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Multiyear budgeting and health (care) objectives: stability, effectiveness, innovation

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Introduction

- Budgetary procedures at RIZIV/INAMI complex and outdated
- Reform of the budgetary procedure is one of the proclaimed objectives of the government. Process started in December 2020 but far from finished

- My presentation will mainly focus on procedures and I will be very down-to-earth... Apologies for the lack of inspiration

Structure

1. Why?
2. How? The bumpy road towards a final report
3. The report of WCS
4. And now?
5. What about pharma?
6. What about hospitals?

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Why?

Societal challenges

- increase chronic and affluence diseases, multimorbidity
- shortcomings in mental health care
- scarcity on labour market
- demographic changes (ageing population, increasing diversity) and changes in social norms
- climate change
- technical evolutions, era of large data, privacy issues

- financial sustainability of health care budget
- problems of financial accessibility

Institutional challenges

- insufficient focus on prevention – population approach necessary (territorial decentralization)
- need for more integrated care
- "health in all policies" – interaction with other policy domains (income, housing, education, job quality, environment, ...)

Present situation

1) Focus on one-year budgeting with an a priori fixed growth norm : no long-term budgetary perspective
   - Projections based on (short term) trend extrapolation and detailed (ad hoc) information on the specific sectors
   - During the year: corrections (often for each sector separately) to stay within the budget

2) No well defined long-term objectives (either health or health care) at the federal level

Present situation

3) “Initiatives” mainly inspired by proposals of the individual convention commissions, i.e. committees with stakeholders (care providers, sickness funds), organized in silos (different committees for different sectors)

4) No real ex post evaluation of new initiatives

5) Complicated institutional arrangements make coordinated policies difficult

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Pros and cons

- Good: budgetary norm well respected; involvement of stakeholders
  - Note: fixing the budgetary (growth) norm is a government decision

- Bad: no multi-year perspective, no coherent proactive policy in function of objectives, too many restricted silos, no coherent policy answer to the crucial societal issues

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Principles

- To have a real health policy that can respond to the major challenges we face:
  - a multi-year perspective must be taken (some initiatives will require short-term investments, and only yield longer-term results)
  - policies should be proactively formulated as a function of explicit objectives (and also evaluated accordingly)
  - space must be created for cross-cutting initiatives (which does not exclude sectoral initiatives)
  - all players within the system must constructively subscribe to this logic

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The bumpy road towards a final report

Time line

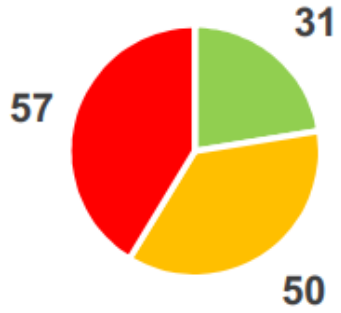
- End of 2020: explicit statement of the stakeholders to move into the direction of multiyear budgeting with health objectives – general principles endorsed by Insurance Committee and General Council in 2020

- Launch bottom-up process: 3/21

- Open call for proposals, to be submitted by Convention Commissions, but also by interested outsiders (e.g. academics, KCE) – deadline 4/21

Evaluation

- Evaluation of (>300) proposals through a structured procedure, involving RIZIV/INAMI-administration and task forces – resulting in score green/orange/red
- Based on evaluation formal and substantial criteria (quintuple aims)
  - better population health
  - better quality of care
  - health equity, accessibility
  - clinician well-being
  - cost-effectiveness



- Note: there are always trade-offs. That is where ideological/ethical differences will come to the fore.

