

How to move towards a more integrated health system and more coherent health policies taking into account the Brussels realities

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While I share the position of Schokkaert and Van de Voorde on many points, I think it is important to offer a few reactions based on a more general view of public health and on a Brussels viewpoint, given that the Brussels Region is especially concerned by the adverse effects of the various possible directions that changes to the system could take.

1. Is it possible to think about changes in the Belgian health care system without taking a broader view of the Belgian health system in general? What are the connections between the health care system and public health policies in Belgium?

The health care system is just one aspect of the health system in general. Health care is one among a number of health policy tools.

It is not just the economic issues that are crucial in the development of the health system. From a public health viewpoint, our health system needs to evolve in order to be capable of meeting the current major challenges relating to the population's health. The first such challenge is the significant increase in the relative weight of chronic diseases, usually characterised by a long pre-clinical period susceptible to prevention measures, a long period during which curative care is necessary, but also a long period of incapacity and disability without proper recovery. Such health problems are mainly found in older age groups, and old people can suffer from more than one chronic disease. Our health system is not adapted to this development: it is still excessively oriented towards curative care and the categorisation of care into narrow and disjointed specialist fields, and characterised by a split between curative and preventive care.

The other big challenge our health system is facing, is how to contribute effectively and fairly to improving the overall health of all the country's citizens and hence reduce social inequalities with regard to health.

One of the consequences of this twofold challenge is the growing need for health policy to come up with a comprehensive approach to integrate, harmoniously and continuously, the needs for medical treatment and the needs which are not strictly linked with health care, but which are essential for improving quality of life. These new challenges involve a huge investment in well-being policies (support for enabling people to stay at home, support for social networks and neighbourhood solidarity, increases in human resources rather than technical resources, and so on) and networking between the different medical and social actors.

The question then crops up if a level of political decision-making still exists in Belgium at which coherent public health policies can be decided. Is there a level of power at which the various tools of a health system (health promotion measures, preventive action, curative care, social support, human

guidance, etc.) can be linked together, taking account of the need for and effectiveness of each type of measure?

At federal level, institutional change has further reinforced an approach which is almost exclusively oriented towards health care, with a significant emphasis on management aspects. The National Institute for Health and Disability Insurance (INAMI/RIZIV) has become an increasingly important actor in health policy, to the detriment of the Ministry of Public Health. The confusion between health policy and health care policy is virtually systemic¹.

Aside from health care, there are federal, community and regional policies governing other essential aspects of health (e.g. food security and research at federal level, prevention at community level, the organisation of certain care sectors at community or regional level, etc.). However, the budgets available for these health policies which are not directly associated with care are extremely limited compared with the budget for health care, and there is no decision-making level at which the distribution of budget allocation among these strategies could be discussed on the basis of their actual effectiveness in improving health. The separation of prevention and curative health care also contributes to maintain social inequalities with regard to health (De Spiegelaere, 1999).

Despite the creation of consultation platforms intended to improve coordination with regard to health (Interministerial Conference), it is extremely difficult, if not impossible, to develop coherent public health policies across the institutional policy levels in Belgium at present.

It is therefore essential to change the situation, and not just for the economic reasons set out in the lead piece. Such a reform must involve improvements in the capacity to develop public health policies which are coherent and complementary, in other words to make budget allocation choices linked to general objectives. This involves strategic choices not just within health policies, but also between different policy areas. For example, if we wish to reduce social inequalities with regard to health, it is undoubtedly more sensible and more efficient to increase the financial capacity of those on lower incomes, rather than to burden the health care budget with complex measures aimed at improving access to care for those on low incomes (Couffinhal et al., 2005)². The major challenge presented by the increase in diabetes (ultimately involving substantial costs for sophisticated treatment equipment) can only be met by coherent measures relating to such varied fields as policy on mobility, sport, food price regulation and the fight against the social inequalities which are the source of a growing build-up of problems of severe obesity and diabetes among socially disadvantaged groups.

