Defederalisation of health care in Belgium: solidarity, quality, efficiency and health policy

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INTRODUCTION.

In this contribution we will first describe the need for solidarity, in order to create a sustainable health system. But one cannot deny that there are important differences in the way health care is practised in the North and the South of the country. We will look at socio-economic, cultural and historical aspects of those differences. Next we will look at strategic issues including a 2-step scenario for defederalisation. Finally, we stress the need for a fundamental reform of health policy development: we need something completely different, not "more of the same".

A BROAD PLATFORM OF SOLIDARITY.

We actually spend in Belgium 10.1% of our GDP in health care. The annual budget of the National Institute for Health and Disability Insurance (RIZIV/INAMI/NIHDI) is almost 27 billion Euros. A health care system can only be sustainable if there is a broad platform of solidarity, contributing to the necessary resources. That is a clear argument in favour of collecting the resources at the federal level in a socially just way through contributions and taxes (we do not go into the discussion whether we should collect resources by taxes only or in the mixed way as we do actually). The nationally collected resources, can then be distributed to the 3 regions, according to the needs of the population living in the regions. For this distribution, we can use the formula that has been developed in the framework of the financial responsibility of the insurance organisations (sickness funds).

THERE ARE DIFFERENCES BOTH IN NEEDS AND SUPPLY.

Looking at the socio-economic indicators and looking at morbidity and mortality data, makes clear that the 3 regions (Flanders, Wallonia, Brussels) have different health needs. The region of Brussels suffers most from poverty, cardiovascular diseases are more prevalent in Wallonia, comparative studies show consistently differences in functional status between Wallonia and Flanders. At the supply side, there are differences in use of medical imaging (costs per inhabitant are in general higher in Wallonia), differences in pre-operative laboratory assessment (more tests in Wallonia and Brussels), differences in certification of euthanasia-cases, but also differences in attitude of physicians (the principle of patient-list is more accepted by Flemish family physicians),… These striking differences in uptake of the use of the global medical record between the North and the South reflect probably a different vision on interaction between providers and patients. The uptake of the diabetes-trajectory is more important in Flanders than in Wallonia, maybe reflecting attitudes towards stronger organisation of health care delivery pathways. Also differences in benzodiazepine consumption and antibiotic-consumption may reflect differences in attitudes both from the demand-side and the supply-side. Moreover, the differences are not limited to Flanders versus Wallonia: for some

indicators there is a clear North-South axis in Europe: antibiotic utilisation increases from Denmark to Spain, resistance of bacteria illustrates the position of Brussels as a "turning-point" (much more resistance in European countries south of Brussels, than north of Brussels). Also the differences in the way the Human Resources Planning has been implemented in Flanders and Wallonia, illustrate a different approach: in Flanders there is an entrance examination since 1997, in Wallonia this is still a debate.
It is not appropriate to look at those differences from a perspective that the one region is "doing better" than the other: a lot of differences can be explained by social determinants, by economic determinants, but also by historical developments. It is obvious that Flanders, after the 16th century, has been much more influenced by "Nordic" developments, whereas Wallonia is more influenced by "Latin" developments.

THE ACTUAL SITUATION.

It is obvious that the actual distribution of responsibilities in health care, does not lead to a performant policy. The example of the prevention and screening is a clear illustration of the difficult co-habitation of the actual competencies in the North and the South. Mental health is a clear example of a non-homogeneous distribution of competencies and responsibilities, leading to deficiencies in care. Addressing the important social disparities in health in Belgium, requires intersectoral action, involving the sectors of work, housing, education, community development,… most of these domains are actually with the regions and the communities, whereas the curative sector is mainly a federal competency. Both the analysis at the micro-level and the daily practice in the different sectors of health care, illustrate the need for more homogeneous distribution of competencies, in order to make the system more equitable and more cost-effective. Change is needed, and looking at the international literature, we see that the most performant health systems nowadays in Europe (Sweden, Denmark,…) and also internationally (Canada) have decentralised the policy, organisation and delivery of health care.

