International comparison of reimbursement principles and legal aspects of plastic surgery

KCE reports 83C

Federaal Kenniscentrum voor de Gezondheidszorg
Centre fédéral d'expertise des soins de santé
Belgian Health Care Knowledge Centre
2008

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Centre fédéral d'expertise des soins de santé
Belgian Health Care Knowledge Centre
2008

KCE REPORTS 83C

Title :	International comparison of reimbursement principles and legal aspects of plastic surgery.
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Conflict of interest :	Stan Monstrey is sometimes invited to give lectures about plastic surgery.
Disclaimer:	The external experts collaborated on the scientific report that was subsequently submitted to the validators. The validation of the report results from a consensus or a voting process between the validators. Only the KCE is responsible for errors or omissions that could persist. The policy recommendations are also under the full responsibility of the KCE.
Layout :	Ine Verhulst.

Brussels, 14th July 2008

Study nr 2007-25

Domain : Health Services Research (HSR)

MeSH : Surgery, Plastic ; Jurisprudence ; Reimbursement Mechanisms

NLM classification : WO 600

Language : English

Format : Adobe® PDF™ (A4)

Legal depot : D/2008/10.273/45

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How to refer to this document?

De Gauquier K, Senn A, Kohn L, Vinck I; International comparison of reimbursement principles and legal aspects of plastic surgery; Health Services Research (HSR); Brussels: Belgian Health Care Knowledge Centre (KCE); 2008-07-14; KCE Reports 83C; legal depot D/2008/10.273/45

Executive summary

1 INTRODUCTION

This report came about due to the ongoing increase in plastic surgery interventions and their cost for the Belgian statutory health insurance, which has been observed for several years. In addition, there is the booming business of private clinics for plastic surgery, raising concern about quality of care and public health.

The objective of this report is to issue recommendations regarding the criteria for coverage of plastic surgery by the statutory health insurance and to propose a legal framework which would help guaranteeing the quality of care of plastic surgery interventions.

One of the main problems faced in this report is the lack of a universal definition of plastic surgery and, especially, of its main entities i.e. reconstructive and aesthetic surgery. Reconstructive surgery is traditionally described as the speciality which aims at correcting malformations that are present at birth or acquired due to trauma, illness or surgery. Aesthetic or cosmetic surgery, on the other hand, aims at correcting the shape of the body or symptoms of aging, which are all variations of a normal appearance. Aesthetic surgery interventions have no clinical necessity as such and are performed on the patient's demand. However, the distinction between both is not always clear-cut, differs among countries and can be the subject of discussion.

In order to reach our objective, a descriptive analysis was performed of plastic surgery in Belgium and in four neighbouring countries i.e. France, United Kingdom, the Netherlands and Germany. Introduction and methodology are presented in Chapter one and two. Chapter three presents the criteria these countries use to determine which plastic surgery procedures are covered by the statutory health insurance. In chapter four, we tried to assess the number of plastic surgery procedures and their cost. Chapter five gives an overview of the legal aspects of plastic surgery in relation to the definition, health practitioners, establishments and advertising. Chapter six offers a reflection on the ethical societal aspects of plastic surgery. Finally, chapter seven presents the conclusions of the report.

2 METHODS

The major part of the information was acquired through an intensive search of grey literature completed by expert answers. Only the part on social security lent itself for a systematic search of the literature. A major problem is the lack of statistics on plastic surgery provided in private clinics. The volume of plastic surgery interventions in Belgium was assessed only with the help of claims data provided by the National Institute for Health and Disability Insurance (NIHDI). Since reimbursement is mostly limited to reconstructive procedures, it is likely that these data represent only the tip of the iceberg. Moreover, these claims data have several shortcomings, as is clearly mentioned in the report. The selection of procedures related to plastic surgery within these claims data was based on expert opinion and can possibly be subject to criticism. The same accounts for the decision to label certain procedures as being borderline plastic surgery. Finally, a roundtable was organised with Belgian ethicists to discuss the ethical societal aspects of plastic surgery in Belgium.

3 RESULTS

3.1 CRITERIA FOR COVERAGE OF PLASTIC SURGERY BY THE STATUTORY HEALTH INSURANCE

The general rule is that reconstructive surgery is covered by statutory health insurance while aesthetic surgery is not. Nevertheless, the criteria for coverage are not always clear-cut in relation to the distinction between reconstructive and aesthetic surgery.

Many countries struggle with so-called borderline interventions that balance on the thin line between reconstructive and aesthetic surgery. As soon as the aesthetic improvement tends to become as or more important than the resolution of the medical problem, the discussion arises whether an intervention is still eligible for reimbursement.

In Belgium, tens of thousands of borderline interventions are yearly reimbursed by the statutory health insurance. These relate to corrections of ears, nose or eyelids that are covered without any condition for reimbursement whatsoever, but also breast reductions and abdominoplasties that are only reimbursed in case of functional impairment. The problem is, however, that this criterion is not clarified, which makes it the physician's responsibility to assess whether the functional discomfort is severe enough for the intervention to be covered.

The lack of clear criteria for reimbursement can cause uncertainty and inequity for patients and treating physicians, NIHDI inspectors and medical advisors of sickness funds.

Because of a lack of clear, national guidelines on functional discomfort, there are differences between Belgian sickness funds in the way their medical advisors decide on the eligibility for reimbursement. But, even if prior approval by the sickness fund is not necessary, inequity can still be a problem for patients who then become submitted to the judgment of the surgeon.

On the other hand, when it is the surgeon's responsibility to decide on eligibility for coverage, he always faces the risk of verification by the NIHDI posterior to the intervention. When the inspector concludes that the functional discomfort was not severe enough, the physician or the hospital will have to pay back all costs that were reimbursed.

Countries that managed to have clear-cut criteria for reimbursement of plastic surgery should serve as an example.

In France, the delimitation of reimbursement is based on five possible conditions that have to be respected by the surgeon: indication, invoicing, training, infrastructure and data collection.

The Dutch drew up three lists of services: those with unlimited reimbursement; with conditional reimbursement; and those that are not covered.

The French example also taught us that a thorough inspection of the reimbursement criteria can have a huge impact.

In 2006, the French National Health Insurance Fund (CNAMTS) launched a nationwide inspection on all plastic surgery procedures that required prior approval and that were performed by both plastic surgeons as other specialists. The savings due to this inspection were substantial: majority were realized by refusing prior approval requests, but there were also fewer requests due to the deterrent effect of the inspection.

The success of the inspection was made possible by means of an elaborate training programme for the inspectors that was put into practice by the CNAMTS and the scientific association of plastic surgeons. It lead to the formulation of clear-cut definitions of reconstructive and aesthetic procedures and their reimbursement rules.

Medical costs related to complications caused by primarily aesthetic operations are not always reimbursed.

Most countries have no specific rules on the reimbursement of complications resulting from aesthetic surgery. In Germany, however, a law was implemented in 2007 that forbids the coverage of medical complications in relation to aesthetic surgery. In the UK, the NHS does not permit the revision of treatments originally performed outside the national system.

3.2 VOLUME OF PLASTIC SURGERY

The volume of plastic surgery in Belgium could be analysed in more detail with the help of claims data from the NIHDI.

In 1995, Belgian statutory health insurance reimbursed 78 000 plastic surgery interventions with an insurance cost of €10.1 million. In 2006, there were 110 000 interventions which were financed with €21.1 million. This implies that plastic surgery grew with 41% in number and 108% in insurance cost, in eleven years time. Compared to the evolution of the total expenditures for health care by statutory health insurance, i.e. 62% increase in the same period; it seems that the insurance costs for plastic surgery increased relatively more.

The most frequent procedures were those on skin and soft tissues which accounted for 35 800 interventions, in 2006. Procedures on eyelid and eyebrow came second with 26 600 and nose procedures were third with 25 500 interventions, in 2006. The same year, there were 12 400 plastic surgery interventions on the breast, 6 000 on the abdomen, 3 500 on the ear and, finally, 340 repairs of cleft lip and/or palate.

In 1995, only one out of three plastic surgery procedures was performed by a plastic surgeon. This increased to 41% in 2006. The number of plastic surgeons that invoiced procedures to the National Institute for Health and Disability Insurance increased from 139 plastic surgeons in 1995, to 200 in 2006.

A sub analysis was done of so-called borderline plastic surgery procedures i.e. certain procedures for breast malformation, nose pyramid correction, ear correction, eyelid surgery and abdominoplasty. In 2006, the NIHDI had covered 32 000 borderline interventions which represented 29% of the abovementioned 110 000 reimbursed plastic surgery procedures and 33% of the total insurance cost of the latter. Borderline surgery doubled in number between 1995 and 2006 and showed a threefold increase in insurance cost, which was substantially more than the remaining plastic surgery procedures. Plastic surgeons were relatively more implicated in borderline surgery of which they performed 57% in 2006.

3.3 LEGAL ASPECTS OF PLASTIC SURGERY

While many countries struggle with this, only France and the UK issued a legal definition of aesthetic surgery.

In Belgium, any physician is, in principle, allowed to perform plastic surgery. In France, on the other hand, they tried to assure the surgeon's competence by defining specific training requirements for certain plastic surgery procedures.

A recent French Law stipulated that registered plastic surgeons were entitled to perform all plastic surgery. Other specialists, on the other hand, were only permitted to perform plastic surgery in the anatomic areas in which they were qualified. General practitioners were excluded from plastic surgery.

In addition, the French drew up a list of aesthetic surgery procedures that, in practice, could only be performed by the abovementioned surgeons.

Another way of protecting patients against malpractices is by clearly defining which patients' rights must be respected in relation to plastic surgery, as is done in France and the UK.

In other countries, general patients' rights such as the right to information and the right to informed consent are applicable, but without any specific rights in relation to plastic surgery.

In addition, France and the UK issued detailed regulations for the facilities where plastic surgery is performed, in an attempt to further rationalize the delivery of plastic surgery.

In many countries, private clinics for plastic surgery boomed in a non or poorly regulated environment. Due to this, there were problems of lack of reliable statistics, of patients that were insufficiently followed-up after surgery and of quality issues.

Since 2005, all French facilities where plastic surgery is performed must adhere to specific quality conditions that relate to the organization of the facility, its personnel and the equipment. In the UK, private clinics performing aesthetic surgery have to register with the Healthcare Commission and are required to meet national minimum standards. In both countries, authorisation is reviewed every 5 years.

In the Netherlands, registration is not compulsory for private clinics. The latest inspection report of those clinics that were registered, spoke of insufficient safety and quality. In Belgium, private clinics do not have to be registered and physicians do not need permission to start a private clinic.

Some countries made attempts to regulate advertising about plastic surgery, but without much success.

France issued a Law that banned all forms and methods of publicity and advertising, but private clinics often by-pass this law with the use of foreign-hosted Web sites. Belgium issued a law that forbids advertising about implants, but, in practice, there are many offences.

3.4 ETHICAL SOCIETAL ASPECTS OF PLASTIC SURGERY

A roundtable discussion with Belgian ethical experts brought some new but controversial insights in the criteria to assess whether a plastic surgery intervention should be reimbursed.

The aptness of the currently used medical necessity criterion in decisions about coverage of plastic surgery was questioned. A possible alternative could be to take into consideration the patient's quality of life, which would include functional as well as psychological gain. At the same time, however, this reasoning raised questions about its societal acceptability and affordability.

Another problem pointed out by the ethicists, is the fact that breast enlargement for women with total failure of breast development is not covered, while transsexual men undergoing gender-conversion have their breast implant reimbursed. This situation uncovers a problem of sex discrimination in the Belgian reimbursement criteria that should be solved.

4 RECOMMENDATIONS

The criteria for coverage of plastic surgery by statutory health insurance need to be clear-cut, especially in relation to the distinction between reconstructive and aesthetic surgery. Well defined reimbursement criteria will create maximal clarity, equity and security for patients and physicians.

- Surgical procedures could be classified in three NIHDI lists indicating the mode of reimbursement: a first list of purely reconstructive procedures that are always covered by the statutory health insurance; a second list of purely aesthetic procedures that are never reimbursed; a third short list of so-called borderline interventions that are only reimbursed after prior approval by the sickness fund.
- Clear-cut and unambiguous criteria should be specified in relation to the indications eligible for reimbursement. A list of indications should be defined for each surgical procedure separately and represent the consensus of a group of experts in the field (surgeons, NIHDI, sickness funds). The CNAMTS' example has proven that such a list of criteria is actually feasible, well accepted by practising surgeons and money-saving.
- The reimbursement criteria should be made known and available to all stakeholders i.e. surgeons, medical advisors of sickness funds, NIHDI inspectors and patients. The best way to achieve maximal compliance seems a multimedia information campaign made up of CD-ROMs, trainings and a Web site.
- A committee of surgeons, representatives of NIHDI and sickness funds and of the community could possibly decide on specific cases for which the decision on reimbursement remains unclear and undecided. In stead of leaving it to the medical advisor of the sickness fund to decide on the eligibility for reimbursement, the risk for inequity can probably be reduced when this decision is taken on the national level, by this committee.

A proper legal framework would help guaranteeing the quality of care of plastic surgery in Belgium.

- The first step would be to define a legal definition of plastic surgery and to make a clear distinction between reconstructive and aesthetic surgery and, on the other hand, between aesthetic surgery and aesthetic medicine.
- It seems essential to assure the surgeon's competence by defining specific training requirements for physicians who are allowed to perform plastic surgery.
- Another way of protecting patients against malpractices is by clearly defining that surgeons should be obliged to inform their patients on the procedure and its possible risks (verbally and in writing), to deliver a detailed cost estimate, to foresee a reflection period of at least 15 days and to provide a number of post-operative consultations.
- It is necessary to guarantee a safe environment for interventions. Private practices and private clinics where surgical acts are performed should be obliged to register and comply with minimum quality requirements. They will only be acknowledged when they meet strict conditions in relation to safety, hygiene, quality, continuity of care, data collection, personnel, equipment and infrastructure. This will also imply the organization of inspections by the regional authorities and possible sanctions in case of non-compliance with the defined requirements.

Scientific summary

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LIST OF ABBREVIATIONS

Abbreviation	English	Other languages
AWBZ	Exceptional Medical Expenses Act	Algemene Wet Bijzondere Ziektekosten
BIG		Beroepen in de individuele gezondheidszorg
BBR	Bilateral breast reduction	
CCAM		Classification Commune des Actes Médicaux
CEAP	Committee for evaluation of professional procedures	Commission d'évaluation des actes professionnels
CMDS	Clinical Minimum Data Set	Minimale Klinische Gegevens (MKG) Résumé Clinique Minimum (RCM)
CNAMTS	National Health Insurance Fund	Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés
CNOM	National Council of the Order of Physicians	Conseil national de l'Ordre des Médecins
CVZ	Health Care Insurance Board	College voor zorgverzekeringen
DBC	Diagnosis treatment combination	Diagnose Behandeling Combinatie
DGÄPC	German Association for Aesthetic-Plastic Surgeons	Deutsche Gesellschaft für Ästhetisch-Plastische Chirurgie
DRIPS	Dutch registry of implants in Plastic surgery	
ENT	Ear Nose Throat	Oto-Rhino-Laryngologie (ORL)
FMDS	Financial Minimum Data Set	Minimale Financiële Gegevens (MFG) Résumé Financier Minimum (RFM)
G-BA	Federal Joint Committee	Gemeinsamer Bundesausschuss
GDP	Gross Domestic Product	Bruto Binnenlands Produkt (BBP) Produit Intérieur Brut (PIB)
G-DRG	German Diagnosis Related Groups	
GMC	General Medical Council	
GP	General Practitioner	
GVU law	Law on the statutory health insurance	Wet betreffende de verplichte verzekering voor Geneeskundige Verzorging en Uitkeringen
HAS	High Health Authority	Haute Autorité de Santé
HSCs	Health Service Circulars	
ICD	International Classification of Diseases	
INNF	Interventions Not Normally Funded	
IGZ	Health Care Inspectorate	Inspectie voor de Gezondheidszorg
KCE	Belgian Health Care Knowledge Centre	Federaal Kenniscentrum voor de Gezondheidzorg Centre fédéral d'expertise des soins de santé
NHS	National Health Service	
NICE	National Institute for Clinical Excellence	
NIHDI	National Institute for Health and Disability Insurance	Rijksinstituut voor Ziekte- en Invaliditeitsverzekering (RIZIV) Institut National d'Assurance Maladie-Invalidité (INAMI)
NSFs	National Service Frameworks	
NZa	Dutch Healthcare Authority	Nederlandse Zorgautoriteit
OECD	Organisation for Economic Co-operation and Development	
OOP	out-of-pocket payment	
QoL	Quality of Life	
PCT	Primary Care Trust	

RDQ	Research, Development & Quality department	
RBSPS	Royal Belgian Society for Plastic Surgery	
SGB	Social Code Book	Sozialgesetzbuch
SHAs	Strategic Health Authorities	
SHI	Statutory Health Insurance	
SOFCPRE	French Association of plastic, reconstructive and aesthetic surgery	Société Française de Chirurgie Plastique Reconstructrice et Esthétique
VHI	Voluntary health insurance	
Zvw	Health Care Insurance Act	Zorgverzekeringswet

1 INTRODUCTION

This report came about due to the **ongoing increase in plastic surgery** interventions and their cost for the Belgian statutory health insurance, which has been observed for several years. In addition, there is the booming business of private clinics for plastic surgery, raising concern about quality of care and public health. [a]

The **objective** of this report is to issue recommendations regarding the **criteria for coverage** of plastic surgery by the statutory health insurance and to propose a **legal framework** which would help guaranteeing the quality of care of plastic surgery interventions.

In order to reach these conclusions, a descriptive analysis was performed of plastic surgery in Belgium and in four neighbouring countries i.e. France, United Kingdom, the Netherlands, and Germany. Three aspects were studied: criteria for coverage of plastic surgery by social security, volume of plastic surgery and legal aspects. Finally, it seemed essential to discuss the ethical societal aspects of plastic surgery since decisions about coverage are often a reflection of political and thus cultural choices. To this end, a round table was organised where a group of experts discussed the ethical societal aspects of plastic surgery in Belgium.

One of the main problems faced in this report is the lack of a universal definition of plastic surgery, and, especially, of its main entities i.e. reconstructive and aesthetic surgery.

- **Reconstructive surgery** is traditionally described as the speciality which aims at correcting malformations that are present at birth or acquired due to trauma, illness or surgery.[1, 2] Reconstruction of the breast after mutilating cancer treatment or surgery to correct a nasal deformity which causes functional problems are both examples of reconstructive surgery.
- **Aesthetic or cosmetic surgery**, on the other hand, aims at correcting the shape of the body or symptoms of aging, which are all variations of a normal appearance.[1, 2] These interventions have no clinical necessity as such and are performed on the patient's demand. An arched nose that causes no functional impairment whatsoever and that is corrected purely for aesthetic reasons, is clearly an example of aesthetic surgery.

However, the distinction between both is not always clear-cut, often differs among countries and can be the subject of discussion. There are several reasons for this complexity:

- Reconstructive and aesthetic surgery use the same surgical techniques, applied on the same organs, but for different purposes. This implies that the **legal nature of a surgical act can change according to its intention**. Surgery that corrects sagging eyelids, for example, can be reconstructive or aesthetic, depending on whether the visual field is impaired or not.
- The distinction between reconstructive and aesthetic surgery is of great importance for the **coverage by the statutory health insurance**. In principle, reconstructive surgery is covered by social security (provided it meets the criteria defined by the legislation) whereas aesthetic surgery is hardly ever covered since it is considered as the patient's personal choice.
- Moreover, some acts of **reconstructive surgery may sometimes have an aesthetic dimension** as well. Breast reduction, for example, will relieve patients of their medical problems (e.g. back ache or eczema) but will also lead to an aesthetic improvement that will be equally appreciated by the patient. As soon as the aesthetic gain seems to

[a] In this report, the term 'private clinic' refers to an establishment that is not financed with public funds.

become more important than the resolution of the medical problem, the discussion arises whether the intervention is still eligible for reimbursement.

In this report, we will focus on both entities of plastic surgery, i.e. aesthetic as well as reconstructive surgery, but also on the so-called **borderline interventions**, that balance on the boundary between reconstructive and aesthetic surgery as described above.

Aesthetic medicine, on the other hand, is not considered in this report. Aesthetic medicine resembles aesthetic surgery because both are performed for purely aesthetic reasons, but it concerns procedures which do not require an operating table or anaesthesia.[3] Past years, aesthetic medicine has become a booming business on which public authorities will have to keep a close eye. The fact that aesthetic medicine is often performed by non-surgeons or even non-physicians creates an inherent danger to patient safety.

Another problem faced in this report is the **lack of data on plastic surgery provided in private clinics and private practices**. At present, in Belgium, private clinics do not have to be registered and physicians do not need permission to start a private clinic. Consequently, there are no statistics on the number of private clinics or on the amount of interventions in these clinics. This shortcoming makes it difficult to assess the true magnitude of plastic surgery in Belgium and of possible quality problems in these establishments.

2 METHODOLOGY

This report aimed at studying four aspects of plastic surgery, i.e. criteria for coverage by social security, volume of plastic surgery, legal aspects and ethical societal aspects. The first three aspects were studied in five European countries i.e. Belgium, France, UK, the Netherlands and Germany. The major part of the information was acquired through an intensive search of grey literature completed by expert answers on set topics. Only the part on social security lent itself for a systematic search of the literature according to the KCE Process notes.[4] The volume of plastic surgery interventions in Belgium was assessed with the help of claims data provided by the National Institute for Health and Disability Insurance (NIHDI). Finally, a roundtable was organised with Belgian ethicists to discuss the ethical societal aspects of plastic surgery in Belgium. The methodology of this roundtable is presented in Chapter 6 on page 76.

2.1 RESEARCH QUESTIONS

The first research question looked for criteria for coverage of plastic surgery by social security and was phrased as follows:

How to delimit the role of social security in the field of plastic surgery? Which criteria are used to delineate purely aesthetic surgery from reconstructive surgery?

In order to determine the different search terms for the literature search, the review question was formulated according to the SPICE-format:

- *Setting*: Belgium, Netherlands, France, United Kingdom, Germany
- *Perspective*: the general public
- *Intervention*: delineation of aesthetic surgery from reconstructive surgery
- *Comparison*: not relevant
- *Evaluation*: not relevant

The second research question focused on the volume of plastic surgery in the selected countries:

How much plastic surgery is performed in each country? Was there an increase in the number of interventions in the past decade? Are there statistics on the amount of plastic surgery performed in private clinics?

The third research question dealt with the legislation:

How is plastic surgery defined? What are the regulations concerning plastic surgery with regard to health practitioners, establishments and advertising?

As far as the selection of the comparator countries was concerned, this decision was based on several arguments. France was added because of its similarities with the Belgian health care system and its recent change in legislation; United Kingdom and the Netherlands because they appeared most in the pilot-searching of basic bibliographic databases (pre-assessment for the pre-project form); and, finally, Germany was added to complete the list of Belgium's neighbouring countries.

Finally, the fourth research question focused on the ethical societal aspects of plastic surgery in Belgium:

Which criteria should be used to assess if an intervention of plastic surgery should be reimbursed by social security? How should this decision-making process be organized? What about complications in relation to aesthetic surgery: should these be covered?

2.2 SEARCH FOR EVIDENCE AND SOURCES OF INFORMATION

Data sources used to identify studies were electronic bibliographic databases and the reference lists of the retrieved articles and, on the other hand, grey literature and correspondence. Hand searching of journals was not performed because of time constraints. The literature search was performed by one reviewer and only for the first research question.

First, a search was performed of the Medline, Embase, CRD and Econlit electronic databases. The choice of databases and of search terms was based on a previous pre-assessment.

Search algorithms combined following MeSH or free-text terms: (plastic surgery or reconstructive surgery or cosmetic surgery) and (unnecessary procedures or health care rationing or medical legislation or patient selection or government regulation or insurance coverage or reimbursement or accessibility) and (Belgium or France or Germany or Great Britain or Netherlands). The search was not limited to a specific study design or period, nor was there a language restriction. Reference lists of retrieved articles were used to complete our search. Details on the search strategy in the electronic bibliographic databases are provided in Appendix 1.

Second, we searched the grey literature, e.g. Web sites of government departments and agencies, academic and research institutes, professional groups, health insurers et cetera. In addition to this, we used some search engines which searched across the Internet (Google) or within a specific Website. Plastic, reconstructive and cosmetic surgery were the main keywords for this search combined with the keywords referring to rationing or legislation (see above), if necessary. Details on the search strategy in the grey literature are provided in Appendix 2.

Finally, we contacted several organisations or authorities in order to retrieve additional information on the organisation and legislation of plastic surgery in the different European countries. A list of experts is provided in Appendix 3.

2.3 SELECTION AND CRITICAL APPRAISAL OF ARTICLES

Concerning the articles extracted from electronic bibliographic databases, a first selection was based on the title. Papers that were clearly not relevant to the key questions were eliminated. Then a selection was made based on the abstracts. Finally, the same reviewer confirmed the eligibility of the identified studies by reading the entire articles. The inclusion or exclusion decisions for abstracts and full texts were based on criteria resulting from the SPICE components of the search question.

- *Setting*: Belgium, the Netherlands, France, United Kingdom, Germany
- *Perspective*: the general public
- *Intervention*: delineation of purely aesthetic surgery from reconstructive cosmetic surgery

We did not perform a quality assessment of the articles because of its limited relevance for this topic.

2.4 NUMBER OF RETRIEVED ARTICLES, IN- AND EXCLUDED STUDIES AND REASONS FOR EXCLUSION

From a total of 147 studies identified by our search in the electronic bibliographic databases, 46 were potentially relevant on the basis of the title and were reviewed in detail. A second selection based on the abstract identified another 24 articles that were clearly not relevant to the key questions. After elimination of these, 22 articles remained. The search of their reference lists yielded two extra articles, bringing the total on 24 articles which we tried to study in detail on the basis of the full text.[5, 6]

Ten articles could not be assessed because their full text was not available.[7-16] Six articles were excluded because they did not focus on the delineation of aesthetic surgery from reconstructive cosmetic surgery.[5, 17-21] Finally, eight articles remained eligible for information extraction.[6, 22-28] The flowchart provided in Appendix 4 gives an overview of the abovementioned selection process.

2.5 EXTRACTION OF INFORMATION FOR INTERNATIONAL COMPARISON

The international comparison for the first research question was based on a checklist of items. Because of the study's specific focus on plastic surgery, the checklist contained only a limited number of variables which give a general overview of the health system. Emphasis was put on the coverage of plastic surgery by the social security system.

- What are the criteria for reimbursement of health care costs in general and for plastic surgery specifically?
- Which surgical procedures in the domain of plastic surgery are reimbursed?
- What is the rationale for these specific criteria?
- How are these criteria implemented and evaluated?

The checklist for data extraction is provided in Appendix 5.

2.6 CLAIMS DATA FOR BELGIUM

2.6.1 Data sets

The only data sets used to analyse the volume of plastic surgery in Belgium were those provided by the National Institute for Health and Disability Insurance (NIHDI). The **NIHDI** provides **claims data** on the services covered by the compulsory health insurance, labelled with nomenclature codes and delivered in both ambulatory care settings and hospitals.

It has to be acknowledged, however, that NIHDI data, in general, have **several flaws**:

- Most aesthetic procedures are not reimbursed by Belgian social security and, therefore, are not invoiced with nomenclature codes. This implies that the NIHDI claims data contain **no information on non-reimbursed plastic surgery performed in private practices, private clinics or registered hospitals**.
- Claims data are **fraud-sensitive**, especially in relation with topics such as plastic surgery. Although this assumption was not proven, it is likely that physicians fraudulently invoice certain aesthetic procedures with nomenclature codes for reconstructive reimbursed interventions. This possibility should at least be taken into consideration when analysing claims data.
- Claims data do not register the reason for which a patient is treated or examined; there is **no registration of diagnosis**, co-morbidities or complications. Such a registration is, on the other hand, provided in the clinical minimum data set. Nevertheless, there were other reasons not to use the latter, as explained on page 14.

More specifically for this study, **the NIHDI data lacked** the following information:

- Although the documents N^{bis} contain information on the out-of-pocket payments (OOP) of patients in 2006 (see Appendix 7), it was decided **not to study the cost for the patient** and limit the analyses to the insurance cost. This decision was based on the assumption that, in case of plastic surgery, the OOPs are not sufficiently representative for the real patient's cost since they do not take into account the supplements which are mostly paid on top of the co-payments. Information on supplements is not available in the documents N^{bis}.

- The **insurance cost only includes the fees for the physician** performing the surgery and not the costs for possible related costs such as anaesthesia, hospitalisation, fees of other physicians and medication.
- In addition, there is **no information on the number of hospital admissions** related to plastic surgery.

The volume of reimbursed plastic surgery in Belgium in the years 1995 and 2006 could be inventoried with the help of three NIHDI datasets i.e. the Documents P, N, and N^{bis}. Their layout is briefly described in Appendix 7. The documents P focus on the health care deliverers and prescribers while the documents N^{bis} enable a more detailed study of the socio-demographic characteristics of the patients receiving these health care services. The documents N are aggregated data that provide information per year of deliverance.[29]

The data analysis started with three subsets of data on the basis of the Documents P and N^{bis}, which were created at our request by the Research, Development & Quality department (RDQ) of the NIHDI.

- **Subset A** of the Documents P selected all services delivered by specialists with the qualification of Plastic Surgeon (i.e. identification number ending on 021, 210, 219, or 222), irrespective of which Chapter of the fee schedule (the "nomenclature") these services belonged to. See Appendix 6. The rest of the physician's identification number was made anonymous by the RDQ.
- **Subset B** of the Documents P contained all services of Chapter V Article 14c (Plastic Surgery) of the fee schedule, irrespective of the qualification of the health care deliverer.[30, 31]
- For all services selected in subset A and B, **subset C** of the Documents N^{bis} was created, containing information on the place of residence of the patients (provincial level).

A great disadvantage of the abovementioned subsets was that they did not contain any information on procedures outside Article 14c (Plastic Surgery) performed by physicians other than plastic surgeons. Because of this shortcoming, **subset D** was created on the basis of the Documents N. The same services were selected as in subset A and the year of deliverance was 1995 or 2006. The advantage of subset D is that it delivered information on all health care deliverers. The combination of subset D with subset A made it possible to calculate the percentage of procedures delivered by plastic surgeons versus other physicians. Appendix 8 provides the layout of all subsets.

2.6.2 Selection of services related to reimbursed plastic surgery

It has to be emphasised that the selection of procedures related to plastic surgery in the Belgian claims data was not based on a validated methodology but on expert opinion only. Therefore, it is possible that certain decisions about exclusion or inclusion of procedures will be subject to criticism. The same accounts for the decision to label some procedures as being 'borderline' plastic surgery.

Instead of analysing only the interventions defined as plastic surgery in the fee schedule (i.e. Article 14c) or those invoiced by plastic surgeons, the researchers took the decision to deviate from this usual path. To this end, a selection was made, with the help of external experts, of **all procedures in the fee schedule which were related to plastic surgery**, irrespective of the Article they belonged to in the fee schedule and of the speciality of the surgeon.

In a first step, the **non-surgical services were excluded** in subset A. These represented 74% of the total amount of services invoiced by plastic surgeons, and concerned consultations, laboratory tests, radiology, fees for supervision of hospitalized patients and services in relation with internal medicine, anaesthesia and reanimation. Then, within the surgery discipline, a second selection was made of services that were most frequently delivered by plastic surgeons.

The remaining services finally represented 24% of the original dataset A and originated from several disciplines i.e. general surgery, abdominal surgery, thorax surgery, stomatology, ophthalmology, orthopaedic surgery, Ear Nose Throat (ENT) surgery, neurosurgery, dermatology and, of course, plastic surgery.

Subsequently, these **surgical procedures were regrouped according to the anatomical region** to which they related. This amounted to eight main categories with several subcategories as illustrated in Table 1.

Table 1 : Classification of all reimbursed procedures delivered by plastic surgeons on the basis of the Belgian fee schedule

Main Category	Subcategory
Skin and soft tissues	Flap
	Skin graft
	Implant
	Burn
	Scar
	Lesion/Tumour
Breast	Malformation
	Cancer surgery
	Reconstruction after mutilating surgery
Ear Nose Throat	Nose full reconstruction
	Nose correction
	Nose septum excision
	Ear full reconstruction
	Ear correction
	Cleft lip/palate
	Other
Eye	Eyelid/Eyebrow
	Eye cavity
Stomatology	
Musculoskeletal	General
	Arthroscopy
	Neck/Trunk
	Shoulder/Arm
	Wrist/Hand
	Pelvis/Leg
	Ankle/Foot
Nerve Surgery	
Abdomen	Abdominal wall
	Abdominoplasty & arm or thigh lift
	Eventration/Hernia

Within this vast amount of procedures, a final selection was made with the help of the external experts. The following **surgical categories** of Table 1 were **excluded** from further analysis:

- Procedures for superficial cutaneous and soft tissue lesions such as cryotherapy (i.e. liquid nitrogen therapy), sutures and excisions. It concerns the so-called **minor surgery** ('petite chirurgie' in french) which is mostly performed by general practitioners and dermatologists, under local anaesthesia or without any anaesthesia whatsoever. Although plastic surgeons frequently perform minor surgery, our analyses showed that they represent only a minority (4%) of the enormous amount of procedures that are invoiced.
- Other categories were excluded because it concerned interventions which **exceed the usual practice and expertise of plastic surgeons,** e.g. breast cancer surgery, eye cavity procedures and

interventions related to eventration and abdominal hernia. Hand surgery, of which procedures can be retrieved in the main categories 'musculoskeletal' and 'nerve surgery' of Table 1, is evolving to become a separate surgical speciality. The same accounts for maxillofacial surgery of which procedures are categorized in the main categories 'other ENT' and 'stomatology'.

Table 2 gives an overview of the remaining reimbursed plastic surgery procedures that were selected for further analysis in section 4.1.1 on page 34. A detailed overview of the invoice codes i.e. nomenclature codes that belong to the reimbursed plastic surgery is provided in Appendix 12.

Table 2 : Final selection of reimbursed plastic surgery procedures on the basis of the Belgian fee schedule

Main Category	Subcategory
Skin and soft tissues	Flap
	Skin graft
	Implant
	Burn
	Scar
	Tumour
Breast	Malformation
	Reconstruction after mutilating surgery
Nose	Nose full reconstruction
	Nose correction
	Nose septum excision
Ear	Ear full reconstruction
	Ear correction
Lip and palate	Cleft lip and/or palate repair
Eye	Eyelid & Eyebrow
Abdomen	Abdominal wall
	Abdominoplasty & arm or thigh lift

Finally, some external experts requested for a **sub analysis** of a selection of plastic surgery procedures which they labelled as borderline.

The terminology of **borderline plastic surgery** relates to procedures that balance on the boundary between aesthetic and reconstructive surgery. In general, borderline plastic surgery procedures have no clear criteria for reimbursement and have come under scrutiny because of their marked increase in numbers, for several years. The experts used following criteria to label procedures as borderline: procedures which are only reimbursed after prior approval by the medical advisor of the sickness fund (e.g. breast reduction); procedures lacking a clear criterion for reimbursement (e.g. functional discomfort as criterion for abdominoplasty); procedures for which no condition whatsoever is defined in the nomenclature (e.g. skinplasty of the eyelid). More information on the reimbursement criteria is available in section 3.1.4 on page 16.

Although the abovementioned criteria apply to several of the reimbursed plastic surgery procedures that are outlined in Appendix 12, the experts finally decided to label only the following interventions as borderline:

- procedures for breast malformation;
- nose pyramid corrections;
- ear corrections;
- eyelid plasty;
- abdominoplasty.

The invoice codes of these borderline plastic surgery procedures are those highlighted in grey in Appendix 12.

Since aesthetic surgery as such is not reimbursed in Belgium, it was considered appropriate to label the **remaining plastic surgery procedures** of Appendix 12 (those that are not marked) as non-borderline i.e. **reconstructive** plastic surgery. Therefore, in results section 4.1.4 (see page 46) the distinction is made between borderline and reconstructive plastic surgery. But, again, it has to be emphasised that this decision can be subject to criticism.

2.6.3 Geographical variation

The geographical variation in the 'consumption' of reimbursed reconstructive and borderline plastic surgery based on insurance cost per 100 000 residents was analysed.[32] The distribution was calculated on a provincial level and was based on the province of residence of patients undergoing surgery, as provided in subset C. The Belgian map is divided in ten provinces (Antwerpen, Vlaams-Brabant, Brabant wallon, West-Vlaanderen, Oost-Vlaanderen, Hainaut, Liège, Limburg, Luxembourg and Namur) and the Region of Brussels-Capital.[33]

Data analysis was performed with Excel and SAS.

2.6.4 Decision not to use the Clinical Minimum Data Set

Early in the course of the study, the decision was taken not to use the Belgian Clinical Minimum Data Set coupled with the Financial Minimum Data Set (MKG-MFG, RCM-RFM) to study the volume of plastic surgery in Belgium. In theory, these data could have been useful though, since they register *all* admissions in registered hospitals i.e. those with and without reimbursement by statutory health insurance, using the international ICD-9-CM classification and the Belgian nomenclature.[34]

The main reason for this decision, however, was that the additional information resulting from such an analysis would probably not even out the effort. In comparison with the NIHDI claims data, the clinical minimum data set seemed to add little extra value to the data analysis. First, like the NIHDI claims data, this coupled dataset does not contain information on plastic surgery in unregistered private clinics (see page 57) where, allegedly, a substantial part of plastic surgery is performed. Second, it was doubted that the analysis of the diagnostic codes used for plastic surgery procedures would deliver valuable information for this report. There is a considerable chance that the diagnostic codes are not filled in correctly in case of hospital stays which are not eligible for reimbursement by the statutory health insurance (i.e. aesthetic procedures). But, even in the case of reimbursement, it is plausible that the hospitals and/or the physicians use incorrect codes to hide certain malpractices.

3 CRITERIA FOR COVERAGE OF PLASTIC SURGERY BY SOCIAL SECURITY

The global results for all five countries are depicted in the summary of finding table at the end of this section (Table 4 on page 32).

3.1 CRITERIA FOR COVERAGE OF PLASTIC SURGERY BY SOCIAL SECURITY IN BELGIUM

3.1.1 Health Expenditure in Belgium

The OECD estimated total health expenditure in Belgium as a percentage of the gross domestic product (GDP) at 10.3%, in 2006. Total health expenditure per capita was $3 389 purchasing power parity and public expenditure amounted to 72.3% of total health expenditure.[35]

3.1.2 Population coverage in Belgium

Belgium has a system of compulsory health insurance with a very broad benefits package that covers almost the entire population (99%). Compulsory health insurance implies that all individuals entitled to health insurance must register with a sickness fund.[36]

3.1.3 General rules for reimbursement in Belgium

The National Institute for Health and Disability Insurance (NIHDI) is responsible for the general organization and financial management of the compulsory health insurance. Within the NIHDI, there are various Conventions and Agreements Committees (doctors, dentists, nurses, physiotherapists, etc.) which negotiate fees between insurers and health care providers. One example is the National Committee of Physicians and Sickness Funds, the so-called Medicomut. These committees are assisted by technical councils which suggest changes to the fee schedule in their specific field e.g. introduction or deletion of reimbursable services. The Technical Pharmaceutical Council, the Technical Medical Council and the Technical Dental Council are examples of those technical councils. Finally, it is the task of the Committee for Health Care Insurance ('Verzekeringscomité') to draft the annual global budget target and to determine the distribution of the budget for the different health care sectors. The task of actually providing insurance belongs to the sickness funds, which receive their financial resources from the NIHDI. They are also in charge of medical auditing: they verify that services have really been carried out and that the fees were charged conform to regulations. Some services are only reimbursed if there has been a prior approval by the medical advisors of the sickness funds.[36]

The services that are covered by compulsory health insurance are described in the nationally established fee schedule (the 'nomenclature'), which lists more than 8 000 services.[37] For each service, invoice code, key letter, relative value, tariff and reimbursement rate are specified. The tariff is calculated by multiplying the key letter (which is assigned a certain monetary value) by the relative value. Services not included in the fee schedule are not reimbursable. Sickness funds are legally bound to reimburse any claim from their insured members for care delivered by any registered health care provider at the agreed fee levels. The fee schedule is negotiated yearly or biennially between representatives of the sickness funds and of the health care professionals. At regular intervals, new treatments are introduced into the benefits package and treatments that have become obsolete are removed. Certain types of health care are excluded from the reimbursement system, e.g. alternative therapies such as acupuncture, homeopathy and osteopathy. Plastic surgery, spectacles and orthodontics are only reimbursable under certain conditions. Some preventive health care costs are borne by the State and thus provided free to patients e.g. vaccinations for children and breast cancer screening.[36]

3.1.4 Rules for reimbursement of plastic surgery in Belgium

Article 34 of the law on the statutory health insurance coordinated on 14th of July 1994 (**GVU law**) states that this health insurance, in principle, does not reimburse services performed with an aesthetic purpose, unless under certain conditions stipulated by the King and after advice from the Committee for Health Care Insurance.[38] This formulation is slightly broader than the one in the fee schedule (the '**nomenclature'**) which mentions that procedures with a *purely* aesthetic purpose are not covered by the statutory health insurance unless it concerns services which were accepted for rehabilitation programs in order to give the insured the possibility to acquire or keep a job position (see Chapter I Article 1 § 7 of the fee schedule).[39, 40] Although the difference between both formulations is subtle, the broadest formulation is by definition the most enforceable one since the GVU law is of higher order than the fee schedule which is defined by Royal Decree.[41]

Chapter V **Article 14c** of the fee schedule describes the services belonging to the speciality of plastic surgery; procedures which may be performed by plastic surgeons and by physicians undergoing specialist training to become plastic surgeon.[30, 31] Nevertheless, these interventions are not the exclusive right of the plastic surgeons because of the so-called **connexity**. Connex or related services are indicated by the fee schedule as services which may be invoiced by physicians because these services are related to their discipline, although they do not belong to their specific qualification (see Chapter V Article 10 § 4 of the fee schedule).[42, 43] In case of surgical services, the fee schedule specifically stipulates that all surgery services belonging to Article 14 are interconnected (see Chapter V Article 15 § 1 of the fee schedule).[44] These rules imply that other specialists may also perform the plastic surgery procedures if these are related to their discipline and that plastic surgeons are not limited to the services of Article 14c.

It is the task of the **Technical Medical Council** of the National Institute for Health and Disability Insurance (NIHDI) to define which plastic surgery services should be reimbursed and to formulate proposals to change the nomenclature accordingly. Two-thirds of the members of the Technical Medical Council are representatives of physicians; the others are from the sickness funds (see Artcle 28 of the GVU law).[45]

In regard of reimbursement of plastic surgery procedures by the compulsory health insurance, several situations are possible.

- **Procedures that are clearly reconstructive of nature** i.e. for disfigurements following trauma or disease, or congenital defects **are always reimbursed**. Examples of such procedures are skin grafts for patients disfigured by burns.
- Surprisingly, **even interventions that are less obviously reconstructive**, e.g. correction of prominent ears and surgery on eyelids, **are reimbursed without any condition whatsoever**. Prominent ears bring on no functional impairment and eyelid surgery is not always performed because of a diminished range of vision. Although these interventions are balancing on the thin line between reconstructive and aesthetic surgery, thousands of them are yearly reimbursed by Belgian health insurance, as illustrated in section 4.1.4 on page [46].
- **Purely aesthetic procedures** are **never reimbursed**, and are therefore not given an invoice code in the fee schedule (e.g. face lifting and lipo-aspiration). The NIHDI found it necessary to explicitly mention that breast enlargement for women with psychological problems because of underdeveloped breasts, tattoo removal and hair implants are not eligible for reimbursement.[30, 31]
- Some procedures are only reimbursed **after approval by the medical advisor** of the sickness fund; breast enlargement with prosthesis in case of a tubular breast (code 251576/580) or in case of a unilateral breast hypoplasia (code 251650/661); breast reduction because of functional discomfort (code 251613/624) or reduction of the heterolateral breast in

case of congenital hypoplasia of one breast (code 251635/646).[30] The criterion 'functional discomfort' is not explicitly described in the fee schedule and, in case of breast reduction it is the medical advisor's task to assess this discomfort. Because of a lack of national guidelines, there are differences between sickness funds in the way their physicians decide on whether the discomfort is severe enough to authorize the procedure. A description of the nomenclature codes is provided in Appendix 12.

- Finally, there are interventions for which it is the **physician's responsibility** to assess whether the **functional discomfort** of the patient is severe enough for the intervention to be covered by the compulsory health insurance. This rule applies, for example, to **abdominoplasties and arm or thigh lifts** (codes 241253/264, 241275/286, and 241754/765, see Appendix 12).[46] Nevertheless, the National Institute for Health and Disability Insurance can always perform an 'a posteriori' verification (i.e. posterior to the intervention) of the indications for this intervention. When they conclude that the functional discomfort was not severe enough, they will ask for a recuperation of all costs that were reimbursed for this intervention. Since it was the physician's decision to consider the patient eligible for reimbursement, it is up to the physician or the hospital to pay back the costs, and not the patient. In 2006, the Belgian senator Defraigne pointed out to this problem of 'legal insecurity' for surgeons who are both judge and judged, and asked for a clear definition of the criterion functional discomfort.[47] In addition, this lack of definition of functional discomfort can also cause inequity problems for the patient because he is submitted to the judgment of the physician.

  The **functional discomfort** criterion is also applied to interventions which aim at **correcting the nostrils** (code 253153/164, 253175/186, 257994/258005, 258016/020 as described in Appendix 12). In this case, the nomenclature stipulates that these procedures should only be performed when obstruction to airflow through the nose was assessed by a rhinomanometry (i.e. method of assessing nasal resistance).[30, 48] The results of this exam should be kept in the medical file in case of a verification by the NIHDI posterior to the intervention.

In Belgium, there is no specific rule that prohibits the reimbursement of medical **complications** caused by aesthetic operations which were initially performed without financing from the statutory health insurance. This seems to imply that such complications are covered. The introduction of a new invoice code, in March 2006, for the reimbursement of the removal of breast prosthesis in case of so-called documented complications (code 251591/602) supports this assumption.

In rare cases, additionally to the fee schedule, procedures are reimbursed through the **Special Solidarity Fund** ('Bijzonder Solidariteitsfonds', BSF). This fund is part of the National Institute for Sickness and Invalidity Insurance (NIHDI) and is operational since 1990. The Fund complements the compulsory health insurance coverage and reimburses certain expenses for chronically ill children and for rare diseases, rare indications and innovative techniques which are not (yet) refunded by the Belgian or a foreign compulsory insurance scheme.[49] Concerning plastic surgery, the BSF mentioned in its yearly report 2006 that it accepted a few requests for the reimbursement of botox, for example for spastic patients. Intégra®, a new surgical alternative for the treatment of massive burns or the correction of severe scars, was also accepted for reimbursement by the BSF.[50]

Key Points

Criteria for coverage of plastic surgery by social security in Belgium

- **According to the GVU law, services with an aesthetic purpose are not reimbursed. This law is of higher order than the nomenclature which mentions that procedures with a purely aesthetic purpose are not covered unless they are necessary to acquire or keep a job.**
- **It is the task of the Technical Medical Council (NIHDI) to define which plastic surgery services should be reimbursed.**
- **Reconstructive procedures that are clearly reconstructive of nature, i.e. for disfigurements following trauma, disease or congenital defects, are always covered.**
- **Surprisingly, even some interventions that balance on the thin line between reconstructive and aesthetic surgery are reimbursed without any condition. Examples of the latter are correction of prominent ears and surgery on eyelids.**
- **Purely aesthetic procedures are never reimbursed: face lifting and lipo-aspiration, but also breast enlargement for women with psychological problems because of underdeveloped breasts, tattoo removal and hair implants.**
- **In some cases, procedures can only be reimbursed after approval by the medical advisor of the sickness fund. This condition is applied to several breast procedures: enlargement with prosthesis in case of a tubular breast, or in case of a unilateral breast hypoplasia; breast reduction because of functional discomfort. Because of a lack of national guidelines, however, there are differences between sickness funds in the way their physicians decide on whether the discomfort is severe enough to authorize the procedure.**
- **Finally, there are interventions for which it is the surgeon's responsibility to assess whether the functional discomfort of the patient is severe enough for the intervention to be covered. This rule applies to the abdominoplasty and nostril correction.**
- **The criterion functional discomfort is not described. This lack of definition causes inequity for patients and legal insecurity for physicians because of the threat of verification by the NIHDI posterior to the intervention.**
- **There is an invoice code for the removal of breast prosthesis in case of complications. The absence of other rules seems to imply that complications of aesthetic surgery are covered.**

3.2 CRITERIA FOR COVERAGE OF PLASTIC SURGERY BY SOCIAL SECURITY IN FRANCE

3.2.1 Health Expenditure in France

According to the OECD Health data, total health expenditure in France as a percentage of GDP was 11.1% in 2006, total health expenditure per capita was $3 374 purchasing power parity and public expenditure amounted to 79.8% of total health expenditure.[35]

3.2.2 Population coverage in France

Since 1 January 2000, statutory health insurance covers the whole population, i.e. all those legitimately resident in France.[51] Complementary voluntary health insurance (VHI) covered about 91% of the French population in 2004.[52]

3.2.3 General rules for reimbursement in France

In order to be eligible for reimbursement, diagnostic services, treatment, drugs and prostheses should have been provided or prescribed by a doctor, a dentist or a midwife. Services have to be distributed by health care professionals or institutions registered by the statutory health insurance system and be listed on the positive lists currently in operation.[51]

The positive lists of procedures, drugs and devices eligible for reimbursement by the health insurance funds are defined by the National Health Insurance Fund ('Caisse nationale de l'assurance maladie des travailleurs salariés', CNAMTS) which is the equivalent of the Belgian NIHDI. The CNAMTS is hereby assisted by the three main sickness funds, the High Health Authority ('Haute Autorité de Santé', HAS) and the Union of Voluntary Health Insurers ('Union Nationale des Organismes d'Assurance Maladie Complémentaire', UNOC). Within the High Health Authority, it is the Committee for evaluation of professional procedures ('Commission d'évaluation des actes professionnels', CEAP) that formulates recommendations on which medical procedures are eligible for reimbursement and at which conditions.[53] The CNAMTS is responsible for setting the tariffs for medical procedures, drugs and devices, and for determining the levels of co-payment and co-insurance.[52] Since April 2005, the 'Classification Commune des Actes Médicaux' (CCAM), a new positive list for reimbursed medical procedures, has been implemented.[54] The CCAM presents a list of over 7 000 coded procedures and is fully comprehensive in content as it contains details of all medical procedures, even those that are not reimbursable.[55, 56] Each procedure corresponds to only one label and one code, so there is no ambiguity and it is easy to use. The classification is according to anatomic classification and specialities.[52, 57] The CEAP's recommendations on eligibility for reimbursement are based on their appreciation of the benefit (in French defined as 'service attendu') provided by the procedure under assessment. This covers the diagnostic or therapeutic benefit, based on safety, efficacy and contribution to the treatment strategy. On the other hand, the public health benefit is appreciated, based on impact on the morbidity and mortality related to the disorder treated, on patients' quality of life, on the care system and on public health policies and programs. Public health benefit also depends on the severity of the disorder treated and on whether the procedure meets an unsatisfied need.[b] For certain kinds of care, such as physiotherapy, thermal cures and plastic surgery prescription by a doctor is not a sufficient condition for reimbursement. Coverage by statutory health insurance is subject to the prior authorization ('accord préalable') from the medical advisors of the sickness funds, who examine the patient's case history and sometimes interview him.[51]

3.2.4 Rules for reimbursement of plastic surgery in France

In France, a distinction is made between reconstructive plastic surgery and aesthetic plastic surgery. The former will induce a transformation from 'the abnormal or pathological' into 'the normal' in case of congenital malformations or disfigurements following cancer, accidents or burns. The latter transforms an 'inharmonious', but normal situation into a 'harmonious' one. Both types of plastic surgery use the same **surgical techniques** which **are all mentioned in the CCAM**.[59]

Until now, the Committee for evaluation of professional procedures ('Commission d'évaluation des actes professionnels', CEAP) did not formulate any recommendations on plastic surgery.[60]

Reconstructive surgery is covered by statutory health insurance, but reimbursement can be restricted to specific conditions or subjected to prior authorization ('accord préalable') from the sickness fund.

