ITINERA INSTITUTE ANALYSE
ONAFHANKELIJKE DENKTANK | KLARE IDEEËN, KLAAR VOOR ACTIE

The rise of the health economy: challenges, opportunities and options for reform

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2010/12
16| 08| 2010

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Abstract

Demographic, scientific and technological evolutions are increasingly putting financial strain on Belgium's healthcare system. Both public and private healthcare expenditures are on the rise. Without thorough, structural reforms we risk the unfortunate but inevitable decline of a system previously renowned for its quality and accessibility. The purpose of this article is to offer some food for thought on healthcare policy reform in Belgium. We will focus on new roles for all the actors of the healthcare system, new financial and non-financial incentives for the healthcare providers and organisations to accept and expand these new roles, and a broader (horizontal?) reorganisation of the system placing the patient and the pathology at its very core (also known as the continuum of care). In our conclusion, we plead for a better reflexion on healthcare funding.

Key words: public and private healthcare expenditures, healthcare reform, healthcare policy, sick funds, e-Health, continuum of care, healthcare financing.

JEL Codes: H51, I18

Introduction

At the beginning of the 21st century demographic, scientific and technological evolutions are increasingly putting financial strain on healthcare systems all over Europe, indeed in almost all developed countries. These evolutions are destined to increase as the century progresses, further exacerbated by the dismal budgetary and fiscal legacy of the 2007-08 financial and economic crisis. Governments, administrators, and healthcare professionals are forced to think anew about the foundations of healthcare organisation. In Belgium, the elementary pillars of our healthcare philosophy – quality combined with accessibility and free choice – are already eroding. A proactive and ambitious reform involving patients, providers, payers, the industries, policymakers, and academics will be needed to prevent further gradual decline.

We must identify trends and challenges first. Based on these a suggestion of possible policy options will be made. A pragmatic and realistic approach – we do not have the luxury of ideology or romanticism – can be taken seriously only if the priorities and limits of promising solutions are defined. The purpose of this article is

to offer some food for thought on healthcare policy reform in Belgium, based on the stated necessity of such reform. Our purpose is not to provide a comprehensive or academic analysis, but rather to indicate – with a bird's eye view for the big picture – the unmistakable trends and future challenges that are upon us and to draw some of the plain conclusions they suggest.

I – Trends and challenges: the underestimated rise of the health economy

1. Public healthcare expenditures on the rise

In 1970, public healthcare expenditures were still under the billion euros. Ten years later, they accounted for more than € 3 billion. By the end of the millennium, public health care expenditures had reached € 12 billion and it is already certain this figure will again be doubled by 2010. In 2005, the public healthcare budget already equalled €17 250 358 000, in 2007 €18 873 404 000, and in 2009 almost €24 billion. Compare this figure with the € 850 million in 1970 and the metaphor with the universe seems straightforward: always expanding and expanding.

Of course, these are absolute figures. Translated into percentages of total Belgian Gross Domestic Product (GDP), we have seen for over 30 years an average annual growth of close to 5 percent in real terms, i.e. on top of inflation. This is obviously much faster than the average economic growth in this country, indicating that the public healthcare expenditure are continuously outpacing overall economic capacity. From the strict perspective of sustainable public budgets, therefore, the growth of healthcare spending is inherently unsustainable.

We have nonetheless managed to survive such an expenditure explosion by giving ever increased weight to the relative importance of healthcare in the total social security budget. In 2009, the share of public health care expenditures in the total social security budget was close to 35% (2). In 1980, it was a mere 22%. It is therefore fair to say that healthcare is gradually cannibalizing social security (3). The victims of this budgetary evolution are the first pillar pensions, the unemployment insurance benefits and child allowances, all of which have seen their relative levels reduced over time. This situation is untenable in the long run and has already led to a series of budgetary operations that are perhaps necessary or inevitable, but that share a common characteristic in that they restrict the offer of, or access to, healthcare in this country, one of the very strengths of our healthcare system.

On the other hand, the virtual growth norm of 4.5% (on top of inflation) has become somewhat of a political fetish in the past couple of years. The annus horribilis 2009 saw the Belgian economy shrink with 3%, while the public healthcare budget grew with an astonishing 7%. Even though part of this relative rise of 10% is earmarked for a "future fund", it should be clear to all objective observers that such an expansion rate is doomed to cause entitlement crises in the long run.

2. Private healthcare expenditures on the rise

Although our healthcare expenditures are financed by an ever expanding public budget, the patients themselves have to carry some of the burden. The OECD computed that 27.7% of the total healthcare expenditures in Belgium are paid by the patient-citizen (or his/her employer), either as out of pocket expenses or through private insurance(4). Only four OECD countries have an even more important share of private expenditure: the US, Canada, Spain and Switzerland (Figure 1), with Canada and Spain basically in the same ballpark. To put it bluntly: only in the US and in Switzerland are healthcare expenditures more privatized than in Belgium.

