INDIA ip PLATFORM

# Focus Group: Health Care

## An Invitation to Join In

### Universal Health Care – How Flanders and India can Help Each Other

Based on the input we have received in the past few months from various actors in the domain of health care, this note gives the outlines of a possible direction they could jointly work towards. It is by no means a finished product: the ideas have to be developed further, the questions need to be formulated more clearly by the different experts involved, and channels for funding need to be identified. What we have tried to do here is provide a framework to contribute to this joint endeavour.

*Paradise on earth*

It is not an exaggeration to say that the Belgian system of universal health care is one of the best in the world: it provides medical care of a very high standard that is affordable and accessible to everyone. In Europe most countries have similar systems, but none are as comprehensive and social as the Belgian system. About 99 per cent of the population in Belgium is covered by the compulsory health insurance which includes more than 8,000 types of services[1]. The essence of this system is an idea born out of solidarity: groups of people put an amount of money together to provide in each other's health care. The idea is simple: by carrying the burden together it becomes less heavy. Even though over time the small-scale initiatives grew into a well-organised system, partly covered by the government, its core of solidarity is still as essential to it as it was originally. Without this aspect of solidarity the system would lose its foundation and eventually collapse.

At first sight this does not seem likely to happen soon: a study conducted by the Flemish government in 2011 shows that 92% of the Flemish people are "overall happy about the health care in our country." The same study also states that 76% of the Flemish people think it is "unfair" to make health care dependent upon a person's income[2]. In another, more recent study, conducted among the Belgian

[1] Gerkens, S., Merkur, S. (2010). *Belgium: Health system review. Health Systems in Transition*. In Grijpstra, D., Broek, S., Buiskool, B-J., Plooij, M. (July, 2011). *The role of mutual societies in the 21st Century.* Brussels, © European Parliament.

[2] Pelferne, E. (2013). *Perceptie van de gezondheid en de gezondheidszorg bij Vlamingen. Resultaten van de ISSP – survey 2011*. Brussel. Vlaamse Overheid, Studiedienst van de Vlaamse Regering. D/2013/3241/047

population and commissioned by the RIZIV[3], participants responded to 81% of the questioned aspects with a very great to overwhelming degree of satisfaction about the Belgian health care system[4]. On the basis of these figures one sees no immediate reason for concern. Yet, there *are* serious reasons for concern.

*Sustainability of the health care system?*

First of all, the financial need of Europe dictates a reduction in state subsidies for its health care system. The increasingly older population, by contrast, is exerting pressure to increase the outlay on its health care system. But the greying population is not the only problem. The growing medicalization (increase in treated diseases and the number of pills prescribed), the increase of diseases related to a high standard of living and the increasing cost of new techniques and medical devices, equally threaten the sustainability of our health care system[5]. The financial pressure will only grow in the future. If nothing happens an increasing part of the health care budget in Flanders will inevitably have to be carried by the patients.

On the other hand, already today we see indications of shortcomings in a few crucial aspects of the current system. The recent study conducted by the RIZIV[6], shows that not all Belgian citizens experience the kind of access our health care system claims to give. A part of our population delays or cancels a doctor's appointment or does not undergo important surgeries because they are scared to end up in poverty. The RIZIV study shows that 10% of the population faces a serious problem of access to the health care system. For those who do have a good access to the health care system, a shortage of medical staff is manifesting itself. Another problem patients face are long waiting lists for treatments that require scans from highly specialised and costly devices of which there are only a few in Belgium.

These trends are increasingly looked upon as our inescapable destiny: our standard of living will not remain the same and this will include cuts in our system of health care.

*The foundation of solidarity under pressure*

Equally worrying, however, is a trend that seems to go hand in hand with this acceptance: a disappearing or disintegration of the foundation of the system of mutualities: its solidarity. Whether or not it is an effect or another cause of the unsustainability of this system, a trend towards less solidarity in our society is apparent. A few indications:

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[3] The 'Rijksinstituut voor Ziekte- en Invaliditeitsverzekering' is a federal Belgian institute that plays an important rol in providing and regulating the insurances for sickness and invalidity.

[4] Elchardus, M., Te Braak, P. (2014). *Bevolkingsenquête 'Uw gezondheidszorg, Uw mening telt!' Onderzoek uitgevoerd in opdracht van het Rijksinstituut voor Ziekte- en Invaliditeitsverzekering (RIZIV) naar aanleiding van zijn gouden jubileum*.

