The impact of the global economic crisis on the health care systems of Belgium, France and the Netherlands: policy recommendations for the Republic of Korea
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Acknowledgements

The authors would like to thank Dr Kim Jong-dae, President of the National Health Insurance Service (NHIS), Republic of Korea for providing the opportunity to undertake this study and for his insightful comments on the development of the health financing system in the Republic of Korea when reviewing a draft of this report. In particular, the NHIS is gratefully acknowledged for its financial support and for commissioning the study.

Dr Son Dong-koog and Park Byeonghee of the NHIS Research Center acted as the focal point for the NHIS and provided many resources and helpful inputs.

We are also very grateful to colleagues at the Ministry of Health in the Republic of Korea for providing data and information, particularly, to Jang Young-jin and Kim Keunchan from the National Health Insurance (NHI) Policy Division for their generous support, as well as to Kim Young-Hak from the Internal Cooperation Division for his coordination of the communication between the Ministry of Health, the NHIS and the World Health Organization (WHO). In addition, special thanks are extended to Lee Yoon-shin and Kim Tae-young from the NHI Pharmaceutical Policy Division for their helpful advice and insightful discussions.

At the Health Insurance Review and Assessment Service we gratefully acknowledge Kim Ae-Ryun, manager of the Patient Classification System Development Division, for her insightful feedback on diagnosis-related group policy and the development of the patient-centred information technology system within the NHI in the Republic of Korea.

We also extend our thanks to Professor Kwon Soonman at the Graduate School of Public Health, Seoul National University, for his helpful advice in addressing all the points related to the policy options recommended for the Republic of Korea.

This report is a collaboration between WHO Headquarters (HQ) and the European Observatory on Health Systems and Policies. We are grateful to Joseph Kutzin (WHO HQ), as the coordinator of the Health Financing Policy team at WHO HQ for his general support, to Matthew Jowett (WHO HQ) for his valuable views on the key issues impacting on the policy recommendations and to Nuria Quiroz Chirinos for her great administrative and organizational support. Anna Maresso (London School of Economics and Political Science Health and Social Care/European Observatory on Health Systems and Policies) was responsible for coordinating the three country case-studies component and for editing the report. We also thank Dr Cristina Hernández-Quevedo and Anna Sagan for editing the case-studies for France and the Netherlands, respectively.

Finally, we thank all the discussion partners that took part in the consultation meeting for this study in September 2014 in Geneva.
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List of abbreviations

ACS  Complementary healthcare aid (France)
AFBZ  General Fund for Exceptional Medical Expenses (Netherlands)
ALD  Long-term illness (France)
AME  State medical aid (France)
ANSM  Agency for Medicines and Health Products (France)
ARS  Regional health care agency (France)
AWBZ  Exceptional Medical Expenses Act (Netherlands)
CAK  Central Administration Office (Netherlands)
CDM  Chronic disease management
CIZ  Centre for Needs Assessment (Netherlands)
CMU  Universal health care coverage (France)
CMU-C  Public complementary insurance (France)
CPI  Consumer price index
CVZ  Health Care Insurance Board (Netherlands)
DBC  Diagnosis and treatment combination (Netherlands)
DMP  Disease management programme
DREES  Directorate of Research, Studies, Evaluation and Statistics (France)
DRG  Diagnosis-related group
DUR  Drug Utilization Review (Republic of Korea)
EMU  Economic and Monetary Union
EU  European Union
FFS  Fee-for-service
FSC  Financial Services Commission (Republic of Korea)
GDP  Gross domestic product
GP  General practitioner
HAS  National Health Authority (France)
HIPC  Health Insurance Policy Committee (Republic of Korea)
HIRA  Health Insurance Review and Assessment (Republic of Korea)
HPST  Hospital, Patients, Health and Territories [Bill] (France)
HTA  Health technology assessment
KCE  Health Care Knowledge Centre (Belgium)
KHCPF  Korea Health Promotion Fund (Republic of Korea)
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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>KoMGI</td>
<td>Korean Medical Guideline Information (Republic of Korea)</td>
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<td>KRW</td>
<td>Korean Won</td>
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<tr>
<td>ICT</td>
<td>Information and communication technology</td>
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<tr>
<td>INN</td>
<td>International non-proprietary name</td>
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<tr>
<td>INSEE</td>
<td>National Institute for Statistics and Economic Research (France)</td>
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<tr>
<td>IT</td>
<td>Information technology</td>
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<tr>
<td>LHV</td>
<td>National Association of General Practitioners (Netherlands)</td>
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<tr>
<td>LSE</td>
<td>London School of Economics and Political Science</td>
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<tr>
<td>LTC</td>
<td>Long-term care</td>
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<td>LTCI</td>
<td>Long-term care insurance (Republic of Korea)</td>
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<tr>
<td>LVG</td>
<td>Rural Health Care Association</td>
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<tr>
<td>MAP</td>
<td>Medical aid program (Republic of Korea)</td>
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<td>MFDS</td>
<td>Ministry of Food and Drug Safety (Republic of Korea)</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>NHI</td>
<td>National health insurance (Republic of Korea)</td>
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<td>NHIS</td>
<td>National Health Insurance Service (Republic of Korea)</td>
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<tr>
<td>NIHDi</td>
<td>National Institute for Health and Disability Insurance</td>
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<td>NSSO</td>
<td>National Social Security Office</td>
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<td>NVZ</td>
<td>National Hospital Association (Netherlands)</td>
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<td>NZa</td>
<td>Dutch Health Care Authority (Netherlands)</td>
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<tr>
<td>OMS</td>
<td>Association of Medical Specialists (Netherlands)</td>
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<tr>
<td>ONDAM</td>
<td>National Goal of Health Insurance Spending (France)</td>
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<td>ONPES</td>
<td>National Observatory on Poverty and Social Exclusion</td>
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<td>OOP</td>
<td>Out-of-pocket</td>
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<td>PHI</td>
<td>Private health insurance</td>
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<td>PPP</td>
<td>Purchasing power parity</td>
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<tr>
<td>RIZIV</td>
<td>National Institute for Health and Disability Insurance (Belgium)</td>
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<tr>
<td>RBRV</td>
<td>Resource-based relative value</td>
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<tr>
<td>RSA</td>
<td>Active solidarity revenue (France)</td>
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<tr>
<td>SCP</td>
<td>Netherlands Institute for Social Research</td>
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<tr>
<td>SFEF</td>
<td>Funding Entity for the French Economy</td>
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<td>SHI</td>
<td>Statutory health insurance</td>
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<tr>
<td>SNS</td>
<td>National health strategy (France)</td>
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<tr>
<td>VHI</td>
<td>Voluntary health insurance</td>
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<tr>
<td>VHN</td>
<td>Netherlands Practice Posts Association (Netherlands)</td>
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<td>VWS</td>
<td>Ministry of Health, Welfare and Sport (Netherlands)</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>Wmo</td>
<td>Social Support Act (Netherlands)</td>
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<td>ZN</td>
<td>Associated Health Insurance Companies (Netherlands)</td>
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<td>Zvw</td>
<td>Health Insurance Act (Netherlands)</td>
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Background
The global financial crisis, which began in late 2007, did not only have an impact on European countries but also on those in other regions. The economy of the Republic of Korea was also affected, as evidenced by drops in the annual growth rate of real gross domestic product in 2008 and 2009. However, with the rebounding of the world economy and the implementation of diverse stimulus policies, the country’s economy returned almost back to normal in 2010. In line with this economic trend, national health insurance (NHI), the major health financing scheme in the Republic of Korea, recorded deficits in 2009 and 2010 but returned to surplus from 2011. Thus, the country has not struggled as much as some European countries from the financial pressures deriving directly from the financial crisis.

However, financial pressure on health care has always been and continues to be a major issue that needs to be addressed. During the crisis, the three countries analysed in this report (Belgium, France and the Netherlands) have responded with diverse policy measures to relieve the financial pressure on the health sector and on health budgets. However, it is notable that there had been ongoing reforms and policy changes in these countries that started long before the economic crisis.

There is no argument that mobilizing more resources and improving the efficiency of health spending have always been challenges in health policy. Reflecting this, the policy recommendations for the Republic of Korea in this report were derived not only from examples of policy responses to the crisis, but also from existing reforms or policy actions which started before and continued after the crisis, if relevant. Diverse policy measures will be described according to three categories:

1) Mobilizing more resources to meet current or future expenditure
2) Reducing health spending by changing coverage while also ensuring financial protection
3) Managing health care costs more efficiently.

Policy recommendations for the Republic of Korea
Mobilizing more resources to meet current or future expenditure
In this category, the first policy option that could be considered is to increase social health insurance contributions as the NHI scheme mainly relies on contributions as its main financing source. During the economic crisis, France introduced new social security measures for the earmarked social security budget while the Netherlands increased the income ceiling for income-dependent SHI contributions and, consequently, a contribution cap was lifted. Given that, currently, the Republic of Korea has a relatively low NHI contribution rate for employees, an increase in the NHI contribution rate is worth considering. However, if a higher NHI contribution rate across the board would be difficult to implement, an alternative option would be to apply a selective increase for higher-income earners (as it is the case in France).

Introducing new taxes or increasing an existing tax on unhealthy food or products is often used as an alternative financing method for health while lessening the burden on the labour market. France is very active in this policy area by levying taxes on tobacco, beer, and sugary and energy drinks. For the Republic of Korea, where tobacco is the only product on which a tax is levied, a number of options are available that would mobilize additional resources as well as promote public health. These include increasing the tobacco tax, modifying the tobacco taxation formula to a percentage of the price (as opposed to the current policy of applying a fixed amount on the price) and introducing new taxes on unhealthy foods and beverages, such as sugary foods and alcohol.
A general tax captures more diverse sources of revenue and is likely to be more progressive than social health insurance contributions. Thus, putting more general tax revenue into resources for health helps to improve equity in health financing while increasing available funds. In the Netherlands, a government subsidy to the health insurance scheme is used for protecting vulnerable groups, such as children under 18 and low-income groups. In Belgium, a government subsidy aims to fill the gap between social security and the fixed government budget, creating a countercyclical function to health system financing (to some extent). In the Republic of Korea, the NHI Fund receives a government subsidy which is set as a proportion of NHI contribution revenue. However, precisely because the current formula is based on NHI contributions, the government subsidy cannot serve as a counterbalancing function in times of economic downturn as this subsidy will also go down, along with decreases in NHI contribution revenue. Therefore, it is recommended that this formula be modified to ensure diverse functions, such as more robust health financing (including equity), counterbalancing functions in times of economic downturn and long-term sustainability, which can be achieved mainly through general tax revenue.

An automatic mechanism to secure health care funding is a critical means of preparing for changes in the economic environment. Among the three European countries studied, Belgium is the only one that has a reserve fund for its social insurance system; unfortunately, it has not performed well since the onset of the economic crisis. Other European examples, such as Lithuania and Estonia, have well-known reserve funds designed to reduce fluctuations in annual social health insurance revenue. In the Republic of Korea, the NHI is legally prescribed to establish a reserve fund by transferring 5% of total annual costs to it until the reserve reaches at least 50% of total annual costs. However, this requirement has never been enforced. Given the importance of having an automatic stabilizing mechanism in health system financing, revising the NHI reserve fund legislation, along with better enforcement, need to be addressed.

Reducing health spending by changing coverage while also ensuring financial protection

The first policy option that may be considered is streamlining the benefit package, as this is a relatively easy way to generate savings. However, this policy needs to take an evidence-based approach to ensure the efficiency and effectiveness of the services that are covered by the benefit package. In comparison to the three European countries analysed in this report, where some policy actions were taken to add (mainly in Belgium) or limit services based on evidence, in the Republic of Korea, no decisions have been taken to reduce the medical treatments and health services listed in the NHI benefit package, mainly due to the fact that there is no system in place for periodic review. Thus, for the longer term, it is worth considering the introduction of a periodic review system supported by economic assessment processes (such as a health technology assessment) to streamline the NHI benefit package.

Adjusting user charges is another way to make savings on public health expenditure. However, a user charges policy should be carefully shaped given that out-of-pocket (OOPs) payments can easily restrict patients’ access to services. Bearing this in mind, in the Netherlands, while the compulsory deductible for health insurance reimbursement increased from 2008 to 2013, a protection mechanism for vulnerable groups was also implemented alongside it. In the context of the Republic of Korea, in 2011, OOPs constituted 35.2% of total health expenditure, which is very high by international comparison. Given the already high level of OOP payments, in principle, increasing user charges cannot be regarded as a recommended policy option. However, if there is a need to increase co-payments, selective application of higher co-payments, backed by effectiveness criteria, can be considered for certain areas (for example, as in France, where higher co-payments are levied on patients who choose to use services that deviate from established clinical pathways).

Private health insurance (PHI) can play a role in relieving financial pressure on the public budget by protecting people from user charges and OOPs. However, in practice, it has not been a useful policy tool.
in the European Region. Only France, where voluntary health insurance is an integral part of the health financing system and is used extensively to cover co-payments and other user charges, has tried to promote PHI by providing subsidies to vulnerable groups to access PHI. In the case of the Republic of Korea, more than 77% of households purchased at least one PHI policy in 2009. Considering the remarkable growth of PHI over the last decade, it is necessary to seek a policy intervention to balance the respective roles of NHI and PHI. In designing the function of PHI, it is worth reviewing the French example where some services cannot be covered by PHI to ensure that patients remain aware of health care costs.

Managing health care costs more efficiently

Containing spending on pharmaceuticals has long been an important policy area in the World Health Organization European Region. Around 30 countries in the European Region have made policy changes in the pharmaceutical sector, aiming to either reduce pharmaceutical prices or promote the greater use of generic drugs, or both. Likewise, the three European countries considered in this report applied diverse policy tools and measures in an attempt to control pharmaceutical costs, such as using a reference price system in Belgium and preferred pharmaceutical policies in the Netherlands. In addition, France introduced or modified payments to general practitioners (GPs) and pharmacists to encourage them to prescribe and dispense more generic drugs. In the Republic of Korea, both the sizable proportion and rapid increase of pharmaceutical costs have long been one of the challenges of health expenditure control. In response to this, the government of the Republic of Korea has developed and implemented diverse policy measures since 2006, such as changes to the NHI drug registration system (2006) and the introduction of a new pricing system, including huge price cuts on drugs (2011). However, the current brand-based prescription system still dominates and makes it difficult to encourage a shift to more generic usage by restricting the role of pharmacists in substituting cheaper drugs, thus resulting in a much more limited usage of generic drugs. This policy environment is very different from the other three countries examined in this report where drugs are prescribed by international non-proprietary name, which makes it easier to design policies to shift to more generic drugs.

Changes to provider payment are a more direct way to generate savings. However, payment reductions can have different impacts on the efficiency of health spending depending on the way they are designed. The experience of the three European countries analysed in this report, shows that freezes or budget cuts on provider payment in individual sectors, such as GPs and specialists, were a common tool. However, such countries also employed other policy tools to control costs at the macro level, such as imposing a growth cap on the health budget (Belgium) and implementing price agreements (the Netherlands), which played a critical role in managing expenditure in this area. In the Republic of Korea, using financial pressure to induce policy momentum, in 2012, mandatory diagnosis-related groups (DRGs) came into force as a payment method for clinics and hospital departments, but only for seven disease groups. One factor that is critical for the Republic of Korea is that there is no policy tool to control health expenditure at the macro level; so even if the DRG payment system were to be expanded as planned, it would still have only a limited influence on expenditure in inpatient settings. Thus, development of a cost-containment policy tool at the macro level should be considered. In this context, the macro level mechanisms used in Belgium, France and the Netherlands have policy relevance for the Republic Korea.

There is no doubt that good quality primary care can play a critical role in treating patients efficiently. France tried to strengthen primary care by shifting care from hospital to primary or community level, while at the same time reinforcing the role of GPs in chronic disease management (CDM) by applying a pay-for-performance payment component. Belgium and the Netherlands took similar actions with more focus on reinforcing GPs’ roles in CDM, along with modification to payment schemes. However, in the Republic of Korea, it is difficult to design policies to strengthen primary care under the current health care delivery system where functional divisions are not clearly delineated among the different levels
of health providers. Thus, to reinforce the role of primary care, the introduction of a more fundamental policy should be considered, one that includes a clearer definition of the different roles of providers. This should be followed by a clear incentive scheme imbedded within the various provider payment schemes, particularly GP remuneration, to promote better coordination of services.

Finally, to enhance the efficiency of services, investment in e-health and expanding the use of care protocols are strongly recommended. Notably, these policies make more sense when longer-term savings are desired since they require investment in the shorter term. Belgium established an e-health digital platform in 2008 and MyCareNet (2009) to exchange electronic data and improve the monitoring of patients. Another policy attempting to use resources efficiently was the development of clinical guidelines for health care providers, which has been implemented in all three European countries. In the Republic of Korea, information technology-based systems are highly used in the health care sector, whereas the development and use of clinical pathways lag behind other countries. The low use of clinical pathways is not surprising given that NHI payment mainly relies on a fee-for-service (FFS) payment model. From the point of view of physicians, there is no motivation to follow care pathways, which usually aim to ensure quality treatment with a minimum level of treatment. While the application of the DRG payment system for seven disease groups may contribute to facilitating the wider adoption of care pathways with quality assurance criteria, it is difficult to expect much process in this area unless modifications are also made to the dominant FFS provider payment system currently in place.

Conclusion

Looking at the experiences of Belgium, France and the Netherlands, many fiscal austerity measures have been undertaken in the health sector. However, it is notable that the overall direction of health policy has aimed mainly to increase the long-term sustainability of the health financing system. Taking this point, the policy recommendations for the Republic of Korea are not limited to policy responses designed solely to meet financial pressure. Rather, the approach in this report is to extend more comprehensive recommendations that have relevance to the health care system in the country as a whole; appropriate and timely implementation will require prioritizing policies with different focuses that reflect the specific challenges and health system objectives of the domestic context.
Chapter 1
Introduction

Sustainable and appropriate health care financing is a key goal for well-functioning health systems because it ensures that available resources provide health care services to the population that needs them. Just as importantly, health care financing policies should be in line with health system goals, such as promoting protection for households against financial risk due to health care costs and achieving an equitable distribution of the burden of funding the system. From this perspective, the global financial and economic crisis that began in 2007 has imposed a substantial challenge for many countries, especially for those most affected. While budgetary cuts in public spending have had to be employed, at the same time, more restricted resources have prompted governments to also explore the scope for greater efficiency gains within their health care systems. The mix of responses taken by different countries obviously has depended on the impact that the crisis has had on their economies, the duration of the crisis and the resilience of their public sectors, including their health sectors, to sustain any shocks associated with fiscal retrenchment.

In response to concerns by the World Health Organization (WHO) Member States over the impact of the global financial and economic crisis, a high-level consultation on the financial crisis and global health was held in Geneva in January 2009. Along with this, also in 2009, the WHO Regional Committee for Europe adopted the resolution approved by the Health in times of global crisis: implications for the WHO European Region high-level meeting. This resolution emphasized the need to continue to protect vulnerable populations and sustain equitable and efficient delivery of health services in the context of the financial crisis. One key way to do this is to analyse the policy options for responding to the negative impacts of the economic crisis on health system and health outcomes, and identify health financing policies and health system-related measures that could be used in the short and longer term to counter economic downturns. Thus, monitoring the responses of different countries to the challenges posed by the crisis presents an opportunity for valuable cross-country learning.

Objectives of this report

This report aims to understand health policy responses to the economic crisis in three selected European countries (Belgium, France and the Netherlands) and to draw on the lessons learnt from these experiences to develop recommendations that can be applied to the Republic of Korea's health system. In particular, the three European countries chosen share similarities with the health system of the Republic of Korea in that they are all social health insurance systems and share a history of striving to contain growing health care costs while maintaining equitable and accessible services for their populations. In this context, it is not only these countries' direct responses to the impact of the economic crisis that is of interest; in addition, their ongoing policy strategies that both preceded the onset of the crisis as well as their continuing responses are analysed.
It is important to note that the framework adopted in the analysis does not view the achievement of financial balance as the primary goal of health systems; rather this is treated as the budget constraint within which a health system functions. Thus, reforms pursued by different countries should be considered in the light of their potential impact on the attainment of primary health system goals, which can include health gain (level and equity), responsiveness, financial protection and equity in finance. From a health policy perspective, specific intermediate objectives can also be defined, such as equity in the distribution of system resources and in the use of health services, quality of care, efficiency, and transparency and accountability.

**Structure of this report**

This report contains five chapters: following this introduction, three chapters focus on the policy responses to the crisis in Belgium, France and the Netherlands, while a concluding chapter outlines the policy recommendations for the Republic of Korea. For each of the selected case-study countries, an overview is provided of the health financing system to provide the necessary context and understand the purpose and consequences of the policy strategies that have been implemented. This is followed by an analysis of the responses to the economic crisis in three broad areas:

1. Changes to public funding for the health system ie. the publicly-sourced resources dedicated to health;
2. Changes to health coverage (population entitlement, the composition of the benefits package and the application of user charges); and
3. Changes to health service planning, purchasing and delivery.

The final chapter on the health care system in the Republic Korea also begins with an overview of the financing system to provide the relevant contextual framework and highlight the similarities and differences with the three European countries. This section looks at revenue collection and sources, financial risk pooling, purchasing arrangements, provider payment systems and benefits design. The chapter then goes on to analyse relevant country case-study experiences for the context of the Republic Korea's health system context and presents a number of recommendations or policy suggestions organized along the following lines:

1. Policy options for mobilizing more resources to meet current or future expenditure
2. Policy options for reducing health spending by changing coverage while also ensuring financial protection
3. Policy options for managing health care costs more efficiently.

This chapter concludes by stressing that many policy options gained from the country case-study experiences may be relevant for the Republic of Korea's health system context. However, the adoption of any recommendations relies first and foremost on the setting of policy priorities in line with the health system's goals and values, as well as on an assessment of implementation requirements and challenges. Underlying this is the need to consider the political, historical and cultural background of each country, and to keep these aspects in mind when modifying any potential reform strategies to fit the context the Republic of Korea.

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1 The framework for this part of the analysis was developed as part of a wider study on the impact of the economic crisis on countries of the WHO European Region by the European Observatory on Health Systems and Policies and the WHO Regional Office, to be published as two companion volumes in February 2015 (see Thomson et al., in press; Maresso et al., in press).
References

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Chapter 2
The impact of the economic crisis on health and the health system in Belgium
Irina Cleemput, Joeri Guillaume, Carine Van de Voorde, Anna Maresso

The health care financing system in Belgium

The Belgian institutional framework
Belgium is a federal state with three levels of government: the federal government, the federated entities and the local governments (provinces and municipalities). Health policy is the responsibility of both the federal and federated entities. The federal authorities are responsible for regulating and financing the compulsory health insurance system; setting minimum standards for running hospital services; providing hospital budgets; financing heavy medical care units; the legislation covering different professional qualifications; and the registration of pharmaceuticals and their price control. Federated entities are responsible for the organization and financing of health promotion and prevention; maternity and child health care and social services; different aspects of community care; coordination and collaboration in primary health care and palliative care; the implementation of accreditation standards and the determination of additional accreditation criteria; and the financing of hospital investments (Gerkens & Merkur, 2010).

In December 2011, a reform on fiscal federalism was agreed, called the sixth State reform or Butterfly Agreement (Vlinderakkoord in Dutch; L’accord papillon in French). The reform gives more spending responsibilities to the federated entities (estimated at 4.5% of gross domestic product (GDP) in 2011), mainly in the areas of family allowances, health care and labour market policies (OECD, 2013a). The transfer of competencies in the health care sector relates to residential nursing care for older patients; hospital infrastructure; and investment in the organization of primary care. The main option chosen in the reform is to maintain the financing and accreditation of basic (para)medical activities at the federal level and to transfer infrastructure-related and organizational competences to the communities, with effect from 1 July 2014.

Organization of the health insurance system
Belgium has a system of compulsory health insurance covering the entire population (except for some specific uninsured groups – see the section on Coverage on pages 5 and 6). The National Institute for Health and Disability Insurance (NIHDI) manages and supervises the compulsory health insurance system.

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1 The federated entities are subnational levels of government with important powers. The ‘communities’ are entities based on the three language groups/populations in Belgium (Dutch-, French- and German-speaking communities). The regions are based more on economic grounds, and these consist of the Flemish, Walloon and Brussels-Capital Regions.
Altogether there are seven health insurance entities that operate in Belgium. Five national associations of health insurers are the main players and are non-governmental, non-profit organizations, called ‘sickness funds’. There is also one public fund which acts as the insurer of last resort (for those not wishing to join any of the other five sickness funds) and a separate fund only for railway employees. The five national associations comprise a total of about 60 local sickness funds. In the Belgian legal jargon, the term sickness fund is reserved for the local funds. In practice, however, the term is also used for the national associations of these sickness funds. The NIHDI determines the regulatory procedures that are applied to the sickness funds and health care providers. Complementary to these regulatory procedures, the national associations bear financial responsibility for the compulsory health insurance system. The local funds remain responsible for (and act rather independently within) the supplementary insurance market. Membership of a fund is compulsory but individuals can enrol in the sickness fund of their choice. Every three months the insured have the option to change to another fund. Each individual can basically choose among six competing funds (the five national associations and the public fund), but there is also some competition between local sickness funds of the same national association based on their supplementary health insurance benefits. As compulsory health insurance is exclusively a social security matter, this market is closed to new entrants.

In Belgium, the first step towards (partial) prospective financing of sickness funds with a risk adjustment scheme was taken in 1995. Since then the global yearly budget for health insurance has been fixed ex ante, i.e. before actual costs are known. The distribution of these resources among the national associations of sickness funds is based on a mixed reimbursement formula, in which the financial allocations of the sickness funds are calculated according to a weighted combination of their share in the normative or risk-adjusted costs and their share in the actual costs for the year in question. The weight of the normative costs has increased over time from 0.10 to 0.30. In addition, the amount of financial responsibility of the sickness funds is limited: 15% during the initial years and 25% since 2001. This means that if the sickness funds have a surplus, they may set 25% of that surplus aside in a reserve fund. If they record a deficit, they must bear 25% of that deficit themselves by drawing from their reserves or by raising their members’ contributions. If total costs exceed the global budget by more than 2%, the deficit of each sickness fund is limited to 2%. The rationale for this rule is to protect sickness funds from bearing all responsibility for an underestimation of the global budget (Schokkaert & Van de Voorde, 2013a).