Results

- A number of projects was selected, grouped under a set of “objectives”:
  - accessibility
  - prevention
  - integrated care
  - care paths
  - mental health care
- A number of projects in line with government program: accountability, medicines, hospital landscape, nomenclature
- “Appropriate care” initiatives as an additional source of financing new proposals

Color	Code	Title FR	Title NL	2022		2023		2024	
				IN	OUT	IN	OUT	IN	OUT
GDOS Task Force Objectives									
Mental Health									
Green	GDOS-021-1	Rendre la consultation d'un médecin généraliste remboursable pour tous les patients atteints d'une affection psychiatrique grave (APG) qui ont été admis dans un hôpital psychiatrique	Maak een huisartsconsult vergoedbaar voor alle patiënten met EPA (ernistige psychiatrische aandoening) die in een psychiatrisch ziekenhuis zijn opgenomen		442.000 €		442.000 €		442.000 €
Green	GDOS-021-2	Rendre les consultations multidisciplinaires remboursables pour les patients atteints d'une affection psychiatrique grave, conformément à la nomenclature des consultations oncologiques multidisciplinaires	Maak een multidisciplinair consult vergoedbaar voor patiënten met EPA (ernistige psychiatrische aandoening), conform de nomenclatuur van het Multidisciplinair Oncologisch Consult		352.000 €		352.000 €		352.000 €
Green	GDOS-048-4 GDOS-053 GDOS-067-5 GDOS-090 GDOS-094 GDOS-103	Meilleur remboursement et extension des consultations psychologiques, notamment pour les jeunes, en développant des centres multidisciplinaires de proximité surtout en première ligne	Betere terugbetaling en uitbreiding van psychologische consulten, vooral voor jongeren, door lokale multidisciplinaire centra te ontwikkelen, vooral in de eerste lijn		0 €		0 €		0 €
Green	GDOS-106	Soins de santé mentale: une extension de l'offre à toutes les régions, de sorte que dans chaque réseau de soins de santé pour enfants et adolescents dispose d'au moins une offre structurelle à For-K auprès de la psychiatrie.	Geestelijke gezondheidszorg: Een uitbreiding van het aanbod naar alle regio's zodat binnen elk netwerk GGZ voor kinderen en jongeren structureel minstens één aanbod aan For-K beschikbaar is vanuit psychiatrie		12.200.000 €		12.200.000 €		12.200.000 €
Orange	MAC-065	Cluster: soins somatiques pour patients psychiatriques et soins psychiatriques pour patients somatiques chroniques	Cluster: somatische zorg voor psychiatrisch patiënten en psychiatrische zorg voor chronische somatische patiënten						
Orange	MAC-068	« Mini-équipes multidisciplinaires » pour le traitement ambulatoire evidence-based des troubles alimentaires chez les mineurs	"Mini-multidisciplinaire teams" voor evidence-based ambulante behandeling van eetstoornissen bij minderjarigen						
			Subtotal	0 €	-12.994.000 €	0 €	-12.994.000 €	0 €	-12.994.000 €
			Balance		-12.994.000 €		-12.994.000 €		-12.994.000 €

The outcome: no

- The report was not approved by Insurance Committee and General Council
  - most of the partners did not like the procedure, which was felt as an intrusion into their “rights” (social partners, convention commissions)
  - financial implications for separate convention commissions (and partial budgets) considered as unclear
  - some of the specific proposals were unacceptable

- This was not really surprising

A cautious first step for the 2022 budget

- Budgetary process still took up some of the general ideas/principles and also a selection of 15 specific initiatives (for a total of €123 million)

- 7 initiatives are “multidisciplinary” and involve multiple convention commissions. Governance of this additional budget line 0 may be a first step towards the breaking up of the silos

Prévention secondaire et tertiaire, notamment par le biais de trajets de soins, de parcours de soins et de soins intégrés		
1	Pré trajet pour les patients à risque de diabète et suivi des patients diabétiques	5.000
2	Trajet de soins pour enfants obèses	5.000
3	Trajet de soins périnatal (prénatal et postnatal) pour les femmes fragilisées, cf. KCE étude 326	10.000
4	Itinéraire de soins autour du patient avant et après une transplantation d'organe abdominal	4.900
5	Plus de soins psychiatriques mais aussi soins somatiques pour les jeunes avec problèmes psychiatriques	5.000
6	Réduire les réadmissions (nouvelles périodes d'hospitalisation) par le déploiement d'une meilleure réhabilitation pulmonaire et l'augmentation de la qualité de vie des patients concernés par l'amélioration de leurs capacités fonctionnelles	5.000
7	Plusieurs projets dans le domaine de la prévention secondaire et tertiaire dans la première ligne (post-covid)	13.730

Continuation?