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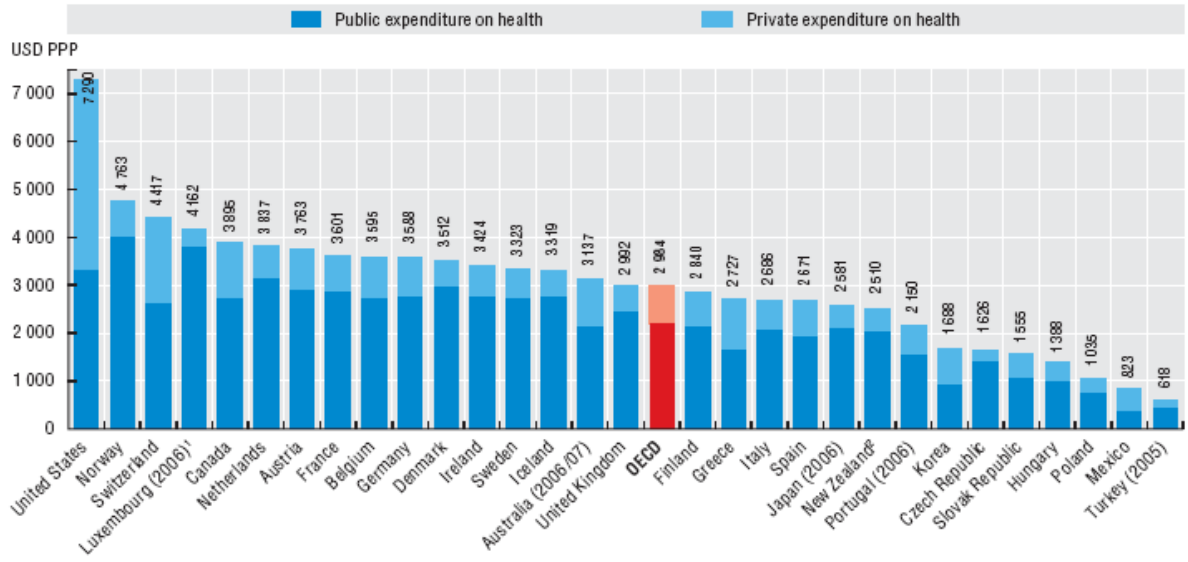
Figure 1: Health expenditure per capita, public and private, 2007

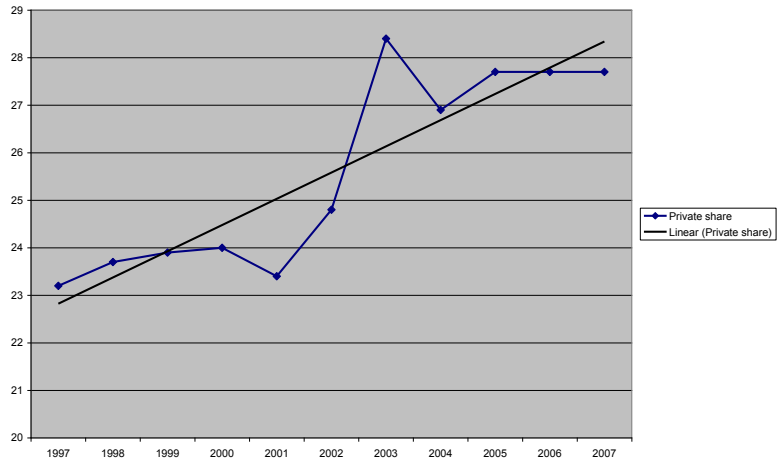


1. Health expenditure is for the insured population rather than resident population. 2. Current health expenditure.

Source: Health at a Glance 2009, OECD Indicators.

This already considerable share of private expenditures has been growing over the past few years, as can be seen from figure 2 below.

Figure 2: Evolution of the private share of healthcare expenditures in Belgium



Source: Health at a Glance 2009, OECD Indicators.

Of course, this in itself is not necessarily a problem. Research learns that, while the marginal utility of consumption goods decreases rapidly with the number of purchases, this is not true for healthcare expenditures. In fact, "as people get richer and consumption rises, the marginal utility of consumption falls rapidly. Spending on health to extend life allows individuals to purchase additional periods of utility. The marginal utility of life extension does not decline"(5). In other words, people are willing to pay for healthcare and for a whole bunch of health related goods and services, simply because they value them. This could be one of the reasons why an increasing number of people are willing to pay for private health insurance. According to the European insurance and reinsurance federation, the amount of privately insured individuals in Belgium has almost doubled in ten years: from 2 667 thousand in 1996 to 4 913 thousand in 2006 (6).

The growth of private expenditure is yet another signal of the evolution of our economy towards a health economy. On the other hand, however, the growing share of private expenditure could be a sign of the public sector's difficulties in healthcare demand. In the same vein, the increased importance of private healthcare expenditures should provoke the question of access to healthcare, particularly given the statistical correlation between poverty and healthcare needs. The policy debate should therefore confront fully and squarely the question of choice and limits in public funding. The alternative is a continued slow erosion of publicly funded healthcare. All this will be to the detriment of the poorest and sickest and is therefore not an attractive perspective and, we venture to claim, not a perspective the public would support if fully informed of the choice we face.