**Coverage**

In the Belgian health insurance system both economically active and non-active people, as well as their dependants, are covered (Gerkens & Merkur, 2010). Eligibility criteria for health insurance are compulsory membership of a sickness fund and payment of an income-dependent contribution (with exemptions for certain groups). Almost the entire population (> 99%) is covered for a broad benefits package. The only exception is some specific uninsured groups, mainly people who did not complete the formalities necessary to be registered with a sickness fund or did not pay their contributions. There are indications that in large cities such as Brussels, Antwerp and Liège the percentage of uninsured people is substantially higher than elsewhere in Belgium (Van De Sande et al., 2005).

Service coverage is broad. There is coverage for physician services, hospital care, prescription drugs, most physiotherapy, most dental care, home health care, nursing home care, psychiatric care, and so on. Not included or hardly reimbursed are spectacles, contact lenses, hearing aids, occupational therapy (except in the context of rehabilitation in an institution), orthodontic care, cosmetic surgery, non-urgent transport to the hospital, less necessary drugs, and complementary and alternative therapies, such as acupuncture and homeopathy. People cannot choose the benefits in their package, as they are the same

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2 Except for railway workers who are assigned to their special fund.
The impact of the global economic crisis on the health care systems of Belgium, France and the Netherlands

for all citizens in the compulsory system. In addition, coverage does not depend on the choice of sickness fund. Reimbursed services are described in the national fee schedule, called the ‘nomenclature’. The nomenclature specifies the fee and the reimbursement level for more than 8000 services. Services not included in the fee schedule are not reimbursable.

The level of reimbursement depends on the type of service provided, the income and social status of the patient, and the accumulated amount of co-payments already paid for that year. For vulnerable population groups, several measures are in place to ensure access to high-quality care. For example, people with a low income are eligible for higher reimbursement of their medical costs. Maximum billing means that people no longer have to pay co-payments on health services for the rest of the year once the sum of the co-payments they have paid exceeds a certain limit. The limit is income-dependent and not all co-payments are included in the system.

Financial
Health care is financed by public and private sources. Public sources are social security contributions by employers and employees, subsidies from the State (progressive direct taxes), alternative financing sources (mainly value added taxes) and allocated and diverse receipts (special social security contributions, solidarity contributions and employers’ contributions for early retirement). In 1995, the government introduced the system of ‘global financial management’ meaning that all social security contributions are collected by the National Social Security Office (NSSO) and accumulated into a single fund. The NSSO then redistributes the contributions on the basis of the financial needs of each sector of the social security system (health insurance, pensions, unemployment benefits, and so on). There are some exceptions. For example, taxes on tobacco and taxes on the pharmaceutical industry are, according to the budget definitions, earmarked for health care.

Although the bulk of the social security contributions are collected into one fund and are no longer earmarked, total contribution rates can be disaggregated according to the social security sector (Federal Public Service Social Security, 2013). The total contribution rate equals 13.07% of gross labour income for employees and 24.77% (without the social contributions paid for annual holidays) for employers. For health insurance these percentages are 3.55% and 3.80%, respectively (7.35% in total). The self-employed pay their own social insurance contributions to a social insurance fund to which they are affiliated, which in turn forwards the funds to the NSSO for the self-employed. The contribution is calculated on the self-employed person’s net professional labour income in a reference year, which is the third calendar year preceding the year during which the contributions were paid. Contributions are paid per trimester and are only due on the income below a ceiling. Specific groups who do not pay social security contributions (mostly low-income groups such as widows/widowers, certain pensioners, students following higher education) are entitled to health insurance only when they pay a personal contribution. The amount depends on the group.

A government subsidy from general taxes closes the gap between the revenue obtained from the social security contributions and the fixed (determined a priori) total budget. Alternative financing sources, mainly indirect taxes, were introduced at the beginning of the 1990s when unemployment rates were very high. The federal health care budget is mainly composed of receipts from the global financial management (proportional social security contributions related to taxable income on labour, State

3 The description does not include the responsibilities of the federated entities, such as prevention and health promotion. The federated entities receive a yearly allocation from the federal government and levy their own taxes.
4 This is not to be confused with the local sickness fund. A social security fund calculates and collects social security contributions from the self-employed and transfers them to the NSSO.
5 The health budget covers the reimbursement of health care costs and the administration costs of the sickness funds and NIHDI.
subsidies and alternative financing – about 82.2% in 2012). A smaller proportion comes from alternative financing sources, earmarked for health care. They mainly consist of value added taxes and taxes on tobacco (9.4% in 2012). The remainder of the budget comes from specific levies, for example, on insurance premiums and pharmaceutical products (RIZIV, 2012).

Private financing sources for health care consist of co-payments and coinsurance rates, supplementary payments, and premiums for private health insurance. Co-payments and coinsurance rates are the difference between the official ‘convention’ tariff for a service and the part of this tariff reimbursed by the NIHDI. In addition to co-payments and coinsurance, some indirect forms of cost-sharing exist. These include the difference between official tariffs and fees that are freely set by providers, called ‘supplements’ in Belgium; charges in excess of some amount (for example, the cost of prescription drugs in excess of a reference price); and health care services not covered by compulsory health insurance. Approximately 20% of the total health care expenditure consists of out-of-pocket (OOP) payments paid by patients. Official co-payments were estimated to be around €1.682 billion in 2011 or 4.2% of the total health care expenditure. Private health insurance is provided by private insurers and by sickness funds. In 2011, reimbursements from private health insurance provided by the sickness funds were equal to 1.9% of total health care expenditure. For private insurers this share amounted to 2.3% (Assuralia, 2013).

Reimbursement decision-making

Reimbursement decision-making in the Belgian health care system mainly relies on negotiations between several stakeholders. The procedure to change the contents of the nomenclature is complex and several committees and councils have to give their advice or approbation. In short, the procedure goes as follows. Most medical professions have separate technical councils and commissions proposing changes to those items of the nomenclature relating to their discipline. The commissions are composed of representatives of the relevant medical profession and sickness funds. Next, the NIHDI’s Health Care Insurance Committee decides on the relevance of the proposals of the different commissions. The Health Care Insurance Committee asks for approval from the NIHDI’s General Council, which assesses budgetary implications and decides on the budgetary feasibility of the proposal. Finally the advice is transferred to the Ministry of Social Affairs and Public Health who accepts or rejects the proposal. The Health Care Insurance Committee consists of representatives of the sickness funds, medical professions and employers/employees/self-employed (the latter have only a consultative role and no voting powers). The fee schedule is negotiated yearly or biennially. In addition to fees and reimbursement tariffs, the negotiated conventions also contain requirements for the content, quality and quantity of care. At regular intervals, new treatments are introduced into the benefits package and treatments that have become obsolete are removed (Gerkens & Merkur, 2010).

The purchaser–provider relationship is organized at the national level and is regulated by collective contracts between representatives of providers and sickness funds. The fees charged by physicians depend on whether or not they subscribe to the convention between physicians and sickness funds. The convention is an agreement between physicians and sickness funds on the tariffs for health care services. Physicians who sign up to the convention are held to the fees defined in the convention and receive certain social benefits in return, such as a supplemental pension plan. Physicians can also be ‘partly contracted’ (for example, between specific hours of the day) or refuse to sign the convention altogether. In the latter case, they can determine their fees freely: the patient pays a supplement which is equal to the amount over and above the convention fee. This supplement is not reimbursable by compulsory health insurance.

For pharmaceuticals, the procedure for reimbursement starts with an application by the producer of the product to the NIHDI. Within the first 90 days after the application, the Ministry of Economic Affairs takes a decision about the maximum price of a new pharmaceutical, after taking advice from a pricing
commission. The pricing commission consists of representatives of different organizations: employers, employees, pharmacists, the NIHDI, wholesalers, consumers, the Ministry of Economic Affairs, the Ministry of Social Affairs and the Ministry of Public Health, and so on. The reimbursement decision is taken by the Ministry of Social Affairs and Public Health, after advice from the drug reimbursement commission. The drug reimbursement commission consists of representatives of the sickness funds, hospitals, universities, professional organizations of pharmacists and medical doctors, and non-voting representatives of the pharmaceutical industry, the NIHDI, the Ministry of Social Affairs, the Ministry of Public Health, the Ministry of Economic Affairs and the Ministry of Budget (Treasury). The drug reimbursement committee formulates reimbursement advice within 150 days after submission of the application. The Ministry of Social Affairs and Public Health has to make a reimbursement decision 180 days after submission at the latest (Gerkens & Merkur, 2010; le Polain et al., 2010).

Payment mechanisms
Compulsory health insurance is combined with independent medical practice. The main payment mechanism for health care providers is a fee-for-service (FFS) payment. There are two systems of payment: (1) direct payment (mainly for ambulatory care), where patients first pay the full cost of the service and then get reimbursed by their sickness fund for part of the expense; and (2) a third-party payer system (mainly for drugs used in an ambulatory setting, home nursing and hospital care), where the sickness fund pays the provider directly and the patient only pays the co-payments, supplements or non-reimbursable services. The third-party payer system can also be applied under specific conditions for ambulatory care to ameliorate financial access for vulnerable population groups.

The main feature of Belgian hospital financing is its dual remuneration structure according to the type of services provided: accommodation costs, nursing activities in nursing units, operating room costs and sterilization, are financed via a prospective budget system; while medical services, polyclinics and medico/technical services (laboratories, medical imaging and technical procedures) and paramedical activities (physiotherapy) are mainly paid on a FFS basis.

Pharmaceutical products are reimbursable if they are on the positive list. There are two mechanisms for the reimbursement of pharmaceuticals, depending on whether they are used in an ambulatory setting or during hospitalization. For drugs used in the ambulatory setting, patients pay a coinsurance rate depending on the category of the drug. Products for life-threatening diseases fall into category A and are reimbursed at 100%. Categories B, Cs and Cx encompass drugs for non-life-threatening diseases or symptom relief and are reimbursed at lower percentages. For drugs used during hospitalization, patients pay €0.62 per day, regardless of the number or volumes of drugs they use. Since July 2006, hospitals are no longer fully reimbursed per product, but receive a yearly prospective budget for all pharmaceuticals administered to patients hospitalized in an acute care hospital (Van De Sande et al., 2010). Most pharmaceuticals are integrated into this budget for approximately 75% of their value; the remaining 25% is still reimbursed per product. Not all drugs are included in the prospective budget, such as orphan drugs and (other) very expensive drugs.

Cost-containment measures
Until now, restricting services or cost coverage within the compulsory health insurance system as a way to cut public expenses, has not been advocated by policymakers. One exception is the shift of about €186 million from the public health care budget to patients through a significant increase in co-payments in 1993. At that time, the economic recession and the commitments accepted by the Belgian government to join the European Economic and Monetary Union (EMU) put the social security budget under severe pressure. This drastic measure (amounting to almost 2% of the total public health care budget) not only increased the financial burden on patients, but also induced a (short-term) volume decrease, especially for
home and office visits made by general practitioners (GPs) (Ministerie van Sociale Zaken, Volksgezondheid en Leefmilieu, 1999). Therefore, in 1994, the government decided to introduce a cap on the total amount of co-payments to be paid by patients for a specified list of medical and paramedical services.

In the 1980s, 1990s and 2000s, most reforms attempted to control the supply of health care and to increase the financial responsibility of the main actors in the system. In 1993, a fixed budget for each subsector of health care was introduced. If the budget limits were exceeded, correction mechanisms would be activated. In 1995, a real growth cap for setting the federal health budget, fixed at 1.5% per year, was introduced. This cap was then raised to 2.5% in the period from 2000 to 2004 and to 4.5% in the period 2005–2011. In 2012, the real growth cap of 4.5% was not applied and lower growth rates were chosen for 2013 (2%) and 2014 (3%). In 1995, sickness funds were also made partially financially responsible for a proportion of any discrepancy between their actual spending and their normative risk-adjusted health expenditures.

To reduce expenditure on pharmaceuticals, several measures have been undertaken. These include a further reduction in prices for products within the reference price system and the establishment of prescription quotas for low-cost drugs (see section on Policies affecting health system input prices on page 21).

**Nature and magnitude of the financial and economic crisis and health system pressures prior to the crisis**

**Nature and magnitude of the economic shock**

Several hypotheses exist on the triggers of the financial and economic crisis in Europe. One hypothesis is that the main source was loose fiscal discipline: fiscal optimism led to economic overheating, which, in turn, led to wage and price increases, reducing competitiveness and finally inducing an imbalance on the balance of payments. Another hypothesis is that the economic crisis was triggered by the crisis in the banking sector: increasing private sector expenditure was financed by the banking sector, but the credits were used suboptimally. In a context of low interest rates, consumers and companies consumed and invested upfront, speculating on future growth. At the same time, the banks did not manage the credit risk in a prudent way (Constâncio, 2013).

However, the banking crisis was also partly due to the global crisis in financial markets. A number of European banks had substantial balance sheet exposures to the housing market in the USA. Faced with losses on several of their assets, banks rebalanced their portfolios by increasing their holdings of ‘safe’ government bonds. However, in the meantime, some banks risked failure, forcing the government to step in and recapitalize these banks to protect citizens’ savings, this at a time when public finances were already under huge pressure due to the recession-induced collapse in tax revenues (Constâncio, 2013). This also happened in Belgium. The Belgian government made almost €21 billion of capital injections in the banking sector between 2008 and 2009 (De Leeuw, 2010). In addition, the government guarantees saving deposits of Belgian citizens up to €100 000 per person. Due to the approaching failure of several banks, the government decided to inject fresh capital into the sector, hoping for a recovery of the economy. Conditions imposed were mainly limited to (a higher) representation on the Board of Directors of the banks. The funds came from regular government receipts, collected through direct and indirect taxes, capital taxes and non-fiscal receipts.

**How well prepared was Belgium for an economic shock?**

**Macro level**

The impact of the global financial crisis on the Belgian GDP was similar to the impact in other countries. The impact became apparent in mid-2008 and in the first semester of 2009, when the GDP per capita was 4% lower than the year before. The economy recovered slowly, and by 2012 had reached a GDP level of
barely 0.1% above the level of mid-2008 (Eurostat, 2013a). Total government revenues increased between 2008 and 2012 from 48.7% of GDP to 51.0% of GDP. At the same time the level of expenditure increased markedly from 45.9% in 2008 to 51.6% in 2012, leading to an increasing government deficit.

The average increase in government expenditure was 2.6% over the last 12 years, 1.3 percentage points higher than GDP growth. Social security expenditure started to increase at a more rapid rate from 2009 onwards. Almost one-third of social security expenditure consists of pensions. The real increase in pensions accounted for 3.4% in 2012. Sickness and disability insurance benefits also increased due to a broadening of welfare measures. This growth in social security expenditure was tempered by the moderate or even decreasing trend in other types of social security expenditure. For example, annual average health care expenditure per capita (which represents almost one-third of the total social security budget) grew by only 0.6% in real terms between 2009 and 2011, much less than in previous years (the annual average growth rate between 2000 and 2009 was 3.7%) (Eurostat, 2013a; OECD, 2013b). Measures that contributed to this tempering of health care expenditure included savings on physician fees and drug reimbursement measures (see section on Changes to purchasing and delivery on page 21).

While the government’s deficit as a percentage of GDP or gross debt had been decreasing since 2000, it started to increase again in 2007 (when it was 84% of GDP) and in 2012 stood at approximately 100% of GDP (Eurostat, 2013b) (see Table 2.1). The increase of the debt ratio was due to the country’s worsening economic prospects, the capital injections the government administered to ailing financial institutions and also to exogenous factors such as the European Union’s (EU) financial measures to support Greece, Ireland and Portugal. In terms of the Belgian government’s sovereign credit worthiness and borrowing capacity, the average 10-year government bond rate generally remained solid, despite some fluctuations, throughout the last decade, even despite the impact of the economic crisis. The average 10-year government bond rate decreased between 2000 and 2005 to reach its lowest level before the crisis in 2005, at 3.4%. The situation worsened afterwards and interest rates started to increase until 2008, reaching 4.5%. However, between 2008 and 2010 trust was regained, particularly after the formation of the new federal government and its budgetary agreements, and this was reflected in a decline in the interest rate. In 2012, Belgian bond rates approximated those of the strongest European countries, at 3% (Eurostat, 2013c).

The net borrowing of the Belgian government quadrupled in absolute values between 2008 and 2009. As a percentage of GDP, Belgium’s net borrowing level was better than the EU average (27 countries) in the period 2005–2011. However, it could not maintain this position in 2012 (Eurostat, 2013b). In view of these economic conditions, the federal government introduced an economic stimulus plan in the middle of 2012 (Federaal Planbureau, 2013). In 2013, a social agreement was established for the non-profit sector in Belgium. This agreement foresaw €40 million earmarked towards financing the costs of 800 additional full-time equivalent positions in the health care sector. Actions related to the health care sector are described in the section on Health system responses on page 12.

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6 For example, women eligible for invalidity pensions receiving them for longer periods after the pensionable age between men and women was equalized; and greater numbers of people with psychiatric disorders and locomotor or connective tissue diseases becoming eligible for invalidity benefits.
An underlying source of pressure for the health care sector not directly linked to the financial crisis, is the increasing population (see Table 2.1). Belgium’s population has increased by 6% over the last 10 years (2003–2012). The composition of the population in terms of age has not changed markedly throughout the years. Since 2003, approximately 20% of the population is under 18 years of age, 62% is between 19 and 64 and approximately 18% is 65 years and older (Statbel, 2013). Within the group of people aged 65 years and older, however, the proportion of people older than 80 increased from 23.7% in 2003 to 29.8% in 2012, demonstrating the rapidly growing segment of the oldest part of the population (Statbel, 2013). An ageing population puts pressure on the health system. The same applies to the share of people at risk of poverty, which is currently almost 25% in Belgium after social transfers. Compared to similar European countries, this is a relatively high rate of poverty risk. The crisis has had a visible impact on the proportion of people at risk of poverty, which started to increase in 2009, after a period of decrease before the economic crisis.

Another pressure on the health system is sustainable financing. On the one hand, Belgium has always attached high importance to health care. In 2013, government spending on health care amounted to 16% of total public spending (National Bank of Belgium, 2013). Another indication for the importance attached to health care is the establishment (in 1995) of the real growth cap for setting the health budget and its

Table 2.1 Demographic and economic indicators in Belgium 2003–2013 (or latest available year)

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<tbody>
<tr>
<td>Population levels (in thousands)(a)</td>
<td>10,355</td>
<td>10,396</td>
<td>10,445</td>
<td>10,511</td>
<td>10,584</td>
<td>10,666</td>
<td>10,753</td>
<td>10,839</td>
<td>10,951</td>
<td>11,035</td>
<td>11,099</td>
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<tr>
<td>People aged 65 and over (% of total population)(a)</td>
<td>17</td>
<td>17</td>
<td>17</td>
<td>17</td>
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<td>17</td>
<td>17</td>
<td>17</td>
<td>17</td>
<td>18</td>
<td></td>
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<tr>
<td>Dependency ratio (%)* (b)</td>
<td>53.09</td>
<td>53.20</td>
<td>52.86</td>
<td>52.50</td>
<td>52.22</td>
<td>52.02</td>
<td>52.13</td>
<td>52.59</td>
<td>52.86</td>
<td>53.27</td>
<td>/</td>
</tr>
<tr>
<td>GDP per capita (USD) current prices and PPP) (c)</td>
<td>29,100</td>
<td>30,600</td>
<td>31,100</td>
<td>33,000</td>
<td>36,200</td>
<td>37,400</td>
<td>36,800</td>
<td>37,800</td>
<td>38,200</td>
<td>/</td>
<td>/</td>
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<tr>
<td>Real GDP growth (%) (c)</td>
<td>1.1</td>
<td>2.6</td>
<td>1.5</td>
<td>3.0</td>
<td>2.8</td>
<td>1.0</td>
<td>-2.7</td>
<td>2.0</td>
<td>1.9</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Government deficit (% of hGDP)(d)</td>
<td>-0.1</td>
<td>-0.1</td>
<td>-2.5</td>
<td>0.4</td>
<td>-0.1</td>
<td>-1.0</td>
<td>-5.6</td>
<td>-3.7</td>
<td>-3.7</td>
<td>-4.0</td>
<td>/</td>
</tr>
<tr>
<td>Government consolidated gross debt (% of GDP)(d)</td>
<td>98.4</td>
<td>94.0</td>
<td>92.0</td>
<td>87.9</td>
<td>84.0</td>
<td>89.2</td>
<td>95.7</td>
<td>95.7</td>
<td>98.0</td>
<td>99.8</td>
<td>/</td>
</tr>
<tr>
<td>Total unemployment rate (%) (d)</td>
<td>8.2</td>
<td>8.4</td>
<td>8.5</td>
<td>8.3</td>
<td>7.5</td>
<td>7.0</td>
<td>7.9</td>
<td>8.3</td>
<td>7.2</td>
<td>7.6</td>
<td>/</td>
</tr>
<tr>
<td>Unemployment – Men (%) (d)</td>
<td>7.7</td>
<td>7.5</td>
<td>7.6</td>
<td>7.4</td>
<td>6.7</td>
<td>6.5</td>
<td>7.8</td>
<td>8.1</td>
<td>7.1</td>
<td>7.7</td>
<td>/</td>
</tr>
<tr>
<td>Unemployment – Women (%) (d)</td>
<td>8.9</td>
<td>9.5</td>
<td>9.5</td>
<td>9.3</td>
<td>8.5</td>
<td>7.6</td>
<td>8.1</td>
<td>8.5</td>
<td>7.2</td>
<td>7.4</td>
<td>/</td>
</tr>
<tr>
<td>Long-term unemployment (as % of all unemployed)(a)</td>
<td>49.6</td>
<td>51.7</td>
<td>51.2</td>
<td>50.4</td>
<td>47.5</td>
<td>44.2</td>
<td>48.8</td>
<td>48.4</td>
<td>44.7</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Long-term unemployment (as % of active population) (c)</td>
<td>3.7</td>
<td>4.1</td>
<td>4.4</td>
<td>4.2</td>
<td>3.8</td>
<td>3.3</td>
<td>3.5</td>
<td>4.1</td>
<td>3.5</td>
<td>3.4</td>
<td>/</td>
</tr>
</tbody>
</table>

Sources: *OECD (2014); *Belgian Federal Government (2013); *Index Mundi; *Eurostat (2013a).
Notes: *The dependency ratio is the ratio between the total number of people aged 65 and older and the number of persons of working age (from 15 to 64). GDP: gross domestic product; PPP: purchasing power parity.

Health system level

An underlying source of pressure for the health care sector not directly linked to the financial crisis, is the increasing population (see Table 2.1). Belgium’s population has increased by 6% over the last 10 years (2003–2012). The composition of the population in terms of age has not changed markedly throughout the years. Since 2003, approximately 20% of the population is under 18 years of age, 62% is between 19 and 64 and approximately 18% is 65 years and older (Statbel, 2013). Within the group of people aged 65 years and older, however, the proportion of people older than 80 increased from 23.7% in 2003 to 29.8% in 2012, demonstrating the rapidly growing segment of the oldest part of the population (Statbel, 2013). An ageing population puts pressure on the health system. The same applies to the share of people at risk of poverty, which is currently almost 25% in Belgium after social transfers. Compared to similar European countries, this is a relatively high rate of poverty risk. The crisis has had a visible impact on the proportion of people at risk of poverty, which started to increase in 2009, after a period of decrease before the economic crisis.

Another pressure on the health system is sustainable financing. On the one hand, Belgium has always attached high importance to health care. In 2013, government spending on health care amounted to 16% of total public spending (National Bank of Belgium, 2013). Another indication for the importance attached to health care is the establishment (in 1995) of the real growth cap for setting the health budget and its
gradual increase until 2012 when a cap of 4.5% was no longer considered acceptable given the pressure on public spending induced by the financial crisis (see the sections on Cost-containment measures on pages 8 and 9 and Changes to public funding for the health system below). Given its generosity, rather than acting as an excessive restraint on health care spending, the cap actually guaranteed annual increases to the financial resources devoted to health care. On the other hand, given the application of the real growth cap in the years well before the financial crisis years, the health care sector was better prepared to absorb the full effects of the crisis, which occurred in 2012. Lower growth caps for the federal health budget were set at 2% in 2013 and 3% in 2014.

A related problem is the Belgian health care system’s heavy reliance on social security contributions for its financing. The low participation rate of people aged 55–64 in the workforce and the growing proportion of inactive (non-working) people are a potential threat to financing (Eurostat, 2013a).

In addition, the level of private expenditure for health care is relatively high, ranging from 20% of total health care expenditure for patients’ OOP costs to 24% for private insurance expenditure plus patients’ OOP costs in 2011 (Assuralia, 2013). This level has remained more or less stable over the last 10 years. From the citizen’s point of view, the supplements that can be asked by non-contracted physicians over and above the reimbursement tariff are a potential threat for the affordability of health care. As supplements are not included in social protection mechanisms, such as maximum billing, they risk reducing the effectiveness of these protection measures. The economic crisis might not have created a sudden increase in such supplements as yet, but this is uncertain as data on (ambulatory) supplements are not systematically recorded.

A weakness in health care delivery is the shortages in certain categories of health care personnel. In terms of supply, there is no problem with the number of physicians supplying services in the country. While the total number of physicians registered at the NIHDI per 1000 population is among the highest in the world (Vanthomme et al., 2010), these data overstate the number of physicians with real clinical activities. Taking only those physicians into account who performed at least one clinical service (consultation, visit), then the number of physicians per 1000 population drops below the European average. However, there seems to be shortages of different types of professionals in the sector, as demonstrated by the number of vacancies for health care-related jobs, excluding physicians, in Flanders (VDAB Studiedienst, 2013). Shortage occupations in the health care sector are nursing (except for midwifery), hospital pharmacy, physiotherapy (increasing demand due to ageing of the population) and general caregivers. Despite these shortages, currently there are practically no waiting times for providing health care services.

**Household level**

Price index data show that inflation has not been as high in health care (i.e. cost of health care services), as in many other sectors in Belgium. Only communication services have had a lower inflation over the last 10 years (Eurostat, 2013d).

