BELGIUM

Country Cancer Profile

2025

European Commission

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The Country Cancer Profile Series

The European Cancer Inequalities Registry is a flagship initiative of Europe's Beating Cancer Plan. It provides sound and reliable data on cancer prevention and care to identify trends, disparities and inequalities between Member States, regions and population groups. The Country Cancer Profiles identify strengths, challenges and specific areas of action for each of the 27 EU Member States, Iceland and Norway, to guide investment and interventions at the EU, national and regional levels under Europe's Beating Cancer Plan. The European Cancer Inequalities Registry also supports Flagship 1 of the Zero Pollution Action Plan. The Profiles are the work of the OECD in co-operation with the European Commission. The team is grateful for the valuable inputs received from national experts and comments provided by the OECD Health Committee and the EU Thematic Working Group on Cancer Inequality Registry.

Data and information sources

The data and information in the Country Cancer Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD Health Database.

Additional data and information also come from the European Commission's Joint Research Centre (EC-JRC), the EU statistics on income and living conditions (EU-SILC) Survey, the World Health Organization (WHO), the International Agency for Research on Cancer (IARC), the International Atomic Energy Agency (IAEA), the European Society for Paediatric Oncology (SIOPE), the European Union Agency for Fundamental Rights (FRA LGBTIQ), the Health Behaviour in School-aged Children (HBSC) survey as well as from the 2023 Country Health and Cancer Profiles, and other national sources (independent of private or commercial interests). The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway. Mortality and incidence rates are age-standardised to the European standard population adopted by Eurostat in 2013.

Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.

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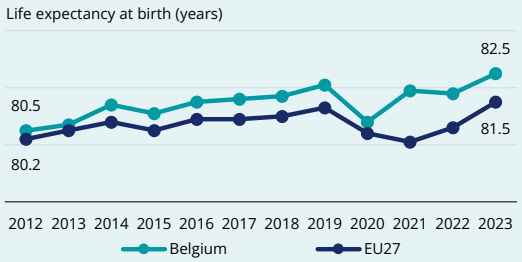
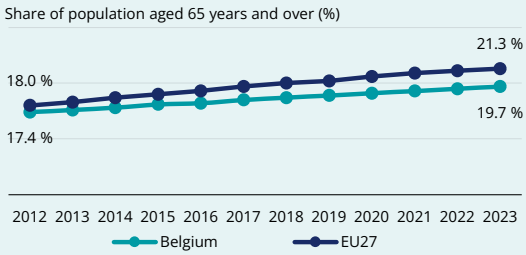
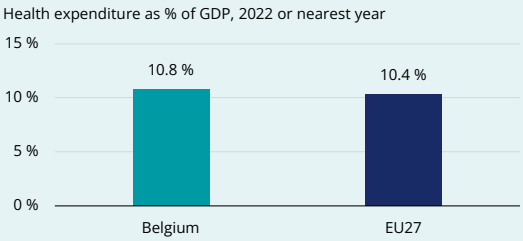
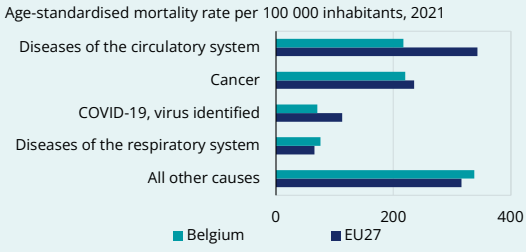


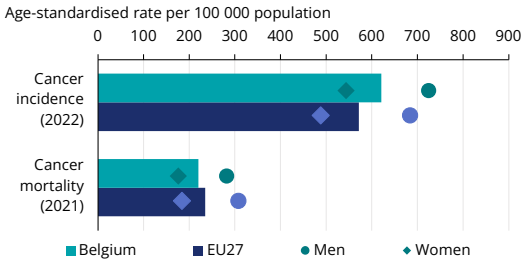






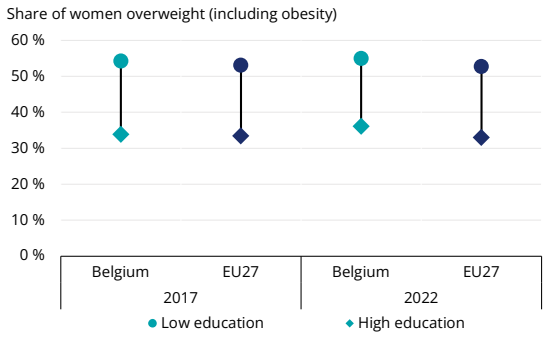
Source: Eurostat Database.

1. Highlights



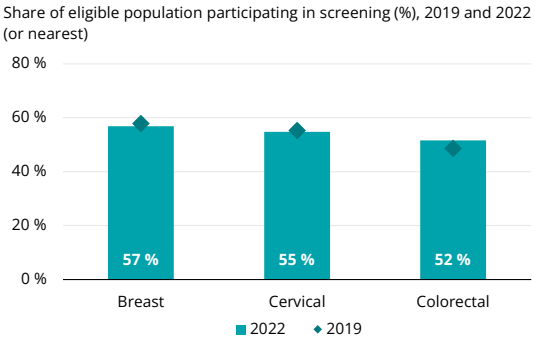
Cancer in Belgium

Estimated cancer incidence in Belgium is higher than the EU average among both men and women. Over the past decade, cancer mortality in Belgium has decreased significantly, and is now below the EU average. There has been a notable reduction in avoidable mortality from lung, breast and colorectal cancers. Individuals with lower education levels – especially men – experience higher cancer mortality rates.



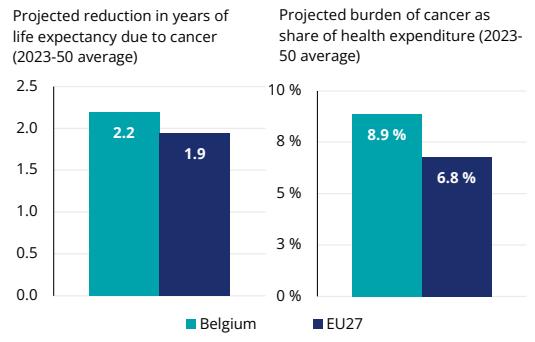
Risk factors and prevention policies

Belgium performs relatively well in managing behavioural risk factors, although challenges remain. Within the Belgian population, men and those with lower education levels are more likely to be daily smokers. To address this, Belgium started implementing a comprehensive anti-tobacco policy package in 2024-25. Alcohol consumption has decreased slightly over the last decade, and the first Inter-federal Plan on Alcohol (2023-25) has been approved with broad governmental support. There are notable regional and socio-economic disparities regarding overweight and obesity, with rates 50% higher among women with lower than higher education levels.



Early detection

Belgium operates population-based cancer screening programmes organised at the regional level. However, most breast cancer screening occurs outside the programme, with lower participation rates in Brussels and Wallonia regions. Colorectal cancer self-sampling is available nationwide. Flanders has an established population-based cervical cancer screening programme and Wallonia began implementation of one in January 2024. The Brussels region is developing a cervical cancer screening programme. All regions in Belgium organise initiatives to boost cancer screening awareness.



Cancer care performance

Belgium's compulsory health insurance covers nearly the entire population, but relatively high out-of-pocket payments are common. Access to imaging exams and radiotherapy without copayments varies widely across regions. Belgium excels in access to newer cancer medicines and innovative molecular tools. Overall, Belgium's five-year cancer survival rates have improved over the recent two decades. Challenges remain in implementing concentrated cancer care, although recent policies – such as concentrated treatment for younger people and complex surgery breast cancer clinics – show promise. Between 2023 and 2050, total health expenditure is estimated to be 9% higher in Belgium due to the burden of cancer.

2. Cancer in Belgium

The cancer incidence rate in Belgium is higher than the EU average among both men and women

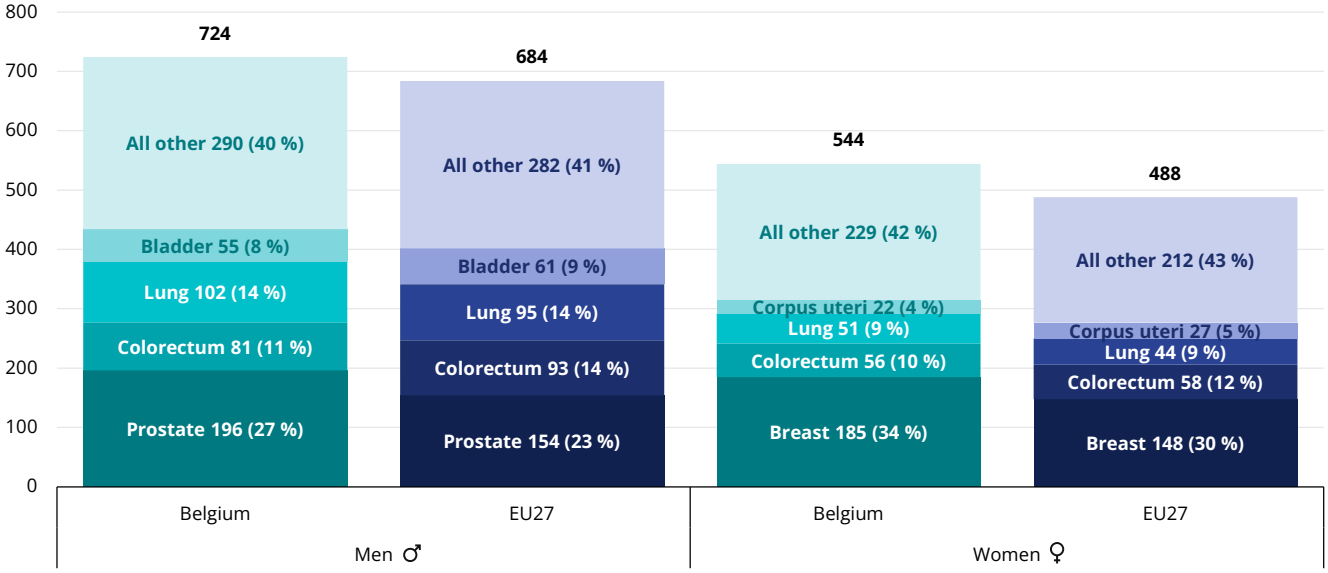
According to the European Cancer Information System (ECIS) of the Joint Research Centre, based on incidence trends from pre-pandemic years, 72 680 new cases of cancer were expected in Belgium in 2022 – a higher cancer incidence rate than the EU average (Figure 1). Consistent with EU trends, men have higher incidence of cancer than women. Among Belgian men, the age-standardised rate was 724 per 100 000 population in 2022 – the twelfth highest rate across EU+2 countries[1]. Among Belgian women, the age-standardised rate was 544 per 100 000, which is about 11% higher than the EU average of 488 per 100 000.

The most common cancers among men and women in Belgium are in line with the pattern across the EU. In 2022, the most common new cancer diagnosis among men in Belgium was prostate (27% of all cancer diagnoses compared to 23% across the EU), followed by lung cancer[2] (14% in Belgium and across the EU) and colorectal cancer (11% compared to 14% across the EU). Bladder cancer and melanoma were the fourth and fifth most common cancers diagnosed among men, accounting for 8% and 5% of incidence rates, respectively, compared to 9% and 4% across the EU. Among women, breast cancer was the most common (34% compared to 30% across the EU), followed by colorectal cancer (10% compared to 12% across the EU), lung cancer (9%, similar to the EU) and melanoma (7% compared to 4% across the EU).

Looking forward, ECIS estimates that cancer cases will increase by 21% between 2022 and 2040.

Figure 1. Estimated incidence of cancer in Belgium was above the EU average in 2022, notably among women

Age-standardised incidence rate per 100 000 population, estimates, 2022



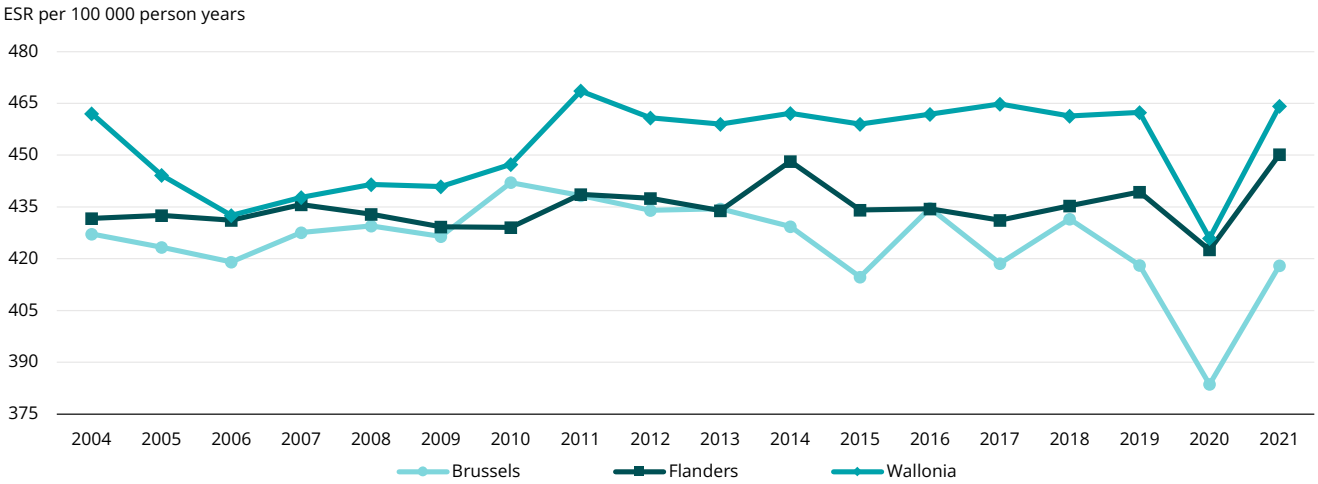
Notes: 2022 figures are estimates based on incidence trends from previous years, and may differ from observed rates in more recent years. Includes all cancer sites except non-melanoma skin cancer. Corpus uteri does not include cancer of the cervix.
Source: European Cancer Information System (ECIS). From https://ecis.jrc.ec.europa.eu, accessed on 10 March 2024. © European Union, 2024. The incidence percentage breakdown was re-computed based on age-standardised incidence rates and as such differs from the percentage breakdown of absolute numbers shown on the ECIS website.

