How healthy is Belgian health care?

This is the transcript of the introductory speech given by Marc De Vos at the CrossTalks Conference on "The Future of Medication" (Brussels, 13th October 2006 - http://crosstalks.vub.ac.be/). The slides referred to can be downloaded from www.itinerainstitute.org.

SLIDE 1 - Good morning ladies and gentlemen.

SLIDE 2 - I will give you a big picture assessment of Belgium's health care system as I see it. I am neither a medical doctor nor a professional economist, but I am somebody with interest in this theme and you will see how I approach this interest.

I will focus on two key issues. I will try to discern here with you some major trends as I see them develop in this big picture that I will try to paint here and connect those trends to the future. I will identify some challenges.

SLIDE 3 - This is the archetype of what is seen as a genuine model, a combination of public funding on the one hand – generous public funding – with a kind of free market competition. This combination, it is said, explains the success of the Belgian health care system and it is for instance quite similar to our educational system, which is also publicly funded and based on competition between the actors. This archetypical model of ours furthermore includes free access to health care – almost free access, I will get back to that – as well as, and this is one of the points that I want to stress, very good staff: our medical profession is highly trained and very active, very motivated.

This is the archetype. To what extend is this archetype still reality today and will it be tomorrow? That's the question that I ask myself and that I address this morning.

SLIDE 5 - Everything goes down to numbers really when you sit down and look at it. And the numbers are quite impressive when you take a look at the evolution of the budget for public health care in this country. These top figures that I present there are of course nominal. They resemble the universe: always expanding and expanding. Maybe they are destined tot contract into a black hole and explode, I don't know. But the real term figure at the bottom line really matters. In real terms we have seen in 30 years an average annual growth of close to 5 percent. That's a figure that I want you to keep in the back of your heads as I move on.

SLIDE 6 - How have we managed to do this? How have we managed to survive such a cost explosion in our social security system, which is much more than health care? The answer to that is very simple; it is by abandoning all the rest of the social security system. When you look at the figures here, the share of public health care in the total social security system has almost doubled – this is a little exaggeration – but it's little. In 1980, it was 22 percent; today it's very close to 40 percent. The result of that is that all the rest is victimized because of the cannibalisation of our social security system by its health care branch. Look at the pension system today. Everybody today recognizes the deficiencies in our first

pension pillar. The legal pensions, when you look at their exchange ratio to previous earnings, are actually at the bottom of the European ranking. The same goes for all the other examples.

This is a situation which is untenable in the long run. And it has already become untenable. We are already developing new priorities for these victims as I call them.

SLIDE 8 – The budgetary explosion I described to you has led to a number of policy implications at both a structural and micro level. Those policy implications I want to highlight now, as I see them, standing from a distance, looking at the overall picture of health care organisation in this country.

When you look at the present situation, one might come to the conclusion that the health care policy in this country has become budgetary policy. Just look at the sheer unending cascade of budgetary measures that have been introduced these past couple of years. I've listed most of them here, I don't need to go through them, but it's quite straightforward. Some of them are highly contentious and highly debated, all of them may be necessary, even desirable, but they all have tradeoffs. Look at the list, they all have tradeoffs. And the trade-off is that this archetype of ours of freely accessible medicine in an open market place that guarantees competition is being eaten away at the edges. That's the trend that we see. That's the trade-off we are paying for these necessary or desirable changes. There is more restriction. There is a restriction in access to health care, there is a restriction in the offer of medical services and that does not blend well with the future if this trend is to continue. That's the first trend that I see on the structural level.

SLIDE 9 - I also see trends for the medical profession. If you sit down and talk with doctors today, they will immediately start waning and complaining about how difficult life has become being a doctor, whether it is in the hospital or as a private practitioner… Doctors also feel less secure in terms of their own social security. Look for instance at the picture of hospital doctors. There is a tendency, that's one of the trends of the previous slide, to concentrate hospitals. Look at the declining percentage of public hospitals on the wave of complete or partial privatisation. That means that the doctors that are working in those hospitals are less secure, especially with regard to their employment status, especially pension rights – that's actually one of the reasons why we do it, to get rid of this pension burden. That's not a happy situation for these people.

They also earn less, or at least the growth of their income is not on a par on the growth of the budget. You see the evolution there, maybe good, maybe bad, but it's a trend. And I don't have to tell you the story about the white anger and the continuing problems we have there.

Growing difficulties for the medical and para-medical profession is therefore a trend. If it is going to continue in the future, then it may undermine one of the key pillars of our success which I mentioned in the beginning. The medical profession is the human capital upon which our health care is essentially still based. There is a growing international market out there for the good doctors. If they don't like it here, they can simply move.

SLIDE 10 - What are the consequences for patients? Just take a look again at the big picture. We see that this public health care

organisation of ours is becoming less and less of a fit for the patients it's supposed to protect. Look at the numbers, we all know them, the staggering numbers of additional private insurances that have been taken out, whether they are individual, through companies or otherwise. Look at the budget. The insurance premiums doubling in about five years time. This, if you make a comparison, looks like America: private insurances offering very high coverage, very expensive coverage on the back of the tax payer, on the back of companies, and becoming an engine for budget growth in their own right. That is a worrying trend for me as well.

SLIDE 11 - This proliferation of private insurances implies that patients now pay more privately than they used to do in the past, on top of out of the pocket expenses. Look at the figures. They come from a recent report of the WHO and are worth noticing. You can always debate the statistical methodology but here you have at least a uniform methodology that allows comparisons with other countries.