3. A case of underestimation: can healthcare's future be sustainable?

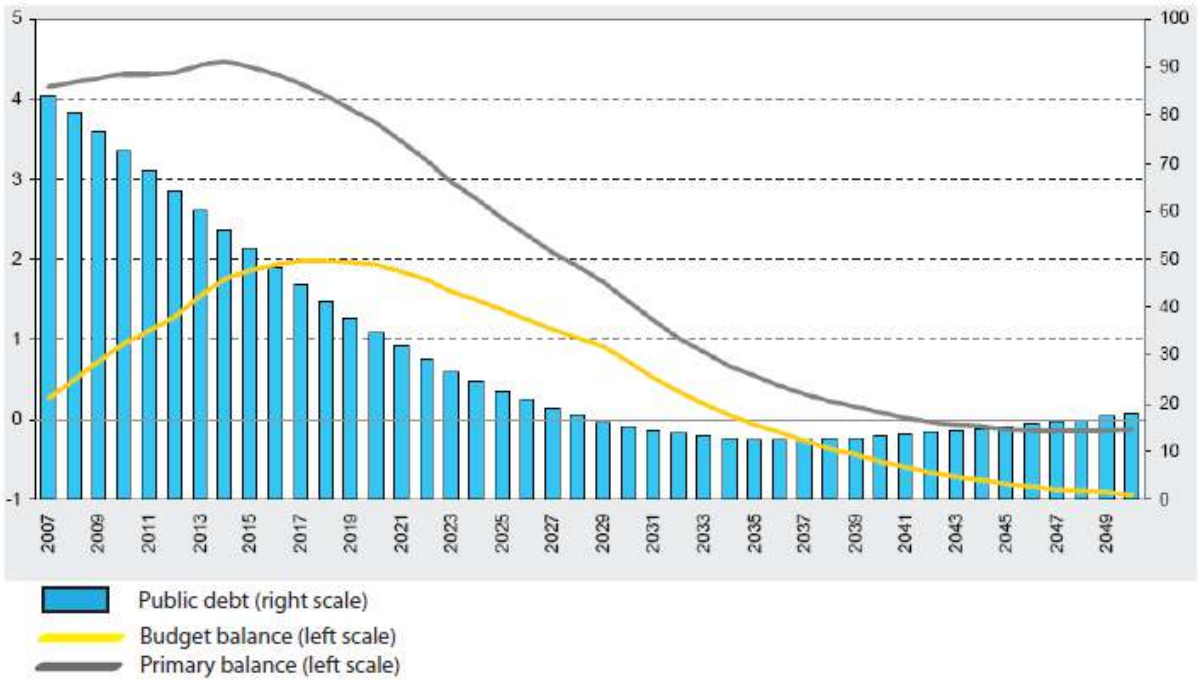
Healthcare's place in society will be increasingly predominant in the 21st century, not only because of well-known demographic developments, but also because of socio-economic, scientific and technological

changes. For Belgium, it is estimated that the phenomenon of ageing, by itself, will 'only' increase healthcare expenses by 0,7% on an annual basis (7) (8). Based on this assumption, one could be tempted to assume only a relatively modest budgetary challenge for future healthcare funding. However, one would be disastrously wrong to do so, for three reasons.

First, the official calculus of the High Council of Finance's Commission on Ageing - the official Belgian bible on ageing costs – assumes that public healthcare expenditures will only rise annually by 2.8% (9) above inflation until 2030, this is a 40% decrease as compared to the average growth rate of the previous three decades. In other words, as we will emphasize below, the official Belgian scenario for ageing seeks to dramatically revert the historical trend of rising public healthcare expenditures, notwithstanding the fact that healthcare needs are expected to increase because of ageing. But it offers not a single clue as to how this historical trend breaker is supposed to happen.

Secondly, the unfortunate 2007-08 financial and economic crises have all but ruined the budgetary scenario. The Belgian public debt is on course to break the 100% of GDP barrier yet again. By contrast, the pre-crisis 2007-2010 stability program – which forms the backbone of Belgium's budgetary strategy in the face of ageing – assumed a public debt of 76% in 2009, a staggering 22 percentage point differential with the actual situation (10). The figure below illustrates the budgetary strategy we ideally should have followed:

Figure 3: Long term budgetary strategy recommended by the High Council of Finance, 2007



Sources: High Council of Finance and the National Bank of Belgium

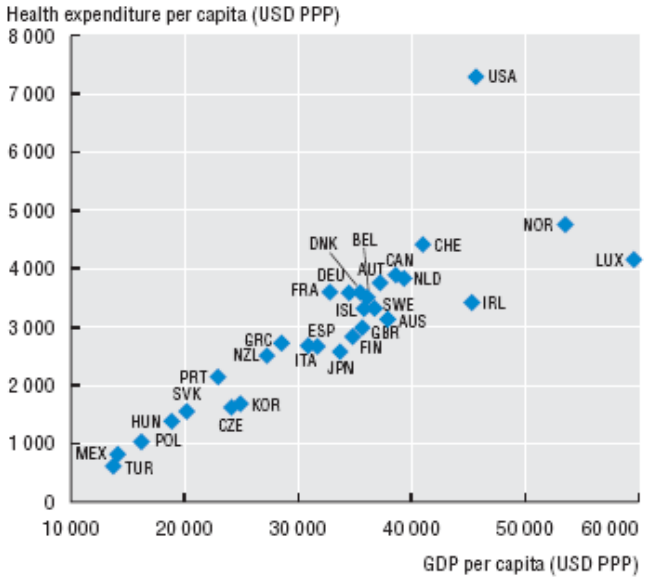
In its revised middle and long term budgetary strategy, the High Council of Finance now advises the Belgian government to reach a global equilibrium by 2015 (11). That way, 80% of the expected cost of ageing could be financed in the long run, meaning 20% is now a virtual deficit. But even reaching the equilibrium by 2015 will require the biggest budgetary effort of the past four decades (12). In other words: the entire scenario of reduced future healthcare spending is now in shambles.

