



RETHINKING HEALTHCARE
IN TIMES OF SCARCITY
AND INNOVATION

Belgian hospitals in transition

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It takes an ecosystem to reform the hospital landscape



Sabrina Suetens
MANAGING DIRECTOR BEMEDTECH

The hospital reform currently on the table, and the choices being prepared today, will help shape how care is organised in Belgium for years to come.

On 24 June 2026, the Interministerial Conference on Public Health approved the proposed reform plans for the hospital sector, based on the expert report and input from different stakeholders. It was this same expert report that formed the basis of our panel debate during our General Assembly on 20 May 2026. The reform starts, of course, with hospitals, but affects the entire healthcare ecosystem: from patients and healthcare professionals to primary care, rehabilitation, home care, policymakers and industry partners. The questions it raises are complex, but the ambition behind it is clear: to ensure that high-quality, accessible and sustainable care remains within reach for patients today and for future generations.

We have been delivering high-quality healthcare for decades. That is something to be proud of. But it should not make us complacent. The pressure on our system is increasing, making the need to organise care differently more urgent.

A ROLE TO PLAY, TOGETHER

At beMedTech, we look at this reform from a very specific position. The medical technology sector is deeply embedded in the way care is delivered today: in hospitals, in primary care, across care pathways and increasingly at home. This makes our sector both directly affected by the choices being made now and well placed to contribute to making them work.

But we cannot do that alone. The hospital reform will only succeed if the different



actors in the healthcare ecosystem work together, listen to one another and challenge each other constructively.

That belief shaped the fourth edition of our General Assembly in its new format on 20 May 2026, where we brought together more than 160 participants from across the healthcare ecosystem.

The purpose of that afternoon was not to provide all the answers. Instead, we wanted to create space for a true conversation about what our healthcare

system needs, where innovation can help, and how different stakeholders can move forward together.

There is no time to lose. But perhaps that sense of urgency is also what can bring us closer together. At beMedTech, we are pleased to play our part: as a committed partner helping to ensure that care remains strong, sustainable and centred on the needs of patients.



KEYNOTES

The following keynotes and debate took place at our General Assembly on 20 May 2026, and therefore before the Interministerial Conference on Public Health approved the proposed reform plans for the hospital sector on 24 June 2026.

What do the experts say about the reform of the hospital landscape?

At the request of the Interministerial Conference on Public Health, a group of experts – supported by the Belgian Health Care Knowledge Centre (KCE) – drafted a report [\(NL | FR\)](#) at the end of 2025 that could serve as a blueprint for the planned hospital reform. While many stakeholders in the Belgian healthcare ecosystem endorse the underlying principles, the note has also raised considerable concern and a number of questions. To clarify what is at stake, Dr Steven Rimbaut outlines the expert note’s main recommendations.

“The objective is to continue guaranteeing high-quality care, while deploying both people and resources as efficiently as possible. There will never be a surplus of funding, and in the coming years we will also be facing a serious workforce challenge. On top of that, our population

is ageing: there are more and more older people with significant care needs.”

USING RESOURCES MORE EFFICIENTLY

The experts did not start from a blank page, but from the existing network of hospitals and infrastructure, says Dr Rimbaut. “Their conclusion is that today, our country has too many acute hospitals that aim to provide too broad a range of services, which means resources are not always used effectively.”

“Today, our country has too many acute hospitals that aim to provide too broad a range of services.”

“ In Namur and Luxembourg, but also along the coast, access to care could come under pressure.

“To address this, the experts propose four types of institutions. The regional general hospital remains the classic acute hospital, but with a minimum scale, a broad care offering, an emergency department, and an intensive care unit. University hospitals must meet the same criteria and, in addition, retain their legally defined responsibilities in education, training and research.”

“Then there is the local medical centre, which will not provide classic hospitalisation or emergency admissions, but will offer day clinic, consultations and other less complex care close to the patient. It may be possible for some LMCs to be organised as focused clinics, where low-risk patients can stay for a limited period, for example after an orthopaedic procedure. Finally, there are the hospitals for intermediate care, which focus on rehabilitation.”

