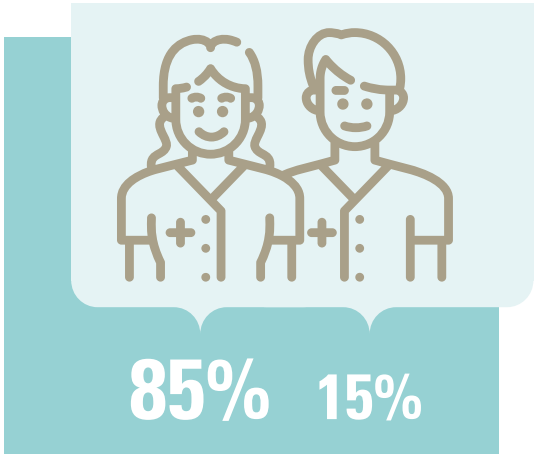



EVOLUTION OF THE NUMBER OF MIDWIVES ACTIVE IN HEALTH CARE AS INDIVIDUALS AND FULL-TIME EQUIVALENTS FROM 2004 TO 2019 AND PROJECTIONS TO 2042




10 Explanation of the weighted population: the 'gross' population projections by the Federal Planning Bureau and the Belgian Statistical Office are multiplied by a consumption rate based on consumption rate based on the consumption of care "honoraria of midwives" by the NIHDI. The average total amount reimbursed by the NIHDI is calculated per community and is the reference value. The rate of health care consumption for each segment of the population is then calculated in relation to this reference value.

# 2. Nurses

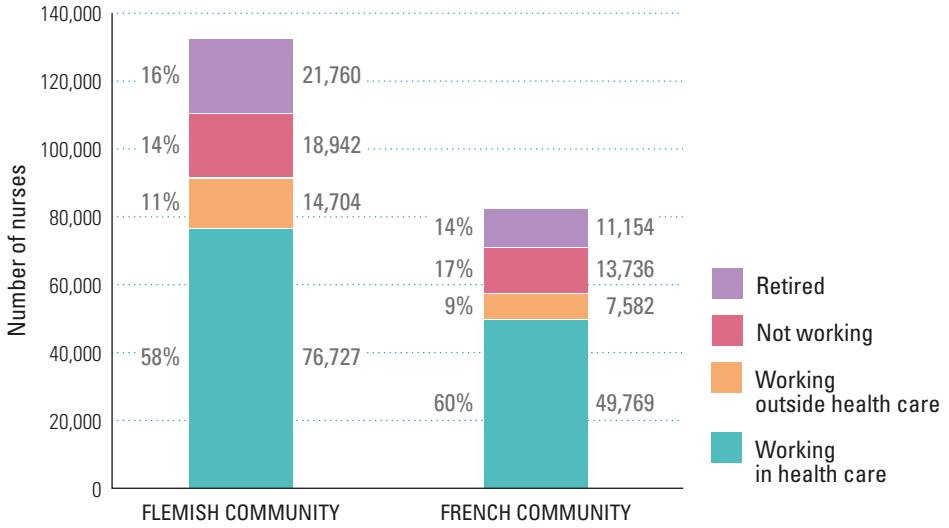



Traditionally, the professional nursing group has been composed **primarily of women**. Belgium has approximately 85% female nurses. This percentage has been stable for many years.

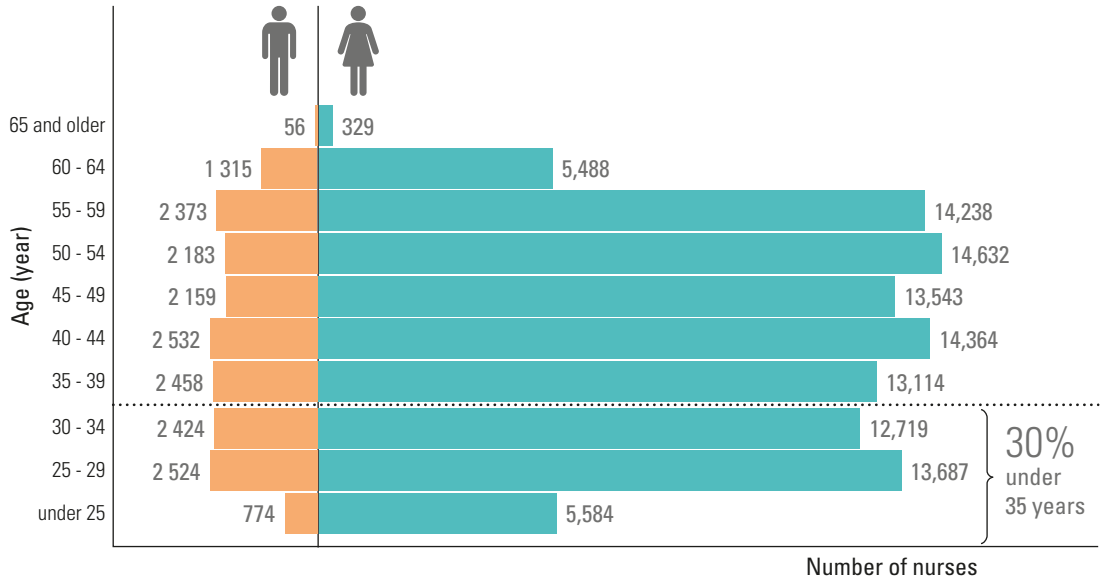
In **2018, 214,374 professional practitioners were licensed to practise nursing in Belgium**. Of these licensed professionals, 59% (or 126,496 nursing practitioners) were active in the health-care sector, 10% were active outside the healthcare field, 15% were not working in Belgium and 15% were already retired.

The age pyramid shows an even distribution of nurses by age.

DISTRIBUTION OF NURSES BY ACTIVITY STATUS AND COMMUNITY, 2018




DISTRIBUTION OF NURSES ACTIVE IN HEALTH CARE BY AGE AND GENDER, 2018



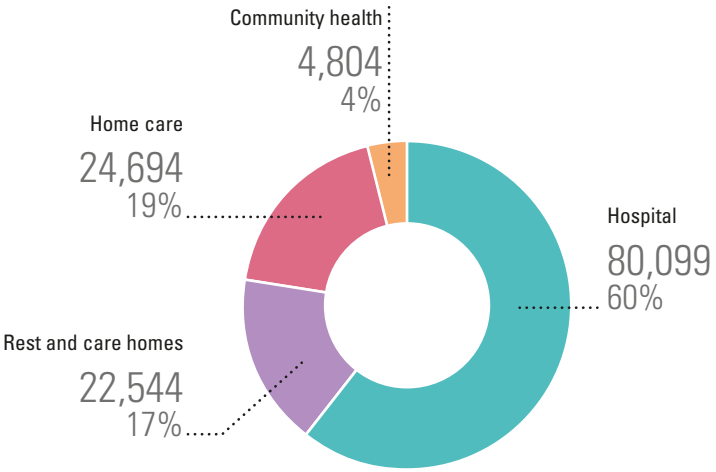
# Nurses

The professional group is also divided equally between the different Communities. 60% of the nurses working in health care work in the Flemish Community and 40% in the French Community. Each year, just over 2,000 individuals are added to the number of nurses working in the healthcare field.

