Study visit of three staff members of the NHSO (Thailand) at the NIHDI (Belgium) [November 12-22, 2013]

Yongyuth Pongsupap, Atthaporn Limpanyalerd, Weraphan Leethnakul, and Patrick Martiny

In the framework of the study visit to Belgium of National Health Security Office officials (NHSO), several two hour meetings were scheduled with managers/experts from NIHDI and partner institutions to learn about Belgian health care and health security system, dialogue on key issues and identify what could be transferable to Thailand or better, what could support reflection in Thailand.

Belgium and Thailand contexts related to health care system historical evolution are extremely different. While in Belgium, health care and solidarity emerged from the grassroots, being progressively nourished by new scientific knowledge and technologies, as well as progressively supported and regulated by the State (a bottom up approach), health care and solidarity in Thailand were top down set up by the government. Health care system developed through a serial of ruptures with traditional practices, scientific western medicine being introduced.

In Belgium, the freedom principle is very much valued, but the public regulation is very strong. Regulation finds its basis from negotiations between stakeholders who definitely must compromise. There is no gate keeping but conditions are set up to make people choosing the best path for the system (among others through the co-payment). In Thailand, there may be much more freedom and less regulation.

In Belgium, since most care providers are self employed and don’t have any salary, fees for service is their main source of income. The power of the national health insurance is consequently important as concerns regulation of practices. In Thailand, care providers under the UC scheme have a salary as civil servants, and NHSO has less mean to regulate the system.

Despite of these differences, the NHSO officials’ study visit at NIHDI allowed to underscore functions which are essential to ensure “Universal Coverage”. For each function, Belgian long experience can give examples on what can be done in a given context but also shows how it may be challenging. It should be carefully checked if these earmarked functions are performed in Thailand, and if it is the case, if they are properly performed, if there is any possibility for improvement. This exercise may lead to identification of specific operational issues which could be explored more in details by other NHSO staff in Belgium in the future.

---

1 Yongyuth Pongsupap (Senior Expert), Atthaporn Limpanyalerd (Director of Bureau of Secretary General), Weraphan Leethnakul (Assistant Director of Songkla Regional Branch Office), and Patrick Martiny (International Guest Expert)
The main functions on which it might be reflected are the following:

1. Distribution of competencies and functions related to health care management among national institutions
2. Provision of health care
3. Funds collection, allocation of finances for health care and pooling
4. Financing health care institutions and health care providers
5. Decision making for payment of fees for services
6. Decision making for payment of medicines
7. Operational management of payment
8. Co-payment by patients
9. Attempts for cost containment
10. Provision of evidence for decision making
11. Accreditation of care providers
12. Monitoring and evaluation
13. Evaluation and inspection

Two main issues were already identified for exchanging more in depth: the information system and the fees schedule (nomenclature)

Information system

In Thailand, development of the information system is in process. It should be effective, relevant and smooth, linking care providers, computer specialists and analysts. Currently, the public health facilities only are concerned, workload is a burden, there may be doubts related to the quality of data. Clinical information is not shared between care providers. Mainly "cooked" figures are forwarded to hierarchy, not data: good indicators are rewarded (incentives). There are initiatives, at national but also at district levels (some pioneers) to improve on the system. It is tried to identify the right questions, the necessary indicators. Mobilization of the appropriate technology is going on.

Much is being done nowadays in Belgium to that respect: many tools, several processes are put in place (E-health, data based shared by different institutions - both for health care and data analysis-), with respect of privacy. There is a link between transmission of data and financing. Since transmission of data is linked with financing, transmission of data is taken seriously; data are right even if control is necessary to prevent possible abuses. Belgium has some experience of partnership with Korea.
Fee schedules (nomenclature) for “primary care”

Belgium has a long experience of setting fees for services. It is the main channel for financing care providers even if more and more the share of input financing is growing (lump sum). Decisions related to fees are made with respect to negotiation between providers and sickness funds. NHSO intends to give access to some of its members (those working for local governments) to “private for profit” general practices, instead of to public facilities, only. To do this, it is necessary to agree on a fee schedule for “primary care”. Several questions may be raised. Is fee for services a good alternative to capitation? What may be the risks and advantages? How to decide on the technicalities for setting a fee schedule? Beside the fees, do others conditions need to be decided on? How to limit the costs? How to control the respect of the rules?

