

REFLECTIONS ON THE VISIT BY THE BELGIAN DELEGATION, FEBRUARY 2003

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Introduction

From 15 to 27 February 2003, a visitor to the Council for Medical Schemes (“the Council”) may have been forgiven for believing that the Council had extended its regulatory powers to the European Union. Apart from the fact that Dutch and French was frequently heard in the corridors, the routine interaction on regulation of medical schemes was interspersed with discussion on regulation of health funders in Belgium and the rest of Europe.

Yet alas, despite the fact that imperialist ambition seems to be driving world politics at present, the Council’s powers remain squarely located within South African borders. The foreign presence in the office was rather the result of a visit by our counterparts in the Belgian health system, at the Council’s invitation.

The delegation was headed by Mr Christian Langendries, Administrator-general of the Belgian Control Office of Mutual Health Funds, together with his General Advisor, Mr Yves Debruyn. Mr Langendries is the direct counterpart in Belgium of our Registrar of Medical Schemes, Mr Patrick Masobe. Mr Jos Kesenne, National Director of the National Alliance of Christian Mutual Health Funds, joined the group to bring a health funder’s perspective to discussions. The National Alliance of Christian Mutual Health Funds is responsible for 43.4% of covered lives in Belgium – equivalent to some four and a half million people. The delegation was completed by Mr Willy Palm, Director of the International Association of Mutual Benefit Societies (AIM), of which the Board of Healthcare Funders of Southern Africa (BHF) is a member.

The idea for this visit was born during 2001, when a small delegation from the Council for Medical Schemes conducted a study tour of the health financing systems of various European countries. In the course of this visit, the Council for Medical Schemes met with their counterparts in the Belgian Control Office of Mutual Health Funds as well as several other important roleplayers in the Belgian health financing sector. The representatives of the Council for Medical Schemes were particularly struck by the stark similarities between the policy imperatives underlying the system of regulating private health care financing in Belgium, on the one hand, and principles underpinning our own Medical Schemes Act as well as policy options currently being debated in the context of Social Health Insurance, on the other.

Of equal interest was the structure and functioning of the Belgian Control Office of Mutual Health Funds. Being a relatively young body, the Council for Medical Schemes and the Registrar's office were most impressed by the streamlined structure and efficient functioning of this office. They were similarly fascinated by the sorts of regulatory control requirements imposed by this office in respect of such issues as rules approval, submission of financial returns and audit reports, internal financial controls of sickness funds, reserve level requirements, reinsurance, investments, health education of members, and criteria for good governance.

"Such a lot to learn, so little time" was the concern of our delegation from the Council for Medical Schemes. At the same time, they wished that they could be sharing the experience of interacting with the Belgian regulators and industry representatives with a broader audience back home. And so they determined there and then to invite a delegation from the Belgian regulators and health funders to South Africa to interact with others at Council and in the office, and with a broader range of stakeholders. Some eighteen months later, this visit materialized.

The visit was a most memorable experience for us. We suspect that the visit was even less forgettable for the visitors, if only for the fact that the intensity of the schedule combined with an acute shortage of sleep resulted in severe exhaustion from which I am sure they are still trying to recover. During their last presentation on the day they were due to fly out, our European visitors politely drew my attention to the fact that that was their tenth formal presentation to different audiences, including amongst others: large gatherings of medical scheme trustees in Johannesburg and Cape Town; the financial solvency task team; the Departments of Health and Public Service and Administration; health care provider organisations; research groups; and trade unions. This was quite aside from two days of workshops and numerous informal discussions. However, before I get lambasted for lack of hospitality to our foreign guests, may I hasten to add that we still managed to fit in whirlwind tours of Soweto, the Apartheid Museum, the Cape Peninsula, and the southern parts of the Kruger National Park. Hence the lack of sleep.