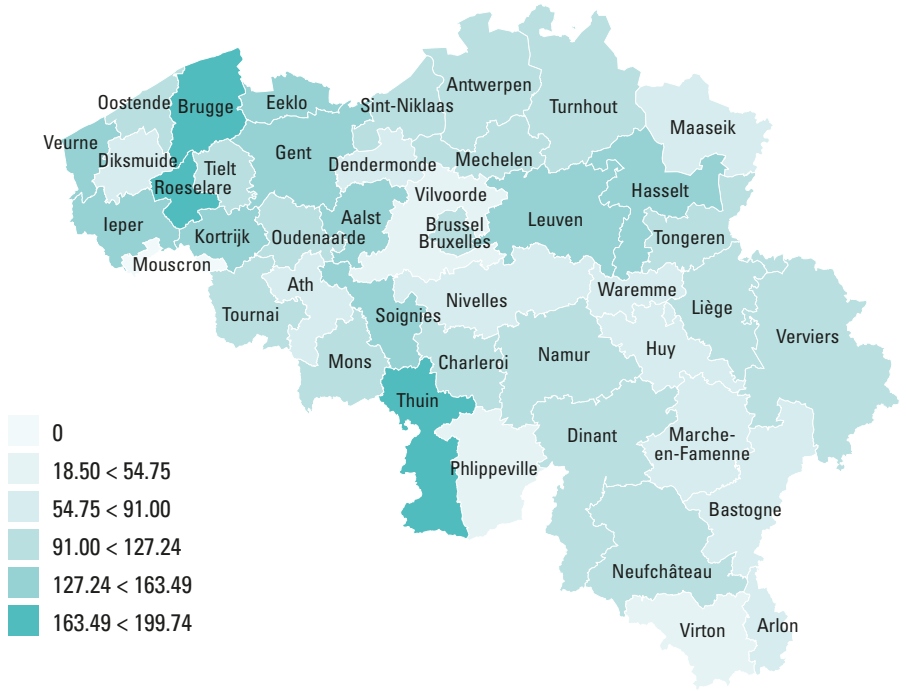
Most nurses had a **salaried professional status** (83%) and mainly worked in a hospital. The nursing and care home sector and the home nursing sector completed the top 3.

The density of the number of nurses working in health care was slightly higher in the Flemish Community (113.6 per 10,000 inhabitants) than in the French Community (109).

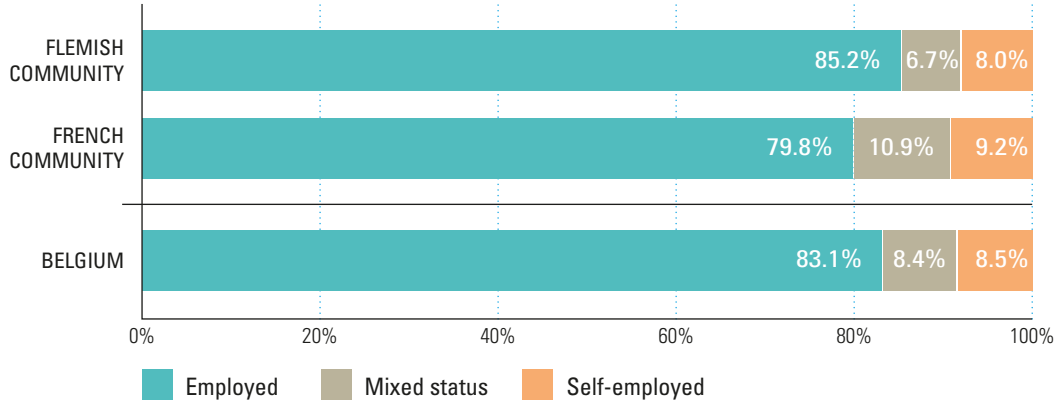
SECTOR OF ACTIVITY OF NURSES WORKING IN HEALTH CARE IN 2018




NUMBER OF NURSES WORKING IN HEALTH CARE PER 10,000 INHABITANTS BY ACTIVITY DISTRICT (31/12/2018)