Third, and most importantly, Belgium's official estimation for the future evolution of healthcare expenditures totally fails to take into account the biggest drivers of healthcare. Indeed, ageing is just the tip of the iceberg of growing health and healthcare expenditures. It is widely acknowledged that several drivers will be responsible for an inexorable push in healthcare expenditures in the decades to come, besides demographics (13):

-Changing lifestyles and the consequent explosion of lifestyle diseases, e.g. related to obesity (14).
-Continued increased specialisation in the medical profession, as the scientific evolution creates ever more avenues and branches.
-Innovation in technology and medicines, opening up new treatments and narrowing down the target group to eventually the level of individual and genetic treatment, where the cost saving effects of blockbuster treatments with huge markets will disappear. The treatments will continue to improve, but their relative cost will rise.
-Consumerism, as people become ever more demanding and willing to improve their health and wellbeing, further blurring the line between medicine, consumption, and life style.
-Greater wealth in both the western world and the now rapidly expanding developed world, feeding further the desire and willingness to pay for health and healthcare.

The key challenge will increasingly be to provide healthcare that is both affordable and accessible, while being of high quality. The link between 'wealth' and 'health' in the shape of healthcare expenditures is borne out by economic research, also in Belgium. The Federal Plan Bureau found that the 'elasticity' of health expenses per capita and GDP per capita – this is the extent to which health expenditure reacts to increased economic growth – is superior to one (15). This means two things: 1. the wealthier people become, the more they are willing to spend on healthcare, and 2. people are prepared to spend proportionally more on health compared to the extra wealth they have acquired. The relationship between GDP per capita and health expenditures is also illustrated in figure 4 below: the "wealthier" a country, the "healthier" a country.

Figure 4: Health expenses per capita and GDP per capita, 2007



Source: Health at a Glance 2009, OECD

All of this indicates that our society is consciously choosing for health, belying the official predictions of a markedly slower growth in healthcare expenditures. Citizens are no longer mere patients who swallow whatever the doctor prescribes. They are becoming more and more conscious healthcare buyers and consumers, further stimulated by increased access to healthcare information via a variety of sources, including the internet. According to some long term estimates, up to one third of a developed country's GDP will thus be spent on healthcare by the end of our century (16). This signals the evolution of our economy towards a health economy, a new stage in economic progress in post-industrial societies.

Economically speaking, it makes little sense to deprive people from something that creates value for them. The bottom line is: rather than being satisfied with the landscape as we know it now, we should allow ourselves to invest more and more consciously in healthcare. We should put our traditional budgetary autism aside and start grasping the economic opportunities that arise from the shift to a health economy. For that to be the case, however, the necessary but narrow focus on budgetary control in public sector funding needs to be lifted and an open debate on the limits and choices in public healthcare provision must be recognized as both inevitable and desirable.

II – A new paradigm: moving beyond the "Brussels' consensus"

To anticipate the budgetary impact of ageing and to discipline governments in the short run for this long term challenge, Belgium has established a virtual savings strategy (the Silver Fund) and an annual rite of

future ageing cost estimation, in the shape of reports from the High Council of Finance's Commission on Ageing. The purpose of these reports is to estimate – and the estimates have never ceased to increase with each annual report as can be seen from the tables below – the expected future cost of demographic ageing, based on a number of parameters of future fiscal, social, and economic performance (17).

The budgetary cost of ageing as a % of GDP in 2030 according to 8 subsequent reports

Report publication	Apr /02	May/03	Apr/04	May/05	May /06	May /07	May /08	Jun /09
Total cost compared to 2000	3,1	4,2	4,5	5,1	4,6	5,1	4,7	6,8

The budgetary cost of ageing as a % of GDP in 2050 according to 4 subsequent reports

Report publication	May /06	May /07	May /08	Jun /09 (2060)
Total cost compared to 2000	6,6	6,9	6,7	9,1

These parameters can be summed up as follows below. We contrast the premise with the past/current performance:
– 1,50% labour productivity growth per year till 2030 (average 1,45% between 1980-2005).
– Activity rate of 70% in 2030 (61,5% in 2009, or a difference of roughly 550.000 jobs).
– Average annual economic growth 2,2% till 2030 (1,8% between 1990-2005).
– Public debt 60% GDP in 2014 (98% in 2009).
– Annual average real term growth of public health care budget restricted to 2,8% till 2030 (near 5% between 1970-2009).

As the list shows, the estimates assume a systematic and marked improvement of Belgium's fiscal, social, and economic performance, coupled to a truly gargantuan budgetary challenge that now belongs to the realm of fiction, thanks to the economic and financial crisis. We have argued elsewhere that such an improvement is very unlikely and in fact amounts to wishful thinking without prior fundamental policy reform (18). Indeed, ceteris paribus, population ageing is likely to impede and slow economic performance, not improve it (19). An older workforce is likely to reduce productivity, not boost it. The High Council of Finance itself recognizes the limits of a purely budgetary strategy and advocates reforms that stimulate growth and employment in order to meet the financial challenge of ageing (20).