1 *EU+2 countries include 27 EU Member States (EU27), plus Iceland and Norway.*

2 *Lung cancer also refers to trachea and bronchus cancers.*

According to the Belgian Cancer Registry, cancer incidence rates vary across Belgium's three regions, with rates in 2021 highest in Wallonia (464 per 100 000 person-years), followed by Flanders (450 per 100 000) and Brussels (418 per 100 000) (Figure 2). In 2004-21, cancer incidence was stable in Flanders, while the trend in Wallonia was increasing and the trend in Brussels was decreasing[3]. In 2020, during the COVID-19 pandemic, cancer incidence decreased in all regions: by 8% in Wallonia and Brussels and by 4% in Flanders. In 2021, incidence rates returned to pre-pandemic levels.

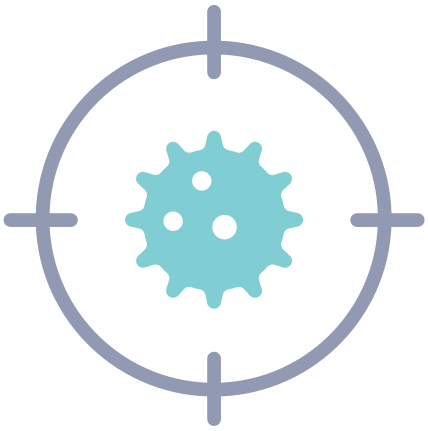
Figure 2. In recent years, disparities in cancer incidence among regions have become more noticeable, with rates highest in Wallonia



Notes: ESR – European standardised rate: includes males and females, all ages, all cancers (excluding non-melanoma skin).
Source: Belgian Cancer Registry.

Cancer mortality in Belgium showed a substantial decrease among both men and women in the last decade and is lower than the EU average

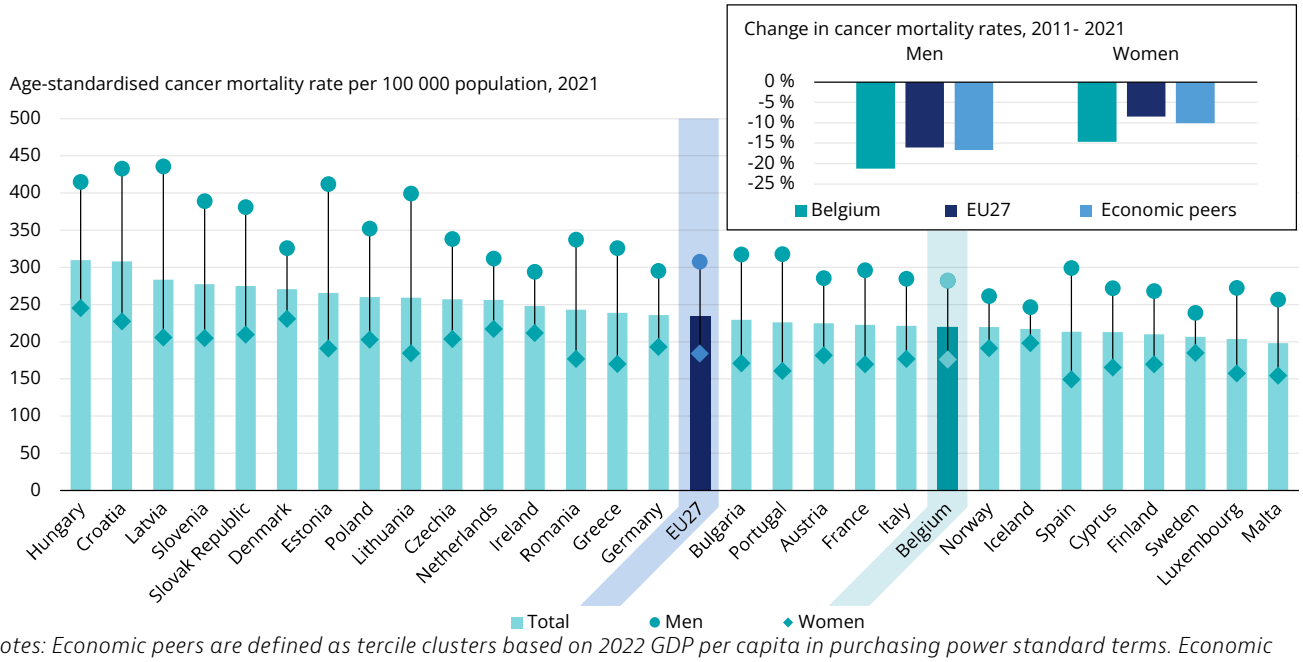
In Belgium, the age-standardised mortality rate was 220 per 100 000 population – 6% lower than the EU average (235 per 100 000) in 2021. As in other EU countries, the cancer mortality rate was substantially higher among men (282 per 100 000) than women (176 per 100 000). Between 2011 and 2021, mortality rates improved among both men and women. The overall improvement in Belgium was greater than the average improvements across the EU and among the country's economic peers[4]. For instance, among men, cancer mortality decreased by 21% in Belgium compared to 17% among its economic peers and 16% across the EU. Among women, mortality decreased by 15% in Belgium compared to 10% among its economic peers and 9% across the EU (Figure 3).



3 *The increase may be explained by improved registration in some Walloon hospitals which started systematic registration recently, as compared to Flanders where such registration started from 2004.*

4 *Economic peers are defined as tercile clusters based on 2022 GDP per capita in purchasing power standard terms. Economic peers for BE are AT, DE, DK, IE, IS, LU, NL, NO and SE.*

Figure 3. Cancer mortality in Belgium showed a higher rate of improvement than the country's economic peers in the same period among both men and women



Notes: Economic peers are defined as tercile clusters based on 2022 GDP per capita in purchasing power standard terms. Economic peers for BE are AT, DE, DK, IE, IS, LU, NL, NO and SE.
Source: Eurostat Database.

Lung, colorectal and breast cancers were the three leading causes of cancer mortality in Belgium in 2021. Lung cancer mortality accounted for 22% of all cancer deaths, colorectal cancer for 9%, and breast cancer for 8%.

Avoidable mortality from lung, breast and colorectal cancers decreased over the past decade

Thanks to improved prevention strategies and advances in treatment options, a large proportion of cancer deaths among people aged under 75 are considered potentially avoidable[5]. Belgium had larger reductions in avoidable mortality when compared to the EU averages in 2011-21 (Figure 4).

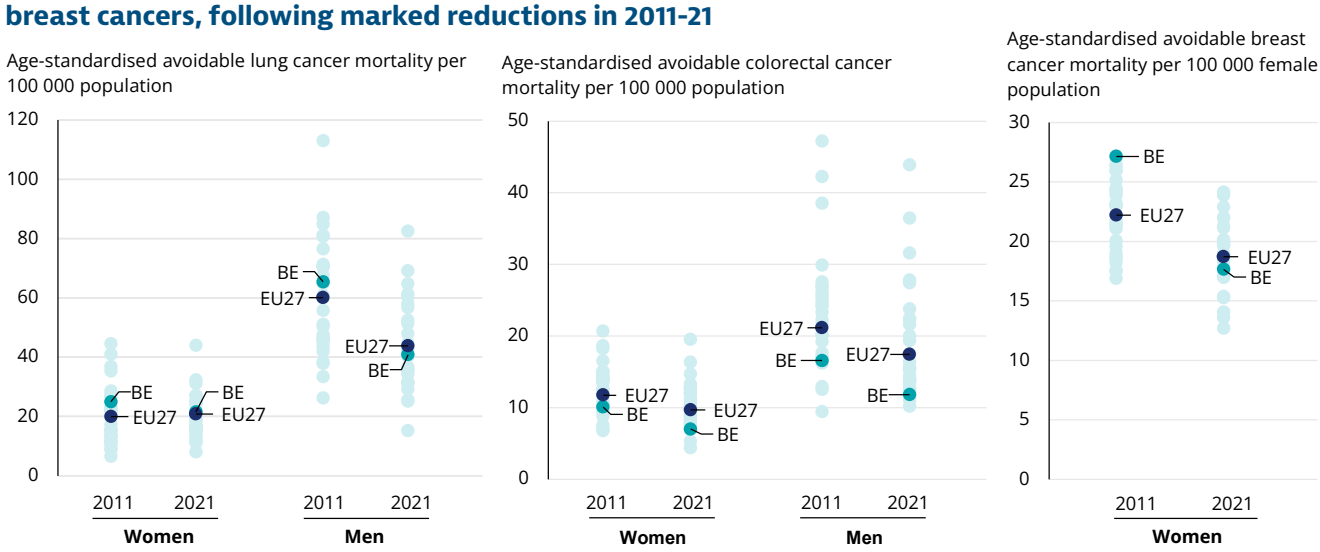
Mortality from lung cancer (classified as preventable) in Belgium in 2021 was 22 per 100 000 women (4% higher than the EU average of 21 deaths per 100 000) and 41 per 100 000 men (7% lower than the EU average of 44 deaths per 100 000). Only mortality from lung cancer among women was slightly higher than the EU average.

In 2011-21, mortality from lung cancer decreased by 14% among women and by 37% among men in Belgium, while the EU averages increased by 4% among women and decreased by 27% among men.

In 2021, Belgium reported a treatable mortality rate from breast cancer of 18 per 100 000 women, which is almost 6% lower than the EU average (19 deaths per 100 000). The Belgian rate had decreased by 35% (from 27 deaths per 100 000) since 2011, while the EU average had decreased by 16% (from 22 deaths per 100 000). These reductions can primarily be attributed to the improved uptake of screening programmes and early diagnosis initiatives (see Section 4). Mortality from colorectal cancer (also classified as treatable) in Belgium was 7 per 100 000 women (28% lower than the EU average) and 12 per 100 000 men (32% lower than the EU average). In 2011-21, the Belgian rate decreased by 30% among women and by 29% among men, while the EU average decreased by 18% among woman and by 17% among men.

5 *Avoidable mortality includes both preventable deaths that can be avoided through effective public health and prevention interventions, and treatable deaths that can be avoided through timely and effective healthcare interventions.*

Figure 4. Belgium performed better than the EU average on avoidable mortality from colorectal and breast cancers, following marked reductions in 2011-21

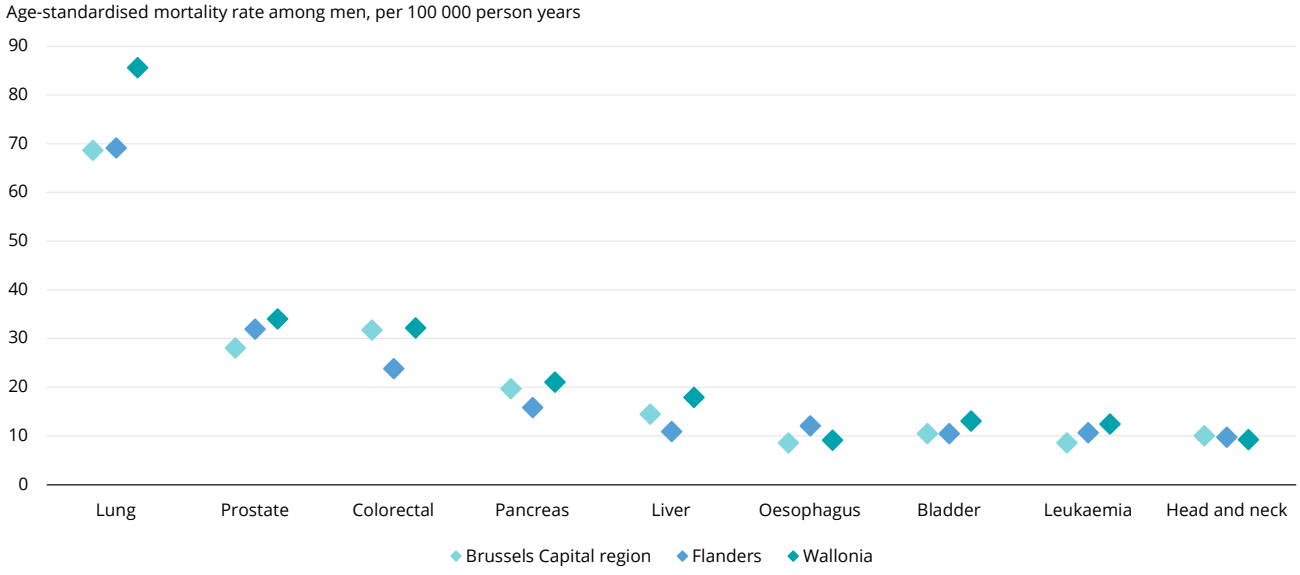


Note: Avoidable mortality figures relate to deaths of people aged under 75.
Source: Eurostat Database. Data refer to 2021.

Men living in Wallonia have a higher mortality rate for lung cancer

Mortality rates by cancer type differ across regions in Belgium – notably among men. Wallonia has slightly higher age-standardised mortality rates for most cancer types among men, except for head and neck cancer and oesophageal cancer (Figure 5). In 2021, lung cancer was responsible for a considerable higher mortality rate among men in Wallonia (86%) than in Flemish and Brussels regions (both 69%). These differences may be explained by higher occupational exposure through employment in mining and area-level characteristics in Wallonia, factors that likely contribute to the documented higher incidence of lung cancer in Wallonia (61.1 per 100 000 person-years, compared to 49.1 per 100 000 in Flanders and 50.4 per 100 000 in Brussels in 2021, according to the Belgian Cancer Registry). Although women in Wallonia have slightly higher age-standardised mortality rates for most cancer types, the rates among Belgian women are more homogeneous across regions than among Belgian men.