A copy of their powerpoint presentation is available on our website. In this report, I do not intend to rehash that presentation. Nor do I wish to provide you with the broad understanding of the Belgian healthcare system that I have now had the privilege to develop. Instead, I'd like to share with you some aspects of our discussions that I found particularly instructive in thinking about the way that we regulate medical schemes in South Africa and the various policy options that confront us in shaping the future of our health financing system. My selection of issues, and the way that I choose to present them, is distinctly personal, and

may differ substantially from the impressions of others who formed part of the discussions. Opinions expressed herein are also not necessarily reflective of official Council positions.

Social Health Insurance as a Component of Social Security

One of the benefits of this particular delegation was their broad knowledge of health care systems in Europe more generally. They were able to elaborate on the differences between a national health service, such as has been implemented in the United Kingdom, and social health insurance. Within the social health insurance systems, they drew the distinction between countries like Belgium and France, on the one hand, where compulsory coverage within the system extends to the entire population, and countries like Germany and Netherlands where no provision is made for participation in the system for persons above a certain income ceiling or where this is optional.

The Belgian system was of particular interest to me in so far as it demonstrated the intrinsic linkages between social health insurance and the broader social security system, including disability benefits, unemployment benefits, pensions, child allowances and compensation for occupational diseases. I think there is a tendency in South Africa, and I too have been guilty of it, of looking at social health insurance policy options in isolation to the broader social security reform process, yet the Belgian experience suggests that you can't de-link one from the other. In the broader social security system, health care provision becomes an interest competing for resources with other social security interests, and the allocation of resources between these competing interests becomes a matter of ongoing public debate based upon societal priorities. Interestingly, in Belgium, health care's share of the social security pie has steadily increased over the past twenty years, to the extent that it is now competing with pensions as the biggest source of social security expenditure.

While the Belgian population appears to be very protective of their social security system, which is regarded as intrinsic to the fabric of their society, spend on social security ranks high on political agendas and public debate. In particular, employer and labour organisations are particularly vocal in these debates because increases in social security expenditure drive up labour costs, discouraging employment and making Belgium less competitive in the global market. In the example given by the delegation, 50% of total spend by an employer on the salary package of an employee went toward income tax and social security contributions.

Structure of the Industry

Whereas health care in South Africa, at least in the private sector, is big business, one gets the impression that, in many respects, in the Belgian health care system the "care" aspect is more prominent than the business aspect. That might seem to be a fairly sweeping statement, but after reading the following facts, you may be inclined to agree with me:

- There are many private hospitals in Belgium, in addition to public hospitals. However, with one exception, all of these private hospitals are not-for-profit institutions.
- Mutual health funds (the equivalent of medical schemes in South Africa) are private not-for-profit associations which see themselves as "social movements" rather than just health insurers. In addition to providing assistance in defraying the costs of medical interventions, they offer a range of other services to members including provision of health promotion services and clinical information, holidays for the chronically ill, babysitting of sick children, and so on.
- All mutual health funds are self-administered. The concept of third party administrators is unknown in Belgium.
- Brokers do not operate in the environment. Of note is the fact that, whereas members are permitted to change between mutual funds once every 3 months, only 0.5% of total beneficiaries switch between funds each year.
- Whereas private for-profit health insurers do exist, their share of the market is very small.

That does not mean that profit motives are not a feature of the Belgian health care system, or that business interests are not placing inflationary pressures on medical expenditure. Private medical practitioners have responded to tariff controls through escalating volume of services and less conservative prescribing habits. Their consulting rooms are rumoured often to be more full of pharmaceutical reps than patients. These issues are the subject to desperate measures by the Belgian government to contain costs, which are discussed in more detail below.

