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THE BELGIAN HEALTH CARE SYSTEM: BALANCING COSTS, CHOICE, QUALITY AND COVERAGE – LESSONS FOR THE UNITED STATES?

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P R O C E E D I N G S

MR. BENJAMIN: Good afternoon, and welcome to The Brookings Institution. My name is Daniel Benjamin. I am now in my fifth week as Director of the United States and Europe, and I was delighted to have been asked to moderate this session, even though it is somewhat far afield from what I usually work on which is terrorists and other aspects of the contemporary landscape.

You do not have to worry that I will burden you with any new knowledge about health care or health care systems of any kind. For me, this is completely *terra incognita*. I have to say that many of have been puzzled lately or have been thinking lately about what is called the French Paradox or also the Gascon Paradox, which is how is it that people who consume a good deal of foie gras and red wine live so much better than the rest of us, especially those of us here in the U.S. For me, this has actually always been the Belgian Paradox because I think of Belgium and I think of pomme frites covered with mayonnaise, the most delicious pomme frites on Earth, by the way, and Norhaus and Marcolini chocolate and the best beer money can buy. Now I find also that you have solved some of the problems having to do with not only your health, but your health care system, and this is demoralizing to an American, because we always view ourselves as being the first ones to the answers.

I am delighted now to introduce Minister Rudy Demontte from the Federal Government of Belgium who is one of the people responsible for these advances. He has been involved in Belgian politics for some time. He began on the staff of the Minister of Social Affairs in the late 1980s, he has been in the

Belgian House of Representatives since 1995, and he is now the Minister for Social Affairs and Public Health. He is going to give us about a 20-minute talk, and after that we will have a distinguished panel to discuss some of the lessons learned from the Belgian Paradox. Thank you very much.

MR. DEMONTTE: Thank you very much for giving me the floor. I have first to apologize for my English. I have been told that it is even worse than my French.

(Laughter)

MR. DEMONTTE: Ladies and gentleman, I am really delighted to be here with you today. Health policy as you know it is one of the most important fields of policy. There is no policy field where a citizen's well-being is so directly involved. In a recent article on health care published in USA Today, my attention was attracted to the following comment I cite: "One of the basic questions about health care is an old one. Should health care be a right for everyone regardless of income, preexisting illness, or bad genes? Or should it be a privilege obtained by hard work or bestowed by good birth? We would never agree that police and fire protection should be distributed on income, so why should health care?" The quote indicates very clearly that debate on health policy issues is and must be essentially based on values, and the question is, do we need values?

One could ask do we really need values, and what kind of values. My answer would be positive for the following reason, we need values. Modern science constantly brings people to new results. The exploding progress in research and technology offers significant benefits and health gains. At the same time, these revolutions raise important problems, improvement in health has no

limits, but resources do have limits. This means that policymakers are always confronted with the need to make choices. I think we can best justify our choices when we demonstrate through our decisions that we respect and implement the values supported by the citing. Let me tell you about what I feel as of European values.

It is important that those values are formulated in an explicit way. Therefore, I was really satisfied that all the Health Ministers of the European Union approved a statement on common values and principles in June 2006. We recognized that the health systems of the European Union are a central part of our social protection and contribute to social cohesion and social justice as well through sustainable development. The overreaching values which underpin our health system are universality, access to good quality of care, equity, and solidarity. Together they constitute a set of values that are shared across Europe.

Universality means that no one is denied access to health care so that it is closely limited to the financial arrangements of the health system and the need to ensure accessibility to all. Equity relates to equal access according to need regardless of ethnicity, gender, age, social status, and ability to pay. Health systems also aim to reduce the gap in health inequalities. Closely linked to this is the work on the prevention of illness and disease by promoting healthy lifestyles.

However, we cannot deny that within the European Union we are still confronted with a fundamental debate about the relationship between the above-mentioned values on the one hand, and the principle of a single economic market on the other hand. It is difficult for me to consider that due to the application of single economic market rules, solidarity should become only a

secondary priority. Although it can be accepted that some market-oriented principles are applied in the health system, I am strong convinced that there are substantial differences between services of the health care sector and services of the commercial market. Health systems must be organized to deliver equitable access to effective care. Health systems must do more than simply meet express demand by individuals, and must actively assess the health needs of the whole population. The market for health care delivery is inevitably imperfect and increasingly complex, creating major information asymmetries. The basis on which a market rests is that the consumer possesses all the information on which he can base purchasing decisions.

This is not the case for health care. Demand for health care is mainly directed by providers. Just try to call five doctors next time you are sick and ask them how much it will cost to treat you. Probably most will say we cannot say until we have seen you because we do not know what is wrong with you or even what it will take us or our colleagues to find out. This is why we need to see you. Of course, there is unequal distribution of risk. High-risk individuals would find themselves priced out of the market because adverse selection mechanisms would apply. Consequently, governance in the European Union has played in the past, and I am convinced it will also be the case in the future, an active role in the organization of health care in order to correct these market failures.

In Europe we can say we have the same values but very different systems. Although we share the above-mentioned common values in health care, the way in which these values are implemented in the national systems are very

different based on different historical developments, cultural differences, and national democratic consensus. Generally, difference is made between Bismarkian and the Beveridgian models, between social health insurance and national health services.

