



BELGIUM'S HEALTHCARE SYSTEM SHOULD THE COMMUNITIES/REGIONS TAKE IT OVER? OR THE SICKNESS FUNDS?

Lead Piece and Reply by
Erik Schokkaert & Carine Van de Voorde

Comments by
David Crainich
Jan De Maeseneer
Myriam De Spiegelaere
Brigitte Dormont
Johan C. Kips
Fred Schroyen
Erik Schut

The Re-Bel initiative aims to rethink in depth, in an open, rigorous, non-partisan way, what the institutions of the Belgian federal state - or of whatever else this part of the world needs to become - can and must look like in the longer term, taking full account of the evolving European context.

The Re-Bel initiative does not aim to produce one programme or manifesto to which everyone involved could subscribe. Its ambition is rather to provide a fertile intellectual environment in which new ideas and promising initiatives of all sorts can germinate and develop, with a concern for their relevance to a thorough reform of Belgium's institutions, but also to the institutional design of other complex polities, most obviously the European Union.

The Re-Bel initiative involves scholars from all Belgian universities, runs a web site, publishes e-books and organizes workshops and public events. It intends to associate to its activities both foreign colleagues and the Brussels-based international community. The working language will usually be English.

The Re-Bel initiative is supported by the University Foundation, which will host all its activities. The University Foundation was founded in Brussels in 1920 at the initiative of Herbert Hoover and Emile Francqui. One of its missions, also central in the Re-Bel initiative, is to foster fruitful contacts and collaboration between academics of all Belgian universities.

Each contribution to a Re-Bel e-book is written under the sole responsibility of its author. The views expressed in it cannot be assumed to be shared by either the Re-Bel initiative as such or the University Foundation.

Re-Bel initiative
www.rethinkingbelgium.eu
contact@rethinkingbelgium.eu

Coordination:
Paul De Grauwe
Philippe Van Parijs

In partnership with
the University Foundation
rue d'Egmontstraat 11, 1000 Brussels, Belgium
www.universityfoundation.be

Table of contents

Foreword Erik Schokkaert	4
Lead Piece Belgium's health care system: Should the communities/regions take it over? Or the sickness funds? Erik Schokkaert & Carine Van de Voorde	5
Comments	25
Prospective payments in the health care sector David Crainich	26
Defederalisation of health care in Belgium: solidarity, quality, efficiency and health policy Jan De Maeseneer	29
How to move towards a more integrated health system and more coherent health policies taking into account the Brussels realities Myriam De Spiegelaere	32
Value-based health care Johan C. Kips	38
Health insurance, efficiency and equity: French debates Brigitte Dormont	40
Decentralization and coordination of health care provision in Norway: which lessons for Belgium? Fred Schroyen	51
Health care reform in Belgium: Going Dutch or waiting for Godot? Erik Schut	61
Reply Reply to Comments Erik Schokkaert & Carine Van de Voorde	68

Foreword

Erik Schokkaert (KULeuven & UCLouvain)

The system of health insurance is an important element in the debate about the future organization of Belgium. It is a focal point in the discussion about the limits of solidarity, the existence of different preferences in the North and the South of the country, and the possible increase (or decrease) in efficiency that may be realized through decentralization. At the same time, the organization of health care is one of the most important challenges facing all rich Western countries. How to accommodate the trend towards increasing expenditures as a result of technical progress, in a situation with growing doubts about the long-run sustainability of government expenditures?

The lead piece of this E-book (by Carine Van de Voorde and myself) argues that the issue of decentralization cannot be analysed separately, but should be integrated in a broader perspective on the future organization of the health care system. Decentralization is desirable, but regional decentralization is only one option. An alternative option is to give more responsibility to the sickness funds and cautiously move in the direction of a model of regulated competition. In both cases the financing of the system should remain at the federal level and personal solidarity is reached through a risk-adjusted distribution of the global budget. Basically all European countries are variants of this general model. The key difference is the role of sickness funds in the system – and this is also the key question for Belgium.

The lead piece is followed by four “Belgian” reactions. Three of them (by David Crainich, Jan De Maeseneer and Johan Kips) have been presented at the Re-Bel Public Event in December 2010. The fourth (by Myriam De Spiegelaere), with special attention for the specific situation in Brussels, is written for this E-book. The E-book also includes three contributions from countries with very different health care systems: Erik Schut describes the Dutch system of regulated competition, Fred Schroyen the regional decentralization in the Norwegian health care system, which is dominated by the government, Brigitte Dormont the growing tensions within the hybrid French system. They all draw some lessons for Belgium. Finally, there is a brief reply by the authors of the lead piece.

Lead Piece

Erik Schokkaert & Carine Van de Voorde

Belgium's health care system: Should the communities/regions take it over? Or the sickness funds?

Erik Schokkaert (KULeuven & UCLouvain)
Carine Van de Voorde (KULeuven)

The future organization of the system of health care and health insurance is one of the main challenges for our society. How to make the benefits of the technological improvement accessible to all citizens in a context of growing awareness of the budgetary consequences? What are the acceptable limits on the freedom of choice, both for patients and for providers? What should be the balance between the market mechanism and government intervention?

All countries in the western world are struggling with these structural questions. We propose to look at the future design of the Belgian health care system also from this angle.¹ This does not mean that the question of decentralization is unimportant. Quite the contrary: both the degree and the nature of decentralization are essential features of the design of any health care system. However, it is necessary to look at the question of decentralization from a broader perspective. This should also help to avoid that one gets stuck in the pernicky discussions about the division of specific competencies between the federal government and the regions or communities, which seem to dominate the negotiations in Belgium now. A long-run perspective is urgently needed. This is the main (not very provocative) message of this paper.

We will first situate Belgium in the broader spectre of the large international variety in health care institutions. Then we describe the main challenges for these health care systems and how countries try to cope with them. One possibility is to move in the direction of the model of regulated competition and we consider the potential desirability of that move in Belgium. We finally discuss the issues of transparency and interpersonal solidarity.

In Belgium, defederalization can be interpreted as a transfer of competencies either to the communities or to the regions. The choice between these two options has crucial consequences, mainly because of the specific position of Brussels. We stay at a more general level and we use the (internationally accepted) terms “regionalization” or “regional decentralization”. In our mind, this does not imply that we take a specific position in the “regions versus communities”-debate. We will leave this question open, although we come back to it very briefly at the end of this paper.

1. The Belgian hybrid

When looking at health care systems, the most striking observation is the wide variety of institutions in otherwise quite similar countries. Indeed, while there does not seem to be a large cultural gap between, say, the Dutch and the Belgians or the Belgians and the French, their health care systems are very different. In the seminal article that laid the foundations of health economics, Arrow (1963) linked this striking phenomenon to the ubiquity of asymmetric information in health care. When consulting a physician, the patient basically is purchasing information from a health care professional. Yet by its very nature, the value of that information is typically not known by the buyer. Trust becomes an essential feature in such a situation. The recognition by society of this information gap has led to the spontaneous growth of non-market institutions, meant to bridge the gap. Those non-market mechanisms can have a negative impact on “traditional” efficiency and therefore

¹ Note that this means that we do not follow a purely “political” approach in which the regionalization of health care is seen as a means to “nation-building” and to foster the national identity of the regions.

introduce new problems. The resulting tensions between competing values have led to the development of a wide variety of institutions. International differences reflect historical developments and social forces that are highly specific to each individual country.² It is therefore very dangerous to simply transfer isolated policy measures from one system to the other, because each of these systems has reached its own individual equilibrium with its own delicate balance of countervailing forces.

In the light of this bewildering institutional variety, it is impossible to set up a coherent typology that would work for an analysis of all problems. In what follows we focus on Western European countries, that all share at least one important feature: their health care systems are nearly universal and compulsory. This universality is implemented in different ways, however. In all European countries the role of the government is essential, but there are striking differences in emphasis. This is mainly related to the role that is played (or not played) by insurers (or, in the Bismarckian systems, sickness funds).

In one cluster of countries the government plays the central role for the financing, the regulation and even the provision of health care. Health care is largely tax-financed and the financial streams go directly from the government to the providers (doctors and hospitals). Doctors are paid a wage or a capitation fee per patient. The English National Health Service (NHS) is (or was) the prototype of this organisational form but it has been taken over in many variants by other countries: Scotland, Wales, Italy, Spain, the Scandinavian countries. The specific design features differ a lot (e.g. local governments play an important role in Sweden and Norway), but in all these countries the main characteristic is strict regulation by the government. It should be noted, however, that in many of these countries there is at the same time a large private supplemental insurance system.

In another cluster of countries (including the Netherlands, Germany and Switzerland), insurers act as third-party payers and as the intermediaries between patients and health professionals. This has a huge impact on the financing structure. Insurance premiums and/or social contributions are the most important financing source. The provider side is often organized in a liberal way with a large degree of freedom for doctors and hospitals – and more freedom of choice for the patients. Fee-for-service remuneration is more important than in the NHS-type systems.

When situated in this broader picture, the Belgian system turns out to be a somewhat strange hybrid. Belgium has a universal and compulsory insurance system with broad coverage, financed mainly through income-related contributions and taxes. These characteristics are typical for a state system. At the same time, provider markets are very liberal and providers are predominantly remunerated through fee-for-service. Moreover, out-of-pocket payments by patients are exceptionally high in an international perspective. These features are *not* what one would expect in a state system. Finally, and most strikingly, Belgium has an atypical structure of health insurance. Five large national associations of sickness funds dominate the market of compulsory health insurance, which is completely closed for new entrants. Membership of a sickness fund is compulsory, but every individual can enrol in the sickness fund of her choice. There is a lot of competition between sickness funds, as they actively compete with each other to attract new members. The national associations play a central role in the collective negotiation process about fees, insurance coverage and regulation within the National Institute of Health and Disability Insurance (RIZIV/INAMI). This negotiation process aims at a subtle equilibrium between sickness funds, providers (including hospitals), social partners and government. In these negotiations the sickness funds act more or less as a cartel. In 1995 the sickness funds were given some individual financial responsibility. We will later see that this responsibility was introduced in an ambiguous way, even further strengthening the hybrid nature of the system. The Belgian hybrid can develop in many directions. The real issue is to choose between these different options.

2. The long-run challenge: accommodating increasing expenditures

Despite the amazing institutional variation, all rich European countries are basically facing the same challenge. Health care expenditures are growing rapidly and are putting an increasingly heavy burden on the government budget. It is now generally accepted that the growth in expenditures is not due to ageing, but is rather caused by the medico-technological progress (see Schokkaert et al., 2005, for an overview of the literature). In a simplistic budgetary view, this increase in expenditures automatically is a reason for concern. From a welfare economic point of view, however, the expenditure increase is only problematic if it does not reflect an increase in the willingness to pay of the citizens.

² See, e.g., the interesting historical comparison of the Netherlands, Germany and Belgium in Companje et al. (2009).

Some interesting (mostly US) studies have argued convincingly that the willingness to pay for benefits in health is in principle very high (see also Dormont, 2009). The most basic argument is formulated by Hall and Jones (2007) as follows: “(...) *as we get older and richer, which is more valuable: a third car, yet another television, more clothing – or an extra year of life?*” The answer seems obvious and does not require sophisticated economic insights: most people would prefer to live another year. A second argument points to the complementarity between different forms of technical progress in health care: “*Improvements in life expectancy raise willingness to pay for further health improvements by increasing the value of remaining life. This means that advances against one disease, say heart disease, raise the value of progress against other age-related ailments such as cancer or Alzheimer’s.*” (Murphy and Topel, 2006). To state it simply: if you know that Alzheimer can be better treated, living longer becomes more attractive – and vice versa. Within a simple formal model of the trade-off between health and wealth, Hall and Jones (2007) find that socially optimal health care expenses in the US will strongly increase in the following decades and could by 2050 represent about 35% of the gross domestic product. Similar results have been found for other countries. All this strongly suggests that the increase in health care expenditures does increase social welfare.

If this is true, what can then be the reason for the growing concern about the increase in health care spending? The only possible answer seems to be that the “private” willingness to pay is not fully reflected in the decisions of the “collective” system. This may have to do with a lack of understanding by the public of the insurance features of the system. However, it may also be related to its large degree of solidarity. Each insurance system imposes some ex post redistribution (“chance solidarity”) between people that are hit by illness and those that are not. However, a collective system without premium differentiation imposes in addition (ex ante) “subsidizing solidarity”, i.e. implicit cross-subsidies from low to high risks. To give an example: we know that people with a lower socioeconomic status and in poor working conditions are bad risks, i.e. will have larger expected health care expenditures. In a private insurance system they would therefore have to pay higher premiums. In a universal and collective system (be it tax-financed or of the Bismarckian type) without premium differentiation, the good risks will co-finance the larger expenditures of the bad risks by paying a larger contribution. Moreover, most universal systems impose in addition income solidarity, in that the rich have to pay larger contributions than the poor. If citizens are not “willing to pay” for solidarity, they will prefer private insurance arrangements and be concerned about the growing expenditures in the collective system.

We can now formulate the crucial challenge. The trend towards increasing expenditures is not likely to stop, as the technological developments may be expected to continue. The choice is therefore not between low and high expenditures but between on the one hand a further extension of the collective system imposing some rationing and redistribution in order to realize more solidarity – and on the other hand the growth of private alternatives, making the technological developments accessible for the rich. As expressing a preference for one of these options necessarily entails value judgments, it is intellectually more honest to make explicit our own ethical position – even if we do not have the space to argue why we take it. We endorse a view that gives priority to the well-being (the real freedom) of the poorest people in society. This implies that institutions should be created to safeguard solidarity, i.e. to make new advanced health treatments accessible to all. In fact, if one takes the position that social inequalities are not problematic, the crucial challenge largely evaporates.

Suppose now that one accepts the desirability of letting technological progress continue while making its benefits accessible to all. Remaining at an abstract level, policy should then be organized along two tracks. First, it is necessary to mobilize as much as possible the willingness-to-pay of citizens and to strengthen the feelings of solidarity in society. Despite the general decline in solidarity, there is no need for despair in this regard. Compared to other welfare state domains, the health insurance system has remained relatively popular. This has to do both with its insurance character (the rich also face health risks) and with the fact of life that among human beings solidarity and altruistic feelings are stronger with respect to health and pain than with respect to, e.g., labour market status. Therefore, it is important to protect the insurance function of the system and to make solidarity as transparent as possible.

Second, the efficiency (the output/cost ratio) should be increased. Citizens are not willing to pay for what they perceive as waste due to bad management. Realism is needed here: because of the ubiquity of asymmetric information, it is utterly impossible to remove all ex post inefficiencies. However, the glaring inefficiencies suggested for example by regional practice variations, should be removed as much as possible. Otherwise we are likely to see a gradual erosion of the support for the universal health insurance system and an intensification of the process of privatization.

We will first discuss the issue of efficiency (sections 3-5). We come back to transparency and solidarity in section 7.

3. Practice variations, efficiency and the introduction of microeconomic incentives

There can be no doubt that inefficiencies are present in the health care sector in all countries. An important indicator of such inefficiencies is the existence of regional practice variations that cannot be explained by differences in needs or patient preferences. At some point, these regional practice variations have played an important role in the Belgian debate about regionalization. However, they occur in all countries. One typical example is in Figure 1, which shows the strong regional clustering of coronary angiography in the United States. The darker the area the larger the number of interventions per capita (after a needs correction). The most convincing explanation for these regional differences links them to the information problems that are inherent to the sector. In a situation of uncertainty about the correct diagnosis and the best treatment, doctors try to coordinate their behaviour with that of their peers. Moreover, the diffusion of new ideas and new techniques also goes through the existing social networks. In such a situation, regional clustering is to be expected (Phelps, 2000).

Figure 1. Use of coronary angiography in the US (Source: Dartmouth Atlas, 1996)

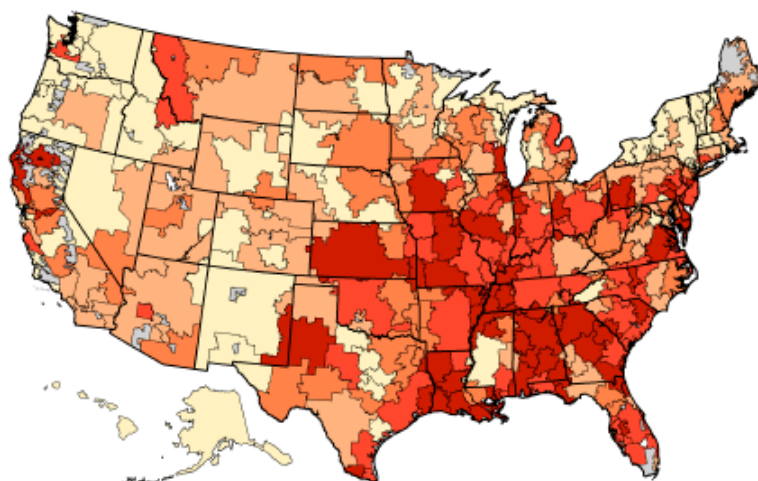
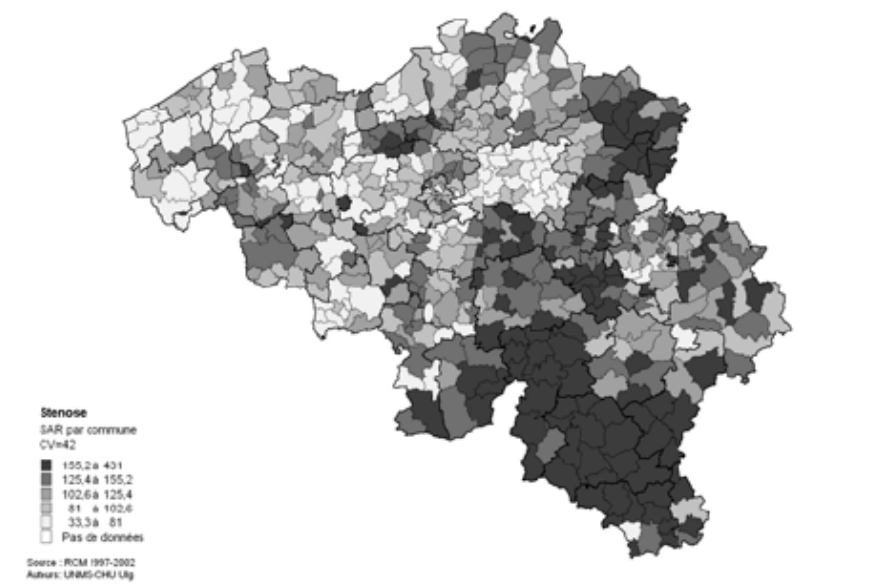


Figure 2. Surgical treatment of carotid stenosis in Belgium (Source: Jacques et al., 2006)



Regional differences in practice patterns are also found in Belgium. These differences are often between the North and the South. In fact, given the explanation put forward in the literature, the opposite finding would be highly surprising. Geographical proximity, linguistic identity and education in the same universities cannot be but important driving forces behind regional clustering due to information transmission. But Figure 2 (showing the distribution of surgical intervention for carotid stenosis, again after needs correction) does suggest that the regional clustering is not always North-South; it is obviously East-West here. The conclusion remains the same, however: as in the other countries, regional practice variations that cannot be explained by differences in needs, suggest the existence of treatment inefficiencies.

The awareness of these inefficiencies has been growing parallel to the concern about the increase in expenditures. According to Cutler (2002), all western countries basically have followed the same sequence of policies, although the precise timing and detailed content vary. In a first stage (starting after World War II), there was an enthusiastic extension of universal health care systems. Somewhere in the eighties of the last century, the growing concern about the increasing expenditures led to policies of explicit rationing through overall budgeting and price regulation. These blunt and linear measures did not work satisfactorily. From the mid-nineties onwards countries entered a third stage with the gradual introduction of more microeconomic incentives.

This Cutler-sequence also describes reasonably well the development of health care reform in Belgium (Schokkaert and Van de Voorde, 2005). We have observed in the recent past a shift towards more prospective (often diagnostic-related) financing of providers (mainly hospitals), and towards more restrictions on “freedom of choice”, both for patients and providers. The opposition to the introduction of more and stronger financial incentives is gradually eroding. The following examples are illustrative: the ‘explosion’ of medical guidelines; the multiplication of prescription profiles and feedback, including the sanctioning of outliers; the promotion of a shared medical record with accompanying rebates on patient co-payments; the stimulation of the use of generic drugs through differentiated co-payments; the gradual development of integrated care programs (e.g. for the treatment of diabetes). In fact, although the term is still taboo, all these policy measures ultimately boil down to the introduction of so-called “managed care” techniques.

One may be confident that the development in this direction will continue. There simply is no alternative and there is by now plenty of evidence that introducing microeconomic incentives increases the cost-awareness of the players in the field (Robinson and Steiner, 1998). At the same time, however, one should be aware that there are no easy solutions, given the nature of the commodity “health care” and the asymmetric information involved. Measures that are meant to increase cost-efficiency will often have undesirable side-effects, such as creating incentives for lowering quality or for selecting the better risks, crowding out important non-material incentives or putting a heavier financial burden on the weaker patients. Therefore, a careful analysis of the specific design features of each measure is needed. For this paper, however, it is sufficient to accept the conclusion that the trend in the direction of managed care will persist.