Until legislative reform of 1990, there were approximately 2000 mutual health funds in Belgium. The law of 1990 introduced a minimum membership requirement (15 000 beneficiaries), and within a year consolidation resulted in a reduction of number of funds to 150. Further consolidation has now reduced

number of funds to less than 100. Consideration is now being given to further increasing the minimum membership requirement to 25 000. Funds with a lesser number of beneficiaries are not considered to be viable or sustainable in the long term. I found this to be an interesting observation in our context, where many schemes do not yet meet our own minimum membership requirement of 6 000. It got me thinking that perhaps developments in the industry, such as the implementation of the new mega Public Service Medical Aid Scheme, should be viewed as useful opportunities for consolidation and overall strengthening of the medical schemes industry.

The mutual health funds are organized into several associations, the largest being the National Alliance of Christian Mutual Health Funds – of which our guest Mr Kesenne is the National Director. Whereas these associations were historically divided along ideological (political and religious) lines, these divisions are becoming less important, and mutual funds compete now for members based on efficiency and attractiveness of supplementary benefits offered. These associations nevertheless still provide useful mechanisms for internal control within the industry, and the associations themselves are subject to penalties if their affiliated mutual funds step out of line.

In addition to the mutual funds organized into these associations, there is a public-run sickness fund, which holds little attraction for members, and only 0.83% of the population belongs to it. This is not comparable to the State-sponsored medical scheme mooted in the South African social health insurance proposals, however, as it was developed for a completely different purpose – to accommodate people who couldn't reconcile themselves with the ideological departure points of the other funds.

Mutual health funds provide both the statutorily prescribed compulsory package of services (which is described in more detail below), and a range of supplementary services to meet specific consumer preferences. A member of any one fund cannot, however, opt out of the supplementary services offered by that particular fund, however, as they believe that social solidarity in the form of cross-subsidisation should take place between all members of the fund even for those supplementary services. This also explains why there are no benefit options within a mutual fund, as this would amount to splitting of the risk pool. It would also increase cost due to erosion of economies of scale.

The funds of mutual health funds in respect of compulsory health insurance are derived mainly from social security contributions, although there are limited government subsidies too. These social security contributions and subsidies are all channeled via a statutory body called the INAMI, which distributes the funds according to a normative risk adjustment formula – more about this below. In

respect of supplementary services, mutual funds are financed by contributions paid directly to them by members.

Risk adjustment

The introduction of a normative risk adjustment formula to determine flow of social security contributions through the INAMI to mutual health funds was a measure to promote greater financial responsibility of mutual health funds. The history of the development of this formula is less important for my purposes now than a broad understanding of how risk adjustment is done and what effects it has. The importance of this is related to the fact that the risk adjustment mechanism is in many respects similar to the risk equalization proposals in the Taylor Committee (Social Health Insurance) report in South Africa – and the INAMI in this role would be performing a function similar to the Central Equity Fund proposed in that report. The normative risk adjustment formula in Belgium is applied both to the distribution of social security contributions in respect of the compulsory health insurance, and to the distribution of government subsidies (from tax revenue) to mutual health funds in respect of voluntary health insurance.

A basic principle behind the risk adjustment is that mutual health funds should not be disadvantaged relative to other mutual health funds as a consequence of having a membership with a poorer risk profile – and that the mutual health funds should therefore be competing on the basis of efficiency rather than capacity to attract good risk (or avoid poor risk).

In determining distribution of subsidies or social security contributions, a basic amount per insured life is determined. Positive or negative corrections are then applied to this amount, depending on the actual risk profile of beneficiaries of each particular fund. These corrections are made on the basis of objective factors which have been proven to be determinants of claims patterns. These risk factors include: demographic factors (age, sex, family type); socio-economic factors (income, vulnerable social groups, unemployment); morbidity factors (mortality and disability); and environmental factors (urbanization and population density). The formula is determined by a consortium of academics in Belgian universities.

The result of application of these adjustment factors is a normatively corrected allocation per insured individual (in a particular mutual health fund), which when multiplied by the number of lives in the fund, will determine the total allocation to that fund. Mutual health funds with a substantially better membership risk profile will therefore receive somewhat less contribution or subsidy than funds with substantially worse risk profiles. The differences in these allocations are accounted for solely by the differences in risk characteristics of beneficiaries – so

that if two mutual health funds had exactly the same membership risk profiles, they would derive exactly the same allocation per insured individuals.