More importantly for our exercise is the last of the aforementioned premises, which seeks to reduce the annual growth rate of public expenditure on healthcare to 2.8% per year, i.e. a baffling reduction of almost 40% as compared to the average growth in the previous 35 years. Given the powerful vectors that will increase rather than decrease healthcare needs in the future, as listed above, this estimate will require policymakers to make fundamental choices on what to finance, and what not. Either the 2.8% will turn out to be a fluke – as it has been ever since the first report of the High Council of Finance in 2002 – in which case

the budgetary challenge (and deficit) will raise inexorably with every waking year, until the day of reckoning. Alternatively, the 2.8% will be respected, in which case the Belgian healthcare system as we know it will have to morph into a newer and sleeker version. Eventually and inevitably, both options will arrive at similar destinations.

The only desirable alternative for our healthcare policy is thus to reform and improve. Without such reforms we will simply not be able to maintain anything near the quality and accessibility we now enjoy. The key angles for healthcare reform are relatively simple:
• More health but less healthcare, by systematic prevention and by accountability for all the actors involved.
• More healthcare with less means, through increased efficiency but without jeopardising the quality guarantor of an open and internally competitive healthcare system.
• A different and more just healthcare with the same means, by drawing the boundaries of public financing less on budgetary grounds and more on the basis of accountability, towards doctors and patients alike.
• More but different means, per example through alternative funding, through an organized second pillar of additional insurance, or through the development of health services for foreign patients.
While principles are relatively simple, their realization, however, can be excruciatingly difficult. This article is not the place for developing a comprehensive and balanced list of fundamental proposals (21). We will, however, indicate some directions with potential, in the hope of broadening mindsets and starting a pragmatic debate on the paradigms of future healthcare organisation in this country, given the budgetary constraints.

III – A new paradigm: desirable evolutions

1. New roles for all the actors

1.1. New roles for the healthcare professionals

To be able to face the healthcare challenges of the 21st century, human resources are an essential component of success. The functions of all the actors have to progressively evolve for our system to be able to respond more appropriately to the patients' expectations and the major challenges ahead. There is a real opportunity to grasp here. This progressive evolution of the functions and roles is fundamental for achieving a fair but sustainable healthcare system. In the lines that follow, we briefly sketch what evolutions – not predictions, but orientations that emerge from the literature – may be in stall for some of healthcare's key institutional stakeholders (22).

The physician of the future will be even more capable as he/she will succeed in integrating his medical practice in a larger dimension that will not focus on the isolated medical deed only. He/she will integrate healthcare management preoccupations and will choose the most suitable alternatives. He/she works in close collaboration or in team with his pairs. New incentives will be introduced in the physician's remuneration to encourage prevention and chronic disease management. In short, tomorrow's physician will have to

take into account the long term more than he/she used to, and his/her institutional role more than before. With patients looking for more and more information (blame the internet), the physician will have to share his knowledge when taking decisions. He/she uses all the possibilities that ICT has to offer and has access in real time to all the available information (thanks to the global file for example). He/she has the possibility to use standardized and optimized procedures (as is the case in Sweden) that the physician can personalize according to his patients' specific needs.

The nurses of tomorrow will have to carry out new tasks that will have to be legally recognized as such. Their functions will evolve to health promotion (first line health assessment, patient education, screening, etc.), the monitoring of stabilized chronic pathologies (like asthma, diabetes or cardio-vascular diseases) and the coordination of care within the hospitals and with the patient. New ways of cooperation between doctors and nurses will thus see the light. These evolutions are very important, "not only to face a demographic decrease [aging], but also to optimize the healthcare system, regulate unrecognised existing practices and add legitimate recognition" (23).

The pharmacist's role will also significantly evolve. Pharmacists will provide an increasing amount of services of high added value: 1) the function of advise and guidance through the healthcare system will gradually increase, 2) the preventive role of the pharmacist will also be expanded, and 3) pharmacists will have to coordinate more with the other healthcare professionals. For all these professions ICT will play an ever more important role. Think of the shared global medical file, the nursing file, electronic prescribing, etc.

The evolution of these different professions towards their new roles will not be possible without a complementary contribution in terms of training. Indeed, for every profession, one or more new dimensions have to be integrated into daily practice. This change of habits, the daily preoccupations and modalities of working will require both training and change management assistance. If we take a look at the training currently delivered in Belgium, we cannot but note that these are not ideally adapted to our future needs. Basic management training is as good as inexistent in a doctor's academic training. Supplementary programmes exist and can be of excellent quality but they require a very important individual investment and are not yet generalised. Therefore, training programmes should be re-examined to integrate new dimensions, once the strategic choices on healthcare organization are taken. In parallel, shorter, well-targeted training programmes addressing specific problems could be organised at the local level. Knowledge of the healthcare system, the integration of management preoccupations, the importance of collaboration and ICT training are themes that should interest healthcare professionals. A recent RIZIV/INAMI study illustrated the huge expectations of doctors in terms of ICT training. In the only university that has integrated these new concepts in its academic education programme, student interest and participation are overwhelming.

1.2. New roles for the sick funds (24)

In the course of this century, the functions of sick funds will have to undergo important evolutions in order to face the challenges ahead. Sick funds can play a crucial role in guaranteeing a sustainable healthcare system, one that delivers quality care to everybody while controlling expenses.

