The evolution of healthcare in Belgium

Jan Bertels
Chief of Cabinet for public health and social affairs

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We spoke to Jan Bertels, who - since October 2020 - has held the position as **Chief of Cabinet for public health and social affairs** for Belgian Health Minister Frank Vandenbroucke. We explored the nature of the planned reforms and the reasoning behind them, why they are needed now and what outcomes the reforms are expected to bring.

Access to healthcare is a basic human right, and it is a fundamental duty of the government to provide public health services. However, the needs of the public, the treatments available and the resources available for funding are constantly evolving. Healthcare policy needs to be adapted to reflect this.

It's therefore no surprise that Belgium is in the process of implementing a series of reforms designed to reflect this changing landscape and prepare the country for the public health it will need in the future.

Why are these reforms needed?

There is a need to move towards investing in better health – taking better care of ourselves - rather than simply treating illness. This approach will mean better, more affordable and more accessible care for all. In addition, for those that do need treatment, the overall quality of care and delivery will improve and access to new and innovative medicines will increase. These should be the hallmarks of a modern, sustainable healthcare system fit for the future.

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What is the scope of the planned reforms?

There are five key elements

- **Addressing the issue of mental health**. We need to ensure that those who need help dealing with mental health issues can access the support they need.
- **Financing of hospitals**. We want to have a clearer demarcation in the funding model than currently exists. For certain conditions, we also want to concentrate expertise in centres of excellence.
- **Contracts for healthcare practitioners**. We want a 'new deal' for general practitioners, one that reflects the way they now work. We also need to recognise that – particularly post-COVID –healthcare practitioners are under greater pressure, and we need to ensure their wellbeing.
- **Creating a greater role for nurses**. They will be able to undertake a wider range of roles, with greater autonomy. This will help spread the workload better among healthcare practitioners
- **Making innovative medicines more accessible and bringing them faster to market**. This will mean working more closely with patients – to ensure we meet their needs – and finding new ways to work with pharmaceutical and health technology manufacturers.

Clearly, these are significant changes, but at the same time they reflect the fact that we already have a very good healthcare system in the country. They can therefore be viewed as 'evolutionary' not 'revolutionary' changes, designed to deliver more – and better targeted – public health.

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What are the reforms designed to deliver?

In the field of mental health, we want to ensure that people in all settings – such as in schools or the workplace - can find the support they need to maintain their mental wellbeing. There is a new convention on mental health in place, with significant investment from the federal government.

For hospitals, the reforms will be twofold. The first is financial; the current approach mixes funding from the government with payments from the specialists who provide their services from the hospital. We want to make it clearer what aspects of the funding is for the hospitals themselves and what relates to the services.

The second aspect will be the creation of 'centres of excellence' for certain conditions. This means that hospitals will not treat all patients. Where specialised care is required – for example in certain cancers or rare diseases – patients should be sent to the designated reference centre for that condition. These reference centres will be determined by the federal government in collaboration with the regions; indeed, the process is already underway, and for certain diseases, the list of hospitals is available on the government website. It means that if specialists are performing procedures that are not in the area of expertise for that hospital, they will not be reimbursed. At the same time, however, we have to make sure that the patient being treated does not suffer unduly as a result; they may not realise that it is not the right centre for treatment.

For general practitioners, we also want to provide them with a ‘new deal’ to reflect the realities of how they now work. The old model of the ‘single-handed’ GP is disappearing, replaced by group practices capable of offering a wider range of services. Overall, this is a positive development, it increases the local services available and helps the mental wellbeing of the GP by sharing the workload. The reforms will see GPs rewarded for the overall health of the patients registered with them. This means more health promotion/prevention measures to encourage people to stay in good health.

Of course, we will continue to pay for hospital treatment of people who require it, but we have put in place indicators of outcomes and of quality. This approach already exists, and is something we will look to grow. We are also looking at patient-related outcomes (PROs), asking them what it is they value most, rather than simply assuming. In some conditions – particularly in areas such as rare diseases - this may not be a cure, but rather an improvement in overall quality of life.