“What is important is that these four types of institutions must not operate separately from one another. Local medical centres and hospitals for intermediate care must be connected to a regional general hospital or a university hospital, creating a shared vision,

capital and governance. The experts also propose minimum criteria, such as at least 240 beds for regional general hospitals and at least 600 births per year for a maternity unit.”

HIGH-QUALITY AND EFFICIENT CARE THAT REMAINS ACCESSIBLE

Dr Rimbaut emphasises that the care of tomorrow must not only be high-quality and efficient, but also accessible. “For each of these three characteristics, the right balance will need to be found, and that will not be straightforward.”

“For example, based on the current criteria, there may be very few acute hospitals left in Namur and Luxembourg. Access could also come under pressure along the coast. We therefore need to properly map the impact on residents, in careful balance with the quality and efficiency of care.”

Dr Rimbaut also notes that several elements are missing from the note. “The focus is solely on general hospitals, but what about mental healthcare institutions? Flemish rehabilitation hospitals? Primary care? And the link with industry and other stakeholders?”



KEYNOTES

Centralising care without losing accessibility: the challenge for AZORG

To make the recommendations more concrete, Peter Verhulst translates the experts' advice into the potential impact on the hospital of which he is CEO: AZORG, the merged hospital in Aalst. "We can support the broad direction, but the recommendations are not perfect, nor are they complete. Like Steven, my main concern is accessibility of care. This is precisely what becomes crucial when acute care is centralised."

"According to the recommendations, we will need to concentrate acute care in Aalst as much as possible, with the exception of planned care and low-risk activities. In time, our two campuses in Aalst will need to evolve towards one regional general hospital, probably in a newly built facility. How quickly that can happen will, of course, depend on Flemish funding."

"In Asse and Geraardsbergen, local medical centres would be created in combination with intermediate care. For Asse, this would mean, among other things, the disappearance of mother and child care – a sensitive issue – as

well as specialised emergency care and the PIT function. Wetteren would then become a hospital for intermediate care, with a focus on rehabilitation. In Ninove, we are working on a new ambulatory project in collaboration with partners in mental healthcare and general practitioners."

In hospital terms, 2029 is almost tomorrow, Verhulst notes. "Transition requires time, staff, infrastructure and temporary financial support. Without accompanying resources, the reform risks grinding to a halt."

"Anyone who has been through major transition processes knows that there is a mountain to climb. This temporarily requires extra people and resources.

“ I have questions about the timing, and about the minimum numbers of procedures and beds.

There are also still many uncertainties around the legal framework, although personally I am less worried about that; it will be resolved. I do have concerns about the timing. Our two hospitals in Aalst have not yet been fully depreciated. This means that a new hospital in Aalst will only be realistic in 10 to 13 years at the earliest."

"Concentrating our emergency departments in one location is not feasible, we don't have the infrastructure for that. The authorities need to accept this, otherwise both accessibility and quality of care will deteriorate."

"The experts also mention 5,000 procedures as a condition for a focused clinic. That seems very high to me: even as the third-largest orthopaedic department in Flanders, we would struggle to reach that number. For a hospital for intermediate care, the note refers to at least 90 rehabilitation beds. By comparison, in Wetteren we have 62 beds, and that is sufficient. This shows that tailored solutions will always be needed to shape the hospital campuses of tomorrow appropriately. And that requires dialogue with the sector, with us."

"It is also important to realise that the new organisation will lead to much more patient transport between hospitals. This calls for clear quality standards, regulation and financing for medically assisted transport, because there are a number of 'cowboys' active in that sector."

“ Work on innovation together with people from hospitals, from the earliest stages of development.

REFORM CREATES OPPORTUNITIES FOR MEDTECH

Verhulst concludes by highlighting the importance of innovation. "If hospitals increase in scale, this also creates opportunities for the medtech sector. Larger hospitals mean larger physician associations. The largest association in our hospital has 90 doctors. Within such groups, there are always people working on innovation who are keen to collaborate with the sector. Identify those people and develop projects together."