**Health system responses**

**Changes to public funding for the health system**

**Health budget**

The setting of health budgets has been subject to legally entrenched growth caps since 1995. Even though these caps were habitually exceeded prior to 2005, they were set at a generous 4.5% from 2005 to 2012. Moreover, given that actual health expenditure has tended to be less than estimated, budget surpluses have accrued over a long period, even during the years after the crisis hit (except for 2012), thus cushioning the impact of tighter fiscal measures during these years.
Since the introduction of the real growth cap in 1995, there has been an annual budget for the compulsory health insurance system. Total federal spending on health care for a given year is equal to the budget for the previous year plus a percentage increase in real terms (the growth cap) and inflation in terms of the health index (consumer price index (CPI) but with goods and services detrimental to health excluded). The important point to note about the health budget growth cap is that although its main purpose is to limit the annual growth of funds allocated to health to a given ceiling, it also legally guarantees the set funding level for the health sector for that year. Moreover, historically, the cap allows for some flexibility in total spending since some exceptional or specific expenses are excluded from the ceiling. These are heterogeneous spending items, such as innovative drugs and services, vaccination and part of salary increases of health care personnel (for example, subsidies to the supplementary pensions of physicians and dentists). Before 2005, the growth cap was mostly not respected, with substantial budgetary overruns\(^7\) (Table 2.2) in particular for pharmaceuticals and to a lesser extent for ambulatory care (OECD, 2005). Over the period 2005–2011, the budget was allowed to grow by 4.5% per year in real terms. Importantly, during the same period, actual spending grew more slowly and the gap between the federal health budget and actual spending widened.\(^8\) Even in recent years when a reduced growth cap has been imposed, actual spending has continued to be less than the set budget.

Although the growth cap is the most important instrument in determining the growth rate of the budget for the compulsory health insurance system, the annual growth rate was in most years far above 4.5%\(^9\) (see Table 2.2). With a growth cap of 2.5% in the period 1999–2004, extensive use was made of the possibility to deviate from the cap by exceptional or specific expenses. After 2005, this budget escape route was hardly used because of the rapid increase in the budget ceiling to a more generous 4.5% (OECD, 2005). In more recent years (until 2012), the difference between the growth cap of 4.5% and the budget increase is mainly due to the way inflation is captured. To determine the health budget for the next year, the expected increase in the health index (corrected CPI) is applied to the total health budget, although in practice indexation does not apply to all parts of the health budget since different indexation rules exist depending on the spending item. Moreover, since the health index of a given year is applied to the health budget of the previous year plus the growth cap of 4.5%, there is a cumulative effect of both measures. Over the period 2005–2011, the accumulated difference between the indexation budget based on the health index and the budget based on applying the different indexation rules amounted to €1.265 million (Belgian Court of Audit, 2011).

\(^7\) Although quarterly budget controls were in place, adjustment mechanisms or penalties were exceptional (Belgian Court of Audit, 2011). Therefore, the growth cap was more a target than a real cap.

\(^8\) Actual spending for 2013 is based on estimations made by the NIHDI.

\(^9\) The increase of 9.25% in 2008 can be partly explained by the integration of the small health risks of the self-employed into the compulsory health insurance system (see the section on Population coverage on page 17).
The impact of the global economic crisis on the health care systems of Belgium, France and the Netherlands

Instead of reducing the real growth rate, the government decided to transfer the budget surplus (the difference between the spending ceiling and actual spending) to be used in the future or to other subsectors of social security (see Table 2.3). Normally, the health care budget includes a mixture of new initiatives and savings. New initiatives have to be balanced by savings in other sectors. For example, increased reimbursement of spectacles or hearing aids can be financed by (increased) turnover taxes on pharmaceuticals. The year 2012, however, was a special year. When new initiatives and savings for the 2012 budget had to be submitted, there was no government in situ. Moreover, in early 2012, the federal government had to impose a package of austerity measures worth €11.3 billion on its public expenditure, of which €2.3 billion was in the health sector. Structural savings accounted for about €553 million. The largest part of savings in the health sector was realized by not applying the growth cap. For the first time since the introduction of the growth cap, the budget was aligned to the amount of estimated expenses and savings, without taking the growth cap into account. Furthermore, no new initiatives were introduced in 2012. For 2013 and 2014, the growth cap was reduced to 2% and 3%, respectively. In 2013, structural savings amounted to €406 million. In addition, a specific budget has been made available for job creation in the not-for-profit sector. Even with the reduced budget growth in 2013, a (smaller) budget surplus was expected (see Table 2.3).

While the budget surplus equalled €148 million in 2005, it amounted to €1.8 billion in 2011. Since 2007, part of the budget surplus has been pooled in a fund called the Fund for the Future (Toekomstfonds in Dutch; Fonds pour le futur in French) to build up a reserve for future costs due to an ageing population. The Fund for the Future is administered by the global financial management. However, due to the economic crisis, no money has been put into the fund in recent years. The fund could only be used at the earliest from 2012 onwards, but until now no funds have been used, mainly because of the yearly budget surpluses. Since 2010, the largest part of the health budget surplus has been transferred to other social security sectors with a deficit.

### Table 2.2 Growth rate of the health budget in Belgium and actual spending between 2002 and 2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Health budget (million €)</th>
<th>Percentage increase over previous year</th>
<th>Actual spending (million €)</th>
<th>Percentage increase over previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>14 412</td>
<td></td>
<td>14 163</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>15 342</td>
<td>6.45%</td>
<td>15 384</td>
<td>8.62%</td>
</tr>
<tr>
<td>2004</td>
<td>16 258</td>
<td>5.97%</td>
<td>16 822</td>
<td>9.35%</td>
</tr>
<tr>
<td>2005</td>
<td>17 398</td>
<td>7.01%</td>
<td>17 250</td>
<td>2.54%</td>
</tr>
<tr>
<td>2006</td>
<td>18 473</td>
<td>6.18%</td>
<td>17 735</td>
<td>2.81%</td>
</tr>
<tr>
<td>2007</td>
<td>19 619</td>
<td>6.20%</td>
<td>18 875</td>
<td>6.43%</td>
</tr>
<tr>
<td>2008</td>
<td>21 434</td>
<td>9.25%</td>
<td>20 677</td>
<td>9.55%</td>
</tr>
<tr>
<td>2009</td>
<td>23 084</td>
<td>7.70%</td>
<td>22 422</td>
<td>8.44%</td>
</tr>
<tr>
<td>2010</td>
<td>24 249</td>
<td>5.05%</td>
<td>22 826</td>
<td>1.80%</td>
</tr>
<tr>
<td>2011</td>
<td>25 869</td>
<td>6.68%</td>
<td>24 077</td>
<td>5.48%</td>
</tr>
<tr>
<td>2012</td>
<td>25 627</td>
<td>-0.94%</td>
<td>24 985</td>
<td>3.77%</td>
</tr>
<tr>
<td>2013</td>
<td>26 677</td>
<td>4.10%</td>
<td>26 215&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4.92%</td>
</tr>
</tbody>
</table>

Source: Rijksinstituut voor Ziekte- en Invaliditeitsverzekering (RIZIV) yearly reports and budget documents.

Note: *Actual spending for 2013 is based on estimations made by the RIZIV (RIZIV, 2013a).
Once the total budget is determined, sub-budgets for categories of spending such as physicians, pharmaceuticals, and hospitals are fixed. The sub-budgets for about 50 spending categories are the result of policy priorities and close consultation between stakeholders. Aggregated spending categories, in line with the yearly reports of the NIHDI, highlight that in 2011 budgets for pharmaceuticals and physicians were cut more than budgets for other health care sectors.

**Statutory health insurance revenue**

No major changes have been introduced since the beginning of the economic crisis in the way health insurance revenue is generated. As mentioned in the section on Financing on page 6, the government subsidy from general taxes closes the gap between social security contributions and the health budget. To limit government subsidies and reduce employers’ contributions (and hence taxing labour), alternative financing sources were introduced long before the crisis (1997), and their share has increased year by year.

**Fiscal policy**

In Belgium, there are no tax subsidies for OOP payments or for PHI premiums. In recent years, excise duties on tobacco and alcohol, which are earmarked for social security in general and health care in particular (tobacco), have been raised. For example, the excise duties on tobacco (July 2013) and on alcohol (August 2013) were increased by 8%. The expected revenue is €50 million in 2013 and €100 million in 2014.

**Priority given to the health sector**

Since the beginning of the 1990s the share of federal spending on health care has steadily increased to reach more than 36% of total social security spending in 2010. The share slightly decreased in 2009 and 2010 (see Figure 2.1).

In effect, the health budget’s growth cap is the most important countercyclical measure that has been used to guarantee the flow of funds to the health sector during the period of economic crisis; that is, until 2012 it provided a legal guarantee that the budget for the compulsory health insurance system could increase by 4.5% in real terms annually. Moreover, between the elections of June 2010 and December 2011 (541 days), Belgium had a federal caretaker government meaning that, in line with Belgian political tradition, no new legal measures could be taken. This exceptional situation “protected” the health insurance system from austerity measures until the end of 2011 when the health care budget for 2012 was decided.

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**Table 2.3 Distribution of the health budget in Belgium between current spending and transfers since 2007 (million €)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Health budget</th>
<th>Current spending</th>
<th>Fund for the Future</th>
<th>Other sub-sectors of social security</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>19 619</td>
<td>19 444</td>
<td>175</td>
<td>/</td>
</tr>
<tr>
<td>2008</td>
<td>21 434</td>
<td>21 128</td>
<td>306</td>
<td>/</td>
</tr>
<tr>
<td>2009</td>
<td>23 084</td>
<td>22 785</td>
<td>300</td>
<td>/</td>
</tr>
<tr>
<td>2010</td>
<td>24 249</td>
<td>23 605</td>
<td>294</td>
<td>350</td>
</tr>
<tr>
<td>2011</td>
<td>25 869</td>
<td>24 776</td>
<td>/</td>
<td>1094</td>
</tr>
</tbody>
</table>

Source: Belgian Court of Audit (2011).
The impact of the global economic crisis on the health care systems of Belgium, France and the Netherlands

Breakdown of spending by agent in 2007 and 2011

Figure 2.2 shows the breakdown of spending on health\textsuperscript{10} into public and private components. Part of the increase in spending by social security (compulsory health insurance) between 2007 and 2011 is due to the integration of the small health risks of the self-employed in the compulsory system (see the section on Population coverage on page 17). Supplementary payments are charges in excess of some amount (for example, the cost of prescription drugs in excess of a reference price) and health care services not covered by compulsory health insurance. These supplementary payments are paid by patients on top of official co-payments. The share of both supplementary payments and co-payments decreased between 2007 and 2011 – from 16.97 to 15.55\% and from 4.5 to 4.2\%, respectively – which is a striking result in a period of crisis. Compared to other countries, the share of private health insurance as a proportion of total health spending is low in Belgium.

Figure 2.2 Public and private health spending in Belgium in 2007 and 2011, as a percentage of total health spending

\textsuperscript{10} Spending by local governments and companies is not included in total health spending (equalling 0.2\% in total spending in 2011).
Breakdown of spending by sector in 2007 and 2011

The evolution of total NIHDI expenditures by health sector is presented in Figure 2.3. The data demonstrate the limited impact of the crisis on the subsectors of health care. Curative, rehabilitative and long-term nursing care expenditure increased in relative terms compared to expenditure for pharmaceuticals and ancillary services to health care. The impact was largest for pharmaceutical expenditure, due to the measures taken in this sector (see section on Changes to purchasing and delivery).

![Figure 2.3 Spending by sector in Belgium in 2007 and 2011, as a percentage of total health spending](image)


Changes to coverage

Population coverage

Since 1 January 2008, (almost) the entire population has been covered for the same health services. Before that date, the benefits package of most self-employed people and their dependents did not include the so-called small health risks (such as ambulatory care, pharmaceuticals for outpatient care, home care and dental care). However, the decision to remove the distinction in coverage between the self-employed and the rest of the population was already taken before the start of the crisis.

Coverage of services

Insurance coverage is uniform for all insured people who are entitled to the same benefits package in the compulsory health insurance system. There are, however, some exceptions. For example, since July 2007, active bandages and (some) painkillers are (partly) reimbursed for chronically ill patients, but not for the general population; and chronically ill children under 18 who are treated in rehabilitation centres receive compensation for travel costs (since May 2011). Since the outbreak of the crisis, no measures were taken to exclude or reduce health services covered by compulsory health insurance. An exception is the health technology assessment-determined reduction in the number of conditions eligible for reimbursed oxygen therapy (2012).

Cost coverage

Belgium has a complex structure of patient cost-sharing. Two cost-sharing arrangements coexist: for some services, patients pay a percentage of the price or fee (coinsurance), for example, 25% of the drug price; for others they pay a fixed amount (co-payment), for example, €6 for a GP consultation. In the period 2008–2013 a number of measures related to patient cost-sharing were introduced. As can be seen from the measures listed in the next sections, there has been an emphasis on trying to minimize financial
barriers to accessing health care and protecting vulnerable groups. Although most of these measures were not necessarily a direct response to the crisis and were already being considered before the crisis, they highlight the primary goal of policymakers.

**General practitioner services**

Before December 2011, cost-sharing arrangements for GP office consultations had a complicated structure. They depended on having a global medical record, on eligibility for increased reimbursement of health care costs, on regular or out-of-hours consultations and GP qualifications. Since 1 December 2011, all co-payments and coinsurance rates for GP consultations were replaced by four co-payments, where the amount of the co-payment depends on eligibility for increased reimbursement and on having a global medical file. Also since December 2011, extra fees for out-of-hours consultations are fully reimbursed by the NIHDI. Although the new cost-sharing structure for GP consultations was mainly motivated by reasons of administrative simplification and not to increase financial accessibility to health care, the measure has facilitated the expansion of the system of social third-party payments (see the section on Protection mechanisms on page 19) (Farfan-Portet et al., 2012).

**Medical specialist services**

Since 1 November 2010, coinsurance rates for specialist care (40%) are subject to a ceiling of €15.50 for individuals not eligible for increased reimbursement. Patients eligible for increased reimbursement have much lower co-payment levels.

**Dental care**

Since September 2005, co-payments have been waived for dental care services for children under 12 years of age. In July 2008, this measure was extended to children up to 15 years of age, and in May 2009 to children up to 18. In addition, the age limit for those eligible to have their annual preventive dental check-up reimbursed was raised to 63 years of age in 2012. The co-payment waivers (since 2008) and the expanded check-up coverage have increased public expenditure for dental services for these user groups (RIZIV, 2013b).

**Pharmaceuticals**

Before April 2010, coinsurance rates for drugs dispensed by community pharmacies were determined by the drug category: 0% for drugs in category A; 25% in category B; 50% in category C; 60% in category Cs and 80% in category Cx. For patients entitled to increased reimbursement of medical costs, the coinsurance rate for drugs in category B equalled 15%. In addition, patient cost-sharing was capped for drugs in categories B and C to avoid large amounts being paid out-of-pocket. Due to the new remuneration system for pharmacists, introduced in April 2010 (see section on Provider payment reforms on page 23), the way the level of cost-sharing was calculated for outpatient drugs dispensed by community pharmacists had to be adapted. A coinsurance rate as a percentage of the reimbursement basis (pharmacy retail price) was replaced by a percentage of the reimbursement basis ex-factory price (usually equal to the ex-factory price). The main objective of the new reimbursement basis was to keep patient cost-sharing unaffected by the new pharmacist remuneration scheme.

**Disease management programme**

As a response to the crisis, cost-sharing has been eliminated for services included in the disease management programme (DMP) for type 2 diabetes patients and for chronic kidney failure patients, both 11

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11 The global medical file was introduced to increase the availability of medical, social and administrative patient information and access to such information (Gerkens & Merkur, 2010). The ultimate aim of the measure was to optimize primary care quality. The GP holds the file with the patient’s consent and shares relevant information with other providers.
introduced in 2009. For example, financial incentives to enter the programme for type 2 diabetes include total reimbursement of all consultations with the coordinating GP, total reimbursement of consultation(s) with the diabetes specialist, partial reimbursement of dietitian and podiatrist consultations, reimbursement of diabetes education and free access to self-management education materials, such as glucose metres, glucose test strips and lancets (Cleemput et al., 2012).

Protection mechanisms
Protection mechanisms have always been present in the Belgian health care system to enhance access to health services for economically vulnerable groups. However, since the onset of the economic crisis, some additional measures have been added. As mentioned previously, OOP payments have been estimated to account for about 20% of total health care expenditure. However, the financial burden of the poor and the sick has been shifted to the public authorities by a wide range of protection measures that can be classified into two groups. The first group consists of measures that reduce the cost of health care for each encounter with the health care system. An example of this is the system of increased reimbursement of medical costs, in which patients with a specific social status (for example, the long-term unemployed or pensioners with a limited gross taxable household income) or households below a certain income threshold are entitled to reduced co-payments and coinsurance rates. The (social) third-party payment system is another example. The second group of protection measures, such as the system of maximum billing that was introduced in 2002, puts a cap on a patient’s total health care costs. Finally, (regulatory) measures to protect patients from supplements that are too high were introduced since the start of the economic crisis.

Increased reimbursement of medical costs
Financial protection of economically vulnerable patients was already provided for in the first Health Insurance Act of 1963. At that time, vulnerable patients were defined as widows/widowers, orphans, pensioners, persons with disabilities and their dependents. They were fully reimbursed. Over the years the definition of the vulnerable population was extended to other groups, the principle of full reimbursement was replaced by increased reimbursement of medical costs (preferential reimbursement) compared to the general population, and eligibility for preferential reimbursement became means-tested. Some people are entitled on the basis of a granted social benefit without conditions based on income, such as people entitled to social integration revenue or social aid from the Public Welfare Centre. Others are entitled on the basis of status so long as their gross annual taxable income does not exceed a certain limit, such as widows/widowers, orphans, pensioners, persons with disabilities or those who have been unemployed for at least one year. Since 1 July 2010, the group of people entitled to preferential reimbursement was extended to members of single-parent families and the age limit (> 50 years) for the long-term unemployed was abolished. Since 1 July 2011, people entitled to a fund for domestic oil from the Public Welfare Centre are also entitled to preferential reimbursement of medical expenses.

Omnio-status
Already in 1994, the General Report on Poverty (Fondation Roi Baudoin, 1995) recommended that preferential reimbursement should be given to individuals based on their income and not on social status. However, due to budget restrictions, it was not until July 2007 that the government responded to this report by generalizing eligibility for preferential reimbursement solely based on income by creating the Omnio-status. All patients with a household income below a certain threshold are entitled to Omnio-status and hence to increased reimbursement of health care costs. While take-up of this status was low in the beginning, at the end of 2012 almost 280 000 individuals were registered. On 1 January 2014, eligibility criteria for Omnio-status and for the increased reimbursement based on social status will have been synchronized.
Extension of social third-party payment system

In general, a direct payment system applies to ambulatory care and the third-party payer system applies to inpatient care and pharmaceuticals. To improve access to health care, the (social) third-party payment system was extended to ambulatory care on 1 July 2011 for some vulnerable population groups, such as people in an occasionally precarious financial situation and people entitled to preferential reimbursement or Omnio-status. Although this measure does not change the amount of co-payments that must be paid, it increases accessibility at the point of use.

Maximum billing system

The “maximum billing” system puts a ceiling on the total amount of co-payments (excluding supplements and also some co-payments) to be paid during a calendar year. The maximum share of co-payments as a proportion of total net taxable household income varies between 2.4% and 3.9%, except for the very poor (with a net taxable income below €11,500) where it can be larger than 3.9%, and the very rich where it can be smaller than 2.4%. The system has been expanded gradually since its introduction in 2002. For example, for chronically ill patients, some non-reimbursed painkillers were included in the calculation of the maximum billing ceiling. Since January 2009, the co-payment threshold has been reduced by €100 for individuals that have exceeded the limit of €450 of co-payments for two consecutive years. These individuals are considered to be chronically ill.

New status for patients with a chronic illness

In September 2013, the status of chronic illness was adopted by the government. The status will be automatically assigned by the sickness funds to patients with at least €300 of health care expenses (not only OOP) for eight consecutive trimesters or who are entitled to the lump sum payment for the chronically ill (zorgforfait in Dutch; forfait de soins in French). Patients suffering from a rare or orphan disease are also entitled to the new status. Patients with the status of having a chronic illness are automatically eligible for the lower maximum billing ceiling (as of 1 January 2013) and for third-party arrangements (as of 1 January 2015).

Supplements

While the system of maximum billing offers protection against the accumulation of co-payments to be paid, it does not include supplements, i.e. extra-billing above the officially agreed tariff. Supplements in the hospital sector are regulated and registered, but information on supplements charged in an ambulatory setting by doctors who have not signed the fee agreement is currently not available. However, a new law on transparency is in preparation that will require physicians and dentists to mention the exact amount (including supplements) that has been paid by a patient on the medical attestation, to be submitted to the sickness fund.

Hospitals and medical specialists can charge supplements on their fees, on the price of the room and on implants and medical devices. In the last few years, particularly since the onset of the crisis, the reimbursement level for implants and medical devices has increased and the fee and room supplements have increasingly been regulated. This regulation is based on the room type. In 2010, supplementary charges for two-person hospital rooms were abolished. Since 1 January 2013, patients in two- or more person rooms are almost fully protected against fee and room supplements. The only exception is the possibility for medical specialists who have not signed the agreement to charge supplements for day-stay care. However, the national commission of representatives of physicians and sickness funds recommends that medical specialists do not charge supplements to patients with preferential reimbursement, chronically ill patients and for day-stay care in oncology.

12 Patients are entitled to this lump sum payment if the sum of their co-payments has exceeded a threshold in each of the two previous years and they can prove that they have lost their ability to live independently to a major extent.
Changes to purchasing and delivery

There also have been efforts to protect access to the health care system by policies intended to control volume or prices. Such policies mainly have been implemented in the pharmaceutical sector: 42% of all savings in 2012–2013 were realized in this sector (Gillis, 2014).

Policies affecting health system input prices

Pharmaceuticals

A wide variety of measures\textsuperscript{13} were taken to reduce input prices, especially of pharmaceuticals (see Table 2.4). Although these measures were part of ongoing reforms, they have been intensified in recent years. They have contributed to decreases in public pharmaceutical spending as a proportion of total health spending, as mentioned in the section on the Nature and magnitude of the financial and economic crisis on page 9.

In Belgium, the reference price level is based on a simple linear reduction (percentage) in the original, ex-factory price of the brand drug (Vrijens et al., 2010). The result is then increased by the distribution and delivery margins to obtain the public price. When the reference price system was first introduced in 2001 for off-patent reimbursable drugs – provided that a low-cost\textsuperscript{14} alternative exists – the percentage reduction was fixed at 16% (imposed by the government). It was then progressively increased throughout the years and since April 2011 has been 31% for drugs included in the reference price system for the first time, with an additional reduction of 6% for drugs included in a reference group for over two years plus a reduction of 5.5% for drugs included for over four years.

Since April 2012, drugs in reimbursement category A (no co-payment) have enjoyed a price decrease of 41% instead of 31% if they are included for the first time, with an additional reduction of 7% (instead of 5.5%) if they are included for over four years. A large number of brand drug companies lowered their price to the reference price level. This method for setting the reference price has the benefit of guaranteeing savings to the public authorities, but has in general not generated price reductions of generic medicines below the reference price (Dylst, Vulto & Simoens, 2012).

On 1 April 2012, an overall price reduction of 1.95% for all drugs came into force. Pharmaceutical companies can choose between this linear reduction of 1.95% on all their products or a flexible reduction of prices for some products (some more than 1.95% and others unchanged). The flexible reduction can only be applied on certain conditions, for example, a maximum 20% reduction per product for pharmaceuticals that have been in the reference price system for less than four years and a maximum of 6% otherwise; pharmaceuticals under a compulsory substitution policy (antibiotics and anti-inflammatory drugs) are excluded. The 1.95% price reduction was also applied on 1 April 2013 resulting in a price reduction for more than 2500 drugs.

In order to allow price comparisons, since 2012 pharmaceutical companies have been required to submit the ex-factory prices of drugs under patent on the Belgian market for more than 5 and less than 12 years, in six EU countries with a comparable standard of living (Austria, Finland, France, Germany, Ireland and the Netherlands). If a significant decrease is observed abroad, the reduction will also have to be applied in Belgium.

Overhead costs

In 2011, the federal government decided to reduce the budget for overhead costs of the sickness funds (i.e. administrative costs) by €433.3 million in 2012, €91 million in 2013 and €112 million in 2014. In response, in 2011 some sickness funds reduced their number of employees.

\textsuperscript{13} The list of measures is not exhaustive.

\textsuperscript{14} Low-cost drugs are generic drugs and brand-name original products that lowered their price to the reference price.
Health workforce and salaries

In 2012, in response to the crisis, the government decided to reduce the amount paid to physicians through FFS by €60 million, to save €122 million on the indexation of these fees and to reduce NIHDI reimbursement to orthopaedists and some types of pharmacists by €8.5 million. As part of these measures, indexation of fees for GPs and medical specialists was reduced to 1.5% (from 2.99%). In 2013, physicians unions and the government agreed to make a saving of €105 million by limiting and reallocating the funding available for indexation on a variety of health personnel and services (clinical biologists, medical imaging, surgery, gynaecology services, and GP and specialist consultations). In contrast to these reductions, in 2013 a social agreement was established for the non-profit sector (see also the section on How well prepared was Belgium for an economic shock? on page 10) in which a budget of €40 million was put aside for financing the cost of 800 additional full-time equivalent positions in the health care sector.

Policies to make drug prescribing, use and pricing more rational

Table 2.4 summarizes the main policies affecting the prescribing, pricing and reimbursement of pharmaceuticals in Belgium. The possibility of generic substitution was introduced by law in 1993, but the royal decree required to put the law into practice was not adopted until 2012. Since May 2012, pharmacists have been required to treat a prescription for acute treatments with an antibiotic or an antifungal, as a prescription by international non-proprietary name (INN), even if a specific brand is mentioned. However, a physician can specify that a brand name drug be dispensed in cases of allergy or intolerance or because of therapeutic reasons. Moreover, since April 2012, community pharmacists have been required to dispense a drug among the group of cheapest drugs for every INN prescription. The group of cheapest drugs are those with the same molecule, administration form and dosage and for which the public price is within a range of 5% above the cheapest (EOHSP, 2014). Since 2005, physicians have been allowed to prescribe drugs by INN. Although this is not obligatory, physicians are encouraged to do so by a quota system introduced in 2005 whereby GPs and other medical specialists are required to prescribe a minimum percentage of low-cost drugs, including drugs prescribed by INN. The minimum percentage differs per medical specialty. Since January 2011, the percentage for GPs has been increased from 27 to 50%.