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b The evaluation criteria of the 'service attendu' are described in article R.162-52-1 of the Social Security Code.[58]

Aesthetic procedures are never reimbursed, although there are two exceptions to this general rule; existence of a health risk or a social harm. These exceptions are an inheritance from the past when the criteria for reimbursement were less logical.[61]

The CCAM stipulates four reimbursement modes for plastic surgery procedures.

- Reimbursement without further conditions applies mostly to procedures which are clearly reconstructive e.g. skin graft for burned patients or reconstruction of the ear with a skin auto graft.
- Other procedures are reimbursed in the presumption that they complied with the specific conditions outlined in the CCAM. The fulfilment of these criteria can be reviewed postoperatively by the sickness funds by means of auditing the surgeon. Female breast reduction, for example, is reimbursed when the following circumstances are met: large breasts are responsible for back ache or psychological problems; preoperative photography's are available for justification; the medical file is documented with information on waist, weight, age and bra size of patient; and the resected volume is preoperatively estimated to be at least 300 g per breast. Another example is the correction of prominent ears (otoplasty), in which case the physician has to prove that the deformity imposes an important social embarrassment on the patient.
- Procedures requiring prior approval ('accord préalable') from the sickness funds are, for instance, breast reconstructions by means of prosthesis. The CCAM explicitly forbids the invoicing of such operations for aesthetic reasons and stipulates that only therapeutic indications are eligible for reimbursement i.e. after mastectomy or in case of congenital absence of mammary glands. Rhinoplasty is another example of a procedure subjected to prior authorization.
- Finally, the CCAM lists the purely aesthetic procedures although they are not reimbursed and no tariff is mentioned. Examples are breast lift (mastopexy) and removal of a tattoo. Appendix 9 provides a detailed description of all aforementioned examples.

Delimitation of these reimbursement modes is based on **five possible conditions** which have to be respected by the physician: indication, invoicing, training, infrastructure, and data collection. The number of criteria specified per procedure varies highly i.e. from nil to five.[55]

- The indication covered by health insurance ('indication') can be explicit and unambiguous as shown by the example of breast reconstruction by means of prosthesis. Other indications, however, are more open to question. Social embarrassment in case of otoplasty or psychological problems in women with large breasts, are examples of disputable indications.
- Invoicing conditions ('facturation') can put a limit on the number of treatments over a certain period of time, on the patient's age, or on the equipment. In other cases, a procedure will only be reimbursed when preceded by another treatment. The most common invoicing condition is that aesthetic procedures may not be reimbursed.
- Training conditions ('formation') can specify that the physician has to have had a specific training for this procedure in addition to his initial training. Sometimes, even the minimum duration of the supplementary training is mentioned.
- Infrastructure conditions ('environnement') can ask for particular surroundings e.g. multidisciplinary team work or cardiovascular surveillance and treatment.
- Data collection conditions ('recueil de données') can specify that a prospective collection of data is necessary.

The procedures of plastic surgery are scattered over several chapters of the CCAM; Ch. 2.2 (eyebrow and eyelid), Ch. 3.2 (external ear), Ch. 6.2.1 (nose), Ch. 7.2.1 (lips), Ch. 16.3 (skin and soft tissues), Ch. 16.4 (hair and nails), Ch. 16.5 (burns) and Ch. 16.6 (breast).[55, 62]

France has **no specific rules about the reimbursement of medical complications** caused by aesthetic operations which were initially not covered by health insurance.

Key Points

Criteria for coverage of plastic surgery by social security in France

- **CCAM lists all procedures, including those that are not reimbursed.**
- **Reconstructive surgery is covered, but reimbursement can be restricted to specific conditions or subjected to prior authorization.**
- **Aesthetic procedures are never reimbursed, but there are two exceptions to this rule; existence of a health risk or a social harm.**
- **Delimitation of reimbursement is based on five possible conditions: indication, invoicing, training, infrastructure and data collection.**
- **There are no specific rules about medical complications.**

3.2.5 Inspection plan on plastic surgery by the CNAMTS

In 2006, the National Health Insurance Fund (CNAMTS) launched a comprehensive nationwide inspection plan.[63] Its main concern was **to make sure that only reconstructive surgery acts are reimbursed**. The inspection plan was applied to the whole range of reconstructive and aesthetic surgery, irrespective of the speciality of the health professionals. It was thus **applied to plastic surgeons and all other health professionals** who are allowed to perform such acts i.e. specialists in ENT, ophthalmology, stomatology, etc.

The inspection plan consisted of **three components**.

- The first component aimed at checking the interventions requiring prior approval ('accord préalable').[64] These were checked from a medical and an administrative angle. First, it was checked whether the medical description of the pathology corresponded to reality. This required physical examination of patients on a case-by-case basis. Second, the administrative requirements were investigated.
- The second component of the plan related to the whole range of plastic surgery procedures, including those that did not require prior approval. This retrospective re-composition of physician's activities was done with the help of financial data on their income. This way, all acts became included in the inspection plan, which enabled the inspectors to check if some acts had escaped the process of prior approval (fight against fraud). Breach of this obligation is considered as a violation of the legal obligations of the physicians and thus subjected to ordinal and criminal proceedings.
- The third component of the inspection plan targeted at plastic surgery performed abroad and submitted for reimbursement in France. Over the past years, the CNAMTS identified several fraudulent practices related to so-called aesthetic tourism. In these cases, french citizens who had aesthetic surgery in a foreign country submitted bills for reimbursement within the framework of EU-Regulation 1408/71 or other bilateral agreements on health care coverage. Because aesthetic surgery is not covered by these agreements, bills referred to other, non-existing interventions are often described as "emergency care". The objective of the third component is to assess the extent of these frauds and their financial impact. On the basis of internal surveys, searches on internet and advertising campaigns, the CNAMTS drew up a list of 19 countries.

The CNAMTS' plan started in October 2006 and was initially designed as a one-year plan, but it was extended to the end of 2008. In September 2007, a preliminary report on the first component of the plan was issued. Table 3 shows the results on the inspection of the prior approvals.[61]

Table 3 : Preliminary results of the CNAMTS inspection plan on plastic surgery procedures which required prior approval (Oct 2006-Sept 2007)

	Number	Percent
Undue requests	1 303	6.7%
Final agreements	12 224	62.7%
Medical refusals	2 561	13.1%
Administrative refusals	1 925	9.9%
Non documented	1 483	7.6%
Total prior approval requests	19 496	100.0%

The CNAMTS investigated in total 19 496 prior approval requests related to plastic surgery. Of these, 1 303 requests (6.7%) were labelled as 'undue'. Some physicians sent a prior approval form to the sickness fund for procedures that do not require this agreement. There are two possible explanations for undue requests: error i.e. poor knowledge of health care legislation or fraud in an attempt to obtain reimbursement of an act that does not require such an agreement. Given the 2-week silence rule (i.e. if the physician does not get a response from the sickness fund within two weeks, the request is considered as accepted), some physicians worked on the assumption that the absence of explicit refusal from the sickness fund could be considered as an agreement, which is obviously wrong. Another 2 561 requests (13.1%) were refused because of medical reasons. This implied that the malformation described by the physician did not correspond with reality. This could only be assessed after physical examination of the patients. Almost ten percent of the requests were refused on administrative grounds. This meant that the administrative requirements were not met, that there was a mismatch between the medical act and the CCAM, or that the surgery was performed by unskilled health professionals. In 7.6% of cases, the investigation was still going on, the request was incomplete or there was a decision-making problem. In the end, the inspectors found that **29.7% of all prior approval requests could be refused**.

The refused requests represented a budget of €6.6 million, which was money actually saved by the CNAMTS. On a total insurance cost of €21.2 million for all submitted prior approval requests, these savings were the equivalent of 31% of the potential costs. In addition, this inspection plan also had a deterrent effect. On the basis of the previous year, the CNAMTS had predicted an insurance cost of €25.6 million for the prior approval requests in the inspection period. In reality, however, this insurance cost was €21.2 million. This implied that the indirect financial impact of the plan due to a decrease in medical expenditure amounted to €4.4 million, which represented a decrease in costs of 17% in comparison with the expected cost. The **total impact** of the first component of the inspection was thus estimated at **€11 million in 12 months**.

Apart from the financial effects, this inspection plan has also been proven very valuable as a **training programme**. Prior to the actual inspection, such a programme was set up by the CNAMTS with the collaboration and **partnership** of the scientific association of plastic, reconstructive and aesthetic surgery ('Société Française de Chirurgie Plastique Reconstructrice et Esthétique', SOFCPRE). The SOFCPRE surgeons issued clear-cut definitions of reconstructive and aesthetic interventions (CPRE) and the underlying malformations.

The inspectors of the CNAMTS, on the other hand, provided elaborate information on the reimbursement rules for these CPRE procedures. Both sources of information were merged during training sessions for the CNAMTS physicians in charge of the inspection plan. The slide shows presented at the sessions were made available on CD-Rom and served thus as a frame of reference. This CD-Rom contained very detailed information on the most common CPRE procedures i.e. breast surgery, abdominoplasty, surgery on eyelids and rhinoplasties.

Thanks to the use of photographs and illustrations of the different types of malformations and clear definitions of which interventions are eligible for reimbursement, this CD-Rom proved to have a high educational value. By means of the training, the CNAMTS inspectors improved their expertise on the CPRE interventions and the surgeons got a better view on the reimbursement rules. Finally, the training was of great importance as it enabled to define common rules applicable to all stakeholders and probably allowed to cut down the number of legal contestations. The collaboration with the scientific association seemed essential for its acceptability by the practicing surgeons.

The final results of the inspection will be made public by the SOFCPRE in November 2008, at their 53rd National Congress.[65]

Key Points

Inspection of the criteria for coverage of plastic surgery in France

- **In 2006, the CNAMTS launched a nationwide inspection on plastic surgery interventions which required prior approval.**
- **All physicians performing these interventions were aimed i.e. plastic surgeons as well as all other physicians which are allowed to perform these acts.**
- **The prior approval requests were checked from a medical (i.e. does the diagnosis correspond with reality) and an administrative angle (i.e. are the administrative requirements fulfilled).**
- **The training of CNAMTS inspectors appeared to be essential for the success of the inspection. Common rules and definitions were issued in cooperation with the scientific association of plastic surgeons. This partnership seemed essential to ensure the acceptability of the inspection, but it also enabled the definition of common rules for all stakeholders.**
- **After one year, 30% of the prior approval requests could be refused. These represented 31% of the total insurance cost for all submitted prior approval requests.**
- **In addition, the deterrent effect of the inspection plan caused a 17% decrease in costs for plastic surgery related to prior approval requests.**

3.3 CRITERIA FOR COVERAGE OF PLASTIC SURGERY BY SOCIAL SECURITY IN THE UNITED KINGDOM

3.3.1 Health Expenditure in the UK

In the United Kingdom, total health expenditure as a percentage of GDP was 8.3% in 2006, total health expenditure per capita was $2 724 purchasing power parity and public expenditure amounted to 87.1% of total health expenditure.[35]

3.3.2 Population coverage in the UK

All persons normally resident in the United Kingdom are eligible for services through the National Health Service (NHS) which can be characterized as a publicly owned health system financed through general taxation.[66]

In 1996, fewer than 11% of the population had some form of private medical insurance.[66]

3.3.3 General rules for reimbursement of healthcare costs in the UK

Unlike other countries in which the range of health care benefits covered under private or social health insurance plans is defined explicitly, the NHS does not specify an explicit list of services to be provided. The statute specifying the scope of the NHS is the National Health Service Act 1977.[67]

At a general level, the 1977 Act imposes a number of responsibilities on the Secretary of State in relation to the provision of hospital and community health services but, for the most part, there is a large degree of discretion about the range of services that are actually provided. Thus the Secretary of State is required to provide services 'to such extent as he considers necessary to meet all reasonable requirements'.[66] Strictly speaking, this means that patients have no entitlement to specific services.[68] On the other hand, case law has established that NHS organizations may not operate a 'blanket ban' on the provision of services (such as particular health technologies or interventions), with the possible exception of treatments where 'the clinical evidence of its inefficacy is overwhelming'.[69] A judgment by the Appeals Court made it also illegal for health authorities to impose a blanket ban on services they consider to be 'low priorities'.[70] Instead, they must adopt a fair and consistent policy for decision-making that adequately assesses exceptional cases by considering each request for treatment on its individual merits.[69] This means that the NHS produces a situation where patients have no specific entitlements to services, but also where little is explicitly excluded.[68] Regulation and policy play an important role in determining which services are available within the NHS. Many of these concepts were introduced by the Labour government in its White Paper of 1997.[71] Concerns over issues of fairness and consistency within the NHS underpinned the White paper with the availability of services to be determined by issues of effectiveness and cost-effectiveness.[68] The practicalities of implementation and delivery were provided in the NHS Plan of 2000.[72] Important components of the regulation include National Service Frameworks, the work of the National Institute for Clinical Excellence (NICE), and guidance from the Department of Health.

National Service Frameworks (NSFs) form one of a range of measures to raise quality and decrease variations in service. NSFs are long term strategies for improving specific areas of care. They set measurable goals within set time frames. The rolling programme of NSFs covers Coronary heart disease, Cancer, Paediatric intensive care, Mental health, Older people, Diabetes, Long term conditions, Renal services, Children, Chronic Obstructive Pulmonary Disease (COPD).[73]

The National Institute for Health and Clinical Excellence (NICE) was introduced in April 1999 to promote clinical excellence within the NHS. NICE produces guidance in three areas of health: public health, health technologies and clinical practice.[74, 75] Compliance with clinical guidelines remains at the discretion of local planners i.e. Primary Care Trusts (PCTs). There is, however, evidence of political 'encouragement' to adhere to these guidelines.[68]

Department of Health Guidance communicates mainly through Health Service Circulars (HSCs). HSCs are formal communications, primarily to NHS chief executives, which usually contain a requirement for significant or urgent specific action.[76] Guidance to PCTs and NHS Trusts may also come from Strategic Health Authorities (SHAs). SHAs are regional organizations accountable to the Secretary of State that manage performance of NHS bodies at the local level.[77] Specifically, SHAs have a duty to support and monitor PCTs and manage their performance in exercising their functions, with a view to improving the quality of health care provided to individuals in their area. SHAs are also charged with the duty to promote a comprehensive health service and can give (statutory) directions to NHS Trusts about any of their functions.[68]

3.3.4 Rules for reimbursement of plastic surgery in the UK

Plastic surgery in the **NHS treats mostly high-priority cases** in relation with restoration of appearance and function following trauma, cancer, degenerative conditions or congenital deformity. **Low-priority plastic surgery** (benign conditions, minor disfigurements, 'cosmetic' surgery), on the other hand, **is rationed**.[26]

On its Web site, NHS Direct gives the following instructions to people seeking plastic surgery: 'To qualify for surgery to improve your appearance, you must meet specific criteria as set out by your local health authority. The NHS will not pay for surgery for cosmetic reasons alone; however, reconstructive surgery and cosmetic surgery to correct or improve congenital abnormalities and injuries will usually be carried out free of charge. You will **need a referral from your GP, a consultation with a plastic surgeon and a psychological assessment**.[78] This instruction gives a good summary of the current procedure in the NHS where Primary Care Trusts (PCTs) are the statutory bodies responsible for delivering healthcare to their local area. In commissioning the range of services needed, PCTs have to decide about how best to allocate their limited resources without exceeding their annual financial allocation. Highest priority for funding is given to those health services of proven benefit in meeting the health needs of the population, whilst access is limited to those of lower priority.[79]

In 2005, the NHS Modernisation Agency and the British Association for Plastic, Reconstructive and Aesthetic Surgeons produced **national guidelines for commissioners of plastic surgery** for conditions that are considered of low priority or for treatments usually not available in the NHS.[80] This document advises on explicit criteria for referral and treatment inclusion thresholds and trigger points within service level agreements and contracts.

The **rationale behind these criteria** is **based on** a revision of existing policies in places across the NHS and on available **evidence of effectiveness and outcome** for individual procedures, developed by a multi-professional expert group consisting of plastic surgeons, nurses, GPs, psychologists and PCT commissioners. Where no robust evidence was available the guidance represents **a consensus view of the expert group**.

These are the general principles of the national guidelines in plastic surgery:[80]

- Commissioners are encouraged to establish a local stakeholder commissioning group that includes plastic surgeons, general practitioners, patient representatives and commissioners to define their local inclusion policies that reflect local needs and priorities, monitor their implementation and review them in the light of experience and emerging clinical evidence.
- Commissioners, working closely with relevant Plastic Surgery specialists and primary care, should develop referral pathways that permit the application of the inclusion policy where relevant.
- Since patients may also be referred to other specialists such as dermatologists, ENT surgeons, breast surgeons and oral surgeons, commissioners should ensure that the same criteria are used for all referrals, irrespective of the specialist or location, to avoid introducing inequalities of provision and the creation of alternative referral pathways to bypass the local inclusion policy.
- The Plastic Surgery specialist to whom the referral is subsequently passed should decide whether the patient would benefit from plastic surgical intervention, and if so, establish that the patient fully understands the risks and benefits of surgery.
- Cosmetic Surgery (surgery undertaken exclusively to improve appearance) will usually be excluded from NHS provision in the absence of previous trauma, disease or congenital deformity. **In exceptional circumstances** and after special consideration, the local stakeholder commissioning group may **allow** a referral for **cosmetic surgery** to proceed. These exceptional circumstances should be primarily clinical e.g.
    - There is a significant likelihood that the individual will gain much higher than average benefit from the treatment.
    - There would be additional benefit through the avoidance of social care.

    - There is a high likelihood that severe psychosocial dysfunction may be alleviated.

  Issues around personal circumstances or concepts of 'worth' to society should be avoided.

- Assessment of patients being considered for referral to Plastic Surgery who may have an underlying genetic, endocrine or psychosocial condition should have had this fully investigated by a relevant specialist prior to the referral to Plastic Surgery being made.
- Referrals within the NHS for the **revision of treatments** originally performed outside the NHS **will not usually be permitted**. Referrers should be encouraged to re-refer to the practitioner who carried out the original treatment.
- An appeals mechanism should be established for patients who are excluded from treatment to have such a decision independently reviewed in a timely fashion.
- Clinical research into the outcomes and health benefits of lower priority procedures should continue and national guidance and local policies should be reviewed in the light of such evidence.
- Psychological assessment can form an important part of the management of some patients referred for low priority procedures. Commissioners will wish to ensure that training is provided for psychologists working in this clinical area to be able to support the implementation of the local guidelines.

The complete list of NHS guidelines with regard to plastic surgery is provided in Appendix 10.

In relation with the local implementation of the NHS guidelines on plastic surgery by Primary Care Trusts (PCTs), some PCTs drew up a **list of interventions not normally funded** ('the INNF list') and set out their policy as to that list.[79, 81, 82] Despite the existence of such an INNF list, these PCTs argue that there is no blanket ban on these procedures since provision exists for the assessment of exceptional circumstances of individual patients. Where it is felt that a patient might actually require such a procedure on the INNF list, some PCTs mention 'exceptional funding panels' that can discuss individual patients.[79]

In 2006, Wraight et al. surveyed the local implementation of the national guidelines for bilateral breast reduction (BBR) of all 303 Trusts in England.[28] The NHS guidelines describe several indications for which BBR is an effective procedure for alleviating the symptoms associated with large breasts (see Appendix 10).[80] Despite these national guidelines and the good evidence for the benefits of BBR, Wraight et al. found that BBR is often considered cosmetic and is rationed at the PCT level. Only 4% of the Trusts accurately followed the NHS guidelines, while many included other restricting criteria that are not in the NHS guidelines. The authors concluded that this **variation in local funding criteria resulted in an inevitable inequity in provision**: a woman living in the catchments of one Trust may be allowed BBR while an identical woman in another area is not. They even concluded that this so-called 'postcode lottery' of healthcare in the UK is rife within plastic surgery and pleaded for a further debate as to what criteria should be met to justify a procedure in a publicly funded health service.

To that end, Wraight submitted his paper and the NHS guidelines to the National Institute for Health and Clinical Excellence and invited them to issue guidance on the topic.[28, 83] To this date, NICE did not publish any guideline on a surgical procedure in the domain of plastic surgery although they are currently developing guidance on liposuction for chronic lymphoedema.[84]

Key Points

Criteria for coverage of plastic surgery by the NHS in the United Kingdom

- **NHS treats mostly high-priority cases in relation with restoration of appearance and function following trauma, cancer, degenerative conditions or congenital deformity. Low-priority plastic surgery i.e. benign conditions, minor disfigurements, 'cosmetic' surgery is rationed.**
- **NHS produced national guidelines for commissioners of plastic surgery (i.e. Primary Care Trusts) for conditions that are considered of low priority or for treatments usually not available in the NHS.**
- **The rationale behind these criteria is based on a revision of existing policies in places across the NHS and on available evidence of effectiveness and outcome for individual procedures, developed by a multi-professional expert group. Where no robust evidence was available the guidance represents a consensus view of the expert group.**
- **Patients need a referral from their GP, a consultation with a plastic surgeon and a psychological assessment.**
- **Exceptional circumstances to allow cosmetic surgery are: a significant likelihood that the individual will gain much higher than average benefit from the treatment; avoidance of social care; or alleviation of severe psychosocial dysfunction.**
- **Revision of treatments originally performed outside the NHS will not usually be permitted.**
- **Some PCTs drew up a list of interventions not normally funded. The variation in PCT criteria possibly results in an inequity in provision.**

3.4 CRITERIA FOR COVERAGE OF PLASTIC SURGERY BY SOCIAL SECURITY IN THE NETHERLANDS

3.4.1 Health Expenditure in the Netherlands

According to the OECD Health data, total health expenditure in the Netherlands as a percentage of GDP was 9.2% in 2005, and total health expenditure per capita was $3 094 purchasing power parity. In 2003, about 62.5% of health expenditures are paid for through public funds.[35]

3.4.2 Population coverage in the Netherlands

Since January 2006, statutory and private (voluntary) health insurance have been integrated into a single and mandatory scheme that provides coverage to the whole Dutch population.[85] This new health insurance scheme has a private structure. Citizens are no longer insured automatically but are obliged to purchase themselves a health plan, but the insurance always comprises a standard package of essential health care.[86]

3.4.3 General rules for reimbursement in the Netherlands

The standard health insurance package consists of two parts: the Zvw-basket and the AWBZ-basket. The former is regulated through the Health Care Insurance Act ('Zorgverzekeringswet', Zvw) and covers acute medical care i.e. short-term hospital care, medical specialist care and care provided by general practitioners.

The latter part is regulated through the Exceptional Medical Expenses Act ('Algemene Wet Bijzondere Ziektekosten', AWBZ) and is intended for uninsurable risks such as those related to chronic illness, psychiatric hospital care, long term hospital care and nursing and the care of the physically and mentally handicapped. The management of the standard health insurance basket, i.e. of what is reimbursed, is one of the tasks of the Health Care Insurance Board ('College voor zorgverzekeringen', CVZ).

Besides the standard package, people can take out a complementary insurance to pay for health care that is not covered by Zvw or AWBZ (the so-called third compartment).[85, 87]

In February 2005, a case-mix system based on 'diagnosis treatment combinations' ('Diagnose Behandeling Combinaties', DBCs) was introduced for the registration and reimbursement of care provided by hospitals and medical specialists.

DBCs cover the entire treatment episode related to the same diagnosis, including the hospital admission, medical interventions and preceding and subsequent outpatient visits. The DBC system offers a catalogue of medical care services.[85, 86] Three DBC categories are defined by the Health Care Insurance Board (CVZ): green DBCs which belong to the standard health insurance basket and are reimbursed; orange DBCs of which reimbursement is limited to certain conditions; red DBCs which are not covered by the standard health insurance.[88] Within the green DBCs, a further distinction is made between list A and list B. For DBCs of list A, hospitals charge fixed tariffs to health insurers and patients. These tariffs are issued by the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa). List B DBCs, on the other hand, are financed with prices which result from negotiations between hospitals and health insurers.[85] In 2008, list B DBCs will cover 20% of the hospital budgets.[89] Applications for alteration of existing DBCs or creation of new DBCs are assessed by the Health Care Insurance Board (CVZ) in collaboration with the Dutch Healthcare Authority (NZa). During this assessment, necessity, effectiveness, cost-effectiveness and feasibility are investigated, and this from the perspective of the patient, the care-provider and the social health care insurance.[87, 90]

3.4.4 Rules for reimbursement of plastic surgery in the Netherlands

In the Netherlands, collective funding for plastic surgery was first regulated in 1970. At that time, there were few plastic surgeons and the Medical Insurance Board wanted to encourage sickness funds to be more generous with compensation for plastic surgery. Accordingly, the first guideline stipulated that operations with an expected positive effect on the patient's personal problems were to be reimbursed. This regulation resulted inevitably in a drastic increase in the number of plastic surgery procedures and their costs. In 1980, the so-called 'own contribution regulation' had to cut the costs of plastic surgery and secure equal application of the criteria. It was stipulated that patients undergoing plastic surgery were charged half of the costs with a maximum of 3 800 guilders, in 1990. The own contribution was omitted when the surgery was meant to correct a physical deficiency falling outside the normal variation range for appearance; when the surgery aimed at correcting or removing a somatic functional disorder or complaint; when the procedure was to prevent or alleviate considerable mental suffering. In spite of these criteria, the amount of plastic surgery interventions kept rising and there were still serious misgivings about the equity of the application of the regulation across the health care funds.[91]

Therefore, **in 1991, cosmetic surgery was removed from the standard health insurance package and placed into the third compartment care for which patients have complete financial responsibility**.[92] The normal variation and mental suffering criteria were removed and the remaining criterion was reformulated in more detail. In the Health Insurance Act ('Zorgverzekeringswet'), there is currently a list of **five conditions eligible for reimbursement**:[93]

- deficiencies in the appearance that evidently cause **physical dysfunction**;
- **mutilations caused by illness, accident or medical intervention;**
- **paralysed or sagging eyelids evidently causing a diminished range of vision;**
- the following **congenital deformations**: lip-, jaw-, and palate clefts, deformations of the facial bones, benignant growth of blood vessels, lymphatic vessels or interstitial tissue, birth-marks and deformations of the urinary passages and genital organs;

- transformation of external genital organs in the case of acknowledged **transsexuality**.

The notes of explanation attached to the Health Insurance Act make explicit that the **following plastic surgery conditions or procedures are not part of the standard health insurance package**:[93]

- paralyzed or sagging eyelids not caused by a congenital defect or a chronic condition present since birth;
- abdominoplasty and liposuction of the abdomen;
- breast implant carried out for other reasons than after a partial or complete mastectomy;
- removal of a breast implant after the previous procedure;
- circumcision.

For the speciality plastic surgery, the **DBC catalogue** 2008 contained 15 748 **green DBC service codes of which reimbursement is unlimited**, 4 125 **orange DBCs with conditional reimbursement** and 1 318 **red DBCs which are not covered** by the standard health insurance.[94] Conditional reimbursement for orange DBCs implies that health insurers have to check if the procedure is eligible for reimbursement according to the Health Insurance Act as abovementioned.[95] In addition, some procedures can only be performed after **prior approval** by the health insurer. Health insurers have started this procedure for DBCs which can be either aesthetic or reconstructive of nature; mostly orange DBCs, but there are also some green DBCs on this so-called limitative list.[96] Appendix 11 on page 113 shows a selection of DBC diagnoses in the domain of plastic surgery and the reimbursement for different kinds of treatments within each DBC.

As reported by one of the external experts, the provision of plastic surgery is currently changing in the Netherlands. Plastic surgery is being drawn away from registered hospitals into private clinics. Health insurers are nowadays contracting private clinics, not only to operate on their insurants with a complementary insurance for non-reimbursed aesthetic surgery, but also on their insurants who are eligible for reimbursed reconstructive surgery. This is illustrated by the Web sites on which private clinics advertise about the reimbursed procedures that can be performed in their clinic, according to the patient's health insurer.[97]

Key Points

Criteria for coverage of plastic surgery by social security in the Netherlands

- **Since 1991, patients have complete financial responsibility for cosmetic surgery.**
- **Five conditions are still eligible for reimbursement: deficiencies that cause physical dysfunction; mutilations caused by illness, accident or medical intervention; paralysed or sagging eyelids with a diminished range of vision; congenital deformations; transsexuality.**
- **Explicit list of procedures that are not eligible: paralysed or sagging eyelids not caused by a congenital defect or a chronic condition present since birth; abdominoplasty and liposuction of the abdomen; breast implant carried out for other reasons than after a partial or complete mastectomy; removal of a breast implant after the previous procedure; circumcision.**
- **The DBC catalogue contains three types: green DBCs with unlimited reimbursement; orange DBCs with conditional reimbursement; red DBCs which are not covered. Sometimes prior approval is necessary.**
- **Even reimbursed reconstructive surgery is currently being performed in private clinics because of contracting between these clinics and the health insurers.**

3.5 CRITERIA FOR COVERAGE OF PLASTIC SURGERY BY SOCIAL SECURITY IN GERMANY

3.5.1 Health Expenditure in Germany

In Germany, total health expenditure as a percentage of GDP was 10.7% in 2006, total health expenditure per capita was $3 287 purchasing power parity and public expenditure amounted to 76.9% of total health expenditure.[35]

3.5.2 Population coverage in Germany

Before the 2007 health reform, about 88% of the population i.e. 70 million people were covered through statutory health insurance ('Gesetzliche Krankenversicherung', GKV) while about 10% relied on substitutive (mainly residents earning above a specified income threshold) and complementary (civil servants) private health insurance. Almost 200 000 individuals had no insurance coverage.[98, 99] From April 2007, SHI becomes mandatory for all German citizens and insurers have to offer at least a basic benefit package to all persons.[100]

3.5.3 General rules for reimbursement in Germany

A fundamental aspect of the German health care system is the sharing of decision-making powers between the 16 Länder, the federal government, and legitimized self-governmental organizations of payers (sickness funds) and providers (physicians, dentists, hospitals).[101] The Federal Joint Committee ('Gemeinsamer Bundesausschuss', G-BA) is the supreme decision-making body of this self-governing system in Germany. Physicians, dentists, hospitals, sickness funds and patients are represented in the G-BA. The G-BA issues directives and thus determines the benefit package of the statutory health insurance (SHI). These directives are legally binding for insured persons as well as for the providers and payers of health care. They are valid for ambulatory treatment, dentistry, hospital care and psychotherapy. Furthermore, the directives define the provision and reimbursement of pharmaceuticals, diagnostic and therapeutic procedures, medical devices and non-medical treatment. In addition, the G-BA is responsible for reimbursement decisions in the SHI. Finally, the G-BA has important responsibilities regarding quality assurance measures for in- and outpatient care.[102]

The G-BA's decision-making process is informed by the most recent scientific evidence concerning the appraisal of effectiveness, benefit, necessity and efficiency of diagnostic or therapeutic procedures within the benefit package of the GKV.[102] Principles for implementation or reimbursement of new methods (medical treatments) in the SHI differ for outpatient and inpatient care. New outpatient treatments are not reimbursed by the SHI as long as the G-BA has not yet decided about a positive benefit of the treatment ('Erlaubnisvorbehalt'). New inpatient treatments, on the other hand, are reimbursed by the SHI, as long as the G-BA has not yet decided about the negative benefit of the treatment ('Verbotsvorbehalt').[103]

The G-DRG system constitutes the Case Fees Catalogue ('Fallpauschalen-Katalog') of services and benefits covered by the SHI for inpatient care.[104] The Uniform Value Scale ('Einheitlicher Bewertungsmaßstab', EBM), on the other hand, lists all procedures covered in the ambulatory sector, both hospital-based as office-based, together with their relative weights for reimbursement.[101, 105]

3.5.4 Rules for reimbursement of plastic surgery in Germany

The entitlements, rights and duties of insured covered by social insurance schemes, most importantly Statutory Health Insurance (SHI), are defined in the **fifth Social Code Book** ('Sozialgesetzbuch', SGB).[101] Article 27 of SGB V stipulates that insured are entitled to be treated when this treatment is necessary to recognize or cure a disease, to prevent its aggravation, or to alleviate its symptoms. Article 12 specifies that the **sickness funds can only reimburse health care services which are adequate, expedient and cost-effective**. Services which are unnecessary and inefficient can not be reimbursed.

Since these criteria apply to most aesthetic interventions, these operations are considered to be 'Selbstzahlerleistungen' and are not financed by the statutory sickness funds. Since April 2007, there is a law which explicitly forbids the reimbursement of **medical complications** caused by aesthetic operations, tattoos or piercings.[25, 106] Even psychological illnesses resulting from an extreme suffering related with the own appearance do not justify the reimbursement of aesthetic operations. The sickness funds stated that such **psychological illnesses should be treated with psychotherapy rather than with surgical interventions**.[25, 106]

Nevertheless, in individual cases, statutory sickness funds can reimburse an aesthetic operation, but only **on request and because the illness value is recognized**. Such an application can only be submitted by plastic surgeons authorized by the association of SHI-affiliated physicians. Requests for reimbursement are usually approved by statutory sickness funds when it concerns congenital abnormalities or disfigurements following cancer, accidents or burns. According to the experiences of the German Association for Aesthetic-Plastic Surgeons (DGÄPC), the following interventions are also frequently accepted for reimbursement within the SHI:[106-108]

- correction of prominent ears in children, before reaching puberty;
- reshaping of the nose in case of breathing problems;
- breast reduction when the patient is suffering from back problems and the resected volume is estimated to be at least 500 g per breast; when eczema under the breast can not be treated dermatologically; for gynaecomastia in male patients;
- breast enlargements for congenital failure of breast development, developmental asymmetry or previous tumour resection;
- scar removal in case of functional handicaps or severe disfigurements;
- skin curtailment when after extreme weight loss large skin folds cause functional limitations (e.g. abdominoplasty);
- eyelid correction when sagging upper eyelids impair at least 25 percent of the visual field; in case of excessive skin in the lower eyelid and a tearing eye.

Key Points

Criteria for coverage of plastic surgery by social security in Germany

- **The fifth Social Code Book specifies that sickness funds can only reimburse health care services which are adequate, expedient and cost-effective. Since aesthetic procedures are mostly unnecessary and inefficient, they are not reimbursed.**
- **Medical complications caused by aesthetic operations, tattoos or piercings are not covered either.**
- **Even psychological illnesses related with the own appearance do not justify reimbursement.**
- **Only SHI-affiliated physicians can submit a request for reimbursement of an aesthetic intervention with the sickness funds.**
- **Requests related to congenital abnormalities or disfigurements following cancer, accidents or burns are usually approved.**
- **The German Association for Aesthetic-Plastic Surgeons made up a list of aesthetic interventions which were frequently accepted for reimbursement (i.e. experience of its members). There is no explicit, legally binding list of covered procedures.**

Table 4 : Comparison of criteria for coverage of plastic surgery by social security in five European countries

Belgium	France	United Kingdom	The Netherlands	Germany
Catalogue describing covered interventions				
Nomenclature of interventions covered by NIHDI	CCAM describes all interventions, reimbursed or not	No catalogue in NHS system. PCTs should apply the NHS guidelines, some draw up a list of interventions not normally funded.	DBC catalogue: - green DBCs: unlimited reimbursement - orange DBCs: conditional reimbursement - red DBCs: not covered	There is no list of procedures which are covered by statutory health insurance.
Criteria for reimbursement				
- Reconstructive surgery is covered. - Article 34 GVU law: services performed with an aesthetic purpose are not covered <-> Nomenclature: purely aesthetic not covered unless rehabilitation programme to acquire or keep job position. - Aesthetic surgery i.e. breast reduction, nostril reconstruction, abdominoplasty covered if functional discomfort. - Breast augmentation for psychological reasons, tattoo removal, and hair implants are explicitly never reimbursed.	- Reconstructive surgery is covered but can be restricted to specific conditions or subjected to prior authorization. - Aesthetic surgery not reimbursed apart from two exceptions: health risk, or psychological or social harm. These exceptions are an inheritance from the past when the criteria for reimbursement were less logical.	- Reconstructive surgery following trauma, cancer, degenerative conditions or congenital disfigurements is performed within NHS - Aesthetic surgery is occasionally performed when: high individual gain, avoidance of social care, alleviation of psychosocial dysfunction	- Five conditions eligible for reimbursement: deficiencies that cause physical dysfunction; mutilations caused by illness, accident or medical intervention; paralysed or sagging eyelids with a diminished range of vision; congenital deformations; trans-sexuality. - List of explicitly not covered procedures: paralysed or sagging eyelids not caused by a congenital defect or a chronic condition present since birth; abdominoplasty and liposuction of the abdomen; breast implant carried out for other reasons than after a partial or complete mastectomy; removal of a breast implant after the previous procedure; circumcision.	- Aesthetic procedures can only be reimbursed when they are adequate, expedient, and cost-effective. - Even psychological illnesses related with the own appearance do not justify reimbursement. - Procedures related to congenital abnormalities, or disfigurements following cancer, accidents or burns are usually covered because they meet the criteria. - There is no explicit list of covered procedures.
Conditions for reimbursement				
Specifications on indication, invoicing and data collection are possible.	Five possible conditions which have to be respected by surgeon: 1) Indication 2) Invoicing	NHS guidelines for PCTs describe explicit criteria for treatment, inclusion thresholds and trigger points.	Conditional reimbursement for orange DBCs.	

	3) Training of surgeon 4) Environment 5) Data collection	Referral from GP and psychological assessment is necessary.		
Evaluation / verification of these criteria				
- Prior approval by sickness funds is sometimes required. - Verification by NIHDI posterior to intervention is possible	- Prior approval by sickness funds is sometimes required. - Verification by sickness funds or CNAMTS posterior to intervention is possible	- Appeal mechanism for patients excluded from treatment	- Prior approval by health insurer is sometimes required for orange, but also green DBCs.	Only SHI-affiliated physicians can submit a request for reimbursement of an aesthetic intervention with the sickness funds.
Problems in relation with criteria				
Functional discomfort is not defined => can cause inequity for patients, legal insecurity for physicians, and possibly improper use.		PCTs do not always respect NHS guidelines and ration cosmetic surgery. This causes an inequity in the provision of cosmetic surgery.		The criteria are very strict, and the reimbursement of plastic surgery by the statutory health insurance is so limited that there seem to be no problems with borderline cases.
Complications of aesthetic surgery				
There is an invoice code for the removal of breast prosthesis in case of complications. The absence of other rules seems to imply that complications are covered.	No specific rules. Does this imply that complications are covered?	NHS does not permit revision of treatments originally performed outside NHS.	Removal of a breast implant that was initially carried out for other reasons than after a mastectomy is not reimbursed. No rules for other interventions.	Since April 2007, there is a specific law which forbids coverage of medical complications.

4 VOLUME OF PLASTIC SURGERY

Because of differences in the definition of plastic surgery and in the procedures that are reimbursed, the information on the number of plastic surgery interventions in the different European countries should be interpreted with caution. In addition, comparison between the countries is hampered by a different level of detail of the available data. Data mentioned in this chapter are, therefore, merely exploratory.

4.1 VOLUME OF PLASTIC SURGERY IN BELGIUM

As explained on page 10, the information on the volume of plastic surgery in Belgium is only based on **claims data from the National Institute for Health and Disability Insurance** (NIHDI) that reimburses services covered by the compulsory health insurance.

As a consequence, there are several shortcomings to be acknowledged in the **data analysis**:

- no information on non-reimbursed plastic surgery performed in private practices, private clinics or registered hospitals;
- claims data are fraud-sensitive;
- no registration of diagnosis;
- cost for the patient was not analysed;
- insurance cost only includes the fees for the physician;
- no information on the number of hospital admissions related to plastic surgery.

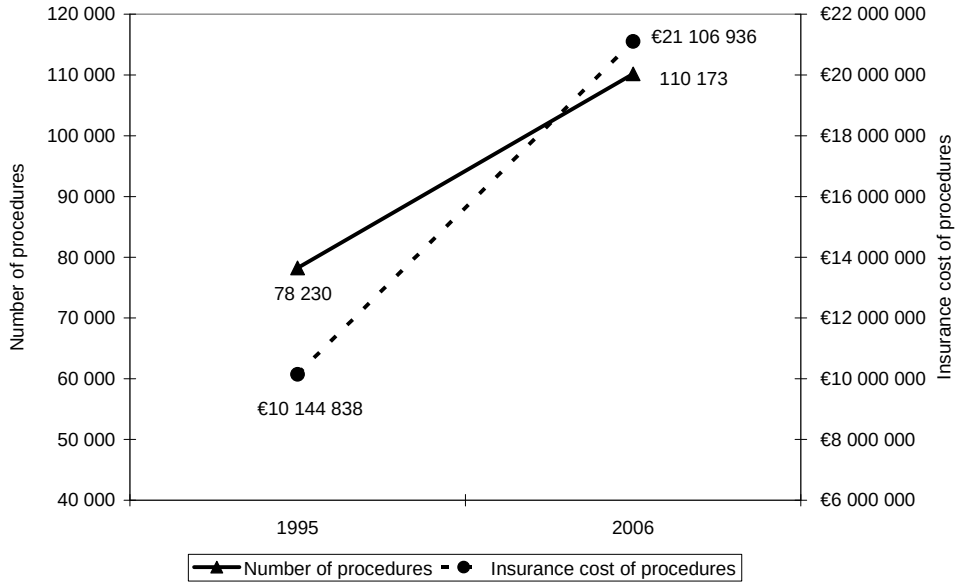
4.1.1 Volume and nature of reimbursed plastic surgery in Belgium

As outlined in the methodology section (see page 11), the analysis of claims data on plastic surgery in Belgium is limited to **a selection of reimbursed plastic surgery interventions**. The list of interventions that were included is added in Appendix 12.

As illustrated in Figure 1, the total number of plastic surgery interventions reimbursed by public health insurance amounted to **78 230 procedures in 1995**, bringing along an **insurance cost of €10.1 million**. Eleven years later, **in 2006**, there were **110 173 interventions costing the health insurance €21.1 million**. This means that, over the past decade, the number of reimbursed plastic surgery procedures increased with 41% and their insurance cost with 108%.

The total NIHDI budget for health care increased in the same period (i.e. 1996-2006) with 62%.[109] Compared to the evolution of the total expenditures for health care, it seems that the insurance costs for plastic surgery increased relatively more.

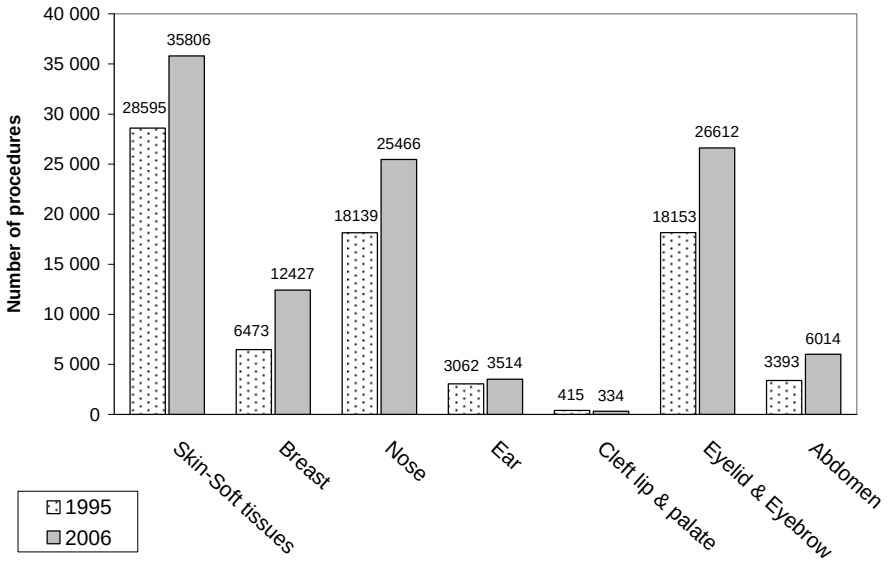
Figure 1 : Evolution of reimbursed plastic surgery in Belgium between 1995 and 2006



Source: National Institute for Health and Disability Insurance

Figure 2 illustrates how these plastic surgery interventions were divided over the selected anatomical regions. The exact numbers behind these percentages are shown in Table 7. The most frequent procedures were those on skin and soft tissues which accounted for 35 800 interventions in 2006. Procedures on eyelid and eyebrow came second with 26 600, and nose procedures were third with 25 500 interventions in 2006. In the same year, there were 12 400 plastic surgery interventions on the breast, 6 000 on the abdomen, 3 500 on the ear and, finally, 340 repairs of cleft lip and/or palate.

Figure 2 : Number of reimbursed plastic surgery interventions according to anatomical region of the procedure



Source: National Institute for Health and Disability Insurance

Table 5 gives an illustration of the share that plastic surgeons have in the reimbursed plastic surgery. The overall **contribution of plastic surgeons** in the totality of reimbursed plastic surgery **increased from 33% in 1995 to 41% in 2006**.

The share of plastic surgeons grew in every anatomical region, except for nose procedures. In 2006, 90% of breast procedures were performed by plastic surgeons. More than half of the interventions on skin and soft tissues, ear, cleft lip, and abdomen were carried out by plastic surgeons. Procedures on nose (4%) and eye (20%), on the other hand, were mainly performed by physicians other than plastic surgeons in 2006.

Table 5 : Number of reimbursed plastic surgery procedures in Belgium between 1995 and 2006 according to anatomical region and percentage performed by plastic surgeons

Anatomical region of reimbursed plastic surgery	Total number of procedures		Percentage performed by plastic surgeons	
	1995	2006	1995	2006
Skin-Soft tissues	28 595	35 806	48,9%	60,6%
Breast	6 473	12 427	73,5%	90,1%
Nose	18 139	25 466	6,4%	4,3%
Ear	3 062	3 514	53,3%	55,2%
Cleft lip & palate	415	334	41,0%	53,0%
Eyelid & Eyebrow	18 153	26 612	14,7%	20,3%
Abdomen	3 393	6 014	48,4%	64,5%
TOTAL	78 230	110 173	33,2%	41,2%

Source: National Institute for Health and Disability Insurance

Table 6 illustrates how many of the reimbursed plastic surgery interventions belonged to **Article 14c** (i.e. plastic surgery) of the nomenclature. In 1995 as well as 2006, this percentage amounted to approximately **38%**.

Table 6 : Number of reimbursed plastic surgery procedures in Belgium between 1995 and 2006 according to anatomical region and article of fee schedule

Anatomical region of reimbursed plastic surgery	Total number of procedures		Percentage from Art.14c (plastic surgery)	
	1995	2006	1995	2006
Skin-Soft tissues	28 595	35 806	72,2%	74,9%
Breast	6 473	12 427	82,8%	90,4%
Nose	18 139	25 466	8,0%	5,9%
Ear	3 062	3 514	63,5%	58,4%
Cleft lip & palate	415	334	0,0%	25,7%
Eyelid & Eyebrow	18 153	26 612	0,0%	0,0%
Abdomen	3 393	6 014	0,0%	0,0%
TOTAL	78 230	110 173	37,6%	37,8%

Source: National Institute for Health and Disability Insurance

Table 7 shows the number of procedures and their insurance cost, in 1995 and 2006, according to anatomical region and type of intervention (in a smaller font). Several procedures show a substantial increase in number i.e. those related to **breast interventions (+92%), abdominal (+77%), eyelid and eyebrow (+47%) and nose (+40%).** Plastic surgery on **skin and soft tissues (+25%) and on ears (+15%)** increased less dramatically. **Cleft lip repairs (-20%)** were performed less in 2006 than in 1995.