Revised report

- Final report was to be prepared for the end of the year 2021. Very broad group of stakeholders with “voting” power.

Scientific Committee

The report of the WCSbis

Composition of the committee

- *Scientific Committee:* Erik Schokkaert (chair), Rita Baeten, Ronny Bruffaerts, Jan De Maeseneer, Joanna Geerts, Lode Godderis, Jean Hermesse, Marine Lugen, Sophie Thunus, Brieuc Van Damme, Carine Vande Voorde, Sara Vandewaetere
- *Contributions by:* Johan Peetermans, Peter Willemé, Dirk Wouters (H5), Philippe Beutels, Mathias Dewatripont (H6), Véronique Delvenne (H7), Jean Macq, Thérèse Van Durme (H8A)

Evaluation of the 2021 experience

- Timing totally unrealistic
- Pros and cons of bottom-up procedure
  - interesting proposals that would not have come out from the traditional process; large participation also by players outside the traditional budgetary circuit
  - huge effort by RIZIV/INAMI administration
  - initiatives not rooted in a coherent long-term health policy view
    - a mix of initiatives
    - no room for larger, more structural reforms

Evaluation of the 2021 experience

- Adaptation of the present concertation structure necessary:
    - how to handle “transversal” budget?
    - how to incentivize the different sectors?
    - how to strengthen the external input, e.g. from experts?
    - how to introduce a real multi-year perspective?

Starting points

- A pragmatic approach: not an ambitious theoretical blueprint of a new system, but a reform proposal with due respect for the actual concertation structure
- Important: without participation of stakeholders reform is impossible
- No proposal about the (re)distribution of the competencies between federal state and decentralized entities (although present situation is deeply problematic)
- No statements about the other crucial issues for the government: hospital financing, pharma budget, reform nomenclature
  - *yet, it is obvious that for a real program of multiyear budgeting with health objectives, hospital financing and medicines must be integrated in the exercise!*

Three “levels” of objectives

- **FIRST LEVEL**: Health objectives (quintuple aims + sustainability) – 10 year targets (with of course regular updates) – parliamentary debate and coordination between regions – Open Method of Coordination
  - Crucial: health in all policies! To reach health objectives (e.g. prevention of cardiovascular diseases or cancer; accessibility of the health care sector), efforts must be made in many policy domains

- **SECOND LEVEL**: Health care objectives at the federal level – 5 year targets (duration of legislature)

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Three levels of objectives

- **THIRD LEVEL**: Initiatives and specific policy measures – short term targets (but often > 1 year) with evaluation ex post
  - two types: “appropriate” care and in the line of broader objectives
  - open call possible, but structured in terms of the objectives

- At each level: clear indicators that can be used to monitor the process (SMART: specific, measurable, achievable, realistic, time-bound)

Budgetary procedure 1

Start from an objective and well documented projection of expenditures (under constant policy) for the next five years (combination of trend analysis with econometric projection model, constructed at the Federal Planning Bureau)

- fix the budgetary room available for new initiatives (difference between budgetary norm and projection)
- explicitly take into account explanatory variables
- analysed and accepted by all sectors

Estimation of budgetary impact of new initiatives and policy measures

Budgetary procedure 2

Yearly analysis of differences between projections and actual expenditures at the level of the different individual sectors

- includes analysis of the causes of the differences
- if “surplus” due to *exogenous factors*: surplus goes to the transversal budget; (if “deficit” due to exogenous factors: reshuffling between sectors)
- if “surplus” due to *efficiency enhancing initiatives* by sector itself: part of the surplus can remain within the sector; (if “deficit” because of lack of efficiency: sector has to remedy the deficit)