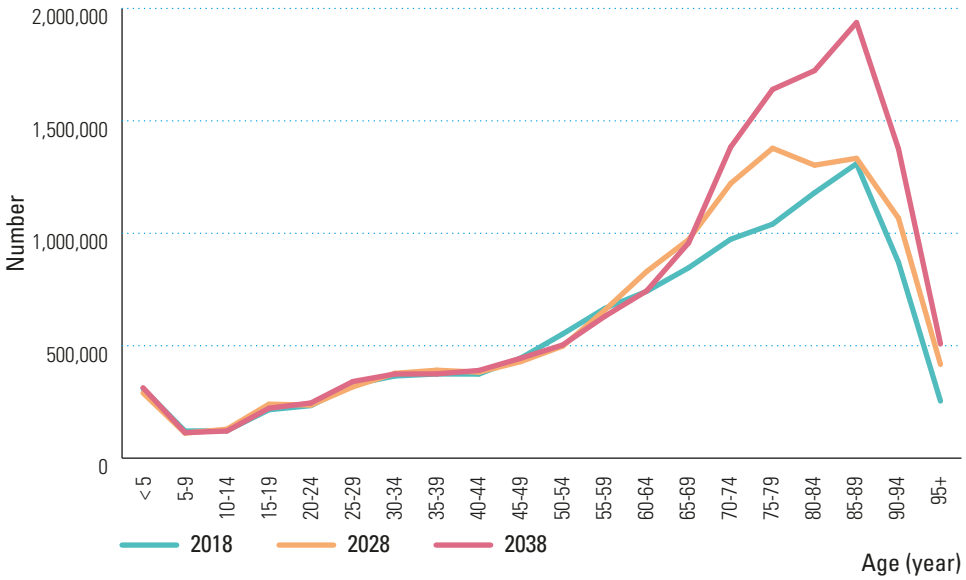

PROFESSIONAL STATUS OF NURSES WORKING IN HEALTH CARE IN 2018



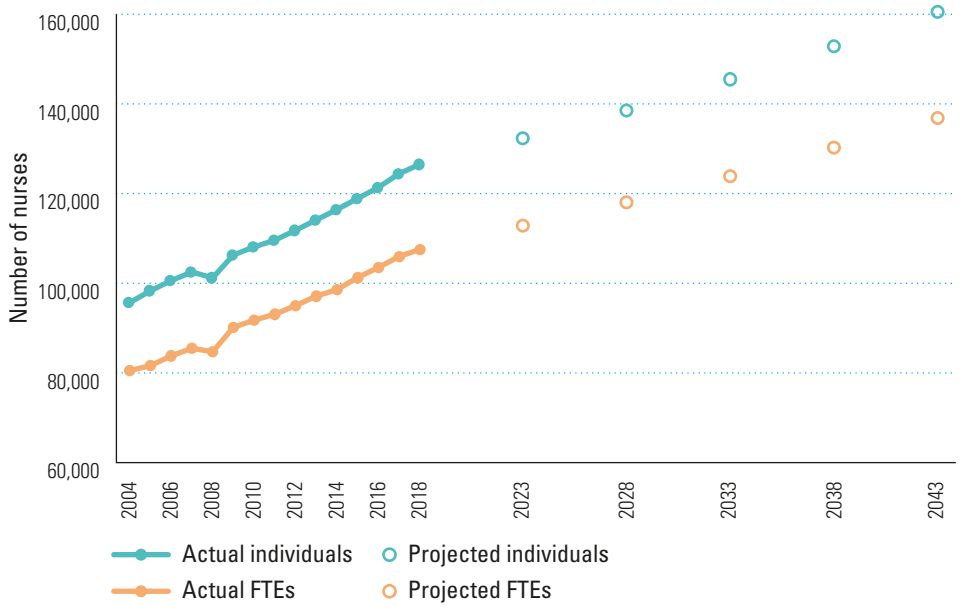
# Nurses

In the nurse supply and demand forecasting exercise, we find that nursing needs between now and 2038 will increase sharply for the age categories 65 and older. At the same time, an increase of just over 25% in the number of nurses working in health care is expected.

SIZE OF EACH SEGMENT OF THE POPULATION IN CURRENT AND FUTURE NURSING CARE IN RELATION TO ITS DEMOGRAPHIC CHANGE[9]

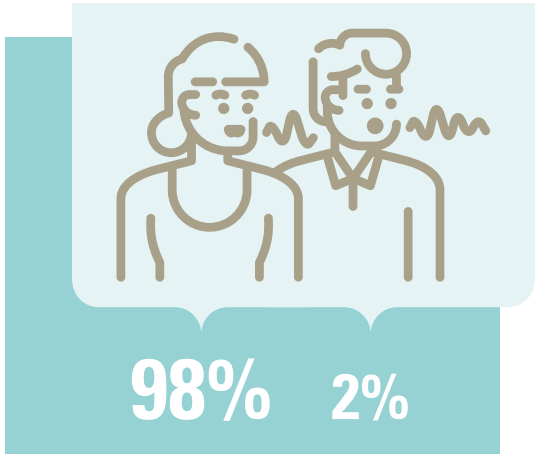



EVOLUTION OF THE NUMBER OF NURSES ACTIVE IN HEALTH CARE AS INDIVIDUALS AND FULL-TIME EQUIVALENTS FROM 2004 TO 2018 AND PROJECTIONS TO 2043




11 Explanation of the weighted population: the 'gross' population projections by the Federal Planning Bureau and the Belgian Statistical Office are multiplied by a consumption rate based on consumption rate based on the consumption of care "honoraria of nurses" by the NIHDI. The average total amount reimbursed by the NIHDI is calculated per community and is the reference value. The rate of health care consumption for each segment of the population is then calculated in relation to this reference value.