For nurses, we want to expand the role they play in healthcare delivery, and take greater advantage of the abilities of specialist nurses. The duties they will be able to undertake will be expanded, and they will enjoy greater autonomy in how they work. This will help spread the workload better for healthcare practitioners and relieve some of the burden on general practitioners.

You mentioned improving patient access to innovative treatments; how will you address this?

We’re looking to reform reimbursement processes in a way that reduces the time for them to reach the market in Belgium. In particular, we want to accelerate this process for those therapies that will meet the highest unmet needs, such as rare diseases. We already have a committee dedicated to this objective, one which includes input from patients and their representatives. As I mentioned already, we want to provide them with the outcomes that matter most to them.

A key part of this approach will be to take an evidence-based approach. Why? Because in Belgium, we feel it’s important to invest in healthcare and particularly in wellbeing. Everyone agrees on the big picture, but ‘the devil is in the detail’ when it comes down to gaining consensus. Investment should follow an evidence-based approach, to ensure resources are directed towards ‘appropriate care’.

Can you speak a little more about ‘early access’?

Bringing new medicines to market is challenging; they need to be shown to be safe and efficacious – no small challenge in a rare disease where there are so few patients for clinical trials.

However, the effectiveness of a treatment – how it performs in the so-called ‘real world’ setting – is more difficult. There are always uncertainties over how well a treatment will perform once they have been licenced, so companies may have received market authorisation for a new product, but may not have received a decision on reimbursement.

What we don’t want is to see that period without reimbursement to act as a disincentive for companies to pursue new therapies; We want patients to have access to treatments that may help them – particularly in conditions where few or no alternatives are available. Currently, companies have, for example, three years to demonstrate the value of their products; we intend to keep that period. However, to promote early access, we have designed an incentive; during that period, we can offer limited reimbursement - at a lower price than the final one - while they gather evidence of effectiveness.

By shifting the full burden away from the manufacturer by providing the certainty of a level of reimbursement, this will act as an incentive to invest in developing medicines for unmet medical needs. This in turn should improve opportunities for patients to have early access to treatments. I should stress, of course, that this is designed for addressing high unmet medical needs - such as rare diseases - rather than for other, less pressing, applications. Indeed, unmet medical needs will be one the priorities of the upcoming Belgian Presidency of the EU during the first half of 2024.

Where do you expect the bottlenecks to be in this process?

It's a good question. To use the pharmaceutical industry as an example, we need to have a discussion – on a European as well as national level – on what represents reasonable pricing for expensive treatments such as gene therapy. Much of the debate revolves around the perceived 'value' of a medicine. We are already working with manufacturers – through initiatives like Beneluxa – to obtain fairer prices. The European Commission is also currently exploring the possibility of legislation to allow a single price – and therefore single market - for medicines in Europe.

Why are you undertaking these reforms now?

On the issue of timing, we would have started these reforms before now, but the COVID-19 pandemic meant that this was not an option; we had to concentrate on the challenge that faced us. It's also worth pointing out that - while the reforms as a whole appear considerable - in reality they're not all happening simultaneously. Indeed, some of them are already underway. The mental health initiative began around 18 months ago, and for other elements there has already been significant progress. For GPs, the execution and operationalisation will be in 2024, in addition , there are roadmaps in place for the pharma industry and for the nurses. The major component – the revision of the nomenclature – will take around two years, and will also see the use of medical imaging technology reformed this year. Not all aspects are completed from a legislative point of view – that will be by June – but the principals have been agreed.

Many will say – rightly – that Belgium already has an excellent healthcare system; how will you communicate the benefits of these reforms to stakeholders?

It's true that Belgium has an excellent healthcare system; however, just because it's good, doesn't mean we can't make it better. Indeed, that's why we enter politics – to change things for the better. It's not to make us look good; the majority of benefits that will arise from these reforms will be seen under another government.

