VUB crosstalks

A perspective through the national health objectives

OBJECTIVES AS SIGNPOSTS

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This is a personal record of the Crosstalks round table held in the context of the *Shake the Disease* project, initiated in 2018 to maintain an open dialogue on the future of health and health care. Following a short introduction by UZ Brussels CEO **Marc Noppen, Ann Ceuppens**, a surgeon by training, director of the Research Department of the Independent Health Insurance Funds (*Onafhankelijke Ziekenfondsen*) and chair of the Health Care Objectives (*Gezondheidszorgdoelstellingen*) Taskforce outlined the societal challenges of the existing health care and health insurance system, and how the national health objectives create the framework for the next multi-annual budget.

The Crosstalks conversations take place each time in inspiring, sometimes less well-known, places that are relevant to health care. This time it was the Health House, a multimedia centre where visitors can learn about the future of health and care. Through very diverse stories and on dozens of interactive screens, visitors can gain an idea of the impact on health care of technologies such as artificial intelligence, 3D printing, wearable and nanotechnology, intelligent algorithms, and deep learning and neural networks. The image these offer was confronting and challenging. Is this the health care - with lots of 'cold' technology - that we want? Where are the autonomous, pro-active patients who co-determine their care paths and how can this process be best supported with the latest technological gadgetry?

From tour to round table

This small plunge into the future of health and health care was an inspiring prelude to a round table on the healthcare objectives which currently serve to point the way forward in Belgian healthcare reform.

Health objectives are important points on the horizon, crucial in a strategic story that will ultimately lead to a concrete and widely supported transformation aimed at providing further health gains for the population as a whole. Our country's highly complex structure makes this exercise even more complicated, but no less essential. As chair of the relevant task force, Ann Ceuppens is ideally placed to explain the working methods, principles and the current state of affairs.

The current state of health & care

Belgium scores well in terms of population health, accessibility of care and efficiency of the system. But that should not be allowed to hide the pain points. Our life expectancy is high (81.6 years), but with large disparities depending on socio-economic status. The inequality gap is deep. Low-educated women live four years less than highly educated ones, low-educated men almost six years less than their highly educated colleagues. About 90% of Belgians in the top income groups state that they are in good health, compared to 60% in the lowest income categories. High incomes quickly find their way to the necessary care, which is easily accessible, while 7% of people living on small budgets talk of unmet medical needs. When it comes to dentistry, the differences become very sharp: more than a quarter of low socio-economic status (SES) families have at least one child who really ought to be receiving dental care. In this point Belgium scores very badly in the EU. We score better than the European average when it comes to treating diseases (thus reducing mortality) but we perform worse in preventing them.

Friction points

In the 2019 the KCE (Belgian Health Care Knowledge Centre) report *Performance of the Belgian health system* the conclusions are clear. There is still a lot of room for improvement by, among other things, combating overconsumption, avoiding inappropriate care, and eliminating variations in practice. Preventive care deserves more attention. Mental health is in bad shape and mental health care shows ominous gaps. The quality of care in residential facilities varies widely. We are faced with a shortage of medical personnel. The complex state structure does not make things any easier.

Corona is proving a hard teacher in all this. For almost two years now, the pandemic has been highlighting the vulnerabilities in all social systems, especially in health care. GPs are overloaded while hospitals need more and better hands at the bedside. Prevention could have tackled the problems before they became so large, while the lack of (multidisciplinary) cooperation is manifesting itself.

A (Canadian) chart from April 2020 shows the classic course of pandemics, including a fourth wave that is being driven by mentally disengaged citizens, in this case healthcare staff, where illness, burnout and delayed care are taking their toll. The chronically ill suffer even more than others, being the first to experience the consequences of the loss of physical consultations, personal contact and the slowly accumulating consequences.

Conceptual framework

All this is the background against which the KCE developed its conceptual framework in 2017 to evaluate the Belgian health (care) objectives and to compare them with similar exercises abroad. This framework is based on four dimensions: quality, accessibility, efficiency, and sustainability. In the course of the process, a fifth was added: fairness. Particular points of attention here were the measurable results being proposed (outcomes, at macro, meso and micro level), the process required for achieving these, and the structure that needs to be put into place.

The objectives serve as a tool for coordinating all the players involved, with the patient or citizen as a crucial player and central factor. This broad commitment is necessary to ensure solid support for the thoroughgoing transformation of health care. The changes have to be supported by all levels of government and health professionals at different levels. This exercise is also impossible without the exchange and follow-up of data and *evidence-based* underpinning. The general objectives need to be translated into (smart) objectives, that is: specific and measurable, with defined time frames and embedded in a strategic long-term vision coupled to an adequate budget trajectory. Beautiful objectives will not get you very far if they are not feasible (read: affordable).

This exercise resulted in a number of recommendations: ensuring cooperation between federal and regional governments, monitoring 'health in all policymaking', integrating citizens' preferences, starting small with a limited number of objectives, and clearly identifying who can contribute what.