If this is taken for granted, the essential question becomes: *who* will manage the care? Looking at the European scene, it is not surprising that in the NHS-countries the lead has been taken by the government. In some of these countries (and definitely so in England), however, this has resulted in the creation of a so-called “internal market” – and even in a broadening of the playfield for private for-profit providers and hospitals. In the countries with insurers the move towards microeconomic incentives has taken the form of a gradual introduction of features of the so-called model of “regulated competition”. The Netherlands is the prominent example here, as they have explicitly modelled the future of their system on the blueprint of this model. Before pondering the future development of the Belgian hybrid, it is worthwhile looking at this blueprint of regulated competition in somewhat more detail.

4. The blueprint of regulated competition – and what was made of it in Belgium

Before the mid-nineties Switzerland was the European country that looked most like a private health insurance system. Germany was a typical Bismarckian country. The Netherlands was in between with an important sickness fund sector, but at the same time private insurers covering 30% of the population. We will come back to the position of Belgium at the end of this section. Coming from these different starting points, in all these countries there has been a development in the direction of what can be seen as a theoretical reference model: that of regulated competition between insurers with risk-adjusted capitation payments (van de Ven et al., 2003,

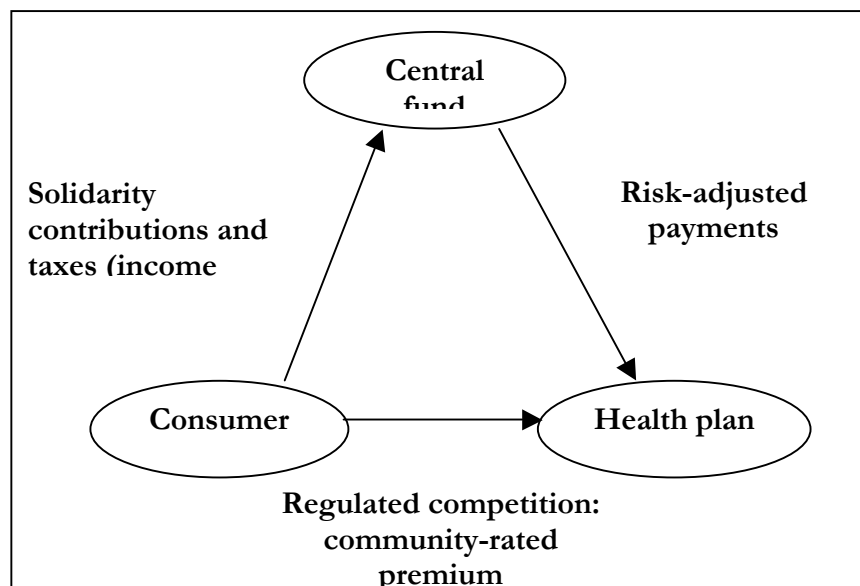
2007). “Competition” is relied upon to improve quality and efficiency; “regulation” and risk adjustment are introduced for equity purposes. The model tries to combine the good features of competitive markets with those of a public system.

In an unregulated competitive health insurance market with heterogeneous ex ante risks, insurers are obliged to adjust their premiums to the individual risks of the insured, i.e. the expected level of their health care costs, in order to break even.³ Consequently, solidarity is limited to chance solidarity between homogeneous risks and it may become difficult for the relatively poor and high-risk populations to find adequate insurance at an affordable price. The potential advantages of a competitive private health insurance market include the supply of a varied menu of policies and, in case of sufficient competition, strong incentives for insurers to control costs and quality.

In a public and centralised health insurance system or a single-payer system, compulsory health insurance is financed through taxes or social security contributions. The freedom of the consumers to choose an insurance policy is severely restricted. In the absence of competitive forces, the system may not be very responsive to consumers' preferences. Moreover, cost control operates through government regulation. The major advantage of a public and centralised system is the possibility to achieve a high degree of subsidizing and income solidarity. The coverage of the (compulsory) insurance system can be made (almost) universal. Because competition is excluded, it can be imposed that every member pays the same premium, even if the risks are heterogeneous. If the premiums are linked to the financial means of the insured, also income solidarity is possible in a public and centralised system.

The rationale of the ‘mixed approach’ of regulated competition is to rely on the efficiency enhancing incentives of market-based reforms while protecting the poor and the unhealthy with appropriate payments. Insured are free to enrol with their preferred insurer and all insurers have to provide an identical package of basic benefits. For solidarity reasons, community rating is imposed, i.e. each insurer has to raise the same premium for all its insured, but these uniform premiums may differ between insurers.⁴ Such premium regulation is not without its problems, however. Pooling high- and low-risk people with community rating creates predictable profits and losses and hence provides insurers with incentives for risk selection. Depending on the information available, this risk selection can take different forms: adapting coverage to deter high-risk individuals, contracting selected providers and direct selection techniques such as selective advertising and mailing. This is where risk adjustment enters the picture.⁵

Figure 3: Regulated competition: a blueprint



³ It is well known that private insurance markets may also be confronted with adverse selection. We will not discuss this problem here, as it is solved anyway in a model of compulsory insurance.

⁴ It is possible to set up a model of regulated competition with some residual premium differentiation (see van de Ven and Schut, 2011), but this model is not (yet) implemented in practice.

⁵ van de Ven and Ellis (2000) give a more detailed description of the conceptual framework of risk adjustment.

Risk-adjustment schemes can come under different variants. Figure 3 sketches the payment flows of what is called an external subsidy system (which is the form implemented by the Netherlands, Germany and Belgium). All concerned citizens pay possibly income-related contributions for basic insurance to the regulator or central fund which redistributes these resources over the insurers by means of risk-adjusted capitation payments. A risk-adjusted capitation payment is independent of the chosen insurer and equals the predicted per capita costs within the risk group to which the member belongs, minus a fixed amount. This fixed amount is paid directly by the insured to the insurer and is equal for all individuals enrolled with the same insurer.⁶

The theoretical benefit of regulated competition with risk adjustment is that it uses market forces to create incentives for efficiency, but within a regulatory framework to guarantee equity. If risk-adjusted payments match the financial risk each insurer would face if operating efficiently, insurers have no incentives to attract the low-risks and avoid the chronically ill. Equally efficient insurers would charge the same premium to their enrollees even if the risk profile of their members is different, because the differences in the risk characteristics would be taken account of through the risk-adjustment scheme. Therefore, risk selection would not be profitable. But at the same time there remains room for competition between insurers. If there are differences in efficiency, the more efficient insurers can ask lower premiums to their members and compete on quality. Since patients can freely choose their insurer they will move to those insurers which offer the best balance between price and quality.

Regulated competition is a theoretical blueprint and not a magic formula solving all problems – its performance in reality will depend on the quality of the risk-adjustment system, on the degree and the nature of competition on the insurance market (including the transparency for consumers), on the relationship between insurers and providers.

What happened in Belgium? Before the nineties the sickness funds got basically all their expenditures reimbursed.⁷ While there were no incentives for risk selection by the sickness funds, they had no incentives to control costs either. On the contrary, they had incentives *not* to control expenditures if this could make them more popular and help them to attract new members. This system has changed in 1995: since then the financial stream going to the sickness funds is partly based on ex ante risks and partly on ex post real expenditures.⁸ Formally, the system looks like the one described in Figure 3, with RIZIV/INAMI playing the role of central fund. Moving towards such a system entails potential dangers and potential advantages. The danger is that without perfect risk adjustment, incentives for risk selection are created. The countervailing advantage (at least in the blueprint) would be that sickness funds get incentives to control costs. Yet, as part of the Belgian political compromise in the nineties, the *individual* sickness funds did not get the necessary policy instruments to achieve the latter objective. As an example: selective contracting with providers and hospitals is forbidden. All the regulatory competencies have stayed with the government (and with the complex structure of deliberative bodies within RIZIV/INAMI). The cartel of sickness funds may even be motivated to increase the predetermined budget of health care as fast as possible, because this basically emasculates the principle of financial responsibility, that is based on the division of that budget.

The organization of the financial responsibility of the sickness funds is another example of the hybrid structure of the Belgian system. There is some paradox here. While the theoretical blueprint of regulated competition tries to combine the best of the “public” and the “private” systems (by trading off a danger of risk selection against improved efficiency incentives), the Belgian system runs the danger of moving slowly towards a combination of the worst of both systems (by still creating incentives for risk selection while creating no room for efficiency improvements). An open debate about the future role of the sickness funds is needed. Refusing this debate out of fear for the introduction of “market forces” in health insurance is like playing ostrich.

⁶ In the alternative so-called “internal risk-adjustment scheme” (implemented in Switzerland and originally in Germany) the risk adjustment is done between the health plans and the regulator. The insured members also pay a flat rate premium directly to the health plan of their choice, but in principle these contributions by the members are sufficient to cover all costs. Health plans with a relatively favourable risk mix of their members pay contributions to the central fund. These are redistributed by the fund to the health plans with a relatively unfavourable risk structure.

⁷ This factual situation did not conform to the financing rules stipulated in the law-Leburton of 1963 – and this discrepancy was one of the political elements that strongly influenced the Belgian debate in the nineties (see Schokkaert and Van de Voorde, 2000).

⁸ We give more details about the Belgian system of risk adjustment in the appendix.

5. Who will manage the care in Belgium?

Let us now return to the question raised at the end of section 3. Who does manage the care in Belgium and who should manage the care in the future? In the light of the previous sections, it will be no surprise that in the present situation decisions are taken by the government after going through the complicated web of advisory bodies. While this complicated structure may have functioned rather well in the past, it should be reformed in the light of the challenges for the future. The multitude of committees is nontransparent and should be simplified. Moreover, the Ministers of Social Affairs sometimes follow the whims of the day and go against the advice of the committees if it is in their short run political interest. Some of the reimbursement decisions with respect to expensive medicines (one of the most delicate examples of priority setting) offer a good example. Finally, the division of competencies between the different levels of government is not coherent. Coordination problems arise when prevention and long term non-medical care are decentralized, while curative medicine remains at the federal level. And the situation gets even more complicated if the federal level keeps implementing prevention measures.

If we combine this snapshot of reality with the conclusion of the previous section on the paradoxical structure of the financing of the Belgian sickness funds and with the broader view on the huge challenges facing all European countries, it becomes obvious that Belgium urgently needs to develop a coherent long-run vision on the decision structures within its health care system. Regional decentralization is one of the crucial issues in that debate. We will leave it aside for the moment and come back to it explicitly in the following section.

Because of the hybrid nature of its system, Belgium can easily move in different directions by strengthening features that are already present now. In fact, such gradual change is the only realistic possibility. Given the delicate balance of countervailing forces characterizing each health care system, drastic structural breaks could be very disruptive and could generate unexpected and undesirable side-effects. Yet, while revolution is not desirable, a clear formulation of long-run objectives is necessary to choose the right path to take. And, as said, we should start moving. Let us structure the different possibilities by putting them on a scale from “more” to “less” government:

- It is possible to further increase the regulatory power of the government. Belgium would then develop in the direction of the type of National Health Service-system that is found in the majority of European countries. Fee-for-service remuneration would become less important and the freedom of providers and hospitals would be restricted. In this model, the role of the sickness funds would be reduced to that of reimbursement or prefinancing agencies and one could even speculate that they are not really needed.
- The existing structure of deliberative bodies could be simplified, refined and adapted to the changing social and economic environment. It would be an illusion to think that this is an easy way to go. It is far from obvious to define what would be an “optimal” structure of these deliberative bodies. In such a situation of uncertainty, the attractiveness of the status quo is considerable.
- The role of the individual sickness funds in the compulsory system could be enhanced. This would imply that Belgium moves slowly and cautiously in the direction of the theoretical model of regulated competition. As suggested in the previous section, the institutional structure to do this is in place. This option would imply that one gives the individual sickness funds more policy instruments to control expenditures.
- The recent tendency towards creeping privatization (with a growing share of individual out-of-pocket payments and of private supplemental insurance) could be explicitly stimulated. This means that the future technological improvements would be channelled to a larger extent through the private insurance system.

Option 2, i.e. the adaptation of the existing structure of deliberative bodies, is in any case necessary. Government regulation will always keep playing an important role in the health care sector and in a country with a long tradition of civil society organizations, negotiations and deliberations will unavoidably remain an essential component of the system.⁹ However, each change in the existing structure of deliberative bodies will induce shifts in the relative power positions of the different players (providers, sickness funds, hospitals, government, etc.). The most important question then is in which direction the structure will (or should) be “refined”.

⁹ The recent experience has shown the advantages of this role played by the civil society. Without a government with full authorities, the social partners have succeeded in managing the system, even to the extent that they have proposed some expenditure cuts.

The option of introducing more NHS-type features is not easy to reconcile with the liberal provider markets that are in place now. Moreover, it is unlikely that this is the best direction to take. As we have seen, many of the European countries that are in this NHS-tradition are moving towards the creation of internal markets – and all are introducing more and more microeconomic incentives that often go against the spirit of exclusive government regulation.

Belgium can also move in the other direction and take up some features of the model of regulated competition. This would imply that individual sickness funds start playing a more active role in “regulating” the first pillar, i.e. in managing the care. They could provide their members with information on the quality and prices of providers and hospitals.¹⁰ The regulator could create room for cautious experimentation with forms of selective contracting with preferred providers and with a limited differentiation of policies, e.g. sickness funds could get the freedom to lower premiums for members that accept some restrictions on their freedom of choice. The individual Belgian sickness funds would then have to develop more intensively their capacities for “managing the care”. Moreover, careful attention should be given to the relationship with providers that are now part of the sickness fund organizations. Yet, given that the financing structure to implement this is already in place and given the present ambiguities in the system, we think that it would be wise to take cautious steps in this direction.

Note that this is not a plea to install quickly the Dutch system in Belgium. At this stage, the model of regulated competition is only a theoretical blueprint. Some observers do believe in its market features, others do not, and given the limited amount of available evidence, “belief” is indeed the correct term to use. Note that we are not even arguing in favour of opening up the compulsory system for private insurers. Unlike the private market players, the Belgian sickness funds have a strong ideological background, the influence of which should certainly not be minimized. They are non-profit organisations with an outspoken commitment to such values as solidarity and equity. We believe that these intangible aspects are essential – but we are well aware that much more scientific work is needed to collect empirical evidence that may convince non-believers. To use the same terminology: in the light of the existing empirical evidence our belief is no more than a belief.¹¹

All in all, however, there seems to be sufficient evidence that a move towards more managed care is likely to be beneficial (if well designed) and that insurers may play an active role in that move. We are well aware that we take a minority position here. Politicians do not like the idea of an increased role for the sickness funds, providers and hospital managers hate it, and in Belgium, even the sickness funds are reluctant. Yet, at the very least we should start taking seriously the ambiguities in the present system of financial responsibility.

What then about the role of private insurers in the second pillar? The arguments in favour of reducing the coverage in the compulsory system are well known. Some suggest that it may lower the labour cost.¹² A second pillar may offer more room for flexibility and freedom of choice. Supplementary insurance can even be seen as an “experimental laboratory”, where new treatments are tested before their integration in the compulsory system. However, the extension of a second pillar is not without its dangers. It may lead to a loss of political support for the universal compulsory system. Overall, there will be less subsidising and income solidarity, and the supplementary system offers additional possibilities for risk selection in the first pillar (Paolucci et al., 2007). In our view of justice, it is therefore clear that, if the scope of the Belgian second pillar is to be extended, it will need to be regulated. Different forms of regulation are possible. One can make enrolment compulsory, in order to avoid adverse selection. One can set limits on the degree of premium differentiation (which would most probably create the need for some system of risk adjustment). One can introduce some form of pooling for extremely bad risks. One can consider regulating the degree of policy differentiation. In each of these cases careful consideration of the compatibility of the regulation with EU-law is necessary. In fact, introducing these regulatory measures will reduce the differences between the first and the second pillar and basically implies that the second pillar also moves in the direction of regulated competition.

¹⁰ Note that, due to the differentiation in supplements, consumer prices in the hospital sector are far from uniform.

¹¹ There is a large literature on the relative performance of non-profit versus for-profit providers and hospitals (see, e.g., Schlesinger and Gray, 2006; Gaynor, 2006), showing a nuanced overall picture. As far as we know, however, there is hardly any literature on the behaviour of non-profit sickness funds in the European tradition.

¹² This argument is not altogether convincing, as it assumes implicitly that workers have an “asymmetric” attitude in wage negotiations, disregarding the advantages of a collective system and completely internalizing the benefits of private insurance. See the discussion about mandated benefits in Summers (1989) and Summers et al. (1993).

6. The paradox of decentralization in Belgium

Where does all this lead us with respect to the debate about decentralization in Belgium? The degree and the nature of decentralization are important, but its consequences will be different depending on the basic choices we have described in the previous section. Let us illustrate.

If we largely stick to the present system in which the central role is played by deliberative bodies, the question becomes if regional decentralization will lead to a beneficial simplification of this structure. Some claim that the present difficulties to take structural decisions are due to “cultural” differences between North and South. This is obviously too easy. There are differences between the different sickness funds, between specialists and general practitioners, between the positions of different political parties – and the relative power positions of different groups are different in the North and in the South. Decentralization of the decision structure would therefore make it indeed easier to introduce regionally differentiated policies that are now blocked. But this is a short-run effect. In the longer run, the different parts of the country would be playing a similar game of negotiations and deliberation as we observe now at the federal level and similar problems would crop up. In fact, unless one thinks very carefully about the design of the new deliberative structure, the additional coordination problems raised by the decentralization might even complicate the problem. This is not a plea against decentralization. But it is a strong plea to think about these basic organisational issues before transferring competencies to the regions or communities, rather than postponing that discussion until the decentralization has been realized.

The most convincing case in favour of regional decentralization can be made when one decides to move in the direction of more government intervention. Given the differences in local preferences and needs and in the socioeconomic environment, it is important to decrease the geographical and cultural distance between the regulator and the actors in the field. Regional decentralization is therefore an essential design feature in all NHS-type countries, although it may take different forms. Usually the financing remains central, but the means are then allocated to the regions in function of their needs. In some Scandinavian countries there is even a strong component of local taxation – accompanied with a (risk-adjusted) redistribution mechanism between the local communities. Local authorities are responsible for the implementation of the regulation and for the direct contacts with providers and hospitals. If Belgium chooses the state option, regional decentralization is desirable and even necessary.

When one opts for a move in the direction of regulated competition, things are much less clear. The membership of the sickness funds is not spread over Belgium in a random way and organizing regulated competition in a regionalized Belgium threatens to create quasi-monopolies for some sickness funds in some regions. Moreover, it is not obvious what would be the consequences of having competing sickness funds that are active in different regions with a possibly different regulatory regime. Regional devolution of the regulatory competencies is not impossible in a model of regulated competition (as shown by the experience in other countries, such as e.g. Switzerland), but requires careful consideration.

As noted before, regional practice variations suggest inefficiencies that have to be tackled with due concern for local circumstances. Moreover, consumers and providers may have different health care preferences. For both these reasons a flexible policy is needed. Regional decentralization of the regulatory power is a necessary condition to reach that goal in a NHS-type system. In the model of regulated competition, however, sickness funds are close to the actors in the field and they will play the role of intermediate agencies. In fact they will have strong incentives to develop regionally differentiated policies, both for reasons of cost efficiency and to make themselves attractive for new members.

There is another paradox here. The stereotypical view is one of Wallonia being to the left and in favour of more government – with Flanders being more liberal and less reluctant to accept market forces. In health care this would logically imply an outspoken support for regional decentralization in the South, and a strong argumentation in favour of more market (and therefore probably less government decentralization) in the North. This is not exactly what we observe in reality...

While we did argue in the previous section in favour of an increased role of the sickness funds, this should not be seen as the main message of this section. Our main message is that it is irresponsible to discuss about decentralization in health care and health insurance without integrating this question in the broader setting of the long-run design of the health care system.¹³ There should be no taboo about decentralization – but at the

¹³ An exclusive focus on decentralization as a *conditio sine qua non* can be defended, of course, if one takes the perspective that Belgium ultimately should be split. We argue that this is the only perspective in which it is defensible. In all other scenarios,

same time it is utterly naive to think that regional decentralization will solve everything. And it is simply wrong to assume that regional decentralization (in whatever form) would leave open all the possibilities with respect to the future organization of health care in Belgium.

7. Interpersonal solidarity and transparency

Until now, we have focused largely on efficiency. We have completely sidestepped the issues of solidarity and transparency. Yet, as emphasized in the second section, this is the second necessary policy track in an adequate reform of the system: to defend solidarity and to make it transparent. Here also, opinions diverge widely. Some claim that each step in the direction of regional decentralization threatens solidarity. Others claim that the present Belgian system imposes a nontransparent solidarity between the different population groups in this country. Both positions are wrong.