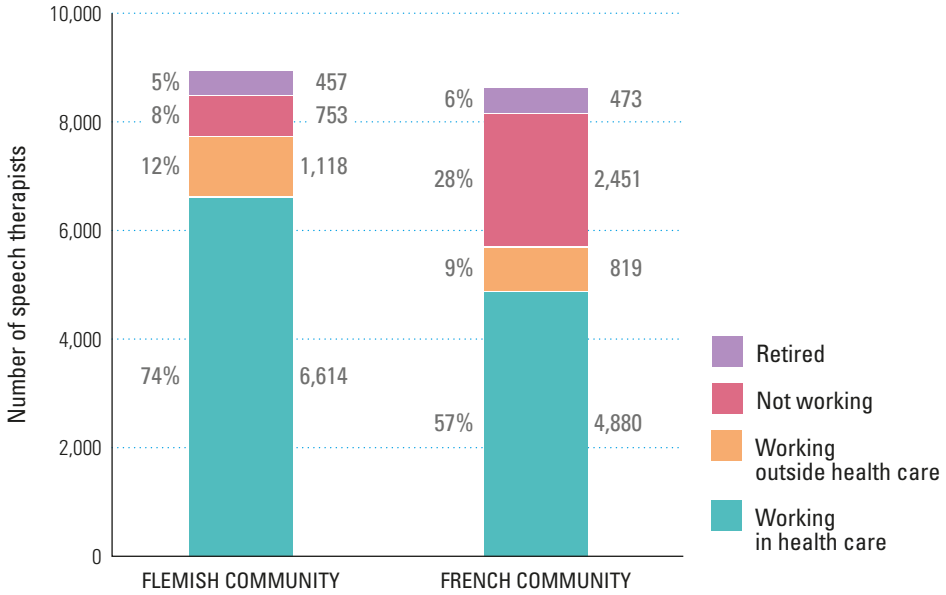
# 3. Speech therapists



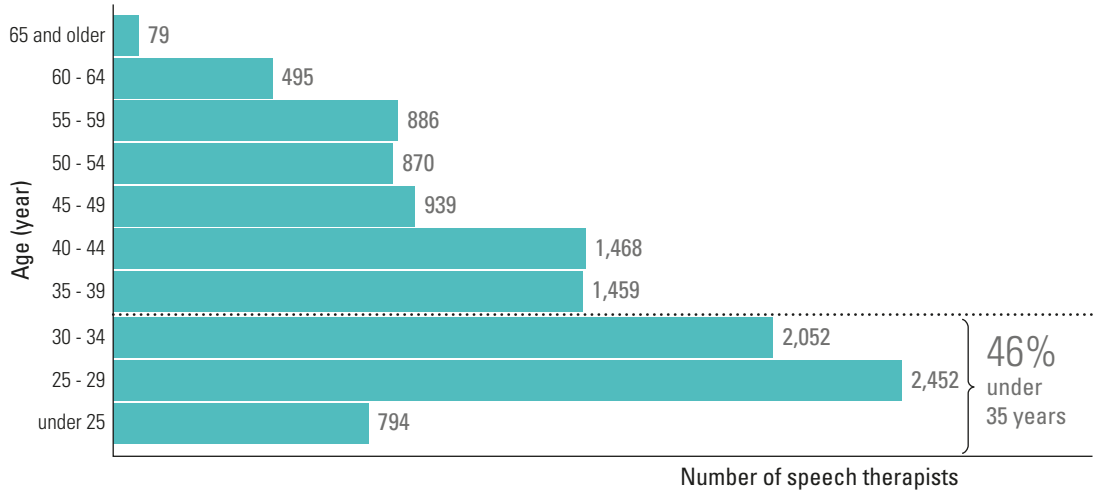

In 2019, there were **17,565 professional practitioners licensed to practise as a "speech therapist"** in Belgium. Of these, 65% were working in the healthcare sector (**11,494 speech therapists**), 11% outside the healthcare sector, 18% not working within Belgium and 5% were retired. Of these speech therapists working in health care, 58% worked in the Flemish Community and 42% in the French Community.

The profession was quite **young and female**, as 46% of speech-language pathologists working in the healthcare sector were under 35 years of age and 98% of them women.

DISTRIBUTION OF SPEECH THERAPISTS BY ACTIVITY STATUS AND COMMUNITY, 2019



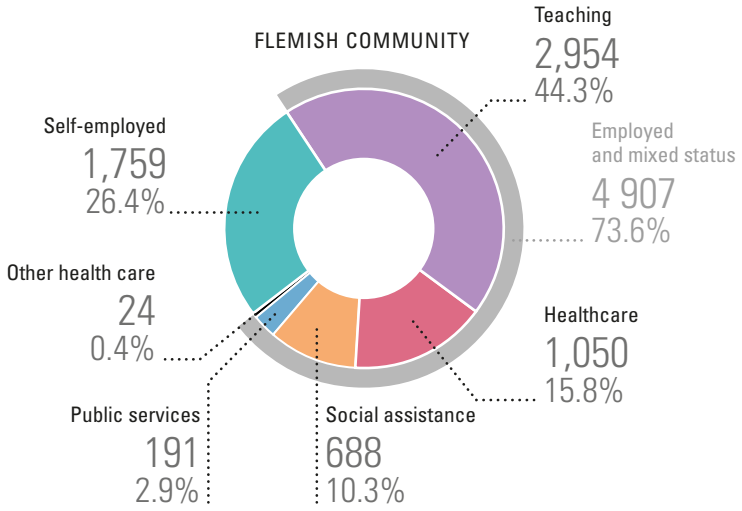

DISTRIBUTION OF SPEECH THERAPISTS IN HEALTH CARE BY AGE, 2019



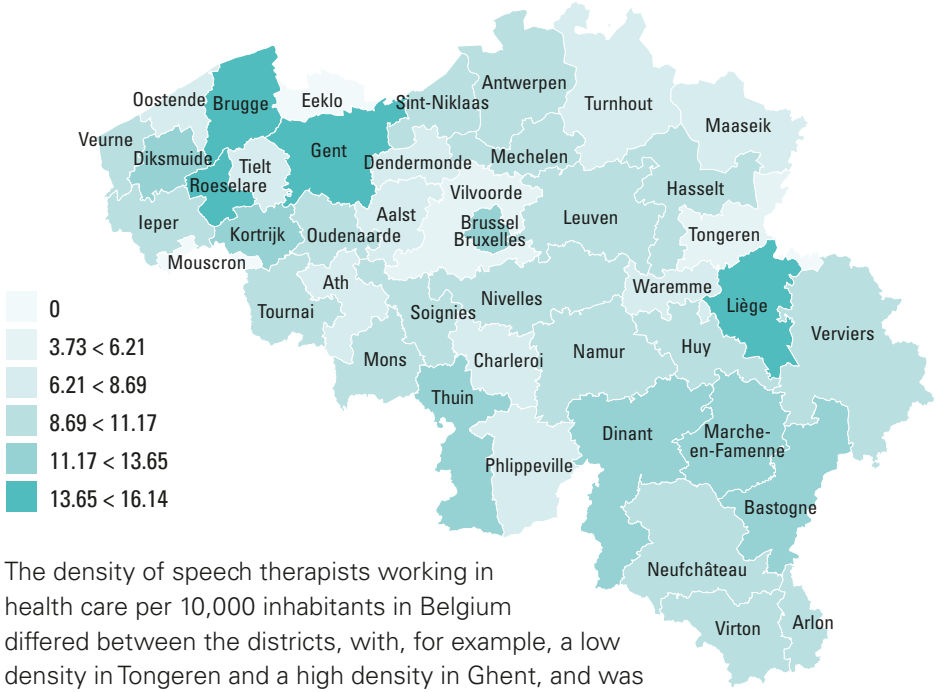
# Speech therapists

Most speech therapists had an exclusively salaried professional status and mainly worked in **teaching**.

OCCUPATIONAL STATUS AND SALARIED SECTOR OF ACTIVITY FOR SPEECH THERAPISTS WORKING IN HEALTH CARE IN 2019[12]

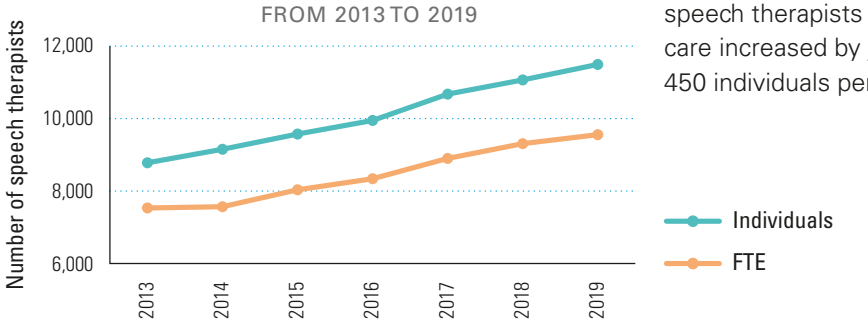



NUMBER OF SPEECH THERAPISTS WORKING IN HEALTH CARE PER 10,000 INHABITANTS BY ACTIVITY DISTRICT (31/12/2019)




The density of speech therapists working in health care per 10,000 inhabitants in Belgium differed between the districts, with, for example, a low density in Tongeren and a high density in Ghent, and was more pronounced in the Brussels-Capital Region than in the other Regions (9.60 in the Flemish Region; 9.76 in the Walloon Region; 12.71 in the Brussels-Capital Region).