Figure 5. The lung cancer mortality rate for men in Wallonia is markedly higher

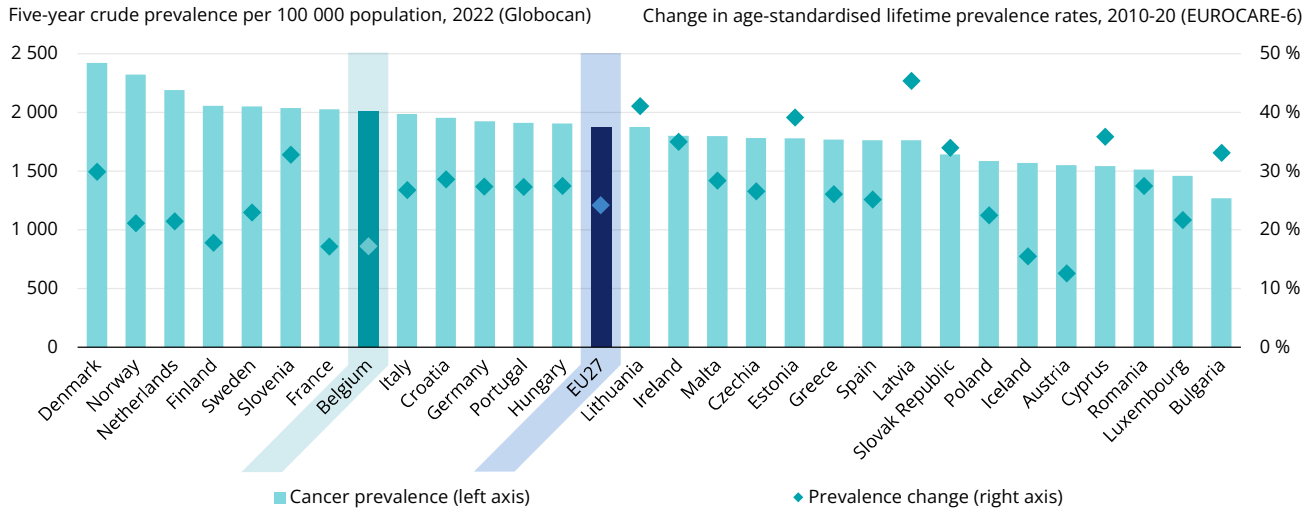


Note: Age-standardised mortality is calculated using the Eurostat 2013 revised European standard population.
Source: Belgian Statistical Office. Data refer to 2021.

Prevalence of cancer in Belgium is the eighth highest among EU+2 countries

In 2022, Belgium had five-year prevalence[6] of 2 007 cancer cases per 100 000 population, which is 7% higher than the 1 876 cases per 100 000 EU average (Figure 6). Between 2010 and 2020, lifetime cancer prevalence increased by 17% in Belgium and by 24% across the EU. This rise highlights the growing importance of addressing risk factors associated with cancer effectively (see Section 3) and of investing on quality of life and survivorship (see Section 5.4), as people are living longer with cancer and more people have a history of the disease.

Figure 6. Belgium has higher five-year prevalence of cancer than the EU average

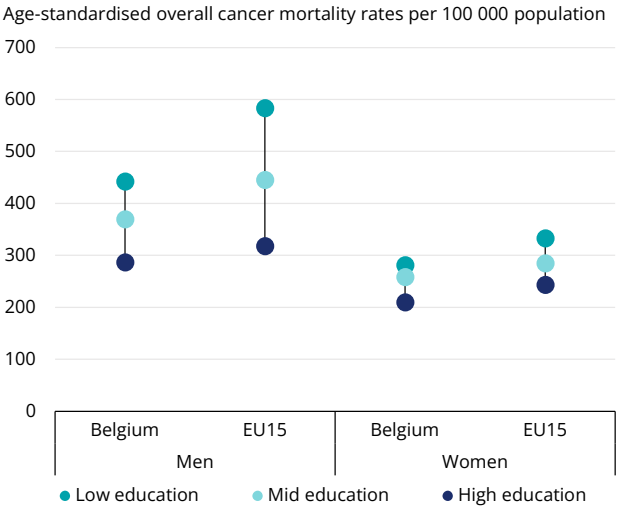


Sources: IARC GLOBOCAN database 2024; EUROCARE-6 study (De Angelis et al., 2024).

People with lower education levels have higher cancer mortality rates in Belgium, especially among men

Age-standardised overall cancer mortality rates are higher among Belgian men and women with lower education levels than higher education levels (Figure 7). This gap is more pronounced among Belgian men, where the age-standardised mortality rate was 55% higher among men with lower education levels (442 deaths per 100 000) than those with higher education levels (286 deaths per 100 000). The gap was 34% between women with lower education levels (281 deaths per 100 000) and those with higher education levels (210 deaths per 100 000). However, the education gaps in Belgium among both men and women are smaller than the EU averages (84% among men and 37% among women).

Figure 7. The education gap in cancer mortality is less marked in Belgium than in the EU15



Notes: Data come from the EU-Canlneq study and refer to 2015-19. EU15 refers to unweighted average of 14 EU countries and Norway.
Source: European Commission/IARC/Erasmus MC (2024), Mapping socio-economic inequalities in cancer mortality across European countries. ECIR Inequalities factsheet.

6 *Cancer prevalence refers to the proportion of the population who have been diagnosed with cancer and are still alive, including those currently undergoing treatment for cancer and those who have completed treatment. Five-year cancer prevalence includes people who have been diagnosed within the previous five years, while lifetime prevalence considers those who have ever received a cancer diagnosis.*

Belgium will implement a new framework to monitor progress on cancer policies

Following the adoption of Belgium's last national cancer plan in 2008, an evaluation of its implementation in 2012 identified specific areas for further investment or improvement. Several initiatives were adopted, such as efforts to improve the concentration of care (see Section 5.2) and to facilitate the professional reintegration of people with a history of cancer (see Section 5.4) and facilitate the integration of molecular diagnosis in haemato-oncology standard of care.

Aligned with these efforts, Sciensano's (the Belgian institute for health) Cancer Centre was mandated by the federal cabinet to develop the Belgian Cancer Inventory (Sciensano, 2024a), which will provide a framework to monitor Belgian policies related to cancer care and control along the continuum of cancer care, and to tackle cross-cutting topics such as patient centredness and inequalities. The Belgian Cancer Inventory is aligned with the pillars and objectives of Europe's Beating Cancer Plan.

This framework was developed with the involvement of Belgian experts to identify the most relevant and actionable indicators for policy making and will include a foresight component to ensure its relevance over time. In 2025, a benchmarking exercise will be conducted to establish meaningful targets. This work will require the support of Belgium's Europe's Beating Cancer Plan Mirror Group, a complementary initiative established in 2021 (Box 1).

Box 1. A multi-stakeholder coalition was established to ensure implementation of Europe's Beating Cancer Plan in Belgium

Belgium's Europe's Beating Cancer Plan Mirror Group (Sciensano, 2024b) comprises a multi-stakeholder coalition of more than 400 experts, including patient representatives, co-ordinated by Sciensano's Cancer Centre. It consists of thematic working groups with an advisory capacity to identify EU-funded calls for proposals that are most relevant to addressing cancer needs and challenges in Belgium and to propose relevant topics for inclusion in future EU Work programmes.

3. Risk factors and prevention policies

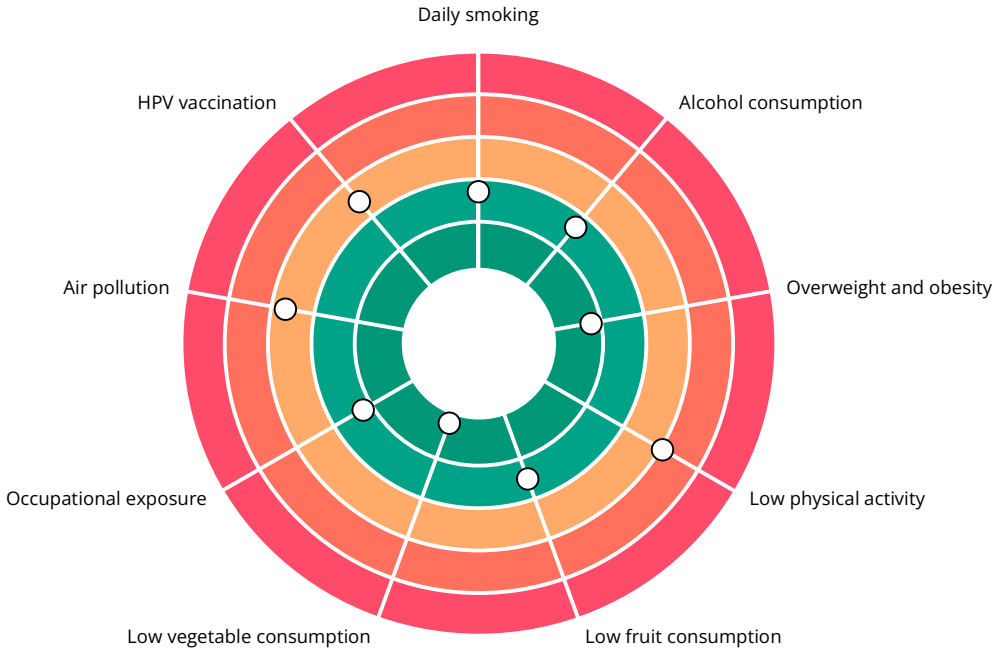
Belgium performs relatively well on managing prevalence of behavioural risk factors

Based on European health surveys, Belgium performs well compared to other EU countries regarding risk factors associated with cancer, including daily smoking, overweight and obesity, alcohol consumption, dietary risks and occupational exposure (Figure 8). However, it underperforms on levels of physical activity.

In 2021, Belgian spending on prevention[7] represented 3% of current health expenditure, which is lower than the EU average of 6%. According to the Institute of Health Metrics and Evaluation, cancer deaths attributed to behavioural risk factors decreased in Belgium over the past decade – from 105 per 100 000 population in 2012 to 88 per 100 000 population in 2021. Similarly, cancer deaths attributed to environmental factors decreased from 37 per 100 000 population in 2001 to 29 per 100 000 in 2021.

7 *Prevention expenditures as reported in health accounts should include activities outside of national programmes (e.g. opportunistic cancer screening or counselling for smoking cessation during a routine physician contact), however in practice countries may have difficulty in identifying prevention spending outside of such programmes.*

Figure 8. Belgium ranks well on daily smoking, overweight and obesity, alcohol consumption, and dietary risk factors but poorly on physical activity levels



Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas. Air pollution is measured as particulate matter with a diameter less than 2.5 micrometres ($PM_{2.5}$).
Sources: OECD calculations based on the 2022 EU-SILC Survey for overweight, obesity, physical activity, fruit and vegetable consumption (in adults); Eurofound Survey for occupational exposure; OECD Health Statistics for smoking, alcohol consumption (in adults) and air pollution; and WHO for human papillomavirus (HPV) vaccination (15-year-old girls).

Belgian men and people with lower education levels are more likely to be daily smokers

According to the European Health Interview Survey, the percentage of people aged 15 and over who are daily smokers decreased in Belgium from 19% in 2014 to 15% in 2019. This trend was observed across all three regions, although the prevalence of daily smokers was higher in Wallonia (19%) than in Brussels (17%) and Flanders (13%) (Sciensano, 2024c). The proportion of men who smoked in 2019 (19%) was higher than that for women (12%), but the reduction in smoking rates from 2014 to 2019 was less marked among men (by 13%) than women (by 26%).

Prevalence of daily smoking was 9% among people with higher education levels compared to 29% among those with lower secondary education and 21% among those with primary education or no diploma (Sciensano, 2023a). Use of e-cigarettes (vaping) among those aged 15 and over was more prevalent among men (6%) than women (3%).

In December 2022, the Belgian Government approved the initiation of a National Tobacco Plan, developed in collaboration with federated entities and incorporating measures proposed by the Minister of Social Affairs and Public Health (Box 2).

Box 2. Belgium is implementing a comprehensive package of anti-tobacco policies in 2024-25

Following the approval of the first comprehensive package of measures as part of the National Tobacco Plan, several initiatives have been implemented in 2024 and will continue throughout 2025. These include tax increases on tobacco products and expansion of smoking bans on transportation to include professional passenger transport from 2024; a ban on displays of tobacco products in stores from January 2025; an extension of the list of public spaces where smoking will be prohibited, such as next to sports fields and in healthcare buildings and places frequented by children and young people, from January 2025; a ban on the sale of tobacco products at temporary points of sale, such as festivals, from July 2025; the launch of large-scale control campaigns focusing on tobacco sales and advertising legislation; implementation of stricter regulations on e-cigarettes; and a ban on the sale of nicotine pouches, including e-cigarettes. Discussions on reimbursement of nicotine replacement therapy are ongoing and extending regulatory measures from traditional cigarettes to all tobacco and similar products throughout 2024-25.

Source: Santé Publique (2022), Stratégie Interfédérale 2022-28 Pour Une Génération Sans Tabac, available at https://organesdeconcertation.sante.belgique.be/fr/documents/strategie-interfederale-2022-2028-pour-une-generation-sans-tabac.

Alcohol consumption decreased slightly among the Belgian population in the last decade

Alcohol consumption in Belgium decreased slightly over the past decade among people aged 15 and over, from 10 litres per person in 2012 to 9 litres in 2019. According to Sciensano (Sciensano, 2023b), between 2013 and 2018, the reduction in alcohol consumption was greater among women (by 12%) than men (by 8%). In 2018, the proportion of hazardous alcohol consumption[8] was higher among men (7%) than women (4%) (Sciensano, 2023b) – especially among people aged 55-64 (14% for men and 8% for women). Among women, prevalence of hazardous alcohol consumption was highest in Brussels (6%) and lower in Wallonia (5%) and Flanders (4%). Among men, prevalence of hazardous alcohol consumption followed a similar distribution: 10% in Brussels, 8% in Wallonia and 7% in Flanders. No relevant socio-economic gradient in prevalence of hazardous alcohol consumption by education level was observed. An action plan covering 2023-25 – the first Inter-federal Plan on Alcohol – was adopted in March 2023 (Box 3).

Box 3. In Belgium, the first Inter-federal Action Plan on Alcohol (2023-25) was approved with support from all federal and regional ministries

In the context of the Inter-federal Strategy on the Harmful Use of Alcohol for 2023-28, Belgian authorities approved the 2023-25 Action Plan on Alcohol. This includes 75 actions focused on reducing alcohol consumption, with priority given to select groups such as pregnant women and adolescents. It is based on recommendations from WHO and the Superior Health Council – the scientific advisory body of Belgium's Federal Public Service Health, Food Chain Safety and Environment. The main goals of the Plan are to strengthen health promotion and prevention efforts, improve access to care, and address pricing and advertising of alcoholic beverages. An independent body has been established to ensure proper oversight of the implemented policies.

Source: Santé Publique (2023b), Plan interfédéral 2023-25 pour lutter contre la consommation nocive d'alcool, available at https://organesdeconcertation.sante.belgique.be/fr/documents/plan-interfederal-2023-2025-pour-lutter-contre-la-consommation-nocive-dalcool.