Table 7 : Evolution of number and cost of reimbursed plastic surgery in Belgium between 1995 and 2006 according to anatomical region of the procedure

Anatomical region & type of intervention	Number of procedures			Insurance cost of procedures		
	1995	2006	increase	1995	2006	increase
Skin-Soft tissues	28 595	35 806	25%	€3 802 599	€8 895 671	134%
Flap	13 110	15 101	15%	€2 147 680	€4 180 547	95%
Skin graft	7 348	3 456	-53%	€ 649 059	€ 578 024	-11%
Implant	197	200	2%	€ 19 437	€ 36 429	87%
Burn	903	1 052	17%	€ 104 413	€ 211 854	103%
Scar	3 660	3 246	-11%	€ 139 525	€ 166 545	19%
Tumour	3 377	12 751	278%	€ 742 485	€3 722 272	401%
Breast	6 473	12 427	92%	€1 132 089	€3 339 697	195%
Malformation	4 429	8 883	101%	€ 810 684	€2 508 233	209%
Reconstruction	2 044	3 544	73%	€ 321 405	€ 831 464	159%
Nose	18 139	25 466	40%	€2 364 092	€3 555 580	50%
Nose full reconstruction	76	73	-4%	€ 17 754	€ 21 790	23%
Nose correction	7 878	14 625	86%	€ 650 843	€1 476 068	127%
Nose septum excision	10 185	10 768	6%	€1 695 495	€2 057 722	21%
Ear	3 062	3 514	15%	€ 609 732	€ 840 426	38%
Ear full reconstruction	60	78	30%	€ 14 635	€ 21 694	48%
Ear correction	3 002	3 436	14%	€ 595 097	€ 818 732	38%
Cleft lip & palate	415	334	-20%	€ 85 414	€ 93 661	10%
Eyelid & Eyebrow	18 153	26 612	47%	€1 356 481	€2 776 557	105%
Abdomen	3 393	6 014	77%	€ 794 431	€1 605 344	102%
Abdominal wall	890	615	-31%	€ 226 427	€ 191 565	-15%
Abdominoplasty etc.	2 503	5 399	116%	€ 568 004	€1 413 779	149%
TOTAL	78 230	110 173	41%	€10 144 838	€21 106 936	108%

Increase = (Nbr or cost 2006 – Nbr or cost 1995)/Nbr or cost 1995
Source: National Institute for Health and Disability Insurance

As illustrated in Table 7, **the changes in insurance cost seem out of proportion in relation with the increase in numbers**. The cost for procedures on skin and soft tissues, for example, increased with 134% between 1995 and 2006, and for breast procedures with 195%. There are several possible explanations for the discrepancy between the evolution of numbers and costs. First, there is the effect of yearly tariff **indexations** which occurred between 1995 and 2006, that were based on the official health index. The fact that the health index for the year 2006 was 118.26 when 1996 is taken as basis (1996=100), indicates the importance of indexation.[110] Second, independently of indexation, several **tariffs were revalued** during this period. In April 2003, for example, the relative values of 17 invoice codes belonging to Article 14c were upgraded.[111, 112] Some of them were revalued substantially as will be demonstrated in the following paragraphs. This revaluation was the first since the creation of these codes in 1984, and was approved by the Technical Medical Council because plastic surgery interventions were the worst-financed procedures of the nomenclature in terms of remuneration per hour. Third, there was the introduction of **new invoice codes** between 1995 and 2006. With regard to Article 14c, for example, eleven new invoice codes for plastic surgery were created in April 2003, which sometimes lead to a shift to new and more expensive procedures.[111]

The following section provides an in-depth analysis of the evolutions visible in Table 7. Additional information, on the level of invoice code, is provided in Appendix 12.

Reimbursed plastic surgery on skin and soft tissues

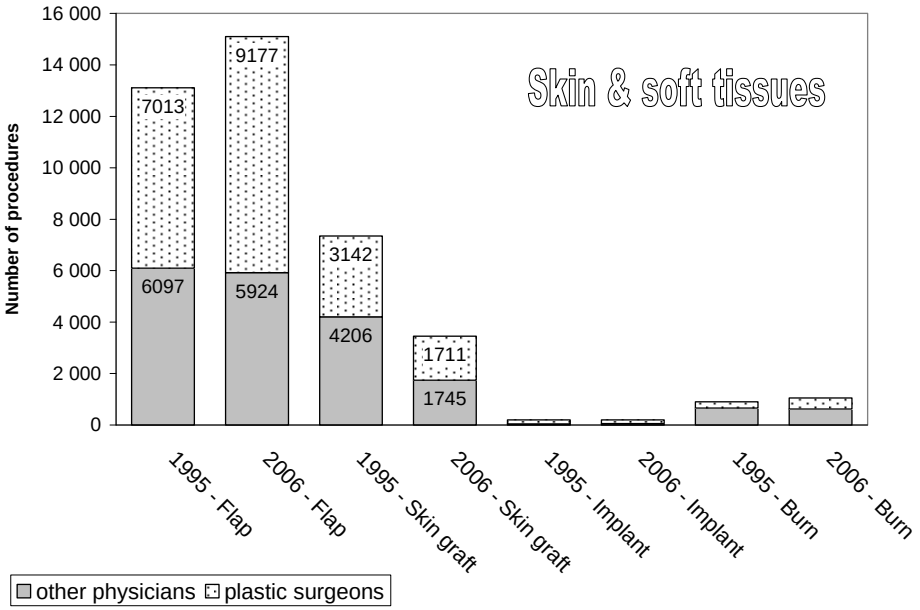
As illustrated in Table 7, flaps were the most frequently performed interventions in the category skin and soft tissues with 15 000 interventions in 2006. Procedures for tumours came second in place, in 2006, with 12 750 interventions, followed by skin grafts and excisions of scars both numbering approximately 3 400.

Excisions of burn wounds or eschars (dead tissue caused by a burn) were performed a thousand times in 2006. Implants, finally, were invoiced only 200 times.

Overall, skin and soft tissue interventions increased with 25% between 1995 and 2006. The total insurance cost grew with 134% in the same period.

- Table 7 shows that the number of flap interventions increased with 15% while their cost reached a 95% increase. Costs grew faster because of two changes in the nomenclature. In 2003, seven invoice codes were upgraded i.e. were attributed a higher relative value. As mentioned earlier, the tariff of a procedure is calculated by multiplying the key letter (which is assigned a certain monetary value) by the relative value. It concerned the following codes: 250176/180 (upgrade from K120 to K150), 250191/202 (K75 to K90), 251812/823 (K300 to K350), 251834/845 (K400 to K500), 251856/860 (K180 to K240), 251871/882 (K75 to K90), 251893/904 (K240 to K300). Simultaneously, two new codes were introduced: 251915/926 and 251930/941 which were altogether invoiced almost a thousand times in 2006.[111, 112] Detailed information is available in Appendix 12. Figure 3 illustrates how the increase in numbers can be written on the account of plastic surgeons who performed 60% of all flaps in 2006.
- In case of skin graft procedures, the reduction in numbers with 53% resulted in an 11% decrease of insurance cost. See Table 7. Again, this discordance relates to the 2003 reform. Four codes were upgraded: 251333/344 (K45 to K225), 251355/366 (K45 to K120), 251370/381 (K180 to 240), 253654/665 (K75 to K120). One new code was introduced i.e. 253676/680, but its use remained limited in 2006. See Appendix 12.[111, 112] Figure 3 illustrates that skin grafts were equally performed by plastic surgeons and other physicians.
- Implants were used slightly more in 2006 (2%). Nevertheless, their cost increased with 87%. See Table 7. This is due to a revaluation of code 251672/683 (K90 to K120) and the introduction of the codes 251694/705 and 251716/720. See Appendix 12.[111, 112]
- Procedures to excise burn wounds or eschars (i.e. dead tissue caused by a burn) were performed 17% more in 2006 than in 1995, and their cost increased with 103%. See Table 7. This cost increase is probably caused by indexation since there were no changes in relative value of invoice codes over the studied years. All nomenclature codes belong to Article 14a 'General Surgery' as illustrated in Appendix 12. In the course of the years, plastic surgeons became more implicated in these procedures. Figure 3 illustrates how their contribution increased between 1995 and 2006.

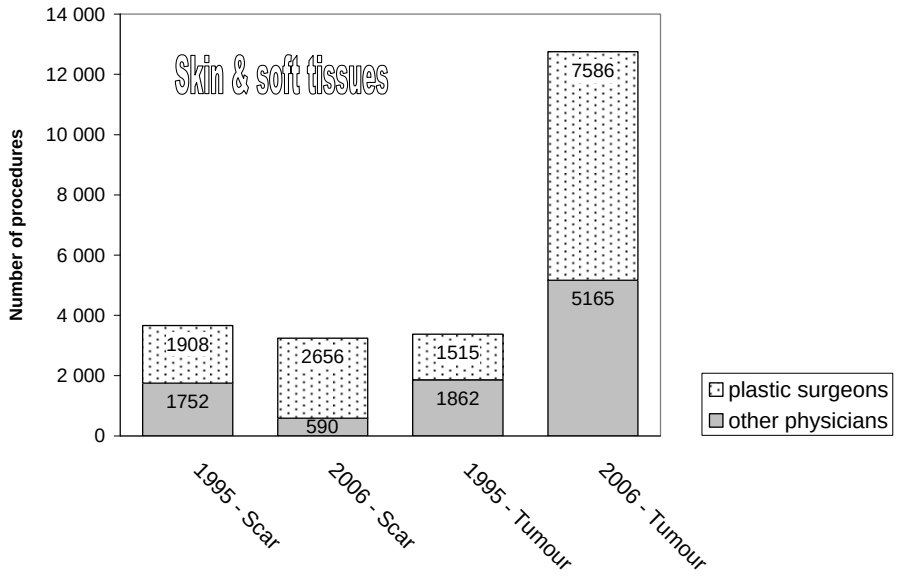
Figure 3 : Number of reimbursed plastic surgery procedures on skin and soft tissues i.e. flap, skin graft, implant and burn



Source: National Institute for Health and Disability Insurance

- The number of scar excisions decreased slightly (11%) between 1995 and 2006 while the insurance cost increased with 19%. See Table 7. As illustrated in Appendix 12, the 1995 nomenclature code (532313/324) belonged to Article 21 'Dermatology'. This code was removed from the nomenclature in 1999 and replaced by the code 221196/200 belonging to Article 14a 'General Surgery' in 2003. Figure 4 shows how the contribution of the plastic surgeons increased drastically in 2006.
- The number of procedures excising tumours or lesions of skin and soft tissues showed a threefold increase between 1995 and 2006. Their cost multiplied by four as shown in Table 7. This increase was due to the introduction of several new codes in 1999 and 2003 as illustrated in Appendix 12. Figure 4 illustrates that approximately 60% of these procedures were performed by plastic surgeons in 2006.

Figure 4 : Number of reimbursed plastic surgery procedures on skin and soft tissues i.e. scar and tumour



Source: National Institute for Health and Disability Insurance

Reimbursed plastic surgery on breasts

As illustrated in Table 7 and Figure 5, procedures for breast malformations are the most frequently performed reimbursed plastic surgery procedures on breasts with 8 800 interventions in 2006. Interventions which aim at reconstructing the breasts after mutilating surgery were performed 3 500 times in 2006. Overall, the breast procedures increased with 92% between 1995 and 2006 while their insurance cost grew with 195%.

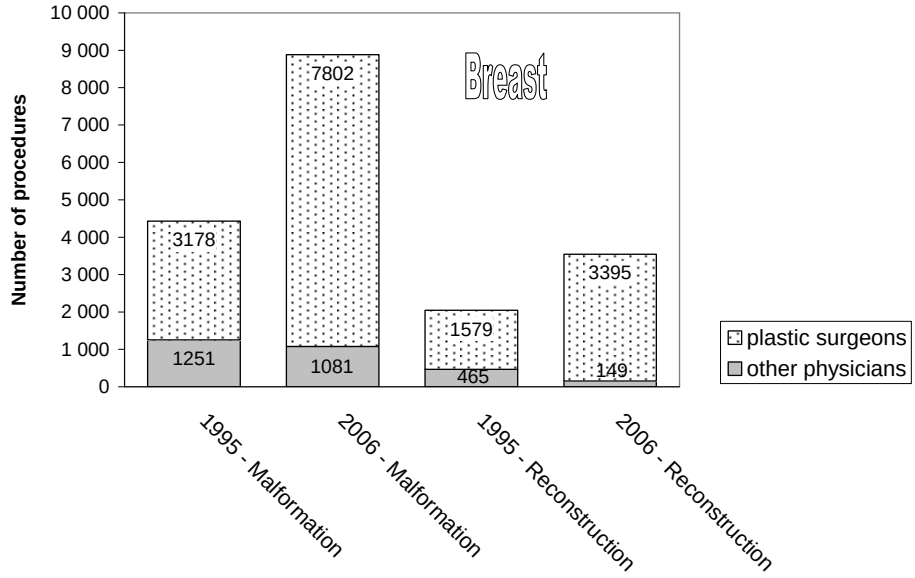
- Procedures for **breast malformations have doubled** in eleven years (101% increase). See Table 7. The main explanation for this huge increment is the **doubling of the number of breast reductions because of functional discomfort** (code 251613/624); 3 328 procedures in 1995 versus 6 668 interventions in 2006. The introduction of **new invoice codes in 2003** was responsible for another 900 supplementary procedures in 2006. These new codes were for breast enlargement in case of a tubular breast (code 251576/580), removal of breast prosthesis because of complications (code 251591/602) and correction of inverted nipple (code 251790/801).[111, 113] Finally, there was a slight increase in procedures for gynaecomastia (code 227113/124, Art.14e Thorax Surgery). See Appendix 12. Figure 5 illustrates well the large involvement of the plastic surgeons in the procedures for breast malformation of which they performed 88% in 2006.

  The insurance cost of interventions for breast malformation increased, disproportionally, with 209%. Possible explanations are: indexation; introduction of new invoice codes; and revaluation of code 251635/646 (K180 to K225) and 251650/661 (K120 to K150).[111, 113] In addition, it was decided, in 2003, that when both breasts were operated on simultaneously, the remuneration of procedures should be the same. Before 2003, the surgeon received only half of the remuneration fee for the intervention on the second breast. This rule was applied to the intervention for tubular breasts (code 251576/580), breast reduction (code 251613/624) and removal of breast implant (code 251591/602).[30, 31]

- **Reconstructive breast surgery** after mutilating surgery was performed **73% more in 2006**, causing a cost increment of 159%. See Table 7. All procedures increased over time, but for the following interventions it was striking; breast reconstruction by implantation of breast prosthesis (code

252431/442), reconstruction of the areolar region (252490/501) and remodelling of the other breast (252512/523). The upgrading of the following codes, in 2003, could be an explanation for the huge cost increase: 252431/442 (K120 to K150), 252475/486 (K240 to K300) and 252512/523 (K180 to K225).[111, 112] See Appendix 12. Figure 5 shows that plastic surgeons performed the majority of the procedures for breast reconstruction.

Figure 5 : Number of reimbursed plastic surgery procedures on breasts



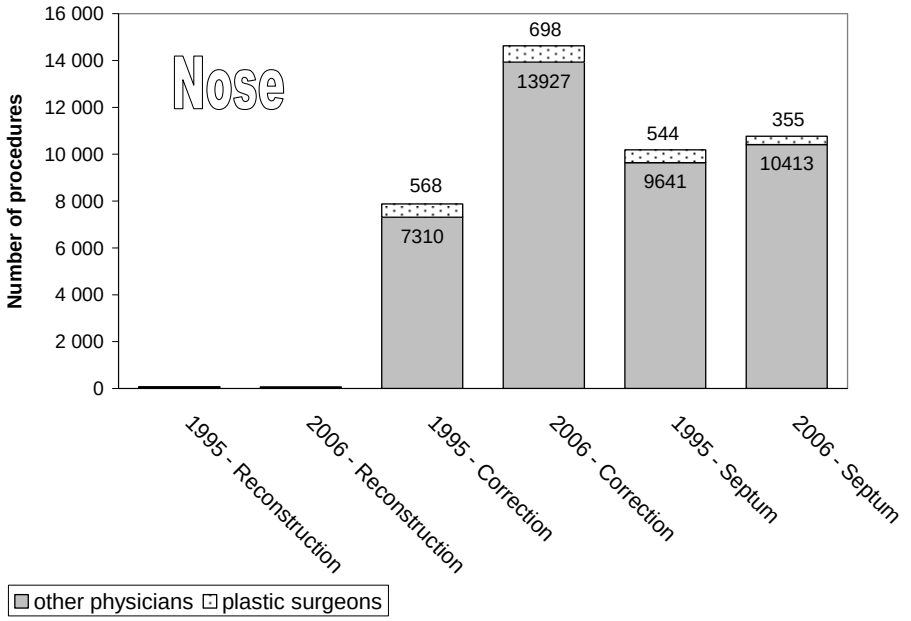
Source: National Institute for Health and Disability Insurance

Reimbursed plastic surgery on the nose

In 2006, Belgian compulsory health insurance reimbursed 25 500 plastic surgery procedures on the nose. Almost 60% of these were operations to correct the shape of the nose, the remaining 40% concerned nose septum excisions. The total number of reimbursed nose procedures **increased with 40%** between 1995 and 2006. Their insurance cost evolved in the same way i.e. 50% increase. See Table 7.

- Complete nose reconstructions are rare. See Table 7.
- Procedures to correct the shape of the nose, on the other hand, were performed 7 900 times in 1995, increasing to 14 600 in 2006; an increase of 86%. The cost increased with 127%. This cost increase is probably caused by indexation since there were no changes in relative value of invoice codes over the studied years. Most frequently performed interventions, in 2006, were: 8 600 bilateral resections of nasal shell (code 255894/905); 2 800 corrections of misshapen nose pyramid by osteotomy, grafting or prosthesis (code 253153/164 and 257994/258005); and 2 400 treatments of fractured nasal bone (code 255916/920). See Appendix 12. As illustrated in Figure 6, these procedures were only rarely performed by plastic surgeons.
- Nose septum excisions accounted for 10 768 procedures in 2006; an increase with 6% in comparison with 1995. Insurance cost increased with 21%. Figure 6 shows how few of these were performed by plastic surgeons.

Figure 6 : Number of reimbursed plastic surgery procedures on the nose



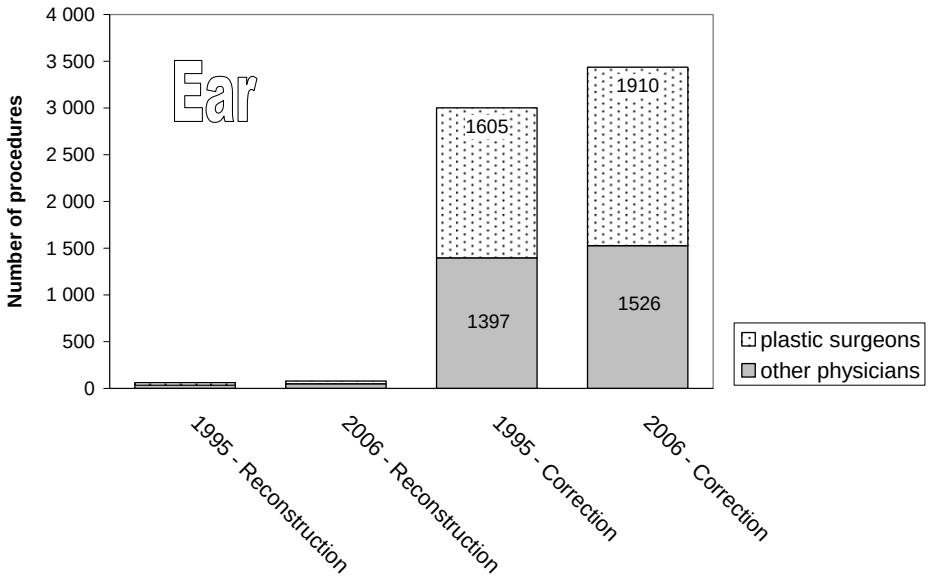
Source: National Institute for Health and Disability Insurance

Reimbursed plastic surgery on the ear

Plastic surgery procedures on the ear increased with 15% between 1995 and 2006 while the insurance cost increased with 38% in the same period. See Table 7.

- Complete reconstructions of the ear were only seldom performed in 1995 and 2006 as shown in Table 7.
- In 2006, 3 400 ear corrections were performed in Belgium, of which 56% by plastic surgeons. In comparison with 1995, numbers increased with 14%, and insurance cost with 38%. See Figure 7. Appendix 12 provides additional information on the different invoice codes.

Figure 7 : Number of reimbursed plastic surgery procedures on the ear



Source: National Institute for Health and Disability Insurance

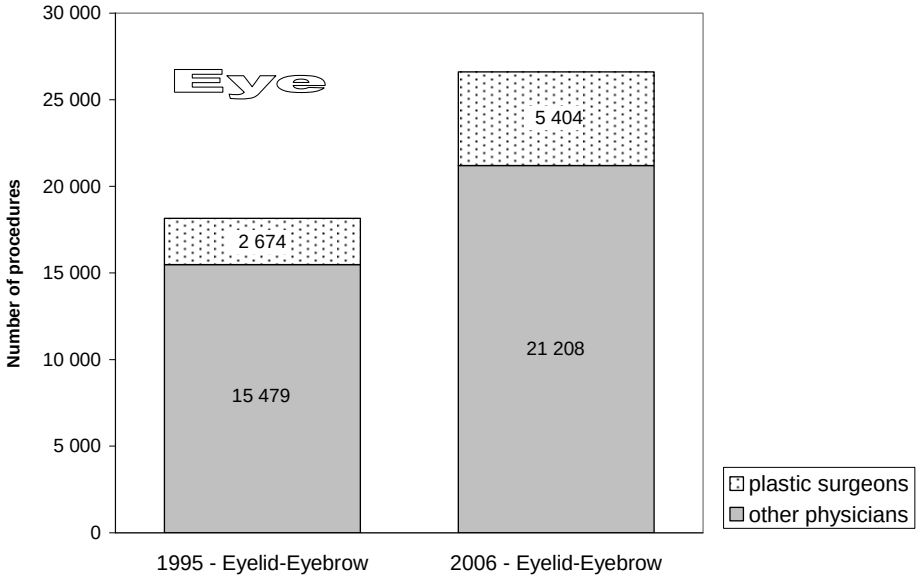
Reimbursed plastic surgery to repair cleft lip and/or palate

Repairs of cleft lip and/or palate were performed 334 times in 2006. This was a **decrease with 20%** when compared to 1995 (see Table 7). Half of these interventions were performed by plastic surgeons (see Table 5).

Reimbursed plastic surgery on eyelid and eyebrow

In 2006, Belgian physicians performed **26 600** procedures on eyelid and eyebrow which was an **increase with 47%** in comparison with 1995. The insurance cost rose with 105%, as illustrated in Table 7. In 1995, plastic surgeons performed 15% of these eye procedures and their portion increased to 20% in 2006. See table 5 and Figure 8. Appendix 12 shows which procedures were most frequent in 2006: 8 000 skinplasties of the eyelid (code 245733/744); 6 600 removals of a chalazion (i.e. little perspiratory gland around the eye, code 245615/626); 3 500 corrections of the upper eyelid (code 245755/766); 3 000 corrections of entropion and ectropion of the eyelid (code 245851/862); 2 000 corrections of a droopy eyelid (i.e. ptosis, code 245814/825).

Figure 8 : Number of reimbursed plastic surgery procedures on eyelid and eyebrow



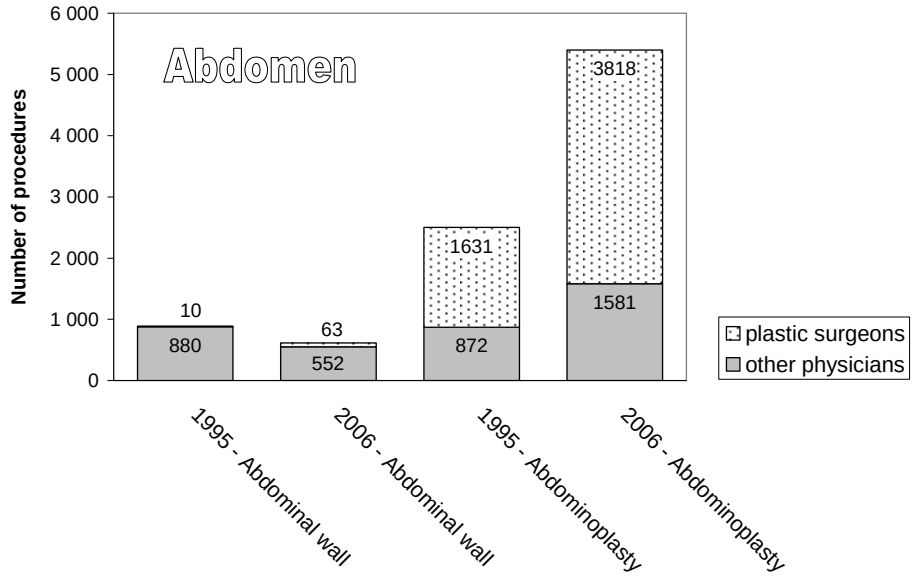
Source: National Institute for Health and Disability Insurance

Reimbursed plastic surgery on the abdomen

As illustrated in Table 7 and Figure 9, the abdominoplasties accounted for the majority of plastic surgery procedures on the abdomen with 5 400 interventions in 2006. Other interventions on the abdominal wall were performed 600 times in 2006. Overall, the abdominal procedures increased with 77% between 1995 and 2006 while their insurance cost grew with 102%.

- The number of procedures on the abdominal wall amounted to 615 in 2006, a decrease with 31% in eleven years. The insurance cost decreased with 15% in this period (see Table 7). In 2006, ten percent was performed by plastic surgeons as illustrated in Figure 9.
- The total number of abdominoplasties and arm or thigh lifts amounted to 5 400 in 2006, an increase with 116% in eleven years. The insurance cost increased with 149% in this period. Seventy-one percent was performed by plastic surgeons. See Figure 9. Appendix 12 shows the explanation for this huge increment i.e. the doubling of the number of abdominoplasties (codes 241253/264, 241275/286) from 2 500 procedures in 1995 to 5 000 in 2006. The introduction of a new invoice code for arm or thigh lift (i.e. fat apron excision in arm or leg, code 241754/765) was responsible for another 450 supplementary procedures in 2006.[111]

Figure 9 : Number of reimbursed plastic surgery procedures on the abdomen

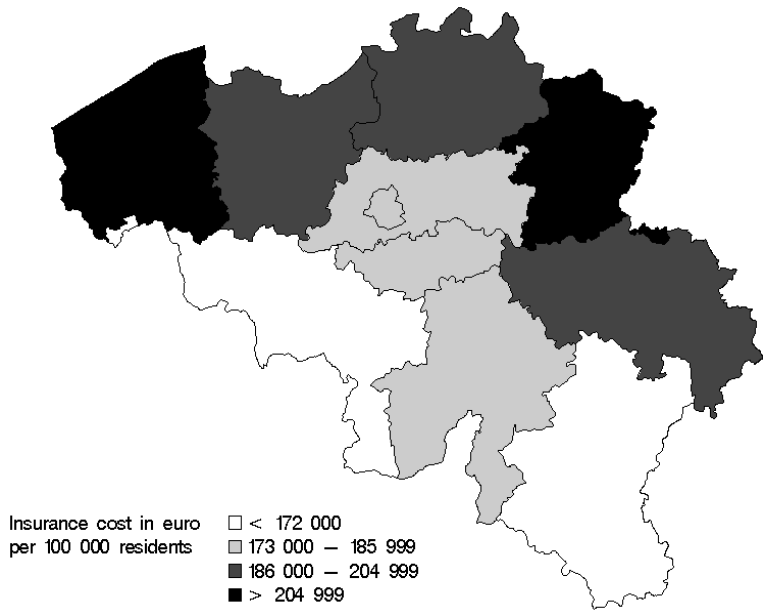


Source: National Institute for Health and Disability Insurance

4.1.2 Geographical variation in the 'consumption' of reimbursed plastic surgery in Belgium

There is a **marked regional variation in the so-called consumption of reimbursed plastic surgery in Belgium**. Figure 10 illustrates how the insurance cost for plastic surgery per 100 000 residents varies according to the province of residence of the patient. The **northern provinces seem to have a higher cost**, while the southern provinces are less expensive in terms of plastic surgery per 100 000 residents. Table 8 provides information on the exact insurance cost per province.

Figure 10 : Geographical variation in the 'consumption' of reimbursed plastic surgery in Belgium in 2006



Source: National Institute for Health and Disability Insurance, 2006

Table 8 : Insurance cost for reimbursed plastic surgery per 100 000 residents, per Belgian province in 2006

Insurance cost for reimbursed plastic surgery per 100 000 residents per province	
Limburg	€ 233 424
West-Vlaanderen	€ 217 562
Liège	€ 204 743
Antwerpen	€ 190 121
Oost-Vlaanderen	€ 189 444
Brabant wallon	€ 185 514
Brussel	€ 181 569
Vlaams-Brabant	€ 175 225
Namur	€ 173 296
Hainaut	€ 170 425
Luxembourg	€ 134 030

Source: National Institute for Health and Disability Insurance

Possible explanations for this geographical variation could be: inequity in accessibility because regional sickness funds apply different rules for reimbursement (in case of prior approval) or patients' attitudes towards plastic surgery that vary with the region they live in.

In Appendix 13, the geographical variation was analysed separately for each anatomical region. It is remarkable how the **variation differs according to the kind of procedure**. Apparently, there exists no simple regional pattern across different procedures.

4.1.3 Plastic surgeons in Belgium

In 1995, 139 plastic surgeons invoiced procedures to the National Institute for Health and Disability Insurance. Fourteen of them had a NIHDI identification number which ended on 021; a number which is used for the plastic surgeons-in-training. In **2006**, the number of plastic surgeons increased to **199**, of which ten were still being trained. All other plastic surgeons had an identification code ending on 210.

As illustrated in Table 9, the number of plastic surgeons varied strongly according to the place of residence of the plastic surgeon. In 2006, the Flemish provinces (i.e. Antwerpen, Vlaams-Brabant, West-Vlaanderen, Oost-Vlaanderen and Limburg) accounted for 118 plastic surgeons i.e. 59% of the total number. Fifty plastic surgeons (25%) resided in the Walloon provinces Hainaut, Liège, Luxembourg, Namur and Brabant Wallon. The Brussels Region, finally, had 31 plastic surgeons living on its territory (16%). However, it should be emphasized that these differences do not necessarily imply a problem of accessibility for patients. In a small country like Belgium, physicians often have their practice at some distance from their residence.

Table 9 : Number of plastic surgeons per province

Province or Region	Number of plastic surgeons	
	1995	2006
Brussel	25	31
Antwerpen	21	26
Vlaams-Brabant	19	29
West-Vlaanderen	12	20
Oost-Vlaanderen	18	29
Limburg	9	14
Hainaut	5	7
Liège	15	23
Luxembourg	2	2
Namur	5	6
Brabant wallon	8	12
Total	139	199

Source: National Institute for Health and Disability Insurance

4.1.4 Focus on borderline plastic surgery in Belgium

As explained in section 2.6.2 on page 14, a selection of procedures was labelled as **borderline plastic surgery because they supposedly balance on the boundary between aesthetic and reconstructive surgery.** In general, borderline plastic surgery procedures have no clear reimbursement criteria and have come under scrutiny because of their marked increase in number, for several years. The experts decided to label the following procedures as borderline: those for **breast malformation, nose pyramid correction, ear correction, eyelid plasty and abdominoplasty**. The remaining plastic surgery procedures i.e. those that are non-borderline, were subsequently labelled as reconstructive plastic surgery. Appendix 12 provides an overview of all reimbursed plastic surgery procedures; those highlighted in grey got the label borderline, those without marking are reconstructive. As mentioned in the methodology section on page 14, it is acknowledged that this **decision to label certain procedures as borderline can be subject to criticism**.

In 1995, borderline procedures represented 20% of the total number of reimbursed plastic surgery. Table 10 shows how their **share increased over the years to reach 29% in 2006**. In terms of insurance cost, borderline procedures had a share of 27% in 1995, increasing to 33% in 2006.

Table 10 : Number and cost of reimbursed plastic surgery procedures in Belgium between 1995 and 2006 according to type of procedure i.e. borderline or reconstructive

Type of plastic surgery	Number of procedures				Insurance cost of procedures			
	1995		2006		1995		2006	
Reconstructive	62 791	80,3%	78 153	70,9%	€7 368 428	72,6%	€14 116 130	66,9%
Borderline	15 439	19,7%	32 020	29,1%	€2 776 410	27,4%	€6 990 806	33,1%
Total	78 230	100,0%	110 173	100,0%	€10 144 838	100,0%	€21 106 936	100,0%

Source: National Institute for Health and Disability Insurance

Table 11 shows the evolution in number and cost between 1995 and 2006. **Borderline plastic surgery doubled in number (107%) and showed a threefold increase in insurance cost (152%)**. **Reconstructive plastic surgery**, on the other hand, showed a **more moderate evolution**: an increase in number with 24% and in insurance cost with 92%.

Table 11 : Evolution of number and cost of reimbursed plastic surgery procedures in Belgium between 1995 and 2006 according to type of procedure i.e. borderline or reconstructive

Type of plastic surgery	Number of procedures			Insurance cost of procedures		
	1995	2006	increase	1995	2006	increase
Reconstructive	62 791	78 153	24%	€7 368 428	€14 116 130	92%
Borderline	15 439	32 020	107%	€2 776 410	€6 990 806	152%
Total	78 230	110 173	41%	€10 144 838	€21 106 936	108%

Increase = (Nbr or cost 2006 – Nbr or cost 1995)/Nbr or cost 1995
Source: National Institute for Health and Disability Insurance

Table 12 illustrates that **plastic surgeons are more implicated in borderline plastic surgery than in reconstructive procedures**. In 2006, 57% of borderline procedures were performed by plastic surgeons, while their share was 35% for reconstructive procedures.

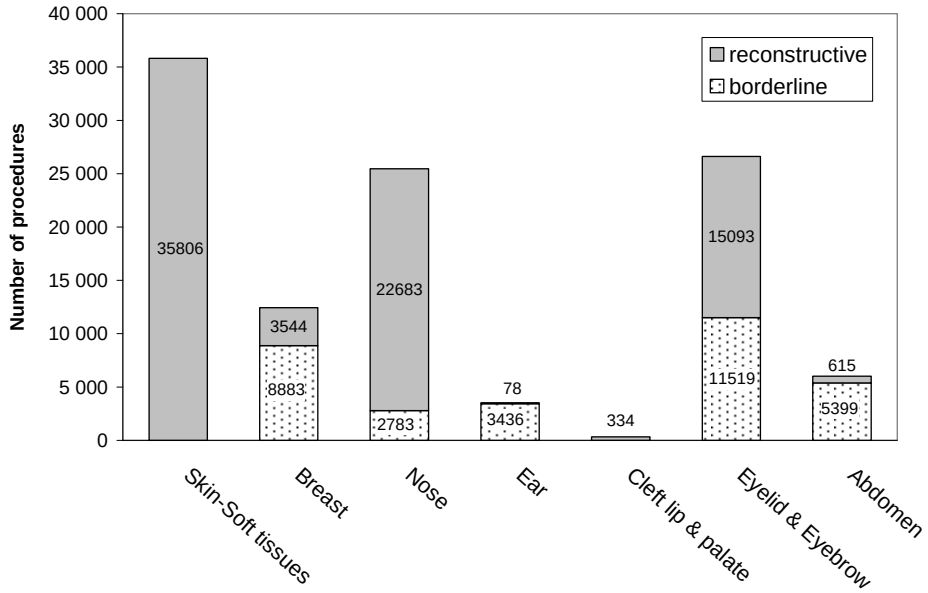
Table 12 : Number of reimbursed plastic surgery procedures in Belgium between 1995 and 2006 according to type of procedure i.e. borderline or reconstructive and type of physician

Type of plastic surgery	Total number of procedures		Percentage performed by plastic surgeons	
	1995	2006	1995	2006
Reconstructive	62 791	78 153	27,5%	34,6%
Borderline	15 439	32 020	56,4%	57,2%
TOTAL	78 230	110 173	33,2%	41,2%

Source: National Institute for Health and Disability Insurance

Figure 11 shows that, in 2006, almost all procedures on ear (98%) and abdomen (90%) were borderline. Of all breast procedures, 72% were considered borderline. For eyelid and nose procedures, the share of borderline plastic surgery amounted to 43% and 11%, respectively. Cutaneous and soft tissue procedures, and cleft lip and/or palate repairs, finally, were not assigned any borderline procedures.

Figure 11 : Share of borderline procedures in the total amount of reimbursed plastic surgery in Belgium in 2006



Source: National Institute for Health and Disability Insurance

Table 13 shows the number of borderline procedures and their insurance cost, in 1995 and 2006, according to type of intervention. **All borderline procedure types except one did at least double in number in eleven years**. Procedures for breast malformations and nose pyramid corrections increased both with 101%; abdominoplasties together with arm or thigh lifts with 116%; eyelid plasties with 179%. The insurance cost increased even more dramatically; several explanations were formulated on page 37. The ear corrections were the only borderline interventions that showed a moderate increase with only 14%.

Table 13 : Evolution of number and cost of reimbursed plastic surgery in Belgium between 1995 and 2006 according to anatomical region of the procedure

Borderline plastic surgery	Number of procedures			Insurance cost of procedures		
	1995	2006	increase	1995	2006	increase
Breast malformation	4 429	8 883	101%	€ 810 684	€2 508 233	209%
Nose pyramid correction	1 383	2 783	101%	€ 390 276	€ 952 485	144%
Ear correction	3 002	3 436	14%	€ 595 097	€ 818 732	38%
Eyelid plasty	4 122	11 519	179%	€ 412 349	€1 297 577	215%
Abdominoplasty	2 503	5 399	116%	€ 568 004	€1 413 779	149%
TOTAL	15 439	32 020	107%	€2 776 410	€6 990 806	152%

Increase = (Nbr or cost 2006 – Nbr or cost 1995)/Nbr or cost 1995
Source: National Institute for Health and Disability Insurance

Key Points

Volume of reimbursed plastic surgery in Belgium between 1995 and 2006

- **Claims data from the NIHDI were the only data source used. These data gave information on the number of procedures and the insurance cost of the fees for the physicians performing the surgery. Consequently, the following information was not available: non-reimbursed plastic surgery performed in private clinics or registered hospitals; number of hospital admissions related to plastic surgery; diagnosis in relation to these procedures; costs for the patient; related insurance costs for anaesthesia, hospitalisation, fees of other physicians or medication. In addition, it has to be acknowledged that claims data are fraud-sensitive; there is always a possibility that physicians fraudulently invoice certain aesthetic procedures with invoice codes for reconstructive interventions.**
- **In 1995, Belgian public health insurance reimbursed 78 000 plastic surgery interventions with an insurance cost of €10.1 million. In 2006, there were 110 000 interventions which were financed with €21.1 million. This implies that plastic surgery grew with 41% in number and 108% in insurance cost, in eleven years time. Compared to the evolution of total expenditures for health care (i.e. 62% increase in same period), it seems that the insurance costs for plastic surgery increased relatively more.**
- **Changes in insurance cost were mostly a lot more substantial than those in numbers. There are three possible explanations for this discrepancy: yearly indexations, revaluation of tariffs and introduction of new invoice codes.**
- **In 1995, one out of three (33%) plastic surgery procedures was performed by a plastic surgeon. This increased to 41% in 2006.**
- **In both years, approximately 38% of plastic surgery procedures were invoiced with nomenclature codes that belonged to the plastic surgery speciality i.e. Article 14c.**
- **Plastic surgery on skin and soft tissues represented 36 000 procedures in 2006, with an insurance cost of €9 million. In number, interventions increased with 25%, in comparison with 1995; insurance cost with 134%. In 2006, sixty percent of all procedures were performed by plastic surgeons. Sorted by number, in descending order, six categories were identified: flap, tumour, skin graft, scar, burn and implant. The second category, i.e. procedures excising tumours or lesions of skin and soft tissues, showed a threefold increase in number between 1995 and 2006 due to the introduction of several new nomenclature codes.**
- **The amount of reimbursed plastic surgery procedures on breasts almost doubled in eleven years time. Insurance cost increased with 195%. Plastic surgeons performed 90% of interventions, in 2006. Interventions that aim at reconstructing the breast after mutilating surgery were performed 3 500 times in 2006. On the other hand, there were almost 9 000 interventions for breast malformations in 2006; their increase was mainly caused by a doubling of the number of breast reductions because of functional discomfort.**
- **In 2006, Belgian compulsory health insurance reimbursed 25 500 plastic surgery procedures on the nose. This was an increase with 40% in comparison with 1995. Insurance costs increased with 50%. Almost sixty percent of all procedures were to correct the nose; the remaining forty percent concerned nose septum excisions. The first category showed an 86% increase between 1995 and 2006; the nose septum excisions, on the other hand, increased only with 6%. Less than five percent of all procedures were performed by plastic surgeons.**
- **In 2006, there were 3 500 ear corrections which was an increase in number with 14% in comparison with 1995. Insurance cost increased with 38%. More than half of the ear corrections were carried out by plastic surgeons.**
- **Reconstructive repairs of cleft lip and/or palate were performed 334 times in 2006, which was a decrease of 20% in comparison with 1995. Fifty percent was by the hand of a plastic surgeon.**

- **In 2006, more than 26 600 plastic surgery procedures on eyelid and eyebrow were invoiced to the NIHDI. This represented an increase of 47% in number in comparison with 1995, and of 105% in insurance cost. One out of five procedures was carried out by a plastic surgeon, in 2006.**
- **Abdominal plastic surgery amounted to 6 000 procedures in 2006, which was an increase with 77% in eleven years, leading to a doubling of the insurance cost. Sixty-five percent was performed by plastic surgeons. The majority of interventions concerned abdominoplasties and arm or thigh lifts, which were carried out 5 400 times in 2006. Reconstructive surgery repairing the abdominal wall represented only 600 interventions in 2006.**
- **There is a marked regional variation in the consumption of reimbursed plastic surgery in Belgium. Northern provinces seem to have a higher insurance cost for reimbursed plastic surgery per 100 000 residents than southern ones. The regional pattern, however, varies according to the procedure.**
- **In 1995, 139 plastic surgeons invoiced procedures to the National Institute for Health and Disability Insurance. In 2006, this number increased to 199.**
- **A sub analysis was performed of so-called borderline plastic surgery procedures, although the decision to label certain procedures as borderline can be subject to criticism. A selection of procedures was labelled as borderline because they supposedly balance on the boundary between aesthetic and reconstructive surgery: those for breast malformation, nose pyramid correction, ear correction, eyelid plasty and abdominoplasty.**
- **In 1995, 15 000 borderline procedures were reimbursed, representing 20% of total amount of plastic surgery and 27% of insurance cost. By 2006, the number of borderline interventions had increased to 32 000, which was 29% of all plastic surgery, and 33% of the total insurance cost for plastic surgery.**
- **Borderline procedures increased more in number and in insurance cost in comparison with the other plastic surgery interventions. Borderline surgery doubled in number between 1995 and 2006, and showed a threefold increase in insurance cost.**
- **All borderline procedure types except one (i.e. ear corrections) at least doubled in number in the period 1995 – 2006.**
- **Plastic surgeons are more implicated in borderline surgery than in the other plastic surgery: in 2006, plastic surgeons performed 57% of borderline procedures and 35% of the remaining plastic surgery.**

4.2 VOLUME OF PLASTIC SURGERY IN FRANCE

In 2006, plastic surgery, which was reimbursed by health insurance, accounted for almost one million admissions in French hospitals. With this, it represented **4.5% of all admissions in acute hospitals**. Table 14 illustrates that 61.4% of these interventions were performed during short stays of less than 2 days and that 65.3% took place in private hospitals.[c] The procedures on skin and soft tissues represented 63.3% of all admissions, followed by the breast procedures which accounted for 16.2%.

[c] Hospitals in France can be public, private non-profit or private for-profit.[51] In this context, the term 'private hospitals' refers to hospitals owned by private organisations but financed, at least partly, with public funds i.e. the so-called PSPH hospitals ("privé participant au service public").

Table 14 : Number of hospital stays for reimbursed plastic surgery in France in 2006

CCAM Chapter		Number of stays in public and private hospitals	Portion of short stays (< 2 days)	Portion of stays in private hospitals
2.2	Eyebrow and eyelid	75 476	85.2%	72.9%
3.2	External ear	33 374	74.1%	72.8%
6.2.1	Nose	61 016	49.6%	74.5%
7.2.1	Lips	9 616	77.7%	73.5%
16.3	Skin and soft tissues	631 418	70.3%	67.3%
16.4	Hair and nails	5 123	96.2%	88.2%
16.5	Burns	20 875	23.7%	3.7%
16.6	Breast	161 185	19.8%	56.0%
	Total	998 083	61.4%	65.3%

Source: Agence Technique de l'Information sur l'Hospitalisation (ATIH)[114]

Because of a change in the classification of medical procedures in 2005, it is impossible to make a comparison of the total amount of plastic surgery between 2006 and previous years.

There are no national data on the **number of aesthetic procedures** not covered by social security, but the French society for aesthetic surgeons (SOFCEP) estimates them to be **around 200 000**. Most common procedures are those related to breast reconstruction, hair transplantation and nose correction.[115]

In 2001, there were approximately 650 plastic surgeons in France who were registered as such by the Order of Physicians.[59]

Key Points

Volume of plastic surgery in France

- **In 2006, plastic surgery reimbursed by health insurance accounted for almost one million admissions in French hospitals, representing 4.5% of all admissions in acute hospitals. Procedures on soft tissues represented 63.3% of all admissions, followed by breast procedures which accounted for 16.2%.**
- **The number of aesthetic procedures not covered by social security, is estimated to be around 200 000, but exact data are not available.**
- **There are approximately 650 plastic surgeons in France.**

4.3 VOLUME OF PLASTIC SURGERY IN THE UNITED KINGDOM

Plastic surgery within the NHS treats mostly **high-priority cases** and comprises five main areas of work: trauma and burns; cancer (skin, head and neck, breast and sarcoma); congenital deformities; tissue degenerative conditions requiring reconstruction and normalisation and improvement of appearance.[116] In 2003, there were **51 NHS Plastic Surgery Units in the UK** (see Appendix 14) and approximately one consultant plastic surgeon for 280 000 population although it was recommended that there should be at least one per 125 000.[116, 117]

In the period April 2006 till March 2007, 216 175 patients were admitted in plastic surgery services in English NHS hospitals (see Table 15). Of these, 49.1% were day cases, admitted for just one day. The other 50.1% had to stay overnight with an average length of stay of 2.8 days. Majority of patients were male (53.0%).[118]

Over the past decade, the number of patients admitted for plastic surgery within the NHS increased with 23.6%. Although this seems to be a substantial increase, Table 15 illustrates that the portion of plastic surgery compared to the total number of hospitalisations remained quite stable over the past years. In the period 2006-2007, the admissions for plastic surgery represented **1.67% of all admissions**.

Table 15 : Number of patients admitted in Plastic Surgery services in English NHS hospitals

NHS year	Total number of Plastic Surgery admissions	Portion of plastic surgery in total number of admissions
2006-2007	216 175	1.67%
2005-2006	215 244	1.70%
2004-2005	204 231	1.69%
2003-2004	202 224	1.73%
2002-2003	200 802	1.76%
2001-2002	186 848	1.68%
2000-2001	185 006	1.66%
1999-2000	183 113	1.64%
1998-1999	174 952	1.59%

Source: NHS Hospital Episode Statistics [118]; one NHS year covers the period from 1st April year t to 31st March year t+1.

Low-priority plastic surgery e.g. benign conditions, minor disfigurements, 'cosmetic' surgery is not paid for by the NHS. Therefore, it **is almost exclusively performed in the private sector** which makes it very difficult to obtain data. We only know of **176** English establishments where **private healthcare providers** offered invasive cosmetic surgery and which were registered by the Healthcare Commission in 2003. Examples of invasive procedures are: face lift, liposuction, breast augmentation and reduction, and abdominoplasty. According to the Healthcare Commission, these invasive procedures represent only 35% of cosmetic surgery provided for outside the NHS, while 65% of procedures within the aesthetic area are not incisional and therefore not regulated. These comprise dermatological based procedures such as: chemical peeling, microdermabrasion, Botox® injection, laser therapy, skin filling injections and microsclerotherapy. The actual number of establishments that provide unregulated cosmetic procedures is unknown.[119] Due to the absence of national data, the true number of cosmetic operations is not known either.

According to the UK National Breast Implant Registry, 10 840 women received a breast implant for cosmetic reasons, in 2005.[120] These data concerned both public hospitals (NHS) as private clinics.[121]

Key Points

Volume of plastic surgery in the United Kingdom

- **In 2006-2007, 216 175 patients were admitted in the 51 plastic surgery services in English NHS hospitals. These accounted for 1.67% of all NHS admissions.**
- **Low-priority plastic surgery is not paid for by the NHS and is therefore almost exclusively performed in the private sector. In 2003, the Healthcare Commission registered 176 establishments which offered invasive cosmetic surgery. The number of aesthetic procedures performed in these private clinics is not known.**

4.4 VOLUME OF PLASTIC SURGERY IN THE NETHERLANDS

In 2006, there were 76 833 admissions for reimbursed plastic surgery in Dutch hospitals, which is 2.3% of all hospital admissions in general and university hospitals. Majority of patients were treated in day care (63.9%) and were female (62.7%).[122, 123]

The numbers in Table 16 indicate a 60% rise in the number of hospital admissions for plastic surgery between 1994 and 2006. Nevertheless, these figures have to be treated with caution because they can not be compared with the total number of hospitalisations in those years.

Table 16 : Number of admissions for plastic surgery in Dutch general and academic hospitals

Year	Total number of Plastic Surgery admissions	Portion of plastic surgery in day care
2006	76 833	63.9%
1999	55 552	55.6%
1994	48 033	42.7%

Source: Landelijke Medische Registratie[91, 122]

These data do not include the private clinics of which some are specialized in cosmetic surgery. Therefore, it is impossible to provide statistics on the total amount of plastic surgery.[91]

Key Points

Volume of plastic surgery in the Netherlands

- **In 2006, there were 76 833 admissions for reimbursed plastic surgery in Dutch hospitals, which is 2.3% of all hospital admissions.**
- **The number of aesthetic procedures performed in private clinics is not known.**

4.5 VOLUME OF PLASTIC SURGERY IN GERMANY

Data on the number of plastic surgery interventions reimbursed by the statutory sickness funds could not be found. The German Association for Aesthetic Surgery (DGÄC), the largest professional organisation for plastic surgeons in Germany, releases its own data on an annual basis and ventures to estimate the total number of so-called 'Schönheitsoperationen' i.e. aesthetic interventions not covered by the statutory health insurance. These data are an amalgam of aesthetic surgery and aesthetic medicine; the latter referring to procedures which do not require anaesthesia.