Why evolve?
The act of the 6th of August 1990 foresees 3 important functions to the sick funds:
a. To participate in the realization of the compulsory healthcare insurance.
b. To intervene financially in the expenses of its members and their dependents for prevention and care in the case of sickness and/or invalidity; and in the attribution of benefits in case of labour disability or in situations where the physical, psychological or social wellbeing can be encouraged;
c. To provide help, information, advice and assistance in the light of promoting the physical, psychological and social wellbeing of their members.

The act of July 14, 1994, goes even further and entrusts the sick funds with a fourth role: the important new responsibility of co-managing the compulsory health insurance. This new task includes, among other things, distributing resources for the health insurance, negotiating tariff agreements and conventions with the healthcare professionals, and modifying the itemization for medical care (the so-called "nomenclatura"). In other words, sick funds are responsible for a more efficient expense management since 1994. This is also why Belgian sick funds are partially responsible for a small part of their expenses (maximum 2%) since 1995.

Our sick funds have very well and for a long time carried out the first two of their aforementioned functions. The third function, however, has not or only partially been realized. The same observation stands for the fourth function: although sick funds have been looking for efficiency gains and economies, they have only done so in a limited number of domains like medication, medical imagery and clinical biology. Thanks to their expertise and influence they could be a powerful partner in containing costs and expenses in other domains such as hospitals or retirement homes. A pragmatic approach to efficiency gains in healthcare will allow us to get more health out of every euro spent. That is why the law entrusted our sick funds with this new responsibility. That is why sick funds should realize that without their full collaboration, a more efficient but socially responsible management of the compulsory health insurance is way harder to achieve. Given the evolutions that await our system (ageing, technological and therapeutic developments, etc.), it is of crucial importance that our sick funds help maintaining the financial sustainability of our healthcare system through efficiency and effectiveness strategies.

Another important driver of change is ICT. As with the banking sector in the previous decennium, the sick funds will undergo a digital revolution: the huge paper flow can, should and will eventually be replaced by electronic communication and digital data exchange. Electrons can replace hands. Electronic web offices thus risk replacing real people if sick funds don't start thinking about new functions with more added value, like the co-management of the compulsory health insurance. This, of course, will require an ambitious occupational resettlement programme in the sick funds' own human resources policies.

The growing influence of European directives is another reason for sick funds to evolve. Whether you like it or not, the weight of Europe in healthcare is going to increase and this trend will only become more noticeable in the years to come. With the rising of cross-border care and the increased mobility of healthcare professionals and patients, the role of our sick funds will become even more complex.

Four opportunities to grasp

1. Develop the third function: "Provide help, information, advice and assistance in the light of promoting the physical, psychological and social wellbeing of the members". Concretely, the sick funds could inform the patient-citizens of best practices, in-hospital risks, and the pathology specialization of healthcare providers. They would, to be able to do so, have to closely monitor our system's quality and accessibility as a whole by monitoring all the different providers individually. Finally, sick funds would have to work closely together with a new organism, yet to be established, that would be in charge of the accreditation of healthcare institutions, the evaluation of professional practices, the quality control of operating blocs, etc (25).

2. Assist the system in evolving from its budgetary logic to a logic based on efficiency gains. This new opportunity basically comes down to answering the question how to get more health out of every euro spent on healthcare. To be able to achieve this, a forum should be developed that brings together providers, public authorities, suppliers, private insurers, sick funds, etc. to think about desirable evolutions and possible efficiency gains in the system. A common database, with restricted and controlled access, would have to be created. Third, together with the private insurers an analysis should be made of the medical treatments and services that today are outside reimbursement and are increasingly raising the share of private healthcare expenditures. It is crucial to identify and understand these trends that are an essential part of our system that is already evolving towards a health economy.

3. Our sick funds could play a key role in e-Health. Information and communication technologies (ICT) have already had a significant impact on economic growth, but also on healthcare and on the delivery of health services in a number of countries. From telemedicine to electronic health records to RFID (26) to embedded sensors, a variety of health ICTs have been shown to improve operational and administrative efficiencies, clinical outcomes, as well as documentation and information flows in a variety of global settings. Chaudry et al. (2006) (27) have scrutinized 257 empirical studies to analyze the impact of health information technology on quality, efficiency and costs of medical care. The analyzed studies unanimously reported positive results on the quality of care through an increasing adherence to guideline- or protocol-based care, clinical monitoring based on large-scale screening and aggregation, transparency, and the reduction of medical errors. ICT was also found to improve healthcare's efficiency thanks to more accurate diagnosis and thus less unnecessary treatments and medication consumption. One examined study reported efficiency gains up to no less than 24%. Chaudry et al. were not able to find relevant studies – they were either too old or methodologically questionable – that showed ICT to be cost reducing in healthcare. Hillestad et al. (2005) (28), on the other hand, computed a cautious estimate – not a proof – of how much money could be saved in the US thanks to the generalised application of the electronic health record (29). The estimation yielded an impressive figure of $513 billion by 2020. ObamaCare in the United States focuses prominently on ICT investment for this particular reason.

For sick funds to grasp this opportunity (that will also benefit the system as a whole), they could start by developing ICT programmes to support their operations. Some sick funds have already started with such initiatives. Earlier this year a telemedicine pilot project was launched to monitor diabetes type 2 patients at home. The centralized database that was mentioned above is another example: it's not realistic to have the

ambition to carry out such huge ICT projects without the detainers of the most relevant information, i.e. the sick funds.

4. More financial responsibility should not be seen as a burden, but as an opportunity for the sick funds to be actively involved in three dimensions that are essential for the future of our healthcare.