The Belgian health system is based on responsible partnership. It is based on social health insurance. In fact, this model incorporates the following elements. First of all, financing is based on risk independent and transference contribution as a percentage of the wages of the insured persons. These contributions or premiums are not linked to the health status of the insured person. The contributions are also collected separately from general revenues. A second characteristic is the solidarity in coverage funding and benefits packages. In my country, the entire population is covered by the social health insurance system. Funding for all insured persons is by risk adjustment mechanisms and through state subsidies. Thirdly, sickness funds play a central role as payers or purchasers. These funds are private, not profit organizations. Every person has to choose a sickness fund or affiliation. In the fourth place, negotiation and consultation are core elements of our social health insurance framework. Sickness funds and health providers negotiate together on the national level about payment schedules, quality of health care, and other matters. The agreements they make offer not only guarantees of financial security to the patients, but introduce also price stability in the system as a whole.

This mechanism of agreements contains equally elements of flexibility in order to achieve the maximum adherence of the health professionals. Finally, the individual choice of providers for ambulatory care and for hospital

care, and the free choice of a sickness fund, other central elements of our social health insurance system.

Belgium has a large range of health care providers and hospitals. We have no waiting lists. It is important to stress that outside of social health insurance, no commercial or for-profit sector has been created. In short, we can say that the organization of the Belgian health care system is based on the associated values of responsible partnership, and responsibilities are shared by employees, employers, sickness funds, health providers, and the government.

Now I should like to say some words about the sustainability and value for money. Nevertheless, as it is the case in many developed countries, we just take up the challenge of achieving financial and long-term sustainability of our health care system. We must make a distinction between the external economic and social environment on the one side, and the threats to sustainability which originate inside the health care system itself on the other side.

The main pressures arise from new technologies' price trends rising, patient expectations, and aging populations. However, the real issue is not from the rising cost of an aging population, it is on the contrary, people today lead longer and healthier lives than just a generation ago. The real issue is that we need to invest the available health care resources wisely to provide best quality returns for the patient.

I agree with the leading health care economist Uwe Reinhardt from Princeton who observed probably a little bit provocatively that catch words are sustainability or affordability. I am not so helpful in the debate on health policy -- the debate which concerns the two main issues, getting better value for growing

health care spending, and organizing the social contract between the better off in the society and the lower-income groups, the value for money debate. It is of course a difficult one. "We pay equally for wasteful care as for valuable care so that we get a good amount of each," wrote David Cutler from Harvard recently. There is no one-size-fits-all solution to achieve cost-effective Fund. Efforts to realize more value for money are often confronted with barriers created by those who pretend that cost is not a consideration in health care. Advances in medical technology are an important factor of increases in health care expenditure.

Therefore, we decided in Belgium to include evidence-based criteria in the health insurance coverage decision making. For sure this is not an easy process. Moreover, and it is a little bit strange, it seems easier to say no to new technologies and procedures than to turn back the utilization of less-effective but conventional practices. We must also make more efforts to reduce the well-known problem of inappropriate variation in medical behavior. The purpose here is to refer to standard profiles for responsible medical prescribing and medical care for the number of hospital stays. A more rational distribution of having medical equipment and centers of cardiology has been decided, and cooperation between hospitals has been encouraged.

A part of the way forward can be made by developing improved measures of health systems' performance so that we know when we are on the right track. The development of a balanced scorecard for the health care system seems an attractive idea. The introduction of pay-for-performance incentives also looks like a promising pathway. Also a robust evidence base on the effectiveness of these programs is not yet available.

And now the headlines of the Belgian health policy between 2003 and 2007. I take this opportunity to inform you about the main topics of our health policy just because I think that an exchange of information is interesting. Although reform took place in this period, we have introduced some major changes in different domains. Specifically, I will mention the information concerning the improvement of accessibility, the creation for room for innovation in the field of pharmaceuticals, the strengthening of the primary-care sector, and the financing mechanism in the hospital sector.

Accessibility relates to different elements. The most important are related to the extent of the health coverage and the benefits which are covered under the social health insurance and, of course, through the impact of cost-sharing and co-payments. Although the entire population residing in Belgium is under the social health insurance, not everybody has the right to the same entitlement. Until now, a difference is made between a general scheme and a scheme for a self-employed person. The latter are only insured for what we call major risks which coincide with hospital care. As from January 1, 2008, this distinction will be abolished progressively. No difference will any more be made based on the professional situation of the patients.

A second important reform concerns the modulation of co-payments. Not all benefits of the benefit package are covered at 100 percent. Patients pay a proportion, approximately 10 percent of the cost for different benefits. Earlier I mentioned already the problem of unequal distribution. In fact, 5 percent of the patients consume 61 percent of the total social health insurance expenditure, but these 5 percent are also charged 35 percent of the total amount of

co-payments. Therefore, the system called maximum billing was introduced. This reform aims to limit the cost of co-payments of each family to a maximum amount per year that varies according to the income of the family the person belongs to. Nearly 10 percent of the households are concerned by this reform. Finally, measures were also taken in favor of specific patient groups, people with low income and patients with chronic diseases.