EVOLUTION OF THE NUMBER OF SPEECH THERAPISTS IN HEALTH CARE AS INDIVIDUALS AND FULL-TIME EQUIVALENTS FROM 2013 TO 2019




On average, based on the change between 2013 and 2019, the number of active speech therapists in health care increased by just over 450 individuals per year.

12 The sectors of employment are known for speech therapists with an employed status but not for the self-employed speech therapists.

# QUALITY

A series of measures are in place to ensure both the quality of the training given to professionals and the quality of the care they provide throughout their career. We will explore them in this last section.

## 1. The consultation bodies

As seen previously, the consultative bodies play an essential role. Based on their recommendations, the training of healthcare professionals is modified and adapted to scientific and technological developments, as well as to the needs of the population.

Based on the recommendation of the councils, it is possible, for example, to extend the competences of certain professions when they deem it necessary. This sometimes goes hand-in-hand with an extension in the duration of studies.

A quality control can also take place through an obligation of continuous training throughout the professional practice, so that their knowledge is regularly updated. Medicine and the healthcare field are constantly evolving, so it is important that the care provided changes accordingly.

The consultative bodies can therefore give their recommendation on a multitude of subjects concerning the quality of care or the quality of training. The people who sit on these bodies include a large number of professionals who carry out their daily activities in addition to this mandate. They are therefore in a better position than anyone else to see what changes need to be made to maintain the best possible level of quality.

# 2. The Quality Act

Another guarantor of the quality of the care provided is the Health Care Quality of Practice Act of 22 April 2019 (hereafter Quality Act).

Its implementation is still in progress. This involves the carrying out of various projects to make this act a reality. These projects include:

| | |
|---|---|
| **Federal Control Commission** | It will eventually replace the provincial medical commissions. Its functions will be broader than those of these commissions. We will examine its role in more detail in section 3. |
| **Register of practices** | It is being developed and submitted to the various advisory bodies during 2022. Once completed, this register will be a database of what type of health care licensed providers are providing, where and with whom they are providing it, etc. The register meets a need in the field and among administrations. |
| **Portfolio** | Through this portfolio, a provider will be able to indicate that they have the necessary skills and experience to perform the practices, as indicated in the practice log. |
| **Computerised patient record** | The Patient's Rights Act [13] enshrines the principle that healthcare professionals must have a carefully maintained and securely stored patient record for each patient. The Quality Act specifies the information that this record must contain. |
| **Cooperation agreements for general practitioner out of hours services** | In the past, there were several ways to organise and fund out-of-hours time within general practice. The Quality Act aims to guarantee a more efficient organisation of care. The objective is to reduce the pressure on individual GPs, while guaranteeing the patient a high quality of round-the-clock medical service and gaining financial efficiency. |

# 3. Health inspectors at the Federal Control Commission

## 3.1. The inspectors

The health inspector has always played a key role in monitoring the abilities of health professionals and the quality of practice. This function has existed since the Health Act was enacted on the 1st September 1945.

Since 1 June 2019, two inspectors, one French-speaking and one Dutch-speaking, have been dedicated full-time to the supervision of health professionals and the protection of public health. They are called **"Healthcare professional medical inspectors"**.

13 Law of 22 August 2002 concerning the Rights of Patients

There are also other types of health inspectors. Some are competent to respond in the event of contagious diseases and infections, while others are dedicated full-time to emergency medical assistance activities.

## 3.2. The Federal Control Commission

The Medical Commissions are an ancient institution, predating the foundation of the Belgian State. With the evolution of legislation, notably the entry into force of Royal Decree No. 78 (1967), they gradually lost their competence in the accreditation of professionals and the recognition of practitioners from abroad.

However, the Commissions have remained competent for monitoring the physical and mental abilities of health professionals and the protection of public health. Their missions included the following:

- temporarily revoke or limit the endorsement of a health care professional when it is determined that the individual's continued practice raises concerns about serious consequences for patients or public health
- contribute to public health and prevent or combat diseases subject to quarantine and communicable diseases
- ensure that the healthcare professions are practised in accordance with the laws and regulations
- investigate and report to the prosecutor's office cases of illegal practice of healthcare professions
- withdraw or limit the endorsement of a healthcare professional who no longer has the physical or mental capacity to continue to practise safely
- etc.

The Quality Act has modernised the organisation of these entities. The Medical Commissions have been replaced by a single, centralised Federal Control Commission, organised into language chambers. Like the Medical Commissions, it is responsible for controlling the physical and mental abilities of professionals.

In addition to the tasks taken over from the former Medical Commissions, new responsibilities have been added.

They include:

- the Quality Act entrusts the Commission with monitoring compliance with quality criteria for the practice of healthcare professionals
- the Control Commission has the power to temporarily ban professionals who represent a danger to patients or public health from practicing

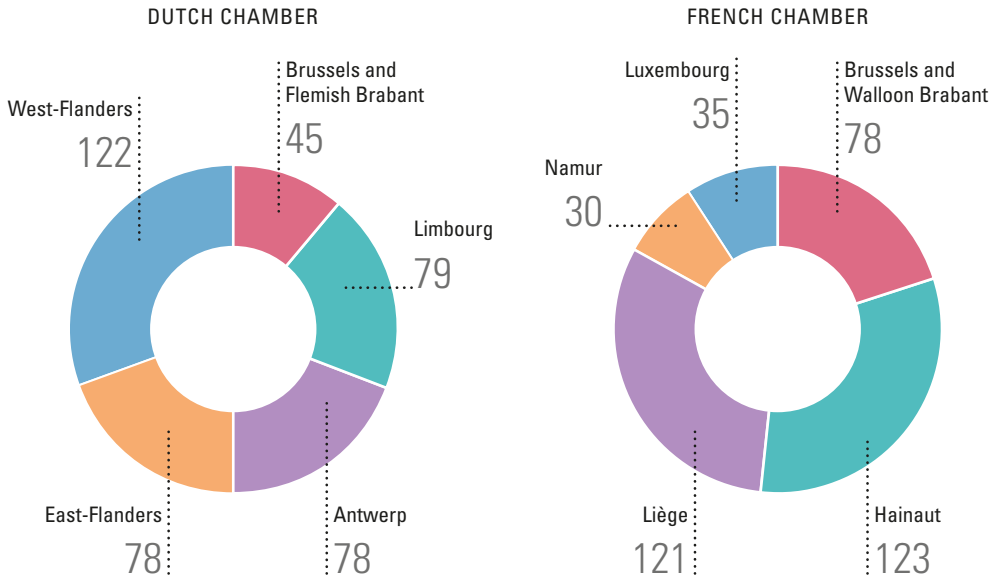
The Federal Supervisory Commission consists of one or more French-speaking and one or more Dutch-speaking chambers. These language chambers take the necessary decisions within the framework of the requirements of the Quality Act on the basis of records or data.