Surpluses or losses generated within a mutual health fund, once that risk adjustment has taken place, are therefore accounted for entirely by efficiencies within the administration of the fund or in terms of health care delivery to its beneficiaries. Efficient funds (which can render coverage at a lower cost than the normative amount) will over time generate surplus funds which can be used to build up reserves or to improve services to members.

Clearly one of the most important prerequisites for the creation of a risk adjustment system (certainly one as precise as the Belgian application) is the capacity of mutual health funds to generate sufficient high quality data to allow for application of the normative formula, and capacity of the regulator to check this data.

Tariff setting

The Belgians visited at a time when tariff setting procedures was a hot topic in the South African health care scene. Needing some inspiration on ways to prevent recurrence of the sorts of tariff impasses we've seen of late in the South African medical schemes industry, we were keen to find out how they did it in Belgium – particularly since they indicated that they have had a relatively stable tariff setting process since 1963. While the system used is sufficiently different not to allow its wholesale importation into South Africa at present, many of the principles underpinning it warrant closer consideration.

There is a two phase process to tariff setting, which takes place at the level of the INAMI. First, taking into account a financial assessment of health needs, a proposed overall budget for mutual fund expenditure on health care provision is determined in an insurance committee, which includes representation of the social partners with the greatest direct interest in health expenditure. This includes: government (which has an interest in balancing health expenditure with other social security expenditure); employers (who wish to contain expenditure to increase economic competitiveness); labour unions (who wish to maximize health benefits to their members while minimizing cost which can detrimentally affect the labour market); providers (who want to maximize remuneration); and mutual health funds (who are seen as advocates of consumer interests). The government representative retains a right of veto on decisions of the committee, however, as government must maintain balance of perspective with other legitimate governmental interests.

Once the global budgetary proposal is made and accepted by government, it is split into partial budgets for the various disciplines by the insurance committee,

and these partial budgets are then referred to tariff convention committees for doctors, dentists and other health professionals. The tariff convention committees have representation of only the funders and the health care providers – and are charged with determining procedural tariffs within the parameters established by the overall budget. Once agreement is reached on these tariffs, they are referred to the Minister of Social Affairs for endorsement, and official publication.

The INAMI then sends a letter to every individual health care professional asking whether or not they accept, and therefore commit themselves to charging according to, the negotiated tariffs.

In the case of doctors and dentists, if 60% of general practitioners and 50% of both specialists and general practitioners agree to the tariffs, the tariffs are finalized as official. Those practitioners who have agreed to the tariffs are bound by them, whereas the others are free to charge in excess of the tariffs (and are then reimbursed by mutual health funds at the same rate as other doctors but make up the difference in copayments by members). In general, more than 80% of practitioners subscribe to the conventional tariffs. Doctors are incentivised to agree to the tariffs, because failure to do so would put them at a competitive disadvantage. This is particularly the case because associations of mutual funds publish lists of “contracted in” doctors on their websites. In addition, a supplementary pension is paid by the State to doctors who subscribe to the tariff.

If either 60% of general practitioners, or 50% of both specialists and general practitioners, do not agree to the conventional tariffs, the Minister of Social Affairs has three options. First, to restart the negotiation process. Secondly, the Minister may fix the tariffs at which mutual funds will reimburse providers. Finally, the Minister may publicly impose fees which practitioners may charge – although this is viewed politically as the most unsavoury of the options.

The process in the case of other health professionals is similar. The only difference is that mutual funds reimburse those providers who do not subscribe to the conventional tariff at a rate up to 25% lower than those providers who do subscribe. The fact that doctors and dentists are not subject to the same penalty is more a consequence of the significant lobbying power of doctors than any logical rationale.