I believe you expect some words about the pharmaceutical policy. Governments all over Europe are struggling to maintain a difficult balance between ensuring affordable access to pharmaceuticals and encouraging innovation and competitiveness. A few years ago this balance was strongly loaded. On the one side we were confronted with high expenditure per capita with overruns every year and a growth rate of nearly 10 percent. On the other side, Belgium is a country with high employment in the pharmaceutical sector and a rather important investor in pharmaceutical research and development. In the last years we have tried to create a new equilibrium. In order to create head room for innovation, it was necessary to advance the use of generic drugs and to introduce strong competitive pricing incentives for products out of patent. Here too we learned 5 years ago the -- pricing system in which the out patent drugs that have the same active ingredient are grouped. Whereas in the year 2000, generic drugs were billed only 1.1 percent of the volume of reimbursed pharmaceuticals, this figure climbed in 2005 to 18.5. In order to obtain the best price for out patent drugs -- procedures were also organized. Equally priced reductions were decided for pharmaceuticals reimbursed for more than 12 years.

Finally, the gross annual budget for pharmaceuticals has been established in consultation with the industry. If the budget is exceeded, a claw-back mechanism is applied and the pharmaceutical industry has to finance a substantial part of the overspending. Besides these measures, a set of incentives for group prescribing practices were put in place in order to enable doctors to make informed choices for rational use. Periodical feedback is organized for doctors that contain their prescription patterns, comparing them with other physicians of the same qualification. I can give you a good example, namely, the use of antibiotics. Due to the permanent action campaigns, the use of these products was reduced the last 5 years with 8 percent every year. Finally, legal targets are fixed to encourage doctors to prescribe generic drugs. This is one side of the balance.

On the other side, specific measures were taken to promote innovation. New drugs are classified in different categories in order to recognize the degree of therapeutic innovation for pricing and reimbursements. A dialogue platform between the government in investing in the pharmaceutical industry was set up presently. Faster access to new treatments for patients was organized. Our procedures were modernized, and a new pharmaceutical agency has been set up.

Last but not least, according to the so-called Lisbon Agenda, specific financial incentives to promote research were enforced by a recent law. In the last few years, pharmaceutical expenditure has stabilized. The growth rate is less than 1 percent. This result was attained nearly without global extra efforts for the patients, and also -- primary care. Although no gate-keeping function was introduced for the GPs in Belgium, we are strongly convinced of the necessity to

take a number of decisions to reassess and strengthen primary care. The reason therefore is obvious. As health care becomes more and more complex, navigation and guidance of patients in line with the help they are seeking and the management of chronic care must be seen as a core competence of the GP. Therefore, we considered in this system the general of a global medical patient record held by one GP freely chosen by the patient as a priority. GPs can charge a fixed amount per year to keep the global medical patient's record and to share relevant information with other providers responsible for the patient. Patients can receive a reduction on their co-payments when their GP is -- of their global patient file.

We are also confronted with other phenomenon which is well known in different countries. In fact, the dominance of specialty care has increased in the last 20 years, while the interest in primary care as a career has waned. Fewer GPs than needed are entering on the medical scene. We are now undertaking a long-term effort to create an organization and financing reforms for primarily care providers. Agreements were made about better remuneration for GPs for consultations, home visits, and out-of-hour shifts. Moreover, a special fund was created which grants loans and subsidies for doctors who will start a practice in a region which a shortage of GPs.

New financing mechanisms for hospitals have been foreseen. In the last 20 years there has been a gradual move toward prospective financing. In 2002 the step was taken to replace the per diem rate by a hospital budget based on -- profile of the hospital stays and on a normalized length of stay. Last year a special pharmaceutical budget was introduced in the hospitals taking into account

also the medical activity of the hospitals. And in the future we must not only integrate medical activity, but also the parameters of the quality of care in our hospital financing system. As a result of these policies, we could present a balanced budget to the Parliament as from 2005 until now. Moreover, we created a positive financial margin and we have shaped an agenda for the future.

Let me take a last question which deals with the preparedness of our health system to meet shifting health care needs due to the increasing burden of chronic conditions. The WHO commented very clearly that chronic conditions will be the leading cause of disability in the next decades, contributing to more than 60 percent of the global burden of disease. If not successfully managed, they will become the most expensive problems to be faced by our health care systems. Health systems have not evolved to meet this changing demand. The specific nature of many chronic diseases as well as the diverse needs that they create requires a multi-phased response. Experiments with new models of care delivery to address the complex challenges posed by the rising burden of chronic illness are developed whereby health care delivery is redesigned to achieve better integration of services across the continuum of care. Experience of integrated-care models is still fairly recent. We must still learn from the challenges associated with implemented integrated care. Challenges are present on the policy and on the organizational level. Implementing integrated care will mean designing new financing methods, tools, and procedures both on the macro and the micro levels. The fragmentation of health care planning, financing, and organization must be overcome by creating the right incentives and partnerships. More attention must be paid to the promotion of healthier lifestyles. Publicity

became in some sense the new smoking. Health condition linked to this emerging epidemic includes two types of diabetes, heart and vessel diseases, and joint problems.

Developing this new design will not be an easy task. In Belgium we have already some experience with what we are calling clinical pathways. Nevertheless, it is essential to bundle our ideas and to benchmark our results with other countries, and related to the issue of integrated care, it is better to use information about technology which can also result in better utilization of resources, and I think it is necessary to place priority on the implementation of electronic health records and telehealth applications. Developing a digital backbone to support communication between providers will be the first priority in our country in the forthcoming years. Recently a new agency was created to coordinate all the efforts of health providers, sickness funds, and governance.