The medical inspectors investigate these files if necessary. In this respect, their investigative powers have been strengthened. Inspections can also be carried out by inspectors of the Federal Agency for Medicines and the control and evaluation service of NIHDI. The Minister of Health also has the power of injunction to investigate facts.

All these measures have been put in place to protect public health. When a health care professional is no longer able to practise, for physical or mental reasons, it is imperative to be able to control the extent to which their activity must be limited or prohibited in order to guarantee patient safety. Furthermore, when a health professional's practice no longer meets quality standards, they must start an improvement process.

Some of the measures of the "Quality Act" are already in place, and others are still being implemented. The long-term goal is to adopt a more modern, transparent and effective monitoring policy than previously, in consultation and collaboration with all healthcare stakeholders.

CASES HANDLED BY THE FEDERAL COMMISSION IN 2020




The graphs above illustrate the number of cases processed by the two chambers of the Federal Commission in 2020 and the distribution of these cases by region. These numbers vary from year to year depending on a variety of factors. In their reports, the chambers may include other relevant details, such as:

- the number of files by profession
- the number of penalties
- the type of records (physical or psychological aptitude assessment, illegal practice, etc.)
- the records based on existing risk to the patient or public health
- etc.

# 4. Quality of training for medical specialists

## 4.1. Specialist physicians

On completion of basic medical training, the new professional may undergo additional theoretical and practical internship to become certified in a particular field. The theoretical part takes place in practice within the universities.

**The practical internship takes place with internship supervisors approved by the FPS Public Health** (see internship supervisor approval section above). Depending on the specialties, this additional training can last between three and six years, at the end of which the specialist physician in training can request approval in the desired specialty (e.g. orthopaedic surgery, etc.). After this specialisation, the specialist physician can take further training to acquire an additional qualification such as intensive care or clinical haematology.

Specialist physicians in training are called *MSFs*.

### FUNDING FOR PRACTICAL INTERNSHIP

Since the conclusion of a collective agreement in May 2021, all MSFs have the same minimum basic pay in hospitals in Belgium. Their salaries are funded as follows:

- by the fees they generate by performing procedures;
- by the funding allocated to hospitals in the budget of financial resources.

In addition, the internship supervisor also receives compensation for the educational component of the internship, via NIHDI.

**For more information about remuneration**

**www.health.belgium.be**

### QUALITY OF THE PRACTICAL INTERNSHIP

The MSF internship quality project is being conducted in **several phases**. Its ultimate goal is to improve the quality of internship, in particular through the implementation of a new internship quality monitoring system.

### ANALYSIS OF THE QUALITY SYSTEM IN DIFFERENT COUNTRIES

The Federal Centre of Health Care Expertise (KCE) published a report in 2010 entitled "Critères de qualité pour les lieux de stage des candidats-médecins généralistes et candidats-spécialistes". This report compares the quality system of internship sites in Belgium with those in France, Canada, the United Kingdom, Switzerland and the Netherlands.

To incorporate the innovations made since 2010, the training quality assessment and improvement project team conducted a similar exercise comparing the quality systems of these different countries.

It was concluded that Belgium has taken few concrete steps towards a quality system, while other countries are still developing. The best practices from other countries will be used in the development of a new quality system.

## E-BROCHURE FOR MSFS

In March 2022, the FPS launched an e-brochure for MSFs. It aims to inform MSFs of the complex division of competencies, the legislation and the structures available in the event of problems during internship.

It provides support and answers questions that MSFs often face during their internship.

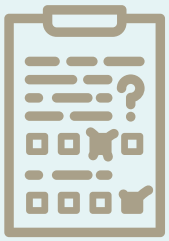
**Consult this brochure:**

**www.macs-aso.be**

## SURVEYS

Key players in training were interviewed to help conceptualise a quality system. They included MSFs, internship supervisors and coordinating internship supervisors.

These questionnaires allowed us to evaluate the current situation and have a vision of the future of the internship.



A total of **2,200 MSFs**, **708 internship supervisors** and **220 coordinating internship supervisors** responded to the survey sent to them

The questions were based on the existing legislation and the criteria of the WFME (World Federation of Medical Education), as well as on the systems of other countries and feedback from the representatives of the assistants' associations and the members of the "Medical Specialists" working group of the Superior Council of Specialist Physicians and General Practitioners.

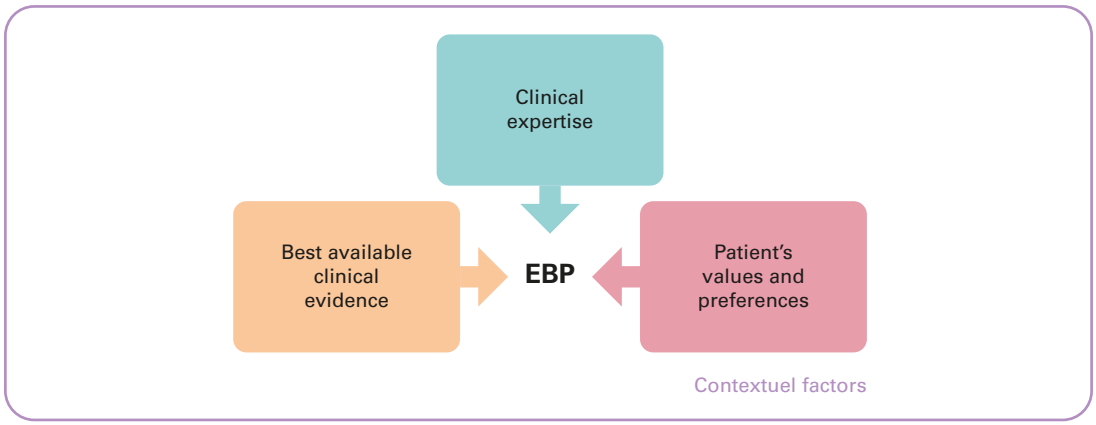
The results, collected in June 2022, were analysed throughout the summer. A report is being prepared and will be sent to the Minister of Health's office at the end of the year with recommendations. This report will then be published.