The total number of aesthetic interventions was estimated to be 400 000 in 2006. Anti-ageing laser techniques and liposuctions are the most common procedures, followed by removal of varicose veins, skin curtailments in arms and legs, and breast augmentations.[124, 125] In 1990, the number of aesthetic interventions was only 109 000, which illustrates the **boom in** aesthetic procedures **in past years**.[126]

Key Points

Volume of plastic surgery in Germany

- **Data on the number of plastic surgery interventions reimbursed by the statutory sickness funds could not be found.**
- **The total number of aesthetic interventions, not covered by social security, was estimated to be 400 000, in 2006. These data are an amalgam of aesthetic surgery and aesthetic medicine. Germany has known a real boom in aesthetic procedures in the past 20 years.**

5 LEGAL ASPECTS IN RELATION TO PLASTIC SURGERY

The objective of this chapter is to provide decision-makers with key information on legal rules and framework in each country, in order to inspire them in relation to possible legal requirements for Belgium.

One must bear in mind that there is no internationally agreed definition of Plastic Surgery as mentioned in the introduction (on page 6). Moreover, the attitude of the society towards plastic surgery, especially in terms of coverage by the social security system, varies across countries. Therefore, each national background has to be considered with care, as it remains largely influenced by cultural factors.

However, it is of great importance to analyze the legal requirements set out by each of these legislations, since all West European countries have faced similar problems, both from a medical and societal point of view. The latter refers to the increasing success of plastic surgery that is inextricably connected with a more general evolution of mentalities, especially in relation to our body image.

The global results for all five countries are depicted in the summary of finding table at the end of this section (Table 17 on page 74).

5.1 LEGAL ASPECTS IN RELATION TO PLASTIC SURGERY IN BELGIUM

5.1.1 Background

5.1.1.1 Delivery of care

As in many western countries, purely **aesthetic surgery is mainly performed in private clinic**s. Over the last years, it is clear that aesthetic surgery has become more and more popular. However, follow-up of the private clinics is impossible since private clinics are **not registered and data are not available**.

5.1.1.2 Delivery of information

The Patients' Rights act is applicable, which includes patient information. However, it is not specific to plastic surgery.

5.1.1.3 Political priorities

Until now, Belgium **lacks specific laws to regulate plastic surgery** (except on medical devices). Some political initiatives were taken, but, so far, without resulting in legislation. Therefore, this chapter will describe general legal principles which are possibly applicable to plastic surgery and gaps in the legislation.

5.1.2 Definition of plastic surgery in Belgium

5.1.2.1 Definition issued by the scientific association

The Royal Belgian Society for Plastic Surgery (RBSPS), which is the **scientific and professional association of plastic surgeons in Belgium, describes plastic surgery as** the speciality which goal it is to correct the human body. Plastic surgery contains **two main entities i.e. reconstructive and aesthetic surgery**. Reconstructive surgery aims at correcting malformations which are present at birth or acquired i.e. due to trauma, illness or surgery. Aesthetic surgery, on the other hand, aims at correcting the shape of the body or symptoms of aging, which are all variations of a normal appearance.[1, 2]

5.1.2.2 Lack of a legal definition

There is **no legal definition of plastic surgery in Belgian law**. Nevertheless, there have been several attempts in past years to fill this legal vacuum.

In February 2007, during the previous Belgian term, two members of Parliament, Giet and Burgeon, proposed a law which would regulate the practice of cosmetic surgery and medicine.[127] Their proposition of law recommended classifying cosmetic surgery in three categories: cosmetic medicine where surgery is not required e.g. injections with botulinum; light cosmetic surgery which can be performed under local anaesthesia e.g. upper lid blepharoplasty; and, finally, heavy cosmetic surgery e.g. breast augmentations. The submissioners argued that such a categorization would allow health professionals to perform only that type of cosmetic medicine or surgery that corresponds with their specialisation and qualification.

Another proposal dates from September 2007 (current term) and was submitted by senator Defraigne.[128] It aimed at the prohibition of publicity on cosmetic interventions which would be defined as any medical or surgical intervention aiming at the modification of the appearances of an individual.

Key Points

Definition of plastic surgery in Belgium

- **The Belgian scientific and professional association of plastic surgeons divides plastic surgery into reconstructive and aesthetic surgery.**
- **There is no legal definition of plastic surgery in Belgian law. Several attempts have been made to fill up this legal vacuum, but without success until now.**

5.1.3 Regulations with regard to health practitioners in Belgium

5.1.3.1 Competences and qualifications

After seven years training in general medicine, physicians are trained for two years in general surgery and four years in plastic surgery. Each of these four years is completed with an exam. The title of "specialist in plastic, reconstructive and aesthetic surgery" will be obtained after the homologation by the ministerial commission.[129] Afterwards, continuous medical education is required i.e. two congresses per year, symposium in the specific domain, university seminars and certification. **Registered plastic surgeons** have a NIHDI identification number which ends on 210, 219, or 222 (see Appendix 6). The Royal Belgian Society for Plastic Surgery (RBSPS) offers a list of all registered plastic surgeons on its Web site.[d] Here, each citizen can find the names and addresses of the surgeons, in alphabetical order, by city and hospital.

Although the title of plastic surgeon is protected, **plastic surgery is not exclusively reserved for plastic surgeons**. All physicians can perform plastic surgery as long as the intervention is performed within the limits of "legal execution of medicine".[130] There are approximately 200 registered plastic surgeons in Belgium, but the number of physicians performing plastic surgery amounts to a lot more. Because the invasive character of many aesthetic interventions is diminishing nowadays, aesthetic interventions are indeed often performed by non-surgeons. And, since purely aesthetic surgery is not reimbursed by social security, there is no incentive for patients to go to registered plastic surgeons. On the other hand, plastic surgeons also work in private clinics, often attracted by wages that are more lucrative than those in the regular circuit.

In future, there will probably be a legal initiative to define the competences of surgeons who want to perform plastic surgery. Such a proposal will be made in collaboration with representatives from the plastic surgeons.[131]

5.1.3.2 Quality criteria in the individual patient-physician relationship

Since plastic surgery is an act of health care, people undergoing plastic surgery are considered as patients. Therefore, physicians who perform these acts are compelled to work in line with their traditional duties, especially professional secrecy, as set out in

[d] http://www.rbsps.be

the deontological code of the Belgian Order of Physicians.[132] Breach of secrecy is considered as a criminal offence according to Article 458 of the Belgian Criminal Code.

The Belgian **Patients' Rights act** is also applicable.[133] According to Article 5, patients have the right to qualitative care. This implies that the surgeon has to comply with the quality standards according to the current scientific 'state of the art'. If surgeons fail to provide qualitative care, they can possibly be held liable if the patient can prove that the damage he suffered was caused by the poor care.

The Patients' Rights act regulates the right to information about the health status, which has to be distinguished from the right to informed consent. Whereas the right to informed consent is linked to a decision, the right to information about the health status is not. The patient has the right to be informed by the health care provider about all information concerning him that is required to understand his health status and the probable evolution. The information has to be communicated in a clear language. In principle, information is given orally, but the patient can request a written confirmation.

The right to informed consent can be derived from the right to physical integrity and to self-determination. The right to receive information prior to consent is regulated in Article 8 of the Patients' Rights act and concerns every medical intervention.

According to the content of the information, the Patients' Rights act enumerates a non exhaustive list of things the patient has to be informed about: nature, purpose, urgency, frequency, follow–up care of the intervention; relevant contraindications; risks and side effects of the intervention; alternatives; financial information. Patients as well as physicians, however, have the right to ask for a written consent form that will be added to the medical file. If the patient refuses to give a written consent, while the physician thinks that a written consent is necessary, the refusal can be noted in the patient's medical file. It has to be stressed that the signature of the patient can only be regarded as valid if the patient has inspected or could reasonably inspect the information. Extremely technical or unclear forms do not meet this condition. Moreover, information has to be given in advance and timely. An informed consent form that has been signed immediately before the intervention can hardly be assumed as an informed consent.

Although the Patients' Rights act provides certain guarantees, compliance can only be verified posterior to the intervention when harm has already been done to the patient. **There are no "a priori" guaranteed minimum quality criteria for the relationship between patient and health care practitioner.**

The proposition of law on the regulation of cosmetic surgery and cosmetic medicine, which was submitted by Giet and Burgeon, in February 2007, recommended the following: to oblige physicians to inform their patients (verbally and in writing); to deliver a detailed cost estimate; to foresee a reflection period of at least 15 days; and to provide a number of post-operative consultations.[127]

Key Points

Regulations with regard to health practitioners in Belgium

- **The title of specialist in plastic, reconstructive and aesthetic surgery is protected and there is a regulation for continuous medical education. But, plastic surgery procedures are not exclusively reserved for plastic surgeons (connexity).**
- **The Belgian Patients' Rights act is applicable. The common principles generally recognised as patients' rights are the right to qualitative care, the right to information, the right to informed consent, the right to a medical record and the accessibility of it and the right to confidentiality. Unfortunately, compliance can only be verified posterior to the intervention when the patient has already been harmed.**

5.1.4 Regulations with regard to establishments in Belgium

In order to get financing from the Belgian authorities, **hospitals have to be registered** i.e. they have to comply with conditions of registration as stipulated in the 1987 Hospital Act (Chapter III, Articles 68-76sexies).[134] These registration criteria are minimum standards related to safety, hygiene, quality and continuity of care. Hospital registration is regulated by the federal Government and implemented by the communities.[36]

Unregistered hospitals, the so-called 'private clinics', fall out of the field of application of the Hospital Act and can operate without or with little inspection. There is no registration on which and how often operations are performed, which hampers quality evaluation. If plastic surgery is performed in private clinics, the minimum safety and quality requirements as mentioned earlier are not applicable. Consequently, there are no minimum criteria guaranteeing a minimum level of quality. Today, **private clinics do not have to be registered** and physicians do not need permission to start a private clinic. Consequently, one does not know how many private clinics exist in Belgium. Merely due to this situation, it is not possible to give reliable statistics on the amount of plastic surgery in Belgium.

A possible solution to rationalize the delivery of plastic surgery could be brought by **Article 76-quinquies of the Hospital Act**.[134] Pursuant to this Article, it is legally possible to define which kind of health care has to be delivered within hospitals (as defined by the Hospital Act i.e. excluding private clinics) and, conversely, which care must be delivered outside hospitals. Until now, however, Article 76-quinquies has not been defined by means of a Royal Decree and is therefore not operational.

Any way, there seems to be a **political intention** to regulate the private clinics. During the previous term (February 2007), the abovementioned members of Parliament, Giet and Burgeon, proposed to submit private clinics to certain registration requirements which were to be set forth in new federal regulations. Such requirements would also imply the organization of inspections by the regional authorities and sanctions in case of non-compliance.[127]

Another problem faced with in Belgium, is the lack of information on **private physician practices**. Therefore, there is no information on the number of private practices where plastic surgery is performed or on the number and quality of these interventions. Despite good intentions, Belgium still lacks the so-called National Register of the Medical Profession.[135]

Key Points

Regulations with regard to establishments in Belgium

- **In order to get financing from the Belgian authorities, hospitals have to be registered as stipulated in the 1987 Hospital Act.**
- **Private clinics do not have to be registered. The enforcement of Article 76-quinquies of the Hospital Act could possibly help in rationalizing the delivery of plastic surgery.**
- **Private practices are not registered either.**
- **Therefore, there is no information on the number of private practices and clinics where plastic surgery is performed, or on the number and the quality of interventions performed in the private sector.**

5.1.5 Regulations with regard to advertising in Belgium

5.1.5.1 Legislation on advertising in Belgium

Since 2005, it is **forbidden by law to advertise about implants** to the general public. Article 9 §4 in the Law on Pharmaceuticals aimed in particular at breast implants.[136] In reality, however, there are several offences, probably because of a lack of law enforcement.

In past years, several **law propositions** have been issued in Belgian Parliament and Senate concerning advertising for plastic surgery.[128, 137-139] The most recent proposal dates from September 2007 (current term) and was submitted by senator Defraigne.[128] This proposal aimed at the prohibition of publicity on cosmetic interventions. It would be applicable to GP's, specialists and establishments exploited by non–physicians. The proposal prohibits publicity for cosmetic interventions except for personal advertisement. Informative publicity, which gives the health care provider the possibility to make him known and to provide information on his activities, would not be prohibited. If personal advertising concerns a specific cosmetic intervention, a number of elements such as education and title of the provider, contra-indications and side effects would have to be mentioned. Finally, the proposal provides penal sanctions in case of violation of the dispositions.[128]

5.1.5.2 European jurisprudence on advertising

In relation to advertising, there are two recent cases of the **European Court of Justice** to be mentioned.

In the **case against Ioannis Doulamis** (Case C-446/05), it is clearly reminded by the European Court of Justice that national legislations are allowed to ban advertising, in the very specific context of medical professions.[140]

In the **case of the Corporación Dermoestética SA** (Case C-500/06), the European Court of Justice has to address the problem of TV advertising in the field of aesthetic care and performed by a private firm.[141] Directive 89/552 on TV broadcasting activities states that TV advertising on drugs and medical treatments is forbidden.[142] The problem is, however, that Directive 89/552 did not supply a definition of what drugs and medical treatments exactly are. Two different arguments have been defended before the European Court of Justice:

- From the European Commission's point of view, medical treatments should only be defined as treatments performed by physicians and prescribed by physicians.
- Conversely, the other party considers that all treatments requiring the involvement of a doctor are medical treatments. Moreover, they argue that national legislations should be allowed to set out more demanding standards than those required by the Directive 89/ 552.

Case C-500/06 is currently still pending. When the European Court of Justice finally judges, its decision should come under intense scrutiny as it will be a major contribution to the definition of medical treatments and have an impact on the subject of plastic surgery.

5.1.5.3 Deontological issues about advertising in Belgium

The advertising issue is incorporated in the **deontological code of the Belgian Order of Physicians**.[132] Chapter III of this code stipulates that information has to be realistic, objective, relevant, verifiable, delicate and clear. Information may not be misleading or comparative. Moreover, results of research or treatments can not be used for publicity aims, e.g. before and after pictures. Recruiting patients is prohibited.

With regard to publicity and advertising, the **National Council of the Order of Physicians issued several recommendations over the past years**.[143]

The improper use of the designation 'plastic surgery', i.e. in the Golden Pages, was considered as misleading advertising and thus condemned by the National Council. Given the public nature of these documents and their popular use, the National Council paid great attention to the use of the designations mentioned in these phone books. In practice, plastic surgery was sometimes used as a synonym for interventions with aesthetic purposes and thus covered a much wider range than plastic surgery itself. Moreover, some physicians without surgical training or qualifications – or even non health professionals – resort to this designation to attract new patients.

In relation with physicians showing up in the media, the National Council reminded that physicians are not allowed to take part in television broadcasts with commercial

purposes and that the use of patients' experience for these purposes is also forbidden. Over the past years, a large number of television broadcasts praised plastic surgery and often presented it as innocuous. The experience of some patients was used or misused during these broadcasts, in order to glamorize plastic surgery and to attract new patients.

With regard to the commitment of physicians in events, the National Council issued a similar recommendation. Physicians are allowed to take part in actually informative events of which the provincial order must be duly informed. Events in which the informative part is of secondary importance are not considered as informative events. Conversely, involvement of doctors in commercial events is clearly forbidden. The misuse of information for commercial purposes, in connection with the doctor's activity must be actively tackled by him. Furthermore, public patient recruitment is clearly forbidden.

Key points

Regulations with regard to advertising in Belgium

- **Since 2005, it is forbidden by law to advertise about (breast) implants, but in practice this law is not respected.**
- **European jurisprudence on advertising states that national legislations are allowed to ban advertising in the very specific context of medical professions. On the other hand, there is currently a case at the European Court of Justice in relation to TV advertising for aesthetic care; discussions on the definition of drugs and medical treatments are ongoing.**
- **The National Council of the Order of Physicians issued several recommendations, insisting on the fact that dissemination of information on plastic surgery should be done carefully.**

5.1.6 Quality measures for specific interventions in Belgium

The last update of the EU legislation on medical devices i.e. **Directive 2007/47/EC** issued on the 5th September 2007, will most probably cause problems with breast implants over the next years.[144] Pursuant to Article 1 of the Directive, a medical device is defined as "any instrument, apparatus, appliance, software, material or other article, whether used alone or in combination, together with any accessories, including the software, intended by its manufacturer to be used for diagnostic and/or therapeutic purposes".

As a result of this Directive, **breast implants intended by the manufacturer for aesthetic purposes** are likely to be considered as **commercial products** and excluded from the category of medical devices.

If Directive 2007/47/EC remains unaltered and is transferred into the Belgian legislation, which is supposed to be done by the end of 2010, it could have several **consequences**:

- In today's legal context, for public health reasons, the supply of breast implants remains the monopoly of pharmacists. This distribution channel risks to be disrupted when Directive 2007/47/EC is transferred unchanged into the Belgian legislation. There is a possibility that alternative distribution channels would be in the position to provide health professionals with breast implants.
- Patients who undergo aesthetic breast surgery and who are implanted breast implants intended by the manufacturer for aesthetic purposes, would perhaps no longer benefit from the strict quality and security demands applied to medical devices nowadays.
- Although this Directive does not reconsider security rules applied to breast implants intended by the manufacturer to be used for medical purposes, it might pave the way for abuses, at least in the field of aesthetic breast surgery.
- It will probably be difficult to impose the use of medical breast implants for aesthetic surgery, as this would be considered a breach of EU

legislation on the free circulation of goods within the EU which is one of the corner stones of the EU law.

- Any measure taken by Member States against import of goods is considered as an illegal restriction. Articles 28 to Article 30 of the EC Treaty have authorized restrictions in very specific cases, especially for public health.[145] Nevertheless, it is also clearly reminded by Article 30 of the EC Treaty that "such prohibitions or restrictions shall not, however, constitute a means of arbitrary discrimination or a disguised restriction on trade between Member States". Hence, it remains uncertain whether restrictions on breast implants intended by the manufacturer for aesthetic purposes, would be allowed by the EU, especially by the European Court of Justice.
- Should breast implants finally fall out of the scope of medical devices, the current Belgian ban on advertising about implants (see section 5.1.5.1) would probably not be applicable any more.

These possible problems are already under intense scrutiny of the Belgian Federal Agency for Medicines and Health Products.

Key points

Regulations with regard to quality measures for medical devices in Belgium

- **Following the updated EU Directive on medical implants, breast implants intended by the manufacturer for aesthetic purposes may be considered as commercial products and be excluded of the category of medical devices.**
- **When transferred into Belgian legislation (by 2010), this Directive would have several consequences on the use of breast implants for aesthetic purposes. These issues are followed-up by the Belgian health authorities.**

5.2 LEGAL ASPECTS IN RELATION TO PLASTIC SURGERY IN FRANCE

5.2.1 Background

5.2.1.1 Delivery of care

Before the enforcement of the 2005 legislation described below, plastic surgery was performed by several kinds of physicians i.e. plastic surgeons, but also other specialists (e.g. ENT specialists, ophthalmologists) and even by some general practitioners. The absence of a legal framework in relation to plastic surgery (aesthetic or reconstructive) had paved the way for abuses and unsafe practices.

5.2.1.2 Delivery of information

Originally, reliable and comprehensive information was not always delivered to the patient and abuses had been denounced. For this reason, in 1996, specific information requirements in relation to the financial aspects of plastic surgery interventions were drawn up. See section 5.2.3.2 for more information on the detailed **cost estimate**.

5.2.1.3 Political priorities

France created a **comprehensive legislative framework** in July 2005. The main objective of this legislation was related to public health by ensuring a **certain security level for patients undergoing plastic surgery**. Two decrees aimed at regulating establishments where plastic surgery is performed, setting the conditions for the practice of plastic surgery and ensuring to patients the competence of the surgeons and the quality criteria lined to every surgical intervention.[146, 147] In practice, only duly trained surgeons and certain other specialists can perform plastic surgery. This common frame provides patients with a good level of security, information and transparency. This was at least the opinion of the International Society of Aesthetic Surgery (ISAPS) which paid tribute to the French legislation on that point.[148, 149]

On the other hand, there was the statutory **health insurance**, whose key objective it was to ensure a **strict application of reimbursement rules** to fight abuses or fraud.

5.2.2 Definition of plastic surgery in France

5.2.2.1 Definition issued by the scientific association

The French scientific and professional association of plastic, reconstructive and aesthetic surgery ('Société Française de Chirurgie Plastique Reconstructrice et Esthétique', SOFCPRE) defines plastic, reconstructive and aesthetic surgery ('CPRE' in French) as **surgery applied to the skin and non-visceral soft tissues**. It entails a very wide range of medical acts and can be used for a wide range of conditions (pathological and non pathological).[150]

Among CPRE medical acts, some of them are considered as **purely aesthetic surgery**: they address physical blemishes either congenital or acquired.

5.2.2.2 Legal definition

Decree 2005-776 defines aesthetic surgery as follows: **surgical acts performed with a view to changing a person's physical aspect**, **on his/her request and without any reconstructive or therapeutic purposes**.[146] The surgical nature of these acts was clearly reasserted, which means that only duly trained surgeons could perform these acts, in accordance with the provisions of the Public Health Code (Art. D6322-43).[151]

The Circular issued in December 2005 to enforce the Decrees of July 2005 has drawn up a **list of the most frequently performed aesthetic surgery interventions** (see Annexe II of the Circular).[152] As a whole, this list entails 22 medical acts and describes four categories i.e. Head and Neck, Chest and Abdomen, Liposuction and Dermabrasion. However, this list is non-exhaustive and indicative, which means that it is **not legally opposable** and must be used as guidance or a decision-making tool only.

5.2.2.3 Specifications issued by the Order of Physicians

The National Council of the Order of Physicians ('Conseil national de l'Ordre des Médecins', CNOM) had to disciplinarily sanction physicians in relation to the definition of aesthetic surgery. Some physicians were sanctioned because they performed acts beyond their actual knowledge, experience or means (violation of Article 70 of the code of medical deontology), others because they performed acts which exposed patients to an illicit risk (violation of Article 71).[153, 154] In addition, these behaviours were also a violation of the Public Health Code (Art. R6322-1 to R6322-29 and Art. D6322-30 to D6322-47).[155-157]

In relation to these sanctions, the National Council of the Order of Physicians specified the following:

- The Order outlined that aesthetic surgery had nothing to do with **minor surgery** and that it required specific competencies and training. The term minor surgery ('petite chirurgie' in French) refers to surgical acts that can normally be performed by a general practitioner and that do not require specific training, like for example sutures or excisions of superficial lesions.
- Secondly, the Order stressed that aesthetic surgery could not be considered as **aesthetic medicine**.

Key Points

Definition of plastic surgery in France

- **The scientific association makes a distinction between reconstructive and aesthetic surgery.**
- **There is a legal definition of aesthetic surgery: physical aspect, patient's request and absence of reconstructive or therapeutic purposes.**
- **The Law even defines a list of the most frequently performed aesthetic surgery interventions, although this list is not legally opposable.**
- **The National Council of the Order of Physicians made a clear distinction between aesthetic surgery and minor surgery and between aesthetic medicine and aesthetic surgery.**

5.2.3 Regulations with regard to health practitioners in France

5.2.3.1 Competences and qualifications

Decree 2005-776 mentions that "Surgical acts must be delivered in duly authorized health care establishments and performed by surgeons with the required speciality or competence, for which the mere degree of general physician or the mere clinical experience cannot be a substitute".[146] Consequently, **general practitioners are excluded** from plastic surgery, while registered specialists in reconstructive and aesthetic surgery are allowed to realise any act of plastic surgery. However, **partial connexity** is allowed within strict limits. The following specialists can only perform plastic surgery limited to the speciality for which they are registered: general surgery (legally speaking, general surgeons can perform all interventions), maxillofacial surgery; stomatology; facial surgery and surgery of the neck; ear nose throat surgery; ophthalmology; gynaecology; urology.

Purely aesthetic surgical acts are meant to be performed by plastic surgeons only. In order to clarify which interventions are considered as aesthetic surgery, the Circular mentioned earlier stated, in a non-exhaustive way, the most frequently performed interventions.[152] Combined implementation of all existing rules lead to the fact that the following acts are **always performed by a plastic surgeon**:

- all methods of liposuction (includes lipo-aspiration);
- treatments for baldness including simple removal of the bald patch or removal of flaps of bald skin;
- dermabrasion to remove wrinkles of the upper and the lower lip;
- injection of non-absorbable materials such as gold threads or notched threads. Injections of botulinum toxin and of absorbable, non-permanent fillers are not considered as cosmetic surgery.[148]

These cosmetic surgery interventions are **not reimbursed** by social security.

Unfortunately, Decree 2005-776 did not define "surgical acts" as such. Indeed, many acts with aesthetic purposes can be performed in a non-surgical environment. These acts are usually called aesthetic medicine, even if the latter expression does not correspond to any legal or scientific concept. Therefore, many non surgical but nevertheless invasive acts with possible severe complications can fall out of the scope of the law.

Moreover, we have to bear in mind that the evolution of techniques can transfer some acts from the surgical domain to the non-surgical domain. Even if this study focuses on surgical acts, this problem needs to be mentioned.

According to Fogli, the new regulations on surgical competence for plastic surgery had positive and negative consequences. The progressive reduction in the surgical activity of nonqualified physicians is evidently considered positive. On the other hand, however, non-specialist general practitioners have formed a lobby and are promoting the use of fillers and other non-surgical techniques outside the scope of the regulations. Their campaign suggests that cosmetic surgery is dangerous.[148]

5.2.3.2 *Quality criteria in the individual patient-physician relationship*

Since plastic surgery is an act of health care, people undergoing plastic surgery are considered patients. Therefore, physicians who perform these acts are compelled to work in line with their traditional duties, especially professional secrecy. As in other countries, breach of secrecy is considered as a criminal offence.

Before the French Patients' Rights Act existed, the obligation to provide the patient with information was already more severe than for other interventions following different jurisprudential cases. Moreover, legislation had already inserted the obligation to have a **consultation** prior to surgery.

Following the French Patients' Rights act (4th March 2002), some principles of the French jurisprudence were inserted into the Public Health Code, especially with regard to the object and modalities of information.[158] With regard to the content of the information, the law states that the **patient has to be informed very precisely** on the **conditions** of the intervention, the **risks** and the possible **consequences** and the **complications**.

Apart from legal requirements, a large number of plastic surgeons, especially members of the scientific association SOFCPRE, decided to deliver further information to patients. To this end, the scientific association wrote specific **information leaflets** concerning the most frequent interventions e.g. breast reduction and augmentation, eyelid surgery, rhinoplasty etc. Appendix 15 provides an example of leaflet with information on breast reduction. Shortened versions of these leaflets were also made available on the Web site.[159] The SOFCPRE made sure that this information was validated from a clinical and a legal point of view.

Since 1996, a **detailed cost estimate** is mandatory for any aesthetic intervention of more than €300 or for which general anaesthesia is required. A framework (list of items) has been set out by an Order of the Ministry of Finance (17th October 1996). Appendix 16 provides an example of such a cost estimate.[59, 160, 161]

With regard to the modalities of the information, Decree 2005-777 mentions that there is an obligatory minimum **15-day reflection period** between delivery of the cost estimate and the surgical intervention.[147] Today, this rule admits no exception, not even when the patients demands it. During those two weeks, the patient can not be charged for anything, except for the fees for consultation.

Moreover, the law inserted the obligation that the surgeon who had the consultations with the patient, is also the one performing the operation. If not, the surgeon has to inform the patient during the consultation of this fact.

Although this regulation provided legal certainty both for physicians and patients, it also increased the administrative burden for the surgeons.[148]

5.2.3.3 *Deontological issues about patient information*

Dissemination of information on plastic surgery has to be considered with great care and always in line with the provisions of the professional code of ethics.

Dissemination of documents or oral information whereby plastic surgery is presented as **risk-free or benign** is considered as a violation of the professional code of ethics.

Information to the public on innovative techniques (i.e. not utterly reliable nor evidence based) is forbidden. Information to fellow colleagues on innovative techniques is allowed, provided it is delivered with all required reservations.

Key Points

Regulations with regard to health practitioners in France

- **Clear distinction between acts allowed to specialists (within the framework of their own speciality) and acts allowed to plastic surgeons only.**
- **GPs are excluded from plastic surgery which resulted in a progressive reduction in the surgical activity of nonqualified physicians.**
- **Aesthetic medicine is still a problem since it remains out of the scope of the French legislation. A shift from aesthetic surgery to aesthetic medicine can put some acts out of the scope of this legislation.**
- **Patient information is very precise and provides a good level of legal certainty both for physicians and patients**
- **The 15-day reflection period provides some protection against thoughtless or irrational decisions.**
- **The estimate provides clear and comprehensive information on surgery costs.**
- **Nevertheless, there are still some deontological issues in relation to physicians' presentation of their own qualifications and competencies, and inaccurate dissemination of information on plastic surgery techniques.**

5.2.4 Regulations with regard to establishments in France

5.2.4.1 Legal requirements for establishments

All facilities where plastic surgery is performed must adhere to specific conditions. The decrees of July 2005 regulated several aspects: authorization, equipment and personnel.[146, 147]

AUTHORIZATION

Plastic surgery can only to be performed in duly authorized establishments. The certification is given and renewed by the head of the public body named "Direction départementale des affaires sanitaires et sociales". In order to examine the request for certification, the following files have to be submitted:

- An administrative file with the identity and the legal status of the applicant, the presentation of the installation, a commitment that characteristics of the installation will not be changed after certification or renewal of the certification, the conventions agreed with one or more health care institutions providing urgency and resuscitation care to organize urgent referral of patients (in cases the applicant does not provide such services).
- A personnel file containing the engagement of the applicant with regard to manpower and qualification of the personnel
- A technical file containing a presentation of the installations, the hospitalisation facilities and the technical capacities (especially with regard to the surgical sector) and a presentation of the modalities of financing of the projects and the provided budget.
- A file regarding the evaluation procedure containing:
  - the objectives of the applicant with regard to quality, safety and continuity of care provided to the patients undergoing plastic surgery;
  - the description of the methods and the indicators allowing to evaluation the realisation of the formulated objectives;
  - the description of the system of processing and collection of medical, technical and administrative data for the evaluation containing the characteristics of the executed interventions, in particular patient satisfaction, the volume of interventions by nature and by degree of complexity and information regarding the surveillance of the risk for medical accidents, hospital-acquired infections or side effects of

medical products. Clear information must be provided on the involvement of health professionals into the evaluation process.

Authorization is awarded for five years, after which is has to be renewed. This **renewal can only be denied in specific cases** (regulatory list of seven cases): breach of legal obligations and requirements, use of advertising, absence of evaluation process, etc.

EQUIPMENT

The installations for plastic surgery have to present such an architectural and functional configuration that the required hygiene standards are guaranteed to every patient. Intimacy and dignity of the patients have to be ensured. Furthermore, the installations for plastic surgery must be clearly **separated from all areas dedicated to commercial activities**. Moreover the establishment has to set up a reception area, an area for temporary or full hospitalisation, a theatre with at least one specific room dedicated to post surgery surveillance.

PERSONNEL

Decree 2005-777 sets out the minimum requirements, in terms of workforce and professional skills for the health professionals working in the health care establishment.

- At least one skilled physicians in plastic surgery (field 1)
- At least one skilled physicians in plastic surgery (field 2)
- At least one skilled physician in anaesthesia and resuscitation
- At least one skilled surgeon in the field of facial-maxillary surgery
- Paramedic team (theatre)
- Paramedic team (apart from theatre): at least one nurse and one nursing auxiliary
- One pharmacist in charge of the use of medical gas.

COMMITTEE FOR PATIENT CLAIMS AND QUALITY OF HEALTH CARE

In each establishment a "Committee for claims and quality of health care" has to be set up. The Committee's mission is to make propositions on improvement of patient management, to defend patients' rights, but also to address patients' claims.

Since the legislation regulating the surgical facilities was only implemented in the course of 2006, its impact on the number of private clinics and their quality of care was not yet assessed.

5.2.4.2 Deontological issues about practices and premises

Before 2005, French physicians were allowed to open two (or even more) medical practices, whenever the region where it is located faces shortage of health care supply. The first opened practice is called the main practice whereas the second is called the secondary practice. In the field of plastic surgery, some physicians infringed the legislation and opened a plastic surgery unit, under the cover of a secondary practice.

The Disciplinary Section of the **Order of Physicians outlined in its jurisprudence** that this kind of unit required a specific authorization (accreditation process as stated by the French legislation) and that this rule did not admit any exception.[153] The concept of secondary practices is now obsolete and has been replaced by multiple places exercise.

Physician's practices or private clinics must not be located in commercial or business premises. As mentioned above, communication between commercial premises and physicians' practice or private clinics is also prohibited.

It was reminded that working in a commercial establishment is prohibited, even if the physician does not instance his title of doctor. This kind of problem occurred in some commercial establishments, that were not clinics but aesthetic and wellness shops that hired doctors as a matter of security.

Key Points

Regulations with regard to establishments in France

- **All facilities where plastic surgery is performed must adhere to specific conditions. Specific requirements relate to: authorization, organization, personnel and equipment. Authorization is reviewed every 5 years.**
- **Since the legislation regulating the surgical facilities was only implemented in the course of 2006, its impact on the number of private clinics and their quality of care was not yet assessed.**

5.2.5 Regulations with regard to advertising in France

5.2.5.1 Legislation on advertising

The French legislation on plastic surgery **prohibits all forms and methods of publicity and advertising**, direct or indirect, in whatever form, including the Internet.[148] This is a traditional legal and ethical requirement for physicians in France (and in other countries). This prohibition also applies to private clinics, but is **often by-passed** with the use of foreign-hosted websites.

5.2.5.2 Deontological issues about advertising

Given its symbolic dimension, plastic surgery has raised specific problems and ethical issues. Some physicians used advertising and commercial methods to attract new customers, irrespective of their ethical obligations. The Disciplinary Section of the **Order of Physicians** (CNOM) had to address several problems in its jurisprudence.[153]

It was reminded that the use of advertising techniques as such - including the uploading of a personal webpage onto a professional website - is prohibited to doctors and clinics as a matter of principle. The use of propaganda material is also forbidden, e.g. flyers.

Dissemination of documents to professionals of the aesthetic industry (e.g. beauticians) with the intent of recruiting new patients is clearly forbidden.

The use of a physician's name, title, or written or oral statements must be considered with great care, especially when they are used by the media or third persons (journalists, commercial firms or entities) and nothing must escape the physician's notice. Absence of reaction against an inaccurate or a commercial use of his statements (e.g. after an interview) is considered as a violation of the professional code of ethics. The same rule is applied to or a wrong or misleading mention of his titles or competencies in such public domain documents as phone diaries.

Dissemination of wrong or misleading information to the public, especially when presenting plastic surgery as risk-free or benign is prohibited.

Legal connections between physicians (as a society member) and private societies must be considered with great care, especially when the activity of the society is clearly commercial.

Key Points

Regulations with regard to advertising in France

- **All forms and methods of advertising are forbidden. However, rules are often by-passed by private clinics.**
- **The use of a physician's name, title, or written or oral statements must be considered with great care, especially when they are used by the media or third persons such as journalists or commercial firms.**
- **Dissemination of wrong or misleading information to the public, especially when presenting plastic surgery as risk-free or benign is prohibited.**

5.2.6 Quality measures for specific interventions in France

In France, no specific recommendations on plastic surgery as such have been issued by the High Health Authority (HAS). Some principles have been reminded by the HAS, especially on clinical premises and equipments, but not on medical acts.

The SPFCPRE has issued some recommendations on quality and quality improvement, but these are not legally binding.

5.3 LEGAL ASPECTS IN RELATION TO PLASTIC SURGERY IN THE UNITED KINGDOM

5.3.1 Background

5.3.1.1 Delivery of care

In the UK, plastic surgery can be performed by plastic surgeons, other specialists and even GPs. Within the NHS, only high-priority (i.e. reconstructive) plastic surgery is performed, while low-priority plastic surgery (i.e. minor disfigurements, cosmetic surgery) is rationed. Cosmetic surgery is almost exclusively performed in private clinics.

5.3.1.2 Delivery of information

Given the traditional weight of patients' associations in the UK, patient information has always been a priority, in plastic surgery as in any other fields of health care.

5.3.1.3 Political priorities

Since the eighties, the British public health authorities have faced major problems in terms of waiting times, even for care of vital importance, like cancer treatment. In this context, plastic surgery did not seem a political priority, as far as the NHS is concerned.

5.3.2 Definition of plastic surgery in the UK

Cosmetic surgery is defined as: Operations and other procedures **that revise or change** the appearance, colour, texture, structure, or position of bodily features, which most would consider otherwise to be **within the broad range of "normal"** for that person.[162]

5.3.3 Regulations with regard to health practitioners in the UK

5.3.3.1 Competences and qualifications

Physicians who wish to practice medicine in the UK need to be registered with the General Medical Council (GMC).[e] The activities that require GMC registration include: working as a doctor in the National Health Service (NHS) or in private practice; prescribing drugs, the sale of which is restricted by law; signing certificates required for statutory purposes (e.g. death certificates).

Since 1 January 1997, it has been a legal requirement that, in order to take up a consultant post (other than a locum consultant appointment) in a medical or surgical speciality in the NHS a doctor must be included in the specialist register. Physicians wishing to work unsupervised in private practice in the UK will also need to hold specialist registration.

The Care Standards Act sets a two-fold regulation.[163] Medical practitioners who work independently in private practice (except GPs) are either on the **specialist register of the General Medical Council** (after 1 April **2002**); or where they were undertaking cosmetic surgery in the independent health care sector before 1st April 2002 (before the law came into effect) and are not on the specialist register, they have to meet specific requirements i.e. have completed acknowledged basic surgical or medical

[e] http://www.gmc-uk.org/

training; have undertaken specialist training in a speciality relevant to the procedures they provide; maintain a record of patients to whom they have provided treatment or services in the establishment, which is made available to the registered person and to the National Care Standards Commission; undertake regular patient satisfaction surveys, a record of which is made available to the registered person and the National Care Standards Commission at least annually. These practitioners are consequently able to practice legally cosmetic surgery with limited specialist training and no supervision.

In 2004, the Healthcare Commission estimated that, in those practices registered to undertake cosmetic surgery, approximately 6% of surgeons practicing were not on the Specialist register; 72% were registered in the speciality of plastic surgery, and 22% in other specialities.[119]

The expert group on the regulation of cosmetic surgery estimated that the **situation is unsatisfactory** because it is hardly possible for patients seeking for cosmetic surgery to evaluate the qualifications and the supervisory network of the surgeon in question. The expert group also mentioned that **there may be a small number of GPs** who are practicing cosmetic surgery as private practice. These GPs are not on the specialist list and they are not submitted to the Care Standard Act 2000.[164, 165]

Currently, **the GMC plans to change the registration system**. They plan to issue doctors with a licence to practice when they are registered.

Privileges of registration will be attached to the licence. Doctors who wish to retain their licence to practice will need to revalidate periodically with the GMC proving that they are up to date and fit to practice and that they have been practicing according to the Good medical practice.[162]

5.3.3.2 Quality criteria in the individual patient-physician relationship

There is **no patients' rights act** in the UK. In addition to the precedents of case law, general patients' rights are incorporated in a (legally non binding) Patients' Charter for England and in several types of guidance issued by the Health Department and the General Medical Council.[166-169]

In May 2006, the "**Good medical practice in cosmetic surgery**" guide was published by the General Medical Council, which describes the duties of the doctors registered with the GMC.[162]

This guidance covers a wide range of subjects, clinical and ethical. Its main objective is to give clear directions on physicians' duties, in the field of cosmetic surgery. This skill field is clearly considered as very specific and sensitive due to the moral and psychological dimension of cosmetic surgery.

Therefore, this guidance deals with physician's obligations as such, but also with the relationship between the physician and the patient. The next paragraph summarizes the different subjects which are addressed in the GMC document.

GOOD CLINICAL CARE

Assessment of patients is the crucial point of good practice. It is designed to address **clinical aspects** (accuracy of surgery itself, from a medical point of view) but also **psychological profile** of prospective patients. Psychological problems or psychiatric disorders have to be identified in due time by the physician.

In any case, a **2 week reflection period** has to be planned for all prospective patients to avoid thoughtless decisions.

Working within the limits of one's own professional competence is considered as a crucial point, both from a medical as from an ethical point of view.

Keeping of patient file must be accurate and adequate, and in line with the requirements of Data Protection Act (1998).

Training requirements, legal requirements for equipments and premises.

Patient information has to be accurate and precise, especially on risks and contra-indications.

Access to care, decision to treat, moral issues: it is of great importance that the physician's own views about the patient's lifestyle, gender, sexuality, and lifestyle do not prejudice the treatment provided for the patient. Physicians are required to remain absolutely neutral, from a cultural and moral point of view.

MAINTAINING GOOD CLINICAL PRACTICE

Continuous training requirements; awareness of quality issues; **reporting of clinical adverse events**; undertaking regular review of performance against the principles of the guidance.

TRAINING

Teaching and training, appraising and assessing: contribution to education programs, supervision of junior physicians.

RELATIONSHIP WITH PATIENTS

Comprehensive and clear (plain language) information delivered to patients on physician's qualifications, patient's own condition, treatment, prognosis, cosmetic procedures, and reasonable expectations. Leaflets should be provided after the first consultation.

Informed consent, confidentiality, dignity and privacy. Patient's right to a second opinion, claims and complaint proceedings.

WORKING WITH COLLEAGUES

Requirements for teamwork, both from an organisational as an ethical point of view.

PROBITY

Dissemination of information on plastic surgery (irrespective of the media), clear information on fees and charges before obtaining the patient's consent (wherever possible), conflicts of interests, involvement in research.

HEALTH (IF PHYSICIAN'S HEALTH MAY PUT PATIENTS AT RISK)

The GMC can stop or limit a doctor's right to practice medicine.[170] In order to do so, it needs evidence of impaired fitness to practise. This might be, for example, because they have not kept their medical knowledge and skills up to date and are not competent; have taken advantage of their role as a doctor or have done something wrong or are too ill to work safely.

The GMC can also issue a warning to a doctor where the doctor's fitness to practise is not impaired but there has been a significant departure from the principles set out in the GMC's Good Medical Practice guidance.

5.3.4 Regulations with regard to establishments in the UK

The majority of cosmetic (invasive) plastic surgery procedures are performed in the private sector. **Independent clinics where cosmetic surgery is practised, are required to meet national minimum standards** published by the Secretary of State under section 23(1) of the Care Standards Act 2000.[163, 171]

The **Healthcare Commission** is the independent regulatory body **responsible for inspecting and regulating** almost all forms of residential and domiciliary care, and other independent services in England. The Healthcare Commission can issue a formal notice of non-compliance to minimum standards, fines of up to £5 000 for specific offences such as failing to comply with conditions of registration, order the withdrawal of a home's licence and the exclusion of individuals from the residential care sector. An establishment is to be inspected to ensure that they are meeting the national minimum standards a minimum of once in **every five year** period.[172] Any inspection may be unannounced. Although the Healthcare commission is not compelled to inspect unregistered establishments, it reviews these facilities when their operations are drawn to the Commission's attention.[119]

The standards recognising legal complications with requiring all cosmetic surgeons to be on the GMC's specialist register, concentrate on the surgeons demonstrating that they are competent in the procedures they undertake.

5.3.5 Regulations with regard to advertising in the UK

There is insufficient regulation of cosmetic surgery advertising. Although the Advertising standards Authority deals with complaints, breaches to the code continue.[173]

5.3.6 Quality measures for specific interventions in the UK

The UK **National Breast Implant Registry** was set up in 1993 following an initiative by the Medicines and Healthcare Products Regulatory Agency.[121] Although registration is voluntary, the aim is to keep as full a record as possible of breast implants procedures carried out in the UK, which can be used to report trends in breast implant usage and as a basis for research. Registrations were received from public hospitals (NHS) and private clinics.

The collected data include: Hospital name, NHS region and funding sector; Patient name, address, date of birth and any local identifier; Manufacturer, reference number, any lot/batch/serial numbers and side implanted for each breast implant; Operation date, indication code, technique code, breast implant position code and comment ; Date, reason and side for explanation procedure; Indicator as to whether the procedure is a replacement; Patient consent to registration and to participation on future studies.

In 2005, cosmetic augmentation was given as the indication for primary surgery in 10 840 patients (90% of primary registrations for 2005).[120]

Key Points

Legal aspects in relation to plastic surgery in the United Kingdom

- **The definition of cosmetic surgery refers to normality.**
- **Physicians wanting to perform cosmetic surgery, have to be on the specialist register of the General Medical Council (after April 2002) or have to meet specific requirements. Nevertheless, there may still be a small number of GPs who are practicing cosmetic surgery as private practice.**
- **The GMC published the "Good medical practice in cosmetic surgery" guide. Strong emphasis is laid on: the assessment of patients (including psychological profile); the trust-based relationship between patient and physician; the importance of the delivery of information to the patient (about surgical procedure, possible risks, fees); a two week reflection period; and the follow-up of clinical adverse events.**
- **Independent hospitals where cosmetic surgery is practiced, are required to meet national minimum standards and are inspected and regulated by the Healthcare Commission.**
- **There is insufficient regulation of cosmetic surgery advertising.**
- **The UK National Breast Implant Registry was set up in 1993. Registrations concerned public hospitals (NHS) and private clinics.**

5.4 LEGAL ASPECTS IN RELATION TO PLASTIC SURGERY IN THE NETHERLANDS

5.4.1 Background

5.4.1.1 Delivery of care

In the Netherlands, the vast majority of plastic surgical acts are performed in private clinics, but, until now, no comprehensive regulation has been set out on that subject. Moreover, aesthetic surgery is not a protected title (see below).

5.4.1.2 Delivery of information

Delivery of information to the patient is, as a whole, satisfying but information requirements are not specific to plastic surgery.

5.4.1.3 Political priorities

The key priority of Dutch health care authority was to clarify which acts have to be covered by the statutory health insurance and which not. A specific list has been drawn to this end (see 3.4.4 on page 28). In general, the gaps in Dutch legislation with regard to cosmetic surgery are similar to the Belgian situation.

5.4.2 Definition of plastic surgery in the Netherlands

As explained below, there is no clear acknowledgment of aesthetic surgery as such and thus no legal certainty on that point. The only concept in use in the Netherlands is "Plastic surgery", whereas "Aesthetic surgery" is not a protected title.

5.4.3 Regulations with regard to health practitioners in the Netherlands

5.4.3.1 Competences and qualifications

Similar to the Belgian situation, candidate plastic surgeons are trained for two years in general surgery and four years in plastic surgery. The law "Beroepen in de individuele gezondheidszorg" (BIG) provides a system of title protection of the user of a title.[174]

The title of "Surgeon" or "Plastic surgeon" is protected if the health care provider is registered in the register of Medical specialists. **The addition "cosmetic" or "aesthetic" is not legally protected** and can even be misleading.

If non-qualified persons use a protected title or a title similar to the protected title, they are punishable by the law BIG.[174, 175]

The Health Care Inspectorate ('Inspectie voor de Gezondheidszorg', IGZ) can inform the public prosecutor on the unlawful use of a medical title and ask for prosecution. The disciplinary court can be informed as well. In that scope, the Central Disciplinary Court for Health Care ('Centraal Tuchtcollege voor de Gezondheidszorg') has judged that a GP violated the law, by using the title of cosmetic surgeon because he mislaid the patient.[176].

The law BIG stipulates that health care providers can perform acts within the limits of their competence and capability. As aesthetic surgery (and aesthetic interventions in general) is not exclusively reserved to the profession of plastic surgeon, other physicians can also perform these acts.

5.4.3.2 Quality criteria in the individual patient-physician relationship

Several general patients' rights similar to the rights elaborated in the Belgian patients' rights act are incorporated in the "Wet op de geneeskundige behandelingsovereenkomst" i.e. right to information, right to informed consent, right to a medical file, right to a second opinion, right to representation for incapable patients and the right to privacy.[177] There are, however, **no specific patients' rights in the domain of plastic surgery**. Moreover, there is no a priori inspection or guarantee of patients' rights. Only if harm to the patients has already been done, physicians having violated these rights can possibly be held liable.

5.4.4 Regulations with regard to establishments in the Netherlands

The law "Kwaliteitswet zorginstellingen" contains several dispositions with regard to good qualitative and safe care like the obligation for health care providers to deliver qualitatively good care which is defined as efficient, effective and patient oriented care.[178] Moreover, qualitative and quantitative personnel and equipment has to be present in order to guarantee qualitative and safe care. In order to systematically inspection and improve care systematic collection and registration of data with regard to quality of care is obligated. Once a year, the health care provider has to prepare a report justifying the policy with regard to the aspects described above.

This report has to be sent to the Health Care Inspectorate (IGZ) that controls the compliance with the "Kwaliteitswet zorginstellingen".

Private clinics also fall within the field of application of the abovementioned "Kwaliteitswet" and are, consequently, submitted to the supervision of the IGZ. In order to perform this task appropriately the IGZ needs a more clear understanding of the existing private clinics. Currently, however, **there is no obligatory registration for private clinics** in the Netherlands which hampers the task of the IGZ. A report of 2003 of the IGZ in which 101 private clinics (in particular cosmetic clinics) were inspected, showed that the expertise of health care providers, the organization of care and the safety policy (in particular the sterilization process) in many clinics was insufficient.[179]

5.4.5 Regulations with regard to advertising in the Netherlands

The Dutch federation of professional associations of physicians ('Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst', KNMG) has very **few rules** about publicity in its code of conduct. There is only Article V.1 which mentions that publicity for and by physicians has to be factual, controllable and understandable.[180] Before 2002, their code of conduct contained more rules about publicity i.e. that publicity should not be meant to bring in patients, that physicians should not collaborate on publicity by a third party.[181] These articles were removed in 2002 because they were in contradiction with the law on competition ('Mededingingswet').[182]

5.4.6 Quality measures for specific interventions in the Netherlands

Since 1995, a register was established of implants in Plastic surgery i.e. the **Dutch registry of implants in Plastic surgery** (DRIPS).[183] The aim of DRIPS was to provide information about the medical practice of plastic surgeons, to control the quality of breast implants and to identify patients in case of medical necessities. Moreover, a database for scientific research and for the quality programme of plastic surgery (e.g. for the visiting committees).

