Reply to Comments

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The different reactions to our lead piece sketch a broad picture of the arguments that are relevant for thinking about the future organization of the Belgian health care system. Many of the thoughts of the discussants are complementary to our own analysis, and, apart from some specific issues, there are not too many points with which we really disagree. All discussants share with us the same concern: how to organize the system so that it can deliver the best results for all Belgians? Rather than focusing on the points of disagreement, we want to point to what seem to us some interesting complementary issues.

The most challenging remark probably comes from Erik Schut who emphasizes that we did not make clear where and why the present system fails. Why not leave everything as it is? Are we rebels without a cause? This was like an eye-opener for us: he is absolutely right that we presented the need for reform as self-evident. We simply followed the dominant opinion in Flanders – perhaps also (but less clearly so) the dominant position in Belgium. Most analysts of the system agree that the present decision structures are untransparent and not sufficiently flexible, but we indeed did not give a detailed overview of specific shortcomings. There are some objective indicators, though: while the quality of Belgian health care is mediocre (see also the contribution of Johan Kips), expenditures are growing more rapidly than in neighbouring countries. The Belgian system seems badly prepared for the expected increase in health care expenditures. Moreover, as in other policy domains, even if the problems are not as severe as is sometimes suggested, the perception that there are big problems and the very different ideas about how to move forward, have brought us in a political impasse. Surely, an open debate is needed about how to break that impasse. Yet, Erik Schut's point is taken (although, coming from a Dutch economist, we suspect that also for him it was more like an academic remark).

A general thread in many contributions (but mainly those of Jan De Maeseneer and Myriam De Spiegelaere) is the need to distinguish between "health" policies and "health care" organisation. We could not agree more: there can be no doubt that other policy domains (such as education, housing and income support) are at least as important for the overall health situation of the population as health care. This is especially true for the poorest and weakest groups in society. It is not so clear, however, what this implies for the future organization of the health system. Jan de Maeseneer seems to see it as an argument for defederalization, Myriam De Spiegelaere suggests that it is an argument against. As a side remark, it is interesting to note that they both take an explicit position on an issue that we deliberately left open in our lead piece: the treatment of Brussels. Precisely because of their emphasis on a coherent public health policy, they advocate that decentralization (if introduced: as noted, their preferences on that point differ!) should be at the level of the Brussels region, not at the level of the community.

However, we do not think that the need for an overall health policy is a decisive argument for or against regional decentralization. Bringing together all the health relevant competencies at one government level is not a miracle solution. Public health is only one of the concerns of educational and housing policy (and probably not the most important one). Life style policies involve measures in the domains of taxation (e.g. taxation of tobacco), transportation and investments in mobility infrastructure (foot paths and bicycle paths). For each of these policy domains, the public health consequences are but one objective. Coordination of the different policies with respect to public

health is definitely needed, but has to take place in a flexible structure. Here also, the welfare state will necessarily be layered with a large degree of shared competencies.[3]

This position also explains why we could focus in our lead piece specifically on health care. No one will deny that health care is one important element of health policy. In fact, equal access to good quality health care is not only important from the point of view of health, but it is also an essential token of equal respect for everybody. An efficient organization of health care is therefore definitely important. Moreover, while coordination with other policy domains is needed, the organisation of the health care system can still be analysed to some extent on its own – and it is certainly worth looking at in some detail. This is what we did in our lead piece, but, as said before, we are ready to admit that this is only a partial approach. Of course, giving more powers to the sickness funds (one of the options we describe) would not at all mean that they also become in charge of all the other public health domains. Government policies remain essential in this regard. The role of the sickness funds in the model of regulated competition is to become "prudent buyers of health care for their members".