In 2001, a closed budget for pharmaceuticals was introduced. Between 2001 and 2005, a claw-back system and other contributions were in place forcing pharmaceutical companies to contribute to the financing of public pharmaceutical spending. In 2006, a single system of contributions (called provisional funds) was installed, which was based on taxes on the turnover of reimbursed pharmaceuticals (9.73% in 2006; 8.73% in 2007; 7.73% in 2008 and 2009; and 6.73% since 2010). Turnover taxes are reduced in some specific situations, for example, if pharmaceutical companies have invested in research, development and innovation, or for specific pharmaceuticals, for example, orphan drugs and drugs in category Cx (contraceptives and antispasmodics) (Gerkens & Merkur, 2010). The mechanism of provisional funds was abolished in 2008 and replaced by a similar system of contributions based on taxes on turnover, which are due in case of a budget overrun and cover up to €100 million. Additional taxes on the turnover of reimbursed pharmaceuticals have recently been implemented in response to the economic crisis. Examples are a ‘crisis’ tax of 1% since 2010 and a tax of 0.13% since 2013 (EOHSP, 2014).

If the sub-budget for pharmaceuticals is exceeded, pharmaceutical companies have to reimburse 65% (later increased to 72%) of the budgetary deficit. The remainder is paid by the sickness funds (Gerkens & Merkur, 2010).
Provider payment reforms

Pharmacists

A new remuneration system was introduced in April 2010, mainly to reinforce the intellectual role of pharmacists and partly to disconnect remuneration from drug prices. The system where pharmacists received a percentage (with a ceiling) of the retail price was replaced by a basic fee for intellectual services (a fixed sum per package for reimbursable drugs, equal to €4.16 since 1 January 2014), and an economic margin (6.04% of the ex-factory price for ex-factory prices smaller than or equal to €60 and €3.62, plus 2% of the difference between the ex-factory price and €60 for ex-factory prices above €60). A third part of the new remuneration system consists of some extra fees, for example, for INN prescribing of drugs in the reference pricing system (€1.28 per delivery since 1 January 2014) or for advisory consultation services in case of new inhaled corticosteroids for asthma (€19.13 per talk; introduced on 1 January 2014).

General practitioners

Although GPs are mainly paid on a FFS basis, the share of lump sum payments increased from 2.6% in 2000 to 20% in 2010 (Verzekeringswereld, 2011). Lump sum payments were introduced for managing the global medical file; for coordinating care in the DMPs for patients with type 2 diabetes and chronic kidney failure patients; and to be on call. General practitioners are also paid a fixed amount per year to use a software package for the global medical file (telematics premium). The policy goals behind the gradual decline of FFS as the dominant remuneration system are diverse. One of the objectives of the DMPs (introduced in 2009) was to reinforce the role of GPs in the treatment and follow-up of patients with a chronic illness. At the same time, the measure aims to increase patient access (see section on Cost coverage on page 18). The lump sum payment for managing the global medical file is also meant to reinforce the role of GPs.

Hospitals

The system of ‘reference amounts’ was introduced in 2002 to detect and control large variability in hospital practices for standard interventions provided in inpatient settings (Van De Sande et al., 2010).
The reference amount is a standard by which the hospital is compared and is calculated as the national average expenditure raised by 10%. Only expenditure on clinical biology, medical imaging and other technical services (internal medicine, physiotherapy and various medico/technical services) are included. If hospital expenditure exceeds the reference amount, the expenditure surplus (difference between hospital expenditure and median national expenditure) is paid back to the NIHDI. In an attempt to increase efficiency of resource use, the system has been expanded to day care and to services provided up to 30 days before the hospital stay (since January 2013).

**Information and communication technology**

There has been a gradual elaboration of the e-health digital platform, set up in 2008 to permit an electronic exchange of secure data between all health actors. Since 2009, the federal government has decided to invest in new software, such as MyCareNet, to improve the monitoring of patients (for example, patients' insurance status, health status and right to increased reimbursement).

**Implications for health system performance**

**Impact on equity**

Earlier sections of this chapter have stressed that safeguarding an accessible health care system of high quality has always been the first concern of policymakers and stakeholders in Belgium. The overview of protection measures that were taken since the crisis in 2008 (see section on Cost coverage on page 18) illustrates this concern. Although we believe that an evaluation of health policy in terms of equity should capture a concept of individual well-being, it is of course also possible to evaluate the evolution on specific indicators reflecting the financial accessibility of the health care system.

**Equity in financing**

A popular aggregate evaluation criterion is the degree of progressivity of the health care financing mix. Progressivity measures were developed to evaluate to what extent health care financing adheres to the ability-to-pay principle. Table 2.5 illustrates how the overall financing mix of health insurance has been growing less progressive since 2006 in that income sources that are proportional to income (mainly social security contributions) are increasingly complemented with receipts from regressive income sources (mainly indirect taxes). However, in Belgium's system of global management, the calculated degree of progressivity of health care financing necessarily rests on arbitrary assumptions about the assignment of health care expenditure to different financing sources. Moreover, the share of private market insurance and the share and distribution of OOP payments (see the section on Financial accessibility of the health care system below) are not captured by the measure of overall progressivity of the financing mix, although these are essential features of an equitable health system.

### Table 2.5 Equity in financing of health insurance in Belgium between 2006 and 2011

<table>
<thead>
<tr>
<th>Financing source</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratio proportional receipts/total receipts</td>
<td>71.1%</td>
<td>71.0%</td>
<td>72.0%</td>
<td>70.6%</td>
<td>69.4%</td>
<td>64.8%</td>
</tr>
<tr>
<td>Ratio progressive receipts/total receipts</td>
<td>18.9%</td>
<td>19.0%</td>
<td>18.0%</td>
<td>17.3%</td>
<td>17.2%</td>
<td>19.4%</td>
</tr>
<tr>
<td>Ratio regressive receipts/total receipts</td>
<td>10.0%</td>
<td>10.0%</td>
<td>10.0%</td>
<td>12.1%</td>
<td>13.4%</td>
<td>15.8%</td>
</tr>
</tbody>
</table>

Source: Renard (2012).

16 For a more elaborate discussion on the concept of well-being as a broader perspective on equity in health, we refer the reader to Schokkaert & Van de Voorde (2013b).
Financial accessibility of the health care system

Over the course of the last 10 years, several policy measures have been taken to stabilize OOP expenditure for health care and to reduce it for low-income population groups. In 2012, patients paid, on average, 6.54% co-payments on physician fees. When co-payments for partly reimbursed drugs are included, the share of co-payments as a proportion of total health care expenditure amounts to more than 8%.

Maximum billing system

Table 2.6 shows the number of patients and households who were reimbursed by the system of maximum billing because they exceeded their income-dependent co-payment limit as well as the total amount of reimbursements in the period 2008–2011. The figures clearly show the effect of the introduction of maximum billing for the chronically ill in 2009 on total maximum billing reimbursements. The decrease in the number of patients receiving such reimbursements in 2010 and 2011 can be explained by a change in the eligibility criteria. Before 2009, as soon as one person with preferential reimbursement in a household reached the co-payment ceiling, all the members of that household (living at the same address) became eligible for maximum billing reimbursements, independent of whether these other household members had preferential reimbursement status. Since 2009, only the household members with preferential reimbursement status are eligible for maximum billing reimbursements if the household has reached the co-payment ceiling.

Table 2.6 System of maximum billing (2008–2011) in Belgium: number of patients/households and total reimbursements

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>1,123,204</td>
<td>1,173,327</td>
<td>1,101,393</td>
<td>1,088,409</td>
</tr>
<tr>
<td>Number of households</td>
<td>630,339</td>
<td>643,343</td>
<td>610,091</td>
<td>602,282</td>
</tr>
<tr>
<td>Total reimbursements (in thousands of Euros)</td>
<td>277,153</td>
<td>305,619</td>
<td>326,335</td>
<td>329,653</td>
</tr>
</tbody>
</table>

Source: RIZIV (2013c).

The impact of the maximum billing system can be translated into a lower average co-payment for reimbursed products and services. For example, without the maximum billing system, the average of co-payments as a ratio of total expenditure for physician fees would have been 7.8% in 2012. The maximum billing system reduced the average co-payment pressure to 6.54%, representing a decrease of more than 16%. We have also observed that the average co-payment pressure for physician fees fell between 2007 and 2012, even independently of the maximum billing system (see Table 2.7) mainly due to increasing lump sum financing for physician services (for example, for services provided within DMPs), the increasing number of patients with a global medical record and its associated benefits (for example, lower co-payments for physician visits) and by the systematic implementation of preferential reimbursement status for specific groups.

Table 2.7 Co-payment pressure in Belgium for physician fees without and with the maximum billing system (as a percentage of total fee expenditures, excluding supplements)

<table>
<thead>
<tr>
<th>Year</th>
<th>Co-payments without maximum billing (%)</th>
<th>Co-payments with maximum billing (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>8.66</td>
<td>7.20</td>
</tr>
<tr>
<td>2008</td>
<td>8.60</td>
<td>7.32</td>
</tr>
<tr>
<td>2009</td>
<td>8.54</td>
<td>7.23</td>
</tr>
<tr>
<td>2010</td>
<td>8.22</td>
<td>6.85</td>
</tr>
<tr>
<td>2011</td>
<td>7.91</td>
<td>6.60</td>
</tr>
<tr>
<td>2012</td>
<td>7.80</td>
<td>6.54</td>
</tr>
</tbody>
</table>

Source: RIZIV (2013c).
Medical houses

Medical houses are primary care centres where a team of GPs, physiotherapists and nurses offers medical care free of charge to patients. The NIHDI reimbursement takes the form of a lump sum per registered patient (risk-adjusted capitation payment), paid directly to the providers working in the medical house. In contrast to their colleagues, health care providers are not paid on a FFS basis, with co-payments from patients. Also in contrast to single-provider practices, patients do not have to pay the full fee upfront and claim reimbursement afterwards. This reduces financial barriers to access to health care services. In general, medical houses are situated in disadvantaged neighbourhoods. However, with the crisis, they are becoming increasingly important. Patients still have to pay for pharmaceuticals, bandages and other nursing material. When a patient goes to another provider (for example, GP not working in the medical house), this service is not reimbursed by the NIHDI (except in case of out-of-hours consultations).

The number of medical houses and the number of people registered with them has increased more rapidly in Belgium since 2003, and this trend continued after the onset of the crisis. In 2008, there were 88 medical houses with just under 189 000 registered patients. On 30 June 2012, there were 129 medical houses with about 274 000 registered patients, representing a 10% increase compared to 2011 when there were 119 medical houses with 250 075 registered patients (RIZIV, 2013d). Consequently, the NIHDI expenditure for medical houses has also increased rapidly from €25.9 million in 2003 to €92.8 million in 2012, with the greatest increase for nursing services. The increase cannot, however, be attributed to the crisis.

Hospital care

The Belgian government has taken several measures to reduce OOP costs for hospitalized patients. Three major measures were taken:

- Protection against room (2010) and fee (2013) supplements charged by hospital physicians for patients staying in a room with two or more beds, independent of the qualification of the physician or the status of the patient, except for non-contracted physicians in day care
- Better reimbursement of medical devices and implants (since 2008, but the effects have been more pronounced since 2012)
- Increased transparency on the costs charged to patients (2013).

These measures have had an impact on patients’ OOP costs associated with hospitalization. There has been an increasing divergence between the cost of a hospital stay in a single room and in a two- or more person room. Physicians and hospitals reacted to the tightening of the regulation by increasing supplements where they were still allowed: between 2004 and 2011 fee supplements for the members of the Christian Sickness Funds increased each year by 5.4%. Nevertheless, the overall cost of a stay in a single room remained more or less stable in recent years, because the increase in fee supplements was compensated by a decrease in material supplements (Schokkaert & Van de Voorde, 2013b; Crommelynck, Cornez & Wantier, 2013). There is, however, large variation among hospitals, with a small fraction of hospitals charging fee supplements that amount to 400% of the official tariff (Crommelynck, Cornez & Wantier, 2013; Laasman, 2013). Hospitals charging large fee supplements are mainly located in Brussels and to a lesser extent in the Walloon Region. For people without preferential reimbursement, supplements in 2012 amounted to an average of €1100 in Flanders, €1490 in Wallonia and €2384 in Brussels. Fee supplements, and to a lesser extent room supplements, were responsible for these striking differences.

Population with preferential reimbursement

An analysis of the data of the Christian Sickness Funds showed that between 2009 and 2011 15% more people became eligible for preferential reimbursement (Christian Sickness Funds, 2012). The socialist sickness funds made similar observations among its members. Since the economic crisis, the proportion
of members from the socialist sickness funds with preferential reimbursement status, including those with Omnio-status, increased from 15% in 2006 to more than 23% in 2012 (Laasman, 2013). Assuming that the extension of eligibility for increased reimbursement in 2007 (introduction of Omnio-status) had already had its complete effect in 2009, this observation may indicate that the number of people in a problematic financial situation is increasing. However, the take-up of Omnio-status was slow, as people were not aware of their eligibility and had to submit a request to their sickness fund on their own initiative. Therefore, it is unlikely that the measures taken in 2007 have already shown their complete effect. Further increases in the population eligible for increased reimbursement can be expected, also due to measures to widen the eligibility criteria (for example, extension of preferential reimbursement entitlement to single-parent families in 2010 and to persons entitled to a fund for domestic oil from the Public Welfare Centre in 2011) and not only due to the economic crisis. Moreover, a more proactive policy to detect people who are eligible for preferential reimbursement will be possible in the near future due to an exchange of information between the NIHDI, the sickness funds and the fiscal authorities.

Postponing health care expenditures for financial reasons

According to the Health Interview Surveys (1997, 2001, 2004 and 2008), an increasing number of households declared they had to postpone health care (medical care, surgery, drugs, spectacles or contact lenses, mental health care) during the last 12 months because they could not afford it. The share of respondents was relatively stable between 1997 and 2004 (around 9%), but increased since then to 14% in 2008. These averages hide large differences due to age, education level, household composition and region. For example, in 2008, 9% of households in the highest education level group postponed health care versus 18% for those belonging to the lowest level group, and 30% of single-parent households reported to have postponed health care for financial reasons. Currently (March 2014), a fifth Health Interview Survey is being conducted.

More recent data from a large online survey (21,957 respondents) on the perception of health care by the Belgian population (CM, 2013) organized by the Christian Sickness Funds in 2013, show a different picture. Of all respondents, 11% reported that they had to postpone health care expenditures for financial reasons. In addition, EU-SILC data highlighted in Figure 2.4 show that self-reported unmet need due to financial reasons declines by quintile of equivalized income.

Finally, a survey conducted in 2013 by the Socialist Sickness Funds amongst 1,521 citizens revealed that 23.6% had postponed health care expenditures or health care services for financial reasons in the last year. The population groups showing the highest rate of self-reported postponed expenditures or care were those aged between 31 and 45 (30.7%), singles with children (40.6%) and people with a preferential reimbursement status (39.4%) or Omnio-status (38.2%). Most frequently, expenditures for pharmaceutical products were postponed (35.6%), followed by dental care services (23.2%). More research is needed to interpret these different numbers.

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17 Unmet need is defined as the share of the population perceiving an unmet need for medical examination or treatment. Reasons include problems of access (could not afford to, waiting list, too far to travel) or other (could not take time, fear, wanted to wait and see, did not know any good doctor or specialist, other).
The impact of the global economic crisis on the health care systems of Belgium, France and the Netherlands

Unmet need

Data on unmet need show that lower income groups in particular perceive that they have unmet health care needs. The reason for needs being unmet is reported to be mainly related to the cost of healthcare (see previous section). Other reasons (travel distance, waiting times, lack of time, not knowing a good doctor, fear, wanting to wait and see and other) accounted for less than 0.6% in all income quintiles up to 2010. In 2011 the relative importance of these other reasons for the lowest income quintile increased compared to financial reasons (mainly “having no time to seek healthcare”). There are no perceived unmet needs due to waiting times in Belgium. A large disparity remains between the lowest income groups (1st quintile) and the highest income groups (5th quintile) with regard to perceived unmet needs in health care (Figure 2.5). This huge disparity has been observed for several years. Before the crisis, a marked downward trend was observed in perceived unmet needs in all income groups as well as in the difference between the lowest and higher income groups. In 2011, the perceived unmet needs started to increase again in all income groups and the gap between the lowest income groups and the higher income groups widened.

Figure 2.4 Self-reported unmet need due to health care being too expensive, by quintile of equivalized income (as a percentage of the population) Belgium, 2013

![Figure 2.4 Self-reported unmet need due to health care being too expensive, by quintile of equivalized income (as a percentage of the population) Belgium, 2013](image)

Source: Eurostat (2013e).

Figure 2.5 Self-reported unmet needs by quintile of equivalized income (as a percentage of the population) in Belgium, 2004–2011

![Figure 2.5 Self-reported unmet needs by quintile of equivalized income (as a percentage of the population) in Belgium, 2004–2011](image)

Source: Eurostat, 2013e.
Impact on transparency and accountability

In 2003, the Belgian Health Care Knowledge Centre (KCE) was established to perform health technology assessments and health services research for policymakers, and to develop clinical practice guidelines for health care providers. The aim is to increase efficiency in health care and improve the transparency of the reasons behind reimbursement decisions.

Current initiatives to increase transparency include a law to increase the financial transparency of health care for citizens. The changing economic and political climate has been one of the motives for this law. With the increasing pressure on government budgets due to the crisis and the financial problems it has created for some groups of citizens, it is felt that it is unjustifiable that there is an almost complete lack of transparency for patients in the financial consequences of using health care. Moreover, to be able to allocate health care budgets more efficiently and to ensure equity, it is important to have transparency about the complete financial consequences of using health care. The proposal to increase financial transparency encompasses many elements: the publication of the status of health care providers (whether they have signed the convention or not) on the website of the NIHDI; a measure to regulate supplements charged for clinical biology, pathological-anatomical research and genetic tests; regulations regarding the information health care providers have to provide to patients about the cost of health care services, medical materials and devices; and regulations on presenting this information on health care service delivery certificates or similar documents.

Impact of the health care sector and wider socioeconomic changes on population health

Mortality

Cardiovascular disease is the major cause of death in Belgium. Improved treatment strategies and preventive efforts have induced a significant decrease in cardiovascular mortality over the last decade. While in 2003 almost 345 per 100 000 people died of cardiovascular disease, this number was reduced to 254 per 100 000 in 2009. More recent data are not yet available. The next most frequent cause of death is cancer, with mortality due to cancer remaining relatively stable between 2003 and 2009 at a level around 228 per 100 000 people a year. The Cancer Plan (launched in 2008) with 32 specific initiatives organized into three main principles (actions on prevention and screening, actions on care, treatment and support, and actions on research, technological innovation and assessment) is expected to show its effects only in the longer term.

Self-reported health

Data on self-reported health by income quintile show that there is a huge gap between the highest and the lowest income groups: about 85% of the population in the highest income quintile report a health state of good or very good, while this proportion is about 59% in the lowest income quintile. This gap has remained stable since 2004. No marked changes have been observed due to the crisis. Self-reported health by education also shows a socio-economic gradient (OECD, 2013). Populations with low education show a lower self-reported health than highly educated population groups. The proportion of the population reporting their health as being good or very good decreased for the low education group since 2008, whereas this proportion remained stable for the medium and high education group. Finally, a difference in self-reported health is observed between men and women in Belgium (OECD, 2013). The difference between both groups has steadily decreased over the last decade.

Disease prevalence

Long-term disability

Between 2005 and 2010 there was a steep increase of 82% in the number of people with long-term disability. It is believed that this is partly due to stricter eligibility conditions being imposed to receive a retirement pension; however, it is difficult to confirm a causal relationship.
Mental illnesses

A survey conducted in 2012 by the socialist sickness funds in Wallonia and Brussels and interviews with GPs, psychiatrists and psychologists, revealed that one in 10 people (very) regularly suffers from depression or anxiety. This is mainly caused by being/becoming unemployed. Health care expenditure data show an increase in the use of antidepressants by 45% between 2004 and 2012. The increase was strongest between 2006 and 2008, but since 2010 the increase has been limited to 4.6%. Of all age groups, those aged between 51 and 70 have experienced the largest increase. The use of antidepressants decreased in children (0–10 years) from 2004 onwards and in adolescents and younger adults (to 30 years of age) from 2008 onwards because alerts were published concerning the increased risk of suicidal thoughts, suicide and self-mutilation associated with the use of antidepressants in children and adolescents. The biggest users of antidepressants are aged between 41 and 80.

The use of antipsychotics has increased significantly since 2004 (50% between 2004 and 2012). The crisis did have an accelerating impact. The biggest users are between 41 and 60 years of age. A consistent growth in their use also has been reported for adolescents and children, particularly for those aged between 12 and 17. The number of patients in this age group increased by 16% while the population decreased by 3% (RIZIV, 2013e).

Mental illnesses are the primary cause of invalidity in Belgium, with 27% of long-term absenteeism being related to mental issues. There also has been a rapid increase in disability benefit claims due to mental health disorders in recent years: 1% of the Belgian population or one-third of all claims (95 000 persons in June 2012 compared with 86 000 in June 2010). Claimants were mainly aged between 40 and 55, but the number of young people is increasing (Solidaris Mutualité, 2012). Moreover, the life expectancy of psychiatric patients is on average 15 year shorter (Van Herck & Van de Cloot, 2013) than the average.

Discussion

The nature of the health system’s response to the crisis

Drivers of change

The drivers of change in the health system in response to the crisis can only be understood against the background of European obligations and some specific characteristics of the Belgian health care sector.

European obligations

In 2009, Belgium was urged by the Council of the EU to take measures to reduce its government deficit, which accounted for 5.6% of GDP at that time. Between 2010 and 2012 the deficit needed to decline by 0.75% of GDP per year (Council of the EU, 2009). By the end of 2012, the objective had not yet been reached, mainly due to the capital injections the government made into the banking sector (about 0.8% of GDP) (European Commission, 2013).

Instruments available since the beginning of the 1990s

Despite this fiscal pressure, the need and possibilities for change in the health care sector were limited in the early years of the crisis. Several factors contributed to this. First, at the outbreak of the crisis in 2008, Belgian policymakers had a set of instruments at their disposal that postponed the impact of the crisis on the health sector. These instruments were introduced at the beginning of the 1990s to fulfil the convergence criteria as outlined by the Maastricht Treaty, which entered into force in 1993. The convergence criteria with respect to government finance imply that the ratio of gross government debt to GDP must not exceed 60% and the ratio of the annual government deficit to GDP must not exceed 3%.

18 Telephone survey in 2012 of 1000 adults between 18 and 75 years and web-based questionnaire for physicians.
19 This rule was not enforced, as most EMU members were unable to meet this criterion before 1999.
at the end of the preceding fiscal year. In 1993, the gross government debt was 137.8% of GDP (National Bank of Belgium, 2013) and the government deficit was 7.5% of GDP (OECD, 2013b).

The main purpose of the reforms in the 1990s was to increase the cost-consciousness and cost-participation of all the partners in the health care sector. The idea of monitoring the development of health spending within an a priori budget and a close monitoring of subsector budget overruns was the first important innovation. A real growth cap was introduced in 1995 to restrict the annual maximum increase in the health budget to 1.5% in real terms. In 1999, when Belgium entered the EMU, the growth cap was raised to 2.5%, and then to 4.5% from 2005, resulting in annual health budget surpluses since that year. Between 2005 and 2010 this budget surplus was transferred to the so-called Fund for the Future, to other subsectors of social security or was used for new initiatives. Moreover, the budget surplus allowed policymakers to focus on protection measures to shelter citizens from potential access barriers to health care. A second innovation of the reforms in the beginning of the 1990s was the introduction of individual and collective financial responsibility of the sickness funds. These structural reforms had been in place for more than 15 years before the outbreak of the crisis, and accorded important protection to the system.

No government for 541 days

A second factor limiting the need for change was that between June 2010 and December 2011 Belgium had a caretaker government that could not impose austerity measures. The health budget for 2011 was thus established under special circumstances: by a government that could not take new legal initiatives, in a context where the general government deficit was very large and where there was a surplus in the health care budget of €1.8 billion. Stakeholders were aware that this situation had protected the health care sector probably more than other sectors. They realized that the need to implement savings was inevitable and the real growth cap could not be maintained given the economic situation. This is illustrated, for instance, by the advice of the NIHDI’s Health Care Insurance Committee, consisting of representatives of the major stakeholders, to transfer €1464.9 million of the surplus in the health care budget (about 5.3% of the total health care budget) to other social security sectors. Moreover, while new initiatives costing €125.8 million in total were still honoured, at the same time savings measures were taken – worth €116.5 million – to compensate for the costs of the new initiatives. In 2012, there was no increase in the health care budget and the decision was taken to reduce the real growth norm for 2013 and 2014, although it still remains positive.

Fiscal federalism reform

The fiscal federalism reform (the sixth State reform) is a third factor explaining health system changes. The State reform is first and foremost a political agreement with a substantial transfer of powers in health care to the communities. The aim of the transfer is to have a more rational distribution of tasks, but the issue of conflicting incentives between government levels has not been addressed (OECD, 2013a).

All of these background factors forced policymakers to be more explicit about choices. Safeguarding and improving financial accessibility to high-quality health care was the first concern. A second priority was to ensure a sufficiently large workforce in the health care sector. The fact that budget proposals for 2012 and 2013 had to be formulated within tight budgetary margins raised awareness among stakeholders that measures to increase health care efficiency were inevitable. In that sense, several agreements (between sickness funds and health care professionals) contained structural measures\textsuperscript{20} based on evidence-based medicine instead of the former linear cuts in indexation. Examples include the revision of the Belgian fee schedule (to take place in the years to come), whereby fees become better correlated with real time investment and costs, measures to increase the attractiveness of general practice, the revision of financing

\textsuperscript{20} Some of these measures have not been implemented as yet.
mechanisms for medical imaging, dialysis and emergency care, the development of DMPs for chronic
diseases, emphasis on preventive and conserving dental care, and the promotion of INN prescribing (see
also section on the Policies to make drug prescribing, use and pricing more rational on pages 22 and 23).