Let us first take up the second point on transparency. We mentioned already that any system of health insurance induces transfers. A collective system such as the Belgian one realizes subsidizing and income solidarity, i.e. ex post transfers from the healthy to the sick, from the rich to the poor, from the good risks to the bad risks. These financial streams are fully transparent. This transparency disappears of course when one focuses on the transfers from Flanders to Wallonia: those transfers depend on the relative incomes and on the health risks in the different regions, i.e. on the distribution of healthy and sick, rich and poor, good risks and bad risks in the population. Interregional transfers have to be “estimated”. It is sometimes claimed that this lack of transparency is problematic and that it would make more sense to set up an explicit solidarity mechanism between Flanders and Wallonia. It is true that such an explicit solidarity mechanism would be more transparent at the level of the regions. However, it would make the system nontransparent with respect to the transfers and the level of solidarity between rich and poor and sick and healthy. The characteristics of the population of the different regions change over time and complicated estimations would then be needed to calculate the real level of interpersonal solidarity. The choice is not between a transparent and a nontransparent system: the choice is between different forms of transparency.

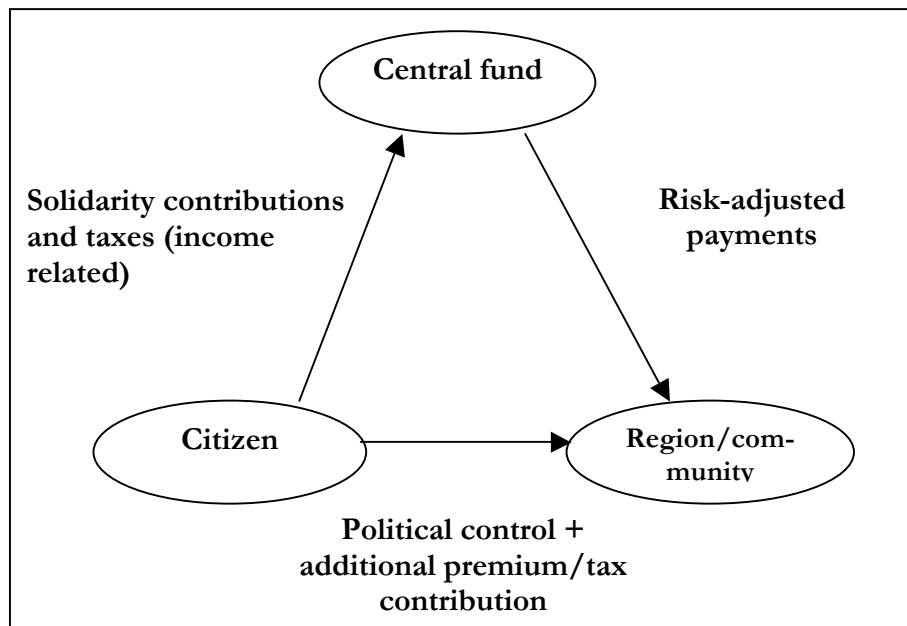
This is ultimately an ethical and political choice. We do not have the space here to discuss it at length. Suffice it to say that in our view solidarity is in the first place a relation between persons. This view is dominant in most philosophical and religious traditions of the world. It creates an a priori in favour of transfers that are based on personal characteristics such as income and health.

However, there are also pragmatic and strategic considerations involved. It is true that pursuing a naive utopian ideal of world solidarity can undermine existing local solidarity mechanisms and thus finally lead to a decrease of the overall level of redistribution (Schokkaert, 2005). On the other hand, feelings of altruism and solidarity in health care have a deep basis in our common humanity. They are closely linked to uncertainty and to the willingness to pay for insurance (also for one’s children). Without these strong feelings a system of “collective insurance” would not be sustainable in the long run. In fact, strengthening the insurance characteristics of the system seems a necessary condition to keep sufficient popular support. Installing an explicit mechanism of regional transfers goes in the opposite direction. First defining one’s identity in linguistic terms and then setting up a system of transfers that is fully nontransparent with respect to personal income and health risks seems the best possible recipe to lose the support for interregional solidarity in the long run.

Note that our general point about the importance of removing waste and inefficiencies gets an additional twist here. If some groups in the population perceive that other groups are abusing the health insurance system, their willingness to pay will be threatened. This is precisely the reason why it is of crucial importance to improve efficiency by introducing microeconomic incentives. It is also of crucial importance to set up a solidarity mechanism that does not reward moral hazard.

the broader questions should come first, even if one is at the end mainly or only concerned about the health care for one’s own community. This is a fortiori true if one is concerned to provide the best possible health care to all Belgians (which is our position).

Figure 4: Interpersonal solidarity and regionalization



Suppose now that we take the desirability of interpersonal solidarity for granted, both for ethical and for pragmatic reasons. We come then to the second point. It is easy to see that interpersonal solidarity can be reconciled with a large degree of regional decentralization. The financing mechanism can be analogous to the one that has been described before in the context of the model of regulated competition. In fact, similar regional distribution mechanisms are in place in almost all countries of the NHS-type (see, e.g., Rice and Smith, 2001).

Its basic principles are illustrated by Figure 4 (which is analogous to Figure 3). The essential element is that the financing remains at the central level. The global budget is then allocated to the regions, based not on their actual expenditures but on the objective health risks of their population. In this way all incentives for efficiency remain intact. A region with larger health expenditures than predicted by the characteristics of its population, will run a deficit and will have to ask additional contributions from its population – or to cut other expenditures. A region with lower expenditures than predicted from the characteristics of its population, will obtain a financial surplus. If a region manages to decrease its expenditures by better prevention or a more efficient organization, it will reap the fruits of its efforts. Note that this system is perfectly transparent with respect to interregional efficiency differences or practice variations: these will immediately be reflected in the additional contributions a region will have to raise. This is a crucial advantage in the light of what we have said earlier about willingness-to-pay.

At the same time the system makes it in principle possible to achieve a high degree of interpersonal solidarity in a transparent way. The central financing scheme allows for income solidarity. Subsidizing solidarity between individuals with different health characteristics is achieved if the relevant characteristic is taken up in the risk-adjusted formula that is used to distribute the means over the regions. The model of Figure 4 has the advantage that the discussion about the degree and the nature of subsidizing solidarity can focus on the real ethical questions, because the financing structure takes care of efficiency issues. Including a characteristic in the distribution mechanism implies that subsidizing solidarity for that characteristic is seen as desirable; leaving it out implies that one holds the region responsible for the resulting differences in expenditures. One extreme option would be to let the division of the budget depend only on the size of the population: there would then be no subsidizing solidarity (but note that income solidarity would be kept!). It seems hard to build an ethically convincing case for such a system: at the very least some correction for age and gender differences is desirable. And the experience with risk adjustment for the sickness funds has shown that the introduction of a more refined regional risk adjustment mechanism is feasible – and ethically desirable.

The choice of which characteristics to include is only one of the design features of the system. Another one is the alignment of the regional distribution mechanism with the mechanism that is used for financing the sickness funds, if at least one opts for a model with risk-bearing sickness funds. This is not so difficult in

principle, since both allocation mechanisms make use only of a given fixed budget and of observable characteristics of the citizens and/or the members. Budgeting in two stages is therefore straightforward. Note, however, that there is no a priori reason why the characteristics taken into account for the compensation of the sickness funds should be the same as those taken into account for the compensation of the regions – or, formulated differently, there is no a priori reason to hold regions and sickness funds responsible for the same characteristics. To give but one (hypothetical) example: regional policy has an effect on regional unemployment rates, while it certainly would be far-fetched to hold the sickness funds responsible for their share of unemployed members.

Another important issue is the choice of the global budget that is to be distributed through the central fund. If this global budget is decreased, the additional contributions to be raised by the regions will increase. In principle it is possible that the regions have to finance part of their expenditures with own contributions. A smaller global budget implies a lower level of income solidarity and between-regions subsidizing solidarity. Introducing a regional distribution mechanism such as the one described in Figure 4 therefore requires an agreement about the long-run development of the global budget.

Note finally that the introduction of such a distribution mechanism can accommodate a choice for decentralization both at the level of the regions and at the level of the communities. Even for Brussels, the solution would be feasible. In fact, if one were to opt for decentralization towards the communities, both communities would act in Brussels in the same way as competing sickness funds in the model of regulated competition.

8. Conclusion

One of the negative side effects of the present discussions about the new structure for Belgium is that the fundamental debate about the future organization of the health care system seems to be completely blocked. If one side in the debate does not want to discuss basic issues, because it thinks that regionalization should come first – and if the other side does not want to discuss basic issues to avoid a significant move towards regionalization, then of course nothing serious can happen. Even worse, if the negotiators only manage to further complicate the existing structure and to introduce some additional incoherencies, then this is definitely a step in the wrong direction.

It is urgently needed to build up a coherent and clear view on the future design of our health care system. To arrive at such a view, some taboos will have to be given up. Interpersonal solidarity is essential, but it can be reconciled with different organisational models, including a far-going regional decentralization. Flexibility and some regional differentiation of policies are needed, but they can be achieved without regional decentralization. The role of government should probably be reduced a bit, but government regulation will always remain essential.

Dutch speaking and French speaking Belgians, those who like and those who hate the sickness funds, those who believe in more government and those who endorse subsidiarity, should leave their trenches and look at the evidence with an open mind. Opportunistic short-run political considerations should not make us forget the long-run challenges.

References

- Arrow, K. 1963. Uncertainty and the welfare economics of medical care. *American Economic Review* 53, no. 5: 941-73.
- Companje, K., R. Hendriks, K. Veraghtert, and B. Widdershoven. 2009. *Two centuries of solidarity. German, Belgian and Dutch social health insurance 1770-2008*. Amsterdam: Aksant.
- Cutler, D. 2002. Equality, efficiency, and market fundamentals: the dynamics of international medical-care reform. *Journal of Economic Literature* 40, no. 3: 881-906.
- Dartmouth Atlas of Health care in the United States. 1996. The Center for the Evaluative Clinical Sciences, Dartmouth Medical School.
- Dormont, B. 2009. *Les dépenses de santé. Une augmentation salutaire?* Paris: Editions Rue d'Ulm, Collection du CEPREMAP.
- Ellis, R. 2008. Risk adjustment and predictive modeling: concepts and applications. *Paying for health care. New ideas for a changing society*. eds. M. Lu, and E. Jonsson, 117-222. Weinheim: Wiley-VCH Publishers.
- Gaynor, M. 2006. *What do we know about competition and quality in health care markets?* NBER: Working Paper 12301.
- Hall, R., and C. Jones. 2007. The value of life and the rise in health spending. *Quarterly Journal of Economics* 112: 39-72.
- Jacques, J., D. Gillain, F. Fecher, S. Van De Sande, F. Vrijens, D. Ramaeckers, N. Swartenbroeckx, and P. Gillet. 2006. *Studie naar praktijkverschillen bij electieve chirurgische ingrepen in België*. Brussel: Federaal Kenniscentrum voor de Gezondheidszorg (KCE): KCE Reports 42A.
- Murphy, K., and R. Topel. 2006. The value of health and longevity. *Journal of Political Economy* 114, no. 5: 871-904.
- Paolucci, F., E. Schut, K. Beck, C. Van de Voorde, S. Gress, and I. Zmora. 2007. Supplementary health insurance as a tool for risk-selection in mandatory basic health insurance markets. *Health Economics, Policy and Law* 2, no. 2: 173-192.
- Phelps, C. 2000. Information diffusion and best practice adoption. *Handbook of Health Economics, Vol. 1A*. eds. A. Culyer, and J. Newhouse, 223-64. Amsterdam: Elsevier.
- Rice, N., and P. Smith. 2001. Capitation and risk adjustment in health care financing: an international progress report. *Milbank Quarterly* 79, no. 1: 81-113.
- Robinson, R. and Steiner, A. 1998. *Managed health care*. Buckingham: Open University Press.
- Schlesinger, M., and B. Gray. 2006. How nonprofits matter in American medicine, and what to do about it. *Health Affairs*, Web Exclusive: W287-W303.
- Schokkaert, E. 2005. The welfare state under pressure. Shifts in the egalitarian ideal. *Sociale zekerheden in vraagvorm*. ed. D. Simoens et al., 385-399. Antwerpen/Oxford: Intersentia.
- Schokkaert, E., G. Dhaene, and C. Van de Voorde. 1998. Risk adjustment and the trade-off between efficiency and risk selection: an application of the theory of fair compensation. *Health Economics* 7: 465-80.
- Schokkaert, E., and C. Van de Voorde. 2000. Risk adjustment and the fear of markets: the case of Belgium. *Health Care Management Science* 3, no. 2: 121-30.
- — —. 2004. Risk selection and the specification of the conventional risk adjustment formula. *Journal of Health Economics* 23: 1237-59.
- — —. 2005. Health care reform in Belgium. *Health Economics* 14: S25-S39.
- — —. 2009. Direct versus indirect standardization in risk adjustment. *Journal of Health Economics* 28: 361-74.
- Schokkaert, E., C. Van de Voorde, P. Willemé, W. Vandevyvere, and C. Verhelle. 2005. De groei van de uitgaven in de gezondheidszorg - een overzicht van de literatuur. *Documentatieblad FOD Financiën* 45, no. 4: 185-238.
- Summers, L. 1989. Some simple economics of mandated benefits. *American Economic Review (Papers and Proceedings)* 79, no. 2: 177-83.
- Summers, L., J. Gruber, and R. Vergara. 1993. Taxation and the structure of labor markets: the case of corporatism. *Quarterly Journal of Economics* 108: 385-411.
- van de Ven, W., K. Beck, F. Buchner, D. Chernichovsky, L. Gardiol, A. Holly, L. Lamers, E. Schokkaert, A. Shmueli, S. Spycher, C. Van de Voorde, R. van Vliet, J. Wasem, and I. Zmora. 2003. Risk adjustment and risk selection on the sickness fund insurance market in five European countries. *Health Policy* 65: 75-98.
- van de Ven, W., K. Beck, C. Van de Voorde, J. Wasem, and I. Zmora. 2007. Risk adjustment and risk selection in Europe: 6 years later. *Health Policy* 83: 162-79.
- van de Ven, W., and R. Ellis. 2000. Risk adjustment in competitive health plan markets. *Handbook of Health Economics 1*. eds. A. Culyer and J. Newhouse, 755-845. Amsterdam: North-Holland.
- van de Ven, W., and F.T. Schut. 2011. Guaranteed access to affordable coverage in individual health insurance markets. *Oxford Handbook of Health Economics*. eds. S. Glied and P.C. Smith, 380-404. Oxford: Oxford University Press.
- Van de Voorde, C. 2010. *Essays on risk adjustment in health insurance*. Leuven: PhD Dissertation.

APPENDIX

Financial responsibility of the Belgian sickness funds

In Belgium the first step towards (partial) prospective financing of sickness funds with a risk-adjustment scheme was taken in 1995 (see Schokkaert and Van de Voorde, 2000). Since then the global yearly budget of health insurance is fixed *ex ante*, i.e., before actual costs are known. The distribution of these resources among the national associations of sickness funds is based on a mixed reimbursement formula, in which the financial means of the sickness funds are a weighted combination of their share in the normative or risk-adjusted costs and their share in the actual costs for the year in question. Although the largest weight is still given to actual costs, the weight of the normative costs has increased over time from 0.10 to 0.30. Also the amount of financial responsibility of the sickness funds is limited: 15% during the first years and 25% since 2001. This means that if the sickness funds have a surplus, they may set 25% of that surplus aside in a reserve fund. If they record a deficit, they must bear 25% of that deficit themselves by drawing from their reserves or by raising their members' contributions.¹⁴

The percentage of financial responsibility is rather low compared to other countries. However, it is applied to a very broad benefits package, including the so-called catastrophic risks of long-run medical care for the chronically ill and the very old. The law imposes that the compulsory insurance cover is identical for all sickness funds. Hence strategic behaviour of the sickness funds in the provision of specific health care services in the compulsory coverage is not possible. Sickness funds compete for new members by the quality of their customer service, by the speed of settling claims and by offering supplementary insurance. Supplementary health insurance is an effective tool for risk selection in Belgium, since the law requires that if the consumer buys a supplementary insurance from a sickness fund both the supplementary insurance and the compulsory insurance must be bought from the same fund (Paolucci et al., 2007). In the last years, the number of items included in the supplementary insurance has steadily increased, with substantial differences between the funds.

The focus on equity of access in Belgium has led to a complicated definition of normative expenditures with a long list of risk adjusters. The weights of the different explanatory variables are derived from a regression analysis. From the very beginning – and contrary to most other countries – the Belgian risk-adjustment formula was based on a partitioning of the vector of explanatory variables into two subvectors: one containing the variables for which individuals or sickness funds cannot be held responsible (Compensation-variables), the other containing the variables for which individuals and insurers are held responsible because they reflect differences in subjective tastes or in efficiency (Responsibility-variables).¹⁵

Since its introduction in 1995, the Belgian risk-adjustment system has been gradually refined by introducing more and better information about morbidity. The results from the current model are given in Table 1. The model, estimated with OLS on almost 600,000 observations, contains 155 variables. Several alternative models were tested before the current model was selected.¹⁶ The reliance on a very elaborate list of risk adjusters including not only variables directly related to the underlying health status of patients, but also socioeconomic variables and variables related to benefit design and geographic location, illustrates that the Belgian risk-adjustment model is rather a needs-adjusted payment model than a health-based payment model (Ellis, 2008). This clearly reflects the concern of the regulator to guarantee as much as possible equity of access to the poor and high-risk population groups.

¹⁴ With the exception that, if total costs exceed the global budget by more than 2%, the deficit of each sickness fund is limited to a maximum of 2%. The rationale for this rule is to prevent that the sickness funds have to bear all responsibility for an underestimation of the global budget.

¹⁵ The theoretical justification for this approach is given in Schokkaert et al. (1998) and Schokkaert and Van de Voorde (2004, 2009).

¹⁶ More detailed information on the estimation procedure and the reasons for some methodological choices can be found in Van de Voorde (2010), chapter 1.

Table 1. Estimation results for the Belgian risk-adjustment model (since 2008, in €)

<i>Variable description</i>	<i>Coefficient</i>	<i>(St.err.)^a</i>
Gender/age		
man of age 0-1	435	(57.31)
man of age 1-5	275	(23.24)
man of age 5-10	412	(25.41)
man of age 10-15	254	(13.50)
man of age 15-20	254	(16.26)
man of age 20-25	129	(21.12)
man of age 25-30	112	(20.90)
man of age 30-35	117	(17.03)
man of age 35-40	248**	(66.32)
man of age 40-45	236	(29.51)
man of age 45-50	270	(23.17)
man of age 50-55	306	(25.84)
man of age 55-60	357	(29.99)
man of age 60-65	510	(39.85)
man of age 65-70	734	(42.14)
man of age 70-75	867	(47.80)
man of age 75-80	1118	(65.64)
man of age 80-85	1149	(85.11)
man of age 85-90	1 653	(153.87)
man of age >90	2 160	(247.74)
woman of age 0-1	339	(55.89)
woman of age 1-5	232	(24.60)
woman of age 5-10	258	(12.51)
woman of age 10-15	271	(16.51)
woman of age 15-20	337	(17.71)
woman of age 20-25	318	(14.49)
woman of age 25-30	523	(18.69)
woman of age 30-35	539	(15.94)
woman of age 35-40	404	(16.70)
woman of age 40-45	381	(19.63)
woman of age 45-50	431	(23.43)
woman of age 50-55	451	(26.36)
woman of age 55-60	510	(27.83)
woman of age 60-65	694	(35.24)
woman of age 65-70	814	(37.57)
woman of age 70-75	953	(42.91)
woman of age 75-80	1 164	(50.94)
woman of age 80-85	1 733	(70.54)
woman of age 85-90	2 693	(113.52)
woman of age 90-95	3 961	(171.27)
woman of age >95	4 690	(331.27)
Widow/widower/orphan	245	(43.05)
Preferential reimbursement	244	(24.92)
Incapacity to work (<1 year)	1 045	(36.24)
Died during 2002	1 502	(171.75)
Living alone	165	(15.02)
Urbanized area	11**	(3.63)
Medical supply ^b	24	(5.46)
Allowance for handicapped	1 232	(114.07)
Subsistence income beneficiary	211	(45.06)
Illness groups of disabled (>1 year incapacity to work)		