Hospitals operate within a budget determined by government, and this also determines the subsidy received by both public and private hospitals from government. The budgets are determined according to reference DRG pricing – and if this reference pricing is exceeded, the hospital is required to pay back a portion of its subsidy to the State.

This process demonstrates the importance of a formal institutionalized structure for tariff setting, where competing interests are able to be fully represented and are able to negotiate in a structured, scientific and disciplined manner. This process is not one which takes place at the end of a year, but is ongoing through standing committees. It further demonstrates the value of this negotiation taking place within the framework of a clear understanding of the financial parameters in which tariff setting can take place. A clear framework is provided for providers to opt in or out of the tariff structures, with clear consequences for the decision (together with understandable incentives to opt into the tariff structure). Finally, the existence of effective deadlock breaking mechanisms all along the way seems to be a crucial component of any tariff-setting system. What is, however, not clear from the Belgian process is how it will accommodate a shift to alternative reimbursement methods, which are starting to emerge in this predominantly fee for service system.

Content of the compulsory package

In thinking around possible policy options for the future of our prescribed minimum benefit package, it was instructive to hear about the make-up of the compulsory package in Belgium. At the outset, it is important to note that the compulsory coverage for formally employed people is more inclusive of minor risk coverage than for self-employed people (who pay lesser social security contributions), although self-employed people have the option of taking out supplementary minor risk insurance through mutual health funds.

Nevertheless, the basic principle applied is that compulsory health insurance should be more rather than less comprehensive, and that in general limitations on coverage should be imposed through greater or lesser copayments (depending on the level of medical necessity or discretion of the procedure) rather than limiting the scope of what is covered. There are nevertheless some limitations on the scope of the package. It does not, for example, include transport of sick people in general (though there are exceptions in relation to emergency transport); certain dentistry procedures (e.g. extractions and prostheses); spectacles (though there are exceptions); and "comfort" as opposed to necessary medicines (e.g. sleeping pills). For some services (such as speech therapy), preauthorization is required.

Copayments on the compulsory package may be as great as 25% on certain procedures, which can be reasonably financially onerous. However, special protection is provided to vulnerable social groups to lessen the burden of copayments. Widows, persons with disability, orphans and pensioners with an income below a determined level have a low annual ceiling on copayments; once that threshold is met during any given year, no more copayments are

payable and the mutual health fund pays in full. Registered chronic patients get a lump sum payment every year to cover a portion of their copayments. Furthermore, in respect of all other persons, there is a relatively high threshold on copayments, beyond which no further copayments are payable, so that no individual bears unlimited liability in the event of catastrophe.

It is interesting to note that coding for the comprehensive package (with code, descriptor and relative unit values) is developed, maintained and owned by the INAMI, which has a standing committee for this purpose comprising various stakeholders.

Governance of mutual health funds

With all the work that is happening in our offices at the moment in relation to medical scheme governance, we wanted to know what the comparable governance structures looked like in Belgium. Apparently, every mutual health fund is governed by a General Assembly. The General Assemblies of all mutual health funds are elected simultaneously once every six years though elections in which every beneficiary above the age of 18 is permitted to participate. There is no overlap of term of office between members of the General Assembly, but they are elected for renewable terms and so there is typically a fair degree of continuity of membership. It struck me that the advantage of all funds having elections simultaneously is that it would allow for national publicity and awareness campaigns to take place to maximize member participation.

The General Assembly then appoints a Board of Administrators which is in charge of general management of the fund and has certain residual powers, and which meets regularly. Certain powers (such as addition of a new service, or mergers) are, however, reserved for decision by the General Assembly. Twenty five percent of members of Board of Administrators may be persons not in the General Assembly.

Day to day management of the fund is performed by a Secretary – broadly equivalent to our principal officers.

Administration costs

When perusing the Registrar's Annual Report, the Belgian visitors were stunned at the level of administration costs in the South African medical schemes environment.