For 2013 and 2014 priorities continue to be accessibility and quality of care. An important additional
objective is financial transparency, especially in the ambulatory sector. Concrete initiatives include
proposed new laws to increase accessibility to drugs for unmet medical needs and to introduce greater
transparency of ambulatory care costs. The major breakthrough regarding transparency will be that,
from 2016 onwards, the health care certificate that patients receive when they visit a doctor will mention
explicitly the supplement paid over and above the official tariff, the latter equalling the sum of the
reimbursed amount and the co-payment.

The pressure on government budgets has also breached certain taboos, for example, regarding the fight
against social fraud, the monitoring of outliers in dental care, the lack of transparency in supplements
paid by patients to medical doctors, the explicit comparison of the quality of care in hospitals, and so
on. For example, measures have been applied in the dental care sector to reduce expenditure because a
small group of outliers was exploiting the system, albeit in a legally correct manner as they could not be
prosecuted for their excessive activities. This was frustrating to the larger group of responsible dentists
acting in the interests of attaining financial balance in their sector. In 2012, the association of dentists
and sickness funds (dento-mutualiste) developed legal instruments to sanction the outliers, to become
effective from 2013. Such action illustrates the goodwill of providers and sickness funds to collaborate to
fight excesses.

**Content and process of change**

As explained previously, the process of change in Belgium following the crisis has been determined to
a large extent by the measures and mechanisms already in place before the crisis. A few observations
can be made. First, the health care budget tends to be estimated on an annual basis and a long-term
sustainable plan seems to be lacking. In its latest report, the OECD recommends the introduction of a
detailed medium-term budget to enhance strategic reflection on the desired level of spending. A focus
on the medium term would also be useful to reflect the effect of new measures in a transparent way
(OECD, 2013a). Second, between 1993 and 2008 the main objectives of health care policy were defined
as keeping health care expenditure within acceptable limits, guaranteeing accessibility and quality while
ensuring respect for therapeutic freedom and freedom of choice. During implementation, it was realized
that accessibility and quality of care were not always compatible with therapeutic freedom and freedom
of choice, but the former were maintained as basic objectives.

The basic principle applied during health policy changes was to first use the existing reserves to take
measures that would not be felt directly. Once the reserves were exhausted, measures started to focus on
increasing efficiency (for example, INN prescribing, day hospitalization, DMPs) and fighting malpractice
(for example, in dental care). Belgium is currently in the process of considering efficiency measures
requiring more structural changes (for example, alternative ways to finance hospital services and
development of additional disease management pathways with adapted financing). With the exception
of pharmaceuticals, the health system did not particularly focus on lowering input prices in its process
of change. More indirect measures, which ultimately have an impact on average input costs, include the
legal means provided to sickness funds to control medical services and to recover incorrectly charged
reimbursements, the means to monitor and sanction outliers in terms of volume, and more accurate
financing of dialysis and medical imaging based on needs rather than on supply or financing.

21 To illustrate the extent of the excesses: simulations showed that 31 dentists (0.4% of all dentists) accounted for 1.35%
and 1.30% of total expenditure for dental care in 2010 and 2011, respectively.
Intersectoral collaboration between institutional health care and ambulatory health care has been relatively weak in Belgium. The examples of disease management are limited to two clinical care pathways, one for end-stage kidney disease and one for diabetes, introduced in 2009. The intersectoral clinical care pathways were evaluated as being successful: a large number of patients participated in the DMPs and the quality of care was considered to be improved. However, as it was not possible to assess the impact of the DMPs on patient outcomes because the observation period was too short, it was decided not to extend the system of DMPs to other target groups.

Better collaboration has, however, been achieved in the area of data analysis and policy research. Belgium has very rich databases on health care consumption and expenditure (excluding fee supplements in the ambulatory sector) but limited resources for the analysis of these data. Because of this and the perceived need to have a stronger evidence base (based on real-life data) for policy changes to cope with the crisis, successful collaborations have been set up between research departments of different institutions, such as the Intermutualistic Agency, the KCE, the NIHD1 and the Scientific Institute of Public Health.

**Implementation challenges**

A major challenge to implement changes in the Belgian health system is dealing with the fragmented structure of the system. Subsectors are pillarized and it is hard to breach the boundaries. The FFS schedule is a list of fees and tariffs for isolated health care activities. It is still the major remuneration system for physicians. Fee-for-service systems contain incentives to provide more services to increase incomes, thus mitigating against the efficient use of resources. In addition, for many procedures, the fees are no longer a good reflection of the real costs because they have never been modified despite evolutions in science and medical practice (RIZIV, 2013b). Therefore, the fee schedule will have to be revised. Along with this revision, hospital financing may be reconsidered and both might be more effectively coordinated, especially from the perspective of integrated care. From this perspective, collaboration between hospitals may also be a challenge. Currently, such collaboration is limited and most hospitals wish to provide all services.

Another challenge will be the possible resistance of stakeholders to measures that are designed to maintain accessibility and quality of care but which might restrict therapeutic freedom and freedom of choice. This relates to additional measures to increase the efficiency of health care and avoid inappropriate use, but also increased transparency in (supplementary) charges to patients in the ambulatory sector that is currently still a black box for both patients and policymakers.

Belgium has rich data on health care expenditure and consumption. However, some data are old and updates are not regular enough to allow swift reactions. This applies, for example, to hospital clinical data (available with a delay of three years) and the data from the National Health Survey (performed only every four years; the most recent available data are from 2008). The technical possibilities are huge, due to the decision taken 20 years ago to introduce a unique registration number for all citizens, creating the theoretical opportunity to couple several databases. This was combined with strict privacy regulations to avoid misuse. Current discussions at the European level, in the context of new privacy guidelines, to abolish the unique national registration number are a threat to the possibilities currently available in Belgium to support evidence-based policy.

A final challenge is related to the State reform, whereby certain health care responsibilities have been transferred to the communities. These fragmented responsibilities between the federal and the regional level will be a challenge for the implementation of integrated care. In addition, the sixth State reform risks increasing overhead costs related to the administration of health care reimbursements, and thus the efficiency of this administration.
Resilience

Rapid change was not felt to be an urgent requirement in the wake of the crisis in Belgium because of the reforms introduced at the beginning of the 1990s and because there was no government for much of 2010 and 2011. Between 2008 and 2012 there was time to formulate policies that met stricter budgetary limits and at the same time could guarantee accessibility to services and more efficiency. When it became clear that the surplus in the health care budget had to be used for other social security sectors, all stakeholders became aware that greater efficiency measures were needed in the health care sector. This mentality change may have long-term consequences, both for the responsible and appropriate use of resources and for the acceptance of efficiency measures.

Technical measures have been taken to improve communication between different official data sources, such as the data from the sickness funds, (clinical) data registered at hospitals to allow them to obtain their annual budget and fiscal data. This offers efficient instruments for generating data that are directly useful for policy makers.

Belgium has invested in the monitoring of the health care budget since 1994 and in 2010 investments were made to prepare an assessment of Health System Performance (Vlayen et al., 2010). A core set of 55 indicators was identified, of which 40 would eventually be measured. After the publication of the preparatory report in 2010, additional indicators were added, relating to health promotion, mental health care, general medicine, long-term care, end-of-life care, continuity of care, patient centeredness and equity. In 2012, the first Health System Performance Assessment report was published (Vrijens et al., 2012). The report highlighted that the strengths of the Belgian health system are related to the vaccination rate in children, survival rates 5 years after a breast cancer or colorectal cancer diagnosis, relational continuity with GPs and increases in the prescription of low-cost drugs. Room for improvement was found in very high suicide rates, the growing number of people who are overweight or obese, the coverage rate of breast and cervical cancer screening in target groups, the high rate of caesarean sections and the social inequalities in many indicators.

Conclusions

The financial and economic crisis did not have a huge immediate impact on the Belgian health care system, mainly due to measures to protect the health care budget installed before the crisis. Because of the real growth cap applied to the health care budget since 1995 and budget surpluses built up in previous years, the Belgian health system was well prepared to buffer the effects of the economic crisis. Budgetary margins were often used to improve accessibility to health care. Accessibility and quality of care are and have long since been the major objectives of health care policy, with respect for therapeutic freedom and freedom of choice. Therefore, when it became necessary to start taking measures, the focus was first on measures that would not be felt immediately by patients. Misuse of the system and outliers in terms of volumes of health care service provision were tackled first. Efficiency measures were then taken. Measures taken in the pharmaceutical sector were very effective. Future plans for efficiency measures will focus on evidence-based reimbursement (for example, fee-related real costs), appropriate use and financing of medical imaging, dialysis and DMPs, efforts to promote primary care and the further development of integrated care for chronic diseases.

Resistance may be expected from stakeholders when efficiency measures reduce therapeutic freedom and perhaps freedom of choice. In addition, changes in financing, envisaged, for instance, for the national fee schedule used in FFS reimbursement, will be challenging, as it currently determines the income of health care providers.

Moving towards more integrated care will require a mentality shift among stakeholders. The sixth State reform will make this shift even more challenging, as some health responsibilities are moved to the
communities, while others remain a central government responsibility. Goodwill and communication between the different levels will be indispensable.

Data technical measures have been helpful in the process of implementing evidence-based policy changes. Several measures have been taken in the past to facilitate communication between data sources. Involved stakeholders are increasingly aware of the benefit of collaborating and are increasingly setting up formal collaborations to develop policy-preparing documents.

It is expected that the consequences of the economic recession will continue to be felt during the years ahead. The Belgian stability programme established in 2010 aims to reduce government debt to end the EU excessive debt procedure that was to be achieved by 2012 and to restore budgetary balance by 2015. The objective is to maintain a socially secure society, with accessible and efficient health care.

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2. The impact of the economic crisis on health and the health system in Belgium

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Acknowledgements

The authors would like to thank Professor Erik Schokkaert from the Department of Economics at the University of Leuven for reviewing this case-study chapter and for his very constructive comments and suggestions. All errors remain those of the authors.
Chapter 3
The impact of the economic crisis on health and the health system in France
Matthias Brunn, Karen Berg Brigham, Karine Chevreul, Cristina Hernández-Quevedo

The health care financing system in France

Financial responsibility for health care in France is mainly borne by statutory health insurance (SHI). However, SHI only funds around three-quarters of health spending, leaving considerable scope for complementary sources of funding, such as private voluntary health insurance (VHI). Moreover, funding for long-term care for older people and people with disabilities is financed differently. It is partly financed by a dedicated fund created in 2004, the National Solidarity Fund for Autonomy (Caisse nationale de solidarité pour l’autonomie). Its resources come from SHI and the ‘solidarity and autonomy contribution’ that is generated from the revenue of an unpaid working/solidarity day (journée de solidarité) contributed by the French working population. Local authorities and households also participate in financing long-term care for older people and people with disabilities.

Statutory health insurance resources mainly come from a tax broadly earmarked for social security called the general social contribution (contribution sociale généralisée), based on total income and not only on earned income, as was the case before its introduction in 1991. Within the general social contribution, defined percentages are earmarked for certain social security sub-branches; the health segment receives the largest share. Additional revenue accounts for around 13% and comes from specific taxes, such as ‘sin taxes’ (for example, on tobacco and alcohol consumption) or taxes on pharmaceutical companies’ turnover. Funds are pooled at national level and there are no formal allocation mechanisms.

Statutory health insurance coverage is established according to resident status and entitlement is based on employment, unemployment, student or retirement status. Since the introduction of universal medical coverage (couverture maladie universelle; CMU) in 2000, the State has covered the health care costs of residents not otherwise eligible for SHI. Illegal residents who have applied for residency are covered by a special program (aide médicale de l’État; AME). Statutory health insurance covers a broad range of services and goods that are provided in hospital or defined in positive lists for outpatient care. Within Europe, the level of coverage in France is considered quite generous, offering rapid access to care and the latest innovations. The rate of coverage varies across goods and services; for example, the coinsurance rate is 30% for physician visits and dental care, 40% for ancillary services and laboratory tests and 20% for hospitalization. For most drugs, coinsurance amounts to either 35% or 70%, but ranges from 0% for non-substitutable or expensive drugs to 85% for drugs judged to have a low medical benefit. However, there

1 For more information on SHI, see Chevreul et al. (2010).
are several conditions for which patients are exempt from coinsurance, such as chronic conditions covered under the long-term illness (affection de longue durée; ALD) scheme or pregnancy after the fifth month. Coinsurance amounts are generally covered by VHI, which provides reimbursement for co-payments and better coverage for medical goods and services that are poorly covered. However, deductibles introduced after 2004, with the aim of improving coordination of care and reducing patient consumption, cannot be covered by VHI or else the insuring entity would be subject to financial penalties in the form of doubled premium taxes.

Over the recent decades, VHI has gained an important role in ensuring equity in access and financing of health care. It covers 88% of the population on a private basis. Since 2000, to ensure that the measures increasing patients’ coinsurance would not result in greater social inequities in access, public complementary insurance (couverture maladie universelle complémentaire; CMU-C) has been offered on a voluntary basis to lower socioeconomic groups, covering 6% of the population. In addition, to help people at the margin of the CMU income ceiling to access VHI, a voucher scheme called aide pour une complémentaire santé (ACS), financed by the CMU Fund, was created in 2004.

Statutory health insurance covers care provided by both public and private health care providers who are under contract with the SHI. Patients who consult these providers are reimbursed for a share of the cost of care. The relationships of independent private health professionals with the SHI are defined at the national level in agreements called conventions, signed between the National Union of Health Insurance Funds (Union nationale des caisses d’assurance maladie) and representatives of the professions. Agreements for each profession are signed to cover a period of four or five years, or renewed until a new agreement is signed. However, there are regular amendments that take into account changes following the yearly Social Security Finance Act and other new measures. Purchasing relations with hospitals differ, since public and private hospitals are the responsibility of the Ministry of Health.

Statutory health insurance pays for hospital acute care by means of a diagnosis-related group (DRG)-type payment method (tarification à l’activité). In addition to the 20% coinsurance amount, a hospital catering flat fee amounting to €18 per day is the responsibility of patients or their VHI. Self-employed professionals are paid on a fee-for-service (FFS) basis and patients are reimbursed based on official tariffs. However, certain self-employed doctors are allowed to practice extra-billing (that is, apply user charges beyond the agreed tariff with the SHI), which impairs the objective of ensuring equity in access. Financial incentives to improve the quality and efficiency of doctors’ practices and to decrease the level of extra-billing were initially implemented in 2009 through individual contracts with general practitioners (GPs). These measures were expanded and generalized in 2012 as part of the national bargaining agreement and extended to specialists. Measures designed to rein in excessive extra-billing include a new voluntary ‘Access to health care’ contract aimed at doctors who practice extra-billing (known as sector 2). In exchange for maintaining their fee practices at 2012 levels, doctors benefit from social and fiscal advantages. Doctors with fee practices that are deemed excessive may be subject to sanctions as a last recourse.

In 2012, total expenditure on health in France was estimated at €243 billion or 12% of gross domestic product (GDP). Expenditure on personal health care accounted for three-quarters of total health expenditure (€183.6 billion), representing an average of €2806 per person. Of this, 74.3% was SHI-funded, with complementary VHI financing 12.9% and households covering 7.3% in out-of-pocket (OOP) costs (Eco-Santé, 2014). As in other European countries, health care expenditure has steadily increased. As a result, since the late 1990s, SHI annual expenditure has been capped by a national ceiling on SHI expenditure (objectif national des dépenses d'assurance maladie; ONDAM), approved by the French Parliament. If the health care system is found to exceed its projected budget by more than 1%, a special parliamentary Alert Committee can ask the head of the Directorate of Social Security (the watchdog for all social security branches) to present a financial rescue plan.
To contain SHI expenditure, two categories of measures are used. The first, known as the ‘strict accounting cost-containment policy’, primarily focuses on decreasing the size of the benefit basket and levels of coverage, resulting in a shift towards VHI coverage. Several new mechanisms were introduced after 2004. A coordinated care pathway was implemented, with higher coinsurance for patients consuming care out of this pathway; further, new categories of co-payment for patients were created, with the introduction of deductibles on some categories of care, such as drug packages, doctor and nurse consultations or patient transportation. Finally, there was stricter control of statutory tariffs, and starting in 2013, cost-effectiveness analyses have been introduced as a mandatory element in health technology assessment (HTA) of innovations.

The second category of measures is called the ‘medically based cost-containment policy’. It was developed in the 1990s after a long period of strict accounting policies that led to ongoing conflicts between doctors and the SHI. Medically based cost-containment focuses on the reduction of financial and equity loss due to medical practice variations and aims to improve medical practice. The main tools used are: the implementation of lifelong learning; the development of practice guidelines by national agencies; and the introduction of good practice commitments within professionals’ collective agreements with the SHI. At first, coercive measures, such as fines for not following continuous education, were used to enforce this new policy, but these were slowly abandoned towards the development of incentives, most recently, the introduction of payment-for-performance (P4P) for individual doctors based on meeting good practice targets. Overall, it appears that the coercive medically based cost-containment policy did not lead to major improvements in collective practice and much is expected from the P4P approach.

**Nature and magnitude of the financial and economic crisis and health system pressures prior to the crisis**

**Macro level**

The 2008 recession marked the end of a growth cycle dating back to 2002, as the impact of the May 2007 subprime crisis finally manifested itself in the real economy. Growth had already begun to slow in the previous year in the face of falling housing investment, increasing trade deficits and rising commodity prices, which had an inflationary effect that diminished household purchasing power.

A confluence of factors impacted on both household wealth and the competitiveness of French firms. Consumption declined under the weight of decreased disposable income combined with falling stock market indices and home values. At the same time, the drop in unemployment between 2006 and 2008 resulted in slower productivity growth due to faster employment growth for individuals with lower education levels and thus higher labour costs. The cash flow problems and the credit crunch of September 2008 led to an abrupt fall in activity, the collapse of confidence indices, temporary shutdowns in certain industries, a halt in corporate investment and higher unemployment (OECD, 2009).

At the macroeconomic level, France was less exposed to the effects of the financial and real estate crises than other countries due to the relatively low level of household debt. Nonetheless, the worldwide crisis threatened French banking institutions, leading the government to undertake emergency measures in October 2008: one allowed banks to refinance themselves with a State guarantee and another injected equity into the banks to improve their solvency. At the same time, the government instituted a lending

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2 A 100% State-owned agency, the Société des prises de participation de l’État was created; it acquired securities of indefinite term issued by the banks concerned and earns an annual interest of 8.2%.

3 The Société de Financement de l’Économie Française (SFEF), owned 66% by the banks and 34% by the state, was set up to provide loans for a period of five years. Conditions include: posting collateral that meets certain requirements in terms of quality, and an interest rate that represents a margin of 180 basis points over the rate SFEF pays for its borrowings.
programme for businesses with up to 5000 employees as well as an investment fund providing venture
capital to deter foreign takeovers of firms in strategic sectors. The European Commission (EU) also took action
with an EU-wide rescue plan that included cuts to the European Central Bank’s key interest rate and easing
of its lending conditions for banks. French banks weathered the crisis in relatively good shape compared to
other countries: only two banks suffered sufficiently heavy losses to threaten their solvency, while most of
the other French banks were profitable in 2008 (OECD, 2009).

At the fiscal level, a series of measures in 2007 and 2008, including a reduced number of tax brackets and
a more generous earned-income tax credit, led to lower personal and corporate income tax revenues.
However, these and other tax cuts were not accompanied by sufficient control over public expenditure,
and the deficit as a percentage of GDP passed the 3% threshold in 2008, reversing the trend from 2003 to
2006, when the general government deficit shrank from -4.1 to -2.3% of GDP (OECD, 2009) (see Table 3.1).

Table 3.1 Demographic and economic indicators, France 2000–2012

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<td>31454</td>
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<tr>
<td>gross debt (% of GDP)</td>
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</tr>
<tr>
<td>Total unemployment</td>
<td>9</td>
<td>8.2</td>
<td>8.3</td>
<td>8.9</td>
<td>9.3</td>
<td>9.3</td>
<td>9.2</td>
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<td>7.8</td>
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<td>rate (%)</td>
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<tr>
<td>Unemployment – Men (%)</td>
<td>7.5</td>
<td>6.9</td>
<td>7.4</td>
<td>8</td>
<td>8.4</td>
<td>8.4</td>
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<td>7.8</td>
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<td>9.3</td>
<td>9.3</td>
<td>9.1</td>
<td>10.1</td>
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<tr>
<td>Unemployment – Women (%)</td>
<td>10.8</td>
<td>9.7</td>
<td>9.3</td>
<td>10</td>
<td>10.3</td>
<td>10.3</td>
<td>10.1</td>
<td>9</td>
<td>8.4</td>
<td>9.8</td>
<td>10.1</td>
<td>10.2</td>
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<tr>
<td>Long-term unemployment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>39.1</td>
<td>39.3</td>
<td>34.6</td>
<td>37.7</td>
<td>42</td>
<td>39.9</td>
</tr>
<tr>
<td>(as % of all employed)</td>
<td></td>
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</tr>
<tr>
<td>Long-term unemployment</td>
<td>3.5</td>
<td>2.9</td>
<td>2.9</td>
<td>3.5</td>
<td>3.8</td>
<td>3.8</td>
<td>3.9</td>
<td>3.4</td>
<td>2.9</td>
<td>3.4</td>
<td>3.9</td>
<td>4</td>
<td>4.1</td>
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<td>(as % of active</td>
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<td>population)</td>
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</tbody>
</table>

Sources: *OECD (2013); European Commission (2013).

Notes: The dependency ratio is the ratio between the total number of people aged 65 and over and the number of persons of working age (15–64); f = forecast; GDP = gross domestic product; PPP = purchasing power parity.

4 Known as Prime pour l’emploi (PPE).
The impact of the global economic crisis on the health care systems of Belgium, France and the Netherlands

Household level

At the household level, the effect of falling house prices on household wealth and consumption was lower than in countries with greater exposure to the real estate crisis (see Figure 3.1). Indebtedness levels were much lower in France due to generally stricter lending conditions. Moreover, with a savings ratio of 12% at the onset of the crisis, households were able to resort to their assets. The bankruptcy rate remained relatively low and consumption remained fairly stable at the beginning of the crisis. However, unemployment rates sharply increased from a 10-year low of 7.2% in early 2008 to 9.6% by the end of 2009, with more moderate increases in 2010 and 2011 (OECD, 2009) (see Table 3.1).

Figure 3.1 Household mortgage debt in France as percentage of disposable income, 1991–2007

<table>
<thead>
<tr>
<th>Year</th>
<th>FRA</th>
<th>USA</th>
<th>GBR</th>
<th>DE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
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<td>1993</td>
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<tr>
<td>2007</td>
<td></td>
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</tbody>
</table>

Source: OECD (2009).
Notes: FRA: France; USA: United States; GBR: Great Britain; DE: Germany.

Health system level

Major structural problems in the French health system prior to the crisis included lack of coordination between hospital and ambulatory services, between private and public provision of care, and between health care and public health (the latter being concerned with prevention rather than delivery of care). At the onset of the crisis, the Ministry of Health (MoH) was preparing the Hospital, Patients, Health and Territories (HPST) bill aimed at integrating public health, health care delivery and financing by creating a one-stop shop at regional level, the Regional Health Care Agency (Agences Régionales de Santé; ARS). Since 2010, the ARSs in the 26 French regions govern all these aspects of the health system and have a major role in articulating the ambulatory, hospital, and health and social care sectors.5

Moreover, the financial sustainability of the health system was relatively fragile at the onset of the crisis. Since the 1980s, the need to control SHI expenditure had led to several measures attempting to contain demand, to increase SHI resources or to decrease SHI expenses, frequently leading to an increase in patient OOP payments. In acknowledgement that such measures may have negative effects on equity in access, counterbalancing measures were introduced. These included the creation of safety nets for given populations, such as free public complementary health insurance for low-income groups and financial aid for purchasing VHI contracts for households with an income just above the ceiling for free complementary health insurance.

5 From 1 April 2010, and with the aim of achieving better governance of the system at the regional level, better response to needs and greater efficiency, the ARS was created to merge seven regional institutions from: the Regional Hospital Agency, the Regional Union of Health Insurance Funds, the Regional Health Insurance Fund, the Regional Directorate of Health and Social Affairs, the departmental Directorate of Health and Social Affairs (which was the subsidiary of the MoH at the departmental level), the Regional Public Health Group and the Regional Health Mission. For additional information on the role of the ARSs, see Chevreul et al. (2010).
Despite these measures, socioeconomic disparities in access to health care were increasing and, as a consequence, disparities in health status remained significant. These social health inequalities result not only from risk factors, such as alcohol and tobacco consumption, but also from differences in access to health care that seem to increase over time. In 2008, 16.5% of the population aged 18–64 years reported having forgone health care in the last 12 months for financial reasons, while this share was 14% in 2006. This inequity in access was concentrated in a limited number of goods and services for which patients’ OOP expenditure is the highest. Dental care was of greatest concern (10.7% of the population aged 18–64 years had forgone dental care in the last 12 months), followed by spectacles (4%). Forgoing health care increases inversely with the level of income: people in the poorest quintile forgo three times more care than people in the richest quintile. Several public policies have been implemented since the late 1990s to tackle this issue, mainly focused on improving access to health care, although they have not shown significant results (Chevreul et al., 2010).