The fundamental question that needs to be asked, then, before any discussion about decentralising health competencies, relates to the most effective level for responsibility for these policies. It is clear that in the current situation, it is hard to imagine reversing the direction of institutional reform – although from a purely theoretical viewpoint the possibility of refederalising certain aspects of health policy must be raised and will be discussed below. It is evenly clear that it is highly unlikely to imagine a single policy level for all health-related competencies. This is because maintaining and improving public health involves action in a huge variety of fields which can never be combined at a single policy level. However, what is needed is a policy level at which the broad outlines of health policy can be democratically discussed and the budgetary consequences taken.

¹ For example, it is very difficult to put the reduction of social health inequalities on the agenda at federal level because it is automatically narrowed down to the reduction of inequalities in access to medical care.

² Improving access to care by means of specific measures in the health care system is costly and relatively ineffective. Some of the financial obstacles are replaced by administrative obstacles because of the complexity of the measures. This money could probably be spent more effectively on increasing the purchasing power of those on low incomes and/or reducing certain unavoidable costs such as housing and energy. In the Brussels Capital Region, 26% of households state that they have to postpone or abstain from care for financial reasons (Demarest, 2010). This proportion is nearly twice as high as in the country as a whole, despite lower medical consumption. The explanation lies not only with the high proportion of people living below the poverty threshold, but also with the particularly high costs of housing in this region, which reduces the amount of money available to spend on care.

2. How can the proposals on health care management be reconsidered within a more comprehensive vision of public health policy?

In order to convert the question “Who will manage care in Belgium?” to “Who will manage the health system in Belgium?”, I will consider the various options by discussing their advantages and drawbacks, with a particular focus on the situation in Brussels and the impact on equity.

If we agree to broaden the framework of debate to the health system rather than just the health care system, the proposal in the lead piece to reinforce the role of the health insurance funds in care management raises a series of problems.

Is it conceivable that within a given territory (whether the whole country or individual regions), structures such as the health insurance funds can define the main directions of a comprehensive health strategy? All that can be expected is a consolidation of current trends: a lack of coordinated strategies in public health, the selection of “customers”, not through a phenomenon associated with resource allocation (cf. risk-adjusted payments), but through the strategic and competitive choices that would be made. For example, one health insurance fund might tend to favour their clients to use a progressive pathway from primary health care to second-line medical care in order to reduce costs and because it believes that this represents a positive strategy for care quality. It could financially favour prior consultation with a general practitioner, or penalise direct consultation of a specialist. Another health insurance fund might be more in favour of freedom of choice of service providers and care pathways, and would therefore avoid any measure that restricts this freedom. It might leave it to the patient to pay the additional costs associated with this strategy. The first would more readily attract a less prosperous public which is very sensitive to cost reduction, whereas the second would attract a wealthier public, which is prepared to pay more in order to keep its freedom of choice, including in terms of care pathways. Along with this selection of target groups, an additional subscription fee could be charged by the second, thus emphasising the duality even further. The service provision would then adapt to these differences, with one care sector that would be less expensive, but with reduced freedom of choice of providers and a serious risk of longer waiting times to see specialists, because the more expensive care sector with greater freedom of choice would attract most of the specialists, to the benefit of a wealthier set of patients. Such dualisation already exists and is rapidly increasing.

The risk of a situation where divergent or even contradictory public health strategies exist side by side is a real one in the absence of a policy level with the means to impose coherent policies (including by means of financial incentives)³.

The increasing role of the health insurance funds in the management of health care will not permit a reduction of the gap between the health care sector and other policy areas relating to health. Lacking any forum to negotiate with decision-makers outside the health care system, they are unable to effectively articulate health care policies with other measures. They can only attempt to keep the health care budget as high as possible, even if this is to the detriment of other, more efficient policies to improve health. Lacking any means to act on people’s living conditions, they will be tempted to place an ever greater emphasis on individual responsibility, which will contribute to an increase of social inequalities in health.