4.5% of contributions to mutual health funds in Belgium is spent on administration costs, for the delivery of both health and disability insurance. The real annual increase in administration costs in Belgium is less than 1%.

The Belgians considered the absence of both third party administration and brokers to explain, to some extent, the low administration expenditure relative to that of South African medical schemes.

The Control Office of Mutual Health Funds

The Control Office, counterpart to our office of the Registrar, was established through statutory reform in 1990. It is headed by an Administrator-general, equivalent to our Registrar of Medical Schemes. The Administrator-general reports to a Council, consisting of a Chairperson and 6 other members, appointed by the King for 6 years, including a representative of the Health Ministry with veto power (although this veto has never before been exercised). The Council is advised by a standing technical committee, also appointed for 6 years, comprising industry representation and representatives of the INAMI. The technical committee has advisory powers only.

The Control Office, like ourselves, is financed by levies imposed on medical schemes. It has a similar number of staff as our office (approximately 50 people), falling into four divisions, namely: the Office of the Administrator-general; Financial, Accounting and Actuarial Services; Legal Services; and General Affairs (Corporate Services).

- **Rules**

Rules of mutual health funds, or amendments to such rules, need approval by the office. These rules pass through a dual review by the Financial Service Division and the Legal Service Division (unless the rules are purely technical, in which case only the Legal Division reviews them).

A time limit for review of rule amendments by the office is imposed by law. The office has 45 days to review rules, but can request a further 30 day extension from the fund. A further defined period is allowed for communication of the decision to the scheme. Failure by the office to approve or reject amendments in that time results in their automatic validity. Until the office grants approval, new services cannot be publicized in any way by the fund – and implementation of any change is at the risk of the fund, who will have to compensate affected parties (including members) if the changes were subsequently not approved.

Provision is made for mutual funds to appeal against a decision of the office within 15 days of that decision being communicated to them.

- **Reserve regulation**

Three separate forms of reserves are required to be held by mutual health funds in respect of services for which they receive member contributions.

First, in respect of important and potentially expensive services, particular funds must be set aside which differ from service to service (called “technical provisions”). The quantum of these funds is calculated on an actuarial basis or as a percentage of expenditure of the preceding year – the percentage determined by various factors indicative of risk facing the scheme. For example, up to 50% of hospitalization expenditure of a mutual fund in the preceding year may need to be kept as reserves as part of these technical provisions.

Secondly, provision must also be made to cover claims that have been incurred but not recorded (IBNR). Typically 6% of the previous year's expenditure must be kept in reserve for IBNR.

Thirdly, an additional solvency margin must be maintained by the fund, to cover circumstances which are difficult to predict and which can detrimentally affect the solvency of funds. In respect of every service offered by a fund, a percentage of the previous year's expenditure (either 12.5% or 20%, depending on the nature of the service) must be maintained in reserve for solvency purposes.

If the required reserve levels are not met, the Control Office requires the mutual fund to provide a recovery plan to the office within 3 months which must contain a 3 year financial forecast for the scheme.

- **Reinsurance**

Reinsurance is not permitted at all for the compulsory package. In explanation, the Belgian visitors said: “otherwise it would be an insurance entity, not a mutualistic entity!”.

In respect of the supplementary coverage, reinsurance is permitted for cover for medical care abroad and for financial interventions that can exceed 5000 euro per year (R45 000) – up to a maximum of 80%. Reinsurance can have an impact on the technical provisions portion of the solvency requirements. In this regard, however, it is instructive to note that in Belgium reinsurance contracts are typically taken out for five to ten years, during which time the conditions are generally not permitted to change. In this regard, the Control Office reviews reinsurance contracts

before any set off against technical provisions in solvency requirements is permitted.

- **Auditors**

As in our case, effective financial oversight of mutual health funds in Belgium depends to a large extent on the quality of auditors' reports. The Control Office therefore has a substantial interest in ensuring that auditors are proficient in this environment.