Only about a third of Belgians report meeting recommended levels of daily physical activity, although there are regional and socio-economic disparities

The risk factor in which Belgium underperforms compared to the EU average is physical activity. According to the EU-SILC Survey, in 2022, 74% of people reported undertaking physical activity fewer than the recommended level (three times in a typical week). More men (29%) than women (24%) met this recommendation. Younger populations, such as those aged 16-24, also more frequently met the recommended levels of physical activity (34%) than those aged 25-64 (24%). A socio-economic gradient is evident among Belgians aged 25-64: the share not meeting the recommendation for daily physical activity was higher among those with lower education (84%) compared to those with higher education (73%). Across regions, in 2018, more people fulfilled the physical activity recommendations in Flanders (43% among men and 34% among women) than in Brussels (29% among

8 *Hazardous alcohol consumption is defined as the daily consumption of more than 20 g of pure alcohol by women and 30 g by men, which is equivalent to more than 14 and 21 standard drinks (of 10 g pure alcohol content) per week, respectively.*

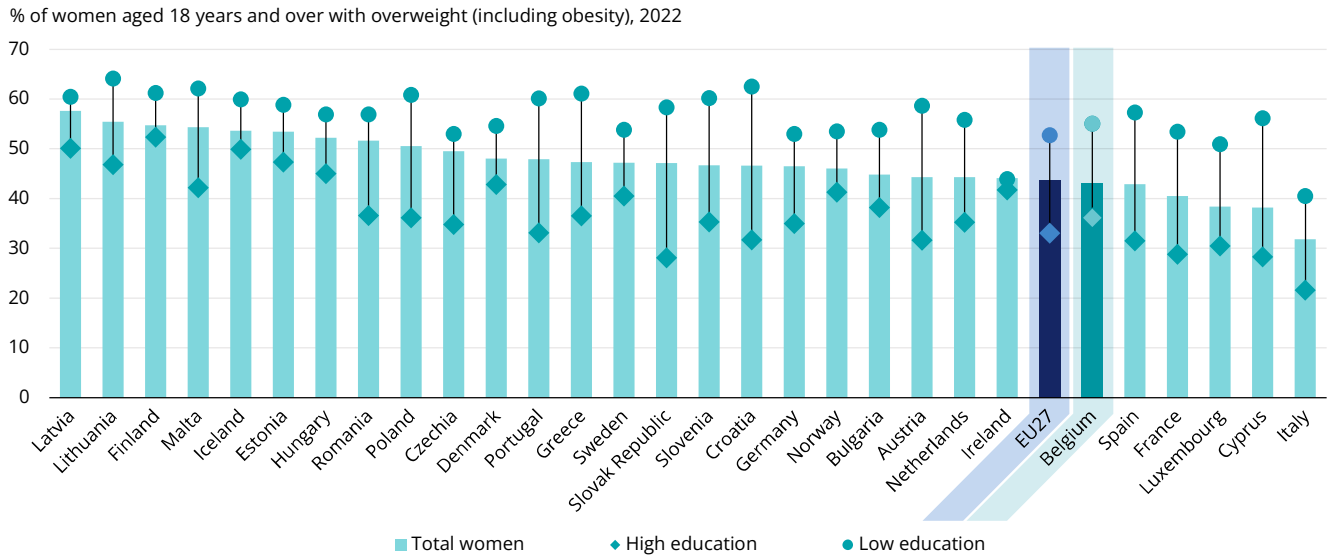
men and 18% among women) and Wallonia (27% among men and 15% among women) (Sciensano, 2021).

The MOVING framework, an initiative of the World Cancer Research Fund International, identified insufficient policy action in Belgium regarding financial incentives to promote physical activity, training for relevant professions outside healthcare, and policies to encourage public transportation and infrastructure that supports physical activity.

Despite relatively good performance in addressing dietary risk factors compared to other EU countries, nearly half of the Belgian population is overweight

In 2022, almost half (49%) of the Belgians aged 18 and over were overweight, with a body mass index (BMI) above 25, and 16% were obese (BMI above 30). Among women, prevalence of overweight (including obesity) was on a par with the EU average (around 43%) (Figure 9), while among men, it was 55% – slightly lower than the EU average (60%). Prevalence of overweight remained stable among women and men during 2017-22. There are large disparities in excess weight by education level, with a higher prevalence of overweight and obesity among Belgian women with lower educational levels (55%) compared to those with higher education levels (36%).

Figure 9. In Belgium, prevalence of overweight among women is close to the EU average



Note: Overweight (including obesity) includes those with a BMI above 25.
Source: Eurostat Database.

The proportion of people reporting low vegetable consumption has increased from 17% in 2017 to 20% in 2022. Education disparities are noticeable: for instance, 13% of people with higher education levels reported not eating vegetables daily, compared to 30% of people with lower education levels.

Wallonia's Prevention and Health Promotion Plan (2023-30) focuses on improving eating habits, decreasing prevalence of obesity and overweight, and increasing regular physical activity among the population. It also focuses on social inequalities. In Brussels, the Integrated Health Social Plan 2023-27 also intends to tackle socio-economic inequalities focusing on healthy lifestyles and health literacy.

The Flemish Institute for Healthy Living, an independent centre of expertise, supports the Flemish Government on health prevention topics, such as nutrition and physical activity. The Institute participates in regional and European projects and develops resources to raise awareness and inform the public.

Belgium outperforms the EU average in managing behavioural risk factors among adolescents, except for alcohol consumption

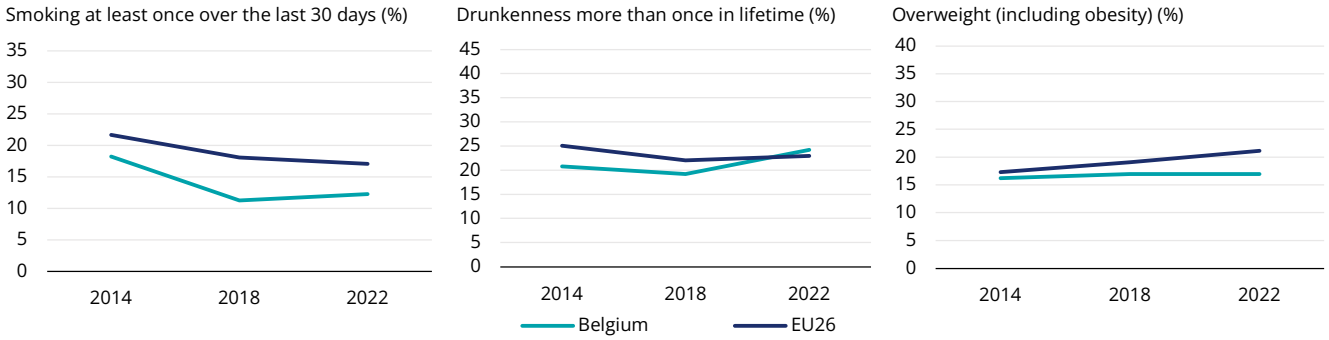
In 2022, prevalence of reported overweight among 15-years old in Belgium was 17%, which is 4 percentage points lower than the EU average (Figure 10)[9]. In addition, among 15-year-olds in

9 *Sciensano's Food Consumption Survey (2022-23) reports that 19% of Belgian children and 21% of adolescents are overweight.*

Belgium, 31% consumed fruits daily (compared to 30% in the EU on average) and 52% consumed vegetables daily (compared to 34% in the EU).

Prevalence of daily smoking among this population was 5 percentage points lower than the EU average (12% in Belgium compared to 17% across the EU), and was similar among boys and girls. Daily tobacco consumption among 15-year-olds in Belgium decreased by 6 percentage points from 18% in 2014 to 12% in 2022. In 2022, the prevalence of daily use of e-cigarettes (vaping) was 17% among young women, which was higher than among young men (15%). Alcohol abuse among adolescents increased from 21% in 2014 to 24% in 2022. In 2022, prevalence of alcohol abuse was almost 2 percentage points higher than the EU average.

Figure 10. Smoking and alcohol abuse among 15-year-olds has increased over time between 2018 to 2022



Notes: Data refer to the average value of Flemish and French regions. The EU average is unweighted. Data refer to 2022, and are based on children aged 15 years. EU26 for smoking and drunkenness; EU25 for overweight.
Source: Health Behaviour in School-aged Children Survey.

Several policies are being implemented to address overweight and obesity among young people in Belgium. Since April 2020, the compulsory national health insurance system has provided reimbursement for up to 10 sessions with a dietician over a two-year period for overweight and obese children aged 6-17. From December 2023, overweight children aged 2-5 have also been eligible for free dietary advice without any copayment. Additionally, multidisciplinary care in recognised centres of expertise is being implemented for children (Box 4).

Box 4. Multidisciplinary care in centres of expertise in paediatric obesity is expected to reduce prevalence of overweight and obesity among young people

The national health insurance system has introduced a care delivery model that involves regular monitoring of children and adolescents aged 2-17. This new approach comprises three tiers: primary care; multidisciplinary paediatric centres of obesity; and centres of expertise for paediatric obesity management. While the first and third levels are already established nationally, the rollout of the second level centres is ongoing, with the goal of establishing a maximum of 25 centres in Belgium (22 centres were operational by the end of 2024). Treatment access is free of charge to children aged 2-17 (copayments were eliminated). A study commissioned by the Health Care Knowledge Centre (KCE) (Primus-de Jong Célia, 2023) has developed an initial set of quality indicators for monitoring this second level of care.

Belgian air quality is improving, although marked regional and socio-economic differences persist

Belgium performs slightly better than the EU+2 average on exposure to air pollution in the form of $PM_{2.5}$, showing an estimated mean population exposure of 11 µg/m³ in 2020, down from 17 µg/m³ in 2010. Exposure to $PM_{2.5}$ was estimated to account for 44 deaths per 100 000 population in 2021, lower than in the EU (57 deaths per 100 000 population).

Exposure to $PM_{2.5}$ is highest in Flanders (11 µg/m³), while in Brussels the highest exposure is to nitrogen dioxide (NO_2), at 20 µg/m³ in 2021 (Sciensano, 2024d), although NO_2 exposure is decreasing across all regions. Conversely, exposure to ozone has been increasing since 2016, with exposure highest in Wallonia (46 µg/m³) and lowest in Brussels (43 µg/m³) in 2021.

To raise awareness and decrease exposure to radon[10] in Belgium, the Federal Agency for Nuclear

10 *Radon is a radioactive, odourless, and colourless gas that occurs naturally in soil and rocks.*

Control collaborates with federal and regional entities to organise annual campaigns. These initiatives encourage and support the public in measuring radon levels at home and provide access to remedial assistance if needed.

Regarding occupational exposure to chemical products or substances, Belgium performs relatively well compared to other EU+2 countries. In 2021, exposure was higher among Belgian men (25%) than women (18%). Policies to prevent exposure to asbestos have been developed. The Federal Agency on Professional Risks has launched a national campaign to assist citizens and companies in detecting asbestos and accessing support for its removal. From 2022, Flanders requires inspection and certification for asbestos and its safe management before the sale of an older building. Belgian companies that remove asbestos must meet certification standards, and the list of certified companies is periodically reviewed to ensure compliance. Wallonia has also requirements of certified companies who can remove asbestos, the list is reviewed periodically to monitor whether companies still meet certification standards. The draft of the third National Plan for the Environment and Health was submitted for consultation at the end of 2023, focusing on reducing harmful effects of chemical substances on the population and the environment.

Regional disparities persist in human papillomavirus vaccination coverage rates

The HPV immunisation rate in Belgium was 69% among girls and 64% among boys, according to regional school surveys in Brussels and Wallonia in 2019 and a general population survey in Flanders in 2020 (Gerkens et al., 2024). In the 2019/20 school year, coverage (girls and boys) was 81% in Flanders and 48% in Brussels and Wallonia (Grammens & Cornelissen, 2021). HPV immunisation programmes are organised by regional governments, and awareness initiatives include leaflets and a dedicated website.

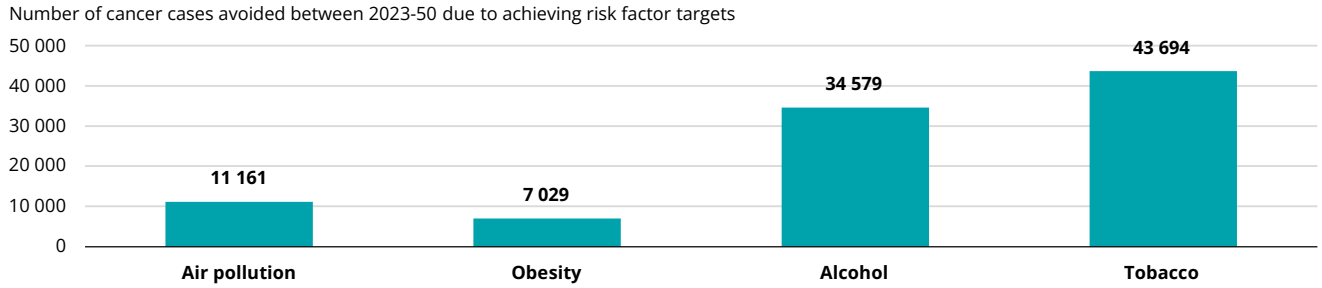
Flanders initiated HPV vaccination for girls aged 12 in 2010, while Brussels and Wallonia began vaccinating girls aged 13-14 in 2012. In 2019, HPV vaccination was extended to boys aged 12-18 in Flanders and 13-18 in the Brussels and Wallonia (primary cohort). The catch-up cohort (boys older than the primary cohort who initially missed the opportunity to receive the vaccine) includes those aged 12-18 in all regions. Vaccination is free for target groups.

In Brussels and Wallonia, vaccination is mostly administered through school health services. School vaccination can be promoted at various levels, such as by the mayor or the council, and may also be prescribed by physicians. Flanders employs a population-wide approach for all girls and boys starting secondary school. Selected HPV vaccines are reimbursed for girls and boys aged 12-18 if they are not vaccinated under the programme of the federated entities.

Achieving cancer risk factor target reductions would prevent many new cancer cases

According to the OECD Strategic Public Health Planning (SPHeP) modelling work, achieving tobacco targets could prevent 43 694 new cancer cases in Belgium between 2023 and 2050 (Figure 11). Similarly, meeting alcohol targets could prevent 34 579 new cancer cases over the same period. An additional 11 161 cases could be prevented by meeting pollution targets, and 7 029 cases by achieving obesity targets.