<i>Variable description</i>	<i>Coefficient</i>	<i>(St.err.)^a</i>
Infectious and parasitary diseases	739 ^{ns}	(560.05)
Tumors	2 242	(331.90)
Endocrine, nutritional and metabolic diseases and immunity disorders	1 667**	(611.58)
Blood diseases and diseases of the hematopoietic organs		
Psychological disorders	20 821*	(9 502.80)
Diseases of the nervous system and sense organs	3 063	(185.44)
Respiratory diseases	349 ^{ns}	(242.09)
Diseases of the digestive system	891*	(427.80)
Urogenital diseases	736 ^{ns}	(416.82)
Congenital malformations	4 973	(1 287.00)
Symptoms and ill-defined conditions	1 850 ^{ns}	(1 127.36)
Accident injuries and poisoning	1 809**	(582.92)
Reference group	493*	(247.92)
	422	(76.28)
Lump sum for chronically ill if entitled to ^a		
Nursing care at home during 3 months (cat. B on Katz-scale)	6 034	(268.45)
Nursing care at home during 3 months (cat. C on Katz-scale)	7 693	(433.60)
Physiotherapy for severe illnesses	3 145	(138.94)
Increased child benefit for a handicapped child	3 063	(339.00)
Integration allowance for handicapped adult	2 787	(223.30)
Allowance for assistance for handicapped elderly	3 943	(159.03)
Allowance for third-party assistance for handicapped	341 ^{ns}	(264.87)
Increased sickness allowance for a person with dependents because of need for assistance	838 ^{ns}	(507.60)
Increased sickness allowance for a person without dependents because of need for assistance	1 235 ^{ns}	(666.83)
Chronic conditions based on prescribed drugs		
Cardiovascular disease: general	269	(21.61)
Cardiovascular disease: cardiac therapy	615	(54.74)
Chronic Obstructive Pulmonary Disease (COPD) (>50y)	899	(54.08)
Asthma (≤50y)	418	(36.17)
Cystic fibrosis	4 795**	(1 323.32)
Diabetes Mellitus (DM) + cardiovascular disease	266	(51.90)
Diabetes Mellitus with insulin	2 456	(129.33)
Rheumatoid arthritis, Crohn's disease, colitis ulcerosis, psoriatic arthritis	652	(124.48)
Psychosis (≤70y)		
Psychosis (>70y)	2 166	(164.63)
Parkinson's disease	4 503	(278.64)
Epilepsy	1 958	(174.06)
HIV	1 394	(117.36)
Chronic hepatitis B or C	8 598	(608.69)
Multiple sclerosis	7 744	(1 676.05)
Organ transplant	8 496	(339.24)
	5 042	(522.19)
DxGroups		
DxGroups (<= 200 observations)	6 836	(219.45)
Other Infectious Disease	3 756	(782.10)
Metastatic Cancer	10 414	(608.49)
Mouth/Pharynx/Larynx/Other Respiratory Cancer	11 632	(1 146.89)
Liver/Pancreas/Esophagus Cancer	9 796	(850.03)
Colon Cancer	10 627	(790.29)
Rectal Cancer	11 874	(720.76)
Lung Cancer	8 630	(560.05)
Breast Cancer	6 816	(299.58)
Blood, Lymphatic Cancers/Neoplasms	19 554	(1 615.06)
Cancer of Prostate/Testis/Male Genital Organs	5 960	(474.31)
Cancer of Bladder, Kidney, Urinary Organs	5 932	(551.64)

<i>Variable description</i>	<i>Coefficient</i>	<i>(St.err.)^a</i>
Carcinoma in Situ/Neoplasm of Uncertain Behavior/	2 753	(374.29)
Diabetes with No or Unspecified Complications	1 813	(383.58)
Diabetes with Chronic Complications	7 948	(673.68)
Other Endocrine, Metabolic, Nutritional Disorders	3 133	(221.56)
Pancreatitis/Other Pancreatic Disorders	6 717	(844.13)
Cirrhosis, Other Liver Disorders	6 014	(546.19)
Diseases of Esophagus	3 560	(323.73)
Peptic Ulcer	5 024	(703.82)
Inflammatory Bowel Disease	5 200	(669.79)
Diverticula of Intestine	4 963	(421.35)
Gallbladder Disorders	3 495	(179.26)
Anal/Rectal/Other Intestinal Disorders	2 610	(247.16)
Rheumatoid Arthritis and Connective Tissue Disease	6 015	(688.21)
Bone/Joint Infections/Necrosis	6 183	(596.30)
Osteoarthritis	7 197	(175.89)
Back Disorders	3 927	(160.73)
Iron Deficiency Anemia and Other/Unspecified Blood	5 010	(529.14)
Blood/Immune Disorders	12 392	(1 255.55)
Dementia	7 931	(401.81)
Major Depression/Manic and Depressive Disorders	6 805	(623.91)
Non-Psychotic Depression	4 727	(539.94)
Alcohol/Drug Dependence	5 527	(611.65)
Headache	1 800	(364.46)
Mononeuropathy	2 090	(338.94)
Valvular and Rheumatic Heart Disease	12 940	(878.98)
Hypertension, Uncomplicated	3 297	(617.66)
Coronary Atherosclerosis	6 432	(222.83)
Post-Myocardial Infarction	3 251	(504.91)
Acute Myocardial Infarction	6 323	(416.27)
Unstable Angina	4 054	(463.68)
Angina Pectoris	2 453	(341.73)
Heart Rhythm and Conduction Disorders	5 570	(349.41)
Atrial Arrhythmia	3 323	(291.92)
Cardio-Respiratory Failure and Shock	7 935	(838.85)
Congestive Heart Failure	5 636	(378.96)
Cerebral Hemorrhage	9 994	(952.64)
Precerebral Arterial Occlusion	6 014	(575.97)
Stroke	7 727	(399.34)
Transient Cerebral Ischemia	3 502	(441.27)
Atherosclerosis of Major Vessel	6 839	(491.07)
Aortic and Other Arterial Aneurysm	9 380	(876.44)
Thromboembolic Vascular Disease	6 163	(435.70)
Peripheral Vascular Disease	6 300	(825.00)
Chronic Obstructive Pulmonary Disease	6 403	(322.93)
Other Lung Disorders	6 991	(911.09)
Renal Failure/Nephritis	19 119	(1 309.07)
Kidney Infection	3 173	(394.38)
Urethral Stricture/Hydronephrosis/Other Renal, Urethral disorders	3 577	(666.47)
Hyperplasia of Prostate		
Genital Prolapse	2 525	(287.70)
Decubitus and Chronic Skin Ulcers	2 744	(205.42)
Hip Fracture	13 358	(1 454.62)
Complications of Medical Procedures and Care	10 489	(390.02)
Major Congenital Disorders	10 895	(1 125.54)
Self-employed	7 317	(997.62)
	-317	(33.10)
Adjusted R²	0.40	
N	593 253	

^{ns}: not significant, *: $p < 0.05$, **: $p < 0.01$, all other variables: $p < 0.001$

^a Heteroscedasticity consistent.

^b The regulator decided to consider medical supply as a responsibility variable.

Except for 'Urbanized area' and 'Medical supply', all variables are dummy variables. Urbanisation and medical supply are two indicators based on a principal component analysis. Urbanisation is based on the population density and the percentage of urbanized area, medical supply on the number of general practitioners, specialists, pharmacists, dentists and physiotherapists. Patients with preferential reimbursement pay reduced co-payments. To be eligible for a lump sum for the chronically ill, two conditions have to be fulfilled. First, the amount of co-payments needs to exceed a threshold during two consecutive years. The second condition concerns the degree of dependency.

Comments

- p. 26 Prospective payments in the health care sector
 - David Crainich
- p. 39 Defederalisation of health care in Belgium: solidarity, quality,
 efficiency and health policy
 - Jan De Maeseneer
- p. 32 How to move towards a more integrated health system and more
 coherent health policies taking into account the Brussels realities
 - Myriam De Spiegelaere
- p. 38 Value based health care
 - Johan C. Kips
- p. 40 Health insurance, efficiency and equity: French debates
 - Brigitte Dormont
- p. 51 Decentralization and coordination of health care provision in
 Norway: which lessons for Belgium?
 - Fred Schroyen
- p. 61 Health care reform in Belgium: Going Dutch or waiting for
 Godot?
 - Erik Schut

Prospective payments in the health care sector

David Crainich (CNRS et Iseeg School of Management, Lille, France)

Erik Schokkaert and Carine Van de Voorde provide in their contribution a clear overview of the issues related to the organization of health insurance in Belgium. In order to design a system that guarantees universal access to all health services, including the medically advanced technologies, they highlight how crucial it is to promote efficiency while making solidarity as transparent as possible. Interesting paths for future changes are suggested and this commentary text addresses two considerations related to the use of prospective payments in the design of health care systems. The first suggests that risk-adjusted prospective payment for physicians' services would advantageously complement the health care system described by the authors. The second indicates that if a risk-adjusted prospective financing of the regions was implemented, the levels at which prevention policies are organized would condition the negotiation about the risk-adjusters to include in the distribution formula and would therefore influence the individual characteristics subject to the interregional solidarity.

The budgetary consequences of the expected growth in health expenditure (even if this growth is from an economic point of view not necessarily unjustified) coupled with the progress in Flanders of political movements questioning the desirability of a federal health insurance make it necessary to rethink our health care system. In this context, the sustainability of a universal health insurance system depends - as Schokkaert and Van de Voorde emphasize - on the extent to which it creates inefficiencies in the use of resources (people are not willing to pay for a system that does not avoid wasteful spending) and on the perception that some groups in the population have about the potential abuse of the health insurance system by other groups.

To tackle the inefficiencies, microeconomic incentives have been introduced in the eighties in the financing of hospitals. The previous payment, solely based on the reimbursement of costs incurred, has been (partially) replaced by a diagnostic-based prospective financing mechanism. The idea was to move from an expensive system to another one more susceptible to simultaneously achieve various objectives such as cost containment, efficiency, quality of care, access to care, *etc.* Risk-based prospective payments have later also been implemented to finance the sickness funds in order to give them the incentives not to reimburse unnecessary medical expenditure. This measure should ideally have been coupled with the introduction of the instruments the sickness funds need in order to control their expenditure. These instruments are however still missing in Belgium. Their introduction (selective contracting with preferred providers and freedom to charge lower premiums for members that accept some restrictions on their freedom of choice are mentioned as examples of instruments that could be potentially implemented) would enhance the function played by the sickness funds within the health care system. The authors suggest to move cautiously towards this model of regulated competition that has the potential to generate greater efficiency while maintaining the access to care for all. It moreover constitutes - given the financial responsibility of the sickness funds implemented in the nineties - the most natural extension of our current health insurance system.

We could go one step further by financing physicians' services through prospective payment based on case mix. In the health care system defended by the authors, the sickness funds are made financially responsible for their members' health expenditure while they only exert an indirect control over this expenditure. Given this framework, the only level at which the financial responsibility is not introduced is that at which medical decisions are made (*i.e.* at the level of the interaction between patients and physicians). Just as hospitals, health insurers and patients are partly financially responsible for their expenditure, it would seem natural to abandon the fee-for-service as the unique physicians' mode of payment. Even if there are no unambiguous evidences of supplier induced demand¹ (the source of inefficiency usually suspected under fee-for-service payment systems), the economic literature indicates that mixed payment systems perform better than purely retrospective or purely prospective payment systems (see Ellis and McGuire (1990), Ma (1994) and Newhouse (1996) among others) when multiple objectives are simultaneously pursued. A well designed payment mechanism (which could be a mix of fee-for-service, risk-adjusted capitation, pay-for-performance,*etc.*) is indeed more sophisticated and thus probably more efficient than a fee-for service payment combined (for instance) with selective contracting in order to achieve quality of care, cost containment, access to care,*etc.* It is therefore important to consider this issue.

We now come to the second comment. In order to deal with the perception that one region may have about the unnecessary use by other regions of the limited resources dedicated to health care, Schokkaert and Van de Voorde suggest the implementation of a risk-adjusted prospective distribution of the global budget (still raised at the federal level) to the regions. This idea is appealing. Instead of reducing the debate to whether the Belgian regions should organize the compulsory health insurance system together or separately, thus, instead of leaving only two options open, the risk adjusted distribution mechanism would bring a lot of flexibility. Several characteristics could indeed be included as risk adjusters in the formula used to allocate the means over the regions. The definition of these characteristics would be the key point of the distribution mechanism since it would determine the degree of interregional solidarity. The public debate organized to identify these characteristics would be important since the support for the compulsory health insurance system depends on the transparency with which the interregional solidarity is organized.

The level at which prevention policies are implemented is however of crucial importance in the definition of the risk adjusters. The authors indeed highlight that this regional financing mechanism preserves the incentives for efficiency since *"A region with lower expenditure than predicted from the characteristics of its population will obtain a financial surplus. If a region manages to decrease its expenditures by better prevention or a more efficient organization, it will reap the fruits of its efforts"* (page 15). This is true as long as prevention actions modify characteristics that are not included as risk-adjusters in the distribution formula over regions. Otherwise regions are covered through the regional distribution mechanism and this incentive for prevention weakens. Consequently, since prevention policies are organized at the regional level in Belgium, the concern for efficiency should exclude from the regional distribution formula risk adjusters that can be modified through individual behaviour. Smoking behaviour or alcohol dependency (for example) would hardly be considered in the debate about the characteristics that should be subject to the interregional solidarity. Since a limited number of characteristics cannot be modified either through individual behaviours or through collective public health policies, we should end up with few risk adjusters in the regional distribution formula.

The objective of this comment is not to reject this regional distribution mechanism to the motive that it excludes some characteristics as risk-adjusters. Its purpose is rather to highlight that a real and exhaustive debate about the characteristics that should be subject to solidarity between Flanders and Wallonia could not take place if we take for granted that prevention policies are organized at the

¹ Belgian data are not fully supportive of the supplier induced demand phenomenon. In an analysis of the correlation between the medical density and health care utilisation, the Belgian Health Care Knowledge Centre indicates in a recent report (2008) that even when evidence of supplier induced demand exists, the extent of the phenomenon is rather weak. The review of the literature provided by Mc Guire (2000) also shows a great variety of results in this regard.

regional level. It instead recommends that the issue of regional solidarity must be included within a global debate that also considers the organization of prevention policies.

References

Ellis R. and T. McGuire (1990), "Optimal payment systems for health services", *Journal of Health Economics*, 9 (4), 375-396.

Ma C. (1994), "Health care payment systems: cost and quality incentives", *Journal of Economics and Management Strategy*, 3(1), 93-112.

McGuire T. (2000), "Physician Agency", *Handbook of Health Economics*, volume 1, chapter 9, Culyer et Newhouse (eds.), Elsevier Science, 461-536.

Newhouse J. (1996), "Reimbursing Health Plans and Health Providers: Efficiency in Production Versus Selection", *Journal of Economic Literature*, Vol. 34, No. 3, 1236-1263.

Roberfroid D, Stordeur S, Camberlin C, Van de Voorde C, Vrijens F and C. Léonard (2007), "Physician workforce supply in Belgium. Current situation and challenges", Belgian Health Care Knowledge Centre Report 72 C.

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

Jan De Maeseneer (Ghent University)

INTRODUCTION.

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

ABROAD PLATFORM OF SOLIDARITY.

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

THERE ARE DIFFERENCES BOTH IN NEEDS AND SUPPLY.

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

indicators there is a clear North-South axis in Europe: antibiotic utilisation increases from Denmark to Spain, resistance of bacteria illustrates the position of Brussels as a "turning-point" (much more resistance in European countries south of Brussels, than north of Brussels). Also the differences in the way the Human Resources Planning has been implemented in Flanders and Wallonia, illustrate a different approach: in Flanders there is an entrance examination since 1997, in Wallonia this is still a debate.

It is not appropriate to look at those differences from a perspective that the one region is "doing better" than the other: a lot of differences can be explained by social determinants, by economic determinants, but also by historical developments. It is obvious that Flanders, after the 16th century, has been much more influenced by "Nordic" developments, whereas Wallonia is more influenced by "Latin" developments.

THE ACTUAL SITUATION.

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

STRATEGIC CONSIDERATIONS...

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

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

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

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

THE NEED FOR A NEW TYPE OF HEALTH POLICY.

A process of defederalisation, requires a complete re-thinking of the way health policy decisions are taken. It is clear that the system where stakeholders (sickness funds and providers) negotiate a compromise on tariffs, is no more able to respond to the challenges of the 21st century. So, a performant health policy should start from the definition of clear goals, that are debated in Parliament, and formulated in terms of objectives for a 5- to 10 year period. This definition of goals should be based on scientific evidence and transparent political decision-processes.

Once the goals are defined, implementation can take place involving the stakeholders. So, if a defederalisation-process just will lead to shifting the actual NIHDI-structure to the regions, it is not worthwhile doing. Fundamental change is needed, that will install a health policy responding to the needs of individuals and populations. If this does not happen, it is questionable if we will be able to maintain and improve social justice in health, a corner stone of our society.

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

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

Myriam De Spiegelaere (Université libre de Bruxelles)

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 even 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.

References

- Couffinhal, A., Dourgnon, P., Geoffard, P.-Y., et al. Politiques de réduction des inégalités de santé, quelle place pour le système de santé? Un éclairage européen. *Questions d'économie de la santé* [92 et 93]. 2005.
- De Spiegelaere, M. Prévention et inégalités sociales de santé chez l'enfant et l'adolescent. Université Libre de Bruxelles. 1999.
- Demarest, S. Enquête de santé par Interview, Belgique 2008. Accès aux soins de santé. Institut Scientifique de la Santé Publique - Louis Pasteur. 2010.
- Ruz Torres, R. and De Ridder, R. Géographie de la consommation médicale - Variations des dépenses de l'assurance soins de santé en Belgique - Données 2006. INAMI. 2010.

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.

Value-based health care

Johan C. Kips (KULeuven & University Hospitals Leuven)

Any reflection on the future organization of the health care system including the organization of health insurance in Belgium, should start by defining what the primary goals are that are to be met. Only then can the question be asked as to whom is to play which role.

Belgian health care is currently characterized by a very high degree of accessibility, with no form of gate keeping or echelons, coupled to extensive coverage of health services through the compulsory and centrally organized health insurance system.

Payment of health care providers is on a fee for service basis. This overall combination results in a high volume, relatively low unit cost health care system that appeals to the citizens. The degree of satisfaction with the system is high, as is the perceived quality of care.

Needless to point out that as in many other countries, the current health care system faces several challenges. These obviously include the well-known effects of the technological innovation and the demographic evolution, with on the one hand an ageing population and associated need for patient centered chronic care models, and on the other hand a predicted shortage of health care workers. Of additional concern is the financial sustainability of the current health care system. The overall cost has increased over the past few years, now reaching 10.3% of gross domestic product, which is higher than the OECD average (1). Of particular importance is that the out-of-pocket expenses for the patient have also gradually increased, now accounting to approximately 29% which again is above the OECD average.

This evolution raises concern as to the accessibility and equity of our health care system.

As clearly explained by Erik Schokkaert en Carine Van de Voorde, the authors of the present paper, this evolution can threaten the accessibility and equity, two essential aspects in our health care system, if this is not accompanied by a similar evolution in the willingness to pay for the system by those that contribute. They rightly point out that citizens are not willing to pay for what is perceived as waste due to bad management. In other words, in order to safeguard the solidarity, an essential cornerstone in our health care system, the efficiency of the system, indeed needs to be increased.

This notion adds a very important aspect to the reflection on the organization of the health care system, namely that of quality of care. In order to be of high quality, care not only has to be safe and effective, but amongst other aspects also efficient (2). Hence, engrained in the definition of quality is the notion of outcome versus costs. This notion is even better coined in the concept of value. Too often, both elements of the value equation, namely outcome versus cost, are looked upon separately, focusing either on improving outcome without taking cost into account, or - and arguably more so - on reducing cost without considering the effect on outcome. What the health care system needs to deliver is added value, which means better care at the same cost or the same care at a lower cost. This also should be the focus of innovation in health care, which encompasses not only new diagnostic tools and treatment modalities, but also new models of patient centered integrated health care especially in relation to chronic disorders.

Adapting this concept implies that the standards of safety and outcome that are to be met in the health care system, need to be clearly defined as a first priority. As a second then comes the question as to whether and how the health care delivery system should or should not be reorganized.

To date, objective measurement of outcomes of care has received little attention in our health care system. Although the perceived quality is high, little or no formal quality control of delivered care exists, that is based on validated process and outcome indicators. International benchmarking exercises, such as the one performed by the European Health Survey (3), would however suggest that based on the data that are available and could be included, there clearly is room for improving the outcome of healthcare in Belgium.

That the objective outcome of care is not necessarily as good as the perceived quality, is increasingly gaining attention amongst those that are concerned about our future health care system. This issue is a key aspect in any discussion on undue variability in health care practices and the related reflections on willingness to pay for the system.

Introducing and embedding a value oriented concept that includes objective outcome measurement in addition to cost containment in our current activity based health care system, requires two major considerations. Firstly, measuring outcome parameters will only induce real improvement if the parameters are considered meaningful by those that use them. Only then will their measurement lead to active involvement of health care professionals, resulting in a continuous quality improvement culture in which data are analyzed and the underlying medical process continuously improved whenever possible. This also means that identifying standards of care and associated outcome parameters cannot be conducted through a mere administrative top down process, but should actively involve representatives of the various stakeholders, including in particular health care providers - both physicians and hospitals.

A second major consideration is whether or not to translate measurement of outcome parameters financially and thus evolve from a pure activity based financing to a model that also includes outcome based incentives. To date, the question of a possible pay for performance shift has mainly been raised, based on existing models in other countries, with respect to financing of health care providers, physicians and hospitals in particular. It would seem sensible to also raise this same question in a broader reflection on the future role of sickness funds and communities/regions in the organization of a value based health care system in Belgium. This would seem an essential element in an integrated approach of the future of our health care system and the responsibility of each of the players involved. A health care system that is geared to deliver added value to its citizens, thus answering the demand for efficiency and ensuring the associated willingness to pay as a essential corequisite for safeguarding the solidarity that is one of the cornerstones of our system.

References

Organisation for Economic co-operation and development (OECD) Health Data, 2010

Institute of Medicine. Crossing the quality chasm, March 2001.