- The development of broad programs and actions (disease management) in the field of prevention and the control and monitoring of specific diseases like asthma, cancer, heart failures, and diabetes.
- In coordination with the other stakeholders, sick funds could promote replacing the purely curative and individual approach by a new, integrated disease management approach that involves all the major players of our healthcare system.
- The development of new financial incentives to support this new approach (coordination, prevention, the use of ICT and the long-term approach). In general, healthcare policy shouldn't focus on the sick people only, but also on keeping healthy people healthy, on detecting early, and on coordinating treatments to ensure recovery and reduce costs of further treatments.

Conditions for success
There are 5 conditions for success

1. Work goal-oriented. Sick funds will not be able to take up all of these new roles at once, which is why they have to make clear-cut strategic choices. The functions that they do not wish to develop, or hardly wish to develop, can be entrusted to other organisations. In other countries, where sick funds do not play such a prominent role, alternatives are available.

2. Develop partnerships. To grasp the abovementioned opportunities, and to realize potentially beneficial projects, both internal as external partnerships will need to be developed. To increase the overall efficiency of our healthcare system will require sick funds to work closely together with the suppliers, the providers, the distributors, and the pharmaceutical industry. Another example of a promising partnership would be with a yet to be created accreditation organisation. Internally, specific project groups would have to be established, and training given. It is important to realize that it is in everybody's interest to make the transition to these new roles as smoothly as possible.

3. Have the courage to suggest an ambitious internal strategic reconversion plan. Without it, both the long-term viability of sick funds could be in peril as well as the sustainability of the system as we know it today.

4. Foster a reflection that focuses on the long term. Too often, Belgium's policy concerns have focussed on the short-term and on yearly budgetary struggles. The crisis has only made things worse. We cannot stress enough how important it is all the actors realize here and now how vital it is to bear a long-term perspective in mind, for themselves and for the sustainability of the system. To that end, a special platform could be created, a healthcare committee of the wise so to speak, that could be fully integrated in an already existing structure (think of organisations such as the Federal Centre of Expertise or the RIZIV/INAMI).

5. Operate proactively on the European level. Free movement of goods, services, and patients in Europe will

have an ever more important impact on our healthcare system. If we want to sustain the values and fundamentals of our system in this new European dimension, we will have to take proactive steps to weigh on the decision making process. The sick funds have all the instruments required to develop the intellectual process and are a crucial partner in the networks of influence. They could especially make use of these instruments during the upcoming Belgian presidency of the European Council.

2. New incentives

To encourage and enable healthcare providers and organisations to accept and expand new institutional roles and responsibilities, financial and non-financial incentives need to be developed.
New incentives that favour coordination between all the healthcare professionals, and that push doctors, nurses and pharmacists to focus more on prevention, chronic disease management and the use of ICT are therefore highly desirable. Today's reimbursement itemization of healthcare performances doesn't support cooperation between the different actors of the healthcare system, a long term vision and a global approach of pathologies. Almost all the measures so far are individual initiatives. These initiatives are not rewarded by Belgium's itemization system.
Moreover, by paying for performance, our fee-for-service system as we know it today insufficiently integrates effectiveness and quality. It does guarantee the independence and the global dynamism of all the providers and should therefore not be questioned as such. It should, however, be complemented by new incentives that are not only tied to individual performance, but also to the larger patient care during a certain amount of time. This type of payment, called payment by capitation, has already been implemented in Belgium – modestly, but not wholly unsuccessfully – for the global medical file managed by the general practitioner.
A hybrid system of capitation and fee-for-service could be very well adapted to the Belgian healthcare system. A system that combines both a fee-for-service element, together with a partial capitation, would guarantee the dynamism of the actors of the system while stimulating healthcare practitioners to take up new roles for the future: actively promoting prevention, guiding patients through the complex healthcare system, share medical files, cooperate in practice groups, chronic disease management, etc. This reasoning can be applied in a similar way to the nursing personnel and the pharmacists.
These incentives should be sufficiently detailed and precise in order to stimulate and reward with accuracy the desired attitudes. A reward that the general practitioner would receive for investing more in information and communication technologies would not be sufficiently targeted per se, as long as it does not specify how much would have to be invested in ICT and, what is more, to what end.
Hospitals could also be stimulated to favour quality, cooperation, and the most appropriate therapeutic alternatives. Today's hospital financing is only based on their activity and doesn't take into account the most suitable alternatives for society. An interesting example that goes in that direction comes from France where hospitals make use of external associations to follow up and coordinate care after the patient is discharged from the hospital. These organisations link patients with first line services and hospitals. They are well organised, and structured in a very professional way (including call centres, user-friendly ICT applications, and people responsible for coordinating everything).
More and more, patients are seen and approached as active stakeholders of our healthcare system, not as mere subjects. Of course, this implies that patients should be made conscience of the true costs of their choices and, where possible, of the more appropriate alternatives. It's essential that patients understand and

are aware of the true costs and the value of the services they 'consume'. For a long time, only out-of-pocket costs were considered an effective instrument for regulating healthcare demand. But out-of-pocket costs applied in a uniform way do not make a distinction between effective, less effective and ineffective care. New incentives should therefore be developed as to inform the patient of the true costs and quality of available therapies. Patients could also be charged more by a specialist if no general practitioner has been consulted beforehand. Another interesting experience to be analyzed: an individual healthcare account from which the insured could draw to pay for his/her healthcare expenses. This 'savings account' would materialize in a balance that would certainly increase the patients' awareness of the budgetary implications of his or her choices. One could even go as far as rewarding appropriate patient behaviour. A conscious preventions strategy will include rewarding efforts and – perhaps – "punishing" risky behaviour.