[5] Descan, J-P., Léonard, C., Lewalle, H., Evrard, D. (2006). *1906 – 2006 Landsbond der Christelijke Mutualiteit, Een eeuw solidariteit*. Brussel. pp. 45-46.

[6] Elchardus, M., Te Braak, P. (2014). *Bevolkingsenquête 'Uw gezondheidszorg, Uw mening telt!' Onderzoek uitgevoerd in opdracht van het Rijksinstituut voor Ziekte- en Invaliditeitsverzekering (RIZIV) naar aanleiding van zijn gouden jubileum*.

1. The survey of the RIZIV[7] shows that a majority of the Belgian population believes that (a) social fraud with regard to health care occurs at a large scale in Belgium, (b) the existing control mechanisms are inadequate to deal with it and (c) there is a demand for more stringent monitoring and reprimanding. The prevailing opinion about the large-scale occurrence of social fraud influences the readiness of people to contribute to the health care system. According to a study conducted by the Flemish government in 2011, only 1 in 4 Flemish people would be willing to pay more taxes in order to improve the health care for all Belgian citizens. The resistance to pay more taxes is the greatest among the younger part of our population: less than 1 in 5 of the young adults is willing to pay more taxes for general health care (18%); about half of the young adults claim to be 'reasonably/ very unprepared' to pay more (46%).

2. Studies, as well as discussions in the media, show that it is no longer unthinkable or undebatable to make refunding of the treatment of diseases or the contribution to the health care system dependent on one's life-style, general health condition or age. About 11% of the respondents in the same RIZIV survey thinks that elder people should contribute more to the health care insurance than young people because they need more health care. The support for differentiation according to life-style is even larger: according to 25% of the Belgian population non-smokers should contribute less than smokers; 28% of the population thinks that people who do not consume alcohol should contribute less than those who do. The costs of diseases and accidents due to reckless behaviour should not be refunded (entirely) according to 17% of the Belgian population.

3. According to the same survey of the RIZIV, 28% of the Belgian population wants to exclude patients above the age of 85 from refunds of vital treatments, 32% is against covering the treatment of rare diseases, and 41% wants to exclude refunds of implants of high-tech hart-devices if the cost of the intervention is above 50.000 Euro. The kind of care we can and want to provide to the ageing part of our population is a question that also lives in other parts of Europe. In Germany, for instance, elderly people are put in homes in Poland because it is cheaper[8].

4. Recently we have seen a few cases where refunds of extremely costly medication or medical interventions were questioned. One such example was the media storm in May 2013, caused by the refunding of the medicine Soliris, which costs 18.000 Euro per month, as part of the treatment of the rare immune disease HUS. Not only the very high price of one treatment, but also the PR-campaign of the pharmaceutical company Alexion which made use of the 7-year old patient Viktor, gave rise to a controversial debate.

5. From the survey among the Flemish population, conducted by the Flemish government in 2011, we learn that the idea of opening up our health care system to foreigners is not evident. To the claim that "people should have access to public health care, even when they do not possess the Belgian nationality," 40 % of the respondents reacted with a clear "yes". According

[7] Ibid.

[8] Connolly, K. (28/12/2012). *Duitsland 'exporteert' bejaarden*. De Standaard. http://www.standaard.be/cnt/dmf20121227_00416090

to about 30% of the respondents, however, access for foreigners to our health care system should not be guaranteed, and the remaining respondents were in doubt (27%) or didn't know (4%)[9].

All these aspects point to a disintegration of the solidarity that forms the foundation of our health care system. Making the contribution to the health care system dependent on the health of a person, for instance, goes directly against the idea of helping each other to make health care accessible to everyone in equal ways. Whether these trends are a consequence of the pressure on our health care system or one of the causes of this pressure, it is clear that it contributes to breaking the system down.

*A move towards medical tourism*

If less treatments are refunded by the mutualities this implies that these have to be paid for by the patients themselves. If the same treatment, of the same quality, is offered in another country at a much lower price it is predictable that people will go abroad for it. The problem with medical tourism, however, is that it brings along a whole range of problems: it is not part in any way of our system of health care but organised through private insurance companies, there is no communication between the doctor at home and the doctor abroad, if medical mistakes are made there is no channel to address them, all complications have to be taken care of by the doctor at home, who often does not have the medical details of the treatment undergone abroad. In other words, patient mobility in the form of medical tourism, in an unguided, unsupervised and uncontrolled way, leads to medical disasters. On top of this, it will strengthen the 'each for him- or herself' attitude and an *ad hoc* approach to health care. People will make use of channels like the internet to go window shopping for the most 'commercially viable' treatments. As such, health care becomes a private affair, unrelated to the health care of others. Such an approach is detrimental to a system based on solidarity, built up over more than a century and rooted in society.