Finally, the question of democratic control must also be raised, given that public health policies would be defined by institutions which are not ideologically neutral, yet which are not elected (attracting customers is not a substitute for democratic legitimacy, because the customers of health insurance funds rarely choose them on the grounds of their ideological position, but rather on the basis of their perceived advantages in terms of individual insurance).

What about the proposal to entrust health policies to the communities or the regions?

³ Radically different options can be expected in the choice of preventive strategies, for example systematic screening versus opportunistic screening, a universal approach versus a targeted approach, etc.

Schokkaert and Van de Voorde have not looked in depth at the differences between decentralisation towards the linguistic communities as opposed to decentralisation towards the territorial regions. Our view is that a decentralisation of public health policy towards the communities has no advantages, but many drawbacks.

The sole argument in favour of the community approach would be the linguistic and “cultural” uniformity of the target population. This “cultural” approach to health could be valid within monolingual regions. The reality in Brussels however is that it does not consist of two juxtaposed cultures, so that the relevance of two different approaches – one which is supposed to serve the needs of the Flemish-speaking inhabitants of Brussels, and another that of the French-speaking inhabitants – is illusory. In reality, Brussels is a constantly shifting mosaic of cultures with specific needs.

In the current institutional context, the Brussels Capital Region pays the highest price in terms of the impossibility of conducting coherent health policies. The present attribution of prevention and health promotion to the responsibility of the communities makes it extremely difficult to develop effective strategies for the population in Brussels. The juxtaposition of community strategies with different objectives, methods and means, the asymmetry in the competencies transferred to the French and Flemish Community Commissions and the lack of resources for the Joint Community Commission considerably reduce the room for manoeuvre. The French and Dutch-speaking services overlap, and planning on the basis of the inhabitants’ actual needs is impossible.

The attribution of further health competencies to the communities would only aggravate these problems. The two communities’ policies in the territory of Brussels remain blind, because neither community can really know what public it needs to reach. Without an identified target population, it is not possible to monitor the state of health of the “linguistic communities” (an unambiguous delimitation of the population is not possible, as there are no sub-nationalities in Brussels).

Moreover, the management of health by the communities would not allow effective coordination with other policies essential to health, other than at the regional level and would therefore amount to a de facto regionalisation.

In the context of the decentralisation of health care policy, Schokkaert and Van de Voorde stress the importance of mechanisms that can avoid the selection of risks and improve efficiency by the attribution of responsibility.

In the scenario of community management, the danger of risk selection is a real one, as the communities don’t have responsibility for the entire population of the territory, notably the Brussels region. One could therefore rapidly witness the development of two-speed health systems in the territory of Brussels, similar to the phenomenon outlined with regard to competition between health insurance funds. A “fair” division between communities via risk-adjusted payments is not possible given the impossibility of assessing the real characteristics of the members of the linguistic communities and the difficulty of attributing responsibility to the communities outside monolingual regional territories.

The territorial approach on the other hand has numerous advantages for the management of health policies. It can be combined with the management of the provision of services – both preventive and curative – and coordination with other policies with links to health, which are themselves also territorial: policies on mobility, housing, employment, regional planning and the environment. Moreover, only a territorial approach enables the health of populations to be assessed and monitored: in order to construct indicators, clearly identified populations are needed. In territorial terms, only the federal and regional levels are appropriate.

The refederalisation of prevention⁴ would supposedly make it possible to develop more coherent health policies, and to integrate preventive strategies more easily in health care with a debate about the distribution of resources based on the effectiveness of the different approaches.

⁴ We are aware that such a proposal would be regarded as “unacceptable” in some quarters.

Apart from the numerous arguments put forward in the lead piece for maintaining interpersonal solidarity at federal level, the federal level also remains, in my view, an indispensable level for the planning of care provision, particularly where specialist care is concerned. Advances in sophisticated technologies make it vital to concentrate certain forms of care and certain diagnostic examinations in a few highly specialised centres which can perform a sufficient number of interventions. Belgium is a small country, and the development of a highly specialised range of services in each region is economically unrealistic. Given the central position of the Brussels Region (geographically speaking), it makes sense for cutting-edge services which are available for the entire population of the country to be concentrated there. The Brussels Region has three university hospitals, and a third of the patients hospitalised in the Region come from the country's other regions. Regional management of service planning would therefore require difficult negotiations between the regions, which would not necessarily be conducted rationally.