To tackle the debt accumulated by the SHI (estimated at around €135 billion in 2009), France implemented a budget cap for SHI expenditure by creating the national ceiling for SHI expenditure (ONDAM) in 1996. One difficulty with this measure is that statutory tariffs for self-employed professionals, medical devices and drugs are negotiated on a multi-year basis and, therefore, are fixed for a given period of time, and there is no a priori control of the volume of care consumed. However, more recent measures have attempted to make ONDAM into a harder form of budget capping. The first measure was creating the Alert Committee in 2004 and the group for the statistical monitoring of ONDAM in 2010, while the second gave the head of the Directorate of Social Security the power to present a financial rescue plan when the overrun is above 0.75% of SHI expenditure or to introduce correcting interventions during the year. These interventions included, for example, a decrease in hospital DRG tariffs set by the MoH (public and private hospitals are under the responsibility of the MoH, and hence, it sets the value of the DRG tariffs) and a freeze in the share of budgets dedicated to the Quality and Coordination of Care Fund (fonds d’intervention pour la qualité et la coordination des soins), to the social and health care sector and, finally, to the hospital block grant for public utility mission (mission d’intérêt général et d’aide à la contractualisation), which is dedicated to the coordination of care, research and teaching, plus epidemiological surveillance and expertise. However, strikingly, these measures barely touched goods and services delivered or prescribed on a private basis by self-employed professionals, when in fact this is the area in which the overrun was greatest, given the limited role of the MoH in the negotiations between SHI and self-employed physicians (measures such as reductions in tariffs for these professionals appear almost unfeasible due to the power of physicians’ unions/associations). For instance, of the €930 million that was spent in excess of the overall target in 2008, €800 million came from the private practice subarea of expenditure, while only €130 million came from the hospital sector.

Finally, France faces the pressure of a rapidly growing ageing population, due to increasing life expectancy (but not to declining fertility rates). The post-Second World War baby boom effect will exacerbate this trend in the medium term. Because the probability of becoming dependent greatly increases with age, the number of frail older persons is expected to grow 40% by 2030 and 60% by 2060, rising from 1.15 million in 2010 to 1.55 million in 2030 and 2.3 million by 2060, corresponding to an estimated 3% of the population (Charpin & Tlili, 2011). As a result, there is an increasing need for long-term care (LTC) to provide personal assistance to frail older persons at home or in nursing facilities or other residential care settings. While the social security system was the main funding source for LTC after its creation, in the last four decades, the local authorities’ responsibility for funding LTC has grown following the creation of a universal allowance with a means-tested coinsurance. Overall, this can be regarded as a shift from national solidarity-based financial protection to local tax-based financial protection, increasing geographical inequity. Moreover, this shift in LTC financing is regressive, as a share of local taxes is not income-based (Chevreul & Berg Brigham, 2013).
Health system responses
Changes to public funding for the health system

The health budget deficit increased by approximately 2.5 times between 2008 and 2010 (rising from €4.4 billion to €11.9 billion), but was reduced to €8.6 billion in 2011 due to better expenditure control and an increase in revenues. In this context, an amendment to the 2012 budget was passed to reduce the health budget deficit to €5.5 billion and the 2013 deficit to €5.1 billion. In 2010, the national ceiling on health insurance expenditures (ONDAM) was met for the first time since 1997. Accordingly, the total health expenditure growth rate has dropped markedly, from a 4.8% increase between 2006 and 2007 to a 2.5% increase between 2010 and 2011. At the same time, public expenditure as a share of total health expenditure has dropped from 77.1% in 2007 to 76.7% in 2011 (OECD, 2013). Expressed as a share of total government expenditure, health sector funding has increased from 14% in 2007 to 15% in 2011 (see Figure 3.2).

Figure 3.2 Percentage of government spending by sector in France, 2007 and 2011

3. The impact of the economic crisis on health and the health system in France

On the fiscal side, the share of tobacco tax revenues earmarked for health was increased in 2007 to 98.75% taking effect from 2009, and the share of capital gains tax revenues earmarked for health was increased from 12.3 to 13.5% in 2011. From 2013, tobacco products that previously benefited from a reduced tax rate are taxed like cigarettes, with a mean contribution of about 81% of the end price. Moreover, in 2013 a new tax on beer was introduced and earmarked for health, generating an expected €480 million. Likewise, since 2012, a new tax on soft drinks of €0.04 per litre was levied, earmarked for health. In addition, the new social security contribution introduced in 2009 (forfait social sur l’épargne salariale) was increased from 2% in 2009 to 4% in 2010, 6% in 2011, 8% in January 2012 and 20% in August 2012 (Marc, 2012). Currently, 25% of these revenues are earmarked for health. Finally, an increase in the earmarked tax for funding social security was implemented for individuals with annual earnings of over €150,000 in 2013.

To meet EU fiscal targets, the government’s deficit plan proposed an additional allocation of taxes to social security in 2012 to be partly financed by reducing tax shelters for payroll taxes earmarked for social security. The reductions in health expenditure of €2.4 billion planned for 2013 were divided between ambulatory care (€1.75 billion) and hospital care (€0.65 billion) and were to be achieved mainly through lower prices for drugs and medical devices in ambulatory and hospital care (€1 billion) and by eliminating inappropriate and unnecessary care. The latter measure is partly set within the national agreement with self-employed physicians, based on increased financial incentives (for example, targets related to the appropriate prescription of antibiotics).

In terms of the SHI revenue base, from 2013 onwards, SHI contributions increased for self-employed people with annual earnings above a certain threshold and, under certain conditions, for elected local officials and people who employ domestic help. In addition, from 2013 onwards, employers have to pay contributions (forfait social) on a portion of severance paid to employees in the context of employment termination by mutual consent. Finally, a new tax (earmarked for the social security budget) has been levied since 2013 on employees with annual earnings over €150,000.

Regarding sources of revenue, the pre-crisis trend of shifting financing from SHI towards private expenditure (see the section on the Nature and magnitude of the financial and economic crisis on pages 42–45) continued during this period. The SHI share of total health expenditure decreased slightly from 73.8% in 2007 to 73.1% in 2011, while the share financed by VHI increased from 13.4 to 13.9% and the share of OOP expenditure increased from 6.8 to 7.5% (see Figure 3.3).
Changes to coverage

Population coverage (entitlement)

There were only minor changes in entitlement for coverage in a population benefiting from 99% SHI coverage prior to the crisis (Chevreul et al., 2010). In 2009, the minimum subsistence income (le revenu minimum d’insertion) was replaced by the active solidarity income (revenu de solidarité active; RSA) to provide income support to the working poor, while enhancing incentives to work. This increased the overall number of recipients of this benefit and the population entitled to free coverage since the beneficiaries of the new RSA automatically has the right to benefit from the statutory CMU and VHI (CMU-C). In addition, the income threshold giving access to the ACS scheme was lifted from 20% above the CMU ceiling to 30% in 2011 and to 35% in 2012, and the State-defined minimum criteria for ACS vouchers delivered by VHI in 2012. Finally, measures to increase coverage of disadvantaged students and people over 60 via the ACS scheme were enacted in 2013.

Benefits package

From 31 March 2013, abortion (and related hospital costs) has been fully covered, leading to an estimated increase in overall expenses from €13.5 million to €31.7 million (LeMonde.fr, 2012). Likewise, contraception for girls aged 15–18 has been fully covered from the same date. At the same time, some drugs with low therapeutic value were delisted in 2010 and 2011 based on effectiveness criteria.

User charges

Overall, user charges for French patients have increased during the crisis (see Figure 3.3). In 2009, the penalty (coinsurance) for patients who do not follow an agreed medical pathway was increased from 40 to 70%. This should be understood in the context of the broader 2004 reform that attempted to make patients more responsible for their consumption of care, including strong financial incentives for VHI not to cover the higher coinsurance and deductibles (applying for doctors’ visits, some procedures and drugs). Moreover, in the context of the delisting of certain drugs described previously, coinsurance rates for certain less effective drugs increased from 65 to 70% in 2010. Likewise, the co-payment for inpatient stays increased from €16 to €18 per day. In addition, the coinsurance rates for medical devices increased.

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6 Décret n° 2013-248 du 25 mars 2013 relatif à la participation des assurés prévue à l’article L. 322-3 du code de la sécurité sociale pour les frais liés à une interruption volontaire de grossesse et à l’acquisition de contraceptifs par les mineures [Decree 2013-248 of 25 March 2013 on the participation of the insured in fees linked to abortion and the acquisition of contraceptive drugs by minors].
3. The impact of the economic crisis on health and the health system in France

from 35 to 40% in 2011. Finally, in 2012, the government abolished the €30 deductible for beneficiaries of statutory medical assistance for undocumented migrants (AME) introduced in 2011.

There has been no specific response of the VHI sector to the crisis and the decrease in SHI coverage. As expected and observed already before the crisis, VHI demand and coverage increased, including also the CMU-C and ACS schemes, which are financed by the CMU Fund and operated by VHI firms (for the role of VHI, see also the section on Utilization and equity on page 51).

Changes to purchasing and delivery

Prices and delivery of medical goods

Under the 2013 Social Security Financing Law, lower prices for drugs and medical devices in both the ambulatory and hospital sectors are expected to result in savings of €1 billion, after price reductions have been repeatedly practiced in previous years. This has been accompanied by incentives to control costs on the delivery side: in 2011, pharmacist remuneration was made partly independent of sales volume to encourage the dispensing of cheaper drug alternatives, which was complemented in 2012 by a P4P payment component rewarding the delivery of generic drugs (CNAMTS, 2013).

Health workforce and salaries

The crisis had a differential effect on the income of the physician workforce, depending on their workplace setting, but there was no specific policy to cut remuneration. While GPs in private practice saw their incomes decrease for two consecutive years (-0.66% and -1.73% between 2008 and 2010), specialists in private practice experienced an increase of 3.18% between 2009 and 2010, after a decrease in the previous year (CARMF, 2012). Salaries of physicians in public hospitals (who have the status of civil servants) decreased by 0.6% between 2009 and 2010, representing a more significant decrease than the 0.2% experienced by civil servants in regional and local administration in the same period.7 The crisis, however, does not appear to have significantly affected the physician workforce: the growth rate of the number of practicing doctors has been constantly decreasing for decades, going from 1.4% in 2002/2003 down to 0.5% in 2007/2008 and nearing zero between 2010 and 2013 (CNOM, 2013). In public hospitals, the number of doctors increased by 1.6% between 2008 and 2009, by 1.8% between 2009 and 2010, and by 0.3% between 2010 and 2011 (DREES, 2011a, 2012b, 2013).

Payment to providers

Pay-for-performance for GPs was introduced on a voluntary basis in 2009 and generalized and expanded as part of the 2012 agreement between SHI and GPs, with GPs receiving on average an additional 5% of their regular income. The P4P scheme encourages GPs to develop prevention activities, improve treatment and follow patients with a range of chronic conditions (mainly hypertension and diabetes), and to improve efficiency by increasing the rate of generic prescribing. The objectives are based on public health priorities set by parliament and recommendations issued by the French National Agency for Medicines and Health Products Safety (Agence nationale de sécurité du médicament et des produits de santé; ANSM)8 and the National Health Authority (Haute autorité de santé; HAS).9 An internal evaluation (with a control group) by SHI suggests moderate improvements, e.g. in the prescription of HBA1c testing for diabetic patients and of low-dose aspirin for heart failure patients. In 2012, P4P was also included in the SHI agreement with cardiologists.

7 All figures concerning physician income in this section account for inflation.
8 The ANSM is the competent authority for all safety decisions concerning health products from their manufacturing to their marketing. It carries out three core missions: (1) scientific evaluation; (2) laboratory and advertising regulation; and (3) inspection of industrial sites. The ANSM also coordinates vigilance activities relating to all relevant products.
9 The HAS was set up in 2004 to bring together under a single roof a number of activities designed to improve the quality of patient care and to guarantee equity within the health care system. Its activities range from the assessment of drugs, medical devices and procedures to the publication of guidelines and accreditation of health care organizations and certification of doctors (Chevreul et al., 2010).
Fees for services performed by certain health professionals, such as radiologists and pathologists, were decreased in 2011, and throughout 2011, 2012 and 2013 official tariffs for laboratory and other diagnostic tests and services were reduced.

Overhead costs: restructuring the Ministry of Health and purchasing agencies

In 2009, the Health Reform Act created the National Agency to Support the Performance of Health and Social Care Organizations and Services (Agence nationale d'appui à la performance des établissements de santé et médico-sociaux), with the mission of helping all health care facilities (both private and public) and social care providers modernize their management, optimize their real estate assets and to monitor and improve their performance to control spending. In addition, a reform to support the pooled procurement of hospital supplies was introduced in 2011, with the aim of achieving lower prices. Finally, since 2008, a series of measures have been undertaken by SHI to address fraud.

Provider infrastructure and capital investment

Financed largely through borrowing, €10 billion was allocated to a five-year hospital sector investment plan from 2008 to 2012, called Hôpital 2012. In light of the increasing debt levels of public hospitals (see Figure 3.4), the aim was to maintain the previous level of hospital investment to support regional planning goals, the development of information technology systems and the updating of safety standards. The first portion of €2.2 billion was spent in the first three years. In 2013, an expenditure of €354 million on capital investments in the hospital sector was planned, with a third of the funds dedicated to improving information systems to improve efficiency. Concomitantly, in 2013, the European Investment Bank signed an agreement to invest €1.5 billion in the hospital sector over three years.

Figure 3.4 Debt rate of public hospitals in France, 2002–2010

Source: DREES (2012b).

Priority setting or protocols to change access to treatments, coordination of care and patterns of use

The 2013 Social Security Financing Law sought to achieve efficiency savings by shifting care from hospitals to primary and community care settings. In this context, incentives have been put into place to encourage hospitalization at home and day surgery. Economic evaluations as part of the HTA process became mandatory, starting in October 2013. In addition, the HAS introduced in 2012 care pathways for certain chronic diseases (including chronic obstructive pulmonary disease, Parkinson’s disease, chronic kidney failure and chronic heart failure) and working documents on the improvement of care organization for older people in 2013.

10 In France, public hospitals account for three-quarters of acute medical care capacity (80% of medical beds and 70% of day care beds) and perform 75% of full-time episodes and 55% of day care episodes.
Waiting times
In 2009, a new system of accreditation for laboratories and volume restrictions was introduced, which may increase waiting times for diagnostic services.

Health promotion and prevention
In 2011, 2012 and 2013, new taxes (or increases in existing taxes) were put in place on tobacco, alcohol and energy drinks (see the section on Changes to public funding for the health system on page 46).

Implications for health system performance
Utilization and equity
Due to the incentives that have been put into place, there has been a rapid increase in the number of at-home hospitalization days (119% between 2005 and 2010), although this still accounts for only a small percentage of hospitalization days (Durand et al., 2010).

Overall, increasing cost-sharing within the SHI system implies: (1) increased reliance on VHI and (2) decreased utilization of care. In 2009, it was estimated that complementary VHI covered about 13% of all health care expenses in France, which is a larger share than in other European countries (Thomson, Foubister & Mossialos, 2009). Greater participation of VHI in health care financing during the crisis has decreased equity in financing because SHI contributions are income-related, while VHI premiums usually are not. Thus, wealthier people spend a lower proportion of their incomes on health care compared to the poor. Moreover, certain population groups, such as the unemployed and the retired, cannot benefit from the more favourable premiums and terms of group contracts.

Concerning utilization, an increasing proportion of individuals reported in 2010 that they had unmet health care needs due to financial reasons. This may be due to the imposition of new or increased user charges, including extra-billing, which limits access to specialist care. Indeed, 15.4% of the population said they did not access health care in 2008 because of the associated expenses (1.2% more compared to 2006). However, this mainly concerned services such as dental care (10%), optometry services (4%) and, to a lesser extent, doctor consultations (3.4%). Foregoing care was more frequent among patients who did not have complementary VHI (over 30% of people in this group) (Després et al., 2011). Likewise, a study conducted in 2012 showed that one out of five recipients of social benefits (minima sociaux) did not access medical care for financial reasons within the past year (Isel, 2014). Another cohort study conducted in 2010 in Paris (3000 people surveyed) found similar results. It reported that 30% of respondents did not seek medical care when they needed it, half of them for financial reasons (DREES, 2012c). In addition, a study by the non-governmental organization Médecins du Monde reported that the proportion of people delaying seeking care increased from 11% in 2007 to 17% in 2008, 22% in 2009 and 24% in 2010. The financial barriers to access health care are further compounded by socioeconomic inequalities, as illustrated by Table 3.2.

Table 3.2. Social inequalities in health and access to care between workers and managers in France

<table>
<thead>
<tr>
<th></th>
<th>Average number of diseases declared</th>
<th>Obesity (%)</th>
<th>Dental problems (%)</th>
<th>Access to dental care in the last 2 years (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers</td>
<td>2.9</td>
<td>15.2</td>
<td>44</td>
<td>63.9</td>
</tr>
<tr>
<td>Managers</td>
<td>2.5</td>
<td>6.3</td>
<td>29.4</td>
<td>82.3</td>
</tr>
</tbody>
</table>

Sources: Dourgnon, Jusot & Fantin (2012); Calvet et al. (2013); OECD (2013).
Overall, the share of the French population satisfied with access to health care decreased from 82% in 2007 to 68% in 2013 (physicians), and from 81 to 70% (dentists). This may be in part explained by higher medical fees. Between 2007 and 2012, the share of GPs practising extra-billing has grown from 15.5 to 17.4%, while for specialists it has increased from 49 to 53% (Coppoletta & Le Palud, 2014).

Two other factors serve to illustrate the increasing inequity in the system. First, since 2002 there has been a disconnection between increases in net income and private health expenditure. Since the latter is growing faster, patients increasingly have to rely on VHI or OOP payments, both of which reduce equity in financing (see Figure 3.5). This seems particularly noteworthy given that nearly 4 million people did not have complementary VHI in 2008 (Perronnin, Pierre & Rochereau, 2011). Second, between 2008 and 2010, the private health expenditure of intensive users of care has increased more rapidly than that of less frequent users of care (see Figure 3.6). This strongly suggests that patients with high needs experience a loss of coverage over time, which is a strong indicator of financial inequity. Finally, a striking indicator of increasing financial inequity appears to be the emergence of a ‘microcredit for health’ of €600 to €4000 for 6–36 months at an interest rate of about 5% (Les Echos.fr, 2010; Banque du Crédit Municipal de Paris, 2008). This loan is proposed by a publicly owned bank, and its main users are unemployed single mothers. The need to increase individuals’ ability to pay for health care is consistent with recent results of a three-year survey assessing the funds that a person estimates to have set aside for OOPs: the amount has decreased from €570 in 2012 to €568 in 2013, and to €523 in 2014 (Sofinscope, 2014).

However, it seems likely that some inequities have been attenuated for the least well-off. There was a slight increase in the number of recipients of the CMU-C from 4.1 million in 2008 to 4.3 million in 2010 (DREES, 2011b) and a marked rise in beneficiaries of the ACS scheme, whose number almost doubled from 469 000 in 2007 to 935 000 in 2012 (Couverture Maladie Universelle, undated).

**Figure 3.5 Evolution of private health expenditure and net income in France, 1995 - 2012+ (index = 100 in 1995)**

Source: HCAAM (2013).

Note: "Index = 100 in 1995. Blue: private health expenditure; red: net income."
The impact of the economic crisis on health and the health system in France

At the same time, in a context in which there is diminishing coverage by SHI, more than 40% of French citizens say that they would prefer to pay more while maintaining the level of social protection, whereas fewer than 30% would prefer a lower level of social protection in exchange for lower contributions (Coppoletta, 2012). This is consistent with findings from a 2010 survey in which respondents expressed a higher need for social protection since the onset of the crisis, concomitantly with a steady decrease in optimism for themselves and future generations (DREES, 2012a).

In addition, it is interesting but perhaps not surprising to note that the financial situation of VHI organizations did not significantly deteriorate during the crisis, despite the obvious effects that the shrinking employment sector had on VHI contracts offered through employers. This is in part explained by the decreasing coverage by SHI, the previously mentioned sustained demand for social protection (Caniard & Meyer, 2012) and the fact that the most costly patients are fully covered by SHI under the ALD scheme.

Monitoring

There is no specific monitoring of the impact of the economic crisis on health or related socioeconomic factors, but several surveys provide an overall picture on perceived health status and socioeconomic factors. For instance, the MoH Directorate of Research, Studies, Evaluation and Statistics (DREES) has commissioned an annual survey since 2000 that poses questions to a sample of about 4000 people on various socioeconomic issues (DREES, 2012d). During the course of the crisis, respondents perceived: growing social injustice, decreasing confidence that the government can adequately address poverty and social exclusion, and decreasing belief that health insurance should be universal. At the same time, the percentage of respondents perceiving their health status as good rose to 74% in 2011, after a reported 71% in 2009 and 2010; likewise, access to health care continues to be considered universal by a high percentage of respondents (72%). At the same time, 26% thought themselves to be in poor health and among those, 6% in bad or very bad health, results that have remained stable compared to previous years. Another report on poverty and social exclusion has been published every year since 2000 by the National Observatory in Poverty and Social Exclusion (Observatoire national de la pauvreté et de l’exclusion sociale; ONPES). In its most recent report for 2012, ONPES highlighted a steep increase in household debt overload in 2008 and a rise in poverty that is particularly marked for young adults (ONPES, 2012). Finally, a scientific publication reported a significant increase in suicide rates for men (but not for women) by 4.7%
The impact of the global economic crisis on the health care systems of Belgium, France and the Netherlands

in 2009, in comparison to increases of 5.5% in Germany and 10.4% in Greece (Chang et al., 2013).

Efficiency

Overall, the health care budget deficit was halved between 2009 and 2012, in part thanks to an increase in SHI revenues and to efficiency improvements, in spite of the fact that the volume of consumption of medical products and services increased by 2.8% in 2011, following a similar increase in 2010. The budget deficit reduction was mainly achieved through a reduction in hospital fees and drug prices. This worked as a buffer against the increase in prices of ambulatory health care services (Le Garrec, Bouvet & Koubi, 2012).

Preparedness

Overall, two measures that were developed before the onset of the crisis may be considered to be the elements that buffered the impact of the crisis on individuals (at least to some extent). First, the RSA was created in 2009 and was extended, under certain conditions, to people under 25 years of age. In 2012, it was provided to almost 2.1 million households. Second, the CMU-C and ACS schemes enable people on low incomes to receive adequate health protection and have allowed an increasing number of people to benefit from such protection (see the section on Changes to coverage on page 48).

Discussion

The nature of the health system’s response to the crisis

Drivers of change

In terms of drivers of change, there has been no direct influence of non-national actors on health system responses in France, unlike in other countries. The most recent policy recommendations of the EC to France in 2013 focused on labour costs and pension schemes, and contained only non-specific recommendations to increase the cost-effectiveness of health care expenditure. French politicians have publicly shown reluctance to adopt any such external advice. Furthermore, no crisis-related funds were received from the International Monetary Fund and actors of the Troika did not play a role in the French crisis response. However, such absence of direct external actors will have to be qualified by long-term processes known as policy learning, transfer or convergence. Several international actors, such as the European Observatory on Health Systems and Policies have been contributing to such developments, which coexist with transnational initiatives, such as direct contacts and networks, for instance, between national agencies or SHI funds. If, in some cases, these ‘soft-drivers’ may have been facilitators of change (for instance, the long-standing European EUnetHTA initiative, fostering a knowledge base for HTA, or the National Health System P4P experience in England, which inspired the French one), they were, however, not per se initiators of change in the context of the crisis.

Hence, there has been no direct influence or use of external agents in the crisis response, nor a concerted strategy to respond to specific phenomena. The main trigger for action in France was the fiscal pressure which pre-existed and has been exacerbated by events since 2008, including the need to meet EU fiscal targets within the Maastricht criteria. Under this pressure, an established set of actors with health budget

11 Representing 344 excess suicides.
12 At the EU level, such direct influence could have been attempted within the scope of the Stability and Growth Pact ensuring that Member States adopt appropriate policy responses to correct excessive deficits by implementing the Excessive Deficit Procedure. This procedure has been in place in France since 2009, and in that year, the European Commission (EC) recommended that France ‘swiftly implement the planned measures and reforms to contain current expenditure over the coming years, especially in the areas of health care and local authorities,’ without further specifications.
13 This was illustrated by representatives of the ruling Socialist Party, who stated that, instead of France following the recommendations, the EC should join French President François Hollande’s fight for a smart economic policy, which conciliates thorough budget policy with the preservation of pro-growth investments’. (EurActiv.com, 2013).
responsibility\textsuperscript{15} then resorted to a familiar set of technical tools, instead of engaging in more significant and adapted responses. These technical tools are largely set within the concept of cost-containment (see the section on the Health care financing system in France on pages 40–42), including accounting measures and incentives for providers to promote the best medical practice. Hence, the response to the crisis was not specific. There was no public debate shaping it, nor systematic efforts to set priorities. Likewise, the sectoral boundaries of the key actors have kept their usual pattern.

\textbf{Implementation challenges}

The barriers to a more substantial reform are rooted in the institutional complexity of the French health care system and the conflicts of power and legitimacy associated with it. Major issues include: (1) the relationship between the State and SHI; (2) the organizational structure and payment system; and (3) the lack of integrated and comprehensive approaches.

With respect to the first issue, a 2004 reform clarified the respective fields of responsibility of the MoH and SHI. However, the shift of financial stewardship from the MoH to SHI is weaker than it could have been. The MoH kept in house the decisions on coverage and pricing for drugs and devices, and SHI’s decision-making power on the rate of coverage of goods and procedures is further weakened because it is directly derived from the level of medical benefit assessed by HAS. Moreover, with regard to professionals’ agreements, the government participates indirectly in the negotiation between SHI and professionals. Professionals’ representatives continue to lobby the Ministry of Health, which retains a strong role in the negotiations (Chevreul et al., 2010; Ettelt et al., 2010).

Second, the organizational and payment structure of the French health care system makes the goal of cost-containment more difficult to achieve, as compared to other national health systems. Indeed, controlling expenditure is a complicated task when the freedom of consumption by patients and provision of services by providers is unrestricted, where care is largely publicly funded and retrospectively reimbursed and where local SHI funds do not have real financial responsibility but are often described as blind payers reimbursing care without having any information on its appropriateness and efficiency. One important structural aspect of the French health system in this context is the fee-for-service (FFS) payment for self-employed professionals based on the national agreements they establish with the SHI. The newly established P4P contracts can be regarded as a first step in reforming the FFS model, although this remains an extremely challenging policy area. One important issue is the significant role of the MoH in the decision-making process and whether any government would have the required political power to defend major reform against the interests of professional groups. This difficulty was illustrated in 2009 by the Ministry of Health and Solidarity’s reversal of the negative financial incentives set in legislation for doctors who refused to sign a contract to deliver care in underserved areas. Controlling expenditure in the private practice sector, therefore, remains a major concern.