Finally, some closing remarks about quality. OECD suggested very well when saying that people are no longer satisfied by looking at health in terms of set spending per head or the number of hospital beds, on the assumption, of course, that they ever did. People will become increasingly critical about shortcomings in their health care system. They wish an answer to the following questions. Do we get all the care we should? How good are survivor rates after serious surgery? What are the best practices? Is it clear that the quality concerns will find better prominence on our political agenda? Therefore, we need to develop quality indicators that go hand in hand with quality information. Together they empower better decisions and with the right policy and willingness to do, they are an important factor to produce health care for all.

This is our mission. By organizing our health system in that way, we will contribute to a positive forward-leading investment. I thank you, I hope that we will be able to exchange our experience to learn from each other because I forgot to tell it in the beginning, but one of the most amazing associations is when you go in a country you always hear you have the best health care system in the world. I believe Belgium has the best health care system in the world, you believe it is the United States, one of us must be wrong. I believe we have very much to learn from each other.

(Applause)

MR. BENJAMIN: Now I would like to thank you for a wonderful presentation. I would like to invite our commentators up. We have first Diane Rowland. Diane is the Executive Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid -- she is an adjunct professor at the Bloomberg School of Public Health at Johns Hopkins, and she has had an array of different positions from Capitol Hill and the Executive Branch as a distinguished expert in this field.

I would also like to welcome Henry Aaron who is a Senior Fellow and the Bruce and Virginia MacLaury Senior Fellow in the Economics Studies Program here at Brookings. He has directed the Economics Studies Program, he has been an Assistant Secretary of HEW, and he brings long-time experience -- including a recent publication, his most recent book, "Can We Say No to the Challenges of Health Care Rationing?"

Diane has to leave a little early so what I would like to do is turn it over to her to begin with, and then we will hear from Dr. Aaron and we can then open the floor for questions.

MS. ROWLAND: Thank you very much, and thank you for having me here. But especially thank you for this ability to hear about the Belgian health system and to hear about a system in which we are struggling with some of the same changes. I do not think that as an American analyst I would ever call ours the best health care system, so I do not think we need to debate that right now. Certainly, any health care system that leaves 46 million of its people out of health insurance coverage has a lot to look forward to in terms of reform, and any system that is the most expensive in the world that is not delivering always the best care out to learn from Belgium. So I really pleased that we could be here today and listen to your comments, and I applaud what you have done and what you are able to do and what you still have yet to accomplish.

I do think though that you framed some of the questions that we all struggle with: do we all get the care we should; how good is the care we get; and can we get better outcomes for the dollars that we are spending on health care.

But what really strikes me is the lesson that I take most importantly from your comments, the importance of having everyone covered. I do not think that we can accomplish any of the things that you propose to do and have gone as well as accomplish cost containment in a system in which we leave 15 to 16 percent of our population without health care coverage and on their own when they try to seek coverage and on their own when they have to go pay for it, often

having to pay retail prices rather than getting the benefits of having a negotiated rate from either their insurance coverer or from a government program.

I look at what is going on in the United States today and I look at some of the states like Massachusetts and a recent proposal from California where there is an increasing recognition of the need to return to universality and universal coverage and put it back on the spectrum. I guess it is a hard reflection for some of us. I worked in the Department of then Health, Education, and Welfare when Henry was there as the chief health policy and economic policy in the department when we thought we would get universal coverage and national health insurance. We have tried it a few more times since in my career, and I guess listening to some of our presidential candidates that are now declaring, today John Edwards announced his health care plan, maybe the universality is being put back on the table both by the efforts that some of the governors have led and now by some of the lead-up to our 2008 campaign.

But one of the other issues that I think your remarks really brought out is that the health system is different from a commercial market, and we have not really learned that very well in some of the policy that we are embracing today in the United States. In fact, you said that health systems must do more than just sell products, they have some other levels of guarantee, and I think one of the struggles we are going through is that we talk about transparency and learn what prices different doctors charge, and your point can you really call five doctors and say what would you charge me for this undiagnosed illness that I have. And we are trying to really move more and more of the decision making onto the consumer as if it is the same as buying an automobile or buying a toaster,

and I think that it really is not. When I look at the whole movement even toward health savings accounts, I take from your comments the importance of primary care and of getting early access to a medical home. Yet we have to wonder in our system if we are saying to people you go out on your own, you find the prices, you find the doctors, that we aren't instead of evolving people toward a system in which they have a medical home where they have standards of care that can be utilized, we are leaving consumers to really go out into a market in which there is little information, little transparency, and no ability to negotiate for the kind of care that they need.

I also thought that from your comments you had the stressful point that it is providers who actually control how health care is delivered, and providers who also control how much we spend on health care, and that it is a lesson to us that if we are really looking at cost containment in the system, we ought to remember it is the physician who writes the prescription on the pad and governs how much and what kinds of drugs are being used and that we really need to have a much more provider-oriented strategy in this country toward bringing down health care costs rather than a consumer and consumer pay more and be a wise purchaser strategy.

I think finally that one of the other lessons is that we hear so much here about how government has no role in health care costs and that we can send out individuals and split the risk pool and let them work on individual issues, but when we talk to our public, when we do our public opinion work, we see that the public actually thinks that their employers have relatively little ability to get them better value for their dollars on health care spending, that they do not think they

have much control over health care costs in the market, and they are now looking at Congress and looking at government to take a bigger role.