A second point that is raised by many commentators (most explicitly by Johan Kips and Fred Schroyen) is the need to devise good quality indicators and to give transparent information about them. Again, we could not agree more. Collecting quality information is necessary for the regulator. It is difficult to see how one can design good policies and evaluate them when this information is missing. We also do believe that disseminating information about quality of care among the patients will be an essential element in any good reform of the system. This is independent of whether we go for giving more powers to the regions or to the sickness funds (see also the importance of quality indicators in Erik Schut's description of the Dutch model). There is a lot of suspicion among Belgian providers about the dangers of spreading information. These misgivings are understandable: it is important that the information that is spread is reliable and that it is presented in a thoughtful and careful way. Yet, here also, immobilism by the regulator and/or by the sickness funds is probably the worst option. Even if one does not share our views about the positive effects of spreading information among the patients, it is still important to avoid the worst-case scenario where information will be distributed in an unprofessional and one-sided way through the Internet.

Some of our sceptical discussants are worried about the definition of the insured basket in a decentralized model. What if regions/communities have different insurance packages and how will private insurers react on such differences (a point raised by Brigitte Dormont)? Or what if sickness funds can differentiate their package? Would this not result in "cheap" low-quality insurance policies for the poor and "expensive" high-quality policies for the rich (a concern expressed by Myriam De Spiegelaere)? Again, it is clear that the problem arises in both models of decentralization. As we wrote already in our lead piece, decentralization with solidarity requires "an agreement about the long-run development of the global budget". However, this formulation in the lead piece is perhaps too much "budget"-oriented. What we really meant is that there should be an agreement about the content of the guaranteed basic health care package. Differentiation (by regions or by sickness funds) is only possible if it comes on top of this guaranteed package – and the size of the guaranteed package obviously is crucial for the level of solidarity. The broader the basic package is defined, the higher the level of solidarity. While we ourselves are in favour of a broadly defined package, its definition should certainly be part of the political debate. In this respect, Jan De Maeseneer proposes to split the basic package so that a part (ambulatory care) would be decentralized, while the rest would remain at the centralized level. We do not believe that this is a good idea, even in a transitional phase. There are close substitution and complementarity relations between different types of care in general, and more specifically between ambulatory and hospital care. Indeed, one of the main challenges for the future is to develop disease management programs integrating the various sectors in a coherent way. In our

[3] See Re-Bel E-book 9: *Social Federalism: How is a multi-level welfare state best organized?*, with a lead piece by Patricia Popelier, Bea Cantillon and Ninke Mussche.

view, this means that it would not be a good idea to split health care policies over different regional levels.

The need to define a basic health care package and to create room for integrated disease management programs raises another issue: the existence in Belgium of an extensive list of items which can be reimbursed, each with their corresponding "price". This is the so-called "nomenclature". Most other countries have adopted a more flexible way of defining the insurance package and it can easily be argued that the rigidity of the Belgian nomenclature makes it more difficult to create new models of care within a coherent financing structure. That is the reason why special programs had to be set up in order to create possibilities for integrated disease management. Decentralisation (whether to the regions or to the sickness funds) would require a more flexible way of thinking about the nomenclature. This would have the additional advantage that it would facilitate movement away from fee-for-service and in the direction of other mechanisms for paying providers that are more closely linked to their performance (an idea put forward by David Crainich and Johan Kips).

None of the commentators questions the idea that the budget of decentralized entities should be risk-adjusted. This is in itself a striking fact – as it is equally striking that risk adjustment is considered essential both in a market-oriented system like the Netherlands (see Erik Schut) and in a typical NHS-type system like Norway (see Fred Schroyen). One can only combine solidarity and decentralization with risk-adjustment. This general statement begs the question of what variables should be included in the risk-adjustment formula. This is a second crucial solidarity element, in addition to the definition of the basic health care package. To think about this issue, there is a simple rule of thumb: if a variable is not included in the formula, differences in health care expenditures which are due to this variable have to be borne by the decentralized entity, i.e. the decentralized entity is held responsible for these differences. This is linked with ethical considerations, but also with political decisions concerning the allocation of regulatory power. As we mentioned already in the lead piece, there is no a priori reason to hold regions and sickness funds responsible for the same characteristics.