From policy to budget

The objectives will only become concrete if they are translated into a budgetary trajectory, which for the time being runs from 2022 to 2024. This budget is drawn up in the context of the government coalition agreement, which includes the transformation of the health system, with explicit mention of improved accessibility and alignment with (new) patient needs. The overarching goal is threefold: to reduce the health gap, avoid preventable deaths and increase healthy life years. In addition, the growth standard will be upped to 2.5% and "this growth standard will not only serve to finance the volume effect in demand, but should also permit new healthcare initiatives that help achieve the set healthcare objectives and reduce patient bills..."

The emphasis is on health*care* objectives, because these are operational objectives that fall within the domain of health

insurance. They are part of a coherent health policy aimed at a fivefold goal:

- To improve the experience of patients and caregivers at the level of **quality of care**.
- To use the available resources **more efficiently** to ensure the sustainability of the healthcare financing system.
- To achieve health equity and eliminate disparities.
- To improve the **job satisfaction (well-being)** of healthcare providers.
- To improve the **health status of the population** and in particular of the chronically sick.

Modus operandi

This plan is being worked out in three task forces (TF). The TF 'Health Care Objectives' sets the priority objectives for the 2022-2024 period and lists the initiatives for achieving them. These initiatives were submitted by the commissions responsible for negotiating sectoral accords and agreements in the health field, academia, research institutions, companies and patients, and were assessed using an evaluation tool.

The TF 'Appropriate Care' lists the priority initiatives for appropriate care with a view to their funding.

The TF 'Multi-Annual Framework' is outlining the system by which these initiatives can be funded.

These task forces are supported by a scientific committee.

This was the first time that this process was applied. It proved very demanding owing to the extensive surveying involved in a participatory model. The first results are the identification of the priority domains:

- The accessibility of health care, in all areas: financial, timing-wise, geographical, cultural, administrative and informational
- Individualized preventive care
- Structured, patient-oriented care, integrated in care pathways
- Mental health

For the first time, a transversal budget was provided for this identification process within the 124 million euros budgeted. These budget proposals include a number of essential levers for making all this happen:

- The digitization of health care: the integrated, electronic and inter-professional patient record is an absolute necessity for efficient, safe care.
- The financing models must be adapted so that greater attention is paid to prevention, patient emancipation, more appropriate care, relevant multi-disciplinarity and collaboration.

- The affordability of care can improve only with tariff certainty and an increased degree of conventionalizing.

This is a continuing story

The final report is to be delivered by the end of December 2021. This will not be an end point, but a basis on which to continue. The medium and longer-term methodology with a conceptual framework with its fivefold goals needs to be further elaborated, with a robust governance model devised. This is necessary because a coherent policy based on health care objectives must take into account the many challenges the health system faces. The exercise is therefore far from finished, but the first steps have been taken.

Questions and answers

In the ongoing participatory process, the voice of the patients is being heard. The RIZIV/INAMI pointed already back in 2014 to a high demand for care among **marginalized groups** such as prison inmates, the homeless, sex workers and undocumented migrants. In the interim report, these groups are not represented among the actors who submitted initiatives. Is there a risk that these voices will not be heard, with these populations consequently left out?

These groups are indeed not directly represented, but their needs are known and explicit attention is paid to them, especially as increasing accessibility and reducing inequality are core goals of the transformation process. In this initial phase, it is mainly the well-known actors who are visible, but the others are also on the map.

The Patient Expert Center pleads for a dashboard for each disease, designed from a patient perspective. If we were to spend 1% of the 41 billion euros spent on health care in Belgium on collecting data and processing it in dashboards, that would come down to a relatively small amount of 410 million. Wise business companies spend a similar budget on collecting data in order to work better, more rationally and more effectively. Why shouldn't our health system do the same?

Dashboards by disease prevent general health goals from being based on misinformation. In Belgium, for example, we score very well in the five-year survival rate for colorectal cancer. If that's the only yardstick, it seems like we're doing very well. But if you look at the entire cycle that the patient goes through from detection, diagnosis, therapy to remission or relapse, something else appears. With early diagnosis we only achieve half of what the Netherlands achieves. We are doing fantastic but very expensive work on the treatment of (late)

diagnosed colorectal cancers (after the patients arrive in the doctor's surgery with complaints), but without the correct figures we do not see that it would have been much cheaper and more efficient to detect and treat these people at an early stage. There are other relevant data that fit into dashboards: the large differences in success rates between different hospitals or the fact that one half of cancer patients are malnourished (which reduces their chances of recovery or survival). In the light of this kind of data, the existing cancer plan is far too general and vague. A bottom-up approach, based on the concrete practice and lives of the patients, is needed to see where the greatest health gains can be achieved, both for patient quality of life and for the health of the budget. That is why patient associations should be able to actively contribute to these health goals.