- Ex post evaluation of recent initiatives

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Budgetary procedure 3

- Budgetary room for “transversal” initiatives:
  - (part of) the initial difference between budgetary norm and projections
  - (part of) the surpluses generated by initiatives of the individual sectors

- Introduction of a new Committee, supervising the process, evaluating the progress into the direction of the health care objectives, with a larger role for external experts

Time line

Itinéraire objectifs de santé

Itinéraire objectifs de soins de santé

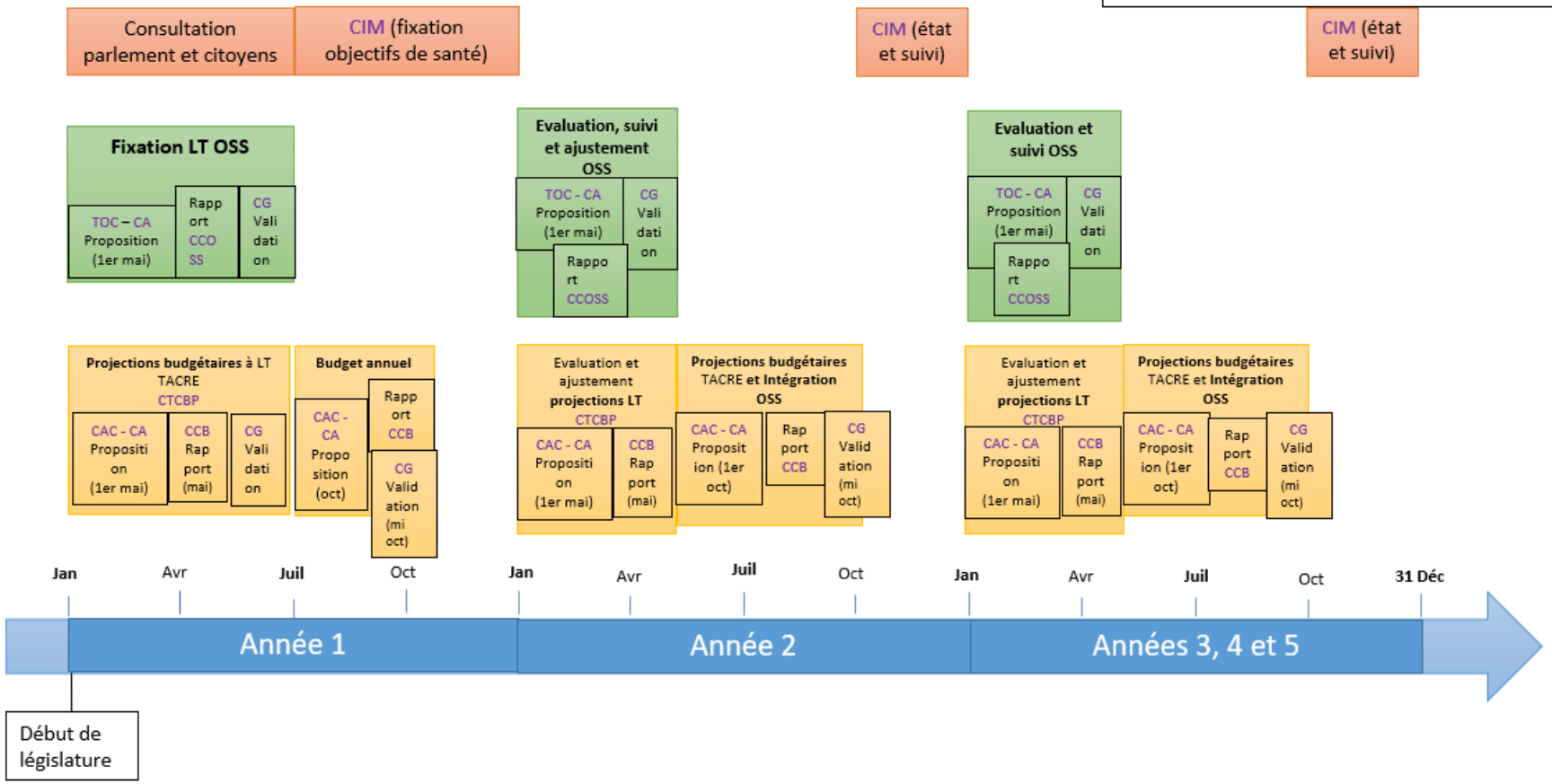
Itinéraire objectifs budgétaires

Abbréviations :