This is actually the first time in our public opinion polling in the last 10 years that the public has been very positive about what government can do instead of being negative, and so I think we are beginning to see in the United States that perhaps the public is a little ahead of our policymakers at learning the value of what government can do and of understanding that it is large entities like your sickness funds instead of multiple tiny entities that really do have the purchasing power to reshape the way that we deliver health care.

I think too that you have given us some instructive examples of the fact that you can control technology and technology dissemination to some degree without incurring necessarily long waiting lists and without incurring public rancor. I am not quite sure in the United States if that would work because we seem to want to control costs, but never to give up any of the care that might be involved for it or have to wait for it, so I do not know if the American impatience will ever be as responsive as the Belgians were to some of the reforms you implemented.

Finally, I think that one of the important things that you give us as a lesson is that you have to be sensitive in cost-sharing and in imposing consumer costs on ability to pay and how that influences those who are very sick. You pointed out that 5 percent of your population incurred 61 percent of your expenditures, here 20 percent incur 80 percent, so we too have a system in which most of the people who use most of the dollars are really sick and would in a cost-sharing sense have higher levels of cost-sharing that do not obviously affect the

wealthy or the healthy. So I think we really need to take some cautionary lessons for both the role cost-sharing can play in helping to moderate utilization, but equivalently to be sure that it is not such a burden that we are not getting the equitable care that people, especially those with limited resources, deserve.

I take away from your talk the fact that we often are too isolated in the U.S. and we need to learn more and listen more to the experiences of others. I think there is a great deal that can be shared and learned about how to implement some of the new technology, some of the new information requirements that we have, but I think you have pointed out to us that it is pretty critical to have coverage for your population as the beginning point of trying to move forward with reforms that would change the health care system. You have pointed out the importance of primary care, something that I think we need to do much more to promote and to gain access to in the United States than we have in the past. And I think you have given us a lot to think about in terms of where we go forward as we now see the recurrence of our health reform debate at the state level and increasingly at the national level, what lessons can we learn from you and from the fact that there may be things that IT can accomplish, and there may be things that talking about pay for performance can accomplish, but the whole health system is a whole lot more complicated than that and we need to make sure that in all of our reforms we do not leave those who are the poorest and the most vulnerable in our society out.

I thank you for your comments, I think you have given us much food for thought, and I appreciate the opportunity to both learn from you and to be here today with you. Thank you.

(Applause)

MR. BENJAMIN: Thank you very much, Diane. We can turn it over to Henry Aaron.

MR. AARON: I once remarked that at Brookings one could find the full gamut of opinion ranging from K to P, and I think that Diane and I are going to exemplify that tradition today in sounding a rather what I would call a centrist but similar note about the problems we confront.

To an American, the most striking aspect of the comparison between discussions of health care in Belgium as the Minister demonstrated today and those in the United States is that Belgians are worried about statistics regarding expenditures that Americans would kill for. The Belgians currently spend a little over 10 percent of their GDP on health care and rising expenditures have been a source of very considerable domestic concern. I cannot remember when we last crossed the 10-percent level, and we are now at 16.

Like most of Western Europe, Belgium spends about three-fifths as much on health care as the United States does, per capita that is, and like most of Western Europe, Belgium achieves slightly better health outcomes than we do in terms of life expectancy and infant mortality. It occurred to when I saw one statistic from the OEC that may be because the obesity rate in Belgium is only about a third that of the United States which as I understand not attributable to superior American cooking.

(Laughter)

MR. AARON: But the statistical comparisons raise a number of puzzles. Lower spending in Belgium occurs despite the fact that it has about 75-

percent more hospital beds per capita, and hospital stays that are about twice as long as they are in the United States. At the same time, a recent comparison published in Health Affairs, one of whose editors is here today, showed that the United States compared to other developed countries does not spend a whole lot more per capita on hospital care than other countries do, but it spends hugely more on outpatient care than other countries do. So I put those two facts together and I am scratching my head. I cannot quite reconcile them.

But these same sources also report that Belgium has about two-thirds more physicians per capita than the United States, and that they typically practice in a way that American analysts now criticize as just terribly inefficient, namely, as solo practitioners. To compound that sin, I read that they still engage in that atavistic practice of making home visits to patients, something that has vanished from the United States for a long time. One again has to scratch one's head, it really is not as inefficient as we Americans think it is.

Turning to finance, I was struck by three contrasting aspects of Belgian finance, and if I have my facts wrong, I hope somebody will correct me. I will speak in broad qualitative terms. The first fact is that Belgium spends, like most of Western Europe, three-quarters to 80 to 85 percent of total health care spending through government outlays. In the United States, the corresponding number is 45 percent, and as we all know, that applies almost exclusively to the elderly, poor, and disabled, and I am not including whatever revenue loss occurs through the tax system in that total. So for the vast bulk of the population, there is very little direct government spending on health care.

The second fact, and it is really two facts, are that the distribution of patient spending out of pocket seems to be rather different in Belgium than in the United States, with more spending out of pocket at the upper end of the income distribution, and much less down at the bottom. Let me give you an anecdote. If I go to see a physician, at least one who is approved by my health plan, it costs me $15 regardless of what the physician does. My wife had two visits recently to the emergency room. In neither case did she stay overnight, in both cases the bill was slightly over $1,000 each, and we paid something on the order of 5 percent of the total cost of the stay. As I understand it, somebody in my economic position in Belgium would pay more than that for similar services.