More and better use of data is part of the action plan for the health care objectives, for which such data is absolutely vital. These objectives must indeed be fleshed out at various levels. Disease-specific dashboards will take shape in a next step. Prevention is a fundamental starting point and that is why the patient perspective must find a place here.

This exercise is federal. Ideally, we need to arrive at an overarching approach in which **regional and federal levels** meet each other and work in the same way.
Would it not be better to determine at the outset what our total resources are and where we can invest them optimally? Instead of starting at the federal level (with the largest part of the task thereby falling to the RIZIV/INAMI), after which the rest is left to the other levels. We are simply stuck with the existing state structure that cannot be changed. Didn't a minister recently say that the sixth state reform has been catastrophic for health care?

Prevention is earmarked as important. Will there be incentives to keep people healthy? Well-being transcends the various specific competences and is part of primary prevention, in the first, second and third line. The first is mainly regional, while the last is mainly at RIZIV/INAMI level. Aligning what this federal report proposes and what the individual regions are doing (Flanders already has its own objectives in the field of well-being) must become a task of the future. With a concern that prevention be available to everyone and not just to those who can afford it.

Reference is made to the understandable strategy of taking small steps, tailored to what is feasible. Too much, too fast could indeed create (too much) resistance. but how do we

know whether those **small steps** are actually going in the right long-term direction?
We are now in the first phase of an evolutionary process. Moreover, using a consultation model, which makes it complex. This is just a start, and the methodology needs to reflect this as well. In these first steps, things may still look very much like they always have been (and therefore more of the same), but the vision extends beyond the next five years, years that we will need in order to effect fundamental changes.

There is a tension between strategy and reality. A concrete example is childhood obesity, one of the problem areas listed. It is an area in which a lot of gains can be made in the long term. Are there already **concrete proposals** on how to tackle this?
For the time being, cross-cutting budgets have been designated for this, with various initiatives, and it will be up to the methodology still to be developed to determine how we will deal with this in reality. This will be worked out in the final report, which should be completed by the end of the year.

Data is undeniably very important. Digitization an essential lever for making this transition possible. Is there any idea when the sharing of electronic patient records could become a reality? And what about the new Health Data authority?
In the 2022 budget, a budget (partly European, partly federal) has been provided for working on the electronic global medical dossier (GMD). This receives a lot of emphasis throughout the budget as an essential precondition for making 'appropriate care' possible. Its importance is underlined by a small but striking example: the absence of any flow of data between the hospital pharmacy and the city pharmacy. This illustrates the way care is not integrated and points to a failure to pick up opportunities that benefits neither health nor budget. The hope is expressed that this reform bottleneck could be resolved within five years.
Nevertheless, care must be taken to avoid digitization becoming an end in itself. It must be a means to achieve the objectives. The GMD must meet the objectives and not become a means of financing in itself. In other words, it needs to contribute to a better, higher quality life for the patient.
That being said, it was noted that the question of eHealth, GMD and related issues has been raised for years, including during previous Crosstalks discussions, and that the matter has not moved forward. On what does this file always get stuck?
There is resistance from healthcare providers, out of concern

for potential abuse: "What are 'they' going to do with it?" This objectives exercise includes taking these concerns into account and turning them into constructive cooperation.

In the meantime, there are examples from abroad where data sharing does work and with good results. In Switzerland or Israel, for example, electronic health data is shared with and by patient associations. (Patients have this data on their smartphones and can share it with whoever they want.) The aggregation of this data allows a lot to be learned about individual or geographical differences and best practices. *Real world evidence* is collected that is close to the patient's world.

It is important for health care to realize that digital data exchange creates a win-win. Today it is still seen too much as a control system. Research shows the vast majority of patients to be willing to share their data where this benefits the entire patient community. There is a fear that data exchange and transparency will lead to a loss of power or status. Experiences, including from Tuscany, where data from all hospitals has been interlinked), lead to a greater appreciation of and improvement in care. Because it is not a method of pinpointing culprits, but of identifying best practices and disseminating them. We will need an awareness campaign here.

The input and processing of medical data will also have to become an integral part of training. To start with, data must be of high quality, while recording it must become a natural part of good practice. If recording (as was required in the Netherlands a few years ago) is used in the context of financing or remuneration, people will understandably be unwilling to move further forward. In that respect it is wise to look at what has been done in other countries in this area and what pitfalls or stumbling blocks were found there.

Lots to be done

Digitization, financing, nomenclature, organization and organizational levels form the complex context in which plans for better health care must unfold. It's no easy task to make changes in a complex system, which in turn revolves around the (vulnerable) human being, possibly an even more complex system.

The health care of tomorrow is one of the major social projects of the coming decades. It will undoubtedly remain a topic of conversation during subsequent Crosstalks workshops. Crucial themes such as eHealth, inequality or money flows will remain the orientation points in a debate with broad social impact. Concrete examples of proven practices, even more than theoretical reflections, should help keep us on track, by appealing to the imagination, being recognizable and having a lasting impact. Also because they focus on the people who matter: the care recipient and the care provider.