

## **Appendix 1**

### *Financing and organisation of healthcare in The Netherlands, France and Belgium.*

The three countries have an obligatory health insurance system since the middle of the 20th century, reflecting essentially a Bismarkian model.

In The Netherlands, chronic in-patient care (elderly, psychiatric patients and handicapped) is financed through taxes and amounts to 10.25% of the gross wage of employees (AWBZ). Ambulatory and acute in-patient care is financed through premiums to health insurance companies. For people with a lower income, a public insurance system exists. These premiums are 7.4% of the gross wage (5.85% paid by the employer and 1.55% by the employee). People with a higher income, have a private insurance with higher premiums. The Dutch law obliges the many competing health insurance companies to guarantee a basic insurance package against a uniform premium (approximately € 1,036 per year for one individual). In the Netherlands, two thirds of the population are public insured and one third private. For provisions included in the basic insurance package there is no or minimal patient contribution for public as well as for privately insured patients. For healthcare provisions not reimbursed, reinsurance is possible for all subjects through an additional (private) insurance. Premiums, risks covered and level of coverage differ greatly among kind of insurance chosen and among the health insurance companies. Approximately 90% of Dutch subjects have some kind of additional health insurance. Patients with chronic diseases may have to pay higher premiums for this additional (re-)insurance. In general, the healthcare providers are paid directly by the health insurance companies and patients have no direct payments. Healthcare providers working in academic hospitals are usually paid through salaries. General practitioners and non-academic physicians are paid on a capitation basis for the public insured patients and on fee per service basis for private insured patients. Physiotherapists working in the ambulatory sector are paid per service. All other healthcare providers are salaried. Historically, in The Netherlands there is a strong primary care organisation acting as gatekeeper towards access to secondary and tertiary care.

In France, healthcare costs as well as sickness and work disability benefits are paid by the Sécurité Sociale (SS), which is financed through social contributions by employers and employees. The social

contribution equals 19.6% of the employee's gross wage (12.8% paid by the employer and 6.8% by the employee) but these include contributions to pay for sick leave and work disability. Patient contributions for healthcare are substantial and can be as high as 40% of the total costs. Therefore, 80% of French patients have an additional private health insurance at one of the many competing insurance companies. Premiums, risks covered and level of coverage of the risks differ greatly among kinds of insurance chosen and among the health insurance companies. Patients with a chronic disease may have to pay higher premiums for the additional private health insurance. On the other hand, some patients with a chronic disease (among which severe AS) can be exempted from out-of-pocket contributions imposed by the SS and disease related healthcare costs will be fully reimbursed. Physicians and other healthcare providers working in academic hospitals are salaried. General practitioners, non-academic physicians and physiotherapists are paid on a fee per service basis. Patients pay their own contribution directly (ticket modérateur) to the healthcare provider. In contrast to the situation in The Netherlands, access to specialist care is not limited by the gatekeeper role of primary care.

In Belgium, healthcare provisions are mainly paid by a limited number of health insurance companies which are financed partly by social contributions (7.35% of the gross wage; 3.55% by the employer and 3.80% by the employee) and a (small) premium by the members. In addition, there are important patient contributions which are maximised. For elderly, severely handicapped, widows without income and orphans the level of patient's contribution is lower. Possibilities for reinsurance for patient contribution are limited to the costs of hospitalisation. Physicians and other healthcare providers working in academic hospitals are salaried. General practitioners, non-academic physicians and physiotherapists are paid on a fee for service basis. Depending on the service consumed, patients pay only the personal contribution (technical procedures and drugs) or pay the whole amount and are reimbursed afterwards (physician visits). Access to specialist care is not limited by the gatekeeper role of the general practitioner.

**Table 1** Financing of healthcare at macro-economic level

	The Netherlands	France	Belgium
Social contributions from taxes	4.80%	5.90%	34.80%
Public health insurance premiums	73.80%	66.40%	40.60%
Private health insurance premiums	14.10%	9.10%	5.80%
Patient contribution	7.30%	17.00%	17.90%
Other sources	0.00%	0.80%	1.00%