### THE FUTURE OF MSF INTERNSHIP

Based on the survey results, a step-by-step plan will be developed to improve the quality of training. This will also require the adaptation of the current legislation.

## 5. Evidence-based Practice (EBP)

"EBP" refers to "Evidence-based Practice". It is defined as "the conscientious, explicit, and judicious use of current evidence in making decisions about the care of individual patients".




As illustrated in the diagram above, the primary objective of EBP is to combine:

- individual **clinical expertise**;
- with the best available **clinical evidence** from systematic research;
- while taking into account the **patient's values and preferences**.

A fourth dimension is added, namely **"contextual factors"**. These are the elements (such as cost and resource availability) that potentially affect or hinder the strength of a recommendation or the implementation of a guideline.

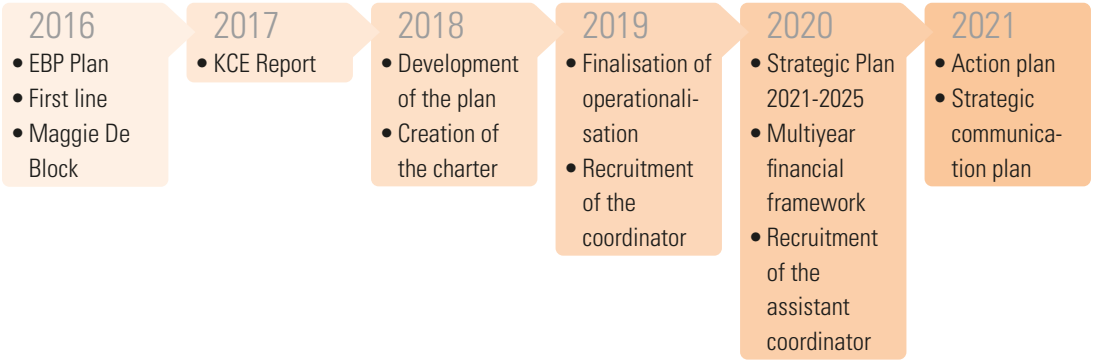
EBP plays a major role in **health policy** in two main areas:

- it contributes to improving the quality of care in terms of effectiveness and efficiency, and
- it helps to keep health care spending under control.

Healthcare practice is increasingly based on **scientific evidence, which is constantly evolving**. Staying informed of the latest science is a real challenge for providers. **Clinical practice guidelines** and other EBP materials are **developed and disseminated to support healthcare practitioners in this process**.

This involves the participation of various stakeholders, who collect and disseminate reliable information, evaluate these materials, share knowledge through training, etc.

It is to ensure the **coordination of these initiatives** that the EBP Network was created in 2018.




The Network combines the expertise of Core Partners[14] with that of stakeholders such as professional and patient associations; they are all represented on an advisory board.

The strategic unit of the Minister of Public Health, the FPS Public Health, NIHDI and the FAMHP are actively involved in the EBP Network via the steering committee. They participate by providing funding and contributing to the definition of strategic directions.

The activities of the Belgian EBP network respect the EBP life cycle.


14 Such as KCE, WOREL (Working Group for the Development of Primary Care Recommendations), Minerva, CDLH (Cebam Digital Library for Health), Ebpracticenet and CEBAM (Belgian Centre for Evidence-Based Medicine)

- **Prioritisation:** the objective is to select the **priority topics** and propose a strategic approach to the different EBP activities.
- **Development:** the objective is to maintain or increase the quality and accuracy of EBP products and develop new EBP products for Belgian users.
- **Validation:** the objective is to evaluate the **scientific and methodological validity** of the EBP products developed. The approval of the Validation Unit guarantees the quality, precision, appropriateness and validity of EBP products for the Belgian context; it is a prerequisite for the dissemination of clinical practice guidelines within the EBP network.
- **Dissemination:** the objective is to **actively disseminate** clinical practice guidelines and other validated EBP products to various users.
- **Implementation:** the objective is to **stimulate the implementation** of EBP principles and increase the adoption of EBP products.
- **Evaluation:** the objective is the development, selection, implementation, and monitoring of procedures for evaluating the implementation, compliance, and/or impact of clinical practice guidelines or other EBP products disseminated through the EBP Network.

**For further information on EBP:**

**www.health.belgium.be**

# FUNDING

Because the professional is at the heart of the health field, the necessary resources must be implemented to enhance their functions and improve their working conditions over the long term.

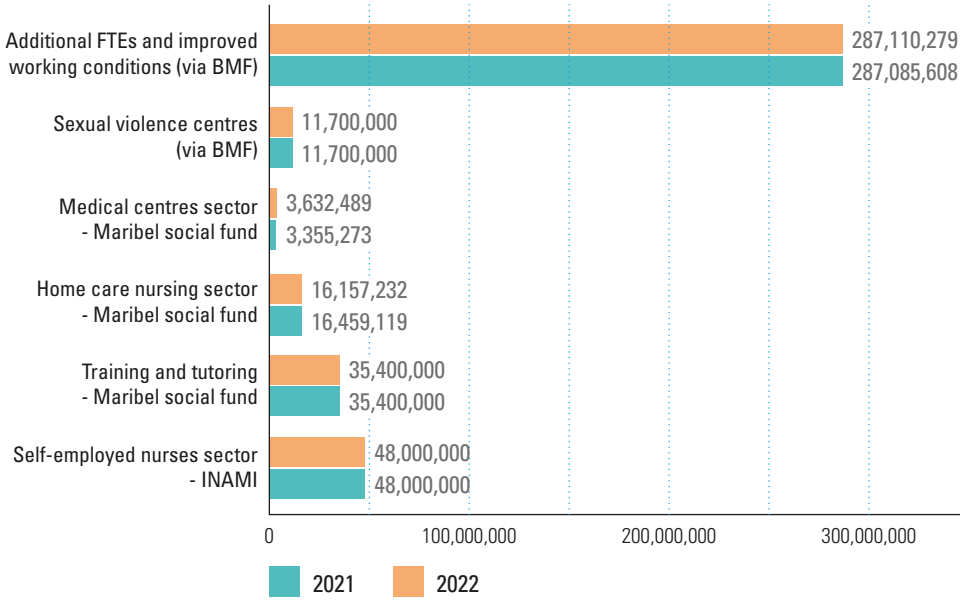
Here, we will highlight two actions launched for these purposes. One specifically affects the nursing profession, while the other has reformed healthcare functions in a global manner.