Figure 11. Belgium could prevent more than 43 000 new cancer cases between 2023 and 2050 by achieving target reductions in tobacco



Notes: The target for tobacco is a 30% reduction in tobacco use between 2010 and 2025, and less than 5% of the population using tobacco by 2040. For alcohol, the target is a reduction of at least 20% in overall alcohol consumption and a 20% reduction in binge drinking between 2010 and 2030. For air pollution, it is an annual average $PM_{2.5}$ level capped at 10 µg/m³ by 2030 and at 5 µg/m³ by 2050. On obesity, the target is a reduction to the 2010 obesity level by 2025.
Source: OECD (2024), Tackling the Impact of Cancer on Health, the Economy and Society, https://doi.org/10.1787/85e7c3ba-en.

4. Early detection

Belgium has population-based screening programmes organised at the regional level

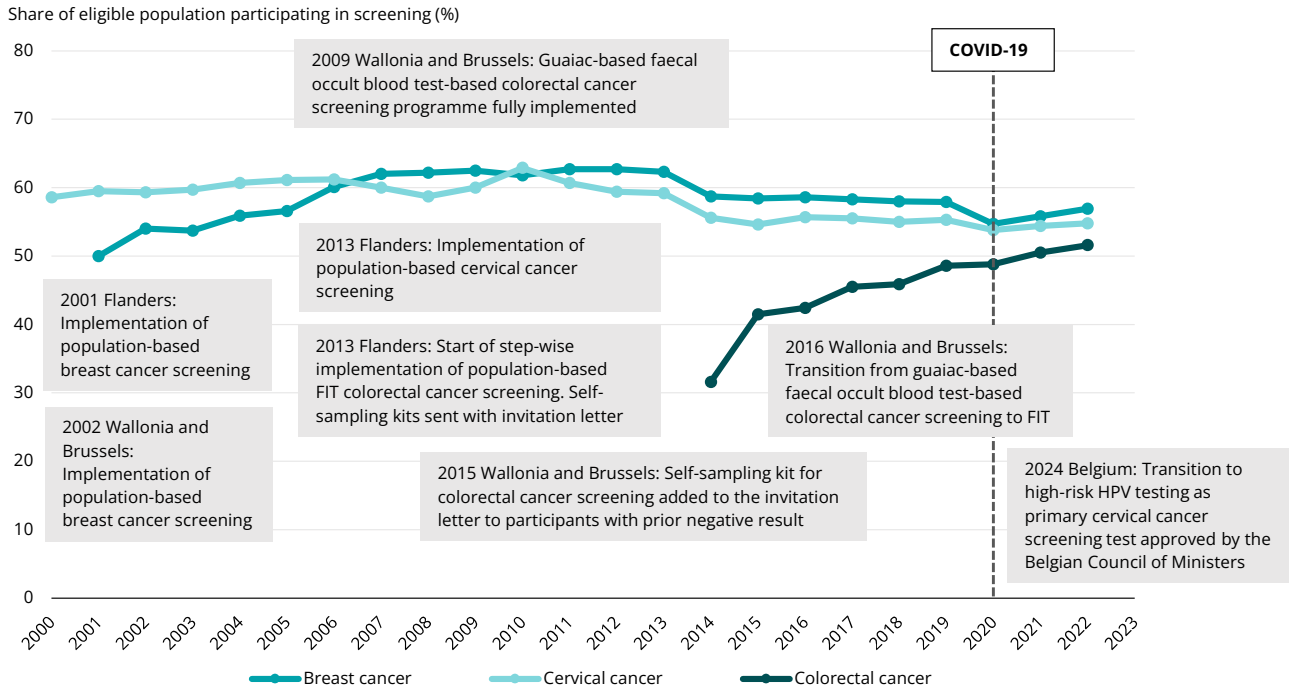
Screening programmes in Belgium are organised by regional agencies: the Centre Communautaire de Référence (CCR) in Wallonia, Bruprev in Brussels, and the Centrum voor Kankeropsporing (CvKO) in Flanders. The colorectal screening programme organised by the CCR in Wallonia also covers the German-speaking community of Belgium. Screening tests are reimbursed by the national health insurance system. A Royal Decree from the Walloon Government in January 2024 outlined long-term strategies for population-based screening programmes for breast, colorectal and cervical cancers. This decree regulates the operationalisation of these programmes, including the roles of preventive medicine centres and invitation strategies. As of June 2024, the Walloon Government approved financing for colorectal, breast, and cervical cancer screening for an indefinite period.

All three regions in Belgium have a population-based breast cancer screening programme for women aged 50-69, implemented in 2001 in Flanders and in 2002 in Brussels and Wallonia. Flanders has had a population-based cervical cancer screening programme using smear tests for women aged 25-64 every three years since 2013. In the Brussels region, a screening programme for cervical cancer is under development; meanwhile, screening is recommended for women aged 25-64, with smear tests reimbursed every three years. In Wallonia, invitations for cervical cancer screening for the target population are planned to begin in 2025.

Colorectal cancer screening started in 2009 in Brussels and Wallonia regions and in 2013 in Flanders. The target population, aged 50-74, can undergo a free faecal immunochemical test (FIT) every two years.

According to the Belgian Cancer Registry, in 2022, uptake of breast cancer screening (57% of the eligible population) and cervical cancer screening (55%) was rebounding to pre-COVID-19 pandemic levels, whereas colorectal cancer screening rates continued their upward trend, rising from 32% in 2014 to 52% in 2022 (Figure 12).

Figure 12. Uptake of breast and cervical cancer screening is recovering following the COVID-19 pandemic, while participation in colorectal cancer screening has continued to increase



Notes: For cervical cancer screening, the reported coverage rate excludes women who are not eligible for medical reasons. For colorectal cancer screening, the participation rate is calculated both within and outside organised programmes.
Source: Belgian Cancer Registry.

In Belgium, most women are screened for breast cancer outside the population-based screening programme, and participation rates are lower in Brussels and Wallonia

According to the KCE, in 2021, the percentage of women aged 50-69 who had had at least one mammogram in the past two years through population-based screening was highest in Flanders (49%) compared to Brussels (9%) and Wallonia (4%) (Gerkens et al., 2024). Most women screened in Brussels and Wallonia are screened outside the population-based programme (opportunistic screening). For instance, in 2021, 44% of additional mammograms were performed outside the population-based screening in Brussels and 45% in Wallonia. In Flanders, only an additional 20% were performed outside the programme.

Invitations to breast cancer screening in Belgium are sent every two years with explanatory information but no follow-up reminders. In Flanders, invitations include an appointment at a certified mammogram unit. According to the Belgian Cancer Registry, the 2022 participation rate for screenings, both within and outside of population-based programs, varied across regions; 64% of eligible women were screened in Flanders, compared to 46% in Wallonia and 43% in Brussels.

Belgian women with higher education levels are more likely to participate in breast cancer screening. According to the Survey of Health, Ageing and Retirement in Europe wave 8 (2021/22), 61% of Belgian women with lower education levels had received a mammogram, compared to 67% with higher education levels. This six percentage point gap is lower than the EU average gap of nine percentage points, making Belgium the EU country with the thirteenth highest education-related disparity in mammogram participation.

Colorectal cancer self-sampling screening is implemented nationwide, but invitation strategies differ across regions

Participation rates in colorectal cancer screening have shown an overall increasing trend since implementation of the population-based screening programme in Flanders in 2013. This was followed by the transition from guaiac-based faecal occult blood testing (gFOBT)-based screening to a FIT-based screening (self-sampling) in Wallonia and Brussels in 2016 (Figure 12). In 2022, the share of the eligible population screened was 52%, representing a 20 percentage point increase from 2014 (32%). Coverage of the eligible population in 2022 was lowest in Brussels (32%) and Wallonia (33%), compared to 63% in Flanders. Nevertheless, coverage in Brussels and Wallonia has been increasing.

Self-sampling is implemented nationwide, although the invitation strategy and the means of obtaining the self-sampling kit differs across regions. In Brussels, the target population receives a testing kit by mail, but also can obtain a kit free of charge from any pharmacy in the region. In Wallonia, screening invitations are sent to the target population, and individuals may order a self-sampling kit online or ask their GP or pharmacy. In Flanders, the invitation letter, the self-sampling kit and an information leaflet are sent by post to the target population.

Only Flanders has implemented a population-based cervical cancer screening programme, but implementation in Wallonia has begun

In 2022, the share of eligible population screened for cervical cancer was 55%, which is on a par with the rate in 2014 (55%). The participation rate among regions is similar, at 52% in Brussels, 53% in Flanders and 54% in Wallonia. The national transition from conventional cytology testing to high-risk HPV testing as the primary screening test every five years for women aged 30-64 was approved by the Belgian Council of Ministers in 2024. Sciensano and federated entities are currently finalising an HPV Roadmap, which describes all practical aspects related to HPV-based screening, such as task distribution between the federal government and federated entities. A pilot of self-sampling for specific population groups is ongoing in Flanders and in discussion in Wallonia. An analysis of involvement of GPs and pharmacists is under way (Box 5).

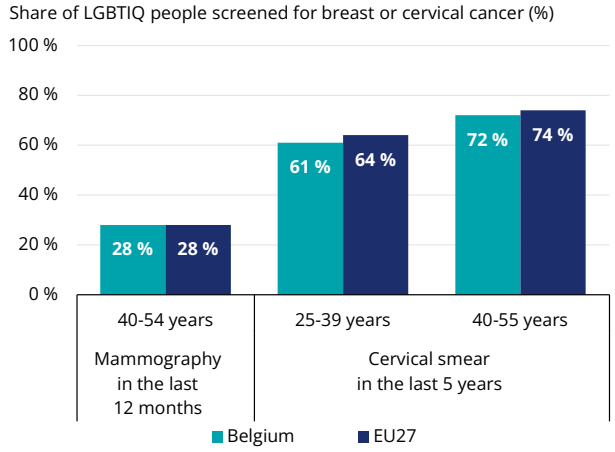
Box 5. An analysis of offering self-sampling in cervical cancer screening among underscreened women, with the involvement of GPs and pharmacists, is under way in Belgium

GPs and pharmacists are already involved in test provision for colorectal cancer screening in Brussels and Wallonia. Evidence on the feasibility and effectiveness of integrating GPs and pharmacists into cervical cancer screening is being examined at the national level. Specifically, evidence on GP involvement in self-sampling for cervical cancer screening is being collected. The ESSAG trial, running from 2021 to 2025 under the co-ordination of Ghent University, is evaluating the effect of GP-based interventions on the coverage of cervical cancer screening in Flanders, including self-sampling for HPV. The study specifically targets women who have not been screened in the last six years. The control group receives the standard invitation from the CvKO (invitation for a cytology test performed by their GP or gynaecologist), while another group receives the self-test with easy-to-understand information sent to their home address by their GP, and a third group is recruited when eligible women consult their GP for any reason, and the GP provides them with the self-test kit. These findings will inform policy decisions by federated entities.

Among LGBTIQ people, breast cancer screening participation is on a par with the EU average, while cervical cancer screening rates are lower

According to the EU LGBTIQ Survey III, participation in cervical cancer screening among LGBTIQ persons in Belgium is lower than in other EU countries (Figure 13). In 2023, 61% of LGBTIQ cisgender females, trans women, and intersex people aged 25-39 in Belgium reported having had a smear test in the previous 5 years, which is lower than the 64% reported across the EU. Among those aged 40-55, 72% reported having had a smear test, compared to 74% in the EU. For breast cancer screening, 28% of relevant LGBTIQ people aged 40-54 in Belgium reported having had a mammogram in the previous 12 months, which is on a par with the EU average.

Figure 13. LGBTIQ people in Belgium participate less in cervical cancer screening than their counterparts in the EU



Note: LGBTIQ survey results refer to age groups and/or screening intervals that do not align with the population screening approach in EU countries, and should not be compared.
Source: The European Union Agency for Fundamental Rights (EU LGBTIQ Survey III).

The possibility of a screening programme for groups at higher risk of lung cancer is under discussion in Belgium

Belgium participated in the NELSON Study – a pivotal study on lung cancer screening (de Koning et al., 2020). This was the largest European randomised controlled trial (in Belgium and the Netherlands), which showed a reduction in mortality among individuals at higher risk of lung cancer who underwent screening with low-dose computed tomography (CT). A 2024 report from the KCE (Desimpel et al., 2024) showed that low-dose CT screening could be cost-effective in Belgium, assuming a willingness-to-pay threshold between EUR 20 000 and EUR 30 000 per quality-adjusted life year gained. Nonetheless, the trade-off between clinical benefits and potential harms must be considered carefully, along with the capacity of the health system.

Belgium is currently participating in the EU4Health "Strengthening the Screening of Lung Cancer in Europe" Project (SOLACE), which aims to support and optimise the implementation of lung cancer screening programmes across Europe. Additionally, pilot activities for risk-based lung cancer screening have been conducted in the Antwerp area.

All Belgian regions organise initiatives to enhance cancer screening awareness

Several policies have been implemented to raise awareness about cancer screening. In Flanders, the organisation responsible for screening maintains a dedicated website, which is available in nine languages in addition to French and Dutch. The Flemish Government, in collaboration with the CvKO, organises annual campaigns to promote breast cancer screening. In Wallonia, cervical cancer screening awareness campaigns include radio and television announcements, and a dedicated website about cervical cancer screening is available.

Belgium participates in several EU projects aimed at informing risk-based screening strategies. One such project is the Joint Action Prevent Non-Communicable Diseases, under which pilot projects have been developed to assess implementation of personalised risk stratification for cancer screening, leveraging individual-level data, including genetic and behavioural data.

5. Cancer care performance

5.1 Accessibility

Compulsory health insurance covers nearly the entire population, but Belgians make high out-of-pocket payments

In Belgium, disease-oriented care is a federal competence, while prevention, screening and healthcare organisation fall under regional jurisdictions. The compulsory national health insurance system, managed by the National Institute for Health and Disability Insurance (NIHDI), finances healthcare by allocating a prospective budget to sickness funds. Belgian residents must affiliate with a sickness fund of their choice. Coverage of health insurance is near universal (99% in 2022) and is not selective based on health risks. However, some populations at higher risk of social vulnerability – such as irregular migrants or people without a fixed address – are not covered by the national health insurance system.

In 2022, health spending in Belgium corresponded to 11% of GDP. In 2022, government spending and health insurance covered 74% of health spending in Belgium. Costs borne directly by health services users through out-of-pocket (OOP) payments increased by 30% between 2011 and 2021. In 2022, the share of OOP payments in overall health spending was 20%, higher than the EU average of 15%. OOP payments may be partially reimbursed by private insurance.