In contrast, down at the bottom of the income scale, stop-loss provisions which effectively insulate people at the bottom of the income scale from almost any out-of-pocket cost if one excludes unapproved drugs, protects the bottom end of the distribution far better and more pervasively than is the case here in the United States. The bottom-line question and one that I think Americans should ask everybody they see from Western Europe is this, how exactly do you really keep costs under control? We do not ask that question because unlike Diane and me, a great many Americans are too busy congratulating ourselves for having the best health care system in the world, a claim which I actually think has an element of truth, but only an element of truth.

The Belgians have been troubled by rising costs. The Minister did not emphasize that so much today, but I believe it has been an important part of the debate there as the share of GDP rose inexorably going to health care, and I think I understand why. It is that increasing costs are always troublesome because

they require very significant adjustments. But the U.S. level of spending is so much higher and we do not to all appearances get more, certainly not correspondingly more, in the way of health care than the Belgians do, and the proof is, as the Minister suggested, they have a significant export business to Brits and Swedes who are coming to avoid queues to the Belgian system and to get at least comparably high-quality care.

My conclusion is to ask Mr. Demontte not to worry about being an impolite guest, but to give us his advice on how you manage successfully to rein in costs. Listening to you and having done a bit of reading before this session, it occurs to me as Diane suggested in her remarks that the explanation may well be that you have a number of large payers who have very considerable leverage over the health care delivery system, in contrast to the United States which has literally hundreds of thousands of small payers, one really big payer, namely, Medicare that is politically proscribed from using its market power to try to control spending, and that we get what we would expect in a situation comparing those two environments. Thank you very much.

(Applause)

MR. BENJAMIN: Thanks to both of our panelists, and at this point I would like to open it up to the floor for any questions you might have for the Minister or for Diane Rowland or Henry Aaron. So please raise your hand, and when you are given the mike, please do introduce yourself.

QUESTION: I have a question for the Minister. I am Tom -- from Merck. Mister Minister, if I could ask you on a point I think I understood you to make which was that in Belgium there is no for-profit private sector providing

health care, and could you elaborate on that and what that means? For example, are all doctors government employees? Are they only paid by the government? I was not sure I understood exactly what you meant.

MR. DEMONTTE: Like I told it, it was difficult to understand. We have a very open system. We have a kind of balance between different interests. First of all, what concerns at the hospitals, the doctors, institutions from our health care system, they can be public institutions or private. But anyway, when you speak about the institutions, they enter in a frame of a convention so you keep a certain freedom, you have the freedom of your own money, but you have to answer to conditions that we have fixed in the law.

For instance, let's take different examples. When you enter in the hospital, there are what we call general conventions with the different specialists, and when you undergo an operation, we fix the amount that can be reimbursed by the state. Someone can say because I am a very big specialist, I want more than the price that is fixed by the law. How does it work then? Then the person has complementary insurance and can say let's go, I choose you. I want you to make the operation and I have complementary insurance. Or the person can say I will pay the difference from my own. Or the person can always say I do not believe the added value of your personal intervention has to be paid so much and I will take another specialist.

To answer your question, the status of the institutions can be public or private, but when we speak about the private institution, it is not based on the idea of making profit with a system of shareholders. So we have some

institutions that can say we are private institutions, but they have always to answer to the same kind of rules.

The doctors' concerns in the ambulatory care, we do not have state doctors in Belgium. They are a very small minority and they are -- officers and they are a very small minority, and they are not general practitioners that you meet. They have for instance control tasks or such things. All the others are private GPs. They just have to know the people they will cure or care. These people will be reimbursed on the basis of tariffs that have been negotiated with the state insurance company. How does it work? These are general agreements, and if people want to have another doctor that did not agree with the convention, because you are not obliged to follow the general convention, you stay free to say I follow tariff that have been negotiated or you can say no, I do not follow them. If someone goes to a doctor who has no conventions, he or she knows she will have to pay maybe another tariff, but the reimbursement stays based on the convention. So it is a little bit an analogy the same system as the one as I described in the hospitals. I do not know if it is clear, because for me it sometimes very difficult in English.

MR. BENJAMIN: We have another question right here.

QUESTION: Mr. Demontte, thank you very much for this presentation. I am Belgian and I have lived here for the last couple of decades, and for once I am proud to be Belgian to indicate from the whole group here the superiority of the Belgian medical system which I have been associated with with my father and my relatives.

I will mention three points that I have written down here, cost increases in Belgium; it is easy to go to the doctor. It is easy to get a doctor to come to your house. You call him in the morning and he says I will come at 3:00 or at 4:00. You are assured one or two doctors. You can stay in the hospital for many more days, and you indicated twice as long as here. It is not delivering a baby and out tomorrow morning, you stay several days until you are convenient and the family situation is taken into account and very much appreciated by the Belgian public.

I know you debate a lot with doctors, and some of them hate you, and the pharmaceutical industry must hate you, hospitals must hate you. Congratulations for all this, and stand up for that and stick it out.

One element that Henry also indicated is the supply of doctors in this country. Milton Friedman already mentioned when he was a graduate student and he had a monopolistic supply of doctors, the limit of the number of doctors of the medical school, totally different in Belgium, so we have twice as many doctors. Henry indicated a percentage I was unaware of.

One element that did not come up is the tort system in this country. I am a -- 30 percent of the fee is in order to pay the insurance. This is something that I think maybe in the reforms in this country should be and deserved to be looked at. Thank you.