## 1. The Fonds Blouses Blanches (White Coat Fund) (FBB)

The Fonds Blouses Blanches was established by the implementation of the Act of 9 December 2019. Under this Act, budgetary resources are made available to improve the employment and supervision of nursing practitioners, and the attractiveness of these professions.

The purpose of the fund is to finance a net increase in the employment of caregivers, the improvement of working conditions for caregivers, and training and support for mentoring projects.

DISTRIBUTION OF THE FONDS BLOUSES BLANCHES (WHITE COAT FUND) RESOURCES FOR 2021 AND 2022




The expenditures that may be made from the Fund also include those for support staff who relieve the caregiver of the burden of care, and who are in direct contact with the caregiver to enable them to increase their effective time for patient care, with a priority on bedside care.

**Learn more:**

**www.becaremagazine.be**

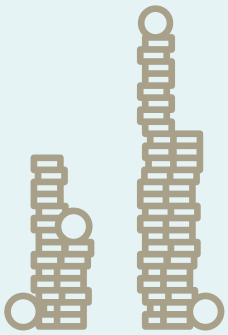
## 2. IFIC

The principle of the IFIC (Institute for the Classification of Functions) is as follows: each sectoral function is described by means of identical criteria for all functions and classified in a function category on the basis of the result obtained.

To these job classifications are added salary models; the applicable scales are determined by the categories in which the jobs are classified. The new IFIC functions therefore focus on the tasks performed and the content of the function to determine the compensation to which workers are entitled.

### IMPLEMENTATION IN THE FEDERAL PRIVATE HEALTHCARE SECTOR

Between September 2016 and March 2021, various collective agreements were made to implement the new classification and the new salary model.



The implementation of this new model represents a **6% increase** in payroll for the affected federal private health sectors - a total of more than **450 million euros** for 2022.

The procedures put in place by the social partners ensure that no employee in service suffers a loss of salary as a result of the implementation.

The implementation took place in phases:

1. In **phase 1**, all workers in service on 30 April 2018 received a function award and then were given the option of opting into the new IFIC schedule or retaining their existing salary terms based on their monetary benefit over the remainder of their career, with the exception of specialist nurses who received a specific job title or specific job qualification award.

   An employee who opted out of the IFIC system would therefore continue to enjoy their existing salary conditions, including any future increases agreed upon.

   All newly hired workers since 1 May 2018 received their function award and corresponding IFIC scale directly.

2. In **phase 2**, starting on 1 July 2021, the implementation of IFIC was applied 100% to all employees in service, it being understood that the application of the new scales would in no way result in a reduction in salary.

   Nurses registered for a title or qualification who received a premium for their specialisation and were not paid according to the IFIC model retained their right to this premium as long as they continued to perform a nursing function.

## IMPLEMENTATION IN THE FEDERAL PUBLIC HEALTHCARE SECTOR

Negotiations between the social partners resulted in the conclusion, within Committee A, of four memoranda of understanding on the implementation of IFIC in the public sector.

The job classification and the associated scales are identical in the federal private and public health sectors.

The procedures put in place to supervise the implementation in the federal public sectors (assignment of duties to workers, recourse, choice of scale) were similar to the application procedures in the private sectors, but have been adapted to the specific nature of the public sectors.

Workers in service who elected the IFIC scale prior to 6 December 2020 have been paid under the new schedules since 1 July 2021.

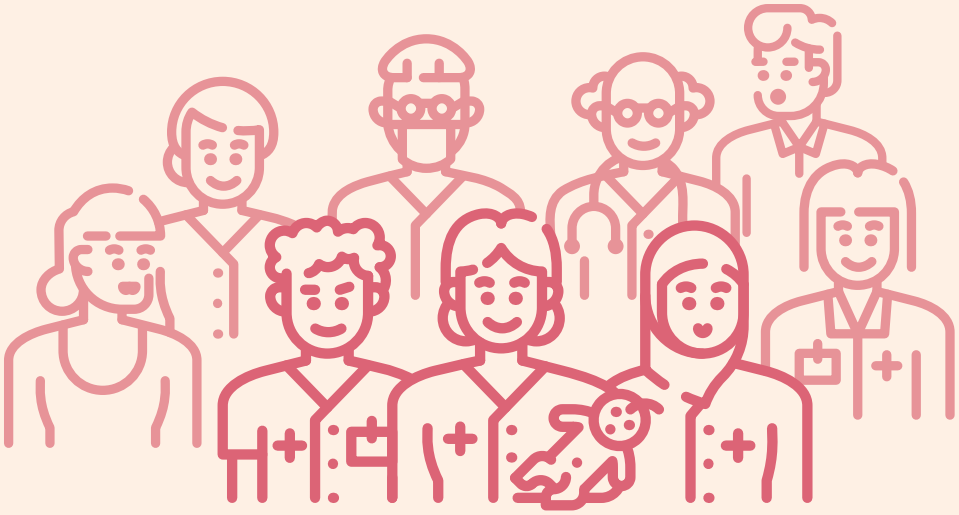
Workers newly hired on or after 9 November 2021 are paid at the new rates if their job function was activated in the hospital. Non-activated functions are not subject to the new scales.

**For more information:**

**IFIC**

# CONCLUSION

Through the journey of **Nora**, **Déborah** and **Joël**, we were able to follow the path that thousands of people who want to work in the healthcare field follow every year.



From their training to their day-to-day work, these professionals are dedicated to providing the best possible care to the public.

As health policies are launched, we support them to make this journey as smooth as possible.

It is through the courage, determination and resilience of healthcare practitioners around the world, and here in Belgium too, that we have weathered a pandemic of a scale new to us all. And it is also thanks to them that we can gradually return to "normal life".

This edition wanted to highlight their efforts and sacrifices. The hours spent sitting on school benches, in hospital corridors, in the office, at patients' bedsides, in consultations during night shifts; the tears shed in the changing room, the laughter exchanged between colleagues in the break room, the reports completed despite their tiredness, etc.

None of this has gone unnoticed. For all this, and more, we would like to thank them. And long after the pandemic, after the applause has died down, we will stand with them and listen and respond to their needs.

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