Acknowledgment

NHSO is grateful for the commitment of all concerned resource persons from NIDHI and related institutions who made efforts to understand the delegation sent to Belgium and forward concise and relevant information.
Annex 1: Content of the internship program

<table>
<thead>
<tr>
<th>Topics</th>
<th>Key resource persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/ Introduction of the Belgian health system</td>
<td>T. Rousseau Project collaborator NHIDI</td>
</tr>
<tr>
<td>2/ The role of the National Social Security Office in Belgium</td>
<td>K. De Ridder General Advisor NSSO</td>
</tr>
<tr>
<td>3/ The role of the sickness funds in the Belgian health care system</td>
<td>J.-P. Bronckaers Doctor Manager National Union of Liberal Mutualities</td>
</tr>
<tr>
<td>4/ Role of FPS Health and the Directorate-General for Healthcare facilities organization</td>
<td>C. Denonne Attaché FPS Public Health</td>
</tr>
<tr>
<td>5/ Nomenclature of health care services</td>
<td>B. Winnen General Adviser NHIDI</td>
</tr>
<tr>
<td>6/ Reimbursement of medicines</td>
<td>E. Vanhaeren, V. Van De Velde Attachés pharmacists NHIDI</td>
</tr>
<tr>
<td>7/ Accreditation and qualification of healthcare providers</td>
<td>B. De Vos Attaché NHIDI</td>
</tr>
<tr>
<td>8/ Controlling healthcare services and benefits</td>
<td>B. Hepp General Director Dep. Medical Evaluation and Inspection NHIDI</td>
</tr>
<tr>
<td>9/ Role of Belgian Health Care Knowledge Centre</td>
<td>F. Vrijens Project Manager KCE</td>
</tr>
<tr>
<td>10/ Budgetary and financial management of the health insurance</td>
<td>M. Breda Actuarial Advisor NHIDI</td>
</tr>
<tr>
<td>11/ The Belgian health insurance databases</td>
<td>M. Daubie Docteur en sciences de gestion NHIDI</td>
</tr>
<tr>
<td>12/ Recent reforms and current policy challenges of the Belgian healthcare system</td>
<td>R. De Ridder General Director Healthcare Dep. NHIDI</td>
</tr>
</tbody>
</table>
Study visit of three staff members of the NHSO (Thailand) at the NIHDI (Belgium)  
November 12-22, 2013

Annex 2: Summary of findings

Distribution of competencies and functions related to health care management among institutions

1. Competencies related to health care management are distributed among the federal – Ministry of Health and Social Affairs, Ministry of Finances, Ministry of Budget, Ministry of Economy - and also the community governments (Flemish, German, French), and their related public services.
2. At federal level, several institutions are under the authority of the Minister of Public health and Social affairs: NOSS (National Office for Social Security) & NISSE (National Institute for the Social Security of the Self-employed), FPS (Federal Public Service) for Public health, FPS Social security, NIHDI (National Institute for Health and Disability Insurance), IPH (Scientific Institute of Public Health), SHC (Superior Health Council), KCE ...
3. Responsibilities are clearly assigned; if any misunderstanding, it is referred to the State Council.
4. All these institutions cooperate.

Provision of health care

1. Main values of the Belgian health care system are solidarity/equity and accessibility of quality of care, freedom of choice for patients (and no gate keeping), therapeutic freedom for physicians…
2. Health care is mostly provided by not-for-profit organizations (hospitals) and self-employed care providers. Health units are mostly paid with lump sum and according to DRG. Care providers are mostly paid through fees for services, but more and more, the share of complementary lump sum is growing.
3. There is strong public regulation and governance is based on negotiations between main stakeholders: employers & unions, sickness funds, professional associations, academics ...
4. Equity/solidarity is somehow taken into account at level of funds collection (income and other taxes, contributions …) and the possible co-payment (special status for deprived patients, maximum billing, categorization of drugs). There is one system only which covers the whole Belgian population: same care for all.