5.5 LEGAL ASPECTS IN RELATION TO PLASTIC SURGERY IN GERMANY

5.5.1 Background

5.5.1.1 Delivery of care

In Germany, delivery of care is mainly performed by private clinics and has boomed quite anarchically over the last years. The absence of a reliable legal framework is the key problem.

5.5.1.2 Political priorities

Until now, the main concern of the federal government is to avoid the coverage of aesthetic surgery, in the current context of Social Security reforms. There were some proposals to set up specific legal requirements but, so far, in vain.

5.5.2 Definition of plastic surgery in Germany

In today's German legislation, there is **no legal definition** of aesthetic surgery as such. It is included into a much wider concept of plastic surgery.

5.5.3 Regulations with regard to health practitioners in Germany

5.5.3.1 Competences and qualifications

Speciality of Plastic and aesthetic surgery is part of the wider speciality called Plastic surgery in the German sense, i.e. surgery of body superficial tissues: reconstructive surgery, hand surgery, burns and aesthetic surgery. Within the framework of the 5 year training period, a minimum number of self-performed operations are required.

However, **no specific training requirement is legally compulsory for physicians who perform plastic surgery**. Moreover, aesthetic medicine, as in other western countries remains a grey zone.

5.5.3.2 Quality criteria in the individual patient-physician relationship

There is **no patients' rights act** in Germany. General patients' rights, however, are incorporated in a (legally non binding) Patients' Charter and in deontological regulations for physicians.[184, 185]

5.5.4 Regulations with regard to establishments in Germany

Health care establishments that meet the requirements for surgical activities are allowed to perform plastic surgery. At present time, there are **no specific requirements imposed on hospitals or private clinics for plastic surgery** as such.

This situation is considered as unsatisfactory by most of stakeholders, especially the GÄCD (Gesellschaft für Ästhetische Chirurgie Deutschland), whose objective it is to issue scientific guidelines on plastic surgery, but also to rationalize this industry.[186-191]

Key Points

Legal aspects in relation to plastic surgery in the Netherlands and in Germany

- **In Germany and in the Netherlands, there is no clear-cut distinction between aesthetic and reconstructive surgery.**
- **Therefore, no real legal certainty or protection can be provided to the plastic surgery patient.**
- **Legislation on health care establishments does not enable health authorities to control the domain of cosmetic surgery.**
- **Today's situation is considered problematic in both countries.**

Table 17 : Comparison of legal framework for plastic surgery in five European countries

Belgium	France	United Kingdom	The Netherlands	Germany
Definition of plastic surgery				
Scientific definition makes a distinction between reconstructive and aesthetic surgery. No legal definition available.	Scientific definition of reconstructive and aesthetic surgery. Legal definition of aesthetic surgery: on patient's request & no therapeutic objective. List of most frequently performed aesthetic surgery but not legally opposable.	Definition of cosmetic surgery refers to normality.	No legal certainty. Concept of "plastic surgery" "Aesthetic surgery" or "Cosmetic surgery" not protected titles	No legal certainty. No legal definition of "aesthetic surgery". Use of wider concept of "plastic surgery".
Regulations with regard to health practitioners				
The title of specialist in plastic, reconstructive and aesthetic surgery is protected, and there is a regulation for continuous training. But plastic surgery procedures are not exclusively reserved for plastic surgeons (connexity).	Registered plastic surgeons are allowed any act of plastic surgery. List of aesthetic surgery that can only be performed by registered plastic surgeons. Other specialists: partial connexity allowed but only for anatomic areas for which they are qualified. General practitioners are excluded from plastic surgery.	Physicians wanting to perform cosmetic surgery in private clinics, have to be on the GMC specialist register (since 2002) or meet specific requirement. There may still be a small number GPs practising cosmetic surgery in private practice. Ongoing reform of the registration process.	Regulation for training of plastic surgeons. Title of "Plastic surgeon" is protected; "cosmetic or aesthetic surgeon" is not protected. Connexity is allowed.	Plastic surgery is acknowledged as a speciality but not required to perform plastic/aesthetic surgery.
Patients' Rights Act is applicable. No specific obligations with regard to plastic surgery.	Specific legal obligations in relation to plastic surgery: 1. Comprehensive patient information about the surgical procedure and its potential complications. 2. Detailed information about surgical fees and services (cost estimate). 3. Mandatory 15-day reflection period.	"Good medical practice in cosmetic surgery" guidance specifies physician's duties: 1. Comprehensive patient information about the surgical procedure and its potential complications. Emphasis on written patient information. 2. Information on fees. 3. 15-day reflection period. 4. Comprehensive patient assessment, including psychological profile.	Patients' Rights Act is applicable. No specific obligations with regard to plastic surgery.	

Regulations with regard to establishments				
Hospitals have to be registered as stipulated in the 1987 Hospital Act. Private clinics do not have to be registered. Possible solution brought by Article 76-quinquies of Hospital Act?	All facilities where plastic surgery is performed must adhere to specific conditions. Specific requirements relate to: organization, personnel and equipment. Authorization reviewed every 5 years	Private clinics where cosmetic surgery is performed are required to meet national minimum standard. Registration and inspection (every 5 year) is task of Healthcare Commission.	No compulsory registration for private clinics. Private clinics that are registered are also inspected. Last report 2003: safety and quality standards insufficient in private clinics.	No specific legislation in relation to plastic surgery
Regulations with regard to advertising				
Since 2005, it is forbidden to advertise for (breast) implants. In reality, several offences. European jurisprudence on advertising states that national legislations are allowed to ban advertising in the very specific context of medical professions.	All forms and methods of advertising are forbidden. However, rules are often by-passed by private clinics (with foreign-hosted websites).	Insufficient regulation of cosmetic surgery advertising. There are many complaints.	Few rules about advertising.	No specific legislation
	Use of physician's name and statements to be considered with great care.			
Quality measures for specific interventions				
Updated EU Directive on medical implants could possibly have consequences on the use of breast implants for aesthetic purposes.	Scientific association issued some clinical recommendations on quality, but not legally binding.	National Breast Implant Registry was set up in 1993; registrations concerned NHS hospitals and private clinics.	Dutch registry of implants in plastic surgery was established in 1995.	GÄCD issued some clinical guidelines on plastic surgery, but not legally binding.

6 ETHICAL SOCIETAL ASPECTS OF PLASTIC SURGERY IN BELGIUM

6.1 INTRODUCTION

Several ethical questions can be raised in relation with plastic surgery.

When the scope of medicine is broadened from the pure therapeutic to the so-called convenience medicine, this raises questions about the role of medicine.[192] Should medical skills be used to serve the image of our body, as defined by social and cultural images, or by individual, and therefore, subjective preferences? In addition, there are the discussions about the "do not harm principle" or "how much risk is too risky and for what benefit?". Other moral issues concern reconstructive as well as aesthetic interventions. What is, for example, the best moment in a person's life course (i.e. child, adolescent, adult, aged) to perform these interventions?

There are dozens of publications which discuss these issues; in papers, books, professional or political journals or the general press.

Besides questions about the deontological attitude of the physician, there is discussion about the role of the community in response to these demands. Indeed, in an economical context of limited financial resources, there is a choice to be made by the society. Priority setting in plastic surgery evokes ethical questions about the role of public health insurance; which cases and to which extent should be reimbursed by social security. Should the community pay for surgical interventions which are not purely reconstructive? On which criteria could decisions be based?

It is not the scope of this project to find an answer for specific cases i.e. specific interventions or individual cases. The objective of the roundtable is to propose a general way of decision making which can serve as a template when specific cases have to be judged.

6.2 METHODOLOGY

A limited review of the literature on 'ethics' and 'plastic surgery' and on 'social security coverage' and 'plastic surgery' was performed in Medline, Embase and Econlit to prepare a roundtable with ethicists and to discuss results. Google search and hand searching completed the research.

Six ethicists and two plastic surgeons were invited to participate in a roundtable on ethical issues in plastic surgery and, more precisely, on how the society can decide on which plastic surgery should be reimbursed.

The objectives of the roundtable were:

- To propose generic criteria to be used by the decision-makers to assess if an intervention of plastic surgery should be reimbursed or not by the social security.
  - Which general principles could be used in the decisional process? Not only to review the current list of interventions already reimbursed, but also to assess new interventions in the future.
  - Are there more explicit criteria on, for example age, or type of interventions that could lead to decide that the intervention should be reimbursed?
- To propose a decision making process.
  - At which point in time should decisions on reimbursement be made? Which ethical principles are engaged if the decision is taken a priori i.e. prior to the intervention? What if this decision is taken posterior to the intervention? Who should assume the financial risk in the latter case?

    - Should the decision be taken ad hoc or do we need a list of interventions to refer to? Which ethical problems can emerge if the system is strict or flexible?
    - If an individual assessment is deemed necessary, who should perform it?
    - Should an appeal be made possible?
- To address the issue of complications related to aesthetic surgery :
    - Should surgical procedures and medical costs that result from cosmetic surgery (e.g. complications, removal of ruptured prosthesis) be reimbursed?

Participants in the roundtable received the general questions in advance, as well as a brief description of some borderline cases of breast surgery. The following conditions were labelled as borderline because of a lack of clear criteria for reimbursement; breast hypotrophy or total failure of breast development, breast hypertrophy, breast asymmetry and tubular breasts.

During the meeting, after a brief reminder of the objectives of the report and of the roundtable, a plastic surgeon commented on the breast surgery cases and showed further 'borderline' examples eligible for reimbursement i.e. surgery on sagging eyelids (blepharoplasty), surgery to reshape the nose (rhinoplasty) and abdominoplasty.

Finally, the results of the limited literature search were summarized in a discussion text which offers supplementary information on how other ethicists think about the societal aspects of plastic surgery. Since this discussion is not based on a systematic review of the literature (and therefore inexhaustive) and does not represent the opinion of the ethicists present at the roundtable, it was decided to add the discussion text as Appendix 17.

6.3 RESULTS

Five experts have finally taken part in the roundtable i.e. one ethicist, one plastic surgeon, one philosopher, one moral scientist and one sociologist.

6.3.1 General principles and framework to delimitate the reimbursement of plastic surgery by social security

The experts proposed several general principles to be taken into account when a decision has to be made on the reimbursement of plastic surgery.

In Belgium, nowadays, plastic surgery falls within the **general framework of medical necessity** which implies that the question is raised whether the intervention is medically justified. The main, medical criteria to justify an intervention are the presence of a functional impairment or medical problem related to an underlying condition (e.g. eczema under large breasts). Nevertheless, for several interventions, these **criteria are questionable**:

- The criteria are difficult to measure i.e. there are no objective measures that can be used to classify a problem in a medically necessary or unnecessary category.
- The criteria are not applied to all plastic interventions. Blepharoplasty (eyelid surgery), for example, is always reimbursed, even when there is no impairment of the visual field. The same accounts for the correction of prominent ears that is always covered by social security, although this is absolutely not a matter of functional impairment or medical complications.
- There is a problem of sex discrimination; breast enlargement for women with total failure of breast development is not covered, while transsexual men undergoing gender-conversion have their breast implant reimbursed.
- The lack of transparency and objective criteria creates legal insecurity for the plastic surgeons. For some procedures, e.g. abdominoplasty, they are given the responsibility to decide on the eligibility for reimbursement,

while this decision can always be put in question by a NIHDI inspector, posterior to the intervention. We will discuss this aspect in the next section.

In relation with this framework of medical necessity, the plastic surgeon proposes to **create a clear distinction between reconstructive and aesthetic surgery**. The proposal is to define reconstructive surgery as those interventions that aim at repairing a malformation or an anomaly. Conversely, aesthetic surgery will be defined as the interventions that aim to correct a deformity i.e. a variation of the normal appearance. Reconstructive surgery will give rise to a reimbursement by social security while aesthetic surgery will not. The question of the boundary between aesthetic and reconstructive remains, though, because of the absence of clear and objective rules.

One expert proposes to completely change the way of thinking and to **abandon the classic 'medical necessity' framework** in which medicine is about repairing dysfunctions. He refers to other medical interventions that do not seem to belong in this framework although they improve human health as it is defined by the WHO (i.e. physical, psychological and social well-being). Assisted reproduction is an example of an intervention that is often not about repairing a medical problem, but about helping two people fulfilling their desire to have children. Aesthetic surgery belongs to the same category of interventions that lack a medical necessity, but that can improve human well-being.

The proposition is therefore made to give up the medical paradigm and to examine interventions and their possible reimbursement in the light of the **impact of the intervention on the quality of life** (QoL) of the patient. This QoI could be **translated in QALYs** (Quality Adjusted Life Year) and would consider functional as well as psychological gain for the patient. Consequently, the decision about reimbursement would depend on the cost-effectiveness of the treatment: the most cost-efficient plastic surgery interventions would be reimbursed, regardless of their nature i.e. aesthetic or reconstructive. Empirical studies (i.e. evidence based) will be needed to assess which interventions are cost-effective and serve as a reference for other kinds of surgery. The principle of cost-effectiveness could even be expanded to all decisions about health care budgets.

But, as the others point out, this way of thinking is certainly **not neutral**, and can raise several questions:

- Is the social security system likely to completely change his paradigm that is used to evaluate the opportunity of an intervention?
- What if appears that a purely aesthetic intervention significantly improves the QoL? Will the society be willing to reimburse this intervention?
- Is the society likely to accept the fact that decisions about health care budgets will be taken on the basis of QoL and economical factors?
- How will QoL be measured? Is there information on the impact on the QoL for every intervention? More research will be needed.
- QoL is culturally linked and will probably evolve rapidly in time. The criteria would have to be closely monitored.
- What if all interventions show a significant impact on the QoL? In this case, the questions on how to decide which interventions should be reimbursed will not be solved.

The ethicists also mention the role of society in its attitude towards aesthetic surgery. It is the society that determines how the human body should look and how much this **body image** is worth. When the discussion is about suffering from aesthetic deformities, it is really difficult to determine criteria. The financing of cosmetic surgery with public funds is a reflection of the question about what the society wants.

6.3.2 Process of decision making

The current conditions for reimbursement of plastic surgery in Belgium are described in Chapter 3 (see page 16). In summary, there are four possible situations:

- Some interventions, reconstructive of nature, are always reimbursed. Disfigurements following trauma or cancer, for example, are always covered by social security and do not need a prior authorization from the sickness fund. Surprisingly, the same applies to the correction of prominent ears.
- Purely aesthetic interventions like face lifting and lipo-aspiration, on the other hand, are never reimbursed.
- For other interventions, for example abdominoplasty, it is up to the surgeon to assess whether the sickness fund (i.e. social security) will pay for the intervention. The criteria on which the surgeon has to rely his decision are vague, e.g. functional impairment, medical troubles. There is always a risk that the physician is checked on after the intervention (a posteriori) by the National Institute for Health and Disability Insurance (NIHDI). When the latter considers that the interventions should not have been covered by social security, the physician or the hospital have to pay back the costs.
- Finally, there are interventions, such as breast reduction, for which the patient needs a prior approval by the sickness fund. In theory, the patient should be examined by the medical advisor of the sickness fund, but this is not always the case because of these physicians' high workload.

According to the ethical experts, the **decision about the reimbursement of an intervention has to be made prior to the intervention** and should not be the responsibility of the surgeon only. Currently, the surgeons' therapeutic freedom risks to be curtailed by the fact that they have to take considerable financial risks. Due to the fact that there can be doubts about the coverage of an intervention, surgeons will probably sometimes decide not to proceed with an intervention because they do not want to take this financial risk. Nevertheless, the obligation for the patient to be examined by a medical advisor should be limited because it is not comfortable for the patient and it could damage the confidence-based relationship between the physician and the patient.

The **information of the patient remains important**. The physician has the responsibility to inform the patient about all aspects of the intervention i.e. consequences, risks, results that could be expected, cost, etc. Patients also have to be prepared to a possible imperfect result.

To limit the cases where the patient should be seen by the medical advisor, it is **necessary that the NIHDI elaborates clear criteria** to delimit as much as possible the 'grey area' that encompasses cases of which the eligibility for reimbursement is unclear.

The surgeon proposes to set up a **joint committee** with surgeons and payers (medical advisors of the sickness funds and representatives of NIHDI). This committee would meet four times a year to decide on specific cases for which the decision on reimbursement is still unclear. Members could decide whether the intervention will be reimbursed. The possibility of a special nomenclature code for the reimbursement of very specific cases could be considered.

Even a **psychological assessment seems not appropriate** because such evaluation would once again be arbitrary because the decision would be made by a single person without objective criteria.

The ethicists insist that **representatives of the society** have to participate in the decision making process. It should not only be physicians and representatives of the social security deciding on the criteria. Particularly, since these criteria are closely linked to the society.

Seeing that plastic surgery is predominantly performed on women, it is necessary to involve sufficient women in this participation process. The problem is raised that these civil participants will perhaps be difficult to identify. Patients who had plastic surgery are probably not very likely to come forward or to organise themselves in patient groups.

In addition, the discussion will turn around a whole discipline in stead of one specific disease, or intervention. Representatives could perhaps be issued from an organisation of healthcare users or from parliament.

Finally, patients should have the possibility to make an **appeal** on the decision of the sickness fund.

6.3.3 Covering complications related to aesthetic surgery

In today's context, every immediate complication of aesthetic surgery is taken in charge by the social insurance without any written rules in this domain. In addition, there is no rule for possible long-term complications except for the removal of breast prosthesis.

Ethicists remind that, in Belgium, everybody who is in need should receive health care and that social security should cover the costs. This right is not dependent on the person's risk profile; reckless drivers, those who love dangerous sports, tobacco or alcohol are all entitled to health care. The same **principle of solidarity has to remain for those suffering complications of aesthetic surgery**.

Key Points

Ethical societal aspects of plastic surgery in Belgium

- **The current framework of reflection on the appropriateness of a plastic surgery intervention is its 'medical necessity'; the presence of a medical problem or functional impairment seems to justify the reimbursement of a plastic surgery procedure by the statutory health insurance.**
- **For several interventions, however, the current distinction between aesthetic and reconstructive surgery is not clear-cut; criteria are not objectively measurable and are not applied in the same way to all plastic interventions. The fact that breast enlargement for women with total failure of breast development is not covered, while transsexual men undergoing gender-conversion have their breast implant reimbursed, uncovers a problem of sex discrimination in the Belgian reimbursement criteria that should be solved.**
- **It is proposed to give up the medical paradigm and to found decisions about coverage of plastic surgery on the impact the intervention has on the quality of life of the patient. This way, functional as well as psychological gain for the patient would be taken into consideration and only the most cost-efficient plastic surgery interventions would be reimbursed. The principle of cost-effectiveness could even be expanded to all decisions about health care budgets.**
- **The decision about the reimbursement of an intervention has to be made prior to the operation. There should be clear-cut criteria on the eligibility for reimbursement. A joint committee could possibly decide on undecided cases. Community representatives should participate in this committee.**
- **The sharing of information with the patient on the expected result of the procedure and possible risks is important.**
- **A psychological assessment of the need of the patient is considered not appropriate.**
- **Every complication that is health-endangering should be covered by the compulsory health insurance including those resulting from aesthetic surgery.**

7 CONCLUSIONS

The conclusions are clustered around the four research questions and are based on the described findings and results for Belgium, France, United Kingdom, the Netherlands and Germany.

7.1 RESEARCH QUESTION 1: CRITERIA FOR COVERAGE OF PLASTIC SURGERY BY THE STATUTORY HEALTH INSURANCE

The rationale behind criteria for coverage of plastic surgery differs among countries.

- In Belgium, France and the Netherlands, the framework of reflection on the appropriateness of a plastic surgery intervention is based on its medical necessity. This implies that reconstructive procedures, i.e. those that aim at treating a medical problem or a functional impairment, are considered appropriate for reimbursement, while purely aesthetic procedures are not.
- In the UK, on the other hand, the rationale behind criteria for the treatment of low-priority cosmetic surgery within the NHS was based on available evidence of effectiveness and outcome for procedures, developed by a multi-professional expert group. When robust evidence was unavailable, criteria were defined by consensus.
- In Germany, the Law explicitly specifies that sickness funds can only reimburse health care services which are adequate, expedient and cost-effective. Since aesthetic procedures are mostly unnecessary and inefficient, they are not reimbursed.

The general rule is that reconstructive surgery is covered by statutory health insurance while aesthetic surgery is not.

- Reconstructive plastic surgery is related to the restoration of appearance and function following congenital deformity, accidents, burns or cancer. Aesthetic or cosmetic plastic surgery, on the other hand, aims at correcting an inharmonious but normal shape of the body, without any clinical necessity being present and is performed at the patient's request.

Nevertheless, the criteria for coverage are not always clear-cut in relation to the distinction between reconstructive and aesthetic surgery.

- Many countries struggle with so-called borderline interventions that balance on the thin line between reconstructive and aesthetic surgery. As soon as the aesthetic improvement tends to become as, or, more important than the resolution of the medical problem, the discussion arises whether an intervention is still eligible for reimbursement.
- In Belgium, tens of thousands of borderline interventions are yearly reimbursed by the statutory health insurance. These relate to corrections of ears, noses or eyelids that are covered without any condition for reimbursement whatsoever, but also breast reductions and abdominoplasties that are only reimbursed in case of functional impairment. The problem is, however, that this criterion is not clarified, which makes it the physician's responsibility to assess whether the functional discomfort is severe enough for the intervention to be covered.
- Even in France, there are still two exceptions to the general rule that says that aesthetic surgery is not covered. As it happens, a limited number of aesthetic procedures can be covered when there is proof of a health risk or social harm.
- In the UK, the NHS issued national guidelines for primary care trusts (PCTs) in relation to conditions that are considered of low priority. Although these guidelines mostly advise on explicit i.e. medical criteria for

treatment, they also mention so-called exceptional circumstances that may allow a treatment for cosmetic surgery: high individual gain; avoidance of social care; alleviation of severe psychosocial dysfunction.

- In Germany, plastic surgeons drew up an unofficial experience-based list of aesthetic procedures that have been reimbursed in the past by the statutory health insurance.

The lack of clear criteria for reimbursement can cause uncertainty and/or inequity for patients and physicians.

- Because of a lack of clear, national guidelines on functional discomfort, there are differences between Belgian sickness funds in the way their medical advisors decide on the eligibility for reimbursement. But, even if prior approval by the sickness fund is not necessary, inequity can still be a problem for patients who then become submitted to the judgment of the surgeon.
- On the other hand, when it is the surgeon's responsibility to decide on eligibility for coverage, he always faces the risk of verification by the Belgian National Institute for Health and Disability Insurance (NIHDI) posterior to the intervention. When the inspector concludes that the functional discomfort was not severe enough, the physician or the hospital will have to pay back all costs that were reimbursed.
- In the UK, there is a problem of inequity in provision of low-priority plastic surgery. Due to limited resources, some PCTs do not follow the national guidelines and ration the delivery of these services.

Countries that did manage to have clear-cut criteria for reimbursement of plastic surgery should serve as an example.

- In France, the delimitation of reimbursement is based on five possible conditions that have to be respected by the surgeon: indication, invoicing, training, environment and data collection.
- In a way, one could consider the criteria to be clear-cut in the UK. Due to their limited resources, some PCTs drew up a list of interventions not normally funded. Apart from the aforementioned problem of inequity in provision, such a list is probably quite clear-cut for the patient and for the physician.
- The Dutch Health Insurance Act gives a clear description of conditions and procedures that are eligible, or not, for reimbursement by the standard health insurance package. This list was translated in three lists of diagnosis treatment combinations (DBC): green DBCs with unlimited reimbursement; orange DBCs with conditional reimbursement; and red DBCs that are not covered.

The French example also taught us that a thorough inspection of the reimbursement criteria can have a huge impact.

- In 2006, the French National Health Insurance Fund (CNAMTS) launched a nationwide inspection on all plastic surgery procedures that required prior approval and that were performed by both plastic surgeons as other specialists. After one year, the impact of the inspection was estimated at a saving of €11 million, which was 43% of the predicted insurance costs for plastic surgery related to prior approval requests. Majority of these savings were made by refusing prior approval requests, but there were also fewer requests due to the deterrent effect of the inspection.
- The success of the inspection was made possible by means of an elaborate training programme for the CNAMTS inspectors. The programme consisted of training sessions and a CD-ROM, and was the result of a fruitful collaboration between the CNAMTS and the scientific association of plastic surgeons, which lead to the elaboration of clear-cut definitions of reconstructive and aesthetic procedures and their reimbursement rules. This partnership seemed essential to ensure the acceptability of the

inspection, but it also enabled the definition of common rules for all stakeholders.

Medical costs related to complications caused by primarily aesthetic operations are not always reimbursed.

- In Belgium, there is an invoice code for the removal of breast prosthesis in case of complications. In the Netherlands, however, removal of a breast implant that was initially carried out for aesthetic reasons is not reimbursed. France seems to have no specific rules on this aspect. The absence of (other) rules implies that complications of aesthetic surgery are covered in these countries.
- In the UK, on the other hand, the NHS does not permit the revision of treatments originally performed outside the national system. In Germany, a law was implemented in 2007 that forbids the coverage of medical complications in relation to aesthetic surgery.

7.2 RESEARCH QUESTION 2: VOLUME OF PLASTIC SURGERY

Due to a lack of data, it is very difficult to compare countries in terms of their volume of plastic surgery.

- A major problem faced in the study of the volume of plastic surgery, is the lack of data on procedures performed in private clinics. This makes it difficult to assess the true magnitude of plastic surgery in the studied countries and of possible quality problems in these establishments. The only statistics available are those on interventions reimbursed by the statutory health insurance. Since reimbursement is mostly limited to reconstructive procedures, it is likely that these data represent only the tip of the iceberg.
- But even the statistics on reimbursed plastic surgery are not really apt to compare countries because of differences in the definition of plastic surgery, the criteria for reimbursement and the level of detail of the data.
- Only a comparison in terms of percentage of hospital admissions that were related to reimbursed plastic surgery seems admissible. In France, plastic surgery accounted for 4.5% of all reimbursed admissions in acute hospitals, in 2006. In the UK, this was only 1.7% which seems to confirm the NHS's focus on high-priority plastic surgery. The Netherlands were somewhere in between with 2.3%. For Belgium and Germany, there were no data on the number of hospital admissions related to plastic surgery.

The volume of plastic surgery in Belgium could be analysed in more detail with the help of claims data from the NIHDI.

- It is clearly mentioned in the report that these claims data have several shortcomings. The selection of procedures related to plastic surgery, on the other hand, was based on expert opinion and can possibly be subject to criticism. The same accounts for the decision to label certain procedures as being borderline plastic surgery.
- In 1995, Belgian public health insurance reimbursed 78 000 plastic surgery interventions with an insurance cost of €10.1 million. In 2006, there were 110 000 interventions which were financed with €21.1 million. This implies that plastic surgery grew with 41% in number and 108% in insurance cost, in eleven years time. Compared to the evolution of the total expenditures for health care by statutory health insurance (i.e. 62% increase in same period), it seems that the insurance costs for plastic surgery increased relatively more.
- The most frequent procedures were those on skin and soft tissues which accounted for 35 800 interventions, in 2006. Procedures on eyelid and eyebrow came second with 26 600, and nose procedures were third with 25 500 interventions, in 2006. The same year, there were 12 400 plastic

surgery interventions on the breast, 6 000 on the abdomen, 3 500 on the ear and, finally, 340 repairs of cleft lip and/or palate.

- In 1995, only one out of three plastic surgery procedures was performed by a plastic surgeon. This increased to 41% in 2006. The number of plastic surgeons that invoiced procedures to the National Institute for Health and Disability Insurance increased from 139 plastic surgeons in 1995, to two hundred in 2006.
- There is a marked regional variation in the consumption of reimbursed plastic surgery in Belgium; northern provinces seem to have a higher insurance cost for plastic surgery per 100 000 residents. This regional pattern, however, varies across different procedures.
- A sub analysis was done of so-called borderline plastic surgery procedures that supposedly balance on the thin line between reconstructive and aesthetic surgery i.e. certain procedures for breast malformation, nose pyramid correction, ear correction, eyelid surgery and abdominoplasty.
- In 2006, the NIHDI had reimbursed 32 000 borderline interventions which represented 29% of the abovementioned 110 000 reimbursed plastic surgery procedures, and 33% of the total insurance cost of the latter. Borderline surgery doubled in number between 1995 and 2006 and showed a threefold increase in insurance cost, which was substantially more than the remaining plastic surgery procedures. Plastic surgeons were relatively more implicated in borderline surgery of which they performed 57% in 2006.

7.3 RESEARCH QUESTION 3: LEGAL ASPECTS OF PLASTIC SURGERY

While many countries struggle with this, only the UK and France issued a legal definition of aesthetic surgery.

- In the UK, cosmetic surgery was defined as procedures that revise or change bodily features which most would consider otherwise being within the broad range of normal.
- In 2005, France issued a legal definition of aesthetic surgery: surgical acts performed with a view to changing a person's physical aspect, on his/her request and without any reconstructive or therapeutic purposes.
- The French Law even defined the most frequently performed aesthetic surgery interventions, although this list is not legally opposable.

In France, they tried to assure the surgeon's competence by defining specific training requirements for different plastic surgery procedures.

- Although every country has training requirements for plastic surgeons, plastic surgery, as such, is not exclusively reserved for the registered plastic surgeons but is also performed by other specialists, sometimes even general practitioners.
- A French Law limited this so-called connexity in 2005. Registered plastic surgeons were entitled to perform all plastic surgery. Other specialists, on the other hand, were only permitted to perform plastic surgery in the anatomic areas in which they were qualified. An Ear Nose Throat specialist, for example, would only be permitted to perform plastic surgery in the face and the neck. General practitioners were excluded from plastic surgery.
- In addition, the French drew up a list of aesthetic surgery that could only be performed by the abovementioned surgeons.

Another way of protecting patients against malpractices is by clearly defining which patients' rights must be respected in relation to plastic surgery, as is done in France and the UK.

- Physicians have the legal (France) or deontological (England) obligation to inform their patients, verbally and in writing, on the procedure and its possible risks and on the fees and charges. French surgeons are obliged to provide patients with a detailed cost estimate for aesthetic procedures. Both countries foresee a reflection period of 15 days. In the UK, physicians are urged to provide a number of post-operative consultations.
- In other countries, general patients' rights such as the right to information and the right to informed consent are applicable, without any specific obligations in relation to plastic surgery.

In addition, France and the UK issued detailed regulations for the facilities where plastic surgery is performed, in an attempt to further rationalize the delivery of plastic surgery.

- In many countries, private clinics for plastic surgery boomed in a non- or poorly regulated environment. Due to this, there were problems of lack of reliable statistics, of patients that were insufficiently followed-up after surgery and of quality issues. For all these reasons, some countries drew up minimum legal requirements for the private sector in an attempt to rationalize the delivery of care in these establishments.
- Since 2005, all French facilities where plastic surgery is performed must adhere to specific quality conditions that relate to the organization of the facility, its personnel and the equipment. In the UK, private clinics performing aesthetic surgery have to register with the Healthcare Commission and are required to meet national minimum standards. In both countries, authorization is reviewed every 5 years.
- In the Netherlands, registration is not compulsory for private clinics. The latest inspection report of those clinics that were registered, spoke of insufficient safety and quality.
- In Belgium, private clinics do not have to be registered and physicians do not need permission to start a private clinic. Private practices do not have to be registered either.

Some countries made attempts to regulate advertising about plastic surgery, but without much success.

- France issued a Law that banned all forms and methods of publicity and advertising, but private clinics often by-pass this law with the use of foreign-hosted Web sites.
- Belgium issued a law that forbids advertising about implants, but, in practice, there are many offences.

Finally, there were some quality initiatives in relation to medical devices.

- The UK and the Netherlands set up a national registry for (breast) implants in an attempt to provide information about the amount of procedures, to control the quality of implants, and to identify patients in case of medical complications.

7.4 RESEARCH QUESTION 4: ETHICAL SOCIETAL ASPECTS OF PLASTIC SURGERY

A roundtable discussion with Belgian ethical experts brought some new, but controversial insights in the criteria to assess whether a plastic surgery intervention should be reimbursed.

- The fact that breast enlargement for women with total failure of breast development is not covered, while transsexual men undergoing gender-conversion have their breast implant reimbursed, uncovers a problem of sex discrimination in the Belgian reimbursement criteria that should be solved.
- The aptness of the currently used medical necessity criterion in decisions about coverage of plastic surgery was questioned. A possible alternative could be to take into consideration the patient's quality of life, which would include functional as well as psychological gain. Only the most cost-efficient plastic surgery interventions would be reimbursed. At the same time, this reasoning raised questions about its societal acceptability and affordability.
- The decision about the reimbursement of an intervention has to be made prior to the operation. There should be clear-cut criteria on the eligibility for reimbursement. A joint committee could possibly decide on undecided cases. Community representatives should participate in this committee.

8 APPENDICES

APPENDICES ON METHODOLOGY

APPENDIX 1 SEARCH STRATEGY TABLES IN ELECTRONIC BIBLIOGRAPHIC DATABASES

Project number	2007-25_EPB
Project name	Plastic Surgery
Project part	Literature search on criteria for coverage of plastic surgery by social security
Author (of the search strategy)	Kristel De Gauquier
Methods	According to the KCE Process notes Health Services Research (HSR).[4]

Date	18/01/2008
Database	**Medline** OVID version
Years covered	No time limit
Search Strategy	

#	Search History	Results
1	exp Surgery, Plastic/	20222
2	exp Reconstructive Surgical Procedures/	30518
3	cosmetic surgery.mp.	842
4	1 or 2 or 3	49688
5	exp Unnecessary Procedures/	1477
6	exp Health Care Rationing/	8673
7	exp Legislation, Medical/	14833
8	exp Patient Selection/	29182
9	exp Government Regulation/	12335
10	exp Insurance Coverage/	5917
11	exp Insurance, Health, Reimbursement/	29048
12	exp Health Services Accessibility/	56365
13	5 or 6 or 7 or 8 or 9 or 10 or 11 or 12	141595
14	4 and 13	630
15	limit 14 to humans	617
16	exp france/ or exp germany/ or exp great britain/ or exp netherlands/ or exp belgium/	413440
17	15 and 16	70

Language restrictions	none

Date	18/01/2008
Database	**Embase** via Embase.com
Years covered	No time limit
Search Strategy	*No. Query Results* *Results* #1. 'plastic surgery'/exp 135,823 #2. 'aesthetic surgery'/exp 7,314 #3. 'cosmetic'/exp OR 'cosmetic' 38,687 #4. #1 OR #2 OR #3 167,179 #5. 'unnecessary procedure'/exp 905 #6. 'national health insurance'/exp 3,959 #7. 'national health service'/exp 39,443 #8. 'medico legal aspect'/exp 53,195 #9. 'social security'/exp 7,023 #10. 'patient selection'/exp 43,037 #11. 'government regulation'/exp 11,903 #12. 'public health insurance'/exp 535 #13. 'reimbursement'/exp 21,461 #14. #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 177,017 #15. #4 AND #14 3,289 #16. 'human'/exp 10,651,539 #17. #15 AND #16 2,998 #18. 'france'/exp OR 'united kingdom'/exp OR 'netherlands'/exp OR 'belgium'/exp OR 'germany'/exp 426,584 #19. #17 AND #18 103
Language restrictions	none

Date	18/01/2008
Database	**Centre for Reviews and Dissemination databases, University of York (CRD):** **DARE (Database of Abstracts of Reviews of Effects)** **NHS EED (NHS Economic Evaluation Database)** **HTA database**
Years covered	No time limit
Search Strategy	

	Search	Records
# 1	MeSH Surgery, Plastic EXPLODE 1	14
# 2	MeSH Reconstructive Surgical Procedures EXPLODE 1	102
# 3	cosmetic	72
# 4	#1 or #2 or #3	171
# 5	MeSH Unnecessary Procedures EXPLODE 1 2	34
# 6	MeSH Health Care Rationing EXPLODE 1 2 3	263
# 7	MeSH Legislation, Medical EXPLODE 1	5
# 8	MeSH Patient Selection EXPLODE 1 2	282
# 9	MeSH Government Regulation EXPLODE 1 2	5
# 10	MeSH Insurance Coverage EXPLODE 1	104
# 11	MeSH Insurance, Health, Reimbursement EXPLODE 1 2	410
# 12	MeSH Health Services Accessibility EXPLODE 1 2	543
# 13	#5 or #6 or #7 or #8 or #9 or #10 or #11 or #12	1318

	# 14 #4 and #13	7
	# 15 MeSH France EXPLODE 1	351
	# 16 MeSH Germany EXPLODE 1 2	479
	# 17 MeSH Great Britain EXPLODE 1	1689
	# 18 MeSH Netherlands EXPLODE 1	335
	# 19 MeSH Belgium EXPLODE 1	93
	# 20 #15 or #16 or #17 or #18 or #19	2865
	# 21 #14 and #20	0
Language restrictions	none	

Date	18/01/2008
Database	**Econlit** OVID version
Years covered	No time limit

Search Strategy

#	Search History	Results
1	plastic surgery.mp. [mp=title, original title, abstract, name of substance word, subject heading word]	2
2	reconstructive surgery.mp. [mp=title, original title, abstract, name of substance word, subject heading word]	0
3	cosmetic surgery.mp. [mp=title, original title, abstract, name of substance word, subject heading word]	1
4	1 or 3	3
5	unnecessary procedures.mp. [mp=title, original title, abstract, name of substance word, subject heading word]	0
6	health care rationing.mp. [mp=title, original title, abstract, name of substance word, subject heading word]	13
7	legislation.mp. [mp=title, original title, abstract, name of substance word, subject heading word]	4113
8	patient selection.mp. [mp=title, original title, abstract, name of substance word, subject heading word]	13
9	government regulation.mp. [mp=title, original title, abstract, name of substance word, subject heading word]	327
10	insurance coverage.mp. [mp=title, original title, abstract, name of substance word, subject heading word]	548
11	reimbursement.mp. [mp=title, original title, abstract, name of substance word, subject heading word]	495
12	accessibility.mp. [mp=title, original title, abstract, name of substance word, subject heading word]	735
13	6 or 7 or 8 or 9 or 10 or 11 or 12	6194
14	4 and 13	0
15	exp france/ or exp germany/ or exp great britain/ or exp netherlands/ or exp belgium/	0
16	14 and 15	0

Language restrictions	none

Merging the studies from Embase and Medline showed 26 duplicates and resulted finally in 147 articles.

APPENDIX 2 SEARCH STRATEGY TABLES FOR SPECIFIC WEB SITES

General Web sites

Date	03/12/2007
Name of resource	**European Observatory on Health Systems and Policies, HiT country profiles on France, Germany, United Kingdom and the Netherlands**
Publisher of resource	WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies
Web address	Home page: http://www.euro.who.int/observatory/Hits/TopPage France: http://www.euro.who.int/document/e83126.pdf Germany: http://www.euro.who.int/Document/E85472.pdf United Kingdom: http://www.euro.who.int/document/e68283.pdf Netherlands: http://www.euro.who.int/Document/E84949.pdf

Date	03/12/2007
Name of resource	***Health*BASKET, Phase 1, Individual Country analyses – Benefit reports on France, Germany, England and the Netherlands**
Publisher of resource	Health Benefits and Service Costs in Europe is a project funded by the European Commission and directed by the European Health Management Association (EHMA).
Web address	Home page: http://www.ehma.org/projects/default.asp?NCID=112 France: http://www.ehma.org/_fileupload/File/Projects/Benefit_Report_France.pdf Germany: http://www.ehma.org/_fileupload/File/Projects/Benefit_Report_Germany.pdf England: http://www.ehma.org/_fileupload/File/Projects/Benefit_Report_United_Kingdom.pdf Netherlands: http://www.ehma.org/_fileupload/File/Projects/Benefit_Report_Netherlands.pdf Synthesis report: http://www.ehma.org/_fileupload/File/Projects/HealthBASKET-SYN-REP-051025EDIT_2.pdf

Date	03/12/2007
Name of resource	**OECD Health**
Publisher of resource	OECD (Organisation for Economic Co-operation and Development)
Web address	Home page: www.oecd.org/health OECD Health data 2007: http://www.oecd.org/document/16/0,3343,en_2649_37407_2085200_1_1_1_37407,00.html
Data	OECD Health Data 2007 - Frequently Requested Data

Web sites related to Belgium

Date	19/02/2008
Name of resource	**De Belgische Kamer van volksvertegenwoordigers**
Publisher of resource	De Belgische Kamer van volksvertegenwoordigers
Web address	http://www.dekamer.be

Date	19/02/2008
Name of resource	**De Belgische Senaat**
Publisher of resource	De Belgische Senaat
Web address	http://www.senaat.be

Date	19/02/2008
Name of resource	**Koninklijke Belgische Vereniging voor Plastische, Reconctructieve en Esthetische chirurgie**
Publisher of resource	Koninklijke Belgische Vereniging voor Plastische, Reconctructieve en Esthetische chirurgie
Web address	http://www.bspras.org

Date	19/02/2008
Name of resource	**Société Belge de Médecine Esthétique**
Publisher of resource	Société Belge de Médecine Esthétique
Web address	http://www.sbme.eu

Date	19/02/2008
Name of resource	**Femmes Prévoyantes Socialistes**
Publisher of resource	Femmes Prévoyantes Socialistes
Web address	http://www.femmesprevoyantes.be

Date	19/02/2008
Name of resource	**Mouvement Réformateur (MR)**
Publisher of resource	Mouvement Réformateur (MR)
Web address	http://www.mr.be/

Date	04/12/2007
Name of resource	**Orde van Geneesheren**
Publisher of resource	Orde van Geneesheren
Web address	http://www.ordomedic.be/

Date	19/02/2008
Name of resource	**American Academy of Aesthetic Medicine (AAAM)**
Publisher of resource	American Academy of Aesthetic Medicine (AAAM)
Web address	http://www.aaamed.org

Web sites related to France

Date	04/12/2007
Name of resource	**L'assurance maladie en ligne**
Publisher of resource	La Caisse nationale de l'Assurance Maladie des travailleurs salariés (CNAMTS)
Web address	http://www.ameli.fr/

Date	04/12/2007
Name of resource	**Le ministère de la santé, de la jeunesse et des sports**
Publisher of resource	Le ministère de la santé, de la jeunesse et des sports
Web address	Home page: http://www.sante.gouv.fr/ Tarification à l'activité: http://www.sante.gouv.fr/htm/dossiers/t2a/accueil.htm

Date	04/12/2007
Name of resource	**la Haute Autorité de Santé**
Publisher of resource	la Haute Autorité de Santé
Web address	http://www.has-sante.fr

Date	04/12/2007
Name of resource	**Syndicat National de Chirurgie Plastique Reconstructive et Esthétique**
Publisher of resource	Syndicat National de Chirurgie Plastique Reconstructive et Esthétique
Web address	http://www.esthetique-chirurgie.org/

Date	04/12/2007
Name of resource	**Portail de la Chirurgie Plastique Reconstructive et Esthétique**
Publisher of resource	Société française de chirurgie plastique recontructice et esthétique (SOFCPRE)
Web address	http://www.plasticiens.org/

Date	04/12/2007
Name of resource	**Société française des chirurgiens esthétiques plasticiens**
Publisher of resource	Société française des chirurgiens esthétiques plasticiens (SOFCEP)
Web address	http://www.sofcep.info/accueil.asp

Date	05/12/2007
Name of resource	**l'Agence Technique de l'Information sur l'Hospitalisation**
Publisher of resource	l'Agence Technique de l'Information sur l'Hospitalisation
Web address	Home page: http://www.atih.sante.fr/ CCAM version 10 (12/09/2007) : http://www.atih.sante.fr/?id=0003100027FF

Date	07/12/2007
Name of resource	**Code de la sécurité sociale**
Publisher of resource	L'Union des caisses nationales de sécurité sociale
Web address	http://www.ucanss.fr/services/textes_documents/code_ss/html/pages/interface.html

Date	28/01/2008
Name of resource	**Classification Commune des Actes Médicaux**
Publisher of resource	L'Agence Technique de l'Information sur l'Hospitalisation
Web address	http://www.ccam.sante.fr/

Date	28/01/2008
Name of resource	**Conseil National de l'Ordre des Médecins (CNOM)**
Publisher of resource	Le Conseil National de l'Ordre des Médecins (CNOM)
Web address	http://www.conseil-national.medecin.fr

Date	28/01/2008
Name of resource	**Légifrance**
Publisher of resource	Le Secrétariat général du Gouvernement
Web address	http://www.legifrance.gouv.fr/

Web sites related to the United Kingdom

Date	10/12/2007
Name of resource	**The House of Commons and the House of Lords**
Publisher of resource	The House of Commons and the House of Lords
Web address	http://www.publications.parliament.uk/

Date	11/12/2007
Name of resource	**Socialist Health Association**
Publisher of resource	Socialist Health Association
Web address	http://www.sochealth.co.uk/law/nhsact1977.htm

Date	12/12/2007
Name of resource	**National Institute for Clinical Excellence (NICE)**
Publisher of resource	National Institute for Clinical Excellence (NICE)
Web address	http://www.nice.org.uk/

Date	12/12/2007
Name of resource	**Department of Health**
Publisher of resource	Department of Health
Web address	http://www.dh.gov.uk/en/index.htm

Date	12/12/2007
Name of resource	**NHS Choices**
Publisher of resource	Department of Health
Web address	http://www.nhs.uk/Pages/homepage.aspx

Date	12/12/2007
Name of resource	**Healthcare Commission**
Publisher of resource	Healthcare Commission
Web address	http://www.healthcarecommission.org.uk

Date	13/12/2007
Name of resource	**The British Association of Plastic, Reconstructive and Aesthetic Surgeons**
Publisher of resource	The British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS)
Web address	http://www.bapras.org.uk/

Date	22/01/2008
Name of resource	**The British Association of Aesthetic Plastic Surgeons**
Publisher of resource	The British Association of Aesthetic Plastic Surgeons (BAAPS)
Web address	http://www.baaps.org.uk/

Date	13/12/2007
Name of resource	**Gloucestershire Hospitals NHS Foundation Trust**
Publisher of resource	Gloucestershire Hospitals NHS Foundation Trust
Web address	http://www.gloshospitals.nhs.uk/

Date	13/12/2007
Name of resource	**North Somerset Primary Care Trust**
Publisher of resource	North Somerset Primary Care Trust
Web address	http://www.northsomerset.nhs.uk/

Date	23/01/2008
Name of resource	**HESonline (Hospital Episode Statistics online)**
Publisher of resource	The NHS Information Centre for health and social care
Web address	http://www.hesonline.nhs.uk

Date	24/01/2008
Name of resource	**BUPA**
Publisher of resource	The British United Provident Association - BUPA
Web address	http://www.bupa.co.uk/

Date	24/01/2008
Name of resource	**General Medical Council**
Publisher of resource	The General Medical Council - GMC
Web address	http://www.gmc-uk.org/

Web sites related to the Netherlands

Date	12/02/2008
Name of resource	**Rijksinstituut voor Volksgezondheid en Milieu (RIVM)**
Publisher of resource	Rijksinstituut voor Volksgezondheid en Milieu (RIVM)
Web address	http://www.rivm.nl/gezondheid/

Date	12/02/2008
Name of resource	**Ministerie van Volksgezondheid, Welzijn en Sport**
Publisher of resource	Ministerie van Volksgezondheid, Welzijn en Sport
Web address	http://www.minvws.nl/

Date	12/02/2008
Name of resource	**Stichting AB: Wet- en regelgeving sociale zekerheid**
Publisher of resource	Stichting AB
Web address	http://www.st-ab.nl/index.html

Date	12/02/2008
Name of resource	**College voor Zorgverzekeringen (CVZ)**
Publisher of resource	College voor Zorgverzekeringen (CVZ)
Web address	http://www.consumenten.cvz.nl/ http://www.cvz.nl/

Date	12/02/2008
Name of resource	**Nederlandse Vereniging voor Plastische Chirurgie (NVPC)**
Publisher of resource	Nederlandse Vereniging voor Plastische Chirurgie (NVPC)
Web address	http://www.nvpc.nl

Date	12/02/2008
Name of resource	**Zorgverzekeraars Nederland (ZN)**
Publisher of resource	Zorgverzekeraars Nederland (ZN)
Web address	http://www.zn.nl

Date	12/02/2008
Name of resource	**Nederlandse Zorgautoriteit (NZa)**
Publisher of resource	Nederlandse Zorgautoriteit (NZa)
Web address	http://www.ctg-zaio.nl/

Date	12/02/2008
Name of resource	**DBC - Onderhoud**
Publisher of resource	DBC - Onderhoud
Web address	www.dbconderhoud.nl

Date	13/02/2008
Name of resource	**kiesBeter.nl**
Publisher of resource	Centrum voor Volksgezondheid Toekomst Verkenningen van het Rijksinstituut voor Volksgezondheid en Milieu (RIVM)
Web address	http://www.kiesbeter.nl/

Date	13/02/2008
Name of resource	**Prismant**
Publisher of resource	Prismant
Web address	http://www.prismant.nl/

Date	14/02/2008
Name of resource	**Werken met DBCs**
Publisher of resource	Ministerie van Volksgezondheid, Welzijn en Sport
Web address	http://www.werkenmetdbcs.nl/

Date	14/02/2008
Name of resource	**Nederlandse Vereniging voor Esthetische Plastische Chirurgie**
Publisher of resource	Nederlandse Vereniging voor Esthetische Plastische Chirurgie
Web address	http://www.nvepc.nl

Date	21/02/2008
Name of resource	**Orde van Medisch Specialisten**
Publisher of resource	Orde van Medisch Specialisten
Web address	http://www.orde.nl

Date	21/02/2008
Name of resource	**Koninklijke Nederlandsche Maatschappij ter bevordering der Geneeskunst**
Publisher of resource	Koninklijke Nederlandsche Maatschappij ter bevordering der Geneeskunst - KNMG
Web address	http://knmg.artsennet.nl/themes/24