"When it comes to funding, as a larger organisation you are better placed to find your way to organisations such as VLAIO, and to philanthropy. Resources from you, the industry, are also indispensable. Scale has an impact on the use of data. We are sitting on a mountain of data and are currently building a data lake for the whole of Belgium. This will make it much easier for you to work with validated and analysed data."

"I am convinced that the relationship with suppliers such as yourselves must evolve from a supplier relationship into a strategic partnership. Building innovation together, from a shared vision and mission. And doing so from the earliest stages of development, because no one knows better what needs to happen than the person standing next to the patient. This should continue through to commercial launch, so that we can jointly share the added value of the innovation with colleagues and peers. Here too: reach out to those people in hospitals and involve them in your projects. This is already happening: at AZORG, we have already completed such pathways with many of you, with positive results."





PANEL DISCUSSION

From expert note to practice:

6 voices on the care of tomorrow



Moderator: Pascal Verdonck
PROFESSOR OF MEDICAL TECHNOLOGY
AT GHEENT UNIVERSITY

Successfully reforming the hospital landscape and making our care future-ready will only be possible if all stakeholders are involved. That is why we brought together six key opinion leaders from different branches of the healthcare ecosystem, each with their own expertise and perspective.

The debate was skilfully moderated, with a touch of humour, by Pascal Verdonck. He is Professor of Medical Technology at Ghent University, Vice-President of the Belgian Association of Hospital Managers, former CEO of AZ Maria Middelaere and Chair of its Board of Directors, as well as board member at a wide range of other healthcare institutions and organisations.

The panel members discussed three topics: the expert note, our current and future capacity for innovation, and integrated care.

The participants were:



Mickaël Daubie, Director-General of the Health Care Service at the National Institute for Health and Disability Insurance, where he has worked since 2004.



Stephanie Devisscher, adviser on hospital financing and national health insurance at Zorgnet-Icuro, and an economist specialised in healthcare.



Philippe Devos, CEO of UNESSA, the French-speaking federation of hospitals and care institutions in Belgium. He is a former intensivist and an influential opinion leader.



Dieter Goemaere, Director Hospitals at GIBBIS, the umbrella organisation for Brussels-based social-profit healthcare institutions. He is an economist with broad experience in healthcare.



Dr Johan Vijgen, Head of Electrophysiology at Jessa Hospital and Heart Centre Hasselt, President of BeHRA (Belgian Heart Rhythm Association).



Alexander Alonso, General Manager at BD Benelux and Chair of beMedTech since 2020. He is an experienced leader in the medical devices sector.

1 The experts' recommendations

For Mickaël Daubie, three areas of work need to move forward together: the funding of care, with the reform of the nomenclature and hospital financing; the efficient use of that funding, through value-based healthcare; and the organisation of the care landscape, including the reform of the hospital landscape.

"The hospital reform often receives less political priority than hospital financing, while both need to be addressed together. This can only succeed if all actors are willing to engage, without taboos: policymakers, the field and the administrations. And we need to put our own house in order. The National Institute for Health and Disability Insurance manages €45 billion, while we barely know how efficiently that money is spent, because we do not measure it sufficiently. This needs to improve, although that will also be a challenge. We manage that enormous budget with 'only' 350 people, and in two years' time we will lose another 50."

“ The hospital reform will only succeed if all actors are willing to engage, without taboos: policymakers, the field and the administrations.

MICKAEL DAUBIE

"Everyone agrees that there are too many hospital sites and that this needs to change," says Philippe Devos. "Not because the minister says so, but because it is necessary. Healthcare professionals no longer want to work across so many different locations either. As regards the reform, I advocate rapid political decisions and gradual implementation, so that staff, infrastructure and primary care can follow. Because changing the care offer does not mean that care demand will change."

“ I advocate rapid political decisions and gradual implementation, so that staff, infrastructure and primary care can follow.

PHILIPPE DEVOS

"The biggest problem today is uncertainty. Hospitals are willing to invest in concentration, but only if they know where the government wants to go. Otherwise, they may invest in the wrong locations, because the authorities take a different view. We therefore ask for swift political decisions now, within a clear legislative pathway."

