Minister van Sociale Zaken en Volksgezondheid
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Government can – and must – encourage value

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Overview

- Quickscan of the Belgian health care system
- All health care systems require efficiency improvements
- Value added of the ICHOM approach
- Some background on Belgian health care
- Value driven health care in Belgium

Quickscan of the Belgian HCS: how are we doing?

- Health expenditure: 10,2% of GDP
  - 78% publicly financed: tightened allowed real growth (2016: +/- 1%)
  - Relatively high share of out-of-pocket expenses in health expenditure: 18%
- High patient satisfaction
- High self-reported health status
- High accessibility (financial and care system)
- Moderate quality of curative care, with signs of improvement
- Weakly developed health promotion and prevention
- Weakly developed mental health care, with recent improvements
- Room for improvement with regard to efficiency of the health system: inadequate, unnecessary, excessive care
- Significant health inequalities
  - Socio-economic
  - Regional
- Complexity of health care governance as a result of consecutive state reforms

Quickscan of the Belgian HCS: (federal) reform programs

- Significant federal government change in 2014: start of structural reforms
- An ambitious change portfolio:
  - Hospital reform: organisation and financing system
  - Development of mental health care
  - Integrated care for chronic patients
  - eHealth roadmap
  - Innovation: pacts with pharmaceutical industry and medical devices industry
  - Reform of health care professions legislation
  - Reforms of governance: health objectives, modernising “concertation” mechanisms, redesign of health care administrations
  - …

Efficiency improvements needed

- Government spending everywhere under pressure: budget cuts not only in health care
- But health care needs keep on growing

- Public health & social affairs:
  - Avoid blind, linear budget cuts as much as possible
  - Efficiency improvements to meet growing needs
    - Efficiency = value added / cost
    - Improvements, in a language that appeals both demand (patients) & supply (providers)
- Challenge in Belgium: distribution of authority between federal state *(health care planning, reimbursement of operating costs)* and regions *(accreditation, funding of infrastructure)*

Efficiency: ICHOM approach

- Value added = outcomes that truly matter to patients (and providers want)
  - Focus on broader customer viewpoint
  - Not ‘narrow’ focus of processes under provider control
- Outcomes, specific per medical condition
- Delineation by three key groups of stakeholders:
  - Physicians, outcomes researchers and patient advocates
- Focus on 20 most prevalent conditions as accelerator for a new value based paradigm
- Systematic, standardised outcome measurement is an absolute necessity for value based health care

Belgium: ‘mixed’ social security system

Beveridge type	Bismarck type
- Social coverage citizens (guarantee of basic income)	- Social coverage of the worker
- Public administration (possibly decentralised local)	- Administration by social partners + controlled by state (tripartite)
- Financing from public budget (tax)	- Financing through social security contributions on labour income
- Public health care providers	- Private health care providers
NHS-type	**Continental social health insurance type**

Health care policy making à la Belge

- Government decides about global (public) budget
- Decisions about spending:
  - Strong impact of stakeholders (social partners, physicians, sickness funds, hospitals, …), because of their expertise – much more than government
    ?? do *stakeholde*r or *common interests* prevail ??
  - Strong consultation – negotiation tradition → compromise, incremental changes - no big bangs
  - Separate decisions for each subsector (silo approach, fragmentation) → no global optimisation
- Consequences:
  - Stability - gradual change, few major structural reforms

Value-driven health care in Belgium

- New focus in policy making:
  - Patients as active stakeholders
  - Evidence based policy measures
  - Tackling waste: faults, overconsumption, abuse, fraud
  - Development of health (care) objectives
  - Pluri-annual budgets
- Reform of the hospital sector and funding
  - Reduction of acute care beds & number of hospital sites
  - More care coordination
    - among hospitals
    - Between hospitals and other health care providers

To accomodate the care needs of a growing population with chronic conditions and multimorbidities, with interactions among different treatments