3. From vertical to horizontal organisation

The Belgian healthcare system is essentially vertically integrated. From the top down, the government decides on budgets, the RIZIV/INAMI allocates budgets, the mutual funds (or private insurers) assure reimbursement, the hospitals organize and centralize care, the specialists provide specialist care, and the general practitioners provide general care. This slicing up of the healthcare cake induces turf wars and causes mutual isolation between different levels in healthcare provision. From the perspective of health outcomes this is a suboptimal situation, especially since a large percentage of healthcare expenditures is linked to a limited group of pathologies. It would be more logical, and indeed more productive, to adopt a horizontal approach where the main pathologies would be targeted in a succession of stages: from information and sensitisation (prevention), to screening, early diagnosis, and eventually team treatment with various health care professionals involved in the particular disease on a platform basis. Healthcare providers, with the right government support and structure, could thus work more closely together to improve the coordination and access to health, and to ensure better health outcomes. Today's parcelled out approach could thus make room for a continuum of care which integrates the whole healthcare chain.
According to the World Health Organization, "continuum of care" offers a complete service array, from hospital to home care, and requires all medical and social services within the community to be brought together. The connection of all healthcare initiatives on all levels of the healthcare system is also part of the continuum of care. The patient therefore stands in the centre of the healthcare supply chain. For every patient and for every type of pathology, the most adequate and available treatment is suggested. Not the profitability for anyone level or actor, but the patient's needs are the most important selection criterion when treatment is offered. Obviously, this implies more coordination and integration between the different healthcare levels and healthcare services.

The distinction between a 'vertical' and a 'horizontal' approach to healthcare is not sacrosanct. There are, for instance, certainly issues of organisational complexity in framing a horizontal, disease- and patient-oriented approach. But what the above illustrates is the need for the Belgian healthcare organisation to reconsider both the individual role of the respective levels or actors in healthcare organisation and the way they collaborate for ensuring optimal health outcomes with improved efficiency. The current vertical division of healthcare organisation does not easily allow such reconsiderations, but on the contrary reinforces interest group style reflections (soft corporatism) at the expense of efficiency or health outcome. We need the

freedom to reconsider the relevance, position, and purpose of the current institutional actors in the healthcare system if we are to preserve its healthcare performance for the future.
Conclusion: Towards an open reflection on healthcare funding?

We have seen that:
-While even today a large percentage of Belgian healthcare expenditure is already private;
-Public healthcare expenditure in the future will increasingly suffer from the gulf between what is required and what is affordable, as the Belgian repartition system meets the combined challenge of ageing, the exponential growth of healthcare demand, and the painful legacy of the 2007-08 crises.

Our paper has focused primarily on efficiency and effectiveness. But, in all likelihood, this will take us only so far. There will be no escaping the stark budgetary reality, especially if one takes into account competing social security needs in pensions. This sober reality should force us to recognize what is already a reality today and what may increasingly become a necessity tomorrow, i.e. that healthcare funding is both a public and a private affair. The solid policy approach is not to deny this combination but to confront it and have a societal debate about the combination and organisation of both. The policy of denial allows private funding to develop organically in an insufficiently regulated market, as has been the case until now. This results in limited transparency, uncontrolled price increases, reduced competition, adverse risk selection on the part of insurers, and could eventually lead to a real two-speed society between those who can and those who cannot afford private insurance of some kind. In many ways the current Belgian landscape of private healthcare insurance resembles the questionable US landscape prior to ObamaCare.

The very sensitive debate about the limits of public health care provision needs to be brought into the open. It will, of course, be a very difficult and sensitive debate. We will have to dare asking some unpopular questions. Political courage will be needed to invest in long-term reforms that will require both time and money. Additional, potentially sensitive, data will have to be collected to come to a true understanding of the components and the budgetary weight of our private healthcare expenses. The limits of public health care provision will have to be determined, not on ad hoc basis but on a fundamental and principled societal basis. The role and responsibility of various actors will have to be (re-)defined, since we could have to organize additional pillars of health care funding by recalibrating the responsibilities of citizens, employers, insurers and mutual funds. In the same vein, patient responsibility would have to be considered and organized, implying a variety of ethical questions on the limits of solidarity and on the scope of personal responsibility.

The debate will thus undoubtedly be difficult, but at the same time cathartic. It will allow us to rationalize and democratize the vagaries of currently ad hoc budgetary decisions. It will allow us to streamline and organize a fair and responsible market for various forms of private insurance, ensuring due attention to solidarity and to coverage of the poor and the ill. It will allow us to set ethical rules of personal conduct and responsibility, making the residual solidarity fairer and more defensible. In short: the budgetary pressures that will weigh upon the future evolution of healthcare should allow and force us to improve healthcare on all levels: in organization, effectiveness, quality, and finance. The impending budgetary crisis for healthcare may yet prove to be the conduit for reform that will re-establish a high-level and accessible healthcare system on a sound footing for the decades ahead.

Footnotes

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