Dieter Goemaere sees a fundamental shift: from maximum accessibility of care towards greater efficiency, quality and quality measurement. "This requires a dual movement: upscaling and more collaboration."

"Our care is high-quality and accessible. We must not lose that accessibility. At the same time, our complex systems do not make reforms any easier; they will take time. And policymakers need to help us with that."



“Our care is high-quality and accessible. We must not lose that accessibility as a result of the reforms.”

DIETER GOEMAERE

“Today, hospitals know that they need to change, but not where they need to go. They have to develop a business plan, but they do not know the future financial systems, the governance or the budgetary framework. We are therefore asking policymakers to provide greater clarity in the short term: on how the reforms will be aligned with each other, what the precise objectives are, and how we will have sufficient certainty and resources during the transition. Because implementation will certainly be as great a challenge as the reform itself.”

For Dr Johan Vijgen, the hospital reform can help valorise ambulatory care, provided it is implemented thoughtfully. “Low-risk procedures, such as the implantation of devices, can be carried out in an ambulatory setting. Such a locoregional satellite – the local medical centre described in the note – must, however, still have a link with a general or university hospital, so that patients can move smoothly to primary care or if necessary back to the main centre. High-risk procedures can also be carried out on an ambulatory basis, in a hospital environment, and provided adequate financing is available.”

Hospital financing is complex, Stephanie Devisscher explains. “The ‘Budget of Financial Means’ covers basic operating costs, but only accounts for a part of the total costs of a hospital. Hospitals obtain the remaining part from NIHDI conventions and from contributions from physicians’ fees.”

“That is what makes this reform so challenging. Normally, you first develop a vision of how you want to organise care, and then build a financing system that supports that vision. Now, different reforms are running in parallel, including the reform of the nomenclature, for example, but the bridge between them is not being made.”

“This creates uncertainty for hospitals. Moreover, every transition costs money before you can reap the benefits. The note does pay attention to this, although I hope hospitals will not have to bear those transition costs themselves.”

Alexander Alonso points out that Belgium tries to invent a great deal itself, while countries such as the United States, the Netherlands and Denmark already offer examples of networks and integrated care models. “The experts’ proposals are based on trends and challenges in our healthcare system, which is positive. Other countries are facing these challenges as well and have developed solutions. Perhaps we should adopt more from abroad and draw inspiration from good practices elsewhere, or at least from parts of them.”

“I look at it positively. Change has begun, and as a medtech sector we embrace change. The challenges in healthcare are precisely the areas where we help provide solutions through our products and services.”



2 The sector's capacity for innovation

Pascal Verdonck posed an open question: in the future, should hospitals simply follow what the government imposes, or should they themselves be engines of innovation?

"Innovation is the implementation of a solution to a challenge, a solution that brings added value for the patient and for society. With better outcomes, at lower cost. If you look at it that way, there is actually not that much innovation in our country today, certainly not in terms of processes and organisation. And where innovation does exist, how can it remain affordable in times of budgetary pressure?" says Verdonck.

"In discussions about innovation, the focus is often on cost and the capacity to innovate. But I like to turn the question around," says Alexander Alonso. "The real question is: will our healthcare remain affordable without sufficient innovation? I think the answer is clear ..."

"Investing in innovation helps tackle the biggest challenges. One of my major frustrations is that many innovations already being used in other countries never make it into care practice here in Belgium. That is unfortunate both for patients and for our healthcare system, because they cannot benefit from those advantages."

“ One of my major frustrations is that many innovations already being used in other countries never make it into care practice in Belgium.

ALEXANDER ALONSO

The creation of an innovation fund remains the minister's intention, Mickaël Daubie confirms. "It will not only focus on hospitals, but also on the ambulatory sector. Innovation must be understood broadly: not only products, but processes as well."

"As an administration, we also need to become more efficient in how we assess and implement innovation. Today, initiatives from different administrations are not always well coordinated. Innovation should not be added as an extra layer; it needs to be embedded in care processes."