The federal level also remains the most appropriate for a series of important competencies for health policy, such as scientific research, consensus elaboration, health registers⁵, etc.

However, the federal level as the privileged level for defining public health policies, also has some disadvantages. Continuing community tensions may severely impair the ability to develop ambitious policies, and even the slightest proximity to local actors may constitute an impediment to a cross-cutting approach.

The development of public health policies could also be considered at the regional level, under the condition that community competencies such as prevention and health promotion could be managed at regional level. If this regionalisation of health competencies is inconceivable for legal or political reasons, it would then be necessary to define a "Brussels Community" with specific cultural characteristics, including bilingualism. The simplification of the situation with regard to the communities in Brussels therefore seems vital to us⁶. From now on, the term "regionalisation" will be used in a territorial rather than an institutional sense.

Like the federal level, regionalisation offers the advantage of permitting a territorial approach, of defining a clear target population for all health services – both preventive and curative – and of making available a health information system for monitoring and planning. It also provides a forum for democratic negotiation on decisions relating to health policy in the broad sense. Furthermore, policies could be conducted which are better suited to the specific characteristics of the population.

In addition to the need to maintain interpersonal solidarity at federal level, the regionalisation of the health system is only possible for the Brussels Region if important levers are maintained at federal level, including those relating to the planning of second-line care. However, the adverse effects that can be expected should encourage greater caution before the management of primary and second-line care is split between multiple policy levels.

Although theoretically one can agree with the proposed model (see fig 4 p 15), the vital question remains of what criteria should be used for the distribution of resources and for the attribution of responsibility. The inclusion of socio-economic variables in the criteria for appraisal and/or responsibility attribution is particularly sensitive.

To what extent are the regions responsible for the increased health risks associated with social deprivation within their population? In order to be "responsible", should a region such as Brussels, which is constantly attracting a population that is often poor and low-skilled both from abroad and from the other regions, close its doors, barricade itself in, and send back to the other regions the poor migrants who seek refuge there? How can we really measure a region's achievements in improving health, when there are significant population shifts which are themselves related to the socio-

⁵ The cancer register is an example of a structure which has been established with the different policy levels. However, it would never have been set up without the efforts and significant financial support of the federal level.

⁶ In other words, a single authority in Brussels for Community-related matters, instead of the three Community Commissions.

economic situation⁷? Should responsibility be attributed with respect to results or resources? How should we account for the fact that the investments (of both people and time) needed in order to modify lifestyles (e.g. increasing the amount of exercise people take, improving nutritional balance, reducing smoking, etc.) vary greatly depending on the socio-economic level of the population? It can therefore be expected that more expensive strategies will need to be introduced in areas where there is a high concentration of deprivation (certain areas of Wallonia and Brussels). The distribution of resources should be able to take into account very accurately the shifts in population and health needs, and not solely on the basis of care consumption data⁸: despite greater needs, underconsumption of care can be observed in the Brussels Region (Ruz Torres and De Ridder, 2010). Demographic change can be very rapid in an urban region such as Brussels, so the variables used for the distribution of resources will need to be rapidly updatable.

Conclusion

Any discussion of the political development of the health care system should take place within the context of a more general reflection on the capacity to conduct health policies whose object is to improve the health of all citizens.

The health care system needs to be reoriented in order to meet the health challenges of tomorrow. These challenges involve greater integration of the health care system in broader policies on public health and well-being.

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⁷ For example, there are households which, having benefited from genuinely effective policies in order to improve their social status, leave the Brussels Region to buy more affordable housing in Flanders or Wallonia.

⁸ Discussion of the factors currently used (see Appendix), and in particular their ability to assess health needs via care consumption data, lies outside the scope of this article.