Since October 2023, primary healthcare has been free of charge for individuals aged up to 24, sometimes as part of a multidisciplinary care pathway. A new organisational and financing model – the New Deal – began piloting in 48 general practices in April 2024. This aims to balance the financing of GPs' clinical work, and to enhance interdisciplinary collaboration, continuity of care, prevention and patient empowerment, while reducing the administrative burden.

In 2003, Belgian law established defined oncology care programmes with specific statutory standards, which each hospital must comply with. The programmes are categorised as "basic oncological care" (less complex treatment and follow-up) and "oncological care" (more advanced diagnostic and therapeutic options). In 2020, Belgium had 62 basic oncology care programmes and 84 oncology care programmes.

Belgium has fewer physicians and more nurses per 1 000 new cancer cases than the EU average

The density of physicians in Belgium (571 per 1 000 new cancer cases) is lower than the EU average (679 per 1 000), while the density of nurses (1 859 per 1 000 new cancer cases) is higher than the EU average (1 376 per 1 000) (Figure 14). As of December 2023, Belgium has 371 oncologists (220 women and 151 men) and 3 395 registered cancer nurse specialists (2 030 women and 365 men). The latter are mostly located in Flanders (density of 0.33 cancer nurse specialists per 1 000 population), followed by Wallonia (0.26 per 1 000 population) and Brussels (0.15 per 1 000 population) (Santé Publique, 2023a).

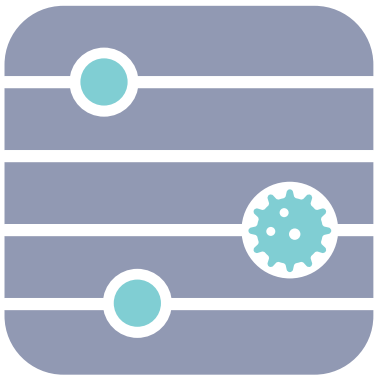
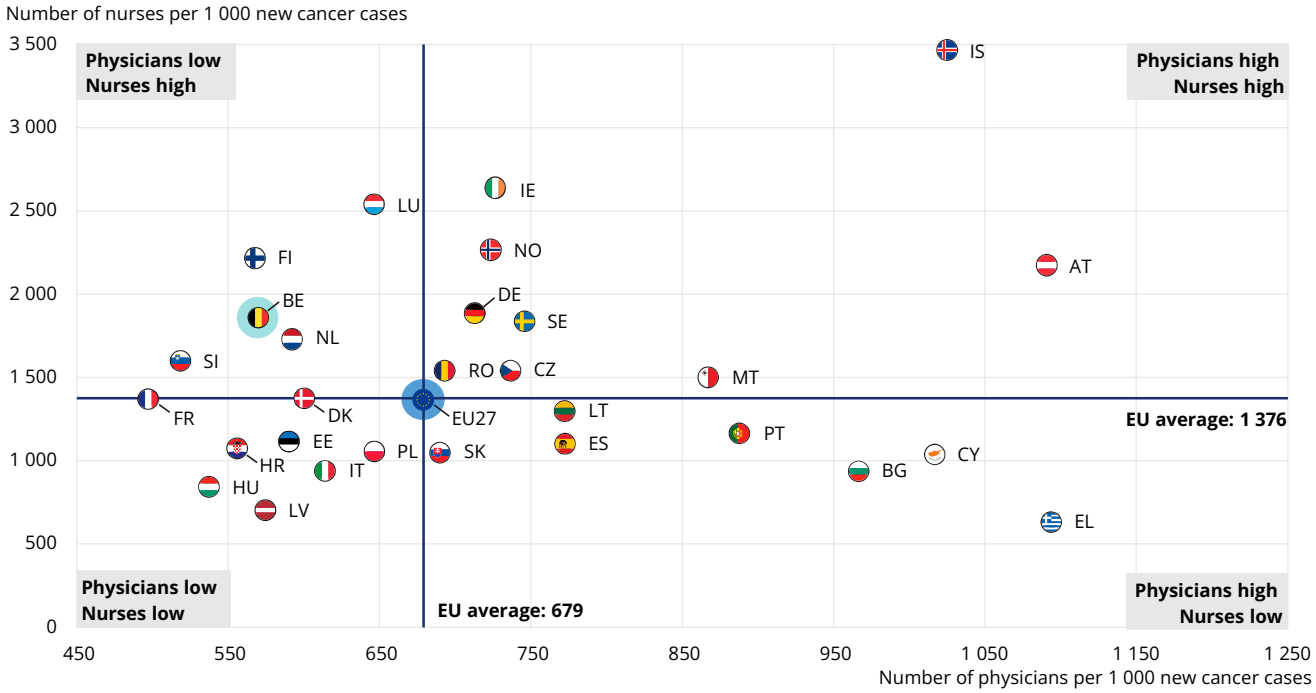


Figure 14. Belgium has a below-average supply of physicians and an above-average supply of nurses per 1 000 new cancer cases compared to the EU average



Notes: The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). Data refer to practising nurses except in Portugal and the Slovak Republic, where they refer to professionally active nurses. In Greece, the number of nurses is underestimated as it only includes those working in hospitals. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors. The EU average is unweighted.
Source: OECD Health Statistics 2024. Data refer to 2022 or latest available year.

The density of practising physicians increased by almost a quarter during the last decade, from 2.9 per 1 000 population in 2010 to 3.6 per 1 000 in 2022. Additionally, the number of practising nurses increased by nearly 20%, from 9.6 per 1 000 population in 2010 to 11.6 per 1 000 population in 2021. Considering the density of practising physicians in terms of full time equivalent workers (FTEs), all three regions are similar, with 2.2 FTEs per 1 000 population in Flanders and Wallonia, and 2.1 per 1 000 in Brussels (Gerkens et al., 2024). The number of practising nurses is higher in Flanders (9.7 FTEs per 1 000 population) than in Brussels (9.4 per 1 000) and Wallonia (8.9 per 1 000).

To address workforce shortages, new roles for nurses, task sharing and shifting, and financial incentives are being implemented

Belgium is reorganising nurses' roles and tasks to reduce their administrative burden and enhance their autonomy. In March 2024, the Council of Ministers approved a draft decree that defined the training, roles and prerequisites for advanced practice nurses and specify the onco-speciality for nurses. This is part of broader discussions about innovative care models, such as nurse-led care, and planned recognition of new roles like clinical research nurses.

Recent policies have been implemented to support the workforce, including financial boosts for training and improving working conditions. Since mid-2021, a collective agreement has introduced a new salary model that compensates healthcare staff based on their tasks. This model represented a 6% increase in pay for the affected federal private health sector, totalling over EUR 450 million for 2022, and particularly benefiting early-career and specialist nurses. Additionally, new tasks have been considered, such as pharmacists being able to review the medication of people with polypharmacy. In 2022, EUR 100 million was invested to improve working conditions such as increasing end-of-year bonuses.

Belgium participates in the EU Joint Action "Strengthening eHealth for Cancer Prevention and Care" (eCAN), which includes telemedicine and remote monitoring. This two-year project, co-ordinated by Sciensano, explores the impact of teleconsultation and telemonitoring on different populations of people with cancer. The results are expected to inform recommendations for integrating telemedicine and remote monitoring into the healthcare system. The follow-up Joint

Action, scheduled to start in 2025, will focus on strengthening the digital capacities of cancer centres related to telemedicine and health data exchange. It also aims to inform the development of a reimbursement scheme for remote medical consultations.

Access to imaging exams and radiotherapy without copayments varies greatly across regions

In December 2023, Belgium had 274 specialist physicians allowed to practise radiotherapy oncology (159 women and 115 men). Decisions on acquisition and utilisation of medical equipment requiring high investment – such as CT/integrated positron emission tomography (PET) and magnetic resonance imaging (MRI) units and linear accelerators (LINACs) – are centralised and restricted to hospital sites.

In Belgium, the volume of radiation therapy equipment increased by 20% from 2010 (15 per 1 000 000 population) to 2017 (18 per 1 000 000). According to 2024 data from the International Atomic Energy Agency, most equipment is relatively new, with 26% being 5-10 years old and 24% being 10-15 years old. Between 2012 and 2023, the volume of CT scanners increased by 70% to 26 per 1 000 000 population (similar to the EU average), and the volume of MRI units increased by 9% to 11.6 per 1 000 000 (lower than the EU average of 18 per 1 000 000) (Table 1).

Table 1. Disparities in equipment volume and fee supplements for imaging exams could exacerbate inequalities among people with cancer in Belgium

Volume of CT scanners		Volume of MRI units	
2012	**2023**	**2012**	**2023**
Belgium			
15.1 per 1 000 000 population	26.1 per 1 000 000 population	10.7 per 1 000 000 population	11.6 per 1 000 000 population
EU averages			
21.4 per 1 000 000 population	26.5 per 1 000 000 population	12.4 per 1 000 000 population	18.4 per 1 000 000 population

Percentage of radiologists fully adhering to conventional pricing by region		
Brussels	Flanders	Wallonia
62% for MRIs 61% for CT scans	30% for MRIs 31% for CT scans	88% for MRIs 89% for CT scans

Notes: Data for medical technology availability refer to 2012 and 2023 (or nearest years). The EU average is unweighted.
Source: OECD Health Statistics 2024 and De Wolf & Landtmeters (2023a).

In 2021, 44% of CT scans and 21% of MRI scans performed in Belgian hospitals incurred fee supplements, charged by radiologists who do not fully adhere to conventional pricing[11] (De Wolf & Landtmeters, 2023a). The percentage of radiologists fully adhering to conventional pricing is higher in Wallonia than in the other two regions (Table 1). Almost 5% of people with cancer in Belgium who underwent radiotherapy in 2021 were charged additional fees, concentrated mainly in Brussels (95%) and to a lesser extent in Flanders (4%) (De Wolf & Landtmeters, 2023b). In November 2023, the Minister of Social Affairs and Public Health approved a regulation requiring all hospitals to provide CT scans and MRIs at official rates.

Belgium performs well on access to newer cancer medicines with public reimbursement or coverage schemes

Decisions on reimbursement for early access to innovative medicine increasingly use population-based and named-patient-based approaches, both before and after marketing authorisation, funded by governments or insurers.

11 *In Belgium, practitioners have the option to either adhere to tariff agreements negotiated between their representatives and sickness funds or to impose additional fees beyond official tariffs. Conventioned practitioners agree to follow these negotiated tariff agreements and refrain from charging supplementary fees.*

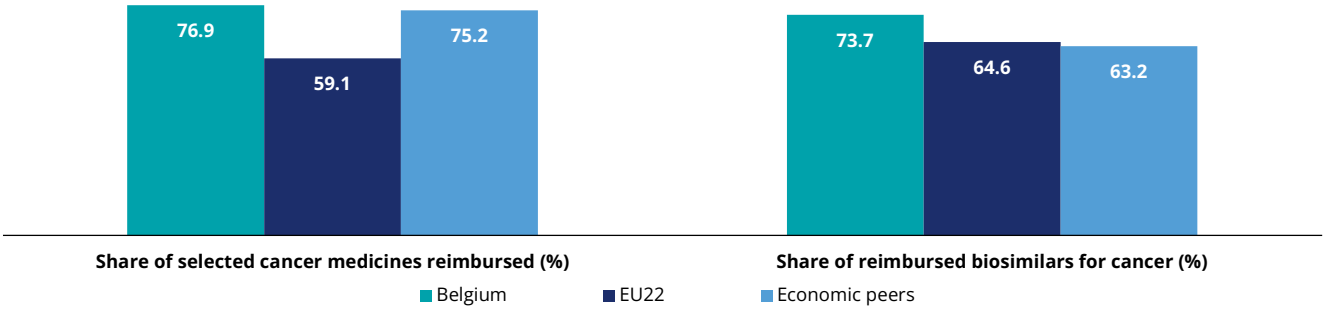
Currently, fewer than 10% of clinically eligible patients benefit from early access schemes for a given medicine/indication.

For breast and lung cancer medicines with high clinical benefit, 77% are publicly reimbursed in Belgium, which is higher than the averages across the EU (60%) and among the country's economic peers (75%) (Figure 15). Belgium ranks third in the EU for the shortest mean time between marketing authorisation and coverage application, at typically 15 days after European Medicines Agency (EMA) authorisation. Reimbursement decisions for cancer medicines or indications do not restrict eligible patient populations defined by the EMA. In addition, from 2024, the new convention reimburses off label drugs in paediatric cancers.

Biosimilars significantly reduce treatment costs by offering more affordable alternatives to original biologic medicines. The share of biosimilars for cancer medicines with public reimbursement in Belgium is 74%, surpassing the EU average of 65% and that among its economic peers (63%).

As personalised cancer therapies grow, biomarker testing is becoming increasingly relevant for determining optimal treatments for people with cancer. To ensure access to such treatment in a timely manner without additional financial burden, Belgium introduced a double reimbursement procedure in 2019. This ensures that people receive reimbursement for both biomarker testing and relevant selected treatment. The Belgian roadmap for introducing innovative molecular tools (Next-Generation Sequencing) into standard of care, the Commission Personalised Medicine (ComPerMed), and the Companion diagnostic platform are other initiatives which help to foster access to innovative cancer medicines.

Figure 15. In Belgium, the share of oncology medicines with public reimbursement is higher than the averages across the EU and Belgium's economic peers



Notes: The analysis includes a sample of 13 indications of 10 new cancer medicines for breast and lung cancer with a high clinical benefit and 19 biosimilars of three cancer medicines (bevacizumab, rituximab, trastuzumab), with active marketing authorisation by the European Medicines Agency as of 26 March 2023. The data represent the share of the indications or biosimilars that were on the public reimbursement list on 1 April 2023. Economic peers are defined as tercile clusters based on 2022 GDP per capita in purchasing power standard terms. Economic peers for BE are AT, DE, DK, IE, IS, NL, NO and SE. The EU average is unweighted.
Source: Hofmarcher, Berchet and Dedet (2024), "Access to oncology medicines in EU and OECD countries", https://doi.org/10.1787/c263c014-en.

5.2 Quality

Over the past two decades, five-year cancer survival rates have improved

The relative five-year survival rates for breast, colorectal and lung cancers have improved from individuals diagnosed in 2004 to those diagnosed in 2017 (Figure 16). According to the Belgian Cancer Registry, for those diagnosed between 2015 and 2019, the overall five-year survival rate is higher among women (72%) than men (64%). There are no regional differences in relative survival rates for breast, cervical and prostate cancers. However, colorectal cancer survival rates are lower in Brussels (65%) and Wallonia (66%) than Flanders (70%).