Stephanie Devisscher sees clear room for innovation, provided it brings real added value. "It is still too much of a blind spot when we talk about the future of our care: how do we create more room for innovation? The resources are there, even today. But we sometimes spend them on suboptimal processes. If we can reduce that waste, even partially, resources will be freed up that we can invest in innovation. And that is urgently needed to make care more future-oriented and to ease the work of healthcare professionals."

Philippe Devos sets out three criteria that innovation must meet. "Hospitals face three major problems: growing budgetary pressure, staff shortages and maintaining quality with fewer resources. Innovations that address only one of



these problems while ignoring or even worsening the others are not of interest to hospitals. If, as a company, you have an innovation that reduces workload, limits costs and maintains or improves quality at the same time, every hospital will welcome you with open arms.”

Dieter Goemaere distinguishes between technological-medical innovation and organisational innovation. “Both are needed to create value for patients and healthcare providers. Due to staff shortages, time is becoming scarce. Technology can help, for example by automatically registering parameters and avoiding errors. But organisational renewal is just as important: task delegation from doctor to nurse, from nurse to care or logistics assistant, and rethinking who performs which actions.”

He warns against an innovation fund that is organised too centrally. “Innovation must emerge bottom-up, with room to test and fail. If the reform of fees and governance were to result in doctors, hospitals and industry being less able to invest together locally, that would put innovation at risk. The reason we excel in robot-assisted surgery in our country today is that a number of doctors and hospital administrators decided at some point: let’s invest in this together.”

“We have been discussing reimbursement for telemonitoring with the authorities for 15 years,” says Dr Johan Vijgen. “For a certain group of heart failure patients, this has recently become reimbursed in practice. But other patients, people with an implant, are still left behind. Yet, telemonitoring of devices such as defibrillators and pacemakers also creates clinical and health-economic value: less time lost, less transport, better follow-up and more efficient use of staff.”

“ **An AF clinic can perfectly operate on an ambulatory basis if there is proper reimbursement for specialised nurses and telemonitoring.**

DR JOHAN VIJGEN

“Our telemonitoring, atrial fibrillation (AF) and heart failure nurses do essential work, but today this happens without appropriate nomenclature. An AF clinic can perfectly operate on an ambulatory basis if there is proper reimbursement for specialised nurses and telemonitoring. It would also help the authorities make savings, as the number of hospitalisations would decrease.”



3 Integrated care

The third topic of discussion was the transition from hospital-centred care to integrated care. Although the experts behind the note focused on hospital care, we are increasingly living in the reality of transmurial care. Pascal Verdonck refers to this as the care continuum.

“You first need to connect with the patient, with the help of data. Then you can integrate care around that patient. Personalised care, including precision medicines. Only then do you achieve true value-based healthcare. And then the question becomes: who will be responsible for the outcomes?”

Philippe Devos sees an institutional problem: primary and secondary care do not fall under the same minister. “Integrated care always requires interministerial work. Outcome-based financing can help, but those outcomes first need to be measured. This requires interoperable software and shared data. I think the greatest gains can be made at the transition points: from emergency care to hospitalisation, from hospital to GP, from specialist to primary care. Today, no one really feels ownership of those transitions.”

“Take the example of eye care software that extracts data from devices very well, but does not generate a useful report for the GP. The technology serves the specialist workflow, but not care continuity. The solution? Proofs of concept, global financing of complete pathways and gradual scaling once the added value for the patient has been demonstrated.”

Stephanie Devisscher emphasises that integrated care must be organised from the patient’s perspective. “And there are already many good examples: complex wound care, palliative collaboration, home hospitalisation, support for residential care centres by geriatricians and transmurial pathways. The challenge is to make them structural and to scale them. IT is a prerequisite, but it is not enough. You need a ‘warm handover’: the patient needs to know who can be contacted in case of questions or problems. Integrated care only succeeds when patients do not get lost in the system, but remain actively involved in their care.”

“ Integrated care only succeeds when patients do not get lost in the system, but remain actively involved in their care.