Both David Crainich and Myriam De Spiegelaere link this issue (rightly so!) to prevention and to the need to integrate health care in the broader context of overall health policy. Surely, as noted before, sickness funds cannot be held responsible for the overall health policy: hence, they cannot be held responsible for the ensuing differences in health care expenditures. Things are different for regions: if they are responsible for prevention measures, they should be able to reap the fruits of their efforts through the financing mechanism. There are tricky issues here. The one raised by Myriam Despiegelaere on the treatment of socioeconomic status is a particularly difficult one. Suppose that regions are not to be held responsible for differences in the socioeconomic status of their inhabitants (the case of Brussels is typical), but are responsible for prevention. At first sight, this is easy to take into account by including socioeconomic status variables in the distribution rule and not including variables related to lifestyle (such as smoking behaviour or alcohol dependency). However, suppose now that the two variables interact, in that it is more difficult to change lifestyles (e.g. smoking behaviour) for low socioeconomic status groups. The theoretical literature has shown that in such cases of interaction, one has to face trade-offs, i.e. one can only compensate the decentralized entities fully for differences in the socioeconomic status of their constituents, if one gives up the principle that they have to bear the full consequences of their (lack of) prevention policies. We analysed these issues extensively in some of the theoretical papers that we refer to in the lead piece (Schokkaert et al., 1998; Schokkaert and Van de Voorde, 2004, 2009). Our own position certainly would be that it is desirable to include socioeconomic status in the distribution rule (as is now already done in the present financing system of the sickness funds), but again, this is a matter of ethical and political choice.

In our lead piece we raised the basic question: if Belgium wants to decentralize its health care system, should the communities/regions take over, or the sickness funds? After reading the commentaries, we remain convinced that this is a crucial question. Of course, this does not mean that the central government would lose all its power. As an example, we do agree that there are clear advantages for a small country like Belgium to keep decisions about investments in heavy medical equipment to some extent at the central level. Yet, our basic question then remains. Not all our commentators take an explicit position in that debate, and those who do, have different opinions. Jan De Maeseneer and Myriam De Spiegelaere, both with a public health background, seem to reason with an ideal of overall government planning in mind – for them the sickness funds do not fit very well in the picture. On the other hand, the foreign commentators (all economists, we must admit) seem to agree about the importance of a split between purchasers and providers. This is even true for Fred Schroyen in his analysis of the Norwegian system. There remain large differences, of course. Brigitte Dormont with her French experience is much more sceptical towards more competition between sickness funds than Erik Schut who would like to push the Dutch system even more in the direction of competition. The more one believes in the importance of individual incentives and in the ethical value of respecting individual preferences, the more sympathy one will have for the sickness fund model. After all, individual citizens are able to choose the sickness fund they prefer; they will be less inclined to choose the place where to live on the basis of their health care preferences. The more one believes in the advantages of planning and in an objective, de-individualized definition of "health", the less sympathy one will have for the sickness fund model.

We are happy that all our commentators seem to share our conviction that the evaluation and design of health care reform should be evidence-based. The contributions by Brigitte Dormont, Fred Schroyen and Erik Schut are particularly instructive in that they show how different countries are struggling with the same challenges of reconciling efficiency with solidarity and how strongly the reforms in these countries depend on the system they inherited from the past. Equally instructive is the focus on solidarity in all these countries. This is perhaps less surprising for France and for Norway (although the transfers are large in the latter case) than for the Netherlands, where it is remarkable how non-profit insurers have gained prominence in the model of regulated competition. The debate in Belgium would be more interesting if there were less ideology but more respect for empirical evidence, and less grand statements about solidarity but a deeper discussion about how to implement it through specific institutions. A refusal to keep solidarity intact should not be hidden as a desire to make the system more efficient. And a refusal to introduce unpopular but necessary measures to increase efficiency should not be sold as a courageous defence of solidarity.