MR. DEMONTTE: I believe my wife still loves me, and my cat.

MR. BENJAMIN: Your cat is a doctor?

MR. DEMONTTE: My cat is not a doctor.

(Laughter)

MR. AARON: Cats do not love anybody.

MR. DEMONTTE: I have to manage very contradictory interests, and people think always they have more to expect about -- so for instance when you take the general practitioners, their wages have been risen very much more than since the 1970s they did not have such big augmentations of wages. They are not still happy. I know it is something in human nature to be like this. But we have to manage with a real problem, that is, it is the problem of having an adequate answer to the demands of the people. You see that some specialties now are rarer. For instance, in Belgium we have a problem with pediatricians, and I do not know whether it exists in English, geriatrics. Why? Because their wages as specialists are lower than for other specialties and is an orientation during the studies toward the specialties that give more money. I can understand it, that is why are now rising the wages of certain specialists in Belgium.

About the limitation of the GPs in Belgium, I have a lot of critics now because I want to maintain a system of -- so for the very long list of people hating me in Belgium, the deans of universities hate me also. No, no, it is not true. They are not aware that they have more GPs almost anywhere else in the world, and they still want more. But it means also that it is not automatically because there are a lot of GPs that costs of health care rises. This is something interesting because there is an ideology saying this. So you see anyway the results are there.

When I came into the department, we had a deficit from almost the first year of 700 to 750 million euro in the department. Now we have a margin, and this is important. It is not to get money, it is to reimburse new medications, it

is to answer better to the needs of the society, and this is what I believe is the most important, to have an agreement around your policy. It is to convince people that what you do, you do not do it only for money, but money is a means to achieving better quality.

MR. BENJAMIN: Thank you, Diane, for coming today. We know that you have to run to another engagement, but thank you very much. Do we have any other questions?

MR. GUZNER: My name is Merrill Guzner (?). I am curious about how these sickness funds operate. You said they were not insurance companies as such, and yet they negotiated with the providers. If you could maybe describe a little bit about the legal structure of the sickness funds, I would be curious to hear that.

The second question related to that is have there been any high-profile battles between patient advocacy groups or Belgian citizens and decisions made by these sickness funds? Presumably in certain cases they have limited care where it was deemed either not cost-effective or somehow it just was not worth the money for the system to pay for.

MR. DEMONTTE: I will maybe leave the floor for this question to our specialist here because he is the general director of the insurance health care system in Belgium.

SPEAKER: In fact, the sickness funds have a special characteristic. They have different functions. They are not only insurers or purchasers of care, but they are also administrators of the system. That is of course a huge task in which they have to balance and make a tradeoff in their

organizations. The third task of them is to be the patients' advocates. In fact, sickness funds are making agreements on the national level between all the health professionals. I think it is one of the characteristics of our system that we are negotiating all the time with doctors, with physicians at hospitals and so on, in order to make the right balances, and these agreements are binding for the doctors and are binding for the other health providers.

In fact, their receive money on risk -- basis. This question of funding, they are of course related to the risks they have on the population. We have seven sickness funds. They are not-for-profit. They have different tasks. I explained earlier the financing mechanism. I do now know which elements you want to know, how are the functioning, or can you explain a little bit more which elements you would like me to stress out?

MR. GUZNER: Presumably they come in the negotiations with physicians and/or possibly from the general population, there are demands, if you will, for certain treatments. For instance, I just read either over the weekend or last week, not in Belgium but in Great Britain, where the National Institute for Clinical Effectiveness is being pressured to support pills for Alzheimer's disease even though most of the evidence suggests they are not very effective, and yet there is a big advocacy campaign to get them paid for. I do not know if that is going on in Belgium, but when confronted by an issue like that, how has it made controversial decisions, how does it deal with that, does it come under pressure, what kinds of pressure.

SPEAKER: There are patients' advocates, but one of the characteristics that I have not mentioned yet is the fact that they all the same

benefit basket to cover, they cannot negotiate or compose a proper benefit basket. A benefit basket is defined on a national basis between the health providers and of course the Minister and Ministry. Therefore, when there are complaints of patients, they will be discussed in the negotiation commissions, but they cannot differentiate in the health basket between one sickness fund or another. They are not competing on benefit baskets, for instance. They have to apply the same prices also. It is in fact the same system as in Germany. And you have of course contact with the patients because they are reimbursing the patients, and when the patients are paying too much or when patients have complaints about not reimbursed practices or not reimbursed products, of course, that will come from the bottom up and each year sickness funds together with the administrators of the systems are making an inventory of needs and are looking if we can integrate these elements, this technology, this new procedure, into the benefit basket.

MR. BENJAMIN: Are there any other questions?

QUESTION: How do the contributions work for the citizens? Is it through wages? Are there employee shared contributions, employer shared contributions as well? Is that bracketed by income?

SPEAKER: You have to make a difference between the official rate and the implicit rate. In fact, in Belgium we have one social security funding, funding which is going into employment and pension schemes, retirement schemes, family allowances and so on. One of these parts is attributed to health insurance. A few years ago, 10 years ago, there was a proper rate and we saw that every year our budget came to a deficit, while all the budgets of social security had benefits, for example, family allowances, that we make a whole sole funding

of social security. In fact, the implicit rate of the health insurance should be 12 percent of the wages.

QUESTION: With no limit?

