Part 1: Belgian constitutional reforms with regard to healthcare
Constitutional structure

- 3 **communities**: competencies related to ‘persons’
- 3 **regions**: competencies related to ‘territory’

(In theory)
Constitutional structure

- **Regions**: matters related to economic activities, agriculture, environment, regional transport, ....
- **Communities**: matters related to the individual, use of languages, cultural matters and education

    Healthcare = competency of the communities

**But:**
- **Flanders**: fusion of parliaments and governments of community and region
- **Wallonia**: lots of healthcare issues are ‘transferred’ from the French-speaking community to the Walloon region
Constitutional reform of 1980

- Second state reform: major changes
  - Creation of Flemish, French-speaking and German-speaking community
  - Creation of Flemish and Walloon region

- Ambulatory services
- Care in- and outside institutions (with exceptions: f. ex. hospitals)
- Health education
- Preventive healthcare
Constitutional reform of 1980

Exceptions: federal level retains:

- organic law: major outlines – basic regulation (hospital law)
- **financing** of overhead costs (BFM = Budget Financial Means)
- health insurance (compulsary)
- rules concerning the **planning** of health services
- **national « accreditation » criteria for hospitals** (minimum standards for the running of hospital services):
  - ✓ when repercussions on planning, financing of overhead cost or health insurance
- criteria for the « accreditation » of academic hospitals
- Emergency care and crisis management
- **Accreditation of health professionals** (lawful practice of health professions)
Constitutional reform of 1980

Concern to keep costs of curative care under control: 3 instruments at federal level:

- planning offer
- financing overhead costs (BFM)
- reimbursement medical services
Constitutional reform of 2014

• Sixth state reform (again major changes => transferred competencies: +/- 20 billion euros)

• Delegated to the communities:
  – Accreditation process of health professionals (accreditation norms remain at the federal level)
  – Hospitals:

  ![Accreditation norms](image)
  ![Communities](image)

Financing:
- hospital infrastructure / equipment
- Elderly care (outside hospitals)
- Long-term care
Constitutional reform of 2014

• More then ever: need for consultation between regional governments and between federal and regional level
  – How: conference of all the ministers of health
  – Ex.: quality of care => every government level has a part of the puzzle, so need for coordination between all policies

Joint declaration? (see further)
Part 2: Reform of the hospital funding system: 10 main messages
1. More quality & efficiency – no savings

Intelligent allocation of resources
No savings policy
No reduction in staffing levels

• Reinvesting suboptimally allocated resources within / between & outside hospitals, by
  – Closing non-utilised hospital beds
  – Reducing hospital length of stay – and transfer to post-acute care settings
  – Avoiding unnecessary duplication of diagnostics / excess supply of high tech equipment
## 2. Maintaining strengths – solving weaknesses

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broad accessibility</td>
<td>Structural underfunding of justified care</td>
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<tr>
<td>Extensive supply</td>
<td>Complexity of funding system</td>
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<tr>
<td>Proximity</td>
<td>Administrative burden for hospitals, providers and government</td>
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<td>No significant waiting lists</td>
<td>Few incentives for efficient allocation of resources</td>
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<tr>
<td>High perceived quality (but quality ≠ proximity)</td>
<td>Strong volume driven care</td>
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<tr>
<td>Affordable care</td>
<td>High quality is not rewarded</td>
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<tr>
<td>Highly motivated work force</td>
<td>Fragmentation of care &amp; funding</td>
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<tr>
<td>...</td>
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Minister van Sociale Zaken en Volksgezondheid, Maggie De Block
3. Reinventing the hospital – fit for the current patients’ needs

- Hospital becomes a **medical-technological centre of expertise**, with diagnostic & treatment platforms (≠ “bed house”)

- Hospital as **junction** within one or several transmural **networks** of clinical care
  - Basic hospitals – referral hospitals – academic hospitals
  - Concentration & allocation of patient groups, based on evidence (EBM) and patient interests: critical mass, cost, continuity
  - Expensive equipment assigned to networks, rather than single hospitals
  - Entrepreneurship, bottom-up network building (government sets rules & interferes in case of dysfunctioning)
3. Reinventing the hospital – fit for the current patients’ needs

- Extramural private practices: same criteria wrt infrastructure, staffing, continuity & quality must apply
- **Collaborative** agreements beyond hospital walls, with local cure & care providers
- **Networking** between hospitals, also for:
  - Medical support services, e.g. lab, pharmacy
  - Overhead services; e.g. procurement, ICT
4. Correct funding for justified care, encouraging efficient use of resources

- Starting point: correct funding, real cost, justified care
- Three funding clusters:
  - Care of low variability: little variation among patients → prospective fixed funding per admission
  - Care of medium variability: more, justified variation among patients → stick to logic of closed-end national budget, distributed among hospitals (risk sharing among hospitals)
  - Care of high variability: large degree of uncertainty & unpredictability → funding actual (justified) care
- Collaboration is rewarded:
  - Shared savings within & between networks
  - Bundled payments across hospital walls
5. High quality is rewarded

- Best practices abroad learn that pay for performance (P4P) gives leverage, but careful and step-by-step approach is warranted!

- Targeted, pragmatic approach:
  - Start with a limited part of the budget: 1 to 2%
  - Work with indicators of proven effectiveness, that are supported by stakeholders
  - Avoid extra registrations
  - Apply in the 3 funding clusters
6. Transparant funding of specific missions

- Transparant, *separate* funding of:
  - SES (socio-economic status) impact on hospital cost
  - Specific missions of academic hospitals (clinical education, clinical & translational research, development of new technologies)
  - Expensive equipment
  - Accident & Emergency departments
  - Innovation

- Aim: uniform funding for patient care, per patient type across hospitals
7. Specialist keeps say in honorarium

Key player in hospital functioning

- Medical specialist keeps full say & responsibility about allocation of entire honorarium
- Transparant division of each fee-for-service in two components:
  - Practice costs
  - Professional part
- It is investigated how and under which conditions the practice costs can, in the long run, be coupled with the other hospital funding sources
8. Simplification of funding system & less registration

- Funding system:
  - 3 transparent clusters
  - Actual, separate, funding sources (e.g. funding for hospital stay, one-day care, medication, ...) are gradually integrated

- Registration:
  - Aims? Why do we register?
  - Streamlining among federal agencies
  - Streamlining between federal and regional authorities
9. Targeted and stepwise approach

- Evolution, no revolution

- Work plan:
  - Several years – implementation beyond current term of federal government
  - Global outline → translated into manageable work packages, to be implemented step by step
  - Phased implementation
  - Pilot projects
10. Reform in collaboration with all stakeholders

- At the **federal** level:
  - Task force: cohesion between 3 yards: hospital funding, re-balancing honoraria, RD 78 (health professions)
  - Consultation group, with representatives of:
    - Hospitals
    - Physicians
    - Sickness funds
  - Bilateral consultation with other stakeholders

- At the **regional** level:
  - Interministry conference public health
  - Joint declaration, before Summer 2015
Beleidscel van de minister van Sociale Zaken en Volksgezondheid

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