Health Consumer Powerhouse, Euro Health Consumer Index 2009. www.healthpowerhouse.com

Health insurance, efficiency and equity: French debates

Brigitte Dormont (University of Paris Dauphine and Cepremap)

The French health care system is based on social insurance. It shares many features with Belgium's health care system. Like Belgium, France has universal compulsory insurance with broad coverage, financed through income-related contributions and taxes. At the same time, the market for care is very liberal in both countries. In France, there is almost no rationing in care provision; patients can choose (and freely change) their GPs with no limitations. Despite a gate keeping system set up in 2004, direct access to specialists is not very restricted, because the corresponding penalty is rather small. Doctors are predominantly remunerated through fee-for-service, with the exception of physicians working in public hospitals, and those providing care services in schools or firms. A large proportion of hospital stays occurs in private-for-profit hospitals: one third of total stays and more than half of surgical stays.

On the whole, the French health care system combines strong socialization of financing with loose regulation of efficiency in care delivery. Hence the French health care system can be characterized as hybrid, just like the Belgian system described by Schokkaert and Van de Voorde. Furthermore, the French health insurance system offers a good example of a mixture of public and private health insurance (Barigozzi, 2003; Blomqvist and Johansson, 1997). Of course, the national health insurance (named *Sécurité sociale*) acts as a single payer and provides the bulk of the coverage, but a large number of private health insurers supply complementary health insurance that covers a much smaller, but nonetheless sizeable proportion of health expenditures.

1. Overview of the French health care system

The French health care system is rather costly: according to OECD data for 2008, the proportion of GDP devoted to health expenditures amounts to 11.2%, which places France in second place for health expenditures among OECD countries, behind the USA (16.0%) and slightly ahead of Belgium (which is at the third place with 11.1%). Levels of annual health expenditures per capita are quite similar in France and Belgium. For the year 2008, they are equal respectively to €3,677 and €3,696 (PPP). For the same year 2008, 76.8% of French health expenditures are covered by national health insurance and 13.7% by private complementary health insurance. The remaining 9.5% comes from out-of-pocket payments. This proportion of out-of-pocket payments is one of the lowest among OECD countries.

Given its cost, the performance of the French health care system is fairly good, without being outstanding. In France, life expectancy at birth is one of the highest in Europe. France ranks second worldwide, behind Japan, for life expectancy at birth of women (84.4 years in 2007). But for men France falls back to 13th place (77.5 years in 2007).¹ The French performance is rather poor as regards avoidable deaths (before 65) and conditions connected to risky behaviors (tobacco, and alcohol). Moreover, income-related health inequalities are sizeable in France. Many commentators

¹ In Belgium, the corresponding figures are, for the year 2007, 82.6 years (women) and 77.1 years (men).

incriminate fee-for-service payments and the extensive freedom of French GPs as concerns their localization. These features provide little incentive for preventive care and lead to a very uneven spatial distribution of GPs, who are relatively rare in low income areas. Consequently, not enough screening exams are performed in response to the needs.

This mitigated assessment contrasts strongly with the first place given to France in a worldwide ranking of health care systems carried out by the World Health Organization (2000). This ranking suffers from numerous methodological shortcomings and a sensible economist can hardly believe the results.² It has nonetheless had political consequences in France, where parties in favor of the status quo brandish the first place of France in this ranking to reject any attempt at reorganization.

The preamble to French Constitution states that the Nation guarantees health protection for all. Consequently, the French health insurance system ensures solidarity between the healthy and the sick in order to make care affordable for any citizen. The HCAAM³ (2011), an advisory council in charge of following developments in the French health insurance system and making policy recommendations, has recently stated that the general philosophy of the French system is to espouse the following principle: "From each according to his capacities, to each according to his needs".⁴ According to the HCAAM, this means that (i) the cost of insurance should be related to individuals' level of income and independent of their health; (ii) the benefits should depend on the need for care only, irrespective of the individual's wealth. These principles are close to those put forward by Schokkaert and Van de Voorde for Belgium. It should be stressed that there is a strong consensus of opinion in France on universal solidarity as concerns access to care. For instance, all attempts at introducing deductibles have been met by general protest and rejected. Everybody wants to defend free access to care, without being conscious that non-negligible inequalities already affect the costs of care that some persons have to pay out of pocket (see section 3). Moreover, there is a categorical rejection of any decision that could introduce rationing in care delivery. This climate of public opinion, adroitly maintained by doctors, is a major obstacle for a government that tries to improve efficiency in care delivery.

In France as in Belgium (and in any health care system in developed countries), the main issues are efficiency and equity in care delivery. As concerns equity, there is a general agreement on the principles and the French system performs rather well. Efficiency is much more problematic. The search for efficiency in the context of a public opinion that is rather hostile to the idea has led to decisions that do not really promote efficiency and actually might threaten equity in care delivery.

In France, as in Belgium and elsewhere, the long-run challenge is to accommodate expected increases in health care expenditures. As shown in Dormont *et al.* (2006) and Dormont (2009), the main driver of this increase is the diffusion of medical innovations that improve longevity and quality of life. Of course, it is crucial to improve efficiency in care delivery. But for a given (and hopefully optimal) level of efficiency, there is no point in limiting health expenditure growth if this increase contributes to a gain in social welfare (Hall and Jones, 2007). Depending on the assumption adopted for the pace of technological progress, we can expect French health expenditures to come to somewhere between 14% and 21% by 2050 (Dormont *et al.*, 2010).

How can we cope with such an increase in health expenditures? Four options are conceivable, three of which are close to the ones considered for Belgium by Schokkaert and Van de Voorde: (i) doing

² The ranking is based on the estimation of the relation between health (measured by life expectancy) and health expenditures, while controlling for the level of education (which also influences health). The estimation was performed on data from 191 countries as different as France, USA, Guinea Bissau, the Maldives, Zimbabwe, etc. and assumed that the coefficient describing the influence of education on health is the same, whatever the country's development level. Given this method, the first place attained by France is due to a lower number of years of education in France than in countries of northern Europe, for comparable level of health expenditures. Therefore, the French performance in life expectancy appears to be particularly good. The apparent efficiency of French health care system thus derives from relatively low investment in education (Grignon, 2008).

³ Haut Conseil pour l'avenir de l'assurance maladie.

⁴ It is rather surprising to find this Marxist phrase in an administrative report. However, in the HCAAM report, it concerns only one part of consumption, namely health care. Therefore, it does not have the same meaning at all as the principle that Marx laid out in 1875 as a guide to the construction of communist society, where it concern all individual consumption.

nothing, which implies an extension of the coverage provided by the private complementary health insurance; (ii) extending the role of national health insurance; (iii) accept an increasing role of complementary insurers, while introducing regulated competition to prevent risk selection, guarantee affordability of complementary insurance and provide incentives for contracting with care providers to pursue efficiency in care delivery. The fourth option under debate in France is called “*bouclier sanitaire*”. It consists of putting a cap on annual total individual copayments, while introducing deductibles to finance the resulting additional reimbursements. This option comes down to modifying the distribution of copayments between individuals.

In what follows, I describe the architecture of the French health insurance system, and then consider the equity and efficiency of the French health care system. Then I present the four options that could permit to deal with the future increase in health expenditures. To conclude, I examine how the French experience might possibly be useful to Belgians in rethinking their own system.

2. Architecture of the French health insurance system

From the beginning, national health insurance did not provide a full coverage of health care costs. Copayments were set up in order to limit expenditures. However, these copayments have progressively been covered by complementary health insurance, leading *de facto* to a mixed insurance system: coverage is provided by the compulsory national health insurance and private optional complementary insurance. Currently, the involvement of complementary health insurers is not negligible: in 2008, they covered 13.7% of total health expenditures and 20.7% of ambulatory care. A specificity of France is that complementary health insurers play the roles of both complementary and supplementary health insurance (Colombo and Tapay, 2004). They are complementary in that they participate in the coverage of basic health care services, i.e. the care services to which access is guaranteed to all by the Constitution. They are supplementary in that they cover the costs of other care services, such as comfort in hospital, alternative medicine, extra charges for consultations. The fact that optional insurance reimburses a significant proportion of basic care is specific to France. In many other countries, optional insurance covers only goods and services that are not considered essential to health.

The coverage provided by national health insurance is fairly generous and amazingly steady over time. The proportion of health care expenditures covered by national health insurance was equal to 76.8% in 2008. It was equal to 76.5% in 1970, forty years ago. Given that health expenditures increase more rapidly than GDP, this stability of coverage requires a continuous increase in the rate of income-related contributions and taxes devoted to financing national health insurance. In 1970, contributions equal to 3.8% of GDP were enough to cover 76.5% of health expenditures. For comparable coverage in 2008, a much higher contribution rate, equal to 6.7% of GDP, was required. Given the increase in health expenditures that is expected in the future, maintaining this coverage will not be possible without an increase in the contribution rate.

Yet in France, as in many countries, there is growing political pressure in favor of a limitation in taxes and social contributions. Consequently, for the last several years, the actual rule applied was to avoid raising the contribution rate for health insurance, leading to sizeable deficits for the national health insurance.⁵ Each year, a drama is played out whose scenario is always the same: the government raises the alarm when publishing the extent of the deficit, named “*le trou de la Sécu*”.⁶ It is said that the deficit is catastrophic and that measures must be taken immediately. For many years, the decisions taken consist of increasing copayments, which comes down to implementing a gradual retreat of national health insurance in favor of larger coverage by complementary health insurers. There has

⁵ Anyway, this has entailed in practice an increase in the tax rate to reimburse the resulting debt.

⁶ That is, the “hole” of the *Sécurité Sociale*.

been a slight but continuous erosion of the coverage rate by national health insurance, from 78.5% in 2004 to 76.8% in 2008 (-1.7 percentage points), in favor of OOP payments (+ 1.2 percentage points, from 8.3% to 9.5%) and coverage by complementary health insurers (+ 0.5 percentage point)⁷.

The magnitude of copayments has led to the creation of safety nets to protect the poor and the sick. In 2000, free complementary coverage was instituted for people with low incomes. This shows the recognition by the government of the role of complementary insurance in guaranteeing access to care. About 7 % of the French population benefit from this plan. In addition, people affected by a chronic disease may enjoy 100 % coverage for all care services connected to this disease. To be eligible for this plan, people have to be affected by a condition reported in the official list of “*Affections de longue durée (ALD)*”. In practice, this plan has contributed to the creation of two populations with very different coverage rates: on average, ALD patients are reimbursed 90% of the cost of medical care whereas non-ALD patients are reimbursed only 66%⁸. The road to hell is paved with good intentions: the ALD plan is simultaneously a permissive condition and a motivation for the gradual retreat of national health insurance. Indeed, the stability of coverage described above hides a continuous structural change: the proportion of ALD patients has increased, while the rate of coverage of non-ALD patients has decreased. The two movements fuel each other: for national health insurance, cutting back on coverage makes it possible to finance the patients newly eligible for ALD; for a doctor, giving a patient access to ALD coverage solves the patient’s financing difficulties. The ALD plan thus creates a dynamic that favors extension of the number of ALD patients and deterioration of coverage for non-ALD patients.

On the whole, our national health insurance system is rather complex. Its architecture is characterized by two tiers, compulsory national health insurance and optional complementary health insurance. Within national health insurance, there are different levels of coverage between ALD and non-ALD patients. This organization might jeopardize the system’s performance in equity and efficiency in care delivery.

3. Equity and efficiency: the whole truth about the French system

3.1 *Equity in access to care*

As stated above, there is much concern in France about equity in access to care. The ALD plan could be seen as threatening the system’s cohesion. This plan might also be considered quite unfair, since it is possible to incur very high care costs without being eligible for ALD. However, French people are generally in favor of giving more generous coverage to seriously ill individuals, and they resist attempts to strike illnesses from the list that determines eligibility.

The average coverage rate for basic health care is 79.0%.⁹ However, analysis of equity in financial access to care requires focusing on copayment distribution. Indeed, individual health expenditures are extremely concentrated: each year 50% of the reimbursements by national health insurance result from health care provided to a small minority of patients, who represent only 5% of insured people. This characteristic of expenditure distribution is observed in all developed countries: it is due to treatment costs, which reach extreme values in a few rare cases. Even the very richest individuals are exposed to the risk of a level of health care costs they cannot afford. This characteristic explains why a society that aims to guarantee access to care to all citizens must make health insurance compulsory.

⁷ To avoid going into too many details, we give here the coverage provided by both the national health insurance and the state (the latter contributes for a very small proportion, hardly more than 1%). Figures are given here for the year 2008 to use the same year for all indicators, but French statistics are available for more recent years (DREES, 2010).

⁸ The coverage rate of ALD patients is lower than 100% because they are subject to copayments for care services they use for illnesses other than those for which they were granted ALD status.

⁹ The coverage rate of 76.8% given in our description in section 1 concerns total health expenditures, including supplemental care.

Another consequence of this concentration of health expenditure distribution is that partial coverage by health insurance exposes people to copayments that can reach extreme values, if there is no cap on total annual copayments. In 2005, average annual copayments in France were € 200 for ambulatory care and €45 for hospital care (Briet *et al.*, 2007). But for the 5% of insured people with the highest expenditure (about 3 million individuals), the average copayment for ambulatory care was €1,490 if they were ALD patients, and €943 for non-ALD patients. For the 1% of insured people with the highest expenditure, these figures were equal to €2,737 for ALD patients and €1,460 for non-ALD patients. As concerns hospital care, 9% of patients who went to hospital were subject to a copayment above €1,000. It should be noted that these figures do not include the extra fees that some doctors charge for consultations, above and beyond the national health insurance fee schedule.

Unlike many other countries, France has no ceiling on copayments borne by individuals. They are more or less covered by complementary health insurance. Hence, complementary insurance appears to be a condition for access to basic health care. In fact, giving up on health care is strongly correlated to lack of complementary coverage: one third of people with no complementary coverage report having given up on the use of some care services, a much higher proportion than for people with complementary coverage.

Access to complementary health insurance is hence crucial to access to health care. Currently, only 7% people are not covered by complementary health insurance, a figure which suggests that the problem is not serious. Such a conclusion is not legitimate: given the current regulation of complementary health insurance and the expected growth in health expenditures, it is likely that access to complementary coverage will become more expensive or even prohibitive for an increasing share of the population. About 40% of individuals with complementary insurance benefit from this coverage through their employer. For the rest of the population, complementary coverage is optional and entails payment of a premium which generally increases with age and is independent of income level. Consequently, access to complementary coverage is obtained through a regressive payment: in 2006, the richest households (the top 10%) devoted 2.9% of their incomes to purchasing complementary coverage, while the poorest (the bottom 10%) paid 8% of their incomes. Such a financial effort can be considered prohibitive for low-income people and lead them not to buy insurance.

Moreover, the risk pooling carried out by complementary health insurers is very limited because they compete on a market for insurance that is optional. Three-fourths of reimbursements are provided by non-profit sickness funds that claim to respect the ideal of solidarity.¹⁰ But they compete with private-for-profit companies and cannot equalize their enrollees' premiums without losing all their young and healthy enrollees, which would lead to a rise in the average premium. In this context, complementary insurers have to adjust their premiums to individuals' expected expenditures. In particular, the premium depends closely on the enrollee's age. In addition, while direct risk selection is discouraged by regulations concerning tax exemptions, insurers have developed contract segmentation to select young and healthy clients.

To sum up, the market for complementary insurance is characterized by a lack of solidarity between the rich and the poor and by limited risk-sharing between different groups, together with risk selection. This situation has already led to premium levels which are very high for some households (8% of their income). If future increases in health expenditures were covered by an extension of the scope of complementary health insurance, premium levels would be likely to rise even more quickly

¹⁰ According to Schokkaert and Van de Voorde, the same ideological principles are adhered to by Belgian sickness funds.

than health expenditures¹¹ and become unaffordable for an increasing share of the population. In other words, the current organization of complementary health insurance cannot be maintained without jeopardizing equity in access to care.

3.2 Efficiency in care provision

Efficiency in care delivery is not considered an important issue by most French people and not much has been done to gain in efficiency. Doctors resist any constraint on their activity and they successfully brandish the threat of care rationing to forestall any decision that is not in their interest. At its beginning, national health insurance bore responsibility for care management. Currently, all decisions regarding health care regulation are taken, or at least approved of, by the government. And doctors are reputed to wield such wide influence that they can make or break an election campaign.

Economists distinguish between productive efficiency, which consists in avoiding waste, and allocative efficiency, which implies that health care expenditures are in keeping with individual or collective preferences. Allocative inefficiency arises when there is overconsumption or underconsumption (excessive waiting lists for instance). Overconsumption may result from full coverage of patients because they do not bear any financial consequence of their decisions. Overconsumption may result as well from care providers who induce their patients to use more care services than necessary. This behavior, called supply induced demand, is encouraged by fee-for-service payments that make the physicians incomes depend directly on the amount of care services provided.

In France, the decisions that really affect efficiency have consisted in influencing the demand side by the introduction of copayments. On the supply side, incentives have been set up that have led to an increase in the use of generic drugs. But fee-for-service payments that encourage supply induced demand have been left in place: in ambulatory care and private for-profit hospitals, physicians are self-employed and receive fee-for-service payments. A 2004 reform has introduced a prospective payment per case for hospitals.¹² In principle, this provides strong incentives for efficiency in care delivery, since payments depend on diagnosis at admission and not on the procedures implemented during the stay. But, as in other countries, the stay classification actually used relies closely on procedures implemented during a stay. Furthermore, the nomenclature has been excessively refined in France: the number of classification groups rose from 780 in 2009 to 2,291 classification groups currently. All of this contributes to encouraging an excessive use of invasive procedures, as is the case of fee-for-service payments.

In France, the number of GPs per resident is one of the highest among OECD countries. But their localization is very uneven and not connected to needs. This is a source of inefficiency in care provision. In areas with too many doctors, their earnings are limited by the lack of patients (since they are paid on a fee-for-service basis) and they are likely to induce demand. On the contrary, in areas where GPs are scarce, patients have difficulties in seeing a doctor. Although policy makers are aware of the problem, they have never dared to constrain doctors in their choice of location, in keeping with the general interest.

The influence of complementary health insurers also contributes to inefficiency. Currently, they are passive reimbursement agencies that have no responsibility in managing care. Nevertheless, they compete on coverage, which has led them to cover almost all copayments and to defeat attempts at

¹¹ Indeed, because complementary health insurance is optional, the increase in premiums would be amplified beyond the increase in the covered expenditures, due to the fact that young and healthy people would be likely to terminate their contracts.

¹² This prospective payment system has replaced global budgets for public hospitals and retrospective reimbursements for private hospitals.

limiting unnecessary consumption. For example, the coverage rate for drugs of limited medical interest has been recently reduced to 15% by the national health insurance. Non-profit sickness funds announced they would not cover the remaining 85%. But for-profit insurers covered these drugs, leading the non-profit sickness funds exposed to competition to follow suit.

Another important issue is the extra fees that some doctors are allowed to charge for consultations in ambulatory care or for procedures in private hospitals. To contain health care costs, the national health insurance negotiates a fee schedule with doctors' associations. This schedule provides the reference fees that are used to compute reimbursements by the national health insurance. However, doctors have managed to obtain the creation of a specific category of physicians who are allowed to charge extra fees. In 2004, 14% of GPs and 39% of specialists were allowed to charge extra fees. On average, these amount to an extra cost of 47% above the reference fee. The coverage of these extra fees is very unequal: people with no complementary coverage are not reimbursed for the extra fees; people who have subscribed complementary insurance individually are reimbursed little or not at all. Coverage is more generous for people who benefit from complementary insurance through their employer. Complementary coverage is not only optional; it is heterogeneous and helps a minority of people to afford expensive care. This creates an additional source of inequity since it contributes to maintaining prices that are too high for many citizens.

The French health insurance system has two tiers, with a first-level compulsory insurance, which acts as a single payer, and second-level optional complementary insurers. Our description shows how such a mixed system seems to be incapable of effective care management, since the second tier includes actors that do not share the same objectives as the first-tier insurance.

Another question is whether the existence of a single payer for most expenses could be responsible for the lack of effective care management. The underlying idea is that absence of competition induces no pressure in favor of more efficiency in care delivery. It is true that given the unpopularity of the idea of health care efficiency in France, policy makers have not much incentive to implement reforms that doctors and patients dislike. The alternative seems to be the model of regulated competition introduced in Switzerland, Netherlands, etc. Does it perform better? We turn to this question below.

4. Four options to deal with the future increase in health expenditures

Health care expenditures are likely to keep growing rapidly in the future. For a given level of productive efficiency, this increase contributes to a gain in social welfare and thus to allocative efficiency. Therefore, the health care system should be organized in order to make this growth possible. In France, four options are conceivable, three of which are close to those considered for Belgium by Schokkaert and Van de Voorde.

4.1. No change in the current organization

This would imply an extension of coverage provided by private complementary health insurers, i.e. a gradual privatization of insurance. As explained above, this would entail an increase in copayments and in premiums to buy complementary insurance. It is likely that premiums would become prohibitively expensive for a growing proportion of the population, blocking access to complementary insurance and hence, to care. Moreover, reimbursements to ALD patients would tend to exhaust all the funds of the national health insurance, which would turn into a catastrophic insurance system. Such a change would break with the principles of equal access for all promoted by the French constitution.