In other words, if these threats and trends are not tackled, more will happen to our society than only a decrease of living standard. (1) The decrease of solidarity will weaken our social fabric; (2) the number of people living in poverty will increase; and (3) more people will move towards medical tourism, reinforcing the idea that health is a private responsibility.

But, does it all have to happen like this? We do not think so. On the contrary, we are convinced that it is possible to find solutions to all these problems, while retaining our current standard of living. We believe it is possible to save what is beautiful about our system and even to improve it, if we look at the challenges from a global perspective. This brings us to the idea of a social translation of globalization.

*Social translation of globalisation*

In the early phase of selling globalisation to the European public, the following story was popularized in the media by both politicians and policy makers. Given the relatively cheap skilled labour and lower

[9] Pelferne, E. (2013). *Perceptie van de gezondheid en de gezondheidszorg bij Vlamingen. Resultaten van de ISSP – survey 2011*. Brussel. Vlaamse Overheid, Studiedienst van de Vlaamse Regering. D/2013/3241/047

costs of production of goods and commodities in Asia, it is profitable for the western industries to shift their loci of production there. It also makes macroeconomic sense to do this, despite the resultant loss of jobs in Europe and America, because the cheaply produced goods allow western consumers to benefit. Asian societies and economies will also benefit from this relocation because of its obvious impact on their local economies.

This story has changed in the course of the last five years or so, beginning with the financial mort-gage crisis that America unleashed upon the world. It now transpires that western nations (both consumers and governments) were living above their means and that their massive consumption of cheap goods produced in Asia and elsewhere has substantially contributed to this crisis. Consequently, the story is now one of huge austerity measures and slashing of budgetary deficits across all sectors.

If we put the two stories together, it appears as though 'globalisation' is the root cause of economic crisis and that austerity is the only answer that our national economies can afford. Even though much more can be said about this issue, we have said enough to summarize the slogan of today: European consumers should become poorer if the Asians have to prosper. We do not believe that this story is true, despite its popularity. The capitalist economies generate new wealth and do not merely reproduce and divide a fixed amount of wealth; the prosperity of one section of a people does not require the impoverishment of another section.

Rather than seeing globalization as an evil we think it brings about immense opportunities for social solutions to our problems: if we look at the problems we are facing on a global scale, solutions present themselves to us. The problem of one country is often compatible with a problem of another country, each providing the solution for the other. If we look at Europe and India, we see many such compatible problems. To give just a few examples: Europe has a greying population, India has a very young and dynamic population. Europe has an immense reservoir of scientific expertise, preserved and passed on through a centuries old research tradition; India, on the other hand, has a gigantic number of young graduates who are not being trained in any research tradition. In both cases, the respective situations can be beneficial for each other: experienced retired Europeans can help establishing a research culture in India while their students can be attracted to come and contribute to Europe's development as engineers or doctors.

In the domain of health care too, we see that social globalization can offer a solution to the pressure on our system of health care and by extension those of Europe at large, while at the same time addressing some of the problems that India faces.

*The Indian context*

In India, the following broad changes can be observed in the health care 'system':

Due to the lower standards of living the costs of health care are much lower in India than what they are in either America or Europe. Certain hospitals, however, offer health care of a very high quality. This means one can get sophisticated health care there at comparatively low costs. According to the Indian Medical Travel Association & US News & World Report of 2008, a hip replacement in India costs about one eighth of what it costs in Belgium and a coronary artery bypass surgery comes at around a

fifth of the cost in France.[10] Hence it makes good economic sense for Europeans, Americans and people from the Middle East to seek sophisticated health care in India. As a result, there is an increasing amount of 'health tourism' initiated by American private insurance companies. Amongst other things, this is resulting in the creation of elite hospitals in India catering increasingly to native wealthy clients and foreign patients.

One hugely negative impact of this development is to be seen among the middle class in India. Its growing middle class is squeezed between the increasingly unaffordable treatment in elite hospitals and the very low level of health care provided by government hospitals. The growing small nursing clinics and hospitals are woefully inadequate to meet the demands of this huge middle class. Less than 15% of the Indian population, moreover, is covered by any kind of health insurance and those health care schemes provided by the government that do exist do not cater to the middle class, leaving them out completely.