Funds collection, allocation for health care and pooling

1. There are several schemes (6) for collecting contributions for social security: NOSS (employees and jobless), NISSE (self employed), from civil servants from the periphery
and … from miners and seamen; OSSO (overseas social security office) in charge for overseas workers.

2. Rules are set for contributions. Contributions for social security and taxes represent a high share of the gross salary (a burden). The net salary represents +/- (100/250) of the gross salary, only.

3. It is checked if registration due (declaration) is properly done, if contributions are paid for those who are registered and thus make advantage of the social security.

4. Social security covers health care but also sickness & invalidity, unemployment, retirement and survival pensions, accidents at work, occupational diseases, child benefits, holiday allowances.

5. All funds (but OSSOM) forward their share of contributions earmarked for health care to NIHDI in order to be pooled. Consequently, all have the same rights, same entitlement to reimbursement, according to same rules, this irrespective of the origin of contributions.

6. OSSO has its own regulations, from funds collections to benefits granted to the members.

**Financing health care institutions and health care providers**

1. NIHDI is responsible among others for paying health care providers, for drugs … this for all citizens (but overseas workers); FPS Health is responsible for financing health institutions, through NIHDI.

2. NIHDI financial resources come from contribution according to professional incomes (70%), income taxes (13%), and alternative financing like VAT … (17%). A right balance is necessary in order to ensure proper financing, to prevent too high labor costs, to respect equity and solidarity principles.

3. There is a theoretical growth rate of the budget for health care, but in practice, due to the financial crisis, there are budget cuts.

**Decision making for payment of fees for services**

1. Care providers are paid according to the services they deliver (acts): this is output financing.

2. It is decided which acts may be paid for: there are about 8,000 acts in the nomenclature. Technicalities of each act are defined, as well as conditions for payment. For each act, there is a code.

3. For each act, the importance of payment: a letter-key and a coefficient which determines the level of payment within the letter-key group. Is also decided the reimbursement rate.

4. The value of the letter-key is negotiated yearly or biennially between representatives of the sickness funds and of the health care professionals.

5. Decisions on fees for services are made through negotiations: proposals are made first by a technical committee for the technical content (universities & professional organizations/sickness funds); “conventions and agreements commissions” focus thereafter on financial aspects (professional organization and sickness funds); proposals are reviewed by budget control committee and eventually by the health care Insurance
committee (with all types of care providers negotiation together). The Minister of Social Affairs endorses the proposal.

6. Care providers may refuse the agreement, but lose then some advantages. Theoretically, patients know who respect the agreement and who does not.

7. Decisions are consigned in the official journal for implementation (royal decree).

8. The system allows for easy invoicing and easy follow up (expenditures, epidemiology, medical practice).

Decision making for payment of medicines

1. Ministries of public health, economy and social affairs decide respectively on marketing authorization, price setting, and modalities of reimbursement.

2. At NIHDI, there is a commission “reimbursement of medicines” (universities, professional associations, sickness funds – NIHDI, Ministry and Drug companies are represented but don’t have voting right).

3. Drugs are reimbursed according to categories (several rates of reimbursement). There may be restrictions for reimbursement (conditions to be fulfilled), related to patients, to indications, to prescribers.

4. Copayment depends on socio-economic status of the user (less for OMNIO). There is a “maximum billing” according to revenues.

Operational management of payment (Sickness funds)

1. Sickness funds exist essentially because of the historical development of social security in Belgium. There are seven sickness funds; they grouped in a “national union of mutual health societies” which represents them.

2. All citizens must register in a sickness fund. There is freedom of choice. They may not be refused.

3. Sickness funds ensure co-management of the national health insurance. Represent their members in negotiations related to health care financing.

4. Sickness funds ensure all payments according to the set rules. All have local branches to that effect.

5. Sickness fund medical advisers control the respect of rules.

6. Sickness funds are financed according to the profile of their members (30%) and their real expenses (70%). They share a limited responsibility for the budget execution. If there is excess of expenditures, members have to contribute symbolically to cover the deficit.

7. Sickness funds collect data which they shared with other institutions. They also analyze directly some data to produce information.