4.2. Extension of the scope of National Health Insurance

National health insurance can fully cover basic health care. This option is not that expensive: the reimbursements provided by complementary insurers in 2009 could be financed by an additional contribution of about 2% levied on all incomes. Of course, future increases in health expenditures would involve an increase in the total contribution rate. One advantage of this option is that it extends the scope of compulsory insurance, thus reducing inequalities in access to insurance and to care arising from optional complementary insurance (see section 3.1). In this case access to full coverage for low-income people would entail a cost of 2% of their income (the new contribution) instead of 8% in the current situation. Moreover, it would increase the regulatory power of national health insurance by doing away with the problems resulting from a two-tiered insurance system with unregulated competition for complementary insurers. Such a reform would confine their activities to supplementary coverage for non-basic care services.

Many French citizens are unaware that such an enhanced compulsory health insurance system already exists in the Alsace-Moselle region. This region of France was annexed to Germany between 1871 and 1918. During this period, Bismarck created the German health insurance, which the present day Alsace-Moselle scheme stems from. Financed by a contribution equal to 1.65% of all incomes, this compulsory scheme offers extra coverage on top of the National Health Insurance, leading to a total coverage rate of 90% to 100%. Many members of the French parliament reject the idea of more generous coverage by national health insurance. Surprisingly however, no elected representative of this region has ever proposed to abolish this scheme to make complementary health insurance optional as in the rest of the country.

4.3. Introduce regulated competition between complementary health insurers

Another possibility is to make complementary insurance mandatory, while regulating competition between complementary health insurers. This would acknowledge their existence and give them more responsibility in the coverage of health expenditures and care management. Such regulation is described by Schokkaert and Van de Voorde: the objectives are to prevent risk selection, guarantee affordability of insurance and provide incentives for efficiency in care delivery.

Health insurance should be mandatory for basic care only, that is, care which we consider that all citizens should have access to. Hence, such a reform would require introducing a separation between complementary and supplementary health insurance, the latter remaining optional. The resulting insurance architecture would be very complex and comprise three tiers: compulsory national insurance, compulsory complementary insurance (with several insurers) and optional supplementary health insurance (with several insurers). Moreover, preventing risk selection requires setting up a risk compensation scheme, and more responsibility in care management for complementary health insurers would require continuous transmission of information about insured people from national insurance to complementary insurers. We could expect a huge increase in administrative costs for a small segment of total health expenditures (currently 13.7%).

The only real justification of regulated competition is that competing insurers have more incentives for managing care than a single payer.¹³ But is this true in reality? Schokkaert and Van de Voorde write about “belief” concerning the performance of regulated competition. Actually, the debate seems very ideological. A recent proposal in the USA shows how the model of regulated competition can be used to promote the dismantling of government-run health insurance: a republican Congressman has referred to the Dutch experience to propose replacing Medicare with vouchers provided to

¹³ Indeed, there is no advantage in terms of more choice for the consumer, since regulated competition requires insurers to provide an identical package of basic benefits.

beneficiaries to purchase insurance. In reaction, Okma *et al.* (2011) published a virulent criticism of regulated competition in the Netherlands. This contrasts sharply with the idyllic descriptions generally provided by Dutch economists of the performance of regulated competition in the Netherlands (Greß *et al.*, 2007).

The existence of effective competition is a prerequisite for regulated competition to provide incentives for efficiency in care management. In Switzerland, where regulated competition was introduced in 1996, there is limited evidence of effective competition. Premium variability is very high. Switching rates are low: less than 4% per year. Consumers seem reluctant to switch to less expensive funds, suggesting that competition is not that effective.¹⁴ In the Netherlands too, switching rates are low, around 4%.

To install effective competition, customers must have financial incentives to switch providers. For this purpose, it is preferable to avoid financing through income related contributions alone. In the Netherlands before 2006, 90% of the premium was paid by a central fund and only 10% by individuals. The small monetary gain for switching to a less expensive fund was considered insufficient to compensate for the transaction costs. Consequently, the 2006 reform raised the share of premiums directly paid by individuals to 50%. The gains in efficiency, if any, have thus had a cost in terms of equity. Dutch promoters of regulated competition do not provide much information about cost of access to insurance as a proportion of income and its distribution in the population.

4.4. Introduce a cap on annual *copayments*

The fourth option is called “*bouclier sanitaire*”. It consists of capping annual total individual copayments, while introducing deductibles to finance the resulting additional reimbursements. This option comes down to modifying the distribution of copayments between individuals.

Like full coverage of basic health care by national health insurance (see 4.2) this option might confine the activity of private insurers to supplementary coverage for non-basic care services. Indeed, currently, the main interest of complementary coverage is to insure for extreme copayments, which would be eliminated by the cap. For purposes of equity, promoters of this reform propose to define deductibles and caps that are proportional to income (Geoffard and Lagasnerie, 2009). Despite its simplicity, this proposal could meet with a good deal of resistance: complementary insurers do not favor a measure which could reduce their scope of activity; the idea of setting up deductibles for health care costs is very unpopular, being perceived as a great obstacle to financial access to care.

5. Can French debates on health care shed light on the questions raised in Belgium?

The Belgium situation is somewhat different from the French one because there is no single payer in Belgium: a number of sickness funds are already in charge of covering basic health care. Although the authors lack faith in regulated competition, they seem to consider this option seriously. History strongly influences national institutions. It is not necessary to believe that regulated competition performs well to adopt this system. It is sufficient to acknowledge that sickness funds have an important role in Belgium. Therefore, the most reasonable reform would preserve existing sickness funds and introduce regulation that favors more efficiency and equity. The preexistence of multiple payers is one plausible explanation for the adoption of regulated competition in countries like Switzerland or the Netherlands.

Schokkaert and Van de Voorde design an attractive system of financing organization that permits solidarity at the national level, while allowing for some decentralization and providing incentives for efficiency. In this system, regions would benefit from efforts promoting efficiency. Moreover, they

¹⁴ One explanation for this consumer inertia is the influence of supplementary insurance explored in Dormont *et al.* (2009).

would have autonomy for decisions in accordance with local preferences regarding health care provision and coverage, in addition to the national level of coverage.

Does this proposition resolve difficulties between communities? The principles are excellent but the transition in practice is not simple. For instance, what the authors call “interpersonal solidarity” induces interregional solidarity (on the basis of the objective health risk of populations to avoid rewarding inefficiency). This solidarity concerns a “basket” of care services that has to be discussed at the central level and continuously updated with medical innovations. Suppose one region of Belgium does not want to share much with the others: negotiating a minimal basket of care services can avoid any real solidarity. Afterwards, it is also possible to refuse an update of this basket.

My main concern is that this financing organization introduces two levels of insurance: coverage for the national “basket” and coverage for the regional “basket”. The first level is the same in all regions, while the second might differ across regions. The first level can be provided by a single national payer as well as multiple sickness funds (with regulated competition). The French experience shows that two-tiered insurance is rather dangerous. In the Belgian case, suppose there is a care service that is covered in one region, and not in another one. This care service is likely to be covered by optional supplementary insurance in the second region. Maybe this supplementary insurance will also cover citizens living in the second region who go to the first region to be treated? Then what about regulation of care provision, decisions to treat, and doctors’ payments? It seems to me that private insurers operating on the supplemental insurance market in one region might badly interfere with regulation in another region more generous in coverage. It could eventually be an additional source of tensions between communities.

As a French observer, I deduce from the article of Schokkaert and Van de Voorde that the values of solidarity and equity are not as popular in Belgium as in France. Conversely, it seems that the objective of efficiency is more highly valued in Belgium than in France. The proposal of Schokkaert and Van de Voorde does not solve all the problems. But it defines a way to achieve greater transparency in budget allocation, which is a good start to beginning to live together.

References

Barigozzi F. (2003). The Public-Private Mix in Health Insurance. Palgrave MacMillan Publishers Ltd for the series: Central Issues in Contemporary Economic Theory & policy

Blomqvist A. and P.O. Johansson (1997). Economic efficiency and mixed public/private insurance. *Journal of Public Economics*, 66 (3): 505-516

Briet R., Fragonard B. and J.-P.Lancry (2007). Mission bouclier sanitaire. (<http://lesrapports.ladocumentationfrancaise.fr/BRP/074000602/0000.pdf>)

Colombo F. and Tapay N. (2004). Private health insurance in OECD countries : the benefits and costs for individuals and health systems, OECD health working papers, n° 15.

Dormont B. (2009). Les dépenses de santé. Une augmentation salubre? Opuscule du CEPREMAP, Editions Rue d'Ulm. (<http://www.cepremap.ens.fr/depot/opus/OPUS15.pdf>)

Dormont B., M. Grignon and H. Huber (2006). Health expenditure growth: reassessing the threat of ageing, *Health Economics*, Vol. 15(9), 947-963

Dormont B., P.-Y. Geoffard and K. Lamiraud (2009). The influence of supplementary health insurance on switching behavior: evidence from Swiss data, *Health Economics*, Vol. 18, 1339-1356

Dormont B., J. Oliveira Martins, F. Pelgrin and M. Suhrcke (2010). Health expenditures, longevity and growth, in Ageing, Health and Productivity, Oxford University Press

DREES (2010). Les Comptes nationaux de la santé en 2009, *Études et résultats # 736*. (<http://www.sante.gouv.fr/IMG/pdf/er736.pdf>)

Geoffard P.-Y. and G. de Lagasnerie (2009). Réformer le système de remboursement pour les soins de ville : Une analyse par micro simulation. Document de travail

Greß S., Manougian M. and J. Wasem (2007). Health Insurance Reform in the Netherlands, CESifo DICE Report 1/2007 (<http://www.stefan-gress.eu/mediapool/40/403223/data/dicereport107-rml.pdf>)

Grignon M. (2008). The role of education in health system performance. *Economics of Education Review*, 27, 299-307

HCAAM (2011). L'accessibilité financière des soins : comment la mesurer ? (http://www.securite-sociale.fr/institutions/hcaam/avis/hcaam_avis_270111.pdf)

Marx K. (1875). Critique of the Gotha Programme. (<http://www.marxists.org/archive/marx/works/1875/gotha/index.htm>)

Okma K.G.H., T. R. Marmor, and J. Oberlander (2011). Managed Competition for Medicare? Sobering Lessons from the Netherlands, *NEJM*, 365(4), July 28, 2011, 287-289

WHO (2000). The world health report 2000 - Health systems: improving performance

Decentralization and coordination of health care provision in Norway: which lessons for Belgium?¹

Fred Schroyen (NHH — Norwegian School of Economics, Bergen, and
HEB — Health Economics Bergen)

In this note, I will explain the organization of the Norwegian health care system and assess two recent reforms that were aimed to (de)centralize the provision of health care. I then draw some lessons for Belgium. I start by giving some facts and figures.

1. Facts and figures

Norway is a vast country in Europe's periphery. It has more than 12 times the size of Belgium but less than half of Belgium's population.² People live mainly along the coastline. In 1970, the primary and secondary sector stood for 15.5% and 50%, resp., of total employment. These days, these figures are reduced to 3.5% and 22%, while the tertiary sector has a share of 75%. The contributions to GDP are 2% (P), 40% (S) and 60% (T). That the secondary sector contributes more to GDP than to employment is due to the oil sector. Since the mid 90s, Norway's GDP per capita has started to exceed that of Belgium.

Still, in many respects, Norway is not that different from Belgium. It is a young nation³ with a representative democracy, and two official languages. It operates an extensive welfare state. Though not an EU member, through the EEA agreement Norway benefits from many of the advantages of full EU membership and is bound by Common Market law.

During the last 4 decades, Norway was run either by the Labour Party or by a centre-right coalition. In 2005, the center-right coalition government was replaced by a center-left coalition of the Labour Party, the Socialist Left Party and the Centre Party. The Norwegian economy is a market economy with the state having important stakes in several industries and sectors. There is a strong emphasis on redistribution, both *ex ante*, through a very uniform school system and a very narrow wage distribution, and *ex post* through taxes and transfers. The discovery and exploitation of the oil and gas fields on the Norwegian continental shelf since the mid 70s has been the country's economic blessing. Today, mainland GDP is only 77% of total GDP. Government proceedings from taxes and exploitation rights on oil are collected in a sovereign fund which is valued today at about 400 bn €. Up till now, politicians have managed to comply with the rule never to take out more than 4% — the fund's expected yearly real rate return.

Table 1 presents some socio-economic and health indicators for Norway and Belgium, while Figure 1(a) shows the geographical distribution of GDP per capita in Norway. The relative high figures for the South-West part of the country are due to the oil sector. It is clear that without an extensive redistribution of resources, Norway would be a very unequal country to live in.

¹ Thanks to Jan Erik Askildsen for useful comments.

² Almost 320 000 km², excluding Spitsbergen. Norway has around 4.9 million inhabitants.

³ Norway was under Danish rule till 1814, when it formed a union with Sweden. It became completely independent from Sweden in 1905.

Using life expectancy as a crude measure for the output of health production, both countries score about the same. But total health expenditure per capita in Norway is almost 25% higher than in Belgium. This is surprising because physician density is in both countries around 4 per 1000, and Norway has almost 3 beds less than Belgium per 1000 inhabitants. The sheer size and geography of the country is an important explanatory factor. It means that it is much more expensive to guarantee access to high quality health care for all citizens. For example, for small villages on islands along the coast in Northern Norway, an air ambulance is the only means of bringing patients in time to the hospital. That ambulance cars have to drive for 100km to fetch a patient is not uncommon. These geographical challenges, together with the policy goal of universal access to health care, explain why the responsibility for the provision of care is assumed by the state: no private hospital would find it profitable to settle in one of the northern counties.

Table 1. Some socio-economic and health indicators for Belgium and Norway.

	Belgium	Norway
Population (in 1000)	11 007.0 (2011)	4 949.8 (2011)
GDP per capita (€ PPP) (2009)	31 925	51 898 (total) 40 251 (mainland)
Av. earnings per production worker (€ PPP) (2009)	31 698	37 709
Gini coefficient	28 (2005)	258 (2000)
Life expectancy at birth	77.1 (m) – 82.6 (f)	78.2 (m) – 82.7 (f)
Life expectancy at 65	21.1 (m) – 25.3 (f)	21.4 (m) – 24.9 (f)
Total health expenditure per capita (€ PPP) (2008)	3635	4553
Public share in THE (%)	76% (1996)	84% (2008)
Total health expenditure as a % of GDP (2008)	11.1%	8.5%
Practicing physicians per 1000 (2007)	4.0	3.9
Hospital beds per 1000 (2007)	6.7	3.8

Sources: OECD Health Data, Statistics Norway, and Wikipedia.

2. The organization of the health care system⁴

Like in other Scandinavian countries, Norway's health care system is mainly a public one, both in terms of finance and in terms of provision. Around 84% of total health expenditure is paid for by the Treasury. The remaining 16% comes from out-of-pocket payments. The public health care system is organized along two lines: primary health care is the responsibility of the municipalities; specialist health care is the responsibility of the Regional Health Authorities.⁵ I will first sketch the organization of primary care.

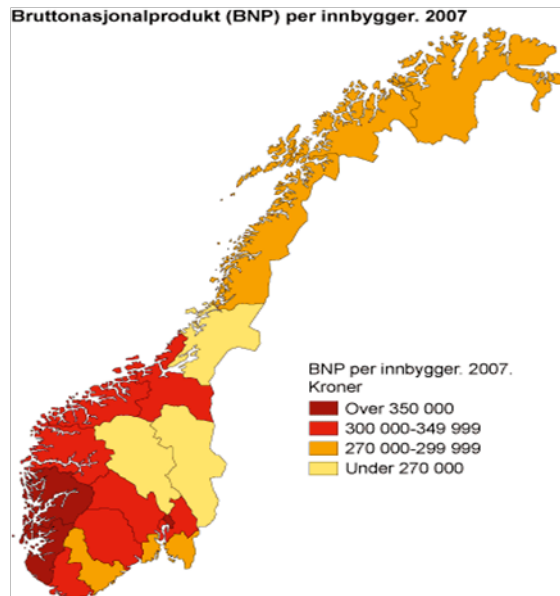
Through the Municipalities Health Services Act of 1987, each of the 434 municipalities is responsible for preventive health care and all primary health care and social services. In particular, they provide general medical practice, physiotherapy, care for the elderly, medical emergency call services. In big cities, the municipality runs one or several emergency centers with doctors, nurses, and ambulance personnel addressing any emergency calls.

⁴ A much more in-depth description may be found in Johnsen (2006).

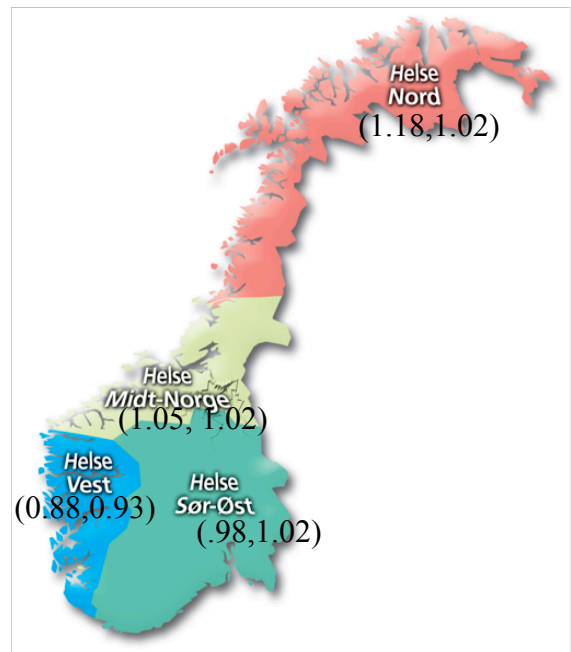
⁵ Long-term care for the elderly also belongs to the responsibility of the municipalities. Dental care is private, except for children for which free public dental care is provided by the counties. I do not consider these forms of care in the rest of this note.

Figure 1.

(a) GDP per capita (NOK) in 2007



(b) The four Regional Health Authorities.



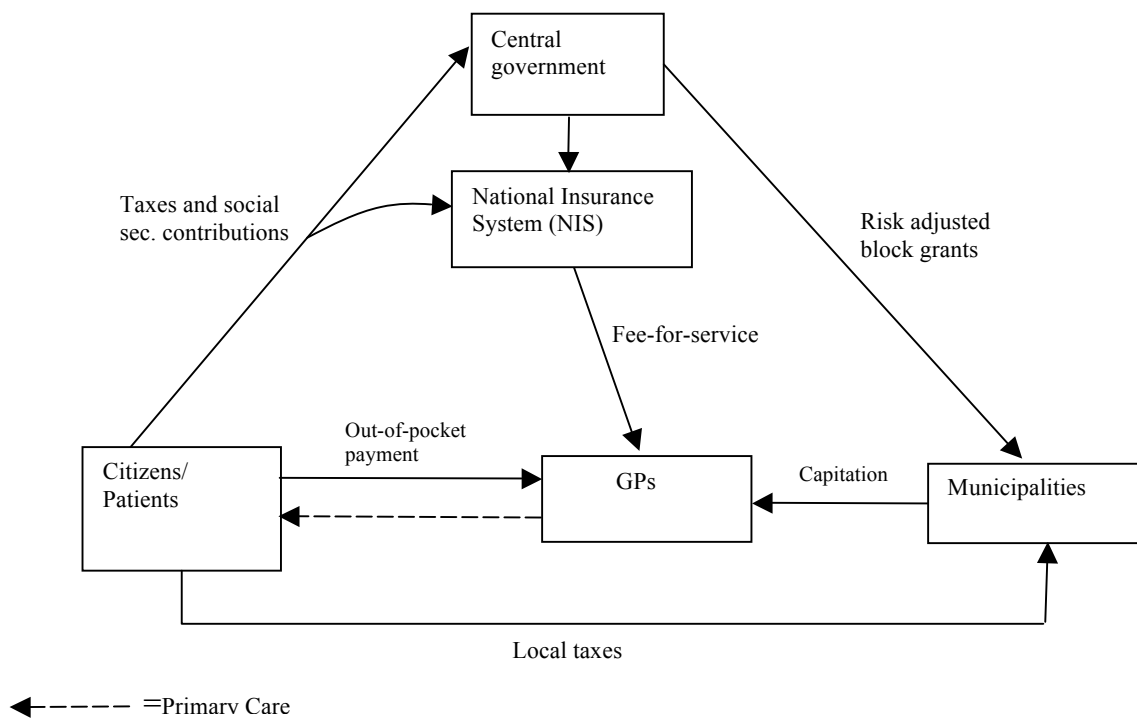
Since June 2001, Norway practices a Regular GP system, whereby each citizen has the right (but not the obligation) to belong to a list of a GP of her choice. Up to twice a year, she can ask to be transferred to another GP's list—provided there is room on that list. The advantage of belonging to a list is that a patient has easier access to her GP (lower waiting time for a consultation) and pays a lower copayment. GPs act as gatekeepers to secondary health care. In general, the only way for a patient to see a specialist is by a referral by her GP or the doctor at the medical emergency centre.

Although municipalities are responsible for GP services, only a minority of GPs are employed by the municipality. The majority is self-employed and works under contract with the municipality. GPs that participate in the municipality's list system are paid a capitation grant, and per consultation an out-of-pocket payment by the patient and a fee-for-service by the National Insurance System (NIS).