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They are designed to improve public health overall, while making healthcare more accessible - both financially and geographically and more affordable. The overall quality of care and delivery will improve and access to new and innovative medicines will increase, but you're correct in saying that we need to convince stakeholders - particularly the public - that these changes will be for the better.

However, we need to convince each and every stakeholder – not simply the public - that this is the right direction of travel. In general terms, this has been achieved, however, 'the devil is in the detail'. There are many, many stakeholders with significantly different – often opposing - priorities, so we have to convince a majority of every reform, not just those that impact them directly.

How will you measure the success of these initiatives?

I think there are two separate metrics. One – which is relatively straightforward – is to see the legislation on these measures pass into law; that's the political measure of success.

Probably the more realistic assessment will become apparent two to three years down the line. By that time, we will be able to look and see whether the changes have genuinely improved public health among the population. Such an assessment will be challenging, but it should look at qualitative measures, particularly quality of life. It's a reality that everyone will need care when they become older. However, what we would hope to see is that – as people approach the end of their lives–the overall quality of their lives has been improved and their quality life years lasted for longer than before. That will be the true measure of success.

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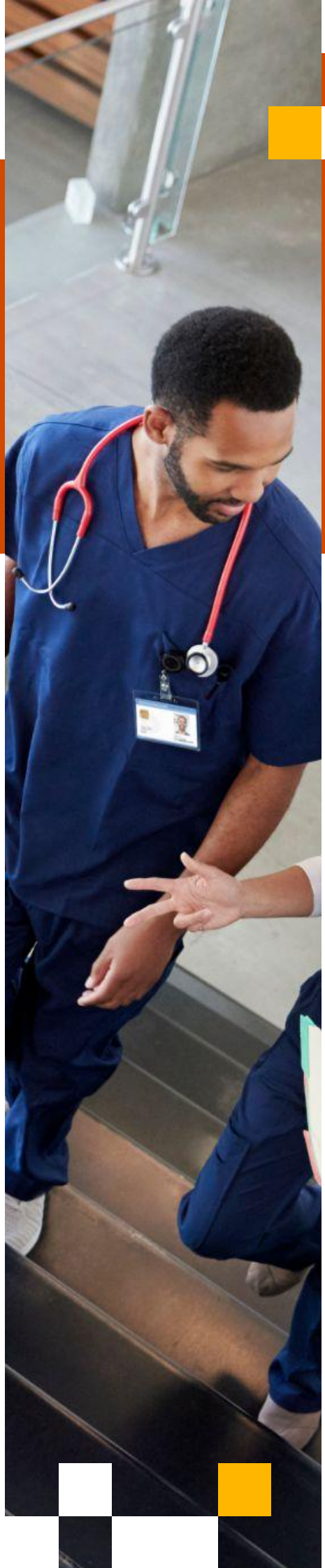
Another important measure should be equality; everyone should have the same expectations at birth, irrespective of location or socioeconomic status. In Belgium, that's not currently the case, and we should be aiming to eliminate those differences. Again, realistically, we won't see clearly whether we have achieved this in two, three or even five years – it will take longer.

What should be the overall message for healthcare stakeholders?

The overarching goal of these five reforms is to prepare our public health system for a future that pursues better wellbeing, rather than more treatment, and that provides more equitable and accessible care. They will help us ensure that our already-excellent standards of care remain that way. Because in our well-resourced, western world, we can't simply assume that – because we are already able to get what we need from our healthcare services – that we don't need change.

For politicians, the reality is that the healthcare environment is constantly evolving and we must adapt our approach to changing conditions and emerging demands. We must learn from crises – we have had a few - and use these insights to do what we do better. It's our political duty; one that we cannot shirk.

We don't claim that these five reforms are the perfect measures; they are the best possible compromises between competing priorities; that's the essence of politics. What we can claim, however, is that the five planned reforms are practical, considered and will deliver the changes we seek with the agreement of the vast majority of stakeholders. That, in itself, should make them a success.



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