LT : long terme
OSS : Objectifs de soins de santé
TACRE : toutes autres choses restant égales

Liste des organes de concertation :

CG : Conseil général
CA : Comité de l'assurance
CCB : Commission de contrôle budgétaire
CCOSS : Commission de contrôle sur les objectifs de soins de santé
CIM : conférence interministérielle
CAC : commissions de conventions et d'accords
CTCBP : cellule technique conjointe pour le budget prévisionnel
TOC : commission d'accord transversale



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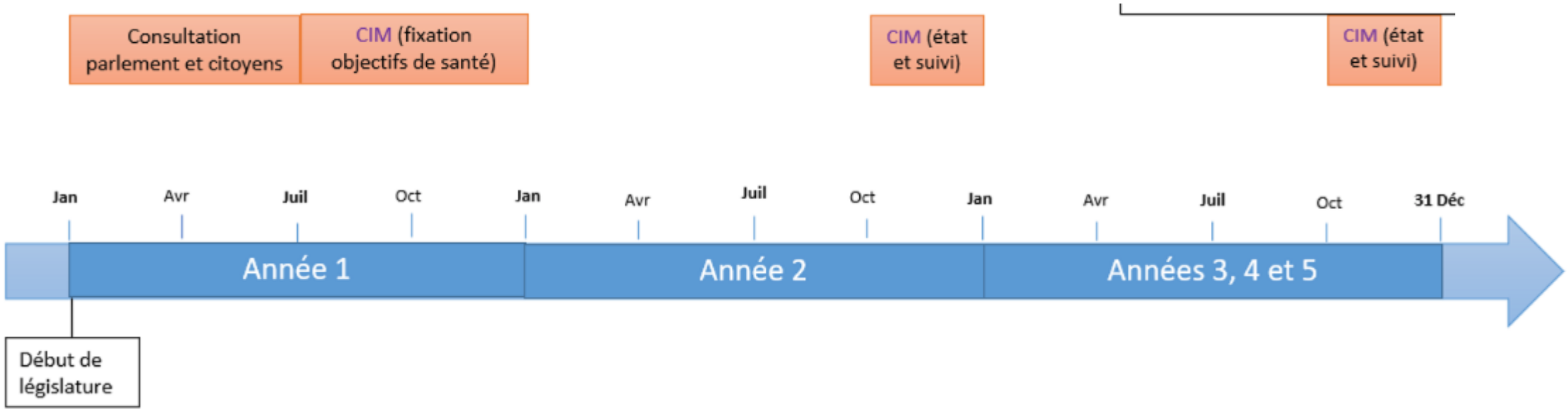
Trajectory health objectives