8. Sickness funds provide complementary services to their members, as well as additional reimbursement of fees for services. To that effect, each sickness fund proposes a complementary insurance.
Co-payment by patients

1. When the main part of the expense is taken care of by NIHDI, a co-payment by the patient is usually requested.
2. Copayment depends on socio-economic status of the user (OMNIO). There is a “maximum billing” according to revenues. For drugs, depends on the category of the drugs, existence of generics, and fulfillment of prescription conditions.
3. There are two modalities for payment: total direct payment and partial reimbursement by NIHDI or “third party paying” which is NIHDI, and payment of the co-payment by the patient.

Attempts for cost containment

Several strategies are implemented:

1. Fixed budget for each subsector of health care + correction mechanisms. More strict budgetary procedure and expenditure control.
2. Reinforcement of the financial responsibility of health care providers through more lumpsum financing.
3. Sickness funds are partially financially accountable for their health care expenditure.
4. A real growth norm (1.5% → 2.5 → 4.5% → 3%) but budget cuts according to the financial context.
5. New pricing and reimbursement system, according to the cheapest equivalent drugs existing in the market (generics).

Provision of evidence for decision making

1. KCE is an institution which provides independent scientific advice to policymakers and healthcare providers on all aspects of healthcare and health insurance.
2. KCE is managed by a board in which main stakeholders are represented. They decide on the studies to be performed among the submitted proposals.
3. Their domains are good clinical practice, health technology assessment, health services research.
4. They employ high qualified staff and also subcontract collaborators like universities.
5. Their credibility is ensured through the strict respect of explicit procedures, international institutional cooperation and scientific publications.
6. They produce guidelines and reports: evidence and recommendations.
7. Decision makers also refer to other institutions for evidence: universities, institute of public health. There is comprehensive health information system which is fed by several institutions. NIHDI has its own scientific council, useful to facilitate/prepare negotiation among stakeholders.
Accreditation of care providers

1. NIHDI organizes accreditation process. Accreditation concerns medical officers, dentists, nurses, physiotherapists.
2. Accreditation is not compulsory (which is different from some other EU countries): there is no sanction if no accreditation. Care providers are entitled to ask higher fees for services if they have accreditation. They also get additional financial benefits (which may cover the costs of accreditation).
3. Criteria for accreditation are usage of patients’ records, a minimal activity, decent prescription, obtainment of education credits (through workshops, meeting with peers).
4. Requirement is minimal. Most active general practitioners have accreditation.
5. There are many committees to validate continuous education sessions. Budget is increasing. Efficiency, even effectiveness is questioned.

Monitoring and evaluation

1. Many institutions provide data which are related to patients, care providers, health institutions, medical acts, DRG, fees …
2. In an attempt to modernize the system, there was harmonization of definitions, of indicators …
3. There are link between data bases. Data can be shared, with limitations to ensure privacy. Data users are entitled to access only the specific data which they need.
4. Data are analyzed in order to follow expenses, draw up budgets, help define health policies, assess the effects of decisions (program, …), fund some providers, inform health care providers (profiles, feedbacks) on their activities, detect frauds, such as mis- or overuse of nomenclature codes …
5. Beside routine data, there is a special follow up of a “permanent sample” to get an easy assessment of the situation.
6. Concerned institutions cooperate to assess the situation (joint report) and take action according to the weaknesses identified.

Evaluation and inspection

1. There is a specific department for evaluation and inspection, staffed with high qualified human resources. It has local sections in the provinces.
2. The aim is proper use of available resources through the respect of the rules. It is evaluated whether medical acts are prescribed or carried out according to the applicable rules and good medical practice.
3. Stress is laid above all on trust, respect and partnership. A good image is to be sustained: information is better and much more efficient, than sanction. Sanction has however a preventive effect.
4. Two main strategies are consequently implemented: firstly, evaluation and information, secondly, fraud detection and sanction.
5. Evaluation target individuals (providers or health institutions) and groups of providers.
6. Provision of information target both providers and decision makers. They concern current rules and assessment of the current practice.

7. There are different levels of sanctions: warning, refunds, fines. Cases may be brought to court or/and forwarded to professional councils. Administrative courts exist within the NIDHI. Rules may also be adjusted according to findings.

8. Evaluation and inspection need to be financed, but all together, there is a good financial return.