Web sites related to Germany

Date	25/02/2008
Name of resource	**Bundesministerium für Gesundheit**
Publisher of resource	Bundesministerium für Gesundheit und Soziale Sicherung (BMGS)
Web address	http://www.bmg.bund.de

Date	25/02/2008
Name of resource	**Die Gesundheitsreform**
Publisher of resource	Bundesministerium für Gesundheit und Soziale Sicherung (BMGS)
Web address	http://www.die-gesundheitsreform.de

Date	25/02/2008
Name of resource	**GACD**
Publisher of resource	Gesellschaft für Ästhetische Chirurgie Deutschland e.V.
Web address	http://www.gacd.de

Date	25/02/2008
Name of resource	**DGPW**
Publisher of resource	Deutsche Gesellschaft für Plastische und Wiederherstellungschirurgie e.V.
Web address	http://www.dgpw.de

Date	25/02/2008
Name of resource	**VDÄPC**
Publisher of resource	Vereinigung der Deutschen Ästhetisch-Plastischen Chirurgen
Web address	http://www.vdaepc.de

Date	25/02/2008
Name of resource	**DGÄPC**
Publisher of resource	Deutsche Gesellschaft für Ästhetisch-Plastische Chirurgie
Web address	http://dgaepc.de/

Date	25/02/2008
Name of resource	**Bundesärztekammer**
Publisher of resource	Bundesärztekammer
Web address	http://www.bundesaerztekammer.de

Date	16/01/2008
Name of resource	**Gemeinsamer Bundesausschuss**
Publisher of resource	Der Gemeinsame Bundesausschuss – G-BA (Federal Joint Committee)
Web address	http://www.g-ba.de/

APPENDIX 3 CORRESPONDENCE LIST

Date of contact	25/01/2007 (interview)
Name of expert	Dr. Dominique FERON
Fonction and/or name of organisation	Principal Medical Advisor, National Union of Socialist Sickness Funds, Belgium
Field of expertise	Belgian compulsory health insurance
E-mail address	dominique.feron@mutsoc.be

Date of contact	10/12/2007 (e-mail correspondence)
Name of expert	Dr Yves HEPNER
Fonction and/or name of organisation	Secrétaire Général du Syndicat National de Chirurgie Plastique Reconstructrice et Esthétique (SNCPRE), France
Field of expertise	Information on which plastic surgery procedures are reimbursed in France
E-mail address	yhepner@claranet.fr

Date of contact	13/12/2007 (e-mail correspondence)
Name of expert	Dr. William M. WRAIGHT
Fonction and/or name of organisation	Plastic surgeon, Department of Plastic Surgery, Queen Victoria Hospital in West Sussex, UK; Member of the British Association of Plastic, Reconstructive and Aesthetic Surgeons
Field of expertise	Author of article: [28]; Supplier of report: [80] (not available on the Internet)
E-mail address	will.wraight@doctors.org.uk

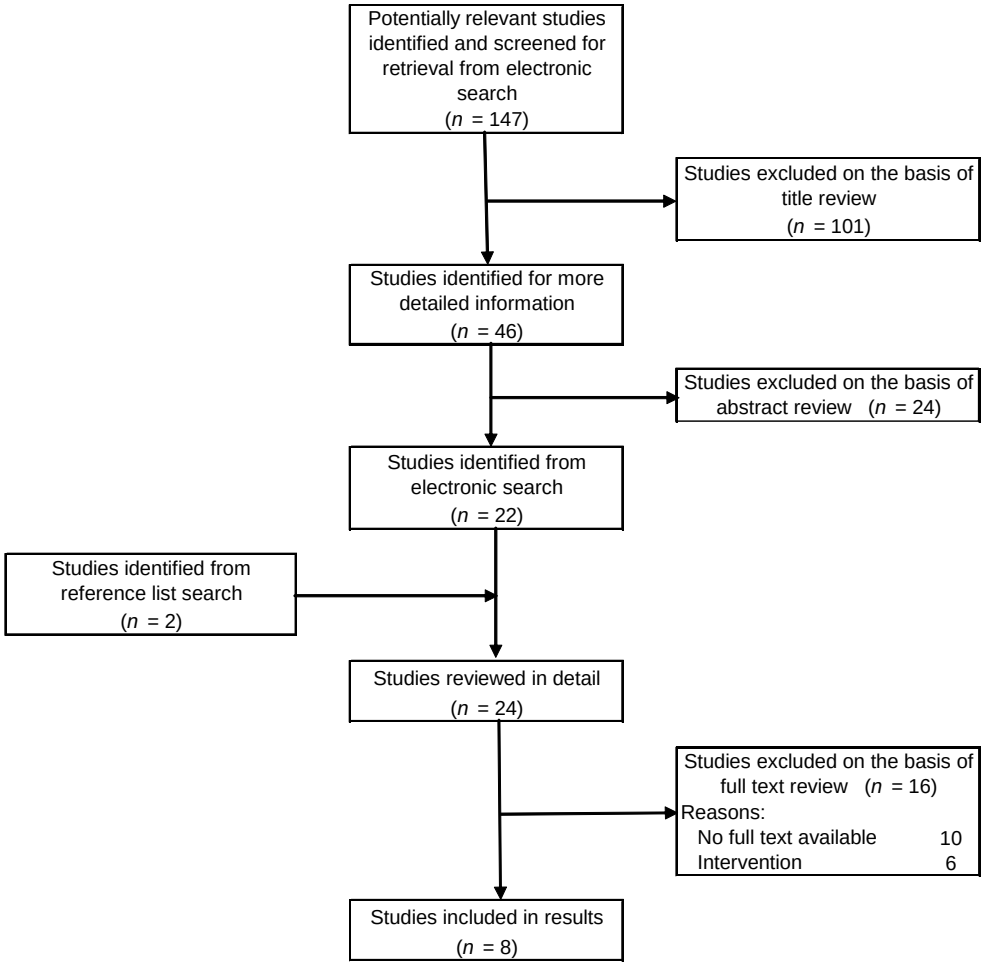
Date of contact	20/02/2008 (paper correspondence)
Name of expert	Dr. Jean-François KNOPF
Fonction and/or name of organisation	Président de la Section Exercice professionnel, Ordre National des Médecins, Conseil National de l'Ordre, Paris, France
Field of expertise	Legal framework plastic surgery in France
E-mail address	/

Date of contact	07/03/2008 (interview)
Name of expert	Dr Béatrice RIO, Dr Gaetano SABA
Fonction and/or name of organisation	Medical Inspectors, Caisse Nationale d'Assurance Maladie des Travailleurs Salariés (CNAMTS), Paris, France
Field of exeprtise	National Control and Inspection Plan
E-mail address	beatrice.rio@cnamts.fr

Date of contact	19/03/2008 (interview)
Name of expert	Dr Gérard FLAGEUL
Fonction and/or name of organisation	Plastic Surgeon ; Member of Société Française de Chirurgie Plastique, Reconstructrice et Esthétique (SOFCPRE) ; Medical expert in legal court cases
Field of exeprtise	Clinical issues; Legal framework
E-mail address	gerard.flageul@wanadoo.fr

Date of contact	16/04/2008 (e-mail correspondence)
Name of expert	Esther PENSADO
Fonction and/or name of organisation	Collaboratrice du Service Evaluation des Actes Professionnels (Haute Authorité de Santé), France
Field of exeprtise	Recommendations on eligibility for reimbursement
E-mail address	e.pensado@has-sante.fr

APPENDIX 4 FLOW DIAGRAM OF LITERATURE SEARCH IN ELECTRONIC BIBLIOGRAPHIC DATABASES CONCERNING THE COVERAGE OF PLASTIC SURGERY BY SOCIAL SECURITY



APPENDIX 5 CHECKLIST OF ITEMS TO BE INCLUDED IN THE INTERNATIONAL COMPARISON CONCERNING THE COVERAGE OF PLASTIC SURGERY BY SOCIAL SECURITY

General overview of the health system
Total health expenditure as a percentage of GDP?
Total health expenditure per capita, US$ purchasing power parity?
Public expenditure as a percentage of total health expenditure?
Percentage of population covered by public or private insurance?

Coverage of plastic surgery by the social security system
What are the general rules for reimbursement of health care costs?
Which surgical procedures in the domain of plastic surgery are reimbursed?
What criteria are used for reimbursement of plastic surgery, and what is their rationale?
How are these criteria implemented?
Are these criteria evaluated?

APPENDIX 6 QUALIFICATION CODES OF PLASTIC SURGEONS

Qualification code	Description
021	Geneesheer-specialist in opleiding voor plastische heelkunde Médecin spécialiste en formation en chirurgie plastique
210	Geneesheer-specialist in de plastische heelkunde Médecin spécialiste en chirurgie plastique
219	Geneesheer-specialist in de plastische heelkunde en in de urgentie-geneeskunde Médecin spécialiste en chirurgie plastique et en médecine d'urgence
222	Geneesheer-specialist in de plastische heelkunde en in de stomatologie Médecin spécialiste en chirurgie plastique et en stomatologie

Source: National Institute for Health and Disability Insurance[193]

APPENDIX 7 LAYOUT DOCUMENTS P, N^{BIS} AND N OF THE NIHDI

Layout Documents P

Zone	Description	Type	Length	Format
1	Codenummer van de verzekeringsinstelling	N	1	Codification
2	Statistische periode (jaar + semester)	N	5	YYYY6 or YYYY7
3	Identificatie zorgverlener	N	11	Codification
4	Norm zorgverlener	N	1	Codification
5	Recordtype	N	1	"1"
6	Nomenclatuurcode/pseudo-code/plafondcode	N	6	Codification
7	Betalingswijze	N	1	Codification
8	Jaar en maand van verstrekking	N	6	YYYYMM
9	Bedrag verzekeringstegemoetkoming	N	14	+/sign last 2 pos dec
10	Aantal gevallen	N	9	+/sign
11	Norm voorschrijver	N	1	Codification
12	Identificatie voorschrijver	N	11	Codification
13	Identificatie plaats van verstrekking	N	11	Codification
14	Identificatie verblijfplaats	N	8	Codification
15	Verblijfsdienst of pseudodienstcode	N	2	Codification
16	Munteenheid	N	1	1 = BEF; 2 = Euro

Source: Inventory of the Belgian health care datasets by Van De Sande et al.[34]

Layout Documents N[bis]

Zone	Description	Type	Length	Format
1	Recordcode = 1	N	1	"1"
2	Verzekeringsinstelling	N	3	Codification
3	Jaar van boeking	N	4	YYYY
4	Maand van boeking	N	2	MM
5	Maand van verstrekking	N	6	YYYYMM
6	Sociale stand	N	3	Codification
7	Nomenclatuurcodenummer	N	6	Codification
8	Normcode	N	2	Codification
9	Geboortejaar	N	4	YYYY
10	Geslacht	N	1	Codification
11	Arrondissement	N	2	Codification
12	Uitgaven	N	16	+/sign last 2 pos dec
13	Gevallen	N	11	+/sign
14	Dagen	N	10	+/sign
15	Remgelden	N	16	+/sign last 2 pos dec
16	Gevallen remgelden	N	11	+/sign
17	Dagen remgelden	N	10	+/sign

Source: Inventory of the Belgian health care datasets by Van De Sande et al.[34]

Layout Documents N

Zone	Description	Type	Length	Format
1	Recordcode = 1	N	1	"1"
3	Verzekeringsinstelling	N	3	Codification
4	Jaar en kwartaal van boeking	N	5	YYMMKw (1 tot 4)
7	Document N nummer	N	3	Codification
8	Boekhoudcodenummer	N	4	Codification
10	Nomenclatuurcodenummer	N	6	Codification
11	Jaar van prestatie	N	4	YYYY
12	Uitgaven	N	16	+/sign last 2 pos dec
13	Gevallen	N	11	+/sign
14	Dagen	N	10	+/sign
15	Gemiddelde kostprijs per geval	S	9	+/sign last 2 pos dec
16	Gemiddelde kostprijs per dag	N	9	+/sign last 2 pos dec
17	Maand van boeking	N	2	01 - 12
18	Munteenheid	N	1	1 = BEF; 2 = Euro

Source: Inventory of the Belgian health care datasets by Van De Sande et al.[34]

APPENDIX 8 LAYOUT DELIVERED SUBSETS OF DOCUMENTS P, N^{BIS} AND N

Layout Subset A and B from Documents P

Zone	Description	Type	Length	Format
1	Year of deliverance	N	6	YYYY
2	Anonymous identification number of health care deliverer	N	6	
3	Qualification of health care deliverer	N	3	Codification
4	Place of residence of health care deliverer (provincial level)	N	2	Codification
5	Nomenclature code	N	6	Codification
6	Number of delivered services	N	9	+/sign
7	Insurance cost of delivered services	N	14	+/sign last 2 pos dec

Layout Subset C from Documents N^{bis}

Zone	Description	Type	Length	Format
1	Year of deliverance	N	6	YYYY
2	Nomenclature code	N	6	Codification
3	Place of residence of patient (provincial level)	N	2	Codification
4	Number of delivered services	N	9	+/sign
5	Insurance cost of delivered services	N	14	+/sign last 2 pos dec

Layout Subset D from Documents N

Zone	Description	Type	Length	Format
1	Year of deliverance	N	6	YYYY
2	Nomenclature code	N	6	Codification
3	Number of delivered services	N	9	+/sign
4	Insurance cost of delivered services	N	14	+/sign last 2 pos dec

APPENDICES ON CRITERIA FOR COVERAGE OF PLASTIC SURGERY BY SOCIAL SECURITY

APPENDIX 9 EXAMPLES OF REIMBURSEMENT CRITERIA FOR PLASTIC SURGERY IN FRANCE

Source: Caisse nationale de l'Assurance Maladie des travailleurs salariés (CNAMTS)[194]

Skin graft for burned patients

CCAM Code: QZEA021

Libellé: Greffe cutanée pour brûlure en dehors de l'extrémité céphalique et des mains, sur moins de 2,5% de la surface corporelle

Prix de l'acte : €68.27

Admission au remboursement : Acte remboursable et pas soumis à une entente préalable

Reconstruction of the ear with a skin auto graft

CCAM Code: GAMA019

Libellé: Réparation de perte de substance du nez par autogreffe composée d'auricule

Prix de l'acte : €218.59

Admission au remboursement : Acte remboursable et pas soumis à une entente préalable

Female Breast Reduction

CCAM code: QEMA013

Libellé: Mastoplastie bilatérale de réduction

Note de l'acte : Indication : hypertrophie mammaire caractérisée :

- responsable de dorsalgies, retentissement psychologique,
- justifiable par photographie préopératoire,
- étayée par : taille, poids, âge de la patiente et taille du soutien gorge
- dont la résection prévue en préopératoire est d'au moins 300 g. par sein opéré.

Prix de l'acte : €368.53

Admission au remboursement : Pris en charge et remboursable sous conditions. Cet acte n'est pas soumis à une entente préalable

Correction of prominent ears (otoplasty)

CCAM Code: CAMA013

Libellé: Plastie bilatérale d'oreille décollée

Note de l'acte : Indication : déformation entraînant une gêne sociale importante

Prix de l'acte : €190.01

Admission au remboursement : Pris en charge et remboursable sous conditions. Cet acte n'est pas soumis à une entente préalable

Breast reconstruction

CCAM code: QEMA006

Libellé: Reconstruction du sein par pose d'implant prothétique

Note de l'acte :

Indication: thérapeutique càd pour absence congénitale (agénésie) ou acquise (amputation).

Facturation: les actes à visée esthétique ne peuvent pas être facturés.

Prix de l'acte : €224.56

Admission au remboursement : Acte remboursable et soumis à une entente préalable.

Rhinoplasty

CCAM Code: GAMA008

Libellé: Rhinoplastie primitive de la pointe

Note de l'acte : Indication : liée à des troubles fonctionnels ou des malformations : séquelles de fente labioalvéloaire et autres malformations nasales, problèmes de ventilation liée à la valve nasale

Prix de l'acte : €209.00

Admission au remboursement : Acte remboursable et soumis à une entente préalable.

Breast lift (Mastopexy)

CCAM code: QEDA002

Libellé: Mastopexie unilatérale, sans pose d'implant prothétique

Prix de l'acte : €0.00

Admission au remboursement : Acte non remboursable

Dermabrasion

CCAM Code: QZNP006

Libellé : Dermabrasion (destruction mécanique de lésion cutanée superficielle ; comprend la destruction de cicatrice cutanée, d'angiome cutané, de ride, de tatouage, de tumeur de la peau et des tissus mous, de verrue) en dehors du visage

Prix de l'acte : €0.00

Admission au remboursement : Acte non remboursable

APPENDIX 10 NHS GUIDELINES IN PLASTIC SURGERY

Source: NHS Modernisation Agency[80]

BREAST PROCEDURES

Female Breast Reduction (Reduction mammoplasty)

Breast Reduction Surgery is an effective intervention that should be available on the NHS if the following circumstances are met:

- The patient is suffering from neck ache, backache and/or intertrigo
- The wearing of a professionally fitted brassiere has not relieved the symptoms
- The patient has a body mass index (BMI) of less than 30 kg/m2

Patients should have an initial assessment prior to an appointment with a consultant plastic surgeon to ensure that these criteria are met. At, or following, this assessment, there should be access to a trained bra fitter and where it is available, laser scanning of the thorax should be considered.

Rationale

Breast reduction places considerable demand on NHS resources (volume of cases and length of surgery) and yet has been shown to be a highly effective health intervention. There is published evidence showing that most women seeking breast reduction are not wearing a bra of the correct size and that a well fitted bra can sometimes alleviate the symptoms that are troubling the patient. Recent evidence has shown that not all commercial bra fitters meet the required standards and so commissioners will need to satisfy themselves that a suitable service is available. The upper limit of normal BMI is 25 Kg/m^2. Patients seeking breast reduction have physical restrictions on their ability to exercise and additional weight in their excess breast tissue (sometimes 3-4 Kg). Major complications for surgery in general and specifically related to breast reduction surgery have been shown to be greater if the BMI exceeds 30. Despite a higher complication rate, obese patients generally benefit from breast reduction. Local policies will need to consider both these factors in setting a BMI threshold for inclusion.

Possible pathways for breast reduction patients are included in appendix A.

Male Breast Reduction for Gynaecomastia

Surgery to correct gynaecomastia is allowable if the patient is:

Post pubertal and of normal BMI (<= 25 Kg/m^2)

There should be a pathway established to ensure that appropriate screening for endocrinological and drug related causes and/or psychological distress occurs prior to consultation with a plastic surgeon.

Liposuction may form part of the treatment plan for this condition.

Rationale

Commonly gynaecomastia is seen during puberty and may correct once the postpubertal fat distribution is complete if the patient has a normal BMI. It may be unilateral or bilateral. Rarely, it may be caused by an underlying endocrine abnormality or a drug related cause including the abuse of anabolic steroids. It is important that male breast cancer is not mistaken for gynaecomastia and, if there is any doubt, an urgent consultation with an appropriate specialist should be obtained.

Breast enlargement (Augmentation mammoplasty)

Will only be performed by the NHS on an exceptional basis and should not be carried out for "small" but normal breasts or for breast tissue involution (including post partum changes).

Exception should be made for women with an absence of breast tissue unilaterally or bilaterally, or in women with of a significant degree of asymmetry of breast shape and/or volume. Such situations may arise as a result of:

- Previous mastectomy or other excisional breast surgery
- Trauma to the breast during or after development
- Congenital amastia (total failure of breast development)
- Endocrine abnormalities
- Developmental asymmetry

Patients who are offered breast augmentation in the NHS should be encouraged to participate in the UK national breast implant registration system and be fully counselled regarding the risks and natural history of breast implants. It would be usual to provide patients undergoing breast augmentation with a copy of the DoH guidance booklet "Breast implants information for women considering breast implants".

It is important that patients understand that they may not automatically be entitled to replacement of the implants in the future if they do not meet the criteria for augmentation at that time.

Rationale

Demand for breast enlargement is rising in the UK. Breast implants may be associated with significant morbidity and the need for secondary or revisional surgery (such as implant replacement) at some point in the future is common. Implants have a variable life span and the need for replacement or removal in the future is likely in young patients. Not all patients demonstrate improvement in psychosocial outcome measures following breast augmentation.

Revision of Breast Augmentation

Revisional surgery will only be considered if the NHS commissioned the original surgery.

If revisional surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them should be based upon the clinical need for replacement and whether the patient meets the policy for augmentation at the time of revision.

Rationale

Prior to the development of inclusion policies such as this, a small number of patients underwent breast augmentation in the NHS for purely cosmetic reasons. There may however be clinical reasons why replacement of the implants remains an appropriate surgical intervention. For these reasons it is important that:

Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy.

Patients should also be made aware that implant removal in the future might not be automatically followed by replacement of the implant.

Breast lift (Mastopexy)

This is included as part of the treatment of Breast asymmetry and reduction (see above) but not for purely cosmetic/aesthetic purposes such as postlactational ptosis.

Rationale

Breast ptosis (droopiness) is normal with the passage of age and after pregnancy. Patients with breast asymmetry often have asymmetry of shape as well as volume and correction may require mastopexy as part of the treatment.

Nipple Inversion

Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded.

Surgical correction of nipple inversion should only be available for functional reasons in a post-pubertal woman and if the inversion has not been corrected by correct use of a non-invasive suction device.

Rationale

Idiopathic nipple inversion can often (but not always) be corrected by the application of sustained suction. Commercially available devices may be obtained from major chemists or online without prescription for use at home by the patient. Greatest success is seen if it is used correctly for up to three months.

An underlying breast cancer may cause a previously normally everted nipple to become indrawn: this must be investigated urgently.

FACIAL PROCEDURES

Face lifts and brow lifts (Rhytidectomy)

These procedures will be considered for treatment of:

- Congenital facial abnormalities
- Facial palsy (congenital or acquired paralysis)
- As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis
- To correct the consequences of trauma
- To correct deformity following surgery
- They will not be available to treat the natural processes of ageing

Rationale

There are many changes to the face and brow as a result of ageing that may be considered normal, however there are a number of specific conditions for which these procedures may form part of the treatment to restore appearance and function.

Surgery on the upper eyelid (Upper lid blepharoplasty)

This procedure will be commissioned by the NHS to correct functional impairment (not purely for cosmetic reasons)

As demonstrated by:

- Impairment of visual fields in the relaxed, non-compensated state
- Clinical observation of poor eyelid function, discomfort, e.g. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow

Rationale

Many people acquire excess skin in the upper eyelids as part of the process of ageing and this may be considered normal. However if this starts to interfere with vision or function of the eyelid apparatus then this can warrant treatment.

Surgery on the lower eyelid (Lower lid blepharoplasty)

This is available on the NHS for correction of ectropion or entropion or for the removal of lesions of the eyelid skin or lid margin.

Rationale

Excessive skin in the lower lid may cause "eyebags" but does not affect function of the eyelid or vision and therefore does not need correction.

Blepharoplasty type procedures however may form part of the treatment of disorders of the lid or overlying skin.

Surgery to reshape the nose (Rhinoplasty)

Rhinoplasty should be available on the NHS for:

- Problems caused by obstruction of the nasal airway

- Objective nasal deformity caused by trauma
- Correction of complex congenital conditions e.g. Cleft lip and palate

Patients with isolated airway problems (in the absence of visible nasal deformity) may be referred initially to an ENT consultant for assessment and treatment.

Correction of prominent ears (Pinnaplasty / Otoplasty)

To be available on the NHS the following criteria must be met:

- The patient must be under the age of 19 years at the time of referral.
- Patients seeking pinnaplasty should be seen by a plastic surgeon and following assessment, if there is any concern, assessed by a psychologist.
- Patients under 5 years of age at the time of referral may benefit from referral with their family for a multi-disciplinary assessment that includes a child psychologist.

Rationale

Prominent ears may lead to significant psychosocial dysfunction for children and adolescents and impact on the education of young children as a result of teasing and truancy. The national service framework for children defines childhood as ending at 19 years. Some patients are only able to seek correction once they are in control of the own healthcare decisions. Children under the age of five rarely experience teasing and referrals may reflect concerns expressed by the parents rather than the child.

Repair of external ear lobes (lobules)

This procedure is only available on the NHS for the repair of totally split ear lobes as a result of direct trauma.

Prior to surgical correction, patients should receive pre-operative advice to inform them of:

- Likely success rates
- The risk of keloid and hypertrophic scarring in this site
- The risks of further trauma with re-piercing of the ear lobule

Rationale

Many split earlobes follow the wearing of excessively heavy earrings with insufficient tissue to support them, such that the earring slowly "cheese-wires" through the lobule. Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk.

Operations on congenital anomalies of the face and skull

Is usually available on the NHS. Some such conditions are considered highly specialised and are commissioned in the UK through NSCAG.

Rationale

The incidence of some congenital conditions affecting the cranio-facial skeleton is small and the treatment complex. It is considered that specialised teams, working in designated centres and subject to national audit, should carry out such procedures.

Correction of post traumatic bony and soft tissue deformity of the face

Is available on the NHS.

Correction of hair loss (Alopecia)

Is available on NHS when it is a result of previous surgery or trauma including burns.

Correction of male pattern baldness

Is excluded from treatment by the NHS

Rationale

So-called "male pattern" baldness is a normal process for many men at whatever age it occurs.

Hair transplantation

Will not be not be allowable on the NHS, regardless of gender—other than in exceptional cases, such as reconstruction of the eyebrow following cancer or trauma.

BODY CONTOURING PROCEDURES

It is recognised that the consequences of morbid obesity will become an increasing problem for the NHS and that robust inclusion criteria need to be developed to ensure that appropriate patients benefit from interventions that change the body contour.

"Tummy tuck" (apronectomy or abdominoplasty)

Abdominoplasty and apronectomy may be offered to the following groups of patients who should have achieved a stable BMI between 18 and 27 Kg/m2 and be suffering from severe functional problems:

- Those with scarring following trauma or previous abdominal surgery
- Those who are undergoing treatment for morbid obesity and have excessive abdominal skin folds
- Previously obese patients who have achieved significant weight loss and have maintained their weight loss for at least two years
- Where it is required as part of abdominal hernia correction or other abdominal wall surgery

Severe functional problems include:

- Recurrent intertrigo beneath the skin fold
- Experiencing severe difficulties with daily living i.e. Ambulatory restrictions
- Where previous post trauma or surgical scarring (Usually midline vertical, or multiple) leads to very poor appearance and results in disabling psychological distress or risk of infection
- Problems associated with poorly fitting stoma bags.

Rationale

Excessive abdominal skin folds may occur following weight loss in the previously obese patient and can cause significant functional difficulty. There are many obese patients who do not meet the definition of morbid obesity (see glossary) but whose weight loss is significant enough to create these difficulties.

These types of procedures, which may be combined with limited liposuction, can be used to correct scarring and other abnormalities of the anterior abdominal wall and skin. It is important that patients undergoing such procedures have achieved and maintained a stable weight so that the risks of recurrent obesity are reduced. The availability of teams specialising in the surgical treatment of the morbidly obese ("bariatric" surgery) is limited, although this may rise with the implementation of NICE guidance in this area. Many patients therefore achieve their weight loss outside such teams and should not be disadvantaged in accessing body contouring surgery if required.

Other skin excision for contour

e.g. Buttock lift, Thigh lift, Arm lift (brachioplasty)

These procedures will only be commissioned in exceptional circumstances.

Rationale

Whilst the patient groups seeking such procedures are similar to those seeking abdominoplasty (see above), the functional disturbance of skin excess in these sites tends to be less and so surgery is less likely to be indicated except for appearance: in which case it should not be available on the NHS.

Liposuction

Liposuction may be useful for contouring areas of localised fat atrophy or pathological hypertrophy (e.g. Multiple lipomatosis, lipodystrophies).

Liposuction is sometimes an adjunct to other surgical procedures. It will not be commissioned simply to correct the distribution of fat.

SKIN AND SUBCUTANEOUS LESIONS

A patient with a skin or subcutaneous lesion that has features of suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment.

Fatty lumps (Lipomata)

Lipomata of any size should be considered for treatment by the NHS in the following circumstances:

- The lipoma (-ta) is / are symptomatic
- There is functional impairment
- The lump is rapidly growing or abnormally located (e.g. sub-fascial, submuscular)

Viral warts

Most viral warts will clear spontaneously or following application of topical treatments.

Painful, persistent or extensive warts (particularly in the immuno-suppressed patient) may need specialist assessment, usually by a dermatologist. For a small proportion surgical removal (cryotherapy, cautery, laser or excision) may be appropriate.

Other benign skin lesions

Clinically benign skin lesions should not be removed on purely cosmetic grounds. This will include, amongst other conditions, skin tags and seborrhoeic keratoses (warts).

Patients with moderate to large lesions that cause actual facial disfigurement may benefit from surgical excision. The risks of scarring must be balanced against the appearance of the lesion.

Epidermoid or pilar cysts (commonly known as "sebaceous cysts") are always benign but some may become infected or be symptomatic. Some may require surgical excision particularly if large or located on the face or on a site where they are subjected to trauma.

Rationale

The decision to remove benign skin lesions from conspicuous sites is a balance between the appearance of the original lesion against the likely appearance of the surgical scar. It is therefore essential that the decision is made by a practitioner fully familiar with the factors affecting the outcome of surgery in these sites and that the excision is carried out by a trained practitioner using fine instruments and sutures in an appropriate surgical setting.

Xanthelasma

Patients with xanthelasma should always have their lipid profile checked before referral to a specialist.

Many xanthelasmata may be treated with topical TCA or cryotherapy. Larger lesions or those that have not responded to these treatments may benefit from surgery if the lesion is disfiguring.

Rationale

Xanthelasma (yellow fatty deposits around the eyelids) may be associated with abnormally high cholesterol levels and this should be tested for.

They may be very unsightly and multiple and do not always respond to "medical" treatments. Surgery can require "blepharoplasty type" operations and/or skin grafts.

Tattoo removal

The NHS will consider removal of tattoos in the following cases:

- Where the tattoo is the result of trauma, inflicted against the patient's will ("rape tattoo")
- The patient was not Gillick competent, and therefore not responsible for their actions, at the time of the tattooing.
- Exceptions may also be made for tattoos inflicted under duress during adolescence or disturbed periods where it is considered that psychological rehabilitation, break up of family units or prolonged unemployment could be avoided, given the treatment opportunity. (Only considered in very exceptional circumstances where the tattoo causes marked limitations of psycho-social function).

Rationale

Many patients seeking tattoo removal are from disadvantaged backgrounds that did not fully recognise the implications of a tattoo on subsequent employment and life opportunities. Most tattoos may be removed by a series of outpatient treatments using an appropriate laser.

Skin hypo-pigmentation

The recommended NHS suitable treatment for hypo-pigmentation is Cosmetic Camouflage. Access to a qualified camouflage beautician should be available on the NHS for this and other skin conditions requiring camouflage.

Vascular skin lesions

NHS treatment is allowed for all vascular lesions except for small benign, acquired vascular lesions such as thread veins and spider naevi.

The planning of treatment of complex major vascular malformations is best carried out in a specialised multi-disciplinary team setting.

Acne vulgaris

The treatment of active acne vulgaris should be provided in primary care or through a dermatology service. Patients with severe facial post-acne scarring can benefit from "resurfacing" and other surgical interventions, which may be available from the plastic surgery service. (See "skin resurfacing" section).

Rhinophyma

The first-line treatment of this disfiguring condition of the nasal skin is medical. Severe cases or those that do not respond to medical treatment may be considered for surgery or laser treatment.

MISCELLANEOUS

Skin "resurfacing" techniques

All resurfacing techniques, including laser, dermabrasion and chemical peels may be considered for post-traumatic scarring (including post surgical) and severe acne scarring once the active disease is controlled.

Botulinum toxin

Botulinum toxin has many uses within the NHS. It is available for the treatment of pathological conditions by appropriate specialists in cases such as:

- Frey's syndrome
- Blepharospasm
- Cerebral palsy
- Hyperhidrosis

Botulinum toxin is not available for the treatment of facial ageing or excessive wrinkles.

Hair depilation (hair removal)

Hair depilation will be commissioned on the NHS for patients who:

- Have undergone reconstructive surgery leading to abnormally located hair-bearing skin
- Those with a proven underlying endocrine disturbance resulting in Hirsutism (e.g. polycystic ovary syndrome)
- Are undergoing treatment for pilonidal sinuses to reduce recurrence
- Hirsutism leading to significant psychological impairment

The method of depilation (hair removal) used should be diathermy electrolysis performed by a registered electrologist or laser. Where laser services are being developed reference to the available evidence base should be made.

Gender reassignment surgery

Gender re-assignment is a highly specialised area of clinical practice and should only be considered, assessed for and carried out as part of a recognised NHS programme of care. Each case should be considered on its individual merits.

APPENDIX 11 SELECTION OF DBC DIAGNOSES IN THE DOMAIN OF PLASTIC SURGERY: REIMBURSEMENT OF TREATMENTS

Selection based on Zorgtype = 11 (Reguliere zorg) and Zorgvraag = 0 (Indien niet van toepassing geen aanvullende code).

DBC	Diagnosis	Treatments	Reimbur-sement	Prior approval
001	Algemeen: Consult, conservatieve behandeling: eenvoudig 1 malig consult zonder behandeling < 20'	11 -14	Green	
002	Algemeen: Consult, conservatieve behandeling: complex 1 malig consult zonder behandeling >20' , second opinion	11 -14	Green	
003	Algemeen: Consult, conservatieve behandeling: kortdurende conservatieve (mede)behandeling, cons. behandeling hypertrophische littekens, inclusief evt. inspuitingen, spalk- drukpak behandeling =< 3 contacten	11 - 14 12 - 13	Green Orange	
004	Algemeen: Consult, conservatieve behandeling: langdurige conservatieve (mede)behandeling, conservatieve behandeling hypertr. littekens, incl. evt. inspuitingen, spalk- drukpak behandeling > 3 contacten	11 - 14 12 - 13	Green Orange	
005	Algemeen: Consult, conservatieve behandeling: klinische conservatieve behandeling , VAC-therapie decubitus	11 - 14 12 - 13	Green Orange	
011	Algemeen: Trauma: verwonding niet in FG, waarvoor transpositie / transplantatie< 1%, wondtoilet / hechten / plakken, kleine necrotectomie	11 - 14 - 21 - 22 - 23- 24 -26	Green	
012	Algemeen: Trauma: verwonding niet in FG, waarvoor transpositie of transplantatie 1-3%, of verwonding in FG waarvoor behandeling <1%, grote necrotectomie / wondtoilet	11 - 14 - 21 - 22 - 23- 24 -26	Green	
013	Algemeen: Trauma: verwonding niet in FG waarvoor transpositie of transplantatie >3%, of verwonding in FG waarvoor behandeling 1-3%, necrotectomie / wondtoilet onder narcose	11 - 14 - 21 - 22 - 23- 24 -26	Green	
014	Algemeen: Trauma: verwonding in FG >3%, of waarvoor axiale lap transpositie, uitgebreid gelaatstrauma	11 - 14 - 21 - 22 - 23- 24 -26	Green	
015	Algemeen: Trauma: verwonding waarvoor microvasculaire vrije lap transplantatie, multipele axiale lappen, uitgebreid composit gelaatstrauma	11 - 14 - 21 - 22 - 23- 24 -26	Green	
020	Algemeen: Defecten / tekorten / littekens: congenitaal, post-traumatisch, post-thermisch, post-radiatie, oncologisch, post-paralytisch, decubitus: herstel defect niet FG met transpositie of transplantatie < 1%, incl. evt.verwijderen TE	11 - 14 - 21 - 22 - 23- 24 -26	Green	
021	Algemeen: Defecten / tekorten / littekens: congenitaal, post-traumatisch, post-thermisch, post-radiatie, oncologisch, post-paralytisch, decubitus: herstel defect niet in FG, waarvoor transpositie of transplantatie 1-3%, of sluiten defect w.o. in FG <1%, d	11 - 14 - 21 - 22 - 23- 24 -26	Green	
022	Algemeen: Defecten / tekorten / littekens: congenitaal, post-traumatisch, post-thermisch, post-radiatie, oncologisch, post-paralytisch, decubitus: herstel defect niet in FG, waarvoor transpositie of	11 - 14 - 21 - 22 - 23- 24 -26	Green	

	transplantatie >3%, of sluiten defect w.o. in FG 1-3%, i			
023	Algemeen: Defecten / tekorten / littekens: congenitaal, post-traumatisch, post-thermisch, post-radiatie, oncologisch, post-paralytisch, decubitus: herstel defect w.o. in FG >3% of sluiten defect met axiale lap transp., incl. evt. verw. TE	11 - 14 - 21 - 22 - 23- 24 -26	Green	
024	Algemeen: Defecten / tekorten / littekens: congenitaal, post-traumatisch, post-thermisch, post-radiatie, oncologisch, post-paralytisch, decubitus: herstel defect met microvasculaire vrije huid/spierlap, of multipele axiale lappen	11 - 14 - 21 - 22 - 23- 24 -26	Green	
025	Algemeen: Defecten / tekorten / littekens: congenitaal, post-traumatisch, post-thermisch, post-radiatie, oncologisch, post-paralytisch, decubitus: herstel defect met microvasculaire vrije huid / spier / bot-lap	11 - 14 - 21 - 22 - 23- 24 -26	Green	
026	Algemeen: Defecten / tekorten / littekens: congenitaal, post-traumatisch, post-thermisch, post-radiatie, oncologisch, post-paralytisch, decubitus: herstel contourdefect met kunststof implantaat (bv trechterborst)	11 - 14 - 21 - 24 22 - 23- 26	Green Green	 Yes
027	Algemeen: Defecten / tekorten / littekens: congenitaal, post-traumatisch, post-thermisch, post-radiatie, oncologisch, post-paralytisch, decubitus: herstel defect met Tissue Expander(s), betreft inbrengen TE(s) en alle inspuitingen	11 - 14 - 21 - 22 - 23- 24 -26	Green	
031	Algemeen: Tumoren, pathologisch weefsel (PW): excisie 1-3 benigne tumoren / naevi niet in FG, abces drainage, kleine necrotectomie	11 - 14 21 - 22 - 23- 24 -26	Green Orange	
032	Algemeen: Tumoren, pathologisch weefsel (PW): excisie 1-3 ben. tumoren / naevi w.o. in FG of 4-10 niet in FG, of mal. tumor niet in FG	11 - 14 21 - 22 - 23- 24 -26	Green Orange	
033	Algemeen: Tumoren, pathologisch weefsel (PW): excisie benigne tumor / PW en transpositie of transplantatie 1-3% niet in FG, of maligne tumor in FG waarvoor transp. of transpl. <1%, 4-10 naevi w.o. in FG	11 - 14 21 - 22 - 23- 24 -26	Green Orange	
034	Algemeen: Tumoren, pathologisch weefsel (PW): excisie benigne tumoren / PW waarvoor transpositie of transplantatie >3% niet in FG, idem voor maligne tumor in FG 1-3% of niet in FG >3%, meer dan 10 benigne tumoren / naevi, 2-5 maligne tumoren	11 - 14 21 - 22 - 23- 24 -26	Green Orange	
035	Algemeen: Tumoren, pathologisch weefsel (PW): excisie tumoren / PW met axiale lap transpositie, excisie met vriescoupe, > 5 maligne tumoren, grote tumoren / PW > 10%	11 - 14 - 21 - 22 - 23- 24 -26	Green	
036	Algemeen: Tumoren, pathologisch weefsel (PW): excisie tumoren met microvasculaire vrije lap, of multipele axiale lappen	11 - 14 - 21 - 22 - 23- 24 -26	Green	
037	Algemeen: Tumoren, pathologisch weefsel (PW): nacorrectie axiale of vrije lap na bovenstaande	11 - 14 - 21 - 22 - 23- 24 -26	Green	
040	Algemeen: Brandwonden: conservatieve behandeling	11 - 12 - 13 - 14	Green	
041	Algemeen: Brandwonden: transplantatie <1% niet in FG	11 - 14 - 21 - 22 - 23- 24 -26	Green	
042	Algemeen: Brandwonden: transplantatie 1-3% niet in FG, of transplantatie w.o.in FG <1%	11 - 14 - 21 - 22 - 23- 24 -26	Green	
043	Algemeen: Brandwonden: transplantatie niet in FG >3%, of 1-3% w.o. in FG of huid-dermistransplantatie	11 - 14 - 21 - 22 - 23- 24 -26	Green	
044	Algemeen: Brandwonden: transplantatie w.o. in FG >3%, (voor secundaire correcties zie ad 02_)	11 - 14 - 21 - 22 - 23- 24 -26	Green	

051	Algemeen: Huidafwijkingen: dermabrasie, peeling, laserbehandeling < 1% per behandeling	11 - 14 12 - 13 - 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
052	Algemeen: Huidafwijkingen: dermabrasie, peeling, laserbehandeling > 1% per behandeling	11 - 14 12 - 13 - 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
053	Algemeen: Huidafwijkingen: tatouage, dermatografie per behandeling	11 - 14 12 - 13 - 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
054	Algemeen: Huidafwijkingen: dermolipectomie bovenarm enkel of dubbelzijdig	11 - 14 21 - 22 - 23 - 24 - 26	Green Red	
055	Algemeen: Huidafwijkingen: dermolipectomie bovenbeen enkel of dubbelzijdig	11 - 14 21 - 22 - 23 - 24 - 26	Green Red	
061	Algemeen: Liposuctie / lipofilling: liposuctie hals, epigastrio, buik	11 - 14 21 - 22 - 23 - 24 - 26	Green Red	
062	Algemeen: Liposuctie / lipofilling: liposuctie armen, bovenbenen heupen, trochanteren, billen, knieen, onderbenen	11 - 14 21 - 22 - 23 - 24 - 26	Green Red	
063	Algemeen: Liposuctie / lipofilling: liposuctie combinatie 2 regio's bdz.	11 - 14 21 - 22 - 23 - 24 - 26	Green Red	
064	Algemeen: Liposuctie / lipofilling: liposuctie combinaties 3 of meer regio's bdz.	11 - 14 21 - 22 - 23 - 24 - 26	Green Red	
065	Algemeen: Liposuctie / lipofilling: lipofilling niet-FG	11 - 14 21 - 22 - 23 - 24 - 26	Green Red	
066	Algemeen: Liposuctie / lipofilling: lipofilling FG	11 - 14 21 - 22 - 23 - 24 - 26	Green Red	
071	Algemeen: Logistieke ingrepen: lysis gesteelde lap, pre-ciscie van lap, pre-operatief ligeren vaten	11 - 14 - 21 - 22 - 23- 24 -26	Green	
072	Algemeen: Logistieke ingrepen: pre-fabricatie kleine lap	11 - 14 - 21 - 22 - 23- 24 -26	Green	
073	Algemeen: Logistieke ingrepen: pre-fabricatie grote lap, of complexe lap	11 - 14 - 21 - 22 - 23- 24 -26	Green	
074	Algemeen: Logistieke ingrepen: inductie weefselgroei	11 - 14 - 21 - 22 - 23- 24 -26	Green	
111	Gelaat: Implantaten: implantatie kunststof, dermis, fascie, klein gebied	11 - 14 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
112	Gelaat: Implantaten: implantatie kunststof, dermis, fascie, groot gebied	11 - 14 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
121	Gelaat: Rimpelgelaat, ptosis facialis, contractuur: facelift enkel of dubbelzijdig	11 - 14 21 - 22 - 23 - 24 - 26	Green Red	

122	Gelaat: Rimpelgelaat, ptosis facialis, contractuur: facelift + halslift en/of voorhoofdslift	11 - 14 21 - 22 - 23 - 24 - 26	Green Red	
123	Gelaat: Rimpelgelaat, ptosis facialis, contractuur: voorhoofdslift	11 - 14 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
124	Gelaat: Rimpelgelaat, ptosis facialis, contractuur: hals- onderkincorrectie, platysma, plastiek, open procedure	11 - 14 21 - 22 - 23 - 24 - 26	Green Red	
125	Gelaat: Rimpelgelaat, ptosis facialis, contractuur: locale correctie ptosis wenkbrauwen	11 - 14 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
126	Gelaat: Rimpelgelaat, ptosis facialis, contractuur: torticollis release	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
131	Gelaat: Oogleden: blepharoplastiek, onder of boven enkel- of dubbelzijdig	11 - 14 21 - 22 - 23 - 24 - 26	Green Orange	 Yes
132	Gelaat: Oogleden: blepharoplastiek, onder en boven	11 - 14 21 - 22 - 23 - 24 - 26	Green Red	
133	Gelaat: Oogleden: correctie ptosis palpebrae, levator platiek of frontalis suspensie	11 - 14 21 - 22 - 23 - 24 - 26	Green Red	
134	Gelaat: Oogleden: entropion- of ectropion correctie, cantopexie, tarsorafie, opheffen tarsorafie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
135	Gelaat: Oogleden: inbrengen goudgewicht	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
136	Gelaat: Oogleden: ooglidreconstructie	11 - 14 21 - 22 - 23 - 24 -26	Green Orange	
151	Gelaat: Neus: correctie weke delen kraakbenig skelet	11 - 14 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
152	Gelaat: Neus: correctie benige + kraakbenige skelet	11 - 14 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
153	Gelaat: Neus: repositie verse fractuur	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
154	Gelaat: Neus: rhinophyma shaving of laser	11 - 14 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
161	Gelaat: Oren: correctie weke delen, enkel- of dubbelzijdig	11 - 14 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
162	Gelaat: Oren: correctie oorskelet enkel- of dubbelzijdig	11 - 14 21 - 22 - 23 - 24 - 26	Green Orange	 Yes
163	Gelaat: Oren: oorreconstructie bij agenesie per fase	11 - 14 - 21 - 22 - 23 - 24 -26	Green	

164	Gelaat: Oren: correctie congenitale oorafwijking, cupears enkel- of dubbelzijdig	11 - 14 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
171	Gelaat: Schisis: primaire lipsluiting / fusie incl. neuscorrectie enkel of dubbelzijdig	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
172	Gelaat: Schisis: secundaire lip- en / of neus / columella correctie enkel of dubbelzijdig	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
173	Gelaat: Schisis: palatorafia anterior, of posterior of totalis	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
174	Gelaat: Schisis: pharynxplastiek	11 - 14 21 - 22 - 23 - 24 -26	Green Orange	
175	Gelaat: Schisis: botimplantaat in kaak	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
176	Gelaat: Schisis: sluiten fistel palatum met locale transpositie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
181	Gelaat: Craniomaxillofaciaal: alloplastische reconstructie schedel	11 - 14 21 - 22 - 23 - 24 -26	Green Orange	
182	Gelaat: Craniomaxillofaciaal: reconstructie schedeldak en / of orbita, enkel- of dubbelzijdig dmv bottranspositie	11 - 14 21 - 22 - 23 - 24 -26	Green Orange	
183	Gelaat: Craniomaxillofaciaal: Le Fort I	11 - 14 21 - 22 - 23 - 24 -26	Green Orange	
184	Gelaat: Craniomaxillofaciaal: Le Fort II of III of osteotomie en distractie	11 - 14 - 21 - 22 23 - 24 -26	Green Orange	
185	Gelaat: Craniomaxillofaciaal: reconstructie met ongevasculariseerd weefsel van schedel, orbita, neus, mandibula	11 - 14 21 - 22 - 23 - 24 -26	Green Orange	
186	Gelaat: Craniomaxillofaciaal: reconstructie met gevascullariseerd weefsel van schedel, orbita, neus, mandibula	11 - 14 - 21 - 22 23 - 24 -26	Green Orange	
187	Gelaat: Craniomaxillofaciaal: monoblok osteotomie of mediane faciotomie	11 - 14 21 - 22 - 23 - 24 -26	Green Orange	
191	Gelaat: Gelaatszenuwpathologie: meloplastiek statische correctie, wig excisie lip, cutane wenkbrauwlift	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
192	Gelaat: Gelaatszenuwpathologie: continuiteitsherstel n. facialis zonder transplantaat	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
193	Gelaat: Gelaatszenuwpathologie: continuiteitsherstel n. facialis met transplantaat, cross-face zenuw-transplant., jump anast.	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
194	Gelaat: Gelaatszenuwpathologie: microvasculaire spierlap transplantatie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
195	Gelaat: Gelaatszenuwpathologie: transpositie temporalis spier-fascielap	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
196	Gelaat: Gelaatszenuwpathologie: neurotomie gelaat	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
211	Lichaam: Mamma correctie: mammareductie, ptosiscorrectie enkel- of dubbelzijdig	11 - 14 21 - 22 - 23 - 24 -26	Green Orange	 Yes
212	Lichaam: Mamma correctie: ptosiscorrectie met augmentatie enkel- of dubbelzijdig	11 - 14 24	Green Orange	

		21 - 22 - 23- 26	Orange	Yes
213	Lichaam: Mamma correctie: gynaecomastie enkel- of dubbelzijdig	11 - 14 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
214	Lichaam: Mamma correctie: subcutane mastectiomie enkel- of dubbelzijdig +/- inbrengen prothese	11 - 14 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
215	Lichaam: Mamma correctie: mamma augmentatie enkel- of dubbelzijdig	11 - 14 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
216	Lichaam: Mamma correctie: capsul(ect)omie evt vervangen protheses, verwijderen protheses, enkel- of dubbelzijdig	11 - 14 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
221	Lichaam: Mamma reconstructie: inbrengen prothese, vervangen prothese, enkel- of dubbelzijdig	11 - 14 24 21 - 22 - 23- 26	Green Orange Orange	 Yes
222	Lichaam: Mamma reconstructie: inbrengen tissue expander enkelzijdig + insuflaties	11 - 14 21 - 22 - 23 - 24 - 26	Green Orange	
223	Lichaam: Mamma reconstructie: inbrengen tissue expander, dubbelzijdig + insuflaties	11 - 14 21 - 22 - 23 - 24 - 26	Green Orange	
224	Lichaam: Mamma reconstructie: axiale (huid/spier)lap reconstructie, zoals TRAM of LD +/- prothese enkelzijdig	11 - 14 21 - 22 - 23 - 24 - 26	Green Orange	
225	Lichaam: Mamma reconstructie: microchirurgische vrije lap reconstructie	11 - 14 21 - 22 - 23 - 24 - 26	Green Orange	
226	Lichaam: Mamma reconstructie: tepel(hof) reconstr. chirurgisch of tatouage/dermatografie per behandeling enkel of dubbelz.	11 - 14 21 - 22 - 23 - 24 - 26	Green Orange	
231	Lichaam: Abdomen: abdominoplastiek, incl navel reinsertie en reven fascia abdominalis	11 - 14 26 21 - 22 - 23 - 24	Green Orange Red	 Yes
232	Lichaam: Abdomen: vetschortresectie (dermolipectomie) zonder navelreinsertie	11 - 14 26 21 - 22 - 23 - 24	Green Orange Red	 Yes
233	Lichaam: Abdomen: mini-abdominoplastiek +/- liposuctie	11 - 14 26 21 - 22 - 23 - 24	Green Orange Red	 Yes
241	Lichaam: Genitalia: phimosis, meatotomie	11 - 14 21 - 22 - 23 - 24 - 26	Green Orange	