Auditors are therefore accredited by the office following passage of an exam administered by the office, once every two years. Exams are drawn up in consultation with the National Institute of Auditors. Renewal exams are more technical than the initial exam. After six years, permanent accreditation is given. An annual comparison of audit reports is made, with feedback to auditors on the quality of their reports.

Apparently, the quality of audit reports has dramatically improved since this accreditation process commenced.

- **Sanctions**

The Control Office has a range of sanctions at its disposal, although the relationship between the office and regulated entities seems to be one characterized by voluntary compliance and immediate implementation of any decision of the office.

Administrative fines may be imposed by the office, the quantum of which depends on the type of offence. While funds may appeal against imposition of a fine, they must pay the fine upfront even if an appeal is pending. If the appeal is successful, the fine is refunded to the fund. The principle in setting the quantum of the fines is that the cost of non-compliance must be more onerous than the gain derived from the offence. The office can also publish in the Belgian official gazette, newspapers, other publications and public noticeboards notice of penalties imposed and any directive which was issued by the office which a particular mutual fund has not implemented.

The option of curatorship also exists, but this is very seldom applied.

Cost escalation

The single biggest problem confronting the Belgian system continues to be escalation of health care costs (so what's new?!) - mainly caused by normal

inflation and the increasing cost of medical technology (which is largely out of the control of mutual health funds). Some 22% of cost increases could be attributed, however, to increase in volume of services provided.

This volume effect may be attributed largely to Belgian's aging population and negative population growth rate – which is a major problem. Some 15% of the population is above the age of 65, and this is rapidly increasing. The volume effect is also attributed to the fee for service system, whereby health care providers compensate for tariff limitations by generating more services.

In response, there is now a growing shift toward capitation type models of reimbursement, and the budgeting of hospitals in terms of reference DRG pricing. In respect of the elderly, there is an increasing shift toward home-based care to contain costs.

There is also growing attention to cost control of pharmaceuticals and curbing inappropriate prescribing behaviour by doctors. Exit prices (at which pharmacies must charge for drugs) are determined by the Ministry of Economic Affairs, and a committee has been set up by government to determine which new drugs should not be reimbursed by mutual health funds. A reference pricing system has been established for generic drugs, which must be at least 26% cheaper than the ethical drug.

In addition, government has introduced a Pharmanet system, which tracks data on all pharmaceutical expenditure, noting prescribing habits of doctors. Data on prescribing behaviour is also routinely sent to doctors, and local peer review groups discuss it. At one stage, government wrote to doctors giving individual information on their prescribing behaviour, and pharmaceutical spend dropped by 30% in the next month in anticipation of government action!

Conclusions

The visit of our Belgian counterparts was a most satisfying and productive visit, and feedback from the various groupings that we met with confirmed that this was the general impression of the visit.

In order to effectively regulate the South African health system, it is imperative that we ensure that policy formulation, analysis and processes of regulating are at all times informed by the most up-to-date information possible on experiences in health care systems around the world. This is also the key to responding to resistance to necessary reform initiatives, which is often borne from ignorance of comparable reform elsewhere.

This visit provided the Council for Medical Schemes, the Department of Health, and numerous other stakeholders in the medical schemes and health insurance industry with invaluable insights into alternative approaches for the financing, organisation and delivery of health care services, the process and content of contemporary health care reform programmes and their implementation in European jurisdictions, and common challenges and opportunities. Sure, there are vast differences in the economies and demographics of the countries, but there is a huge amount of resonance in the principles underpinning the systems and therefore tremendous value in learning about different experience in policy implementation. It was a particularly valuable visit at this juncture when I think we are all still developing an understanding of the implications of the various social health insurance proposals currently under discussion in our country.

The Belgian visitors made it clear from the outset that they don't have all the answers and didn't intend to sell their system to us. But for me, to hear that in the past year, out of a population of 10 million lives covered by mutual health funds only 20 member complaints reached the Control Office, I figured they must be doing something right!