Third, an integrated and comprehensive policy has been argued to be the appropriate response for tackling interdependent health determinants (Elbaum, 2007). The 2004 Public Health Act was an attempt to improve coordination and consistency in public health policies, but this has proven difficult in the French context. The fact that population health is affected by both income and income distribution was not systematically recognized by the public health acts and only two out of the 100 priorities in the 2004 Public

\textsuperscript{15} There is a tradition of joint health budget responsibility between the Ministries of Finance and Health, both chambers of parliament and a range of other actors including the General Accounting Office (Cour des comptes), the National Health Conference, and an Alert Committee composed of: the secretary general of the Social Security Accounting Commission (Commission des comptes de la sécurité sociale), the head of the National Institute of Statistics and Economic Studies (Institut national de la statistique et des études économiques; INSEE) and an additional expert appointed by the president of the Economic and Social Council. This constellation of actors has been in place since 2004 and has not changed during the crisis.
Health Act directly concern health inequities (Elbaum, 2007; Chevreul et al., 2010). Acting simultaneously on several determinants of health requires cooperation between administrations and payers, both at local and national levels. Financing public health policies that deal with health determinants needs to cut across sectors (versus being directed only to the health care sector). However, in the French system, the number of stakeholders (administrative departments) involved at the national and, more importantly, at the local level is high, potentially making this a difficult task. Nevertheless, these potential drawbacks may prove an unexpected political advantage: because of the separation of health care and health promotion budgets, health care professionals may not identify increases in budgets for health promotion as a threat to their budgets (Evans & Stoddart, 2003; Chevreul et al., 2010). Another positive element is the fact that the State and social security budgets were debated and approved simultaneously by the French Parliament for the first time in 2007. The justification was that there is little difference to citizens between taxes and social contributions and that the EU reporting regulations concern the expenditures of all public administration in total. The 2009 HPST bill enacted the merger of health care, public health and SHI funds at the regional level. This can be considered a major step towards the recognition that health needs should be identified and priorities established at the local level with the major stakeholders: hospitals, self-employed health professionals, public health decision-makers, patients' representatives, representatives of the State and representatives of the SHI (Chevreul et al., 2010).

All these elements illustrate the structural shortcomings hindering reforms as well as recent developments representing incremental change. While this sheds light on how the health system response to the crisis was more muted than it could have been, it is interesting to note major measures that were not taken because of the crisis. This was the case for the long-discussed and announced reform of LTC financing (see the section on the Nature and magnitude of the financial and economic crisis on pages 42–45). Despite the major challenge that LTC represents and despite the fact that several concrete reform options were repeatedly debated (Chevreul & Berg Brigham, 2013), the MoH decided, in light of the crisis, not to get a major LTC financing reform under way. One could wonder whether in this case the crisis represented an opportunity not to address a highly controversial policy issue.

While this suggests that the crisis itself represents a barrier to change, on the other hand, it may also be argued that it constitutes an opportunity for health reform. Indeed, one of the impacts of the crisis may be that long-standing issues affecting the French health system and part of the proposed solutions dating to the pre-crisis period seem to receive increasing attention in civil society. For instance, the 2013 National Health Conference has published a memorandum on ‘how to exit the crisis stronger than before’ (Conférence nationale de santé, 2013) in which, among others, the following recommendations are made:

- Do whatever possible not to worsen health inequalities without abandoning the perspective of reducing them;
- Before any decision, make use of analyses of added value and improvement in the relative medical benefit;
- Link financing solidarity with solidarity of care practice.

Hence, these points, well acknowledged by actors inside an ‘inner circle’ before the crisis, seem to be increasingly recognized in a wider arena. This may indicate that efforts for system reform are gaining momentum, albeit at a slow pace. Indeed, in September 2013, the MoH launched the National Health Strategy (stratégie nationale de santé; SNS). It aims to reshape the French health system from 2014 onwards, and is centred on three domains: (1) prevention and information; (2) health care system organization; and (3) patient rights. In its current phase, nationwide stakeholder consultations are organized by the regional

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16 The National Health Conference was created as a permanent body by the 2004 Public Health Act; it brings together representatives of the health professions, health care facilities, regional health conferences (conférences régionales de santé) and a number of additional experts to discuss and define health care priorities at the national level.
ARS (Ministère du travail, de l'emploi et de la santé, 2014). Although the SNS is not, as such, a response to the crisis, it is in part based on the recommendations of the National Health Conference and may be interpreted as using the window of opportunity opened by the economic downturn.

**Resilience and mid-term impact**

Overall, the assessment of the system's resilience yields a dual picture. On the one hand, some elements at the macro and household level (such as household savings and universal coverage, see the section on the *Health care financing system in France* on pages 40–42) have resulted in relatively mild effects on health system outcomes, compared to other European countries. On the other hand, long-standing structural trends (outside and within the health system), in particular social and health inequities, combined with decreasing coverage scope (what is covered) and depth (how much of a benefit cost is covered) (see the section on the *Implications for health system performance* on pages 51–54), appear to have had effects, the full extent of which is yet to be seen.

In fact, while in a number of European countries the crisis is nearing the end, the current situation leads to the presumption that, in France, ‘the worst may be to come’ (Europe1, 2013). Indeed, a recent report by INSEE stresses that the recession that France officially entered in 2009 is atypical in two ways compared to previous recessions: first, GDP in early 2013 remained below any level reached before the crisis and second, the trade balance of manufactured goods remains at a negative level, owing to the lack of competitiveness and exterior demand (INSEE, 2014).

For health system users, this protracted crisis seems to be accompanied by a series of recent phenomena that were perceived as marginal or even unknown before the onset of the crisis. For instance, patients at present increasingly opt for low-cost VHI contracts, involving reduced coverage for so-called comfort benefits (for example, a private room) and the necessity to advance payments at the point of service. In addition, the Internet has played an increasing role, not only as a means to obtain health information but as a tool to save money when seeking health care (Pianezza, 2012). Further, medical tourism appears to have undergone a steep increase in popularity, with patients purchasing or acquiring consultations mainly from Belgium, Spain and Romania. The percentage of French patients buying drugs (in person or online) abroad increased by three points to 8% between 2012 and 2013, and the percentage of French patients consulting specialists abroad increased by one point to 4% between 2012 and 2013 (Sofinscope, 2014). Although these developments should be interpreted in the context of an increasing use of technology and cross-border services across all sectors of society, the data presented in this study raise the question of the extent to which the motivation may be financial rather than an indicator of *zeitgeist*.

**Conclusions**

The financial and economic crisis originating in 2008 has had a multifaceted impact on health and the health care system in France. In terms of immediate effects on perceived health, these appeared to be limited as reflected in consistently high self-rated health. Nonetheless, other emerging trends, such as the increase in the suicide rate for men, may be exacerbated by the crisis. In terms of the changes to the health system following the onset of the crisis, they did not implicate a different set of actors from the pre-crisis period nor did they result from any direct influence or pressure from outside the country. Instead, the actions taken were a continuation of the incremental cost-containment measures undertaken since the late 1990s. Most importantly, these measures include a decrease in scope and depth of SHI coverage, increasing the role of user charges and VHI, as well as supply-side measures, such as drug price reductions.

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17 Services purchased within the EU are covered by SHI at the amount that would be reimbursed if the service had been purchased in France, if (a) previous authorization was obtained or (b) it is recognized as emergency treatment. Otherwise, coverage is decided on a case-by-case basis. Voluntary health insurance generally follows the same mode of operation.
With regard to the midterm impact on the determinants of health, there has been a steady increase in unemployment and household debt, while personal health budgets are decreasing. The most important and burdensome element appears to be the exacerbating effect of the crisis on health and social inequalities as indicated, for instance, by an increasing percentage of low-income health system users foregoing care.

In a context in which it may be anticipated that the full impact of the crisis still lies ahead, the need to rapidly address the issue of equitable health financing is apparent. This is particularly urgent given the increase of private health expenditure and its impact on people with low incomes and high health needs, at a time where the latest macroeconomic figures (February 2014) show that unemployment is still on the rise.

Although there are signs indicating that the move for significant reform is gaining momentum, it remains to be seen whether the government will be able to strike the right balance between equity and cost-containment efforts.

References


3. The impact of the economic crisis on health and the health system in France


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Acknowledgements

The authors and editors would like to thank Dr Sandra Mounier-Jack, Faculty of Public Health and Policy, London School of Hygiene and Tropical Medicine, for her helpful comments in reviewing this chapter.
Chapter 4
The impact of the economic crisis on health and the health care system in the Netherlands
Ronald Batenburg, Madelon Kroneman, Anna Sagan

The health care financing system in the Netherlands

Organization of the Dutch health care system

The Dutch health care system is rooted in the ‘Bismarckian’ social insurance tradition. Traditionally, it had been characterized by a distinction between the mandatory insurance operated by the sickness funds which covers around two-thirds of the population, and voluntary private insurance arrangements. In 2006, a single health insurance scheme, compulsory for all Dutch residents, was introduced, intended to radically change the roles of patients, insurers, health care providers and the government. The main aims of the reform were to increase solidarity and efficiency, decrease government involvement, ensure good access to care and enhance freedom of choice (Schut & van de Ven, 2011).

Three ‘markets’ can be distinguished in the Dutch health care system: the health insurance market, the health provision market and the health care purchasing market (Figure 4.1). Managed competition is now intended to be the major driver in the health care system. Within the health care purchasing market, insurers have to negotiate with providers on price, quality and volume of care. In the health care provision market, patients can choose the provider they prefer. In the health insurance market, citizens can purchase a health insurance plan that best meets their needs. The system of managed competition is currently in place for curative care and some mental health care (up to one year for ambulatory and institutional mental health care). The role of the government has changed from directly steering the system to safeguarding the proper functioning of the health care markets.

Figure 4.1. Markets and key actors in the Dutch health care system

Source: Schäfer et al. (2010).

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1 This section is mainly based on Schäfer et al. (2010) and updated where necessary.
2 The literal translation from Dutch is ‘sick funds’.
The introduction of market mechanisms in the health care sector and the privatization of former public health insurance funds (sickness funds), transformed the Dutch system into a unique variant of a social health insurance system. The health insurance system is divided into three so-called compartments: (1) a compulsory social health insurance system covering the whole population for basic health insurance; (2) a compulsory social health insurance scheme for long-term care (LTC); and (3) complementary voluntary health insurance (VHI) arrangements, which cover health services that are not covered under the two compulsory schemes.

The basic health insurance scheme is regulated by the Health Insurance Act (Zorgverzekeringswet; Zvw), which came into force on 1 January 2006. Health insurers are required to accept all applicants for the basic scheme, without restrictions. Differentiation of premiums for different risk demographics (such as age, gender, or existence of chronic diseases) is not allowed. Instead, community rating must be used while health insurers are free to set the community-rated premiums. Health insurers are compensated for high-risk clients via a risk adjustment scheme. A reduction on premiums can be offered in case of collective contracts (up to 10% of the price of an individual premium). The insured are free to join a collective health plan or buy an individual health plan. The system of collective health plans gives the insured more influence over the insurance companies, since the threat of losing a large number of clients may incentivize insurers to compete on price and quality of care and to offer care that is tailored to the needs of the collective. In 2012, 68% of the insured were covered by a collective health plan (Vektis, 2012). The insurers are free to contract with selected health care providers under the condition that they contract enough providers to ensure good access to care for their clients. Health insurers operate under private law on either a not-for-profit or for-profit basis. The four largest insurers together have a market share of 88% (one of them is for-profit, the other three are not-for-profit) (Schäfer et al., 2010).

The compulsory social health insurance scheme for LTC is regulated by the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten; AWBZ), which came into force in 1968. People who are insured under the AWBZ and have basic health insurance cover with a health insurer (and pay the respective contributions) are automatically registered for entitlements regulated by the AWBZ. However, this does not mean an automatic entitlement for benefits under the AWBZ – care is provided only after a needs assessment by the national Centre for Needs Assessment (Centrum indicatiestelling zorg; CIZ). Provision is organized via independent care offices (zorgkantoren). One insurer per region implements the scheme on behalf of all insurers in a given region and hosts a care office. Citizens have to apply for care at the care office in the regions where they live.

Most health insurers offer complementary VHI plans in combination with the basic health insurance plan (i.e. providers of basic health insurance cover are free to provide VHI cover as well). Contrary to the basic health insurance scheme, however, health insurers are free to set premiums and apply risk selection based on medical criteria or other risk factors to the voluntary plans. According to a clause in the Zvw, health insurers are not allowed to terminate VHI contracts when the client switches to another insurer for the basic package. Some insurers discourage people who have not purchased a basic insurance policy from them from purchasing VHI cover, for example, by demanding a higher premium, which seems to conflict with the competition rules (Roos & Schut, 2009).

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3 ‘Public’ is used for simplicity, although they were at best semi-public or quasi-public (sickness funds were private organizations, but their operations were heavily regulated by the government).
Nature and magnitude of the financial and economic crisis and health system pressures prior to the crisis

Coverage

Basic health insurance scheme

Population coverage of the basic health insurance scheme was 99.9% in 2012 (Statistics Netherlands, 2013). All Dutch residents aged 18 years and older are required to take out health care insurance for the basic health care package. Non-residents, who are employed and therefore liable for payroll tax in the Netherlands, must also be insured. Children under the age of 18 are included in the health insurance policies of one of their parents. Two population groups are exempt from the requirement to purchase basic health insurance: (1) persons who refuse to insure themselves on grounds of religious beliefs or their philosophy of life (for them an alternative arrangement exists); and (2) the armed forces. The breadth and depth of the basic scheme are significant. All curative (somatic and mental) health care that is considered essential, medically effective, cost–effective and unaffordable for individuals is covered. ‘Essential’ care means care that is aimed at preventing loss of quality of life or treating life-threatening conditions. The affordability criteria state that no services need to be included that are affordable for individual citizens and for which they can take responsibility (Brouwer & Rutten, 2004). The content of the benefit package is defined by the government and covers more or less all primary and secondary curative care. Excluded is dental care for people over 18 years of age and some elective procedures, such as plastic surgery without medical indication and, since 2013, simple walking aids. Examples of services that are partly covered are allied health care, some medicines, in vitro fertilization and ambulatory mental health care.

Social health insurance scheme for long-term care

Long-term care insurance is also compulsory for everyone who is legally residing in the Netherlands and for non-residents who are employed and therefore liable for payroll tax in the Netherlands. Exceptions are made for the same two groups as for basic health insurance. Coverage includes: personal care regarding activities of daily living; nursing; guidance (for example, organization of daily activities); treatment; and accommodation. Before a person can qualify for care under the AWBZ, it is necessary to establish whether care is really required and, if so, what type of care and how much care is needed. This is done during a needs assessment at the CIZ.

Voluntary health insurance scheme

In 2012, 88% of the insured took out complementary VHI (Ten Hove et al., 2012). Voluntary health insurance covers care that is not included in the basic package, for instance, dental care, spectacles or physical therapy (for people without a chronic indication). In addition, some co-payments may be covered, for instance, for ambulatory mental health care.

Other financing

Most preventive care and social support (including certain home care services) are not part of the social health insurance or VHI, but are mainly financed through general taxation. Some prevention programmes, for example, smoking cessation programmes, are financed by health insurers.

Sources of revenue, collection, pooling and allocation to purchasing organizations

Basic health insurance scheme

All persons compulsorily insured in the basic health insurance scheme pay a community-rated premium (also called the nominal premium). The community-rated premiums are paid directly to the health insurers. In 2013, the community-rated premium varied from €92 to €112 per month. The nominal premium for children under the age of 18 is paid by the government.

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4 The remainder of this chapter focuses on the two compulsory health insurance schemes; VHI is not discussed.
4. The impact of the economic crisis on health and the health system in the Netherland

An income-dependent contribution is paid by the employer and deducted from the payroll (a separate arrangement exists for the self-employed). In 2013, the income-dependent employer contribution was set at 7.75% of the monthly wage and was capped at €3941 per year. The contribution for the self-employed and pensioners with a private pension was 5.65% in 2013. The income-dependent contribution is collected by the Dutch Tax Office, together with payroll taxes. The government sets the level of the income-dependent contribution, with the notion that, at the national level, the total amount of the income-dependent contributions for adults should amount to approximately 50% of the total funding for the basic health insurance scheme, while the premiums should account for the other 50%. After collecting all the contributions, including the state contribution (for children under 18), the Tax Office transfers the money to the Health Insurance Fund (Zorgverzekeringssfonds), where the money is allocated, after risk adjustment, to the health insurers. The allocation among the health insurers is based on the health risk profiles of their insured populations.

For people aged 18 or older, there is also a compulsory deductible collected by health insurers. The compulsory deductible was introduced in 2008 and was set at €150 per year. It was increased to €350 in 2013 and to €360 in 2014. Care provided by general practitioners (GPs), maternity care and care for children under the age of 18 are excluded from this deductible. In addition to the compulsory deductible, people can choose to pay an additional voluntary deductible in exchange for a reduction in the nominal premium. This voluntary deductible may range from €100 to €500 per year.

Since 2006, a health care allowance funded from general tax has been available for people with lower incomes to ensure access to basic health insurance and prevent undesired income effects. In 2011, 6 out of 10 households received a health care allowance of, on average, €85 per month. In 2013, people with chronic diseases or a disability received a compensation of €99 per year for the compulsory deductible (the compensation was introduced in 2008 and it was €47 in that year). The health care allowance is paid by the Tax Office directly to those with a low income who have applied for the allowance. The compensation for the deductible is paid by the Health Care Insurance Board (College voor Zorgverzekeringen; CVZ) after an eligibility assessment.

Social health insurance scheme for long-term care

To cover the expenses of the AWBZ scheme, a contribution of 12.65% is levied on salaries. The contribution is set by the government and is capped at €4283 per year (2013). The revenues are collected by the Tax Office and transferred to the General Fund for Exceptional Medical Expenses (Algemeen Fonds Bijzondere Ziektekosten; AFBZ), administered by the CVZ. The Central Administration Office (Centraal Administratie Kantoor; CAK) levies the compulsory cost-sharing on individuals who receive LTC. The total amount of cost-sharing depends on the income of each individual. Both sources (contributions and cost-sharing) are pooled into the AFBZ. The CAK pays LTC providers from this fund, based on the payment orders issued by the care offices.

Purchasing and purchaser–provider relations

Health insurers buy basic health care services for their insured populations. They negotiate contracts with hospitals, usually on volume and quality, although some insurers negotiate lump sum amounts with hospitals for the care provided for their clients. The contract negotiations for GP care do not take place with individual GPs, but with committees that represent GPs (huisartsenkringen) and with the representatives

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5 No risk equalization scheme is applied as all citizens are compulsorily insured and there is no choice of insurer.

6 The actual payment for AWBZ care depends on whether patients receive the care in kind or whether they choose a personal budget. For care that is provided in kind, patients settle the income-dependent cost sharing requirements with the CAK. The CAK then pays the providers from the AFBZ on receiving a payment order from the care offices. When patients have chosen a personal budget, they pay the providers directly. The CAK then transfers the personal budget to them after settling the income-dependent cost sharing requirements (Schäfer et al., 2010).
of the National Association of General Practitioners (Landelijke Huisartsen Vereniging; LHV). Negotiations with GPs rarely concern tariffs and are usually focused on increasing the quality of care and the substitution of secondary care with primary care. Selective contracting is allowed. It is becoming more common in the area of hospital care (however, it is still very limited),\(^7\) but not in the area of primary care (all GPs are contracted). Complaints about the strong market power of health insurers are common among some private primary care practitioners, such as physical, speech and occupational therapists. They complain about low tariffs and the high administrative burden – small private practices have contracts with, on average, eight health insurers.

Purchasing of long-term institutional and home nursing is the responsibility of health insurers. The care offices (zorgkantoren; see section on the Organization of the Dutch health care system on pages 62 and 63) negotiate with providers on price, volume and quality of care.

**Payment mechanisms**

The payment of health care providers has changed drastically since the introduction of the 2006 reform. General practitioners are now paid via a combination of capitation fees and fee-for-service (FFS). For hospitals and mental health care, an elaborate diagnosis-related group (DRG)-type system called Diagnosis and Treatment Combinations (Diagnose Behandel Combinaties; DBCs) has been in place since 2005 and was adapted in 2012 (see the section on Transparency and accountability on page 85). Long-term care providers are paid according to an assessment of care intensity needed for each patient. Financing of both hospitals and LTC providers is based on the principle of case-based payment, with ‘money following the patient’. More severe cases receive higher payments.

**Health system pressures prior to the crisis and the nature and magnitude of the crisis**

**Health system pressures and cost control prior to the crisis**

**Health system pressures**

Health care is one of the largest sectors in the Netherlands, as measured by the size of its budget (29% of the total government budget in 2013) and by the number of employees (about 1.4 million people worked in or contributed to the health care sector in 2013) (Statistics Netherlands, 2013b).

The need to contain growing health care expenditure was already recognized as far back as the oil crisis in the 1970s. Expenditure continued to grow in the 2000s (it grew from €46.9 billion in 2000 to €70.7 billion in 2006, an increase of over 50%) (Statistics Netherlands, 2013b) and made the need to contain costs even more pressing. Thus, it is not a coincidence that one of the goals of the 2006 reform was to reduce the total cost of primary and specialized care. Regulated market competition in the three health care markets (Figure 4.1) was introduced and health insurers were given a more central role in contracting with health care providers and purchasing care for their clients. It was hoped that the competition would lead to an increase in the quality of care and a decrease in prices. Hard budgets were replaced by payment mechanisms linking payments with performance mechanisms and complex systems to define and register performance and reimbursement were introduced.

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7 Selective contracting is only recently (since about 2012) becoming more common. Selective contracting may be based on price, but also on the quality of care, for instance, on the number of performed procedures: if the number of times a procedure is performed in a hospital is lower than the minimum number required, the procedure may be excluded from the contract.

8 University hospitals are public institutions. All other hospitals are privately owned and operate (by law) on a not-for-profit basis.
Health care expenditure continued to increase after 2006, reaching €79.8 billion in 2008 (Statistics Netherlands, 2013c) or 10.2% of gross domestic product (GDP; OECD, 2013). Between 2004 and 2008, the growth rate of expenditure increased from 3.5 to 6.8% per year. According to the estimations by the National Institute for Public Health and the Environment (Rijksinstituut voor de Volksgezondheid en Milieuhygiëne), half of the health expenditure growth between 1999 and 2010 can be attributed to growth in the volume of care (number of treatments) and in the number of treatment options, driven by technological advances. In comparison, price increases accounted for 35% of growth and population ageing to 'only' 15%. Treatment of mental health disorders, care for people with a mental disability and dementia accounted for the largest share in the growth of health expenditure, followed by treatment of diseases of the locomotor system and connective tissue. In 2007, mental health disorders\(^9\) accounted for the highest share of health expenditure (20% of total health care expenditure), followed by cardiovascular care (9%) (Slobbe et al., 2011).

**Cost control**

A number of measures had been put in place before the start of the financial crisis to control increasing health care costs. These measures aimed to change the behaviours of both health care users and providers and concerned both curative care and LTC.

Citizens were discouraged from consuming unnecessary care by the ‘no claim’ regulation introduced in 2005. According to this regulation, citizens who had spent less than €225 per year on health care were paid back the difference between this amount and the sum spent, up to €225 for those who consumed no health care. However, the no claim regulation was found to be ineffective\(^10\) and was replaced by the compulsory deductible in 2008.

The reform of the GP remuneration system in 2006\(^11\) (and the change in GPs’ claims behaviour and the increase in supplier-induced demand that followed it) had led to a rapid increase in GP remuneration since 2006 and budget overruns (Schut, Sorbe & Høj, 2013). In 2007, the amount overspent on GP care was €356 million, i.e. approximately 21% over the budget (see Table 4.1). In response, GP fees were frozen (not indexed for inflation) for two consecutive years, 2007 and 2008 (and later the freeze also continued in 2009) (Ministry of Health, 2009).

Overspending was also recorded in the area of specialist care; overspending in this area was much greater (in both absolute and percentage terms) compared to GP care. One of the reasons for overspending in the area of specialist care was that the tariffs of medical specialists had been, since the introduction of the DBC financing system in 2005, based on normative times assigned to treatments that appeared to have been incorrectly calculated. However, it was initially (2008) compensated from additional government revenue recorded in that year and no measures to reduce it were implemented, pending research into the causes of the overspending (Ministry of Health, 2008). In later years, overspending in specialist care was addressed by implementing tariff cuts (see the section on *Shifting costs from public to private sources* on pages 73–76).

\(^9\) Mental health disorders include mental disabilities and dementia and can be treated in both the curative care and LTC sectors (Slobbe et al., 2011).

\(^10\) It did not provide a timely incentive for citizens to consume less health care, as the refund did not take place immediately, but only in the following year.

\(^11\) Previously, GPs were remunerated via capitation for two-thirds of the population and FFS for the other third of the population. The new system is a mix of capitation and FFS for all patients (Schut, Sorbe & Høj, 2013)
The impact of the global economic crisis on the health care systems of Belgium, France and the Netherlands

In the area of pharmaceuticals, a so-called claw-back mechanism had been in place since 1998. Pharmacies receive price reductions from the pharmaceutical industry when buying pharmaceuticals; to redistribute this profit from pharmacies to consumers, a fixed percentage of the reductions is taken back by the government (i.e. clawed back) (Schäfer et al., 2010). This percentage was set at 6.28% and up to a maximum of €6.80 per prescribed medicine, with some temporary increases in 2007 and 2009–2010, due to administrative reasons (rather than due to the financial crisis).

The claw-back was abolished in 2012, when free prices for pharmaceutical care were introduced (Stichting Farmaceutische Kengetallen, 2012). According to Boonen et al. (2010), the government’s attempts to claw back part of the discounts offered to pharmacies were only marginally successful. This was because suppliers increased the prices of pharmaceuticals to compensate pharmacies for the claw-back – this was possible as long as the prices were set below the legally set maximum prices.

