How will the welfare state cope with welfare diseases such as NASH?

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To the Editor,

Last year, it was stated in this journal that Non-Alcoholic Fatty Liver Disease (NAFLD) is becoming the biggest cause of liver disease in western countries (1). NAFLD may gain importance as Non-Alcoholic Steatohepatitis (NASH), a specific and serious form of NAFLD, is on the rise. It is estimated that in Belgium 3-4% of the population are affected by NASH, and it is projected that the prevalence will double by 2030 (2). Currently, over 90 drugs are being developed to treat NASH.

NASH is associated with a 30% or more loss in quality of life of the patient and may lead to death. Current treatments for NASH are based on lifestyle interventions (i.e. diet, physical activity) (1). Unfortunately, it has been estimated that less than 10% of the patients manage to maintain these changes in order for the hepatic fibrosis to regress. Due to the global obesity epidemic and complications of NASH, economic analyses indicate growing costs for the healthcare system and society overall. For instance, liver cirrhosis is associated with a 19% absenteeism rate and a 45% presenteeism rate. A rough estimate for NASH in Belgium shows direct annual medical cost to range between 100 to 400 million euro (3).

How will our welfare system cope with welfare diseases such as NASH given its rising cost? The impact lifestyle choices have on health raises major questions for patients, healthcare professionals and policy makers. Policy makers are grappling with the concept of individual responsibility and health risks even in a solidarity-based system like Belgium's. Recently, societal debate was spurred when non-smoking was an eligibility criterium to be granted access to a drug to treat lung fibrosis. Does the right to health care also imply the personal responsibility to live healthy? Or is freedom to choose a healthy lifestyle inherently limited, as it is largely conditioned by the environment and genes? Regardless of the previous questions, does responsibility matter when we are confronted with human suffering and the resulting costs for society which could be offset by new therapies?

Early prevention strategies remain most appropriate. Fundamentally, stimulating a healthy lifestyle would require a health system that facilitates the healthy life choices much more. This requires investments envisaging long term health and economic gains. This is however challenging given short legislatures at the policy level and financial incentives that pay per "medical treatment" (not prevention) at the level of health providers. Incentivising physicians and other caregivers to focus more on prevention is therefore recommended. But health promotion goes obviously beyond the healthcare sector. For example, investments in the education system and at the workplace, and collaborations with the food industry are needed to tackle overweight. Involving all stakeholders in the development of prevention strategies by using participatory design is therefore needed.

Today, many policy actions can already help citizens to take control of their own health and way of life: investing in health literacy and self-development from primary education, integrating patient coaching modules into the training of caregivers; financially rewarding the amount of time caregivers take to educate their patients; developing detection programs; encouraging patients and providers to use cost-effective technologies; incentivizing patients to go for yearly general check-ups; and finally investing in better data collection about the disease and policy measures. Finally, we hope that policy makers, health care professionals and patients will start to discuss how we can prevent the looming dangers of welfare diseases, while safeguarding our values of solidarity in the Belgian healthcare system.

Conflict of interest

None declared.

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