242	Lichaam: Genitalia: verwijdingsplastiek preaputium dmv transpositie, labia reductie	11 - 14 24 21 - 22 - 23- 26	Green Orange Orange	Yes
243	Lichaam: Genitalia: chordectomie, correctie Peyronie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
244	Lichaam: Genitalia: correctie hypospadie evt met chordectomie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
245	Lichaam: Genitalia: correctie epispadie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
251	Lichaam: Transsexualiteit: resectie mannelijk geslachtsorgaan (scrotum en/of penis)	11 - 14 21 - 22 - 23 - 24 - 26	Green Orange	
252	Lichaam: Transsexualiteit: reconstructie geslachtsorgaan mbv locale transpositielappen	11 - 14 21 - 22 - 23 - 24 - 26	Green Orange	
253	Lichaam: Transsexualiteit: reconstructie geslachtsorgaan mbv microvasculaire vrije lap transplantatie	11 - 14 21 - 22 - 23 - 24 - 26	Green Orange	
300	Hand, voet, extremiteiten: Algemeen: behandeling sympathisch reflex dystrofie (conservatief)	11 - 12 - 13 - 14	Green	
301	Hand, voet, extremiteiten: Algemeen: spalkbehandeling vingers voor contracturen	11 - 12 - 13 - 14	Green	
302	Hand, voet, extremiteiten: Algemeen: abces incisie vingers, hand, haematoom ontlasting, (pees)panaritium	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
303	Hand, voet, extremiteiten: Algemeen: extirpatie ganglion, cyste	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
304	Hand, voet, extremiteiten: Algemeen: nagel-, nagelmatrix resectie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
311	Hand, voet, extremiteiten: Trauma algemeen: compartimentssyndroom, fasciotomie, decompressie, drukspuitletsel	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
312	Hand, voet, extremiteiten: Trauma algemeen: verwonding, hechten, wondtoilet, transplantatie/transpositie < 0.5%, evt. met osteosynthese	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
313	Hand, voet, extremiteiten: Trauma algemeen: verwonding, waarvoor transpositie of transplantatie 0.5-1% evt. met osteosynth.	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
314	Hand, voet, extremiteiten: Trauma algemeen: verwonding, waarvoor transpositie of transplantatie > 1%, of herstel multipele structuren evt. met osteosynthese	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
315	Hand, voet, extremiteiten: Trauma algemeen: verwonding waarvoor axiale lap transpositie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
316	Hand, voet, extremiteiten: Trauma algemeen: verwonding, waarvoor microvasc. vrije lap transplantatie, vingerreplantatie, of herstel mult. structuren met axiale lap transpositie, revascularisatie arm / been	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
317	Hand, voet, extremiteiten: Trauma algemeen: hand replantatie, replantatie 2 of meer vingers / stralen	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
320	Hand, voet, extremiteiten: Fracturen, luxaties: conservatieve behandeling, repositie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
321	Hand, voet, extremiteiten: Fracturen, luxaties: enkelvoudige fractuur, luxatie, waarvoor K-draad fixatie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
322	Hand, voet, extremiteiten: Fracturen, luxaties: fractuur, luxatie waarvoor plaat of schroef fixatie, open reductie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	

323	Hand, voet, extremiteiten: Fracturen, luxaties: multipele fracturen, luxaties waarvoor osteosynthese	11 - 14 - 21 - 22 - 23 - 24 -26	Green
324	Hand, voet, extremiteiten: Fracturen, luxaties: reinsertie volaire plaat, herstel collaterale banden	11 - 14 - 21 - 22 - 23 - 24 -26	Green
330	Hand, voet, extremiteiten: Pezen algemeen: inspuiting(en) tendinitis, volledige behandeling	11 - 14 - 21 - 22 - 23 - 24 -26	Green
331	Hand, voet, extremiteiten: Pezen algemeen: triggerfingerrelease	11 - 14 - 21 - 22 - 23 - 24 -26	Green
332	Hand, voet, extremiteiten: Pezen algemeen: tenolyse	11 - 14 - 21 - 22 - 23 - 24 -26	Green
333	Hand, voet, extremiteiten: Pezen algemeen: verkorten, verlengen, uitsnijden pezen, myotomie	11 - 14 - 21 - 22 - 23 - 24 -26	Green
334	Hand, voet, extremiteiten: Pezen algemeen: pully reconstructie	11 - 14 - 21 - 22 - 23 - 24 -26	Green
335	Hand, voet, extremiteiten: Pezen algemeen: inbrengen silastic rod	11 - 14 - 21 - 22 - 23 - 24 -26	Green
336	Hand, voet, extremiteiten: Pezen algemeen: pees herstel met transplantaat incl. nemen transplantaat	11 - 14 - 21 - 22 - 23 - 24 -26	Green
337	Hand, voet, extremiteiten: Pezen algemeen: pees transpositie / reinsertie	11 - 14 - 21 - 22 - 23 - 24 -26	Green
338	Hand, voet, extremiteiten: Pezen algemeen: multipele pees transposities	11 - 14 - 21 - 22 - 23 - 24 -26	Green
340	Hand, voet, extremiteiten: Pezen specifiek: mallet finger conservatief	11 - 12 - 13 - 14	Green
341	Hand, voet, extremiteiten: Pezen specifiek: mallet finger chirurgisch, strekpees letsel 1-2 pezen	11 - 14 - 21 - 22 - 23 - 24 -26	Green
342	Hand, voet, extremiteiten: Pezen specifiek: correctie boutoniere, swanneck, herstel letstel strekapparaat	11 - 14 - 21 - 22 - 23 - 24 -26	Green
343	Hand, voet, extremiteiten: Pezen specifiek: herstel letsel multipele strekpezen >2	11 - 14 - 21 - 22 - 23 - 24 -26	Green
344	Hand, voet, extremiteiten: Pezen specifiek: herstel letsel buigpees in de peeskoker + ev. vaatzenuwletsel 1 straal	11 - 14 - 21 - 22 - 23 - 24 -26	Green
345	Hand, voet, extremiteiten: Pezen specifiek: herstel letsel buigpees + ev. vaatzenuwletsel multipele stralen	11 - 14 - 21 - 22 - 23 - 24 -26	Green
346	Hand, voet, extremiteiten: Pezen specifiek: herstel buig- / strekpeesletsel pols, onderarm, 1-3 pezen	11 - 14 - 21 - 22 - 23 - 24 -26	Green
347	Hand, voet, extremiteiten: Pezen specifiek: herstel uitgebreid peesletsel pols, onderarm, 'spagetti pols' >3 pezen	11 - 14 - 21 - 22 - 23 - 24 -26	Green
348	Hand, voet, extremiteiten: Pezen specifiek: herstel buigpeesletsel pols, onderarm + zenuw- en/of vaatletsel	11 - 14 - 21 - 22 - 23 - 24 -26	Green
350	Hand, voet, extremiteiten: Zenuwen: inspuiting(en) CTS, neuroom, diagnostisch	11 - 14 - 21 - 22 - 23 - 24 -26	Green
351	Hand, voet, extremiteiten: Zenuwen: CTS, decompressie carpale tunnel / klieven retinaculum, open of endoscopisch	11 - 14 - 21 - 22 - 23 - 24 -26	Green
352	Hand, voet, extremiteiten: Zenuwen: decompressie overige compressie syndromen, neurolyse (incl recidief CTS)	11 - 14 - 21 - 22 - 23 - 24 -26	Green
353	Hand, voet, extremiteiten: Zenuwen: behandeling neuroom, zenuw tumor	11 - 14 - 21 - 22 - 23 - 24 -26	Green
354	Hand, voet, extremiteiten: Zenuwen: microchirurgisch herstel 1-2 digitale zenuwen	11 - 14 - 21 - 22 - 23 - 24 -26	Green
355	Hand, voet, extremiteiten: Zenuwen: microchir. herstel hoofdzenuw(en) medianus, ulnaris, radialis of >2 dig. zenuwen	11 - 14 - 21 - 22 - 23 - 24 -26	Green
356	Hand, voet, extremiteiten: Zenuwen: zenuwherstel inclusief nemen transplantaat	11 - 14 - 21 - 22 - 23 - 24 -26	Green
357	Hand, voet, extremiteiten: Zenuwen: microchirurgisch herstel plexus brachialis	11 - 14 - 21 - 22 - 23 - 24 -26	Green

360	Hand, voet, extremiteiten: Gewrichten: inspuiting(en), volledige behandeling: gewrichten	11 - 14 - 21 - 22 - 23 - 24 -26	Green
361	Hand, voet, extremiteiten: Gewrichten: artrodese IG / MCP / CMC	11 - 14 - 21 - 22 - 23 - 24 -26	Green
362	Hand, voet, extremiteiten: Gewrichten: artroplastiek IG / MCP autoloog materiaal / kunststof gewricht + strekpeestranspositie (1 straal)	11 - 14 - 21 - 22 - 23 - 24 -26	Green
363	Hand, voet, extremiteiten: Gewrichten: multipele artroplastieken + strekpees- reposities + evt synovectomie	11 - 14 - 21 - 22 - 23 - 24 -26	Green
364	Hand, voet, extremiteiten: Gewrichten: CMC1 resectie artroplastiek, autoloog materiaal, ligament reconstr., kunststof gewricht	11 - 14 - 21 - 22 - 23 - 24 -26	Green
365	Hand, voet, extremiteiten: Gewrichten: artrolyse	11 - 14 - 21 - 22 - 23 - 24 -26	Green
366	Hand, voet, extremiteiten: Gewrichten: artrolyse incl tenolyse / peestransposities	11 - 14 - 21 - 22 - 23 - 24 -26	Green
371	Hand, voet, extremiteiten: Bot / amputaties / transplantatie: excochleatie, sequestrectomie, exostose, correctie carpal bossing	11 - 14 - 21 - 22 - 23 - 24 -26	Green
372	Hand, voet, extremiteiten: Bot / amputaties / transplantatie: verwijderen K-draden, osteosynthese materiaal	11 - 14 - 21 - 22 - 23 - 24 -26	Green
373	Hand, voet, extremiteiten: Bot / amputaties / transplantatie: botstandcorrectie, osteotomie, pseudartrose + evt botplastiek	11 - 14 - 21 - 22 - 23 - 24 -26	Green
374	Hand, voet, extremiteiten: Bot / amputaties / transplantatie: botverlenging, distractie osteotomie + evt botplastiek	11 - 14 - 21 - 22 - 23 - 24 -26	Green
375	Hand, voet, extremiteiten: Bot / amputaties / transplantatie: amputatie vinger partieel of geheel	11 - 14 - 21 - 22 - 23 - 24 -26	Green
376	Hand, voet, extremiteiten: Bot / amputaties / transplantatie: straalamputatie evt met straattrans-positie / handversmalling	11 - 14 - 21 - 22 - 23 - 24 -26	Green
377	Hand, voet, extremiteiten: Bot / amputaties / transplantatie: hand / pols / onderarm amputatie	11 - 14 - 21 - 22 - 23 - 24 -26	Green
378	Hand, voet, extremiteiten: Bot / amputaties / transplantatie: verwijdering boventallige vinger of teen	11 - 14 - 21 - 22 - 23 - 24 -26	Green
379	Hand, voet, extremiteiten: Bot / amputaties / transplantatie: teen, duim, vingertransplantatie	11 - 14 - 21 - 22 - 23 - 24 -26	Green
380	Hand, voet, extremiteiten: Ziekten: Dupuytren, reuma, artrosis, synovitis: inspuiting(en), volledige behandeling: Dupuy,reuma,artrosis,synovitis	11 - 14 - 21 - 22 - 23 - 24 -26	Green
381	Hand, voet, extremiteiten: Ziekten: Dupuytren, reuma, artrosis, synovitis: selectieve fasciectomie evt met transpositie of transplantatie 1 straal	11 - 14 - 21 - 22 - 23 - 24 -26	Green
382	Hand, voet, extremiteiten: Ziekten: Dupuytren, reuma, artrosis, synovitis: selectieve fasciectomie evt met transpositie of transplantatie multipele stralen	11 - 14 - 21 - 22 - 23 - 24 -26	Green
383	Hand, voet, extremiteiten: Ziekten: Dupuytren, reuma, artrosis, synovitis: synovectomie buigpees / strekpees / gewricht 1 straal	11 - 14 - 21 - 22 - 23 - 24 -26	Green
384	Hand, voet, extremiteiten: Ziekten: Dupuytren, reuma, artrosis, synovitis: synovectomie buigpezen / strekpezen / gewrichten / multipele stralen, synov. pols	11 - 14 - 21 - 22 - 23 - 24 -26	Green
386	Hand, voet, extremiteiten: Ziekten: Dupuytren, reuma, artrosis, synovitis: combinatie multipele reuma correctieve ingrepen	11 - 14 - 21 - 22 - 23 - 24 -26	Green

391	Hand, voet, extremiteiten: Congenitaal: separatie syndactylie 1 straal	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
392	Hand, voet, extremiteiten: Congenitaal: separatie syndactylie multipele stralen	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
393	Hand, voet, extremiteiten: Congenitaal: correctie complexe syndactylie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
394	Hand, voet, extremiteiten: Congenitaal: correctie onderarm deficienties	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
395	Hand, voet, extremiteiten: Congenitaal: vinger hypoplasie phalanx transplantatie, phalanx dystractie osteotomie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
396	Hand, voet, extremiteiten: Congenitaal: pollicisatie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
410	Pols / onderarm: Algemeen / diagnostisch: inspuiting(en), volledige behandeling: algemeen / diagnostisch	11 - 12 - 13 - 14 - 21 - 22 - 23 - 24 - 26	Green	
411	Pols / onderarm: Algemeen / diagnostisch: spalk behandeling	11 - 12 - 13 - 14	Green	
412	Pols / onderarm: Algemeen / diagnostisch: artroscopie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
413	Pols / onderarm: Algemeen / diagnostisch: denervatie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
414	Pols / onderarm: Algemeen / diagnostisch: uitgebreide analyse chronische polsklachten	11 - 12 - 13 - 14	Green	
420	Pols / onderarm: Fracturen / luxatie: fractuur / luxatie carpalia conservatief	11 - 12 - 13 - 14	Green	
421	Pols / onderarm: Fracturen / luxatie: fractuur luxatie carpalia operatief	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
422	Pols / onderarm: Fracturen / luxatie: behandeling pseudartrosis carpalia met bottransplantaat	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
423	Pols / onderarm: Fracturen / luxatie: inbrengen botspaan	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
431	Pols / onderarm: Ligamenten: ligament reconstructie incl peestransplantaat	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
432	Pols / onderarm: Ligamenten: TFC herstel, plastiek	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
433	Pols / onderarm: Ligamenten: stabilisatie distale ulna	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
441	Pols / onderarm: Reuma, artrose, Kienbock, instabiliteit: resectie carpalia / proximale rij carpectomie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
442	Pols / onderarm: Reuma, artrose, Kienbock, instabiliteit: intercarpale artrodese	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
443	Pols / onderarm: Reuma, artrose, Kienbock, instabiliteit: totale pols artrodese	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
444	Pols / onderarm: Reuma, artrose, Kienbock, instabiliteit: polsartroplastiek kunstgewricht	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
445	Pols / onderarm: Reuma, artrose, Kienbock, instabiliteit: (hemi)resectie distale ulna / Sauvé-Kapandji procedure	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
450	Pols / onderarm: Onderarm / pols: distale radius fractuur conservatief	11 - 12 - 13 - 14	Green	
451	Pols / onderarm: Onderarm / pols: distale radius fractuur chirurgisch	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
452	Pols / onderarm: Onderarm / pols: osteotomie radius / ulna	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
453	Pols / onderarm: Onderarm / pols: behandeling Volkmanse contractuur per fase	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
454	Pols / onderarm: Onderarm / pols: arthroscopie diagnostisch en/of therapeutisch	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
501	Algemeen: Defecten / tekorten / littekens: congenitaal, post-traumatisch, post-thermisch, post-radiatie, oncologisch, post-paralytisch, decubitus: defect/tekort niet FG met transpositie of transplantatie < 1%, incl. evt.verwijderen TE	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
502	Algemeen: Defecten / tekorten / littekens: congenitaal, post-traumatisch, post-thermisch, post-radiatie, oncologisch, post-paralytisch, decubitus: littekencorrectie niet FG met transpositie of	11 - 14 - 24 21 - 22 - 23- 26	Green Orange	Yes

	transplantatie < 1%			
503	Algemeen: Defecten / tekorten / littekens: congenitaal, post-traumatisch, post-thermisch, post-radiatie, oncologisch, post-paralytisch, decubitus: herstel defect/tekort niet in FG, waarvoor transpositie of transplantatie 1-3%, of sluiten defect w.o. in FG	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
504	Algemeen: Defecten / tekorten / littekens: congenitaal, post-traumatisch, post-thermisch, post-radiatie, oncologisch, post-paralytisch, decubitus: littekencorrectie niet in FG, waarvoor transpositie of transplantatie 1-3%, of littekencorrectie w.o. in FG	11 - 14 - 24 21 - 22 - 23- 26	Green Orange	 Yes
505	Algemeen: Defecten / tekorten / littekens: congenitaal, post-traumatisch, post-thermisch, post-radiatie, oncologisch, post-paralytisch, decubitus: herstel defect/tekort niet in FG, waarvoor transpositie of transplantatie >3%, of sluiten defect/tekort w.o.	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
506	Algemeen: Defecten / tekorten / littekens: congenitaal, post-traumatisch, post-thermisch, post-radiatie, oncologisch, post-paralytisch, decubitus: littekencorrectie niet in FG, waarvoor transpositie of transplantatie >3%, of littekencorrectie w.o. in FG 1	11 - 14 - 24 21 - 22 - 23- 26	Green Orange	 Yes
507	Algemeen: Tumoren, pathologisch weefsel (PW): abces drainage, kleine necrotectomie	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
508	Algemeen: Tumoren, pathologisch weefsel (PW): excisie 1-3 benigne tumoren / naevi niet in FG, littekencorrectie niet FG met transpositie of transplantatie < 1%	11 - 14 - 24 21 - 22 - 23- 26	Green Orange	 Yes
509	Algemeen: Tumoren, pathologisch weefsel (PW): mal. tumor niet in FG	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
510	Algemeen: Tumoren, pathologisch weefsel (PW): excisie 1-3 ben. tumoren / naevi w.o. in FG of 4-10 niet in FG	11 - 14 - 24 21 - 22 - 23- 26	Green Orange	 Yes
511	Algemeen: Tumoren, pathologisch weefsel (PW): maligne tumor in FG waarvoor transp. of transpl. <1%	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
512	Algemeen: Tumoren, pathologisch weefsel (PW): excisie benigne tumor / PW en transpositie of transplantatie 1-3% niet in FG, of, 4-10 naevi w.o. in FG	11 - 14 - 24 21 - 22 - 23- 26	Green Orange	 Yes
513	Algemeen: Tumoren, pathologisch weefsel (PW): excisie maligne tumoren / PW waarvoor transpositie of transplantatie in FG 1-3% of niet in FG >3%, 2-5 maligne tumoren	11 - 14 - 21 - 22 - 23 - 24 -26	Green	
514	Algemeen: Tumoren, pathologisch weefsel (PW): excisie benigne tumoren / PW waarvoor transpositie of transplantatie >3% niet in FG, meer dan 10 benigne tumoren / naevi	11 - 14 - 24 21 - 22 - 23- 26	Green Orange	 Yes

Behandelingen: 11 Conservatief poliklinisch; 12 Conservatief met dagopname(n); 13 Conservatief met klinische episode(n); 14 Enkelvoudig polklinisch conservatief; 21 Operatief poliklinisch; 22 Operatief met dagopname(n); Operatief met klinische episode(n); Enkelvoudig poliklinisch met verrichting; 26 Klinisch Zonder Dagen (KZD) operatief met klinische episoden.

Source: DBC Eindklasse Tabel 0304 Plastische chirurgie (v20071001) [94]

APPENDICES ON VOLUME OF PLASTIC SURGERY

APPENDIX 12 CLASSIFICATION OF BELGIAN INVOICING NOMENCLATURE CODES FOR REIMBURSED PLASTIC SURGERY, AND NUMBER AND INSURANCE COST OF THESE PROCEDURES IN 1995 AND 2006

Source of invoicing nomenclature codes: Belgian Fee Schedule ('The Nomenclature')[37]

The data in this appendix comprise all reimbursed plastic surgery procedures, as described in the methodology section (see page 12). These data were delivered by the National Institute for Health and Disability Insurance.

Description of the columns:

First column 'Article Nomenclature' refers to the article of the fee schedule that the invoice code belongs to: Art.14a General Surgery; Art.14c Plastic Surgery; Art.14d Abdominal Surgery; Art.14e Thorax Surgery; Art.14h Ophthalmology; Art.14i Ear Nose Throat Surgery; Art. 21 Dermatology.

Second column 'A/H' indicates in which situation the invoice code is used. 'A' stands for ambulatory and 'H' for hospitalized.

Third column gives the invoice code of the nomenclature.

Columns 4 and 5 indicate when reimbursement by statutory health insurance, respectively, started and ended.

Column 6 gives the Dutch description of the invoice code.

Column 7 gives the same information in French.

Columns 8 and 9 provide information on the number of procedures in, respectively, 1995 and 2006. Columns 10 and 11 supply information on the insurance cost, for the same years.

The last two columns '% plastic surgeons' deliver information on the percentage of procedures performed by plastic surgeons.

The notation ' - ' is used when there are no available data because the invoice code was not reimbursed in that year.

Invoice codes highlighted in grey are those labelled as 'borderline' surgery.

Article Nomen-clature	Invoice code	Reimbursement Start Date	Reimbursement End Date	Description in Dutch	Description in French	Number procedures 1995	Number procedures 2006	Insurance cost 1995	Insurance cost 2006	% plastic surgeons 1995	% plastic surgeons 2006
Skin and soft tissues: Flap											
Art. 14c	250132	1/01/1985	1/04/2003	Buislap- of italiaanse plastiek, hoofdbewerking	Plastique tubulée ou à l'italienne, temps principal	54	-	€ 12 065	-	22%	-
Art. 14c	250143	1/01/1985	1/04/2003			105	-	€ 21 301	-	48%	-
Art. 14c	250154	1/01/1985	1/04/2003	Buislap- of italiaanse plastiek, voorbereidende en volgende bewerkingen	Plastique tubulée ou à l'italienne, préparatoires et complémentaires	82	-	€ 6 491	-	37%	-
Art. 14c	250165	1/01/1985	1/04/2003			47	-	€ 3 166	-	51%	-
Art. 14c	250176	1/01/1985		Huid- of fascio-cutane flap, hoofdbewerking	Lambeau pédiculé cutané ou fascio-cutané, temps principal	5 222	5 819	€ 758 853	€1 227 186	50%	52%
Art. 14c	250180	1/01/1985				3 943	3 165	€ 510 822	€ 590 118	53%	50%
Art. 14c	250191	1/01/1985		Huid- of fascio-cutane flap, bijkomende bewerking, per tijd	Lambeau pédiculé cutané ou fascio-cutané, temps complémentaire, par temps	335	677	€ 24 977	€ 77 950	63%	72%
Art. 14c	250202	1/01/1985				391	358	€ 25 105	€ 36 307	62%	76%
Art. 14c	250213	1/01/1985		Huid- of fascio cutane flap, in één bewerking over een oppervlakte gelijk of groter dan 100 cm²	Lambeau pédiculé cutané ou fascio-cutané réalisé en un temps sur une surface égale ou supérieure à 100 cm²	78	188	€ 21 791	€ 59 838	74%	76%
Art. 14c	250224	1/01/1985				678	1 057	€ 172 086	€ 291 065	65%	78%
Art. 14c	251812	1/01/1985		Voorbereiden van bloedvaten thv receptorplaats en inzetten van de flap bij middel van microchirurgische technieken : termino-terminale arterie en vene anastomose (met of zonder zenuw anastomose)	Préparation des vaisseaux dans le site receveur, mise en place du lambeau, et réalisation des sutures microchirurgicales : sutures vasculaires simples : une artère et une anastomose veineuse (avec ou sans neuro-anastomose)	3	2	€ 1 146	€ 1 062	0%	0%
Art. 14c	251823	1/01/1985				236	141	€ 78 777	€ 70 356	63%	62%
Art. 14c	251834	1/01/1985		Voorbereiden van bloedvaten thv receptorplaats en inzetten van de flap bij middel van ingewikkelde microchirurgische vaatsutuur : termino-lateraal; tweeloopsanastomose	Préparation des vaisseaux dans le site receveur, mise en place du lambeau, et réalisation des sutures microchirurgicales : sutures vasculaires complexes (termino-latérales, canon de fusil..)	1	2	€ 637	€ 1 986	100%	0%
Art. 14c	251845	1/01/1985				182	958	€ 113 693	€ 897 721	68%	88%
Art. 14c	251856	1/01/1985		Spierlap, hoofdbewerking	Lambeau musculaire, temps principal	22	61	€ 4 195	€ 21 062	32%	54%
Art. 14c	251860	1/01/1985				380	492	€ 66 462	€ 149 238	43%	40%
Art. 14c	251871	1/01/1985		Spierlap, bijkomende bewerking, per tijd	Lambeau musculaire, temps complémentaire, par temps	29	42	€ 2 177	€ 4 615	45%	64%
Art. 14c	251882	1/01/1985				159	122	€ 10 367	€ 12 416	54%	54%
Art. 14c	251893	1/01/1985		Spierhuidlap	Lambeau musculo-cutané	41	57	€ 12 230	€ 25 396	37%	84%
Art. 14c	251904	1/01/1985				1 122	948	€ 301 339	€ 390 753	64%	69%
Art. 14c	251915	1/04/2003		Vrijmaken van enkelvoudige weefselflap (bv. spier) en klaarmaken van de vaatsteel voor microchirurgische transfer	Prélèvement d'un lambeau mono-tissulaire (ex : musculaire), et préparation du pédicule en vue du transfert microchirurgical	-	3	-	€ 806	-	0%
Art. 14c	251926	1/04/2003				-	142	-	€ 35 407	-	57%
Art. 14c	251930	1/04/2003		Vrijmaken van samengestelde weefselflap (bv. osteo septo cutaan) en klaarmaken van de vaatsteel voor microchirurgische transfer	Prélèvement d'un lambeau composite pluri-tissulaire (ex : ostéo-septo-cutané), et préparation du pédicule en vue du transfert microchirurgical	-	0	-	€ 0	-	0%
Art. 14c	251941	1/04/2003				-	867	-	€ 287 265	-	91%

Article Nomen-clature	Invoice code	Reimbursement Start Date	Reimbursement End Date	Description in Dutch	Description in French	Number procedures 1995	Number procedures 2006	Insurance cost 1995	Insurance cost 2006	% plastic surgeons 1995	% plastic surgeons 2006
Skin and soft tissues: Skin graft											
Art. 14c	251274	1/01/1985		Dermo-epidermale enten : Over een oppervlakte van minder dan 10 cm²	Greffe dermo-épidermique : Couvrant une surface inférieure à 10 cm²	720	329	€ 35 308	€ 17 348	25%	16%
Art. 14c	251285	1/01/1985				618	200	€ 27 269	€ 9 422	24%	19%
Art. 14c	251296	1/01/1985		Dermo-epidermale enten : Over een oppervlakte van 10 cm² tot 50 cm²	Greffe dermo-épidermique : Couvrant une surface de 10 cm² à 50 cm²	171	139	€ 18 626	€ 17 096	51%	42%
Art. 14c	251300	1/01/1985				957	587	€ 95 904	€ 66 306	36%	41%
Art. 14c	251311	1/01/1985		Dermo-epidermale enten : Over een oppervlakte van 50 cm² tot 200 cm²	Greffe dermo-épidermique : Couvrant une surface de 50 cm² à 200 cm²	108	83	€ 15 854	€ 14 787	53%	67%
Art. 14c	251322	1/01/1985				2 136	871	€ 297 196	€ 142 292	47%	57%
Art. 14c	251333	1/01/1985		Dermo-epidermale enten : Over een oppervlakte van meer dan 200 cm²	Greffe dermo-épidermique : Couvrant une surface supérieure à 200 cm²	0	14	€ 0	€ 4 745	0%	79%
Art. 14c	251344	1/01/1985				1 925	596	€ 87 700	€ 200 705	52%	46%
Art. 14c	251355	1/01/1985		Enten van totale huid (inclusief bedekken van de donoroppervlakte) over een oppervlakte van 10 cm² tot 50 cm²	Greffe de peau totale (y compris le recouvrement de la surface donneuse) couvrant une surface de 10 cm² à 50 cm²	65	80	€ 2 850	€ 12 603	62%	68%
Art. 14c	251366	1/01/1985				125	163	€ 4 535	€ 22 326	55%	70%
Art. 14c	251370	1/01/1985		Enten van totale huid (inclusief bedekken van de donoroppervlakte) over een oppervlakte van 50 cm² tot 200 cm²	Greffe de peau totale (y compris le recouvrement de la surface donneuse) couvrant une surface de 50 cm² à 200 cm²	22	15	€ 4 817	€ 5 304	68%	73%
Art. 14c	251381	1/01/1985				189	139	€ 35 429	€ 41 049	61%	96%
Art. 14c	253654	1/01/1985		Enten van totale huid (inclusief bedekken van de donoroppervlakte) over een oppervlakte van minder dan 10 cm² in het gelaat	Greffe de peau totale (y compris le recouvrement de la surface donneuse) couvrant une surface inférieure à 10 cm², au niveau de la face	260	50	€ 20 248	€ 7 970	22%	78%
Art. 14c	253665	1/01/1985				52	53	€ 3 323	€ 6 604	44%	64%
Art. 14c	253676	1/04/2003		Enten van totale huid (inclusief bedekken van de donoroppervlakte) over een oppervlakte van minder dan 10 cm², behalve het gelaat	Greffe de peau totale (y compris le recouvrement de la surface donneuse) couvrant une surface inférieure à 10 cm², excepté la face	-	83	-	€ 6 371	-	69%
Art. 14c	253680	1/04/2003				-	54	-	€ 3 096	-	69%
Skin and soft tissues: Implant											
Art. 14c	251672	1/11/1992		Subcutaan plaatsen van één expansie prothese	Placement sous-cutané d'une prothèse d'expansion	43	19	€ 4 645	€ 3 051	84%	74%
Art. 14c	251683	1/11/1992				154	105	€ 14 792	€ 14 735	74%	89%
Art. 14c	251694	1/07/1999		Plaatsen van osteogeïntegreerde implantaten voor het vasthechten van een gelaatsepithese met het oog op de correctie van een verminking ten gevolge van een traumatische of aangeboren misvorming	Mise en place d'implants ostéo-intégrables pour la fixation d'une épithèse de la face en vue de corriger une mutilation du visage suite à une malformation d'origine traumatique ou congénitale	-	14	-	€ 3 588	-	14%
Art. 14c	251705	1/07/1999				-	26	-	€ 5 656	-	23%
Art. 14c	251716	1/04/2003		Subcutaan plaatsen van meer dan één expansie prothese	Placement sous-cutané de plusieurs prothèses d'expansion	-	8	-	€ 1 781	-	63%
Art. 14c	251720	1/04/2003				-	28	-	€ 7 618	-	68%

Article Nomen-clature	Invoice code	Reimbursement Start Date	Reimbursement End Date	Description in Dutch	Description in French	Number procedures 1995	Number procedures 2006	Insurance cost 1995	Insurance cost 2006	% plastic surgeons 1995	% plastic surgeons 2006
Skin and soft tissues: Burn											
Art. 14a	221012	1/01/1985		Tangentiële excisie met de dermatoom van verbrande huid of escharectomie van verbrande weefsels, uitgestrekt over : 5 tot 10 pct. van de lichaamsoppervlakte	Excision tangentielle au dermatome de peau brûlée, ou escarrectomie de tissus brûlés sur une étendue : de 5 à 10 % de la surface corporelle	85	152	€ 6 624	€ 13 760	11%	43%
Art. 14a	221023	1/01/1985				392	331	€ 29 374	€ 28 764	15%	27%
Art. 14a	221034	1/01/1985		Tangentiële excisie met de dermatoom van verbrande huid of escharectomie van verbrande weefsels, uitgestrekt over : 10 tot 20 pct. van de lichaamsoppervlakte	Excision tangentielle au dermatome de peau brûlée, ou escarrectomie de tissus brûlés sur une étendue : de 10 à 20 % de la surface corporelle	39	31	€ 6 181	€ 6 086	38%	23%
Art. 14a	221045	1/01/1985				291	335	€ 43 005	€ 64 479	40%	32%
Art. 14a	221056	1/01/1985		Tangentiële excisie met de dermatoom van verbrande huid of escharectomie van verbrande weefsels, uitgestrekt over : 20 pct. en meer van de lichaamsoppervlakte	Excision tangentielle au dermatome de peau brûlée, ou escarrectomie de tissus brûlés sur une étendue : de 20 % et plus de la surface corporelle	1	2	€ 301	€ 698	0%	0%
Art. 14a	221060	1/01/1985				18	18	€ 5 402	€ 6 806	89%	100%
Art. 14a	221071	1/01/1985		Tangentiële excisie met de dermatoom van verbrande huid of escharectomie van verbrande weefsels, uitgestrekt over : tenminste één derde van het gelaat	Excision tangentielle au dermatome de peau brûlée, ou escarrectomie de tissus brûlés sur une étendue : d'un tiers au moins de la face	1	2	€ 160	€ 372	0%	0%
Art. 14a	221082	1/01/1985				12	9	€ 1 524	€ 1 694	50%	11%
Art. 14a	221093	1/01/1985		Tangentiële excisie met de dermatoom van verbrande huid of escharectomie van verbrande weefsels, uitgestrekt over : één hand en vingers	Excision tangentielle au dermatome de peau brûlée, ou escarrectomie de tissus brûlés sur une étendue : d'une main et des doigts	21	11	€ 3 376	€ 2 047	14%	9%
Art. 14a	221104	1/01/1985				29	14	€ 4 414	€ 2 681	55%	43%
Art. 14a	221115	1/01/1985		Tangentiële excisie met de dermatoom van verbrande huid of escharectomie van verbrande weefsels, uitgestrekt over : de twee handen en de vingers ervan	Excision tangentielle au dermatome de peau brûlée, ou escarrectomie de tissus brûlés sur une étendue : des deux mains et de leurs doigts	3	3	€ 723	€ 893	0%	33%
Art. 14a	221126	1/01/1985				8	2	€ 1 925	€ 308	50%	50%
Art. 14a	221130	1/01/1985		Tangentiële excisie met de dermatoom van verbrande huid of escharectomie van verbrande weefsels met bedekken met dermo-epidermale ent tijdens dezelfde operatiezitting : 20 pct. en meer van de lichaamsoppervlakte	Excision tangentielle au dermatome de peau brûlée, ou escarrectomie de tissus brûlés avec recouvrement par greffe dermo-épidermique au cours de la même séance opératoire : de 20 % et de plus de la surface corporelle	0	3	€ 0	€ 1 737	0%	67%
Art. 14a	221141	1/01/1985				3	139	€ 1 404	€ 81 529	99%	96%
Skin and soft tissues: Scar											
Art. 14a	221196	1/04/2003		Uitsnijden van een misvormd litteken, gevolgd door hechting	Excision de cicatrice vicieuse, suivie de suture	-	2 599	-	€ 138 655	-	86%
Art. 14a	221200	1/04/2003				-	647	-	€ 27 890	-	65%
Art. 21	532313	1/01/1985	1/07/1999	Uitsnijden van misvormd litteken, gevolgd door hechting	Excision de cicatrice vicieuse, suivie de suture	2 768	-	€ 110 499	-	54%	-
Art. 21	532324	1/01/1985	1/07/1999			892	-	€ 29 026	-	48%	-

Article Nomen-clature	Invoice code	Reimbursement Start Date	Reimbursement End Date	Description in Dutch	Description in French	Number procedures 1995	Number procedures 2006	Insurance cost 1995	Insurance cost 2006	% plastic surgeons 1995	% plastic surgeons 2006
Skin and soft tissues: Tumour											
Art. 14a	220334	1/01/1985		Heelkundige bewerking wegens expansieve diepe tumoren of letsels aan het gelaat of lippen die brede resectie vergt, inclusief plastiek	Intervention chirurgicale pour tumeurs profondes expansives ou lésions de la face ou des lèvres, nécessitant résection large, plastique comprise	1 481	1 531	€ 342 385	€ 429 627	62%	55%
Art. 14a	220345	1/01/1985				1 003	471	€ 223 481	€ 126 862	52%	35%
Art. 21	531812	1/01/1985	1/07/1999	Heelkundige bewerking wegens expansieve en diepe tumors of letsels van gelaat of lippen die brede resectie vergt, inclusief plastiek	Intervention chirurgicale pour tumeurs ou lésions expansives et profondes de la face ou des lèvres, nécessitant résection large, plastique comprise	683	-	€ 135 221	-	6%	-
Art. 21	531823	1/01/1985	1/07/1999			210	-	€ 41 398	-	11%	-
Art. 14c	251731	1/04/2003		Verwijderen van een gezwel van de huid of de slijmvliezen of ander letsel rechtstreeks toegankelijk door excisie met plastie en/of greffe	Exérèse d'une tumeur de la peau ou des muqueuses ou d'une autre lésion directement accessible, par excision avec plastie et/ou greffe	-	4 716	-	€1 216 026	-	78%
Art. 14c	251742	1/04/2003				-	1 041	-	€ 254 933	-	70%
Art. 21	532674	1/07/1999		Verwijderen van een gezwel van de huid of de slijmvliezen of een ander, direct toegankelijk letsel door excisie met plastie en/of greffe	Exérèse d'une tumeur de la peau ou des muqueuses ou d'une autre lésion directement accessible, par excision avec plastie et/ou greffe	-	1 988	-	€ 458 427	-	4%
Art. 21	532685	1/07/1999				-	77	-	€ 17 758	-	9%
Art. 14c	251753	1/04/2003		Verwijderen van een kwaadaardig gezwel van de huid of de slijmvliezen volgens een micrografische heelkundige techniek met peroperatieve pathologische anatomie, zonder sluiten van de wonde	Exérèse d'une tumeur maligne de la peau ou des muqueuses selon une technique de chirurgie micrographique avec examen anatomo-pathologique peropératoire, sans fermeture de la plaie	-	46	-	€ 16 087	-	78%
Art. 14c	251764	1/04/2003				-	37	-	€ 11 527	-	43%
Art. 21	532696	1/07/1999		Verwijderen van een kwaadaardig gezwel van de huid of de slijmvliezen volgens een micrografische of een analoge heelkundige techniek met peroperatoire pathologische anatomie ; zonder sluiten van de wonde	Exérèse d'une tumeur maligne de la peau ou des muqueuses selon une technique de chirurgie micrographique ou analogue avec examen anatomopathologique peropératoire, sans fermeture de la plaie	-	45	-	€ 13 680	-	2%
Art. 21	532700	1/07/1999				-	22	-	€ 6 376	-	0%
Art. 14c	251775	1/04/2003		Verwijderen van een kwaadaardig gezwel van de huid of de slijmvliezen volgens een micrografische heelkundige techniek met peroperatieve pathologische anatomie, en met sluiten van de wonden, een eventuele ent en/of plastie inbegrepen	Exérèse d'une tumeur maligne de la peau ou des muqueuses selon une technique de chirurgie micrographique avec examen anatomo-pathologique peropératoire, et avec fermeture de la plaie, y compris une greffe et/ou plastie éventuelle	-	1 651	-	€ 709 314	-	91%
Art. 14c	251786	1/04/2003				-	573	-	€ 247 915	-	88%
Art. 21	532711	1/07/1999		Verwijderen van een kwaadaardig gezwel van de huid of de slijmvliezen volgens een micrografische of een analoge heelkundige techniek met peroperatoire pathologische anatomie en met sluiten van de wonde, een eventuele greffe en/of plastie inbegrepen	Exérèse d'une tumeur maligne de la peau ou des muqueuses selon une technique de chirurgie micrographique ou analogue avec examen anatomopathologique peropératoire et avec fermeture de la plaie, y compris une greffe et/ou plastie éventuelle	-	411	-	€ 159 265	-	3%
Art. 21	532722	1/07/1999				-	142	-	€ 54 475	-	0%

Article Nomen-clature	Invoice code	Reimbursement Start Date	Reimbursement End Date	Description in Dutch	Description in French	Number procedures 1995	Number procedures 2006	Insurance cost 1995	Insurance cost 2006	% plastic surgeons 1995	% plastic surgeons 2006
Breast malformation											
Art. 14c	251576	1/04/2003		Borstplastie door implantatie van een borstprothese voor tubereuze borst, per borst	Plastie d'un sein par implantation d'une prothèse mammaire pour seins tubéreux, par sein	-	22	-	€ 5 617	-	95%
Art. 14c	251580	1/04/2003				-	102	-	€ 26 757	-	100%
Art. 14c	251591	1/03/2006		Wegnemen van een borstprothese, omwille van gedocumenteerde complicatie, per borst	Enlèvement d'une prothèse mammaire, pour raison de complication documentée, par sein	-	146	-	€ 8 374	-	72%
Art. 14c	251602	1/03/2006				-	256	-	€ 14 058	-	79%
Art. 14c	251613	1/01/1985		Reducerende borstplastie wegens borsthypertrofie die functionele hinder veroorzaakt, per borst	Plastie de réduction d'un sein pour hypertrophie mammaire entraînant une gêne fonctionnelle, par sein	9	80	€ 2 005	€ 26 652	100%	81%
Art. 14c	251624	1/01/1985				3 319	6 588	€ 724 356	€2 228 923	80%	92%
Art. 14c	251635	1/01/1985		Reducerende borstplastie van de heterolaterale borst in geval van éénzijdige ernstige aangeboren hypoplastie	Plastie de réduction du sein hétéro-latéral en cas d'hypoplasie congénitale majeure unilatérale	2	4	€ 461	€ 1 398	100%	100%
Art. 14c	251646	1/01/1985				48	75	€ 9 652	€ 25 076	85%	87%
Art. 14c	251650	1/01/1985		Implantatie van borstprothese in geval van éénzijdige ernstige aangeboren hypoplasie	Implantation de prothèse mammaire en cas d'hypoplasie congénitale majeure unilatérale	9	35	€ 1 071	€ 7 465	44%	100%
Art. 14c	251661	1/01/1985				77	92	€ 8 500	€ 18 029	77%	91%
Art. 14c	251790	1/04/2003		Heelkundige correctie van ingetrokken tepel, per borst	Correction chirurgicale d'un mamelon invaginé, par sein	-	292	-	€ 48 157	-	90%
Art. 14c	251801	1/04/2003				-	110	-	€ 16 599	-	85%
Art. 14e	227113	1/01/1985		Heelkundige bewerking wegens gynecomastie	Intervention chirurgicale pour gynécomastie	224	485	€ 15 914	€ 37 936	29%	54%
Art. 14e	227124	1/01/1985				741	596	€ 48 725	€ 43 192	45%	71%

Article Nomen-clature	Invoice code	Reimbursement Start Date	Reimbursement End Date	Description in Dutch	Description in French	Number procedures 1995	Number procedures 2006	Insurance cost 1995	Insurance cost 2006	% plastic surgeons 1995	% plastic surgeons 2006
Breast reconstruction after mutilating surgery											
Art. 14c	252431	1/01/1985		Reconstructieve chirurgie door implantatie van prothese, in geval van unilaterale ernstige aangeboren hypoplasie of misvorming, na een mutilerende ingreep van een borst	Reconstruction chirurgicale par implantation de prothèse, dans les cas d'hypoplasie congénitale majeure unilatérale ou de malformation après traitement mutilant du sein	26	93	€ 3 669	€ 19 393	88%	90%
Art. 14c	252442	1/01/1985				554	877	€ 62 761	€ 161 858	83%	93%
Art. 14c	252453	1/01/1985		Reconstructieve chirurgie - operatie 226973 - 226984 of 226995 - 227006 of 227010 - 227021 of 227032 - 227043 of 227054 - 227065 : Door transpostiehuidlap, bijvoorbeeld van het thoraco-epigastrisch gesteelde flaptype	Reconstruction chirurgicale après une opération 226973 - 226984 ou 226995 - 227006 ou 227010 - 227021 ou 227032 - 227043 ou 227054 - 227065 : Par lambeau cutané de transposition, par exemple du type thoraco-épigastrique pédiculé	0	9	€ 0	€ 2 860	0%	56%
Art. 14c	252464	1/01/1985				20	83	€ 5 305	€ 23 581	85%	88%
Art. 14c	252475	1/01/1985		Reconstructieve chirurgie - operatie 226973 - 226984 of 226995 - 227006 of 227010 - 227021 of 227032 - 227043 of 227054 - 227065 : Door spier-huidlap	Reconstruction chirurgicale après une opération 226973 - 226984 ou 226995 - 227006 ou 227010 - 227021 ou 227032 - 227043 ou 227054 - 227065 : Par lambeau musculo-cutané	3	3	€ 917	€ 1 300	100%	100%
Art. 14c	252486	1/01/1985				254	313	€ 70 366	€ 137 447	85%	94%
Art. 14c	252490	1/01/1985		Reconstructieve chirurgie - operatie 226973 - 226984 of 226995 - 227006 of 227010 - 227021 of 227032 - 227043 of 227054 - 227065 : Reconstructie van de areolaire streek	Reconstruction chirurgicale après une opération 226973 - 226984 ou 226995 - 227006 ou 227010 - 227021 ou 227032 - 227043 ou 227054 - 227065 : Reconstruction de la région aréolaire	340	896	€ 47 074	€ 143 684	73%	105%
Art. 14c	252501	1/01/1985				289	261	€ 31 428	€ 30 442	68%	92%
Art. 14c	252512	1/01/1985		Reconstructieve chirurgie - operatie 226973 - 226984 of 226995 - 227006 of 227010 - 227021 of 227032 - 227043 of 227054 - 227065 : Opnieuw modelleren van het heterolaterale orgaan door een reducerende borstplastie, inclusief eventuele implantatie van een	Reconstruction chirurgicale après une opération 226973 - 226984 ou 226995 - 227006 ou 227010 - 227021 ou 227032 - 227043 ou 227054 - 227065 : Remodelage de l'organe hétéro-latéral par réduction d'un sein, y compris l'implantation éventuelle d'une prothèse	23	145	€ 4 645	€ 48 836	78%	91%
Art. 14c	252523	1/01/1985				384	747	€ 75 811	€ 241 700	80%	95%
Art. 14e	227511	1/08/1988		Bijkomend honorarium voor plaatsen van een inwendige prothese - de verstrekkingen 226951 - 226962, 226973 - 226984, 226995 - 227006 en 227010 - 227021 tijdens dezelfde operatiezitting	Supplément pour mise en place d'une prothèse interne après les prestations 226951 - 226962, 226973 - 226984, 226995 - 227006 ou 227010 - 227021 au cours de la même séance opératoire	0	1	€ 0	€ 214	0%	100%
Art. 14e	227522	1/08/1988				151	116	€ 19 429	€ 20 149	57%	87%