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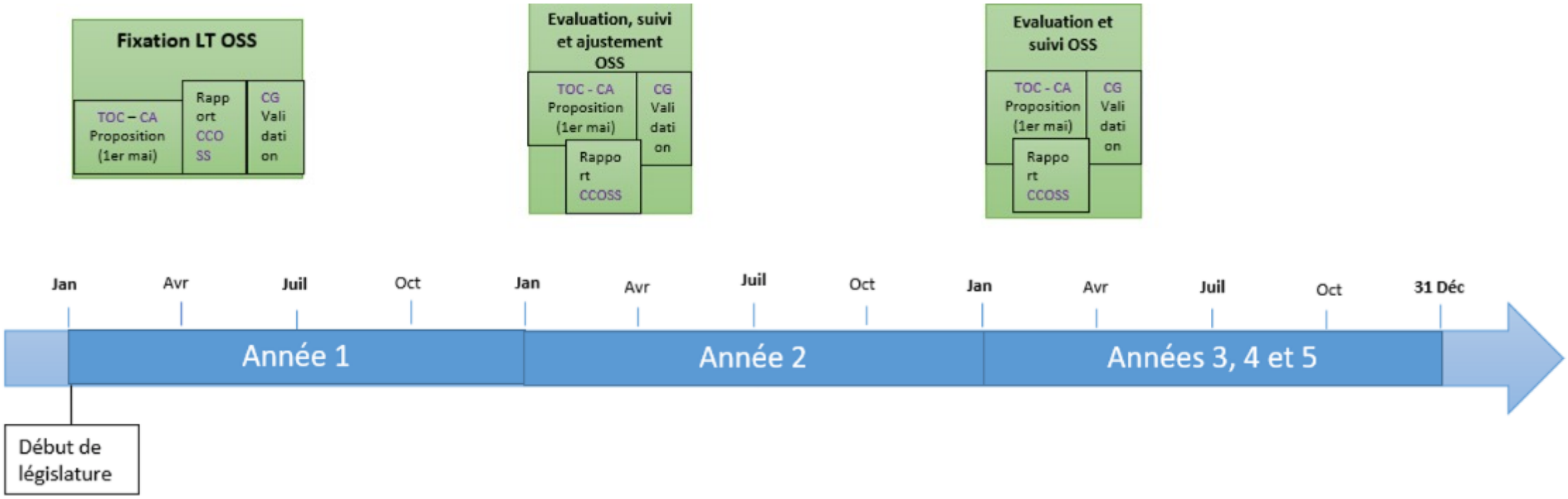
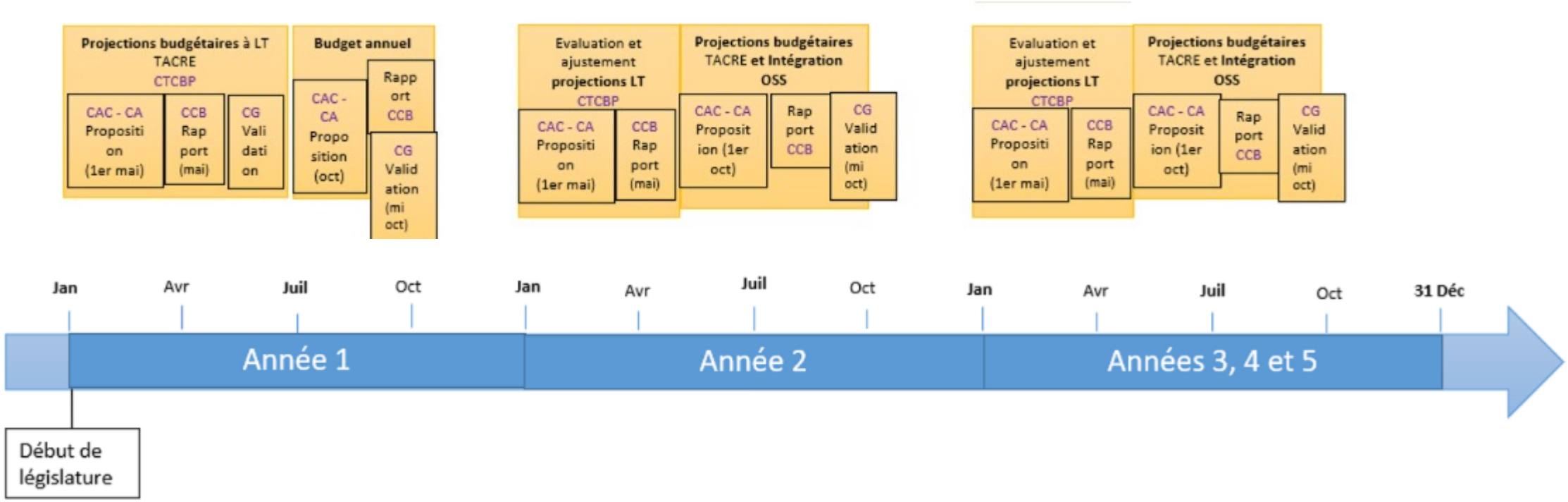
Trajectory health care objectives



Budgetary trajectory



And now?