In Figure 2, I have adapted the 'blueprint' triangle presented by Schokkaert and Van de Voorde (2011, fig 3) to the Norwegian primary care sector. The integration of the purchaser-provider relationship means that it is impossible to identify a third-party payer who has no responsibility for care provision.

The central government allocates grants to the different municipalities based on demand and cost determinants for municipal services (including—but not restricted to—health care). Municipalities also collect income and property taxes from their residents. Since GPs receive a capitation fee per citizen on their list from the municipality, they are incentivized to provide quality.

Figure 2. The 'blueprint triangle' for primary health care in Norway.



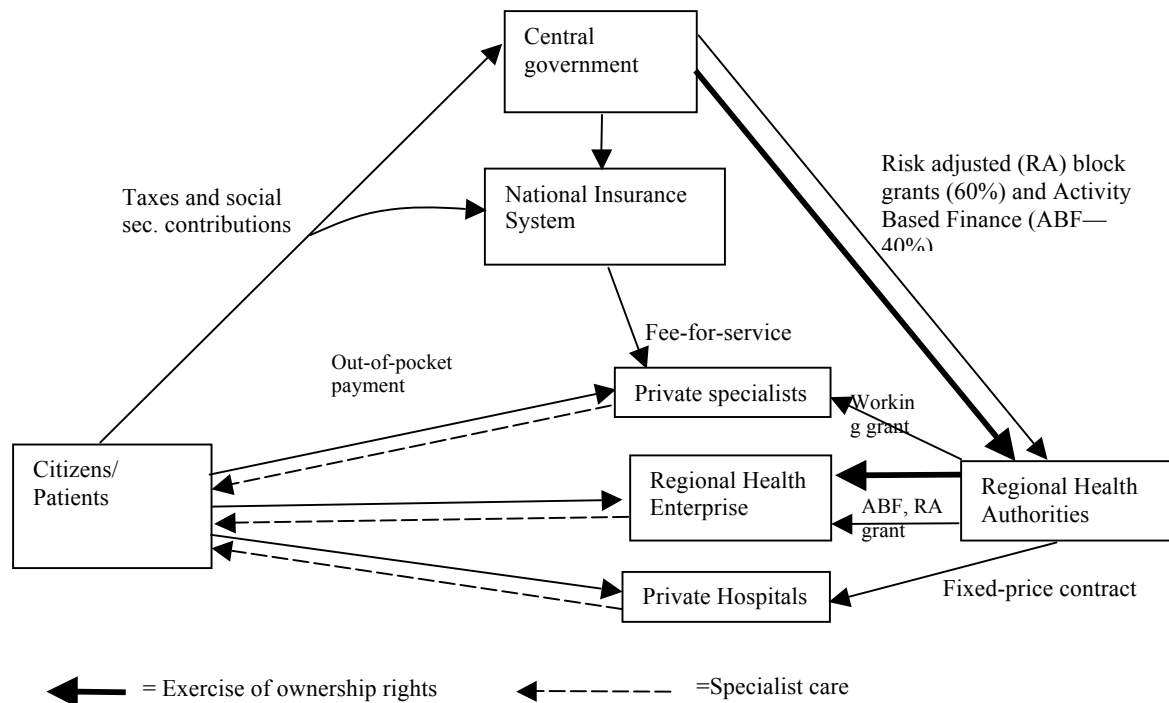
Since January 2002, the responsibility for specialist care is assumed by five *Regional Health Authorities* named according to their geographical location: South, East, West, Mid-Norway and North; South and East merged in June 2007 to South-East. As the single shareholder for each RHA, the Minister of Health exercises her ownership rights by participation in the general assembly. She appoints the board of directors who in turn appoints the CEO. Figure 1(b) locates the four RHAs. In brackets, I have added for each health region (i) the ratio of cost per inhabitant of somatic specialist care to the per capita cost for the whole country, and (ii) the same ratio for DRG point production (2009 figures — source: Helsedirektoratet 2010). Cost per capita in Region North lies 18% above the country average, while the corresponding figure for Region West lies 12% below that average. On the other hand, per capita DRG production in Region North lies only 2% above that for the whole country. This corroborates my earlier statement that health care is more costly to provide in the north than in the rest of the country.

A comparison with Figure 1(a) also makes it clear that *interregional solidarity is a prerequisite for universal access to specialist health care*. I should add that the existence of implicit transfers across the health regions, as exemplified by Figure 1, is hardly subject of public dispute in Norway. What does make the newspaper front pages is any evidence that exists of unequal access to health care (along dimension of income, gender, ethnicity, region, etc).

Each of the RHAs owns a number of Health Enterprises (HE). A single Health Enterprise may consist of somatic hospitals, psychiatric institutions, rehabilitation institutions, hospital pharmacies. The HEs are run by a CEO and an executive board, as are the hospitals themselves. Initially, there existed 43 HEs, but later restructuring has reduced this number to 31. Though the HEs are the RHA's main tool to provide specialized health care in the region, it also enters into contractual agreements

with private hospitals, for example for providing a certain number of elective procedures. Figure 3 displays the ‘blueprint triangle’ for the specialized health care in Norway.

Figure 3. The ‘blueprint triangle’ for specialized health care in Norway.



The central government, through its yearly budget, allocates risk-adjusted grants to the four RHAs. These grants are conditional on the size of the population residing in the region and its age composition. In 2010, 60% of an RHA’s income was made up of this grant. The remaining 40% comes through the Activity Based Financing (ABF) scheme. This is a prospective reimbursement scheme that covers 40% of the costs of somatic specialist health care services. Based on historical cost and activity data, the relative costs of the different DRGs are computed. Per DRG point that is produced within its region, the RHA receives a reimbursement of 40% of this rate.⁶ The fact that the RHAs are reimbursed below marginal cost gives them incentives to exert cost reducing effort. Although the RHAs have full discretion how to finance the different RHEs they own, in practice they apply principles similar to the ones on which their own income was based: needs-corrected block grants and ABF for somatic specialist care.

Specialists that have a contractual agreement with the RHA are paid an annual working grant to cover expenses related to equipment. On top, they receive a copayment from the patient and a fee-for-service from the NIS.

3. Patient rights and out-of-pocket payments

Patient out-of-pocket payments per consultation are relatively high: 136,-NOK (17,-€) when seeing a regular GP, 180,-NOK (22,5€) when seeing a GP specialized in general medicine, and 307,-NOK

⁶ In 2010, the unit price for one DRG point was around 36 000,-NOK (4 500,-€). The fee-for-service was therefore 14 400,-NOK (1 800,-€) per DRG point.

(38,-€) when seeing a specialist.⁷ But once a patient's copayment in a calendar year exceeds 1880,- NOK (235,-€), she gets exempted from further copayments for that year (and the GP receives the equivalent amount from the NIS). Specialist health care delivered when admitted to the hospital is free. Since GPs act as gatekeepers to specialist health care, copayments are not deemed necessary to ration this kind of care. Some co-payments are charged for polyclinical treatments. In case a patient chooses a private hospital treatment that is not encompassed by a contractual agreement between the RHA and the private hospital, the patient pays the full cost.

A salient characteristic of specialized health care in Norway is the existence of waiting lists for elective treatments. For example, within somatic care in 2009, the median waiting time was 49 days. In the same year, 1/3 of the hospitalized patients had to wait for more than 2 months for admission (Helsedirektoratet 2010: 166). Thus, while in-hospital treatment is free, patients often 'pay' in the form of a waiting time.

Patient choice for primary care is restricted in the sense that (i) she can switch GP at most twice a year, and (ii) she needs a referral to see a specialist. A patient that is referred to specialist hospital care has the right to free choice of hospital, not only within the health region she belongs to, but also across health regions. She also has the right to get an evaluation of her medical condition and an assessment whether this condition qualifies for a treatment within an individual specific time limit. Patients have, in other words, the right to be evaluated for a priority class. Four classes can be distinguished:

- 1 Acute care (requiring immediate treatment);
- 2 Elective treatment with an individually specific maximum waiting time;
- 3 Elective treatment without an individually specific maximum waiting time; and
- 4 Other treatment.

Each Regional Health Authority has issued medical guidelines to categorize patients and to assess the maximum waiting time to treatment. Upon referral of a patient, the hospital has to inform the patient within 30 days to which priority class she is allocated, and in case of class 2, a deadline within which treatment will be initiated. In case this deadline is trespassed, the patient may demand treatment elsewhere, in a private hospital, or abroad, at the cost of the Health Enterprise that failed to initiate a timely treatment.

Patients can consult a national information service (www.frittsykehusvalg.no — free hospital choice) that lists per treatment the hospital assessments of the expected number of weeks that lowest priority class patients (i.e., class 3) will need to wait for further diagnosis, polyclinical treatment and/or hospital admission. The service also provides information about four hospital quality indicators: (i) the percentage of 'corridor patients', i.e., patients that due to space constraints may have their bed placed behind a screen in a corridor, or in other rooms that are not defined as bedrooms; (ii) the number of hospital infections as a percentage of the number of hospitalized patients, (iii) the number of operations that were postponed as a percentage of the total number of planned operations, and (iv) the percentage of patient reports that are sent to the patient's GP within 7 days of dismissal.

4. An assessment

The current health care system in Norway is the result of two reforms to make the provision of health care more efficient but at the same time preserving the right to equal treatment. In primary health care, the Regular GP reform of 2001, gave patients the right to be attached to a specific GP of their own choice. In specialized health care, the Hospital Reform of 2002 transfers the ownership of public hospitals from the counties to the RHAs.

⁷ These are the 'office hours' rates for 2011. Evening rates are about 60% higher.

For both types of health care, a distinguishing feature is that the provider and the payer are intertwined. Municipalities have the responsibility to provide access to primary care, and enter into contractual agreements with GPs for provision of this care. Likewise, the RHA are responsible to provide access to high quality specialist care, which is provided by the HEs they own, and by private hospitals with which they have entered into a contractual agreement. Both public entities are financed through risk-adjusted grants from the central government.

The Regular GP reform has received a positive evaluation (Goddager, Iversen and Lurås, 2007). After the introduction of the patient registration system in 2001, waiting times to see a GP show a clear downward trend, and the share of patients receiving the opportunity to see their GP the same day when making the call, has increased steadily.

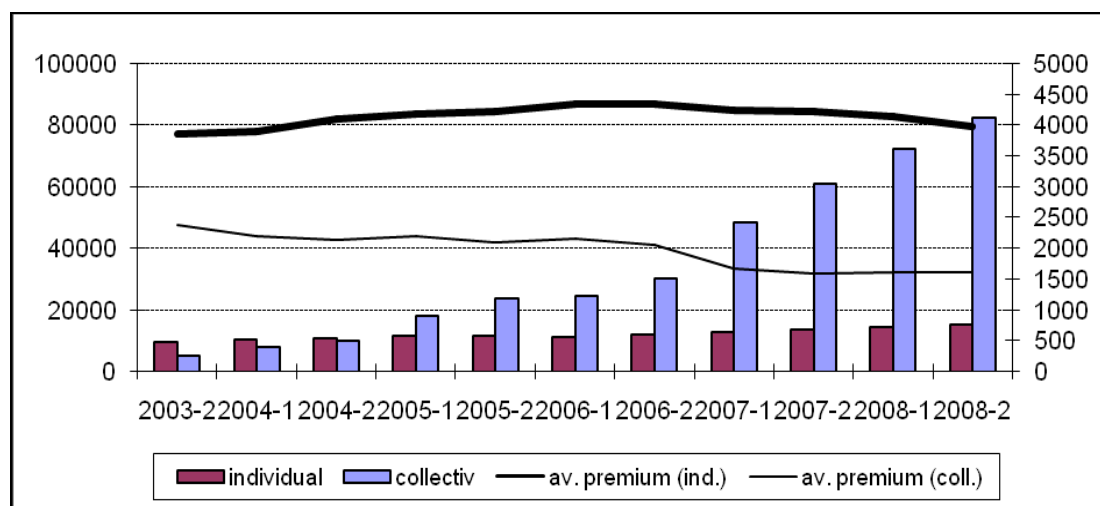
The 2002 Hospital Reform consisted of two components: (i) it established the four RHAs as legal entities that are owned by the Minister of Health, and (ii) it transferred the hospital ownership rights from the 19 counties to these RHA. The arguments for the centralization of provision are the low population density in some counties, and the possibility to exploit increasing returns to scale in the provision of specialized care. But what has been seen as problematic is the double role of the RHAs (and for that matter of the counties before the reform): these entities *order* specialized health care on behalf of the population, but they also own the entities (i.e., the HE—the hospitals) that *provide* that type of care. This absence of a purchaser-provider split may be a good argument for cost efficiency and reaping scale economies, but it is questionable whether an integrated model makes the budget constraints sufficiently hard, especially with the general assembly of the RHAs and parts of the board of directors being made up of elected politicians.

Magnussen *et al.* (2007) show that although planned activity growth for the RHAs is reduced to nearly a zero rate, reflecting a desire of the government to contain overall health care costs, actual activity growth has been in recent years around 4.9%, indicating that the RHAs do not manage to stick to the policy goals of the government. This is also reflected by the fact that each year the RHAs have received supplementary funding from parliament, on average at 3% of total costs—the reform has not hardened budget constraints. A positive development is that both technical and cost efficiency measures have improved, but it is difficult to say to which extent this is due to the new ownership structure, or to the more intensive use of the Activity Based Financing scheme described in section 2. Increasing interregional equity in the supply of hospital services (quality of treatment, waiting times, prioritization) was another aim of the reform. Data from the National Patient Register indicate that during the first three years after the reform, the regional variation in waiting times indeed has been reduced. On the other hand, several studies have concluded that regional variation in the use of hospital services has not seen a significant reduction. Askildsen *et al.* (2010) have compared the prioritization practices in the five health regions with the medical guidelines on prioritization. They find no evidence for centralization of ownership to have led to more equal prioritization practices across the health regions, though they do find a convergence in prioritization practices within RHA. They conclude that centralization of ownership is not sufficient to guarantee equal access to specialized health care across regions, but that the new management structures work well to implement more equality of access within the regions.

In recent years, Norway has witnessed the development of a market for private health insurance. This can be seen as an expression of dissatisfaction with the current state of the public health care sector by (part of) the population. Figure 4 shows the evolution of the number of insurance policies and the average premium levels (1 NOK= 0,125€). In addition to the 98 000 people covered by the end of 2008, one should add another 55 000 that were covered by Vertikal Helse, a representative for Lloyds of London. It is especially the collective (and employer paid) contract segment that has grown fast. These policies guarantee treatment in a private Norwegian or foreign hospital within 28 days (or less).

Aarbu (2010) finds that the presence and length of waiting lists, together with people's income, are the main drivers for private health insurance demand. The rising living standard and the fact that health care is a normal good means that more and more people are no longer willing to face the risk of having to wait months for surgery. Though there may be good arguments for having a mixed health care system,⁸ the fear that private markets for health insurance and health care may crowd out the legitimacy of the publicly provided and tax financed health care sector is a serious one.

Figure 4. The Norwegian market for private health insurance (2003-2008)
Number of contracts (left axis) and average yearly premium (right axis — in NOK).
Source: Hagen and Schroyen (2009).



5. Lessons for Belgium?

The Belgian health care sector has evolved very differently from the Norwegian one. Most providers of health care are private, and there are explicit third-party payers present—the sickness funds. Moreover, Belgium does not face the geographical challenges that exist in Norway. What both systems have in common are (i) income based contributions to finance health care, (ii) risk-adjusted government payments (to the Regional Health Authorities in Norway, to the sickness funds in Belgium), (iii) highly qualified medical personnel, and (iv) patients that are looking for the best type of care. So what can be learned from the Norwegian experience?

Should Belgium move into the direction of an NHS type of system, then one of the lessons from the Norwegian reform is that it is important to restrict the political influence to the determination of the overall goals, but leave it to the regional provider authorities to reach these goals in the most efficient way. Any political influence at the provider level will soften budget constraints and lead to inefficiencies. This calls for a purchaser-provider split.

Irrespective of the organizational structure, I believe it is important that a sector that makes up 10% of a country's GDP, and that is mainly tax-financed, should be as transparent as possible to all the stakeholders: regulators, managers, physicians, and not least, citizens/patients.

Transparency is a necessary condition for controlling or regulating the sector, and for its users and providers to make the right choices. This means that good data material should be collected and made available. I conclude by giving four examples of data material that is collected or considered to

⁸ See, e.g., Marchand and Schroyen, 2005.

be collected in Norway, thereby implicitly asking the question to which extent similar initiatives exist in Belgium:

1. In 1997, Norsk pasientregister (NPR—Norwegian patient register) was established. It included de-individualized data on all patients that wait for treatment or that have received specialized care treatment in a particular year. Its aim is (i) to make management decisions on informed grounds, including the correct remuneration of the hospitals (ABF); (ii) to allow the establishment and quality check of illness registers and registers on hospital quality indicators, and (iii) to contribute to medical and medical-administrative research. Since 2007, parliament decided the register should be transformed into a coded register with personal identification, such that treatments that exceed one year, or that take place in different hospitals can be traced back to the same patient, and such that the data can be linked to other datasets using the national registration number.
2. On the basis of NPR, the Norwegian Health Directorate runs the SAMDATA project. SAMDATA is the acronym for "SAMmenlikningsDATA for spesialisthelsetjenesten"—comparable data for specialized health care. It produces key figures for the entire sector, as well as sector reports for somatic health care, mental health care, and interdisciplinary substance abuse care. The key figure report contains for all regions and hospitals detailed information on cost and activity levels, sources of finance, personnel and bed capacity, waiting times.
3. At the time of writing, a committee of experts appointed by the government has evaluated the information available to patients and GPs about hospitals (cf the national information service www.frittsykehusvalg.no discussed in Section 3). It concluded that this information is insufficient to make an informed free hospital choice, and urges to supplement it with objective information on diagnose and treatment quality (e.g., survival time after cancer treatment), and patient evaluations of hospital treatment. All information should be made available on an easily accessible 'health portal' (Teknologirådet, 2011). Fortunately, Belgian hospitals have very short waiting lists, but they do differ in their use of supplementary fees. Clear information on these supplements would obviously belong to such a health portal.
4. All annual reports, balance sheets and profit and loss accounts of the Regional Health Enterprises are electronically available. At the time of writing, a check of the web page of Helse Bergen (one of the HEs in Health Region West) showed that this information was already available for 2010, while the most recent annual report for the Antwerp hospital group ZNA electronically available is that for 2008, and the key figures date back to 2007.

References

Aarbu KO (2010) Demand patterns for treatment insurance in Norway, NHH Discussion Paper SAM 11/2010.

Askildsen JE, TH Holmås and O Kaarbøe (2010) Prioritization and patient's rights: analyzing the effect of a reform in the Norwegian hospital sector, *Social Science and Medicine* 70, 199-208.

Godager G, T Iversen and H Lurås (2007) Fastlegeordningen: utvikling i bruk, tilgjengelighet og fornøydhet (*The patient registration system: developments in use, accessibility and satisfaction*). HERO Working Paper 2007:6.

Hagen KP and F Schroyen (2009) 'Helseforsikring i velferdsstaten — historikk og prinsipper' (*Health insurance in the welfare state — history and principles*), ch 24 in K Haug, O Kaarbøe and T Olsen (eds.) *Et helsevesen uten grenser?* Cappelen Akademisk Forlag, 2009.

Helsedirektoratet (2010) SAMDATA Spesialisthelsetjenesten 2009 (Oslo: Helsedirektoratet) (available at http://www.helsedirektoratet.no/vp/multimedia/archive/00300/Samdata_spesialisth_300999a.pdf)

Johnsen JR (2006) *Health systems in Transition: Norway*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2006.

Magnussen J, TP Hagen and OM Kaarbøe (2007) Centralized or decentralized? A case study of the Norwegian hospital reform, *Social Science and Medicine* 64, 2129-2137.

Marchand M and F Schroyen (2005) Can a mixed health care system be desirable on equity grounds?, *Scandinavian Journal of Economics* 107, 1-23.

Schokkaert E and C Van de Voorde (2011) Belgium's health care system: should the communities/regions take it over? Mimeo, Re-Bel Initiative.

Teknologirådet (2011) Pasientenes behov for kvalitetsinformasjon på nett (*Patients' need for information on quality on the internet*), *Fra rådet til tinget* 30 (april 2011).

Health care reform in Belgium: Going Dutch or waiting for Godot?

Erik Schut (Institute of Health Policy & Management, Erasmus University Rotterdam)

Ten years ago

More than ten years ago a comparative study of the Belgian and Dutch health care systems concluded that both countries were moving towards a greater financial responsibility of health insurers by means of risk-adjusted payment systems (Schut and Van Doorslaer 1999)¹. As explained in this study, however, this common trend was driven by rather different underlying rationales. Whereas in the Netherlands the increase in financial accountability of health insurers was part of a longer term vision and reform plan - based on the model of “regulated competition” – in Belgium reinforcing the role of the market had never been used in any Belgian official government policy document. Instead, prospective risk-adjusted payments for health insurers had always been present in the Belgian health insurance legislation, but this provision was not enforced until 1995 because the original budget formula was widely perceived as fundamentally inequitable.