Article Nomen-clature	Invoice code	Reimbursement Start Date	Reimbursement End Date	Description in Dutch	Description in French	Number procedures 1995	Number procedures 2006	Insurance cost 1995	Insurance cost 2006	% plastic surgeons 1995	% plastic surgeons 2006
Nose full reconstruction											
Art. 14c	253116	1/01/1985		Rhinoplastie wegens verlies van neus (hoofdbewerking)	Rhinoplastie pour perte du nez (temps principal)	1	7	€ 344	€ 2 769	100%	43%
Art. 14c	253120	1/01/1985				31	23	€ 10 015	€ 9 049	61%	78%
Art. 14c	253131	1/01/1985		Rhinoplastie wegens verlies van neus (bijkomende bewerking)	Rhinoplastie pour perte du nez (temps complémentaire).	7	14	€ 803	€ 1 690	57%	64%
Art. 14c	253142	1/01/1985				21	6	€ 2 120	€ 650	67%	100%
Art. 14i	257950	1/01/1985		Rhinoplastiek wegens verlies van neus (hoofdbewerking)	Rhinoplastie pour perte du nez (temps principal)	1	2	€ 345	€ 798	0%	0%
Art. 14i	257961	1/01/1985				11	17	€ 3 783	€ 6 302	0%	0%
Art. 14i	257972	1/01/1985		Rhinoplastiek wegens verlies van neus (bijkomende bewerking)	Rhinoplastie pour perte du nez (temps complémentaire)	1	3	€ 115	€ 399	0%	0%
Art. 14i	257983	1/01/1985				3	1	€ 229	€ 133	33%	0%
Nose reshape											
Art. 14c	253175	1/01/1985		Plastische correctie van neusgatendrempel met functioneel doel	Correction plastique du seuil narinaire dans un but fonctionnel	2	22	€ 382	€ 5 028	50%	77%
Art. 14c	253186	1/01/1985				18	44	€ 3 153	€ 6 804	39%	48%
Art. 14i	255850	1/01/1985		Resectie van kam van neustussenschot	Résection de crête de cloison nasale	36	192	€ 1 024	€ 6 680	25%	13%
Art. 14i	255861	1/01/1985				25	22	€ 602	€ 532	12%	14%
Art. 14i	255872	1/01/1985		Resectie van neusschelp of neusschelpstaart, eenzijdige	Résection de cornet ou queue de cornet, unilatérale	383	295	€ 11 848	€ 9 465	0%	1%
Art. 14i	255883	1/01/1985				284	193	€ 4 954	€ 3 835	1%	2%
Art. 14i	255894	1/01/1985		Resectie van neusschelp of neusschelpstaart, tweezijdige	Résection de cornet ou queue de cornet, bilatérale	651	3 584	€ 28 712	€ 169 381	1%	0%
Art. 14i	255905	1/01/1985				2 544	5 013	€ 79 043	€ 166 212	0%	1%
Art. 14i	255916	1/01/1985		Behandeling van breuk van de neusbeenderen die een contentieapparaat vergt	Traitement de fractures des os propres du nez nécessitant un appareil de contention	1 306	1 846	€ 68 061	€ 109 189	7%	2%
Art. 14i	255920	1/01/1985				1 194	514	€ 54 663	€ 24 774	10%	6%
Art. 14i	258016	1/01/1985		Plastische correctie van neusgatendrempel met functioneel doel	Correction plastique du seuil narinaire dans un but fonctionnel	6	41	€ 1 147	€ 8 609	17%	15%
Art. 14i	258020	1/01/1985				46	76	€ 6 978	€ 13 074	0%	9%
Art. 14c	253153	1/01/1985		Herstel van een misvorming van neuspyramide door osteotomie of enten of prothese	Réfection d'une déformation de la pyramide nasale par ostéotomie ou greffe ou prothèse	8	137	€ 2 291	€ 47 412	38%	65%
Art. 14c	253164	1/01/1985				416	459	€ 116 886	€ 156 144	67%	70%
Art. 14i	257994	1/01/1985		Herstel van een misvorming van neuspyramide door osteotomie of enten of prothese	Réfection d'une déformation de la pyramide nasale par ostéotomie ou greffe ou prothèse	14	368	€ 4 016	€ 126 853	7%	6%
Art. 14i	258005	1/01/1985				945	1 819	€ 267 083	€ 622 076	4%	3%
Nose septum excision											
Art. 14c	253190	1/01/1985		Submuceuze resectie van tussenschot, inclusief eventuele repositie van tussenschot	Résection sous-muqueuse de la cloison, y compris la reposition éventuelle de la cloison	63	89	€ 9 549	€ 15 299	95%	89%
Art. 14c	253201	1/01/1985				224	99	€ 31 365	€ 15 238	69%	73%
Art. 14c	253212	1/01/1985		Submuceuze resectie van tussenschot, met correctie en repositie ervan in de groeve van een mediane osteotomie	Résection sous-muqueuse de la cloison, avec correction et reposition de celle-ci dans le sillon d'une ostéotomie médiane	26	104	€ 4 666	€ 22 005	65%	49%
Art. 14c	253223	1/01/1985				641	496	€ 106 657	€ 77 550	27%	18%
Art. 14i	258031	1/01/1985		Submuceuze resectie van tussenschot, inclusief eventuele repositie van tussenschot	Résection sous-muqueuse de la cloison, y compris la reposition éventuelle de la cloison	108	262	€ 15 862	€ 44 770	19%	12%
Art. 14i	258042	1/01/1985				912	426	€ 122 573	€ 61 944	4%	3%
Art. 14i	258053	1/01/1985		Submuceuze resectie van tussenschot, met correctie en repositie ervan in de groeve van een mediane osteotomie	Résection sous-muqueuse de la cloison, avec correction et reposition de celle-ci dans le sillon d'une ostéotomie médiane	238	1 612	€ 43 838	€ 334 871	5%	1%
Art. 14i	258064	1/01/1985				7 973	7 680	€1 360 985	€1 486 045	1%	0%

Article Nomen-clature	Invoice code	Reimbursement Start Date	Reimbursement End Date	Description in Dutch	Description in French	Number procedures 1995	Number procedures 2006	Insurance cost 1995	Insurance cost 2006	% plastic surgeons 1995	% plastic surgeons 2006
Ear full reconstruction											
Art. 14c	253610	1/01/1985		Volledige reconstructie van oorschelp wegens aplasie of traumatische amputatie : Hoofdbewerking	Reconstitution totale du pavillon de l'oreille pour aplasie ou amputation traumatique : Temps principal	3	8	€ 1 032	€ 3 159	33%	63%
Art. 14c	253621	1/01/1985				15	16	€ 5 160	€ 6 435	60%	50%
Art. 14c	253632	1/01/1985		Volledige reconstructie van de oorschelp wegens aplasie of traumatische amputatie : Per voorbereidende of aanvullende bewerking	Reconstitution totale du pavillon de l'oreille pour aplasie ou amputation traumatique : Par temps préparatoire ou complémentaire	6	10	€ 688	€ 1 235	100%	70%
Art. 14c	253643	1/01/1985				4	5	€ 402	€ 455	100%	100%
Art. 14i	258215	1/01/1985		Volledige reconstructie van oorschelp wegens aplasie of traumatische amputatie : Hoofdbewerking	Reconstitution totale du pavillon de l'oreille pour aplasie ou amputation traumatique : Temps principal	1	13	€ 306	€ 4 361	100%	0%
Art. 14i	258226	1/01/1985				22	13	€ 6 074	€ 4 520	9%	8%
Art. 14i	258230	1/01/1985		Volledige reconstructie van oorschelp wegens aplasie of traumatische amputatie : Per voorbereidende of aanvullende bewerking	Reconstitution totale du pavillon de l'oreille pour aplasie ou amputation traumatique : Par temps préparatoire ou complémentaire	3	4	€ 286	€ 532	0%	25%
Art. 14i	258241	1/01/1985				6	9	€ 687	€ 997	0%	11%
Ear correction											
Art. 14c	253551	1/01/1985		Correctie heelkunde op het oor (één oor)	Chirurgie corrective de l'oreille (une oreille)	244	337	€ 36 793	€ 59 416	72%	77%
Art. 14c	253562	1/01/1985				134	51	€ 18 667	€ 8 026	57%	53%
Art. 14c	253573	1/01/1985		Correctie heelkunde op het oor (twee oren)	Chirurgie corrective de l'oreille (deux oreilles)	674	1 315	€ 151 262	€ 354 120	82%	91%
Art. 14c	253584	1/01/1985				764	205	€ 169 079	€ 53 917	73%	76%
Art. 14c	253595	1/01/1985		Correctie heelkunde op het oor, per voorbereidende of aanvullende bewerking	Chirurgie corrective de l'oreille par temps préparatoire ou complémentaire	77	98	€ 4 463	€ 6 316	84%	74%
Art. 14c	253606	1/01/1985				22	7	€ 1 014	€ 503	73%	14%
Art. 14i	258156	1/01/1985		Eenzijdige correctieheelkunde op het oor	Chirurgie corrective de l'oreille (unilatérale)	90	278	€ 13 135	€ 49 379	21%	17%
Art. 14i	258160	1/01/1985				156	109	€ 21 055	€ 16 752	9%	5%
Art. 14i	258171	1/01/1985		Tweezijdige correctieheelkunde op het oor	Chirurgie corrective de l'oreille (bilatérale)	171	667	€ 38 570	€ 183 059	39%	18%
Art. 14i	258182	1/01/1985				629	308	€ 138 779	€ 82 987	10%	10%
Art. 14i	258193	1/01/1985		Correctieheelkunde op het oor, per voorbereidende of aanvullende bewerking	Chirurgie corrective de l'oreille par temps préparatoire ou complémentaire	28	56	€ 1 678	€ 4 000	11%	0%
Art. 14i	258204	1/01/1985				13	5	€ 602	€ 257	0%	0%

Article Nomenclature	Invoice code	Reimbursement Start Date	Reimbursement End Date	Description in Dutch	Description in French	Number procedures 1995	Number procedures 2006	Insurance cost 1995	Insurance cost 2006	% plastic surgeons 1995	% plastic surgeons 2006
Cleft lip and/or palate repair											
Art. 14c	253315	1/04/2003		Rhinoplastie na een gespleten lip of gespleten lip en verhemelte	Rhinoplastie pour déformation après fente labiale ou labio-palatine	-	18	-	€ 6 062	-	89%
Art. 14c	253326	1/04/2003				-	68	-	€ 22 509	-	44%
Art. 14i	256012	1/01/1985		Heelkundige bewerking wegens enkelvoudige hazelip	Intervention chirurgicale pour bec-de-lièvre simple	1	1	€ 153	€ 177	0%	100%
Art. 14i	256023	1/01/1985				73	43	€ 10 505	€ 7 648	55%	91%
Art. 14i	256034	1/01/1985		Heelkundige bewerking wegens dubbele hazelip	Intervention chirurgicale pour bec-de-lièvre double	1	1	€ 229	€ 292	0%	0%
Art. 14i	256045	1/01/1985				7	0	€ 1 490	€ 0	100%	0%
Art. 14i	256056	1/01/1985		Heelkundige bewerking wegens hazelip, aanvullende bewerkingen	Intervention chirurgicale pour bec-de-lièvre, temps complémentaires	12	14	€ 871	€ 1 055	75%	86%
Art. 14i	256060	1/01/1985				25	15	€ 1 424	€ 826	52%	73%
Art. 14i	256071	1/01/1985		Heelkundige bewerking wegens wolfsmuil, volledige	Intervention chirurgicale pour gueule de loup, complète	0	4	€ 0	€ 1 462	0%	25%
Art. 14i	256082	1/01/1985				39	40	€ 10 746	€ 14 434	72%	33%
Art. 14i	256093	1/01/1985		Heelkundige bewerking wegens wolfsmuil, navolgende bewerking	Intervention chirurgicale pour gueule de loup, temps complémentaires	4	2	€ 277	€ 184	75%	50%
Art. 14i	256104	1/01/1985				16	3	€ 870	€ 230	100%	100%
Art. 14i	256395	1/01/1985		Staphyloplastiek wegens gedeeltelijk gespleten gehemelte	Staphyloplastie pour division incomplète du palais	1	1	€ 229	€ 266	0%	0%
Art. 14i	256406	1/01/1985				52	4	€ 11 718	€ 1 169	13%	50%
Art. 14i	256410	1/01/1985		Staphyloplastiek wegens geheel gespleten gehemelte	Staphyloplastie pour division complète du palais	11	0	€ 3 159	€ 0	0%	0%
Art. 14i	256421	1/01/1985				90	68	€ 24 625	€ 23 001	50%	66%
Art. 14i	256432	1/01/1985		Staphylorrhafie wegens gedeeltelijk gespleten gehemelte	Staphylorraphie pour division incomplète du palais	6	13	€ 1 376	€ 3 643	0%	0%
Art. 14i	256443	1/01/1985				70	32	€ 15 734	€ 8 376	3%	6%
Art. 14i	256454	1/01/1985		Staphylorrhafie wegens geheel gespleten gehemelte	Staphylorraphie pour division complète du palais	0	0	€ 0	€ 0	0%	0%
Art. 14i	256465	1/01/1985				7	7	€ 2 008	€ 2 327	0%	0%

Article Nomenclature	Invoice code	Reimbursement Start Date	Reimbursement End Date	Description in Dutch	Description in French	Number procedures 1995	Number procedures 2006	Insurance cost 1995	Insurance cost 2006	% plastic surgeons 1995	% plastic surgeons 2006
Eyelid & Eyebrow											
Art. 14h	245534	1/01/1985		Heelkundige exeresis van een invasieve tumor van de marginale rand van het ooglid (histologisch bewezen)	Exérèse chirurgicale d'une tumeur invasive du bord marginal de la paupière (avec preuve histologique)	189	522	€ 21 027	€ 64 161	3%	3%
Art. 14h	245545	1/01/1985				34	48	€ 3 211	€ 4 355	12%	2%
Art. 14h	245556	1/01/1985		Exeresis van een klein angioom of lymfangioom van de oogleden	Exérèse de petit angiome ou lymphangiome des paupières	203	263	€ 5 066	€ 7 385	1%	1%
Art. 14h	245560	1/01/1985				13	5	€ 291	€ 100	15%	20%
Art. 14h	245571	1/01/1985		Heelkundige exeresis van een dermoidcyste van de wenkbrauw die niet tot diep in de oogholte reikt	Exérèse chirurgicale d'un kyste dermoïde du sourcil ne s'étendant pas profondément dans l'orbite	200	158	€ 9 424	€ 8 052	11%	22%
Art. 14h	245582	1/01/1985				31	5	€ 1 375	€ 242	16%	20%
Art. 14h	245593	1/01/1985		Volledige behandeling van xanthelasma (één oog)	Cure complète de xanthélasma (un oeil)	540	732	€ 12 672	€ 18 317	11%	23%
Art. 14h	245604	1/01/1985				21	5	€ 418	€ 115	38%	20%

Art. 14h	245615	1/01/1985		Chalazion : totaal verwijderen door curettage of uitsnijden met of zonder tarsusresectie	Chalazion : ablation totale par curetage ou excision avec ou sans résection du tarse	6 975	6 511	€ 175 124	€ 183 421	0%	0%
Art. 14h	245626	1/01/1985				140	54	€ 3 339	€ 1 434	1%	0%
Art. 14h	245630	1/01/1985		Coloboma van het ooglid (aangeboren of trauma)	Colobome de la paupière (congénital ou traumatique)	50	37	€ 3 893	€ 3 181	12%	14%
Art. 14h	245641	1/01/1985				24	18	€ 1 700	€ 1 210	8%	11%
Art. 14h	245652	1/01/1985		Totale refectie van het ooglid met enkelgesteeld huidlapje op afstand, hoofdoperatietijd	Réfection palpébrale totale par lambeau unipédiculé à distance, temps principal	24	129	€ 6 179	€ 41 137	4%	6%
Art. 14h	245663	1/01/1985				59	69	€ 15 143	€ 20 872	29%	19%
Art. 14h	245674	1/01/1985		Totale refectie van het ooglid met enkelgesteeld huidlapje op afstand, voorbereidende of bijkomende operatietijd	Réfection palpébrale totale par lambeau unipédiculé à distance, temps préparatoire ou complémentaire	7	37	€ 745	€ 4 355	0%	16%
Art. 14h	245685	1/01/1985				8	13	€ 746	€ 1 040	63%	8%
Art. 14h	245696	1/01/1985		Totale refectie van het ooglid door rotatie of verschuiving, inclusief het bedekken van het donorgedeelte, enige of hoofdoperatietijd	Réfection palpébrale totale par rotation ou glissement, y compris le recouvrement de la partie donneuse, temps unique ou principal	33	127	€ 6 046	€ 26 057	15%	5%
Art. 14h	245700	1/01/1985				36	9	€ 6 134	€ 1 799	33%	44%
Art. 14h	245711	1/01/1985		Totale refectie van het ooglid door rotatie of verschuiving, inclusief het bedekken van het donorgedeelte, voorbereidende of bijkomende operatietijd	Réfection palpébrale totale par rotation ou glissement, y compris le recouvrement de la partie donneuse, temps préparatoire ou complémentaire	10	26	€ 752	€ 1 837	10%	38%
Art. 14h	245722	1/01/1985				6	8	€ 316	€ 448	17%	88%
Art. 14h	245770	1/01/1985		Canthoplastiek	Canthoplastie	320	502	€ 23 129	€ 37 767	19%	29%
Art. 14h	245781	1/01/1985				109	89	€ 5 812	€ 4 884	67%	49%
Art. 14h	245792	1/01/1985		Blefarorrhafie of tarsorrhafie	Blépharorraphie ou tarsorraphie	660	223	€ 51 520	€ 17 753	1%	13%
Art. 14h	245803	1/01/1985				140	52	€ 8 498	€ 3 316	18%	12%
Art. 14h	245814	1/01/1985		Ptosis (techniek van Blaskovicz of soortgelijke)	Ptosis (technique de Blaskovicz ou similaire)	369	1 909	€ 82 556	€ 460 764	7%	11%
Art. 14h	245825	1/01/1985				447	201	€ 96 433	€ 48 608	30%	42%
Art. 14h	245836	1/01/1985		Behandeling van entropium of ectropium door galvanocauteriseren	Traitement d'entropion ou d'ectropion par galvanocautérisation	211	141	€ 3 984	€ 2 796	0%	3%
Art. 14h	245840	1/01/1985				6	4	€ 104	€ 87	0%	0%
Art. 14h	245851	1/01/1985		Entropium of ectropium : (heelkundige behandeling)	Entropion ou ectropion (traitement chirurgical)	2 174	2 845	€ 312 298	€ 461 256	3%	7%
Art. 14h	245862	1/01/1985				467	224	€ 62 492	€ 32 382	25%	22%
Art. 14h	245873	1/01/1985		Trichiasis : (heelkundige behandeling)	Trichiasis (traitement chirurgical)	84	107	€ 11 937	€ 17 353	8%	4%
Art. 14h	245884	1/01/1985				10	20	€ 1 299	€ 2 496	50%	0%
Art. 21	531112	1/01/1985	1/07/1999	Volledige behandeling van xanthelasma	Cure complète de xanthélasme	428	-	€ 10 407	-	0%	-
Art. 21	531123	1/01/1985	1/07/1999			3	-	€ 62	-	33%	-
Art. 14h	245733	1/01/1985		Huidplastiek van het ooglid	Plastique cutanée de la paupière	1 785	7 242	€ 226 033	€1 005 634	39%	30%
Art. 14h	245744	1/01/1985				1 089	783	€ 123 571	€ 98 077	58%	55%
Art. 14h	245755	1/01/1985		Heelkundige bewerking wegens blefarochalasis	Intervention chirurgicale pour blépharochalasis	792	3 226	€ 42 579	€ 181 714	36%	46%
Art. 14h	245766	1/01/1985				456	268	€ 20 166	€ 12 152	80%	76%

Article Nomen-clature	Invoice code	Reimbursement Start Date	Reimbursement End Date	Description in Dutch	Description in French	Number procedures 1995	Number procedures 2006	Insurance cost 1995	Insurance cost 2006	% plastic surgeons 1995	% plastic surgeons 2006
Abdominal wall											
Art. 14d	241216	1/01/1985		Plastiek van de buikwand wegens sekwellen van verlamming	Plastie de la paroi abdominale pour séquelles de paralysie	0	7	€ 0	€ 2 211	0%	14%
Art. 14d	241220	1/01/1985				215	202	€ 53 656	€ 62 591	1%	29%
Art. 14d	241231	1/01/1985		Verwijderen van subaponeurotische tumor van de buikwand, waarvoor plastiek door prothese of spiertransplantatie is vereist	Ablation de tumeur sous-aponévrotique de la paroi abdominale, nécessitant une plastie par prothèse ou transplantation musculaire	16	22	€ 3 872	€ 6 480	0%	0%
Art. 14d	241242	1/01/1985				659	384	€ 168 899	€ 120 283	1%	1%
Abdominoplasty & other body contouring procedures											
Art. 14d	241253	1/01/1985		Exeresis van uitgebreide vetschort met functionele hinder : Elliptische resectie	Exérèse de tablier graisseux étendu, avec gêne fonctionnelle : Résection elliptique	42	220	€ 7 008	€ 44 677	62%	65%
Art. 14d	241264	1/01/1985				505	757	€ 71 241	€ 135 958	56%	60%
Art. 14d	241275	1/01/1985		Exeresis van uitgebreide vetschort met functionele hinder : Resectie met huidplastiek en transpositie van de navel	Exérèse de tablier graisseux étendu, avec gêne fonctionnelle : Résection avec plastie cutanée et transposition du nombril	6	28	€ 1 449	€ 8 830	67%	61%
Art. 14d	241286	1/01/1985				1 950	3 933	€ 488 306	€1 191 249	68%	73%
Art. 14d	241754	1/04/2003		Exerese van overtollige huid ter hoogte van een lidmaat, die een functionele hinder veroorzaakt, na een gedocumenteerd en gestabiliseerd gewichtsverlies van ten minste 20%	Exérèse d'un excédent cutané au niveau d'un membre, entraînant une gène fonctionnelle, suite à une perte de poids documentée et stabilisée d'au moins 20%	-	72	-	€ 5 545	-	42%
Art. 14d	241765	1/04/2003				-	389	-	€ 27 520	-	78%

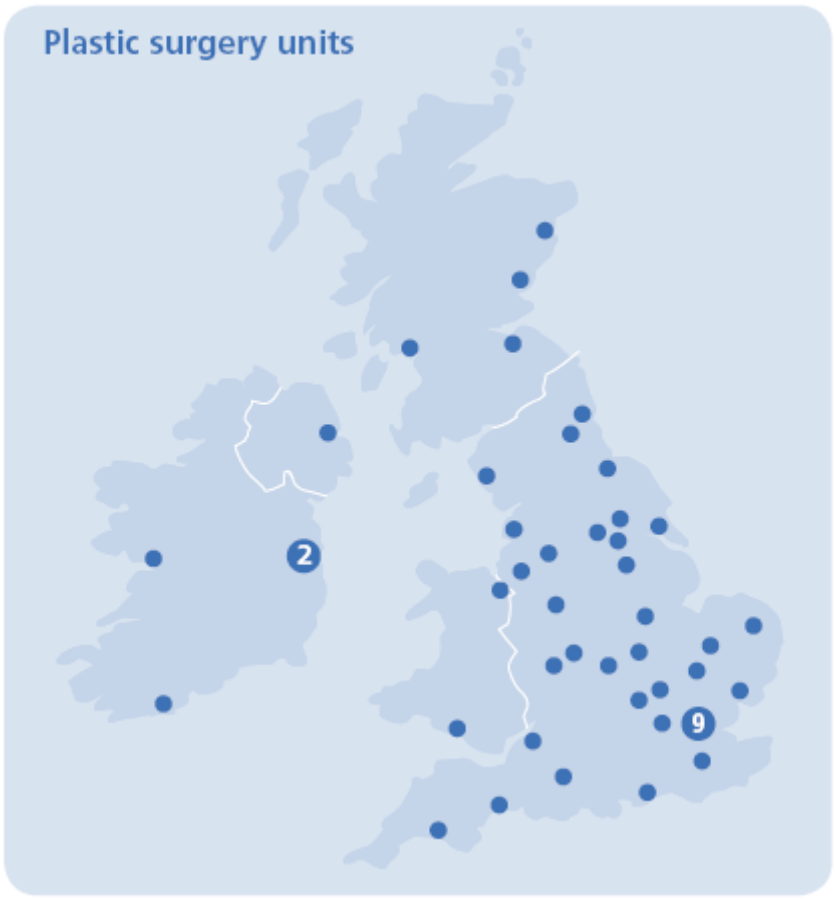
APPENDIX 13 GEOGRAPHICAL VARIATION IN THE 'CONSUMPTION' OF REIMBURSED PLASTIC SURGERY IN BELGIUM IN 2006

Insurance cost for **reimbursed plastic surgery** per 100 000 residents per Belgian province according to anatomical region, in 2006

Skin-Soft tissues		Breast		Nose		Ear	
West-Vlaanderen	€ 112 956	Namur	€ 39 497	Limburg	€ 49 375	West-Vlaanderen	€ 10 821
Oost-Vlaanderen	€ 96 183	Limburg	€ 37 204	Brussels Region	€ 34 877	Limburg	€ 10 334
Brussel	€ 83 514	Liège	€ 34 682	Antwerpen	€ 33 426	Oost-Vlaanderen	€ 8 885
Brabant wallon	€ 80 474	Antwerpen	€ 34 351	Liège	€ 33 250	Antwerpen	€ 8 296
Vlaams-Brabant	€ 79 749	Brabant wallon	€ 33 481	Namur	€ 32 276	Liège	€ 7 519
Liège	€ 74 295	Hainaut	€ 32 299	Oost-Vlaanderen	€ 28 263	Vlaams-Brabant	€ 7 136
Antwerpen	€ 72 735	Luxembourg	€ 31 726	Brabant wallon	€ 28 186	Namur	€ 7 035
Limburg	€ 69 727	Brussels Region	€ 26 805	Luxembourg	€ 28 004	Brabant wallon	€ 6 605
Hainaut	€ 68 261	Vlaams-Brabant	€ 26 185	Hainaut	€ 27 815	Hainaut	€ 6 002
Namur	€ 61 640	West-Vlaanderen	€ 24 167	Vlaams-Brabant	€ 27 578	Luxembourg	€ 4 710
Luxembourg	€ 44 999	Oost-Vlaanderen	€ 22 575	West-Vlaanderen	€ 27 218	Brussels Region	€ 4 452

Cleft lip and/or palate		Eyelid & Eyebrow		Abdomen	
Namur	€ 1 254	Limburg	€ 48 965	Hainaut	€ 18 971
Oost-Vlaanderen	€ 1 114	Liège	€ 41 920	West-Vlaanderen	€ 17 356
Brussel	€ 1 074	Antwerpen	€ 27 459	Limburg	€ 17 149
Brabant wallon	€ 892	West-Vlaanderen	€ 24 156	Namur	€ 15 534
West-Vlaanderen	€ 888	Vlaams-Brabant	€ 22 276	Brabant wallon	€ 14 244
Luxembourg	€ 872	Brabant wallon	€ 21 632	Brussels Region	€ 13 339
Antwerpen	€ 730	Oost-Vlaanderen	€ 20 551	Antwerpen	€ 13 125
Limburg	€ 669	Brussels Region	€ 17 508	Liège	€ 12 473
Hainaut	€ 663	Hainaut	€ 16 413	Oost-Vlaanderen	€ 11 873
Liège	€ 603	Namur	€ 16 061	Vlaams-Brabant	€ 11 867
Vlaams-Brabant	€ 432	Luxembourg	€ 13 587	Luxembourg	€ 10 133

APPENDIX 14 DISTRIBUTION OF NHS PLASTIC SURGERY UNITS IN THE UK



2 units in Dublin and 9 units in London; source: NHS Modernisation Agency, Action on Plastic Surgery [117]

APPENDICES ON LEGAL ASPECTS OF PLASTIC SURGERY

APPENDIX 15 PATIENT INFORMATION LEAFLET ON BREAST REDUCTION ISSUED BY THE SOFCPRE

CHIRURGIE DE L'HYPERTROPHIE MAMMAIRE
OU
PLASTIE MAMMAIRE DE REDUCTION POUR HYPERTROPHIE

Cachet du Médecin :

Information délivrée le : .....

Au bénéfice de : NOM.....

Prénom.....

Cette fiche d'information a été conçue sous l'égide de la Société Française de Chirurgie Plastique Reconstructrice et Esthétique (SOF.CPRE) comme un complément à votre première consultation, pour tenter de répondre à toutes les questions que vous pouvez vous poser si vous envisagez d'avoir recours à une plastie mammaire de réduction.
Le but de ce document est de vous apporter tous les éléments d'information nécessaires et indispensables pour vous permettre de prendre votre décision en parfaite connaissance de cause. Aussi vous est-il conseillé de le lire avec la plus grande attention.

• DEFINITION

L'hypertrophie mammaire est définie par un volume des seins trop important, notamment par rapport à la morphologie de la patiente.
Cet excès de volume est en général associé à un affaissement des seins (ptose mammaire) et parfois à un certain degré d'asymétrie.
L'hypertrophie mammaire implique presque toujours un retentissement physique et fonctionnel (douleurs du cou, des épaules et du dos, gêne pour la pratique des sports, difficultés vestimentaires). Il existe aussi fréquemment un retentissement psychologique notable. Ces troubles justifient la prise en charge par l'assurance maladie.

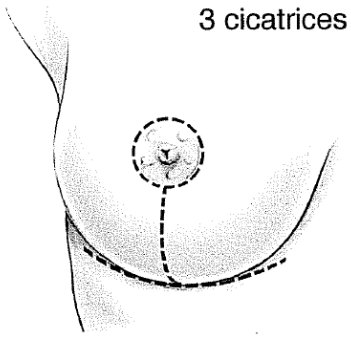
• OBJECTIFS

L'intervention chirurgicale a pour but la réduction du volume des seins, la correction de la ptose et d'une éventuelle asymétrie, afin d'obtenir deux seins harmonieux en eux-mêmes et par rapport à la morphologie de la patiente (deux seins réduits, ascensionnés, symétrisés et remodelés).

• PRINCIPES

L'intervention réalise l'ablation du tissu glandulaire en excès. On conserve un volume en harmonie avec la silhouette de la patiente et conforme à ses désirs. Ce volume glandulaire résiduel est ascensionné, concentré et remodelé.

Il faut ensuite adapter l'enveloppe cutanée, ce qui impose de retirer la peau en excès de manière à assurer une bonne tenue et un bon galbe aux nouveaux seins. Les berges de la peau ainsi découpées sont alors suturées : ces sutures sont à l'origine des cicatrices.
Souvent ces cicatrices ont la forme d'un T inversé avec trois composantes : péri-aréolaire au pourtour de l'aréole entre la peau brune et la peau blanche, verticale, entre le pôle inférieur de l'aréole et le sillon sous-mammaire, horizontale, dissimulée dans le sillon sous-mammaire.
La longueur de la cicatrice horizontale est proportionnelle à l'importance de l'hypertrophie et de la ptose.
Parfois, notamment lorsque l'hypertrophie et la ptose sont modérées, on peut réaliser une méthode dite "verticale" qui permet de supprimer la cicatrice transversale dans le sillon sous-mammaire et de réduire la rançon cicatricielle à ses composantes péri-aréolaire et verticale.



Une plastie mammaire pour hypertrophie peut être effectuée à partir de la fin de la croissance et au-delà, pendant toute la durée de la vie.
Une grossesse ultérieure est bien évidemment possible ainsi qu'un allaitement, mais on conseille d'attendre au moins six mois après l'intervention.
Le risque de survenue d'un cancer n'est pas augmenté par cette intervention.

• AVANT L'INTERVENTION

Un bilan pré-opératoire habituel est réalisé conformément aux prescriptions.
Le médecin anesthésiste sera vu en consultation au plus tard 48 heures avant l'intervention.
Outre les examens pré-opératoires habituels, il peut être utile de vérifier l'imagerie mammaire (mammographie, échographie).
Aucun médicament contenant de l'aspirine ne devra être pris dans les 10 jours précédant l'intervention.

• TYPE D'ANESTHESIE ET MODALITES D'HOSPITALISATION

Type d'anesthésie :

Il s'agit d'une anesthésie générale classique, durant laquelle vous dormez complètement.
Très rarement, dans le cas où le volume mammaire est très important, une autotransfusion sanguine peut être justifiée.

Modalités d'hospitalisation :

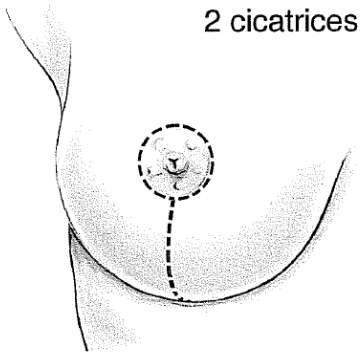
Une hospitalisation de deux à cinq jours est habituellement nécessaire.

• L'INTERVENTION

Chaque chirurgien adopte une technique qui lui est propre et qu'il adapte à chaque cas pour obtenir les meilleurs résultats.
Toutefois, on peut retenir des principes de base communs :
Les tissus enlevés sont systématiquement adressés à un laboratoire spécialisé pour être examinés au microscope (examen histologique).
En fin d'intervention un pansement modelant, avec des bandes élastiques en forme de soutien-gorge, est confectionné.
En fonction du chirurgien et de l'importance de l'hypertrophie, l'intervention peut durer de deux à trois heures.

• APRES L'INTERVENTION : LES SUITES OPERATOIRES

Les suites opératoires sont en général peu douloureuses, ne nécessitant que des antalgiques simples.
Un gonflement (œdème) et des ecchymoses (bleus) des seins, ainsi qu'une gêne à l'élévation des bras sont fréquemment observés.
Le premier pansement est retiré au bout de 48 heures et remplacé par un pansement plus léger, réalisant une sorte de bustier élastique confectionné sur mesure.
La sortie a lieu un à cinq jours après l'intervention, puis la patiente est revue en consultation deux à trois jours plus tard.
On met alors en place un soutien-gorge assurant une bonne contention (dont la taille aura été évaluée au moment du pansement réalisé à la clinique avant la sortie).
Le port de ce soutien-gorge est conseillé pendant environ un mois, nuit et jour, au décours de l'intervention.
Les fils de suture, s'ils ne sont pas résorbables, sont retirés entre le huitième et le vingtième jour après l'intervention.
Il convient d'envisager une convalescence et un arrêt de travail d'une durée de 8 à 15 jours.
On conseille d'attendre un à deux mois pour reprendre une activité sportive.



• LE RESULTAT

Il ne peut être jugé qu'à partir d'un an après l'intervention : la poitrine a alors le plus souvent un galbe harmonieux, symétrique ou très proche de la symétrie, et naturel. Au-delà de l'amélioration locale, cette intervention a en général un retentissement favorable sur l'équilibre du poids, la pratique des sports, les possibilités vestimentaires et l'état psychologique.
Il convient simplement d'avoir la patience d'attendre le délai nécessaire à l'atténuation des cicatrices et d'observer pendant cette période une bonne surveillance, au rythme d'une consultation environ tous les trois mois pendant un an.
Le sein opéré est un sein qui reste naturel et sensible, notamment aux variations hormonales.

• LES IMPERFECTIONS DE RESULTAT

Il s'agit essentiellement des cicatrices, qui font l'objet d'une surveillance attentive : il est fréquent qu'elles prennent un aspect rosé et gonflé au cours des deuxième et troisième mois post-opératoires ; au-delà, elles s'estompent en général progressivement pour devenir, avec le temps, peu visibles. Elles peuvent toutefois demeurer élargies, blanches ou au contraire brunes.
En ce qui concerne les cicatrices, il faut savoir que, si elles s'estompent bien, en général, avec le temps, elles ne sauraient disparaître complètement. A cet égard, il ne faut pas oublier que si c'est le chirurgien qui réalise les sutures, la cicatrice, elle, est le fait de la patiente.

Parfois, il peut persister une asymétrie des seins, qu'il s'agisse du volume, de la hauteur, de la taille ou de l'orientation des aréoles.
Dans tous les cas, une correction chirurgicale secondaire peut être faite, mais il convient d'attendre au moins un an ou deux.

• LES COMPLICATIONS ENVISAGEABLES

Une plastie mammaire de réduction, bien que réalisée pour des motivations en partie esthétique, n'en reste pas moins une véritable intervention chirurgicale, ce qui implique les risques liés à tout acte médical, aussi minime soit-il.

Les suites opératoires sont en général simples au décours

d'une plastie mammaire. Toutefois, des complications peuvent survenir, certaines d'ordre général, inhérentes à tout acte chirurgical, d'autres loco-régionales sont observées surtout en cas d'hypertrophie importante.
Il faut distinguer les complications liées à l'anesthésie de celles liées au geste chirurgical.

- En ce qui concerne l'anesthésie, lors de la consultation, le médecin-anesthésiste informera lui-même la patiente des risques anesthésiques. Il faut savoir que l'anesthésie induit dans l'organisme des réactions parfois imprévisibles, et plus ou moins faciles à maîtriser : le fait d'avoir recours à un Anesthésiste parfaitement compétent, exerçant dans un contexte réellement chirurgical, fait que les risques encourus sont devenus statistiquement presque négligeables.
  Il faut savoir, en effet, que les techniques, les produits anesthésiques et les méthodes de surveillance ont fait d'immenses progrès ces vingt dernières années, offrant une sécurité optimale, surtout quand l'intervention est réalisée en dehors de l'urgence et chez une personne en bonne santé.

- En ce qui concerne le geste chirurgical : en choisissant un Chirurgien Plasticien qualifié et compétent, formé à ce type d'intervention, vous limitez au maximum ces risques, sans toutefois les supprimer complètement.

Heureusement, les vraies complications sont rares à la suite d'une plastie mammaire de réduction réalisée dans les règles. En pratique, l'immense majorité des interventions se passe sans aucun problème et les patientes sont pleinement satisfaites de leur résultat.
Pour autant, et malgré leur faible fréquence, vous devez quand même connaître les complications possibles :

- Les accidents thrombo-emboliques (phlébite, embolie pulmonaire), bien que globalement très rares après ce type d'intervention, sont parmi les plus redoutables. Des mesures préventives rigoureuses doivent en minimiser l'incidence : port de bas anti-thrombose, lever précoce, éventuellement traitement anti-coagulant.
- La survenue d'une infection nécessite un traitement antibiotique et parfois un drainage chirurgical.
- Un hématome peut nécessiter un geste d'évacuation.
- Une nécrose de la peau ou de la glande, en fait rarement observée avec les techniques modernes, peut être responsable d'un retard de cicatrisation.
- Des altérations de la sensibilité, notamment mamelonnaire, peuvent être observées, mais la sensibilité normale réapparaît le plus souvent dans un délai de 6 à 18 mois.
- Surtout l'évolution des cicatrices peut être défavorable avec la survenue de cicatrices hypertrophiques voire chéloïdes, d'apparition et d'évolution imprévisibles, qui peuvent compromettre l'aspect esthétique du résultat et requièrent des traitements locaux spécifiques souvent longs.

Ainsi, dans la très grande majorité des cas, cette intervention, bien étudiée au préalable et correctement réalisée, donne un résultat très appréciable en termes de confort, même si la rançon cicatricielle inévitable en reste le principal inconvénient.

Au total, il ne faut pas surévaluer les risques, mais simplement prendre conscience qu'une intervention chirurgicale, même apparemment simple, comporte toujours une petite part d'aléas.
Le recours à un Chirurgien Plasticien qualifié vous assure que celui-ci a la formation et la compétence requises pour savoir éviter ces complications, ou les traiter efficacement le cas échéant.

* *
*

Tels sont les éléments d'information que nous souhaitions vous apporter en complément à la consultation.
Nous vous conseillons de conserver ce document, de le relire après la consultation et d'y réfléchir " à tête reposée".
Cette réflexion suscitera peut-être de nouvelles questions, pour lesquelles vous attendrez des informations complémentaires.
Nous sommes à votre disposition pour en reparler au cours d'une prochaine consultation, ou bien par téléphone, voire le jour même de l'intervention où nous nous reverrons, de toute manière, avant l'anesthésie.

Ce symbole désigne les Chirurgiens qui sont membres de la Société Française de Chirurgie Plastique Reconstructrice et Esthétique. Ils sont certifiés et compétents en Chirurgie Plastique Reconstructrice et Esthétique.

REMARQUES PERSONNELLES

APPENDIX 16 EXAMPLE OF A DETAILED COST ESTIMATE FOR AESTHETIC SURGERY IN FRANCE

Source: Syndicat National de Chirurgie Plastique Reconstructive et Esthétique (SNCRPE).[160]

CACHET DU MEDECIN Date de la 1ère consultation : .....

DEVIS CONCERNANT UN ACTE MEDICO-CHIRURGICAL A VISEE ESTHETIQUE

Conforme au décret n° 2005-777 du 11 juillet 2005

□ *Le présent document a pour objet de donner à la personne examinée toutes les informations pratiques utiles à sa prise de décision concernant l'acte envisagé exposé ci-dessous :*

.....

.....

Cet acte nécessite une anesthésie : Générale ou Locale (rayer la mention inutile)

En cas de consentement du patient, il sera réalisé par le Dr .....

ayant la spécialité de CHIRURGIE PLASTIQUE RECONSTRUCTRICE ET ESTHETIQUE

reconnue officiellement par le Conseil de l'Ordre des Médecins du département .....

auprès duquel il est inscrit sous le numéro .....

Il est garanti pour cet acte en responsabilité civile professionnelle.

□ **Au bénéfice de :**

NOM..... Prénom.....

Date de naissance ..... Profession.....

Adresse.....

Tel.....

□ **Dans l'établissement suivant :** (Rayer la mention inutile)

Privé : (NOM de l'établissement avec numéro d'agrément de la DASS) :

Secteur privé d'un établissement public :

Ou au cabinet du médecin, disposant de tous les moyens nécessaires au bon déroulement de l'intervention et pouvant pallier à toute éventualité le cas échéant.

□ **A la date du :** .....

□ **1° ACTE A CARACTERE ESTHETIQUE**

Coût global des prestations TTC :

. Frais d'hospitalisation.....

. Frais de séjour.....

. Honoraires du chirurgien.....

. Frais et honoraires d'anesthésie.....

. Coût du matériel implanté ou produit injectable à visée esthétique.....

Soit un TOTAL de.....

□ **2° INTERVENTIONS PRISES EN CHARGE PAR LA SECURITE SOCIALE**

Tarif conventionnel sécurité sociale.....

Honoraires libres du chirurgien.....

Lorsque des dispositifs médicaux ou des produits injectables à visée esthétique sont utilisés, ils doivent être autorisés officiellement. Les références en seront détaillées sur la facture (marque, fabricant, n° de série, lot...).

A titre indicatif: ..... jours d'arrêts de travail peuvent se révéler nécessaires.

Le prix détaillé comprend les soins post opératoires pendant..... mois.

S'agissant d'un acte uniquement à visée esthétique, les examens, l'intervention, les prescriptions et l'arrêt de travail éventuel, ne pourront être pris en charge par l'Assurance Maladie.

Les résultats des examens suivants seront fournis avant l'intervention:

.....

.....

NB : il est à signaler que le coût des examens préopératoires n'est pas compris dans ce décompte.

Le Dr..... fournira à la demande de M....., au médecin qu'il (elle) indiquera, le compte rendu opératoire, conformément aux dispositions en vigueur.

Le présent devis est établi pour une durée de 6 mois à partir de la signature de sa délivrance.

Devis établi en double exemplaire, le .....

Signature du médecin :

1° Mention manuscrite obligatoire "devis reçu avant l'exécution de la prestation de service" et signature de la personne examinée

« ART. D. 766-2-1. – EN APPLICATION DE L'ARTICLE L. 6322-2, UN DÉLAI MINIMUM DE QUINZE JOURS DOIT ÊTRE RESPECTÉ ENTRE LA REMISE DU DEVIS DÉTAILLÉ, DATÉ ET SIGNÉ PAR LE OU LES PRATICIENS DEVANT EFFECTUER L'INTERVENTION DE CHIRURGIE ESTHÉTIQUE.

« IL NE PEUT ÊTRE EN AUCUN CAS DÉROGÉ À CE DÉLAI, MÊME SUR LA DEMANDE DE LA PERSONNE CONCERNÉE.

« LE CHIRURGIEN QUI A RENCONTRÉ LA PERSONNE CONCERNÉE DOIT PRATIQUER LUI-MÊME L'INTERVENTION CHIRURGICALE, OU L'INFORMER AU COURS DE CETTE RENCONTRE QU'IL N'EFFECTUERA PAS LUI-MÊME TOUT OU PARTIE DE CETTE INTERVENTION."

2° Acceptation du devis par la personne examinée, le.....

Mention obligatoire manuscrite "devis accepté après réflexion" et signature de la personne examinée

APPENDICES ON ETHICAL SOCIETAL ASPECTS OF PLASTIC SURGERY

APPENDIX 17 DISCUSSION ABOUT THE ETHICAL SOCIETAL ASPECTS OF PLASTIC SURGERY

Definition

The distinction within plastic surgery between reconstructive, and, on the other hand, aesthetic or cosmetic surgery is often made. Reconstructive surgery concerns interventions to repair a malformation, or a rest lesion after a tumour or trauma. Aesthetic surgery is related to the improvement of a physical alteration due to aging, or a disgrace.[195] However, this distinction remains difficult as they both use the same techniques. Moreover, some acts of reconstructive surgery may sometimes have an aesthetic dimension. Therefore, distinction between reconstructive and aesthetic acts as such remains difficult. Marchac takes therefore the examples of removal of a scar, a benign skin lesion, or a small congenital deformation.[196] He also underlines that to define the type of surgery basing it on its indications is vague because, in the view of the patient, it is not rare that the aesthetic preoccupation will motivate someone predominant to undergo heavy reconstructive surgery, more than the medical consequences. Finally, the result of the operation will often be judged on its aesthetic aspect.[196]

This distinction between reconstructive and aesthetic surgery is often, but not always, linked to its coverage by social security i.e. reconstructive procedures being reimbursed, and aesthetic ones not. The same should be done in Belgium. The problem is, however, how to define the cut off point between the two types of surgery.

Medical necessity

Nowadays, the 'medical necessity' framework is used all over the world to decide on the reimbursement of a medical intervention. But the criteria for reimbursement differ between countries. The international comparison showed us that some countries do not offer any reimbursement for procedures that are automatically covered in Belgium. To assess whether an intervention is considered medical, and should therefore be reimbursed, there are two possible criteria. the international team of researchers that has written a European report on moral issues in Health care with regard to appearance make a distinction between disease and non-disease, and, on the other hand, between treatment and enhancement.[91] Chavoin et al. consider every plastic surgery intervention, aesthetic as well as reconstructive, as a medical intervention because the surgery alleviates the patient's suffering, even if it is a psychological one. The latter are qualified as psychotherapeutic surgery.[195] Hyman et al. talk about improving emotional health, a criterion that seems to respond to the WHO definition of health implying a physical, social and mental well-being.[197] In this approach, aesthetic surgery enters fully in the public health domain. An opinion which is shared by Fogli who states that it is not because the community can not finance the demand for plastic surgery, that it is not a public health act.[198] Nevertheless, Little nuances the place of aesthetic intervention in the scope of health: she says that considering cosmetic surgery irrespective of clinical necessity do not alleviate patients' suffering, but argues that this suffering does not result from disease or physiological dysfunction, and that is therefore not medically justified. According to Little, aesthetic surgery alleviates the suffering due to social attitudes and norms rather than some disease or biological dysfunction.[199] This statement was also made by the researcher of the Erasmus university.[91] However, for Hyman, in the case of aesthetic surgery, "the patient dictates both diagnosis and expected results".[197]

During the roundtable, one additional reflection framework was mentioned: the one based on the impact of the medical intervention on the quality of life.

Another theoretical model we have founded in the literature is Daniel's fair equality of opportunity account of justice in health care. This model assumes that just health care takes into account that "the health impairment often reduce an individual's fair share of the normal opportunity range; healthcare procedure can, to various degree, prevent this from happening, restore an individuals fair share of the normal range of opportunities, or compensate for deviations of an individual's fair share of the normal opportunity range and that fair equality of opportunity is an important and widely supported aspect of our sense of justice".[27]

While different approaches or frameworks can be identified, we must bear in mind that the initial questions of our report write themselves in the current context of the decisional process used by the compulsory health insurance, i.e. the medical necessity framework.

The place of social norms and values

The question is whether the choice to have aesthetic surgery is induced by social norms. The fact that the correction of prominent ears is almost everywhere covered by social security without any functional impairment being present seems to confirm this supposition. In the Netherlands, prominent ears have even been considered as a congenital malformation.[27]

Examples showing that cosmetic surgery is thus well 'normative' and 'value' charged appear in the reflection of the Flemish-speaking group 'de maakbare mens'. Indeed, they underline several arguments used toward the use of cosmetic surgery. These are well related to social values as the self-acceptation of his/her-self, the search for unreachable beauty ideals, the unnatural feature of the surgery, who must change: the society or us?, it is a luxury medicine, it will reinforce the difference between rich and poor people, etc.[200]

Little pointed out clearly the role of norms in cosmetic surgery.[199] She argued that concerns with appearance reflect the influences of social attitudes, values and preferences while not all norms are on the same moral plane. For a same level of suffering, several problems and demands of aesthetic interventions raise different moral considerations. To illustrate it, we will cite only two examples on the three examples developed in her article.[199] The first example is the one of a man who asks for the implantation of a second chin in a fictive society where double chins would be considered as very attractive. The second example describes an actual demand of parents to operate their little boy because of his prominent ears. In the first case, the 'patient' inspires sympathy, he does not correspond to the aesthetical standards of the moment but the society is not culpable for his pain. It is unfortunate and that is unfair but the society is morally tolerant with this physical appearance. In the second example, the price that the little boy has to pay would be expressed under the form of punitive reactions of the others, intolerance and cruelty. He suffers a prejudice rather than a preference like in the first case. The attitude of the society is immoral in this situation. They both are suffering but because of different moral norms.

Maybe not every norm has the same moral dimension (or may be not), which could be the reason why they are not uniformly applied in Belgium. The best example of this lack of uniformity is the rule for reimbursement of breast implants. There are two situations in which breast implant are reimbursed in Belgium: after a mastectomy and for transsexuals who underwent surgery for gender-conversion. These examples seem to indicate that the society considers that 'normal women' should have breast. Nevertheless, women without any breast tissue what so ever are not entitle to reimbursement of breast implants. Is there any moral fundament to this 'discrimination'? If not, it seems obvious that this discrimination should be resolved.

For Van der wilt, the society has to intervene since, in the view of some surgeon, cosmetic surgery is not luxury: it is a need to maintain or restore a balance between an individual and his or her social environment.[27]

Decision making process

The experts underlined the fact that decisions about covering a procedure have to be taken before the operation takes place. Since there is an agreement on the fact that social norms are public, it is possible to make a regulation on this base.[91] This could be theoretically resolved by reviewing the current list, reduce the "grey area" of interventions on the borderline between plastic and aesthetic surgery, and the creation of joint committee consisting of sickness funds, plastic surgeons and patients who should decide on difficult cases. Training of the surgeons and the medical advisors is a solution that has already proven its use in France. That such regulation is not very precise has to be accepted because it is based on social norms that bare nor clear-cut themselves.[91] Therefore, in the European report, they suggest to work with three lists: one for always, one for sometimes and one for never reimbursed interventions. Another suggestion made by de Beaufort et al is to entrust vague cases to a committee of medical and psychological experts.[91] In our roundtable, however, none of the experts has pointed the necessity to include psychologists in the joint committee.

There is also a need to cover exceptional interventions. From a practical point of view, the creation of a special nomenclature code for exceptional cases is not feasible because the key and price attributed to each nomenclature code can not be changed at random. Nevertheless, there should be a solution for special situations. Currently, the special solidarity fund is in charge of these demands. The joint committee could perhaps be charged with recommending to the special solidarity fund those patients who it esteems eligible for a special and exceptional intervention.

The wish of the ethicists to include civil representatives in the decisional process could also be translated in the presence of such people in the joint committee. The problem, however, will be how to define which medical background these patient representatives should have.

Complications

The Belgian compulsory health insurance makes no exception in its solidarity principle: every complication, including those following aesthetic surgery, has to be covered by social security. The nomenclature that counts already a code related to the removal of breast prostheses could be reviewed regarding the most frequent complications, in order to verify that every complication is properly identified by a specific code enabling reimbursement.

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