STRATEGIC CONSIDERATIONS…

Countries with a decentralised health care system, mostly have transferred almost all competencies in relation to health and health care to the regions. There is some logic in this, as health promotion, prevention, cure and care, but also health and welfare are intrinsically intertwined. Therefore, also in Belgium it would be advisable, from a "performance-viewpoint", to bring prevention, cure and care, both in the ambulatory sector and in hospitals to the regions. However, it is probably wise to think about a "plan B", where the change could be made in 2 phases. This requires thorough strategic thinking, that contributes to the goals of a performant health system: relevance, equity, quality, cost-effectiveness, sustainability, person-centeredness and innovation. A suggestion could be to bring all the competencies in relation to the "ambulatory sector" (this includes ambulatory care and care in the home-replacing environment, like the centres for living and care, the nursing homes,…), completely to the regions (this includes planning and financing, recognition of providers and services, organisation of care, integration of prevention and health promotion, cure and palliative and rehabilitative care and integration of well-being and health). Also emergency departments and outpatient care in hospitals, including day-hospitalisation could be included. The aim must be to make the ambulatory system more performant, clearly defining which services are directly accessible and may act as "gate-keeper", and which services need referral from the primary care level. For the "intramural" sector (hospital) the actual distribution of competencies with mainly federal financing, continues, but some illogical distributions (e.g. in terms of infrastructure) are addressed. Also at this level the aim is to improve performance, defining a clear distribution between "secondary care" and "tertiary care" (top-clinical and top-referral care). The actual federal incentives for hospitals in order to transfer segments of care to the ambulatory sector, are strengthened, in concertation with the regions. As defined earlier, the regions receive resources, based on "objective needs". A region that performs well in the ambulatory sector, so that it utilises less "federal resources" for the intramural care for its

inhabitants, receives a "bonus" in order to further strengthen the ambulatory care. This will enhance the shift from "hospital-care" towards ambulatory care and have a positive effect on costs. A performant Quality Assurance System guarantees quality and accessible care at each level. This will be an appropriate strategy to address the challenge of an ageing population adequately.

An important discussion is: at what institutional level will we perform the defederalisation-process? The only possibility in my view is: at the level of the regions. The place where somebody has his/her address, defines which health care system is responsible for him/her. This implies that Brussels becomes a region in its own, being competent for (ambulatory) health care and receiving the resources that are consistent with the needs of the population (the poverty- and health-gap is the biggest in Brussels). We have to face the reality of Brussels: 10% of Flemish-speaking, 30 to 40% French-speaking, and at least 50% "other languages speaking". A health care policy, based on the "Flemish community" or "French-speaking community" is not relevant in this demographical context. The challenge is to realise in Brussels a performant international and multicultural policy focusing on social justice. In my view, it is unthinkable that 2 people, living in the same building in Brussels, would receive a different type of health care, according to the fact that they belong to the "Flemish" or "French-speaking" community, and that one person should have to pay for a certain type of care and the other not. Such a system is detrimental for the social cohesion and we know the political consequences of such a development. This means that we, from Flanders and Wallonia, want to show solidarity in a transparent way with the many vulnerable people living in Brussels who have the right to quality and efficient health care.

Looking at international developments and differences in needs, also within the regions (see e.g. differences in suicide-incidence between Occidental Flanders and Limburg), it is clear that the local authorities, should have a more important role to play in the organisation of health care. This requires that cities and villages have at least 40,000 inhabitants, in order to develop a strong local health policy. The Finnish experience, where local authorities have a huge impact on health care, shows that this may increase the performance of the system. Moreover, this will facilitate the integration of health policy in local social policy, that is absolutely needed in order to address the upstream-causes of social inequities in health.

THE NEED FOR A NEW TYPE OF HEALTH POLICY.

A process of defederalisation, requires a complete re-thinking of the way health policy decisions are taken. It is clear that the system where stakeholders (sickness funds and providers) negotiate a compromise on tariffs, is no more able to respond to the challenges of the 21st century. So, a performant health policy should start from the definition of clear goals, that are debated in Parliament, and formulated in terms of objectives for a 5- to 10 year period. This definition of goals should be based on scientific evidence and transparent political decision-processes.
Once the goals are defined, implementation can take place involving the stakeholders. So, if a defederalisation-process just will lead to shifting the actual NIHDI-structure to the regions, it is not worthwhile doing. Fundamental change is needed, that will install a health policy responding to the needs of individuals and populations. If this does not happen, it is questionable if we will be able to maintain and improve social justice in health, a corner stone of our society.

The views expressed, are the views of the author and do not engage the organisations he is working for.