Improving screening coverage could affect these rates positively, as Brussels and Wallonia have low uptake of colorectal cancer screening compared to Flanders (see Section 4). Additionally, most breast, cervical and prostate cancers in Belgium are diagnosed at early stages (stage I or II), including 75% of women with breast cancer, 58% of women with cervical cancer and 64% of men diagnosed with prostate cancer.

Figure 16. Five-year cancer survival rates for lung and colorectal cancers showed marked improvements in Belgium

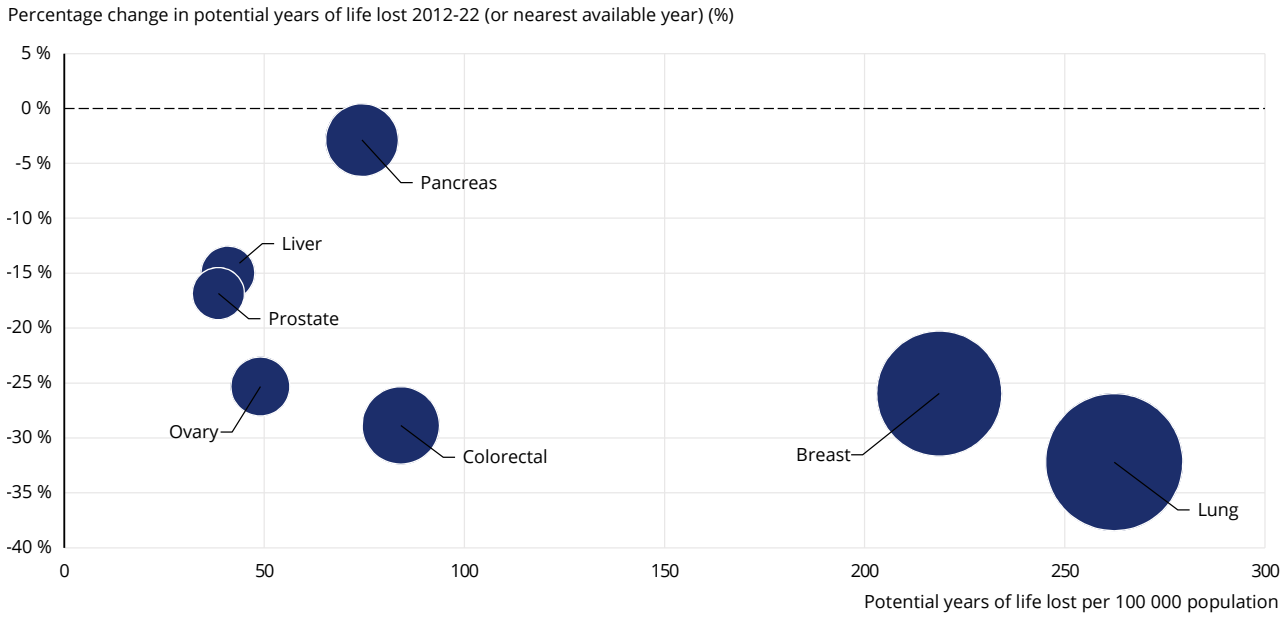
Individuals diagnosed in	Breast cancer	Prostate cancer	Colorectal cancer	Lung cancer	Cervical cancer
Belgium (2004)	88%	N/A	63%	19%	N/A
Belgium (2017)	92%	98%	72%	29%	69%

Notes: Data related to breast, colorectal and lung cancers relate to the cohort of people diagnosed with cancer in 2004 and in 2017; data related to cervical and prostate cancers relates to people diagnosed with cancer between 2017 and 2021; N/A – data not available.
Sources: Belgium Cancer Registry for breast, colorectal, cervical and prostate cancers; Ocak et al. (2021) for lung cancer.

The number of potential of years of life lost has decreased more in Belgium than the EU average

Potential years of life lost (PYLL) is a measure that reflects the impact of different cancers on society by giving greater weight to cancer deaths among younger individuals. Examining the change in PYLL over time across various cancer sites can point to improvements in cancer care systems via reductions in premature mortality. In Belgium, the overall PYLL rate due to cancer across all sites in 2020 was 1 113 per 100 000 population – 18% lower than the EU average (1 355 per 100 000) (Figure 17). The PYLL rate has decreased by 24% since 2012, higher than the decline in the EU. In 2020, the main drivers of cancer-related PYLL in Belgium were lung (262 PYLL per 100 000 population), although it declined by 32% between 2012 and 2022. Breast cancer is responsible for 219 PYLL per 100 000 women, but this figure has decreased by 26% over the past decade.

Figure 17. Lung cancer is responsible for the highest number of potential years of life lost due to cancer per 100 000 population



Notes: The rate of PYLL from breast, cervical and ovarian cancer is calculated in women only, while the rate of PYLL from prostate cancer refers to men. Pink bubbles signal an increase in the percentage change in PYLL during 2012-22 (or latest available year); blue bubbles signal a decrease. The size of the bubbles is proportional to the PYLL rates in 2022.
Source: OECD Health Statistics 2024.

Belgium faces challenges in implementing cancer care concentration, but recent policies show promise

Since 2008, specialised centres for breast cancer have been recognised by Belgian law, based on criteria issued by the European Society of Mastology. These standards are related to the minimum volume of patients treated, the expertise and experience of the medical co-ordinator and other physicians, and the presence of a nurse co-ordinator, among other requirements. Nonetheless, hospitals without this recognition have been able to treat people with breast cancer. Following a 2023 report from the KCE showing a 30% higher mortality rate among women treated in non-specialised centres, the Belgian Government has ceased reimbursing breast cancer treatment administered outside fully recognised clinics as of August 2024, except for follow-up treatment. Full implementation of this measure is planned by January 2026.

Since July 2019, Belgium has concentrated complex pancreatic and oesophageal surgical procedures in recognised centres, with exclusive reimbursement by the NIHDI. Efforts are also underway to centralise care for head and neck tumours. Legislative changes have recently focused on concentrating cancer treatment for children, adolescents and young adults (see Section 6).

As part of the Comprehensive Cancer Infrastructures for the EU (CCI4EU) project, funded under the EU Mission on Cancer, Belgium is participating in the development of a capacity building programme to reduce inequalities in access to cancer care, by supporting EU Member States and Associated Countries in improving or establishing comprehensive cancer infrastructures. This project builds on concluded or ongoing initiatives, such as the CraNE Joint Action, in which Belgium is also involved. Furthermore, Belgium participated in the EU-funded Joint Action Networks of Expertise (JANE), concluded in September 2024. A follow-up proposal, JANE-2, started in October 2024 and aims to establish seven new cancer-focused networks of expertise.

Most cancer cases in Belgium are discussed in multidisciplinary teams

The percentage of cancer cases discussed in multidisciplinary teams (MDTs) increased from 83.4% in 2012 to 90.4% in 2021. MDTs, so-called multidisciplinary oncology consultation, were introduced by a Royal Decree in 2002, with a minimum number of participants defined by law: four physicians from different specialities, including an oncologist. Reimbursement is provided for two in-depth discussions with the patient to discuss MDTs conclusions, including explanations of the diagnosis and treatment plan. Reports from MDTs, as well as from pathology laboratories, provide data to the national cancer registry database.

The Belgian Cancer Registry and federated entities are working to provide and utilise data in quality improvement cycles more efficiently

The Belgian Cancer Registry collects national epidemiological and quality data, including screening, incidence, staging, biomarkers, treatment and survival data, patient-reported indicators, and population mortality rates. Since December 2006, participation in the Registry has been mandatory for oncological care programmes and pathology laboratories, using the national social security number to link to other administrative databases. Despite the wealth of data collected by the Registry, data disaggregation by socio-economic status or deprivation level is still very limited.

The Belgian Cancer Registry is collaborating with federated entities (Flanders, Wallonia and Brussels) and linguistic communities (Flemish, French and German) to integrate data into quality improvement cycles and harmonise data collection for vulnerable groups. This effort builds on the concluded CanScreen-European Cancer Information System (ECIS) project and the ongoing CanScreen5 project, aimed at developing a new data management system for cancer screening data to be incorporated into ECIS. Additionally, the Belgian Cancer Registry and the KCE have undertaken quality improvement initiatives for breast, testicular, oesophagus, stomach, lung, head and neck, and ovarian cancers by developing clinical guidelines, performance indicators and hospital feedback systems. A new Joint Action on Cancer Registries will support the improvement of the quality and the exhaustivity of the population-based cancer registry.

The Belgian Integrated Health Record framework, part of the Belgian e-Health Action Plan 2022-24, aimed to support integrated and multidisciplinary care, notably by focusing on data interoperability, standardisation, and patient engagement. By December 2022, all general hospitals in Belgium had implemented unique patient identifiers, allergy lists, and electronic prescriptions, supported by financial incentives. In March 2023, the Belgian Health Data Agency was established to enhance the availability of health data and ensure secure

data exchanges, supporting data-driven care, policy making, research, and innovation.

Several quality improvement initiatives are ongoing, but development is uneven across regions and cancer types

The Pay for Performance Programme, launched in 2018 for general hospitals, includes cancer-related clinical and pathological indicators about tumours, including mortality data. Hospitals are financially rewarded for achieving the International Society for Quality in Healthcare (ISQua) accreditation certification, as well as for implementing patient safety management systems. Initially, ISQua accreditation rates increased as hospitals opted to participate in the process, with 65% of Belgian hospitals accredited in 2020. This figure decreased to 46% in 2022, following the decision of some hospitals to discontinue their participation in the accreditation process. Since 2018, 94% of hospitals participating in the Programme (96 out of 102 Belgian hospitals) have collected patient-reported experience measures, including some focused on cancer.

The Flemish Institute for Quality of Care, established in 2017, measures and reports cancer-related indicators publicly. In 2023, quality indicators for breast cancer were reported for all Flemish hospitals, allowing public comparison and revealing some variation in their overall good performance.

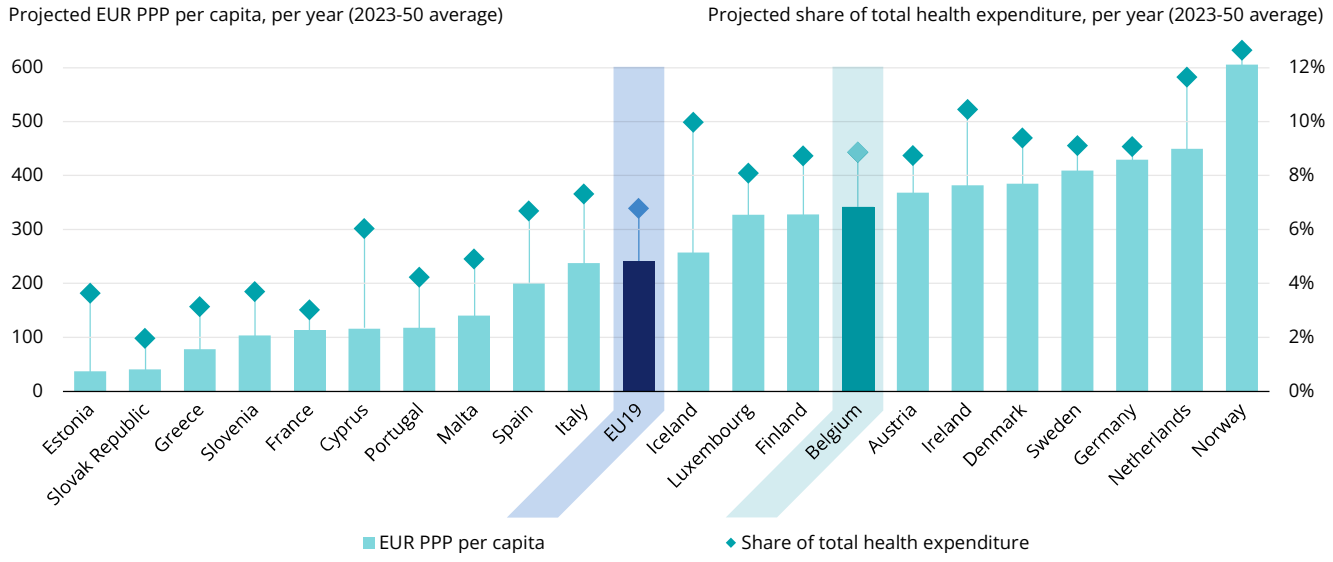
5.3 Costs and value for money

Estimates suggest that the burden of cancer on health expenditure will be higher in Belgium than in the EU

According to OECD SPHeP modelling work, between 2023 and 2050, total health expenditure is estimated to be 9% higher in Belgium due to the burden of cancer. This equates to an average of EUR (PPP) 342 per person per year (Figure 18). This figure is much higher than the EU19 average (EUR 242). Overall, the per capita health expenditure on cancer care is expected to grow by 53% in Belgium between 2023 and 2050, compared to 59% in the EU27.

In terms of other costs, between 2023 and 2050, cancer in Belgium is expected to lead to a loss of 143 FTEs per 100 000 people due to the need to reduce employment, which is lower than the EU average of 178 per 100 000. A loss of 77 FTEs per 100 000 people is also anticipated due to absenteeism and presenteeism.[12]

Figure 18. The burden of cancer on total health expenditure is expected to be higher in Belgium than in the EU between 2023 and 2050



Note: The EU average is unweighted.
Source: OECD (2024), Tackling the Impact of Cancer on Health, the Economy and Society, https://doi.org/10.1787/85e7c3ba-en.

12 *Presenteeism refers to lost productivity that occurs when employees are not fully functioning in the workplace because of an illness, injury or other condition.*

Hospitals' expenditure on reimbursable antineoplastic agents has been increasing by 15-20% annually since 2017

According to the NIHDI in the Monitoring of Reimbursement Significant Expenses (MORSE) report (RIZIV-INAMI, 2021), annual expenditure on reimbursable pharmaceuticals showed an increase of 7% in 2021 compared to the previous year. This growth comprised a 4% increase in expenditure in public pharmacies and close to 10% increase in hospitals. Specifically, expenditure in hospitals, categorised by the Anatomical Therapeutic Chemical classification, indicated substantial growth in the L01X class (antineoplastic agents), which has been increasing at rates between 15% and 20% annually since 2017. In 2021, this category continued its upward trend with a 16% increase compared to 2020.