STEPHANIE DEVISSCHER

“Integrated care is the logical direction, but a ten-year horizon is dangerously slow given the pace of technology,” says Alexander Alonso. “Video, AI, wearables and digital follow-up will evolve faster than policy notes. Financing today is too static: a patient enters hospital, is treated and discharged. That is the financed episode. In integrated care, financing must follow the full pathway. Responsibility is shared, but it must be perfectly orchestrated.”



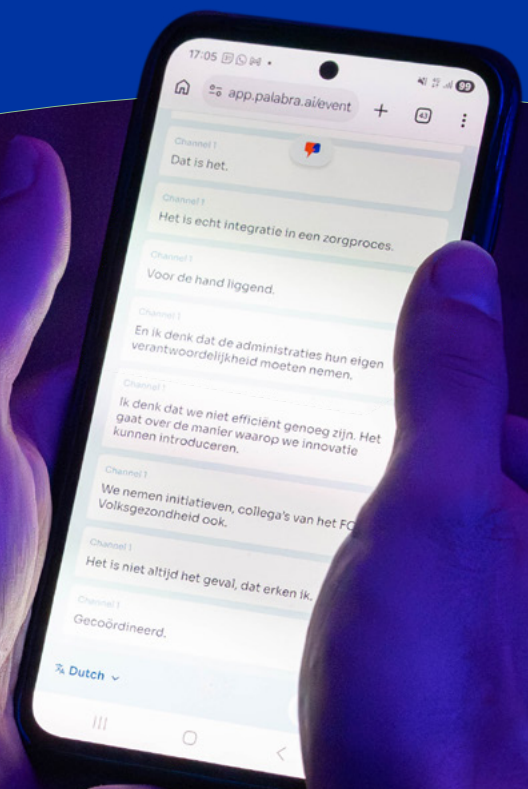
“In the Netherlands, networks are organised around the patient, instead of the patient having to find out where to go. My key question remains: who will be responsible for the outcome in the future? For an infection, a medication error?”

Mickaël Daubie: “If we want to improve outcomes and evolve towards transmural, transdisciplinary collaboration and better prevention, we need to finance our care on a bundled or flat-rate basis. I realise that this is sensitive among healthcare providers, which is why I argue for steps, not for revolution.”

The shift towards integrated care has been under way for some time, says Dieter Goemaere. “In Brussels, a large share of admissions are already day hospitalisations without an overnight stay. Patients leave hospital more quickly, home hospitalisation and telemonitoring are increasing, and there is reflection on better triage for unplanned care.”

“But, particularly in the Brussels-Capital Region, there is a great deal of social inequality. Not everyone can be followed up on an ambulatory or digital basis, even if this is medically possible. Brussels has many people living alone and many single parents; home care is not self-evident for everyone. Digital literacy also varies greatly. The question therefore is: how do we bring everyone along in integrated care?”

Dr Johan Vijgen confirms that integrated care is already a reality in some domains. “For example, we train cardiologists to perform low-risk procedures in smaller hospitals, while high-risk ablations remain centralised. Our AF clinic is also an example of integrated care. We want to bring this even more outside the hospital, closer to the patient, with the specialised nurse acting as the link between the home situation, home nursing, the GPs and the large hospital. And that is working quite well: even or especially for elderly patients.”



From dialogue to momentum

The discussions captured in this paper confirm how valuable it is to bring the right people around the table. Hospital reform is complex. So what is needed to make change happen?

In Belgium, we sometimes wonder whether ambitious plans will truly be translated into practice. But the plan is on the table, the debate is active, and many committed people are working towards the same goal.

Making reform work requires more than policy decisions alone. It requires continued, open dialogue and the courage to step beyond familiar ways of working.

At beMedTech, we are pleased to help create the conditions for that dialogue. Our General Assembly of 20 May 2026 and this paper are part of our federation's broader effort: turning dialogue into momentum, and momentum into better care for patients.



Alexander Alonso
CHAIR OF THE BOARD OF BEMEDTECH