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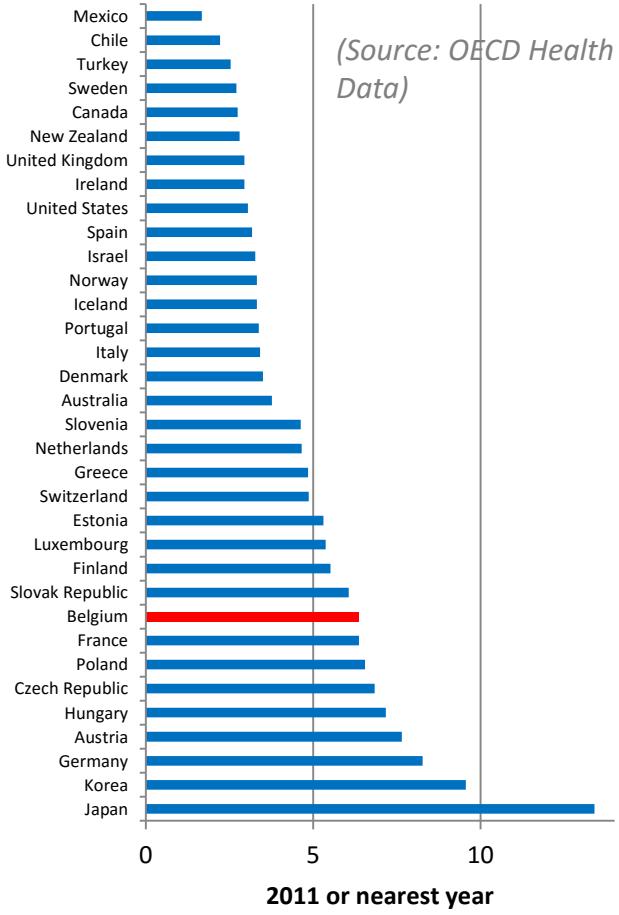
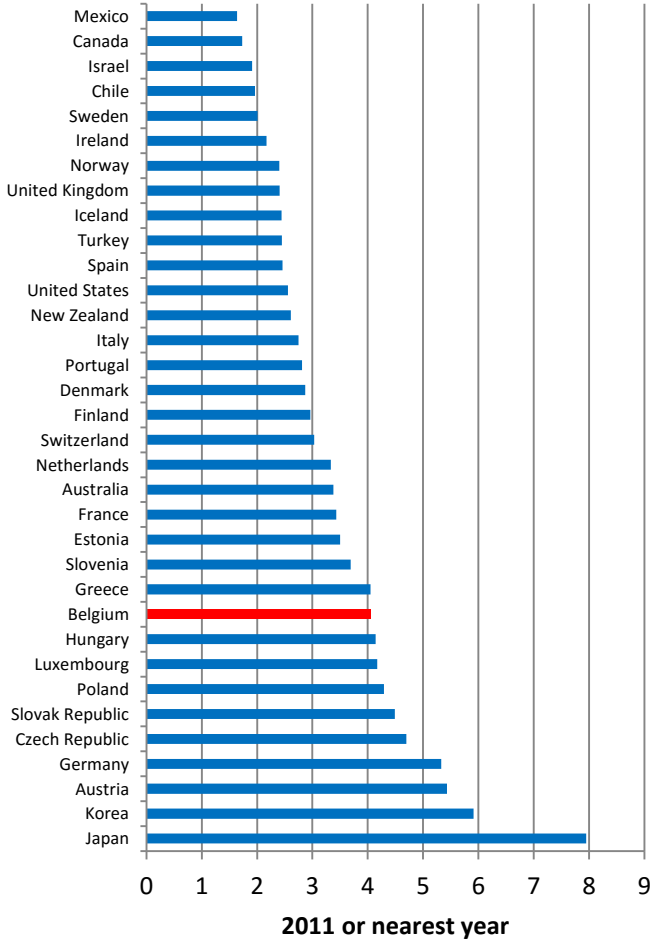
Hospitals: too many beds

Total hospital beds, per 1000 population



(Source: OECD Health Data)

Curative (acute) care beds, per 1000 population



Value-driven health care in Belgium

- Plan for reform of hospital sector and funding
  - Reimbursement, based on justified care
  - 3 funding clusters (≈ variability & predictability):
    - Low variability (highly standardised) → fixed & uniform price per patient / diagnostic group
    - Medium variability → closed-end national budget, distributed among hospitals, based on their casemix and risk adjusted
    - High variability → financial risk more for funding agency
  - Encouraging quality improvement: P4P

Value-driven health care in Belgium

- P4P: best practices abroad learn that P4P gives leverage, but careful and step-by-step approach is warranted!
- Targeted, pragmatic approach
  - For hospital care
  - Start with a limited part of the budget: 1-2%
  - Apply in the 3 funding clusters
  - Work with outcome (or process) indicators of proven effectiveness, that are supported by stakeholders
  - Avoid extra registrations
  - First step: call for proposals from stakeholders

Value-driven health care in Belgium

- Implementation ? "Cold feet" attitude
  - *Hospital budget are too low – P4P is only possible with "new" money*
  - *P4P will require more registration & reporting – less time for the patients*
  - *Why performance measurement? We do perform well – don't you trust us?*
  - *P4P is unfair, since my colleagues will not report accurately*
  - *P4P is unfair: hospitals will more severe patients will be disadvantaged, since risk adjustment or stratification never works*
  - *You get what you measure: no attention anymore for non-measured aspects of care*
  - *Paying 4P will generate perverse effects – measuring & comparing is sufficient*

Value-driven health care in Belgium

Barriers

- Reimbursement incentive structure:
  - Too much volume driven
  - Bad quality (e.g. complications) may be better reimbursed than good quality

Solutions

- Towards outcome based reimbursement
- Reliable & valid outcome indicators, endorsed by providers, patients & experts

Value-driven health care in Belgium

Barriers

- Hope that 'P4P hype' will soon be over

Solutions

- Clinical leadership
- Stakeholders get chance to develop own proposals
- Persistence / perseverance
- Frequent consultation with stakeholders → build confidence, no 'blame'

Value-driven health care in Belgium

Barriers

- Mind set: fear of change, fear of failing
- Risk of faulty or misleading reporting

Solutions

- Clinical leadership
- 'No blame' culture
- Learning by doing *(evolution no revolution)*
- Being a physician, helps
- Auditing, with credible, enforceable sanctions in case of conscious misleading

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