Various strategies are in place to address rising prices of cancer drugs – notably managed entry agreements

Due to high costs of new medicines and the rising numbers of people with cancer and treatments, the budget impact of new cancer medicines has become increasingly critical for coverage and reimbursement decisions in Belgium over the last five years. To address uncertainties in coverage and pricing decisions, Belgium employs strategies such as performance-based and financial managed entry agreements, along with post-marketing studies. According to KCE (Neyt et al., 2021), managed entry agreements are becoming more common in Belgium, with 58% of agreements between the NIHDI and pharmaceutical companies focusing on cancer drugs. However, the same KCE report warns that widespread use of managed entry agreements may incentivise reimbursement submissions without sufficient data on patient benefits, potentially limiting the incentive to generate further evidence during the temporary contract.

Belgium supports the Beneluxa Initiative and International Horizon Scanning Initiative

The Beneluxa Initiative, launched in 2015 by the health ministers of Belgium and the Netherlands, expanded with Luxembourg joining in 2015, Austria in 2016, and Ireland in 2018. These countries collaborate on pilot projects in health technology assessment, pricing and reimbursement, information sharing and policy exchange, and horizon scanning. Horizon scanning aims to identify high-impact innovations for health systems and enhance national decision-making on pricing and reimbursement. Additionally, Belgium participates in the International Horizon Scanning Initiative, introduced in 2017. This includes nine European countries, pooling resources to collect comprehensive data on upcoming pharmaceuticals and serving as a tool to prioritise early identification and evaluation of innovative medicines, including those for cancer.

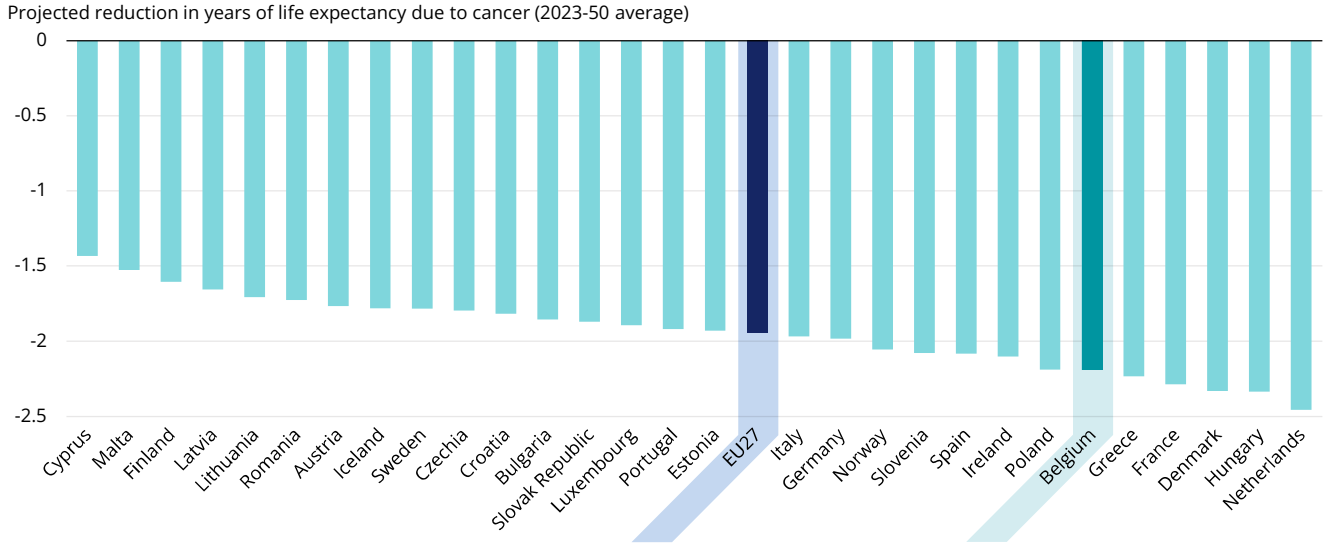
5.4 Well-being and quality of life

Cancer substantially affects life expectancy in the Belgian population, alongside high rates of depression

With incidence of cancer expected to continue to grow (see Section 2), its impact on public health will become increasingly significant. According to OECD SPHeP modelling work, in Belgium, between 2023 and 2050, cancer is expected to reduce the life expectancy of the population by an average of 2.2 years compared to a scenario without cancer, which exceeds the EU average of almost 2 years (Figure 19). To provide context, Belgium took from 2010 to 2019 to increase its life expectancy by 2 years (80.3-82.1 years).

In addition, cancer takes a substantial toll on the mental health of the population through its associated symptoms and treatment side effects, and impact on daily life, social roles and work. According to the OECD's SPHeP model, Belgium is expected to have much higher depression rates because of cancer, at an additional age-standardised rate of 13 cases per 100 000 population per year. This is somewhat below the EU average of 17 per 100 000.

Figure 19. Belgium ranks sixth among EU countries in terms of the impact of cancer on life expectancy



Note: The EU average is unweighted.
Source: OECD (2024), Tackling the Impact of Cancer on Health, the Economy and Society, https://doi.org/10.1787/85e7c3ba-en.

Advances in home-based care and improved access to technology and treatment are expected to enhance quality of life and mitigate chemotherapy side-effects

In Belgium, since July 2023, certain antibiotics and oncologic drugs can be administered at home under specific conditions, including a limited range of chemotherapy, targeted therapy and immunotherapy drugs. The process and costs are being evaluated, with expectations that this measure will enhance comfort for people with cancer.

Use of gene expression profile (GEP) technology has expanded to enable avoidance of chemotherapy treatment in certain cases, such as some types of breast cancer, while maintaining favourable outcomes and reducing side-effects. Since January 2023, a new agreement was established between the NIHDI and recognised breast clinics for reimbursement of GEP tests for specific groups of women with early-stage breast cancer. It is expected that fewer than 1 000 women diagnosed with breast cancer annually will require chemotherapy due to GEP testing.

Furthermore, in 2023, new reimbursements were introduced for treatments aimed at reducing chemotherapy side-effects. These include procedures to cool extremities during taxane-based chemotherapy and scalp cooling to prevent or minimise hair loss. From July 2024, reimbursement also covers head accessories and dental care for specific cases.

The BeONCOsup Project, launched in 2023 with support from the Belgian Federal Cabinet, aims to enhance access and awareness of supportive care for people with cancer or a history of cancer. Under the auspice of this project, Sciensano's Cancer Centre is developing an innovative web tool to list supportive cancer care providers in Belgium, with a focus on supporting people with low health literacy. Belgium has also implemented various policies offering paid and unpaid leave to support carers of terminally ill and non-terminally ill patients, including emergency leave for close relatives or co-residents.

Advanced care planning aims to improve timely access to high-quality palliative care

Since 2002, Belgian federal law has ensured access to multidisciplinary care as part of the general right to healthcare. Since 2012, Belgian authorities have monitored key quality indicators for end-of-life care for people with cancer. This includes monitoring the percentage of terminal people with cancer receiving palliative care, which increased from 53% in 2015 to 57% in 2020, with regional variations. The indicators also measure the timeliness of palliative care initiation, the aggressiveness of end-of-life treatments like chemotherapy, and the percentage of individuals dying in their usual place of residence, which rose from 23% in 2008 to almost 29% in 2020.

In May 2022, a modification to the law on compulsory health insurance led to a definition of palliative statuses to ensure progressive palliative care. Since November 2022, fully reimbursed

advanced care planning by GPs allows patients to discuss palliative care plans without cost. This initiative aims to improve timely access to palliative care by identifying patients who need this specialised care at earlier stages.

Various projects are ongoing in Belgian hospitals to improve survivorship and facilitate return to work following a cancer diagnosis

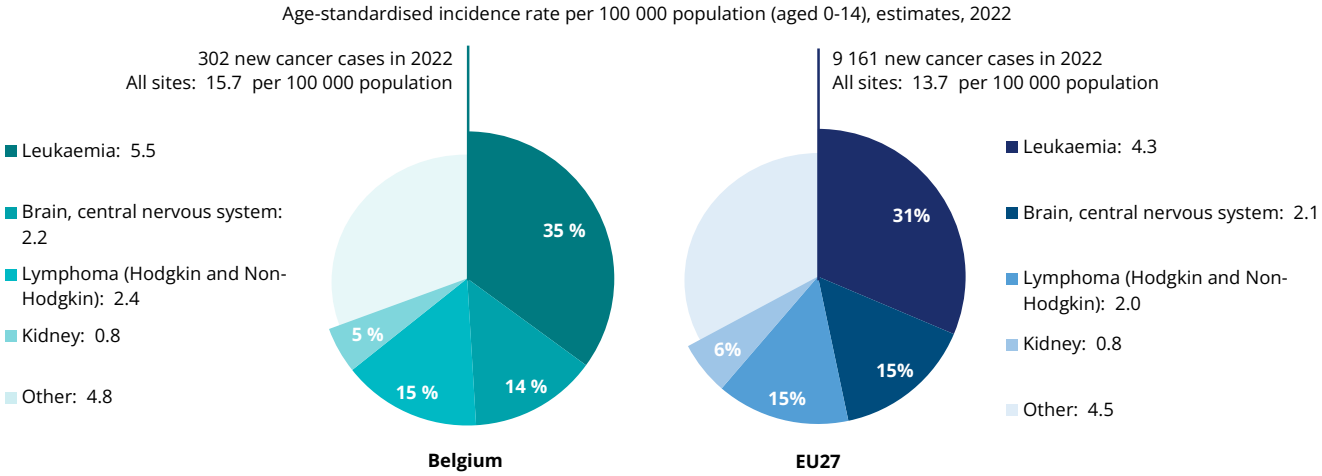
The Belgian Parliament enacted the "Right to be Forgotten" Law in 2019 to enhance the quality of life and societal reintegration of people with a history of cancer by regulating insurance premium increases. In 2022, this law was extended to cover individuals declared cancer-free for eight years as adults or for five years if under the age of 21. From 2025, the standard timeframe will be reduced to five years for all individuals cured of cancer. The list of cancer scenarios covered by this law is progressively expanding and undergoes biennial revision by the KCE to incorporate new scientific insights.

BelNetSup is an ongoing initiative to integrate several survivorship projects across Belgian hospitals, in collaboration with the inter-federal plan for integrated care. Initiatives to support a return to work following cancer include the Kankerwerk website, financed by the non-governmental organisation Kom Op Tegen Kanker, which provides information sessions to assist employers and employees.

6. Spotlight on paediatric cancer

According to ECIS, it is estimated that 302 children and adolescents up to age 15 were diagnosed with cancer in Belgium in 2022. Belgium had an incidence rate of 15.7 per 100 000 children aged 0-14, compared to the EU27 average of 13.7 (Figure 20). In Belgium, incidence rates among boys are higher than those among girls, as is the case in most other EU countries. The most common cancer types are leukaemia, with 5.5 cases per 100 000 children (35%); lymphoma, with 2.4 cases per 100 000 (16%), brain and central nervous system cancers, with 2.2 cases per 100 000 (14%); and kidney cancer, with 0.8 cases per 100 000 (5%). While Belgium has higher cancer incidence rates among children than the EU average, the country has lower cancer mortality, with a 3-year average mortality rate of 1.8 per 100 000 children compared to 2.1 in the EU, according to Eurostat.

Figure 20. Cancer incidence rates are higher among children in Belgium than across the EU



Notes: 2022 estimates are based on incidence trends from previous years, and may differ from observed rates in more recent years. "All sites" includes all cancer sites except non-melanoma skin cancer.
Source: European Cancer Information System (ECIS) for cancer incidence. From https://ecis.jrc.ec.europa.eu, accessed on 10 March 2024. © European Union, 2024.

The European Society of Paediatric Oncology (SIOPE)'s Organisation of Care & Research for Children with Cancer in Europe (OCEAN) Project identified that Belgium has seven institutions treating children and young people with cancer. Of these, four are in Flanders, two in Wallonia, and one in Brussels (SIOPE, 2024). These institutions include paediatric hospitals (both university and general) and hospitals with paediatric units. Legislative changes have concentrated cancer treatment for children aged 0-15, aiming to establish three paediatric haemato-oncology reference centres in Belgium by 2027. These centres will meet standards for supervision, infrastructure, and activity levels to provide complex care for paediatric cancers. They will have an exclusive mandate to administer specific treatments, including the possibility of home care, and will be linked to satellite centres designated by federated entities based on compliance with specific standards to ensure care close to home. Adolescents and young adults aged 16-35 diagnosed with cancer are treated in six designated reference centres since December 2023, which meet defined criteria and have signed a convention with the National Institute for Health and Disability Insurance.

All 13 infrastructural aspects and treatment modalities – such as brachytherapy, stem cell transplants, proton and photon radiation therapy, and a survivorship care clinic – are available in Belgium for children with cancer. Out of the 436 clinical trials involving children and adolescents with cancer in Europe between 2010 and 2022, 84 (19%) were conducted in Belgium. In addition, in 2018, 85% of the 68 medicines identified as essential for treating cancer in patients aged 0 to 18 were available in Belgium, compared to 76% in the EU on average (Vassal et al., 2021).

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovak Republic	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

European Cancer Inequalities Registry

Country Cancer Profile 2025

The European Cancer Inequalities Registry is a flagship initiative of the Europe's Beating Cancer Plan. It provides sound and reliable data on cancer prevention and care to identify trends, disparities and inequalities between Member States and regions. The Registry contains a website and data tool developed by the Joint Research Centre of the European Commission (https://cancer-inequalities.jrc.ec.europa.eu/), as well as an alternating series of biennial Country Cancer Profiles and an overarching Report on Cancer Inequalities in Europe.

The Country Cancer Profiles identify strengths, challenges and specific areas of action for each of the 27 EU Member States, Iceland and Norway, to guide investment and interventions at the EU, national and regional levels under the Europe's Beating Cancer Plan. The European Cancer Inequalities Registry also supports Flagship 1 of the Zero Pollution Action Plan.

The Profiles are the work of the OECD in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by national experts, the OECD Health Committee and the EU Thematic Working Group on Cancer Inequality Registry.

Each Country Cancer Profile provides a short synthesis of:

- the national cancer burden
- risk factors for cancer, focusing on behavioural and environment risk factors
- early detection programmes
- cancer care performance, focusing on accessibility, care quality, costs and quality of life.

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