SPEAKER: With no limit. Of course, there are states and cities, but when we transform our income based on contributions, the implicit rate is 12.0 percent, to be precise.

MR. BENJAMIN: If I could ask one question, I do not know if you have this statistic at your fingertips, but do you know what the comparative compensation is of a GP in Belgium versus one in the United States?

MR. DEMONTTE: Health care in Belgium it costs something like 10 percent of the GP, and here it must be around 15.

MR. BENJAMIN: I meant the individual compensation of a doctor. What does a GP make in Belgium as opposed to in the United States?

SPEAKER: An average -- you have good practices and bad practices, but I think a general practitioner at a good practice will earn in Belgium 150,000 euro, in dollars it is -- but that is all the good practices, and of course the best practices are 200,000 for a general practitioner. There is a fee for services, too, also.

MR. MUSGROVE: I am Phil Musgrove. I am one of the editors of Health Affairs to whom you alluded a while ago. The standard way economists think is that expenditure is prices times quantity, and what Henry pointed out was that the quantities are all going in the wrong direction for this comparison. You have more hospital beds, you have more doctors, and you have fewer limitations on people seeing doctors. That would lead you to think

immediately that it must be that all the prices are lower which is why this last question is important.

If your expenditure is not higher and the quantities are higher, something else has got to be lower, and I think that is probably misleading as we need to cut this down finer partly for the reason given over here. One of these prices is what lawyers are taking home, and that is a large share here of which you have managed to avoid. Another piece of it is the profits of insurers beyond what it would actually cost to run a system and partly that is because we have these thousands of payers. So if you knock those two out of it, then you come down to actual prices times quantities for medical care. I imagine if you do that, the difference would shrink.

But it would still be mistaken because the presumption would be that your doctors and our doctors are doing more or less the same things, and I would be willing to bet that is not true. There is an interesting comparison in a recent issue of Health Affairs, in fact on cardiovascular disease, which shows that we have made great progress in the United States, we really have been very, very successful in reducing deaths from cardiovascular disease, but we may much better for the more expensive things than we do for the cheaper ones, and so we are twisting the quantities in the wrong direction inside the total quantity for doctors and hospitals and it is the detail probably of what your doctors for their $200,000 a year versus what ours do where the difference is going to show up after removing the lawyers' fees and the insurance profit. I do not see that anybody has quite made that comparison, but if that were taken apart so that the quantities are not doctors and not hospital beds, the quantities are specific

procedures, then maybe we would begin to understand the difference in overall expenditure.

SPEAKER: Let me just inject because I think it would clarify the penultimate question and the answer to it about GP incomes. I just asked whether that figure included or excluded practice costs. It includes practice costs. Net incomes are a good deal lower. When you look at physician income figures here in the United States, it is typically net of practice costs, so I am not sure what the size of the adjustment would have to be, and apparently there is a tax differential that is included as well.

SPEAKER: It is a different issue -- undertaken research about income of doctors in OECD countries and we are confronting with huge differences and huge problems of comparison. But to react to Mr. Musgrove's intervention, our administrative costs are very low. We have administrative costs of our health insurance of 4.2 percent of the expenditure which is one of the lowest rates we can see in Europe. And of course, you are right also when you made the conclusion that of course our fees must be not so high, and that is one of the problems of our doctors, of course, to negotiate an affordable level and increase of their fees. And that is one of the advantages. The Minister mentioned in his speech that referring to increase in inflation of medical fees, there is course disagreements, disagreements which must be negotiated within the budgetary target.

MR. BENJAMIN: Do we have any more questions? The coming near anyway, so with that let me bring this to a close. I want to thank Minister Rudy Demontte, and I want to also echo Henry Aaron's remarks which is do not

be shy about saying your system is better than ours. I do not know if it is the best in the world, but with our 16 percent of GDP going to health care, we can learn an awful lot from you, and we hope that you will be back to give us more tips on how to improve our delivery system. We have a notice from the back.

SPEAKER: (Off mike)

MR. DEMONTTE: I have just been informed that we have here a clip that has been made for the sixtieth anniversary of our social security and I believe this clip could be interesting for Americans.

MR. BENJAMIN: Very good, as long as I do not have to operate it.

SPEAKER: It is actually a clip that we had last year made to celebrate the 60 years of the social security system in Belgium, and I will just try to show it to you. It is going to be small as you can see on the screen, but I guess should be fun.

(Video played)

PAULA: Let's go over to our international correspondent Larry Fox. Larry, oh my God, it looks like something terrible has happened to you.

MR. FOX: Hi, Paula. Well, no, actually something really great happened to me today. This afternoon while setting up gear I was run over by a cyclist and luckily I was able to get immediate medical attention. That is not so uncommon here since there are about four doctors for every 1,000 inhabitants. I was taken back to a medical practice, and without even asking for my credit card.

PAULA: What?

MR. FOX: That's right, without even asking for my credit card, a doctor gave me a full medical checkup, and before I knew it, there I was again shipshape and ready to go, and I only had to pay about 20 euro. But do you know what is really amazing about all this, Paula?

PAULA: No, I don't, Larry.

MR. FOX: Social security reimburses 75 to 85 percent. So if you want to break a leg, here is the place to do it. This is Larry Fox reporting to you live from Brussels, Belgium.

PAULA: Wow, that is incredible news. Thank you, Larry.

(Applause)

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