You see how our share of private expenditure is way above that in countries which are not radically different in terms of quality of health care. This comes on top of the explosion in public health care that I mentioned in the beginning, so that means that patients, citizens, companies are actually paying 3 times: through taxes in the public health care, through private insurances and out of the pocket. I do not think personally that this is an agreeable situation. I think that this is not a good trend.

The question is now: what is going to happen to these trends as we progress in the future. I don't have a crystal ball, but I will try to indicate some of the evolutions that are likely.

SLIDE 13 - Ageing and demography: we all know they are inevitable, but do we really let them sink in, that's the question. The challenges of ageing are not primarily in the health care sector. There will be real challenges elsewhere. I give you what I call the Brussels consensus. This is a summary of what the annual report of the official Commission on Greying provides. You see what we have to realise in this country to keep our heads above water. The productivity growth on an annual basis of 1.75 percent: much better than we are used to. Unemployment structure: much better than we are used to. Activity rate: much better than we are used to. About 450.000 additional jobs. The annual economic growth: better than we are used to. State debt reduction must go very quickly in the next years. We need real surpluses, again much better than we are used to.

SLIDE 14 - So there are real challenges if we, following this consensus, have to survive the ageing of our society. We will have to shift a couple of gears in the economic and social situation of our country. That has nothing to do with our health care, but it means that there will be real challenges and priorities other than health care. It means we will not be able to afford the absolute focus of our budget on health care growth as we have done in the past decades.

On top of that, according to the same Commission, we need to restrict the development of the budget of public health care on an annual real term basis to 3 percent till 2030. However, in the past 25 years the annual real term growth rate was a bit less than 5 percent. Again we will have

less public money available on top of everything else I mentioned. That is not an enticing prospect by any account. More budgetary restrictions will only worsen the already worrisome trends I have indicated here. That means that we will have more tradeoffs. The tradeoffs that I mentioned are going to become structural problems of our health care system if we don't succeed in overcoming these challenges. That's my humble opinion. I hope that I'm wrong. I hope that I am not Cassandra.

SLIDE 15 – That is the not so rosy assessment looking from the current landscape. But, without wanting to jeopardize your day, the current landscape is not going to be the future landscape. The future is going to require more health care and more care on top of health care, more than we were used to in the past. Because of the same phenomenon of ageing, but also – as I read it in many articles – because of the inevitable technological and scientific developments of treatment and medication towards a more patients centred and customized health care. That means better and tailor made health care. It also means smaller markets and that implies more budget. If we don't have the budget, it means less health care. That's how simple it is. We will need more money in the future, not less, if we want to provide the same level of health care as we do today. And, because the list of challenges, because of ageing, we will not be able to tank from the state coffers as we have been doing for the past 30 years.

SLIDE 17 - We really need to start thinking out of the box about organizing health care in this country. The trends are in the future but nonetheless, the future is coming closer and closer every day. We have basically two options: the first option is to go down the road of the Brussels consensus as I call it. From the viewpoint that I have, that will mean gradual decline of the level of the public health care system of this country. The negative trends that I have indicated to you will become structural weaknesses. Somewhere down the line in the first half of this century we will wake up to the realisation that Belgium's once famous health care model has become obsolete.

Combined with that, there is of course plenty of wealth out there in our country. That wealth will go to healthcare if patients want it. There will be more multi-speed healthcare in the future if we don't address the issues. The medical profession will increasingly be instrumentalized as budgetary agents and will increasingly be boxed in by restrictions of all stripes. The public dimension of health care will be pressed more and more with ethical questions. Budgetary questions will become ethical questions on the value of life and on choices between groups, more and more so as ageing develops.

SLIDE 18 - Personally, I don't think that this is a desirable option. I would like to think that we can be creative and come up with a second, third, fourth option, I don't have the wisdom in a monopoly here. I think that we need to have an open debate dropping the restrictions of today, dropping ideological convictions and trying to be very pragmatic in assuring that we can achieve what we all want to achieve, namely high level quality health care that is affordable and does not destroy our economy and does not create a multi-speed society in health care provision.

I think that we inevitably will have to conduct the operation that we have already done for pensions, i.e. developing different

pillars. Not allowing them to exist; they already exist today. Let's get real. I gave you the figures about the private insurances. But organising them, streamlining them, making them more efficient, having a policy about them. I also believe we need to have more prevention and more personal responsibility. More insurance principle in short. Incentives matter. As funds are scarce personal choices must be made to bare if the generate external effects. I would like to have the opportunity here to start debating such issues, because the current Brussels Consensus is a dead end street.

We need to be able to spend more, not less on health care. It is worth it: health pays, also from an economic perspective. Since we cannot afford to tax more we will need to be creative. If we succeed to create enough wealth through economic growth, the problem practically solves itself. We will have to address access for the poor, which is very important. We don't want a scenario where health care is for the people who can afford it. We have to be able to combine both private pillars and solidarity. Efficiency is going to be the key. The role of all actors and institutions can and must be questioned from that angle.

At the end of the day, I strongly believe in the potential in this country. We have plenty of resources and potential. We have our human capital in the medical profession. Education is going to be instrumental. We will need doctors with different mindsets as we progress into a different kind of health care.

My conclusion is simple and clear. Belgium's quality health care will gradually decline and cease to exist as we know it unless we address the current undermining trends that will become destructive failures without comprehensive reform. With reform everything is possible, without it much will eventually be lost. The victims will be those that rely the most on public services, not those who can afford private services here or elsewhere.

Marc De Vos
Directeur Itinera Institute
Docent sociaal recht UGent en VUB

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Itinera Institute VZW-ASBL
Boulevard Leopold II Laan 184d - B-1080 Brussel - Bruxelles
T +32 2 412 02 62 - F +32 2 412 02 69
info@itinerainstitute.org www.itinerainstitute.org

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