In both countries health insurers had very limited room and hardly any tools to influence the efficiency of health care provision. In the Netherlands, the lack of conclusive empirical evidence about the effects of regulated competition made successive governments reluctant to ‘hand over’ or to give up traditional cost containment tools (price regulation, supply rationing and entry regulation). In Belgium, such a ‘jump in the competitive dark’ was not even seriously discussed or considered.

But then, of course, the question was what would be the rationale of making health insurers financially accountable without providing them with tools to take on this accountability? The answer in this study was that only providing health insurers with appropriate incentives, but not with accompanying appropriate tools to manage care is rather useless and illogical (Schut and Van Doorslaer 1999).

What changed since then?

What’s the situation in both countries ten years later? What changed since then? Have insurers been provided with more tools to manage care? And, if so, is there any empirical evidence on the effects of this?

The current Belgian situation – as described by Schokkaert and Van de Voorde – seems to be very much the same as a decade earlier. Health insurers are still at limited risk for the health care expenses of their enrollees. Just as ten years ago, 30% of total budget for health insurers is allocated on a prospective basis and the amount of financial responsibility is still limited to 25%, though the risk equalization method has been substantially improved. Perhaps the most important change has been the gradual increase in the use of so-called “managed care” techniques, though – as noted by the authors – in Belgium this term is still taboo. Schokkaert and Van de Voorde are quite confident that due to the continuous pressure to control health care cost inflation the trend in the direction of

¹ Instead of “sickness fund” most of the time the more general term “health insurer” is used.

managed care will persist. Despite the increasing use of managed care techniques, however, the role of individual health insurers is not very much different from a decade earlier. Individual health insurers are still deprived from the necessary tools – such as selective contracting – to manage care. As stated by the authors, all the regulatory competencies have stayed with the government and with the complex structure of deliberative bodies within the RIZIV/INAMI, and the cartel of sickness funds may even have an incentive to raise rather than reduce health care expenditure.

In the Netherlands, a major step in the direction of managed competition was set by the introduction of the Health Insurance Act (ZVW) in 2006. By the introduction of the Health Insurance Act the dual system of mandatory public insurance (for about two-thirds of the population) and voluntary private insurance has been replaced by mandatory private health insurance for everyone. Dutch citizens are required to pay an income-related contribution to a Risk Equalization Fund (REF), covering 50 percent of total expenditure, and a community-rated premium to their chosen health insurer. Children aged below 18 are exempted from paying premiums. Their expenses – around 5% of total expenditure – are paid for by general taxation (and allocated to health insurers via the REF). In addition, two-thirds of Dutch households receive a monthly income-related allowance from the government to make community-rated premiums affordable. An important aim of the reforms is to provide health insurers with appropriate incentives and tools to act as prudent buyers of health care on behalf of their customers. Individuals can choose between insurers on an annual basis (open enrolment) and insurers can selectively contract or integrate with health care providers.

Since the introduction of the Health Insurance Act the focus of health policy has shifted towards reforming the provider market, by creating more room and instruments for insurers to take up their envisioned role as prudent buyer of health services. In the hospital sector, freely negotiable prices were introduced in 2005 for a number of routine hospital procedures (e.g. hip, knee, cataract and inguinal hernia operations), accounting for about 10% of total hospital expenditure. This free pricing segment (known as B-segment) was gradually expanded to about 20% of hospital expenditure in 2008 and to about 34% in 2009. For the rest of the hospital services (known as the A-segment), hospitals still receive a global budget, based on a set of crude parameters determined by the Dutch Healthcare Authority (NZa). In 2005, price regulation was terminated for physical therapists, in 2009 for dieticians and in 2012 this will also be the case for pharmacy services. Since 2010 primary care groups and health insurers are allowed to negotiate integrated (or bundled) payments for providing coordinated care to people with specific chronic diseases (diabetes, vascular risk management, COPD). By contrast, the remuneration for medical specialists is still tightly regulated, though in 2008 the payment structure for self-employed medical specialists was drastically changed from an annually adjusted lumpsum payment per hospital to a fixed payment per Diagnostic Treatment Combination (in Dutch abbreviated as DBC)². The 2006 health care reform also was an important catalyst for the development of performance indicators, both for health insurers and hospital care (Schut and Van de Ven 2011). In 2007, the Health Care Inspectorate set up an ambitious programme (Transparent Care) to develop reliable, comparable and valid information about the quality of hospital care for patients, health insurers, health care providers and policy makers. In 2008, the process of implementing comprehensive sets of indicators (including various structure, process and outcome indicators) was started for 10 diseases (e.g. diabetes, hip and knee replacement, breast cancer) in 33 hospitals. The objective is to expand the implementation of such indicator sets to about 80 diseases for all hospitals in 2011.

Despite these changes, the supply side is still quite heavily regulated, and it is fair to say that with regard to the provider market the year 2006 marks the beginning rather than end of the reforms.

² This fixed payment is derived from a regulated price per hour and a fixed normative working time per DBC. Notice that this change in payment structure provided medical specialists with strong incentives to produce extra services.

Dutch evidence so far

Schokkaert and Van de Voorde argue that at this stage, the model of regulated competition is only a theoretical blueprint, and that given the limited amount of available evidence moving in that direction is merely based on the “belief” that in practice the model would work as in theory. The suggestion that this is just a matter of belief may not do justice to the well-thought consistent framework underlying this model which is partly based on empirical observations, such as the performance of integrated delivery systems like HMOs (Health Maintenance Organizations). Therefore, it is at least plausible that the model might work in practice if all the required preconditions are met. Of course, the proof of the pudding is in the eating. Given that in the Netherlands considerable progress has been made in the direction of the theoretical blueprint of regulated competition, empirical evidence is growing. Early experiences with the new Health insurance Act were formally evaluated in 2009 and are discussed in two recent papers (Boonen and Schut 2011, Schut and Van de Ven 2011).

Competition among health insurers

What’s the evidence so far? First, the reforms seem to have induced significant price competition among health insurers. As a result, health insurers incurred substantial losses on providing basic health insurance coverage during the first three years of the reforms. In 2007 and 2008 these losses were largely compensated by profits on supplementary insurance and, in 2007, also by positive investment results. In 2009 basic health insurance was profitable for the first time. The strong price competition triggered a rapid consolidation of the health insurance market. Mergers seem to be primarily driven by the pursuit of scale economies in administration and by increasing regional buying power vis-à-vis health care providers. In 2010, the four largest health insurers had a joint market share of almost 90 percent. The other six independent health insurers all participate in a purchasing cooperative (Multizorg VRZ) to jointly negotiate and contract with health care providers. Hence, health care providers typically negotiate contracts with only five different purchasers. In this respect, the structure of the Dutch health insurance market has become quite similar to the Belgian health insurance market, which is dominated by five large sickness fund associations.

Are health insurers becoming effective purchasers?

The key question, of course, is whether health insurers take up their proposed role as prudent buyers of health services. So far, the results of the reforms appear to be mixed. On the one hand, there is evidence that health insurers increased administrative efficiency and were able to constrain prices of hospital services and outpatient prescription drugs. Over the period 2006-2009, health insurers have been able to reduce administrative costs per subscriber by about 20 percent (to about 3.2% of total costs in 2009) (Vektis 2009, 2010). In addition, health insurers have been able to constrain the prices for hospital services in the free pricing segment (B-segment). Since 2006 the prices of these hospital services have gone down in real terms, up to 3.3 percent in 2010 (NZa 2011). Competition among hospitals increased due to the entry of a substantial number of freestanding clinics (ZBCs). The average price charged by the fast growing number of these clinics is about 14% lower than the total average price of the freely negotiable hospital services. Perhaps the strongest effect of the reforms so far, has been the downward pressure on generic drug prices (Boonen et al. 2010). The Health Insurance Act allowed health insurers to use preferred drug formularies. In 2008 four of the then five biggest health insurers started to experiment with preferred drug formularies for the lowest priced generics within the same therapeutic class. This means that if a patient chooses a non-preferred drug, the cost of the drug is no longer reimbursed by the insurer. To select preferred drugs health insurers issued tenders for several high-volume generic drugs, which had a dramatic effect on the prices of generics. List prices of the ten biggest-selling generics fell by between 76 and 93 percent, leading to aggregate savings estimated at €348 million (69 percent) per year (Boonen et al. 2010). In 2009, for the first time total expenditure on outpatient prescription drugs covered by basic health insurance dropped by 5 percent, from 4.0 to 3.8 billion euros (NZa 2010).

On the other hand, although empirical evidence is limited, it has been argued that the reforms have raised administrative costs for providers due to the increasing number of contractual arrangements, the introduction of a highly complex product classification system (DBC-system) and the increasing information requirements from supervisory bodies (e.g. NZa, IGZ) and health insurers. In addition, it is argued that the reforms have resulted in (unnecessary) supplier-induced demand and upcoding of DBCs. Despite the reduction of real prices in the free hospital segment, total hospital expenditure increased by about 4 percent per year in real terms. According to the NZa (2011) it is not possible to disentangle hospital revenue growth in price and volume effects because of the gradual expansion of the free pricing segment and the recalculation of the hospital budgets for the regulated segment. Therefore it is not clear whether the production of hospital services in the free segment grew faster than the production in the regulated segment. What is clear, however, that health insurers still contract with all hospitals and primarily negotiate about price. Health insurers have been very reluctant to engage in selective contracting and preferred to use 'soft' positive incentives to encourage enrolees to visit 'preferred' hospitals rather than restricting choice to limited provider networks. Insurers' reluctance to use selective contracting can be at least partly explained by the presence of a credible-commitment problem (Boonen and Schut 2011). Since consumers do not trust that insurers with restrictive networks are committed to provide good quality care, insurers fear that a "managed care backlash" might harm their reputation if they restrict provider choice.

In sum, the general picture is that so far health insurers have been effective in constraining prices but not in enforcing a more efficient utilization of health services.

What about equity?

The increasing role of competition in health care does not seem to have had a negative impact on equity and access to health care facilities. On the contrary, the inclusion of the former private health insurance sector into a universal mandatory health insurance scheme, may well have increased equity. Since 2006, all citizens are entitled to a broad basic benefits package at an affordable premium and are mandated to pay an income-related contribution. Out-of-pocket payments still are the lowest within the OECD (Journard et al. 2010). Despite deficiencies in the risk equalization scheme, there is limited or no evidence of risk selection (Roos and Schut 2011), although some forms of risk selection (e.g. no investments in care for chronic patients for which insurers are not sufficiently compensated) may be difficult to detect. Furthermore, since 2006 hospital waiting lists have been reduced, and for almost all citizens all relevant health care facilities are available at short distance. Hence, the 2006 reforms have been successful in combining competition and equal access.

What next?

From a Dutch perspective, the Belgian health care system gives the impression of a stalemate system. Nevertheless a sense of urgency seems to be growing that the status quo cannot be maintained. As argued by Schokkaert and Van de Voorde, it is obvious that Belgium urgently needs to develop a coherent long-run vision on the decision structures with its health care system. But it is not clear whether this sense of urgency is also present among stakeholders. The authors themselves are quite superficial about what causes this urgent need. They state that the complicated structure of decision making – in which decisions are taken by the government after going through a complex web of advisory bodies – may have functioned rather well in the past, but need to be reformed in the light of the challenges for the future. But they provide surprisingly little evidence about what is wrong with the current system and why the system is not sustainable and should be reformed. The current system is described as being nontransparent, susceptible for short run political interests and suffering from coordination problems. These deficiencies do not seem to be new, however, and it is not clear in what way the current system is underperforming or which challenges cannot be faced without reform. Is the main problem a lack of incentives for efficiency, high administrative costs, a lack of control on total or public health care expenditure, a relative poor performance in terms of outcomes and quality, or growing inequalities in health or access to care (Journard et al. 2010)? Why would simply muddling

through – as in the past decade – not be an adequate policy option for the future? Of course, a Re-Bel without a convincing cause would not easily persuade policymakers that changing the status quo is really needed.

In the Netherlands, the health care system is halfway in the direction of regulated competition. A group of civil servants that had to investigate the prospects of reducing the growth of public health care expenditure in view of the worldwide financial crisis, characterized the current situation as being “*stuck in the middle*” between a centralized system of state control and a decentralized system based on regulated competition (De Kam et al. 2010). According to these civil servants, this situation may lead to the worst of both worlds because it would render the traditional tools of price and supply regulation less effective, while, at the same time, providing health insurers with insufficient incentives and tools to actively manage care. Based on this observation, in March 2011 the new Coalition cabinet launched a proposal to substantially expand the role of the market in the hospital sector, by doubling the share of the free pricing segment from 34 to about 70 percent of total hospital revenues in 2012. In addition, the current ex-post compensations for health insurers have to be phased-out from 2012 to 2014, which will raise the financial risk for health insurers from 75 to 100 percent of total health care expenditure covered by the Health Insurance Act (excluding expenditure for mental health care). At first glance, the government plans can be considered as an attempt to make a decisive step towards a full implementation of the model of regulated competition. However, at the same time the room for competition is severely restricted by the imposition of a macro budget for the entire hospital sector. If total hospital revenues exceed the imposed budget limit, hospitals will have to repay the excess revenue in proportion to their respective share of the market. Contrary to the current system of hospital budgeting, the margin of individual hospitals does not only depend on their own performance but also on the performance of other hospitals. This inconsistent model may result in strategic anticipatory price increases by hospitals (particularly in the relatively weakly competitive regions), and may therefore jeopardize both competition and cost control (Schut et al 2010). Achieving more efficiency by enlarging the role of the market does not seem compatible with the political craving for budgetary certainty.

Is Belgium going Dutch?

Despite their statement that any move towards regulated competition in health care is merely based on belief, Schokkaert and Van de Voorde “think that it would be wise to take cautious steps in this direction.” Apparently, they share themselves among the believers, albeit they stress this is not a plea to install quickly the Dutch system in Belgium. As argued above, however, even the Dutch system is still only halfway in the direction of regulated competition. And the empirical evidence, so far, may not convince “non-believers”, since depending on the interpretation of the evidence the glass may be viewed to be half empty rather than half full (Schut and van de Ven 2011).

“All in all”, Schokkaert and Van de Voorde conclude, “there seems to be sufficient evidence that a move towards more managed care is likely to be beneficial (if well designed) and that insurers may play an active role in that move.” Nevertheless, the authors are quite cautious in recommending handing over the role of managing care to health insurers, and they don’t see a role for private health insurers as in the Netherlands. Their vigilance is based on the fear that a stronger reliance on extrinsic (financial) incentives, may destroy the current commitment of health insurers to values as solidarity and equity. The authors believe that these intangible aspects are essential, although they admit this is also a “belief” because there is hardly any literature on the behavior of non-profit sickness funds in the European tradition. Also in this area, however, some empirical evidence is emerging. A recent empirical study about pricing behavior of non-profit Dutch sickness funds over the period 1996-2004 (i.e. prior to the reforms), found support for the authors’ belief that (competing) nonprofit insurers do not behave as profit maximizers (Douven and Schut 2011). But also after the 2006 reforms, Dutch health insurers still seem to behave in a socially responsible way. In spite of the fact that strong price competition increased incentives for insurers to use supplementary health insurance as a tool for risk

selection in basic insurance, no evidence was found that supplementary health insurance has been used that way (Roos and Schut 2011). Only a minority of health insurers uses health questionnaires when people apply for supplementary coverage. Remarkably, since 2006 the remaining for-profit private health insurers sold their health insurance business to non-profit insurers (or, as in the case of Fortis ASR, were taken over by the State). Although formally Dutch health insurers are private insurers, currently all of them are not-for-profit entities (either mutual companies or cooperatives). Still, as explained earlier, many Dutch people do not trust that health insurers are committed to act in their interest, which is seriously hampering insurers to engage in selective contracting and in managing care (Boonen and Schut 2011). Given that Schokkaert and Van de Voorde apparently take a minority position in recommending a larger role for health insurers in managing care, the distrust towards health insurers may well be even larger in Belgium than in the Netherlands. This may imply that also for an effective agency role of health insurers, relying primarily on extrinsic incentives may be counterproductive. Hence, in organizing health care systems it may be wise to strike a balance between shaping an appropriate extrinsic incentive structure and strengthening important intrinsic incentives. Due to different value systems, this balance is likely to be different in different societies. As the contribution by Schokkaert and van de Voorde makes clear, more research in this area is imperative.

Obviously, the social support in Belgium for going in the Dutch direction seems to be very thin. Moreover, as explained above, it is not even clear where precisely the Dutch are going to. Nevertheless, rather than keep waiting for Godot and maintaining the current illogical health care financing system for another ten years, Belgian politicians would be wise to follow the careful and cautious Re-Bel's recommendations.

References

Boonen, L.H.M.M., S.A. van der Geest, F.T. Schut, M. Varkevisser (2010), [Pharmaceutical policy in the Netherlands: from price regulation towards managed competition](#), in A. Dor (ed.), *Pharmaceutical markets and insurance worldwide*, Advances in Health Economics and Health Services Research 22, Emerald, Bingley (UK): 53-76.

Boonen, L.H.M.M., F.T. Schut (2011), [Preferred providers and the credible commitment problem in health insurance: first experiences with the implementation of managed competition in the Dutch health care system](#), *Health Economics, Policy and Law*, 6(2): 219-235.

De Kam, C.A. J.H.M. Donders, A.P. Ros (red.) (2010). Miljardendans in Den Haag. Over bezuinigingen en belastingen, Sdu Uitgevers, Den Haag.

Douven, R.C.H.M., F.T. Schut (2011), [Pricing behaviour of nonprofit insurers in a weakly competitive social health insurance market](#), *Journal of Health Economics*, in press, published online, DOI: 10.1016/j.jhealeco.2010.12.006.

Journard, I., C. André, C. Nicq (2010), *Health care systems: Efficiency and institutions*, OECD Economics Department Working Papers No. 769. Paris: OECD.

NZa (2010), Monitor Extramurale farmacie 2010, Nederlandse Zorgautoriteit, Utrecht.

NZa (2011) Marktscan Medisch specialistische zorg. Weergave van de markt 2006-2010, Nederlandse Zorgautoriteit, Utrecht.

Roos, A.-F., F. T. Schut (2011), [Spillover effects of supplementary on basic health insurance: evidence from the Netherlands](#), *European Journal of Health Economics*, in press, published online, DOI 10.1007/s10198-010-0279-6.

Schut, F.T., E.K.A. van Doorslaer (1999), Towards a reinforced agency role of health insurers in Belgium and the Netherlands, *Health Policy* 48: 47-67.

Schut, F.T., W.P.M.M. van de Ven, M. Varkevisser (2010), [Prijsconcurrentie gaat niet samen met macrobudget ziekenhuizen](#), *Economisch Statistische Berichten* 95 (4587): 374-376.

Schut, F.T., W.P.M.M. van de Ven (2011), [Effects of purchaser competition in the Dutch health system: is the glass half full or half empty?](#), *Health Economics, Policy and Law* 6(1): 109-123.

Vektis (2009), *Zorgverzekeraars en –financiering. Jaarcijfers 2009*, Vektis, Zeist.

Vektis (2010), *Zorgverzekeraars en –financiering. Jaarcijfers 2010*, Vektis, Zeist.

Reply

Erik Schokkaert & Carine Van de Voorde

Reply to Comments

Erik Schokkaert & Carine Van de Voorde

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.

Also in the Re-Bel e-book series

Re-Bel e-book 1 | Published April 2009

On the interaction between subsidiarity and interpersonal solidarity

Lead piece: Jacques H. Drèze

Editor: André Decoster

Re-Bel e-book 2 | Published April 2009

Does it make sense to regionalize labour market institutions?

Lead piece: Jean-Claude Marcourt & Frank Vandenbroucke

Editors: Bart Cockx & Bruno Van der Linden

Re-Bel e-book 3 | Published June 2009

Public Opinion in a Multilingual Societ. Institutional Design and Federal Loyalty

Lead piece: Nenad Stojanovic

Editors: Marc Hooghe & Dave Sinardet

Re-Bel e-book 4 | Published June 2009

Electoral engineering for a stalled federation

Lead piece: Kris Deschouwer & Philippe Van Parijs

Re-Bel e-book 5 | Published August 2010

Towards a more efficient and fair funding of Belgium's regions?

Editors: Paul De Grauwe & Mathias Dewatripont

Re-Bel e-book 6 | Published October 2010

What does history teach us about the future of Belgium's institutions?

Editor: Bruno De Wever

Re-Bel e-book 7 | Published November 2010

What does geography teach us about the future of Belgium's institutions?

Contributions: Jacques-François Thisse and Isabelle Thomas, Patrick Deboosere, Paul C. Cheshire, Bea Cantillon, Seppe De Blust and Aaron Van den Heede

Re-Bel e-book 8 | Published February 2011

Educational Divergence. Why do pupils do better in Flanders than in the French Community?

Lead Piece: Vincent Vandenberghe

Re-Bel e-book 9 | Published February 2011

Social Federalism: how is a multi-level welfare state best organized?

Lead Piece: Patricia Popelier, Bea Cantillon, Ninke Mussche

All Re-Bel initiative e-books are freely available for download
on www.rethinkingbelgium.eu