The report of the stakeholders

- The report of the stakeholders contains parallel proposals, but some main differences:
  - stays firmly within the existing legal framework
  - less focus on multiyear aspects. No real incentive mechanism
  - much less important role for external experts

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What will happen in the near future?

- Two reports for the Minister, who now will has to start the negotiations with the stakeholders
- Introducing multi-year budgeting with objectives is part of the government program
- COVID-19 pandemic not an easy period to introduce multi-year budgeting!
  - expenditures until now largely financed by additional means – to be integrated into the regular budget
  - uncertainty about long covid

Transversal projects

- Project committee for each of the seven projects, introduced earlier (with external experts in each of the committees)
- Legal structure: proposals have to be approved formally by the convention committees involved
- Steering committee: RIZIV/INAMI (chair), presidents of the seven committees, three representatives sickness funds, three representatives medical professions, representative Minister, *representative KCE, three experts WCSbis*
  - Proclaimed objective: coordination, elaboration generic methodology for handling transversal projects, insertion in long-term vision

What about the pharmasector?

Integration of pharmaceutical expenditures in the budgetary process: how it should work

- Of course, it is not meaningful to formulate a multi year budget with health objectives without including the pharma sector in the exercise from the very beginning (the same is true for hospital financing)

- The decision/negotiation procedure now is intransparent and not always rational or coherent

A philosophical perspective: Norman Daniels

- The priority setting process should satisfy a set of fairness conditions:

1. Decisions and their rationales must be publicly accessible (*publicity condition*)
2. There must be mechanisms for challenge and opportunities for revision of policies in the light of new evidence (*revision and appeals condition)*
3. There must be public regulation of the process to ensure that the other conditions are met (*regulative condition*)
4. Rationales for priority-setting decisions should aim to provide a reasonable explanation, i.e. an explanation appealing to evidence, reasons and principles accepted as relevant by fair-minded people (*relevance condition*)

Predicting expenditures: the BAU scenario

- “Predictions” of the business as usual scenario very difficult in the pharma sector, as innovations are crucial and difficult to predict
- In the actual situation: collaboration between RIZIV/INAMI and pharma for predictions in the short run

- If we want to go for multi-year budgeting, this predictive “apparatus” has to be strengthened and reorganized in a structural way

Evaluating effectiveness

- Popular technique: cost-effectiveness analysis with as the crucial outcome the “incremental cost-effectiveness ratio” (ICER)
  - additional costs/number of QALY’s gained

- Useful, but definitely insufficient for the purpose of multi-year budgeting:
  - QALY is an ambiguous concept. Is it health? As a well-being concept, it is definitely too narrow, even for choices within a fixed budget
    - example: make the maximum billing system more generous versus reimburse expensive drug
  - ICER does not include the macrobudgetary effects (drugs with a very good ICER can be unaffordable) – it does not help to get a better insight in the optimal health care budget (trade-off with consumption)

What about hospital financing?

Remember: different levels

- Three levels:
  - at the highest level a general framework is set: steering based on health (care) objectives, to be translated into concrete policy measures at a lower territorial level (principle: open method of coordination EU)
  - funding of territorial entities (zones) based on population characteristics
  - funding of providers and facilities within the zones?

- Separate funding for highly specialized care in reference centers

What about hospitals?

- Evolution toward "community hospitals“ - population-based and bridge between specialized and primary care

- Strategic planning: hospitals have to integrate themselves in a population approach with focus on health (care) objectives

- Will funding follow?
  - Utopian/dystopian ideas: do the zones get a budget to buy hospital care, or do the hospitals themselves get funding based on population needs?

Conclusion: politicians, lobbies and experts

- At the end, choosing what to reimburse and how much is a political decision!
- The present focus on a growth norm is a rather primitive form of number fetishism
- Multi-year budgeting with democratic discussion about health (care) objectives can help to have a structured and informed debate about these decisions