*The proposed solution: 'global health care'*

Both the situation in India and that in Belgium can be addressed once we look at them jointly: We help *introduce the Belgian model of universal health care in (one region of) India to develop a system that also caters to the Belgian citizens*. We work towards a system of universal or global health care for both Indians and Belgians – introducing a system of health care in India based on our model, while taking away the pressure on the Belgian system. Instead of standing on the side-lines and impoverishing our much-envied health care system or, *we save our health care system by generalizing it*: we promote the idea of a "global health care" by outlining policies and projects for collaboration with India that are beneficial both to Belgium and to India. What nourishes and drives the establishment of such a "global health care" is not just economic profit but above all a possibility to prosper by helping each other, to make society better by taking care of each other's needs and profit from that.

Implementing this solution can only be the result of the collaborative effort of multiple actors and organizations: from governments through insurance companies to hospitals and medical colleges in both parts of the globe. This is something that cannot happen on a short term. Therefore, we suggest to begin with two regions[11] – Flanders in Belgium and Karnataka in India[12] – and work in two phases of implementation.

[10] The total cost for a hip replacement in Belgium was €9115 in 2006-2007 (http://www.test-aankoop.be/gezondheid/heupartrose/nieuws/de-prijs-van-een-heupprothese). The indicative cost for a hip replacement in India is 1200 USD (Indian Medical Travel Association & US News & World Report of 2008).

[11] Even though in this note we focus on the threats to the health care system in Belgium and its effects on Flanders, these are not unique to this region alone. To a large extent they also apply to the rest of Europe. This means that a solution for Belgium can, in the long-term, also bring about a solution for Europe at large. Similarly, India is too large to address as a whole. Here too, successes in one region can be extrapolated to the rest of the country. So, even though we focus on the problems of Belgium and how these can be addressed through collaborations with one Indian state, Karnataka, this is framed within the larger and longer-term objective of addressing the situations of India and Europe.

[12] The region in which the India Platform is building its consortium and focusses its activities.

- In a *first phase* we intend to bring part of the *Flemish health care to India within the structure of our Belgian mutualities and through active collaborations between Flemish hospitals and the existing hospitals, clinics and nursing homes in the region of Karnataka*. In this phase the focus lies on the situation in Flanders and on setting the ground for implementing the second phase, which focuses more on the Indian situation.

- In a *second phase* we intend to *introduce the Belgian model of universal health care system* in India, beginning with Karnataka. This system will also be beneficial to Belgium as it will include health care of Belgian citizens. We intend to meet this challenge by developing consortia of hospitals, medical colleges and insurance institutes and companies in both India and Belgium (to begin with). In the *long term*, this will allow Indian universities and hospitals to play a pioneering role in helping Belgium (and Europe) to re-think and reorient its federal health policies. Here we also see a possibility to rekindle what we risk to lose in Belgium and Europe, the basic solidarity that gave rise to its health care systems. Thinking about how to introduce our health care system in India will inevitably involve a reflection on what makes it valuable to our society.

Even though both phases are essential to the idea of a 'global health care', in what follows we will focus on the first phase and how it can be beneficial to Flanders as this is a note meant for the Flemish stakeholders.

*Universal health care or medical tourism?*

As said, we want to explore whether it is possible to bring part of the Flemish health care to India, within the structure of our Belgian mutualities and in the framework of collaborations between Indian and Flemish hospitals, clinics and nursing homes. How do we see this?

Exploring this avenue will involve time-bound exchange of staff (surgeons, doctors, interns, etc.) between Flanders and Karnataka. Within these exchanges and collaborations pilot projects can be set up in which Flemish patients are treated in India, by their own doctor in collaboration with the local doctors, at the same or even better quality and at a much lower cost. Additionally, revalidation can happen in a nice and relaxing setting together with their partner or a family member, combined with an experience of the beauty of India. In collaboration with the Flemish and Belgian governments, the RIZIV and the Flemish mutualities a structure will be set up through which these treatments can be covered by our mutualities. The quality of the treatment and the revalidation are thus assured at a much lower cost for and burden on the Flemish health care system.[13] In doing so, the ground for austerity measures in the health care system – measures that lead to discussions about differentiated rights to coverage by the health care system and affect the solidarity in our society – can be reduced. Additionally, the financial burden on the patients, the part that is not refunded by the mutualities, can be lowered or removed in the cases of surgeries that are not completely covered at this moment.

[13] Travel and boarding and lodging in a nice revalidation resort of both the patient and the accompanying person included.

The short-term benefit for the Flemish hospitals and doctors is the clinical experience accruing from treating many diseases (which most in Europe read only in text-books or rarely come across). These will be of incalculable value in adding to the expertise of the Flemish hospitals. In the same move, they can also enter into agreements with many new medical colleges in the region of Karnataka and influence their further growth. On the Indian side the doctors will start research collaborations with the Flemish doctors and professors. This will bring about the kind of research culture that is typical for Europe which India lacks. Additionally, it will give hospitals in Karnataka a view from close-by of our system of mutualities. This will be an incentive for an exploration of the local dynamics and kinds of solidarity, indigenous to the Indian society, which could provide the basis of an Indian system of universal health care.

In this framework we could also start training Indian nurses: Flanders has a huge shortage of nurses. India, on the other hand, has a large number trainee nurses. We could set up an exchange, where Indian nurses are first trained in hospitals in India (and also learn Dutch), then come to Flanders for a period of time to be trained and work in Flemish hospitals. When they are ready and wish to do so, they can return to India to work in the hospitals linked to the project.

*How is this idea of 'global health care' different from medical tourism?*

Medical tourism is different from the proposed form of patient mobility in two important ways: (1) It implies a 'fend for yourself' situation. When a person makes use of medical tourism she takes care of her own health care. Any idea of solidarity is entirely absent here. The patient mobility we propose occurs within the Belgian system of universal health care, based on the idea of solidarity. (2) The medical care happens in collaboration with Flemish doctors and with a guaranteed quality and follow-up, thus also protecting the patient from falling in the wrong hands. In the case of medical tourism there is no collaboration between a Flemish doctor and the treating doctor abroad, which leads to major problems and huge costs in the case of medical complications. Our proposed avenue will reduce the pressure on our health care system and thus prevent people to move towards medical tourism.

*What is needed for this?*

Such a solution can only be successful if it is (1) supported by a range of actors in both the Flemish and Indian societies (2) based on fundamental research and (3) implemented by the relevant bodies in Flanders.

(1) Who are these different actors in the first phase?

- Flemish mutualities
- The RIZIV
- Flemish patients organisations
- Flemish hospitals, clinics and nursing homes
- Flemish doctors and researchers
- Scientific associations related to specific diseases

- The Flemish and federal governments in Belgium
- Hospitals, clinics and nursing homes in Karnataka
- Doctors and researchers in Karnataka
- The government of Karnataka
- Health care organisations / associations in Karnataka
- Respected figures of authority in health care in Karnataka

(2) Fundamental research

Bringing about the solution proposed here requires a lot of research on a range of issues:

- Concerns of the Flemish patients: what are the doubts, hindrances, etc. of Flemish patients to go to India for health care? Under what conditions will they be motivated to go to India to be treated? What are the criteria used to make this decision? What kind of problems do Flemish patients confront when they are treated in India and how can these be solved?

- The juridical aspects of such a structure, both in Flanders and in India.

- The issue of language. Even when patients know English, it is not easy for them to communicate symptoms.

- Cultural differences related to health care such as differences in the patient-doctor relationship.

- The local dynamics and kinds of solidarity, indigenous to the Indian society, which could provide the basis of an Indian system of universal health care.

*To enable this research, the research questions will need to be clearly formulated by the different experts involved in this endeavour*. On the basis of these research questions several projects or research activities will need to be initiated. Several smaller projects can be applied for or initiated by the different research groups involved, while at the same time jointly applying for larger and longer-term projects. As mentioned in the introduction, this note is meant as an invitation to (1) help formulate the ideas and the problems to be addressed in better ways, and (2) join in finding funding opportunities of different kinds.

A possibility to start are two or three pilot projects of Flemish doctors of which the different aspects – juridical, medical, social, and cultural – can be studied by the research groups. These doctors will motivate a few of their patients to be treated by them in India as part of a project. On the basis of the input we have received so far, we have tentatively identified two medical domains and a few doctors who are willing to take part in such pilot projects. The medical domains are: (1) orthopaedic surgeries of the knee and hip and (2) cardio-vascular treatments. For both domains, treatments can easily be planned in advance and highly specialised scanning devices are required that are often rare in Belgium but available in the good hospitals in India. With regard to the latter, we could also focus on highly specialised and very expensive treatments such as, for instance, orthopaedic surgeries of the foot.

The current note could function as a framework to work out these projects. User groups can contribute to the formulation of what Flanders needs and explain how they see the benefit in exploring the solution proposed in this note. The respective research groups can work out the research questions specific to their domain of expertise.

(3) Implementation

On the basis of the research the relevant actors in Flanders and Belgium can start setting up new health care policies and structures.