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Overspending in the area of pharmaceuticals in 2007 and 2008 was modest (see Table 4.1) mainly thanks to the preferred pharmaceuticals policy. Since 2005, health insurers have been allowed to identify preferred pharmaceuticals for the three most frequently used active substances omeprazole, simvastatin and pravastatin. From these categories of pharmaceuticals, reimbursement occurs only for those that are at the same price level as the cheapest pharmaceutical (mostly a generic) plus 5%, assuming that active ingredients, concentration and mode of administration are similar. This means that if a patient chooses a non-preferred drug, the extra cost of this drug compared to the preferred drug is no longer reimbursed by the insurer. The list of preferred pharmaceuticals is revised every six months. The health insurers were initially required to set the list of preferred pharmaceuticals collectively, but since July 2008 they have been allowed to do so individually. In 2008, four of the largest five insurers started to experiment with preferred pharmaceuticals, selecting preferred drugs through tenders among suppliers of several high-

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12 The 2007 increase was introduced because certain financial targets agreed between the pharmaceutical industry, the Ministry of Health and the association of health insurers were not met. The 2009–2010 increase was imposed because part of the 2008 claw-back was actually not clawed back due to a court ruling against it. After this was overruled in an appeal, the Dutch Health Care Authority (Nederlandse Zorgautoriteit; NZa) decided to have the shortage in claw-back amount compensated via an increase in the claw-back percentage.

13 The regulation concerns homogeneous products without quality differences and, as such, the regulation should not have negative effects on the quality of pharmaceutical care. If a physician decides that due to medical reasons the patient should receive a non-preferred pharmaceutical, the patient can indicate this in the prescription. The non-preferred pharmaceutical will then be fully reimbursed to the patient (Schäfer et al., 2010).

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### Table 4.1 Overspending in health care in the Netherlands, 2007–2012

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP care</td>
<td>356.4</td>
<td>134.4</td>
<td>50.8</td>
<td>204.3</td>
<td>168.6</td>
<td>231</td>
</tr>
<tr>
<td>%</td>
<td>20.6%</td>
<td>6.8%</td>
<td>2.3%</td>
<td>10.1%</td>
<td>7.6%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Medical specialist care</td>
<td>301.8</td>
<td>113.8</td>
<td>832.3</td>
<td>401.6</td>
<td>246.5</td>
<td>63</td>
</tr>
<tr>
<td>%</td>
<td>17.6%</td>
<td>6.3%</td>
<td>52.4%</td>
<td>23.9%</td>
<td>13.3%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Use of hospital facilities</td>
<td>585.9</td>
<td>-58.3</td>
<td>413.5</td>
<td>869.9</td>
<td>910.2</td>
<td>324</td>
</tr>
<tr>
<td>%</td>
<td>12.8%</td>
<td>-0.4%</td>
<td>2.9%</td>
<td>6.1%</td>
<td>6.0%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Pharmaceutical care</td>
<td>30.1</td>
<td>28.2</td>
<td>-177.5</td>
<td>-306.7</td>
<td>-298.2</td>
<td>-710.6</td>
</tr>
<tr>
<td>%</td>
<td>0.6%</td>
<td>0.6%</td>
<td>-3.3%</td>
<td>-5.6%</td>
<td>-5.3%</td>
<td>-13.2%</td>
</tr>
</tbody>
</table>


Notes: "Overspending: the difference between the actual amount spent and the amount foreseen in the budgets in € millions and as a percentage of the foreseen amount.

1Specialist medical care refers to care provided directly by medical specialists, both in ambulatory and inpatient settings.

2Use of hospital facilities refers to the use of, for example, hospital beds and food, but also provision of, among others, nursing care and the use of laboratory facilities.

GP: general practitioner.
4. The impact of the economic crisis on health and the health system in the Netherlands

volume generic drugs. As a result, list prices of the 10 biggest-selling generic drugs fell between 76% and 93%, leading to an estimate saving of €346 million in 2008 (Schut & Van de Ven, 2011). To put this saving into perspective, total expenditure on pharmaceuticals for acute care (care under the Zvw) was €6019 million in 2007 (Rijksinstituut voor Volksgezondheid en Milieu, 2014). In 2009, the use of preferred pharmaceuticals was extended to more generic drugs and adopted by more health insurers (Schut & Van de Ven, 2011). The total savings in the area of pharmaceuticals can be seen in Table 4.1 (saving has been realized since 2009). The savings are remarkable given that between 2008 and 2012 the total volume of pharmaceutical prescriptions issued to patients increased by 21% (CVZ, 2014).

Rapid growth in expenditure was also noted in the area of LTC. Since the introduction of the AWBZ in 1968, its coverage has been extended from institutional care to many types of care, including home care, mental health care, counselling and aids for people with disabilities. This resulted in a rapid growth in expenditure (see Figure 4.2 for 2005–2012), threatening affordability and necessitating a reform. To put a halt to this, starting in 2007, several types of home care (home help, counselling) were transferred to the municipalities while at the same time their LTC budgets have been effectively frozen (2014). It was assumed that municipalities would be able to provide care more efficiently and tailor it better to the needs of recipients, since they are closer to citizens and, more importantly, since this meant that the rights-based approach of the AWBZ was replaced with a compensation-based approach under the Social Support Act (Wet Maatschappelijke Ondersteuning; Wmo) for services shifted to the municipalities (see the section on Shifting costs between various statutory sources on pages 79 and 80 for more information on the compensation-based approach). This has had far-reaching consequences for health care users since municipalities, charged with the implementation of the Wmo, have much discretion in the way they implement this Act. The success with which this has been implemented varies among municipalities given that the definition of compensation for disabilities varies among them and, as a result, there are differences in the generosity of care provision among municipalities (Ursum et al., 2011). On the other hand, in 2008, extra funds were made available for LTC that have not been transferred to the municipalities (institutional care, home nursing care; i.e. care under the AWBZ) to increase the number of LTC personnel to meet increased demand for LTC: €340 million was reserved for 5000–6000 additional LTC nurses, for the provision of daytime activities for people with disabilities, and to increase the volume of LTC (Ministry of Health, 2008).

Figure 4.2 Indexed growth in health care expenditure per sector in the Netherlands (2005 = 100)

14 Although there have been some increases in the budget, every year the planned budgets for consecutive years have been equal to or lower compared to the budget for the next year (budgets are planned for several, usually five, consecutive years).
Overall, the most successful cost containing measure prior to the crisis was the preferred pharmaceuticals policy, which is still in place today. This policy led to a structural decrease in the growth of health care expenditure. The area where the least cost saving was achieved before the crisis is specialist care.

**Overview of the financial crisis in the Netherlands**

During the 1990s the Netherlands recorded steady economic growth. In 2001 the rate of GDP growth slowed sharply and almost ground to a halt in 2002-3. Some of the downturn was attributable to the downturn in the global economic cycle and much lower rates of export growth in 2001-3 (exports accounted for 70% of GDP in the Netherlands in 2000). Private consumption fell in real terms in 2003 and investment fell in both 2002 and 2003 (EIU, 2008). From 2005, the economic recovery gathered pace until the start of the global economic crisis in 2008 (Schäfer et al., 2010). Most of the acceleration between 2005 and 2008 was due to increased domestic demand (EIU, 2008). GDP growth turned negative in the 4th quarter of 2008 and this trend continued until the end of 2009 (Table 4.2).

**Table 4.2 Demographic and economic indicators in the Netherlands, 2000–2012**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (thousands)</td>
<td>15,926</td>
<td>16,346</td>
<td>16,446</td>
<td>16,530</td>
<td>16,615</td>
<td>16,693</td>
<td>16,695</td>
</tr>
<tr>
<td>People above 65 years old (% of total population)</td>
<td>13.58</td>
<td>14.37</td>
<td>14.86</td>
<td>15.15</td>
<td>15.45</td>
<td>15.91</td>
<td>16.20</td>
</tr>
<tr>
<td>GDP per capita (€)</td>
<td>26,244</td>
<td>33,049</td>
<td>36,148</td>
<td>34,678</td>
<td>35,433</td>
<td>36,007</td>
<td>35,799</td>
</tr>
<tr>
<td>Real GDP growth (%)</td>
<td>3.9</td>
<td>3.4</td>
<td>1.8</td>
<td>-3.7</td>
<td>1.5</td>
<td>0.9</td>
<td>-1.2</td>
</tr>
<tr>
<td>Government debt (% of GDP)</td>
<td>63.89</td>
<td>54.51</td>
<td>64.80</td>
<td>67.63</td>
<td>71.89</td>
<td>76.16</td>
<td>82.74</td>
</tr>
<tr>
<td>Government deficit (% of GDP) (a)</td>
<td>2.0</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>-5.6</td>
<td>-5.1</td>
<td>-4.3</td>
</tr>
<tr>
<td>Government consumption (% of GDP) (b)</td>
<td>39.9</td>
<td>39.0</td>
<td>39.2</td>
<td>38.2</td>
<td>38.9</td>
<td>38.6</td>
<td>39.0</td>
</tr>
<tr>
<td>Private consumption (% of GDP) (c)</td>
<td>50</td>
<td>47</td>
<td>45</td>
<td>46</td>
<td>46</td>
<td>45</td>
<td>46</td>
</tr>
<tr>
<td>Investments (% of GDP) (d)</td>
<td>22.03</td>
<td>20.01</td>
<td>20.50</td>
<td>18.40</td>
<td>17.98</td>
<td>18.09</td>
<td>17.15</td>
</tr>
<tr>
<td>Long-term interest rate (%) (d)</td>
<td>5.4</td>
<td>3.8</td>
<td>4.3</td>
<td>3.7</td>
<td>3.0</td>
<td>3.0</td>
<td>1.9</td>
</tr>
<tr>
<td>Exports (% of GDP)</td>
<td>70</td>
<td>73</td>
<td>76</td>
<td>69</td>
<td>79</td>
<td>84</td>
<td>88</td>
</tr>
<tr>
<td>Imports (% of GDP)</td>
<td>65</td>
<td>65</td>
<td>68</td>
<td>62</td>
<td>71</td>
<td>75</td>
<td>80</td>
</tr>
<tr>
<td>Unemployment rate (%)</td>
<td>3.1</td>
<td>4.4</td>
<td>3.1</td>
<td>3.7</td>
<td>4.5</td>
<td>4.4</td>
<td>5.3</td>
</tr>
<tr>
<td>Long-term unemployment rate (%)</td>
<td>0.0</td>
<td>1.7</td>
<td>0.9</td>
<td>0.8</td>
<td>1.2</td>
<td>1.5</td>
<td>1.7</td>
</tr>
</tbody>
</table>

*Sources: IMF (2013); OECD (2013); CPB (2013); The World Bank (2014).*

*Notes: *EMU balance; *public expenditure, household final consumption expenditure, 10-year government bonds. GDP: gross domestic product; EMU: Economic and Monetary Union.*

In 2009, exports declined sharply (see Table 4.2) as the transport and trade services sectors, the main pillars of Dutch exports, were harmed by the global economic slowdown. The housing market collapsed as banks tightened their lending criteria for new mortgages, and households postponed or cancelled buying new homes. With falling house prices, many households found themselves with mortgages exceeding the value of their houses and decreased their consumption.15 Almost half of the decrease in private consumption can be attributed to the effect of falling house prices (SER, 2013). It is worth noting here that, as a consequence of very lax mortgage lending since the 1990s, since the early 2000s, Dutch households had the highest level of long-term debt in the Eurozone (SER, 2013). Households were also affected by the decline in real wages (since...

15 Individual savings have been negative since 2003.
2010) and an increase in unemployment (during 2009 and from mid-2011 onwards). Business investments declined not only due to reduced (re)export volumes, but also as a consequence of political measures, such as cuts to government spending on defence and the arts and in the budgets of municipalities and provinces (from 2010). Later, in 2012, measures such as the so-called crisis levy applied to incomes over €150 000 per year and an increase in value added tax (VAT) suppressed economic activity further.

Between 2008 and 2011, the government took special measures to support businesses and the banking sector struggling with the fallout of the financial crisis. Almost €6 billion was provided by the central government and a further €1.5 billion by the provinces and municipalities to enable businesses to reduce the working hours of their employees (shift to part-time employment), avoid layoffs and retain skilled workers (with the idea of employing them again full-time when the economic situation improves). In 2008, the government took over Fortis Bank Nederland, including parts of ABN AMRO. It also allocated €20 billion to strengthening capital reserves in the banking and insurance sectors, with the ING Group being the first bank to receive such a capital injection in 2008. In addition, €200 billion was made available in 2012 to financial institutions as a guarantee on bank loans. In 2008, in line with the new European regulation (European Union Financial Sector Assessment Program – Deposit Guarantee Schemes; IMF, 2013), the guarantee on deposit accounts (current and savings accounts) was increased from €40 000 to €100 000 (Government of the Netherlands, 2013).

The rapid increase in public spending and the drop in tax revenues caused a substantial increase in the public budget deficit. In 2013, a set of austerity measures amounting to €6 billion was agreed by the government and the political parties (see the section on Health system pressures since the emergence of the crisis below). The most important of these measures were: a reduction of surcharges; stabilization of salaries in the public sector; and cuts in public expenditure. The aim of the consolidation programme is to significantly reduce the public budget deficit and debt by 2015 to ensure compliance with the public deficit limit imposed by the Stability and Growth Pact. While this package is necessary to meet this limit, it may also cause an increase in the unemployment rate in the near future.

The economic decline and cuts in government budgets continue to create uncertainty for Dutch households and companies. Some optimistic signs could be discerned at the end of 2013, with both GDP and house prices forecast to grow at a minimal pace in 2014. At the same time, Standard and Poor’s Financial Services (a credit-rating agency) downgraded the Dutch economy in November 2013 from AAA to AA+, stating that the Dutch economy is lagging behind other economies in Europe, which are recovering more quickly, and lending some support to the opponents of the current austerity measures.

**Health system pressures since the emergence of the crisis**

In 2009, the government’s revenue from taxes and premiums fell short of the estimates by €18 billion (i.e. by about 23%). Since health care expenditure kept increasing at a steep rate (see Figure 4.2), and accounts for a large and increasing share of total public expenditure (20% in 2010 compared to 13% in 2000; Rijksinstituut voor Volksgezondheid en Milieu, 2013), the pressure to contain health care costs, already apparent before the crisis, became even stronger.

The cuts applied to the health care sector were similar or even somewhat less compared to other public sectors, such as social welfare, defence or education. The share of health care expenditure increased to 25.5% of total public expenditure in 2012 (Ministry of Finance, 2012), while the loss of jobs that affected other sectors was not felt in health care. The yearly nominal growth in health care expenditure fell significantly between 2008 and 2011 (Figure 4.3).
In 2013, it was agreed that public expenditure growth could exceed 2.5% for mental health care between 2013 and 2014, 2.5% for specialized care between 2012 and 2015, and 2.5% for primary care between 2014 and 2017. Nevertheless, planned government spending on health care (including premiums for social security) for 2014 is €77.8 billion or 29% of the total public budget (Rijksoverheid, 2014). This is higher compared to the 2012 share of 25.5%, which means that the assumed growth in the share of health care expenditure in total public spending between 2012 and 2014 is 7% per year on average. Investments in the education of health care personnel have been protected from budget cuts until 2014 to ensure quality of care. In 2014, however, a budget cut was implemented in the area of education of medical specialists – the length of education was shortened and the number of new specialists was reduced (Broersen & Visser, 2013). The education of physicians is the financial responsibility of the Ministry of Education. The Ministry of Health is responsible for educating a sufficient number of medical specialists (education should be of good quality and at a reasonable cost). The Dutch Health Care Authority decides on how much hospitals are paid for educating physicians. This amount is financed from public sources. If hospitals have to invest more than the amount set by the Healthcare Authority, they will have to finance the extra costs through their own means.

The steep increase in the nominal growth in health care expenditure in the early 2000s (Figure 4.3) was mainly due to government programmes to reduce waiting lists. The sharp decrease observed between 2002 and 2005 cannot be easily explained, but it seems to be related to a decrease in the use of and referrals to (specialized) mental health care. Mental health care appears to have been a major driver of health care costs until about 2002. The growth observed since 2006 is due to growth in both the volume of care and in tariffs. The reduction in the nominal growth in health care expenditure after 2008 can be attributed to a sharp decrease in pharmaceutical expenditure and, to some extent, also to tariff cuts (see the section on Shifting costs from public to private sources on pages 73–78).

16 For more information, please visit the Care Training Fund (Opleidingsfonds Zorg) website (http://www. opleidingsfondszorg.nl, accessed 18 November 2014).
Health system responses

Measures to control health care costs have been implemented by the government since 2008 for acute care and since 2010 for LTC. The breach of the Stability and Growth Pact criteria in 2010 reinforced the government’s recognition that an effective control of public costs (including health care costs) was needed. The political drive of the current government (in office since 2012) to reduce the national debt to no more than 3% of the national budget has led to significant reductions in the health care budget. The measures that have been implemented can be grouped into four categories:

(1) Shifting costs from public to private sources;
(2) Shifting costs between various statutory sources (for example, transfer of care from the AWBZ to the municipalities), mostly in combination with major cuts in the budgets;
(3) Substitution of institutional care with home care, and secondary care with primary care;
(4) Increased focus on improving efficiency and eliminating fraud.

Initially, from 2009, the measures were mainly targeted at reducing, shifting costs from public to private sources by limiting the basic package and efforts to prevent improper health care consumption (see the section on Shifting costs from public to private sources below). From 2011 onwards, the measures focused more on structural changes in the area of acute care, with the government seeking to reach a consensus with stakeholders to agree on further cost-containment, and in the area of LTC, where there has been a shift towards more decentralization of care in combination with major budgetary cuts (see the sections on Shifting costs between various statutory sources on pages 79 and 80 and the section on Increased focus on improving efficiency and eliminating fraud on pages 81–83).

Despite all the cost saving initiatives taken between 2009 and 2012, falls in expenditure were only recorded in the area of pharmaceutical care and aids, mainly due to the use of the preferred pharmaceuticals policy and tenders by the insurers; instead, expenditure on all other types of care kept increasing (Figure 4.2).

The previous government fell in February 2010 (due to reasons unrelated to the financial crisis). As a result, cost saving measures in the area of health care came to a total standstill, in a period when achieving savings was very important. No new measures or reforms could be introduced between February and October 2010, when the new government took power.

Shifting costs from public to private sources

Costs were shifted from public sources by reducing service and cost coverage, with patients bearing more of the costs, and by reducing overspending on primary and specialized care by making health care providers more responsible for the amounts overspent.

Population coverage (universality)

Universal population coverage for both curative care under the Zvw and LTC under the AWBZ did not change since the introduction of the Zvw. However, changes in service coverage (see the section on Shifting costs from public to private sources on pages 73–78) have resulted in narrower population coverage for certain services or benefits. For instance, the eligibility for a personal budget was limited (Table 4.3 and Table 4.4); however, people needing care can still receive it through the payment in kind provision.

Service coverage (benefits package)

Several changes to the benefits package have been made since the emergence of the financial crisis (Table 4.3). Changes in the benefit package are prepared by the CVZ and approved by the government before they are implemented. Treatments or aids that are considered to be affordable for individual patients and treatments or aids that are not effective or not medically necessary may be considered for removal from the package.
### Table 4.3 Changes in the benefits package in the Netherlands, 2008–2012

<table>
<thead>
<tr>
<th>Area</th>
<th>Year</th>
<th>Affected benefits</th>
<th>Changes to the benefits package</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatments</strong></td>
<td>2008</td>
<td>Limited dental care for 18-21 year olds</td>
<td>Included</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 hours extra maternity care</td>
<td>Included</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychological counselling, first 8 sessions</td>
<td>Included, with a co-payment of €10 per session</td>
</tr>
<tr>
<td></td>
<td>2009</td>
<td>Severe dyslexia diagnostics and treatment for 6-7 year olds</td>
<td>Included</td>
</tr>
<tr>
<td></td>
<td>2011</td>
<td>Limited dental care for 18-21 year olds</td>
<td>Removed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physical therapy, first 12 sessions</td>
<td>Removed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physical therapy for urine incontinence (all sessions)</td>
<td>Included</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uncomplicated dental extraction by dental surgeon</td>
<td>Removed</td>
</tr>
<tr>
<td></td>
<td>2012</td>
<td>Quit smoking treatments</td>
<td>Included</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physical therapy, first 20 sessions</td>
<td>Removed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dietary advice</td>
<td>Removed, except under certain conditions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treatment of adjustment disorders</td>
<td>Removed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Primary psychological care, 5 sessions</td>
<td>Reduced (number of sessions reduced from 8 to 5)</td>
</tr>
<tr>
<td><strong>Pharmaceuticals</strong></td>
<td>2008</td>
<td>Contraceptives for all ages</td>
<td>Included</td>
</tr>
<tr>
<td></td>
<td>2009</td>
<td>Sleeping pills and tranquilizers (benzodiazepines)</td>
<td>Removed, except for severe cases or for long term use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gastric acid blockers</td>
<td>Removed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Statins (lipid lowering medication)</td>
<td>Reimbursement limited, only if in line with professional guidelines</td>
</tr>
<tr>
<td></td>
<td>2010</td>
<td>Acetylcysteine (reducing the viscosity of mucous secretions)</td>
<td>Removed</td>
</tr>
<tr>
<td></td>
<td>2011</td>
<td>Contraceptives for 21+ and anti-depressives</td>
<td>Removed</td>
</tr>
<tr>
<td></td>
<td>2012</td>
<td>• Gastric acid blockers</td>
<td>Removed</td>
</tr>
<tr>
<td><strong>Medical aids</strong></td>
<td>2009</td>
<td>• Stand-up chairs (sta-op-stoelen), walkers and anti-allergen mattress covers</td>
<td>Removed</td>
</tr>
<tr>
<td></td>
<td>2013</td>
<td>• Simple walking aids</td>
<td>Removed</td>
</tr>
<tr>
<td><strong>Long-term care</strong></td>
<td>2009</td>
<td>• Counselling for people with psychosocial problems</td>
<td>Removed</td>
</tr>
<tr>
<td></td>
<td>2012</td>
<td>• Eligibility for personal budgets limited to people with an assessed need for institutional care or for home care for more than 10 hours per week</td>
<td>Reduced</td>
</tr>
</tbody>
</table>
Exclusions from the benefit package are not always permanent. Lobbying or new scientific discoveries may lead to the exclusion decisions being reversed. For example, smoking cessation therapy was added to the package in 2011, removed from it in 2012, and reintroduced in 2013, following lobbying by anti-smoking organizations (Longfonds, 2013). Coverage of dietary advice was severely limited in 2012 (only reimbursed as part of an integrated care package for a limited number of chronic diseases) and extended in 2013 (although with a limitation to the number of reimbursed hours) as research into the effects of dietary advice revealed that the abolition of dietary advice would lead to higher secondary care consumption (Lammers & Kok, 2012).

**Shifting costs to the insured**

A number of measures have been taken to shift costs from public to private sources. For example, the financial burden borne by the insured or users of care has been repeatedly increased (for example, by increasing the compulsory deductible and cost-sharing) (Table 4.4). These measures were mainly focused on somatic and mental health care; however, all co-payments for mental care were abolished in 2014, when a new remuneration scheme was introduced for ambulatory mental health care providers (psychological care) in the primary care sector (see the section on *Increased focus on improving efficiency and eliminating fraud* on pages 81–83), while LTC was largely unaffected. Only in 2013 was cost-sharing in LTC increased, when a share of taxable assets was added to personal incomes to calculate the cost-sharing. However, the justification for this measure was improving equity in financing rather than cost-shifting or cost-containment (wealthy people with high assets and low incomes paid coinsurance based only on their incomes, which was considered unfair). The measure was first considered in 2009, but it took until 2013 before the Ministry of Health managed to get the regulation through parliament and have it implemented.

However, at the same time, the most vulnerable populations have been somewhat protected from the cost-shifting measures. For example, GP care, maternity care and care for children were excluded from the ‘no claim’ regulation (and later from the compulsory deductible), and, as of 2012, the gradual decrease of the care allowance was adjusted in such a way that people with lower incomes experienced less reduction than people with higher incomes.
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Table 4.4 Measures shifting costs to the insured in the Netherlands, 2008-2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>Introduction of a compulsory deductible of €150 per year, replacing “no claim” regulation</td>
</tr>
<tr>
<td>2009</td>
<td>Compulsory deductible increased to €155</td>
</tr>
<tr>
<td>2010</td>
<td>Compulsory deductible increased to €165</td>
</tr>
<tr>
<td>2011</td>
<td>Compulsory deductible increased to €170</td>
</tr>
<tr>
<td></td>
<td>Gradual decrease of care allowance to take place between 2011 and 2040 by increasing the percentage of income that may be spent on the community rated premium</td>
</tr>
<tr>
<td>2012</td>
<td>Compulsory deductible increased to €220</td>
</tr>
<tr>
<td></td>
<td>The gradual decrease of care allowance (see above) adjusted in a way that lower incomes are protected more than higher incomes</td>
</tr>
<tr>
<td></td>
<td>Introduction of a co-payment for secondary mental health care of €100-200 per treatment</td>
</tr>
<tr>
<td></td>
<td>Increase of the co-payment for primary mental care from €10 to €20 per session</td>
</tr>
<tr>
<td></td>
<td>Increase of the co-payment for stay in mental care hospital of €145 per month</td>
</tr>
<tr>
<td>2013</td>
<td>Compulsory deductible increased to €350</td>
</tr>
<tr>
<td></td>
<td>Maximum income for the eligibility for care allowance decreased from €35 059 to €30 939 for singles and from €51 691 to €42 438 for two person households</td>
</tr>
<tr>
<td></td>
<td>Private assets above €100 000 taken into account when considering eligibility for care allowance</td>
</tr>
<tr>
<td></td>
<td>8% of taxable assets are included in the calculation of cost-sharing for LTC (before assets were not included in the calculation of cost-sharing)</td>
</tr>
</tbody>
</table>

Note: LTC: long-term-care

**Shifting costs to employers**

In 2013, the income ceiling used to calculate the income-dependent contribution was increased from €33 427 per year to €50 853 per year, which means that the yearly cap was increased from €2591 to €3941 (the contribution rate is 7.75%; see the section on the Basic health insurance scheme on pages 64 and 65), placing a higher financial burden on employers.

**Shifting costs to insurers**

Since 2012, health insurers no longer receive retrospective compensation for macroeconomic developments (macronacalculatie) and for outlier risk sharing (hogekostencompensatie), i.e. for large deviations from the budget set by the government (see the section on Quality of care and user experience on pages 84–85). The latter used to compensate 90% of the costs of an insured individual above a certain threshold. The abolition of this compensation was primarily meant to shift the risk for these deviations from the state to insurers, but also to promote competition among insurers: if health insurers bear more risk, they will have the incentive to negotiate better contracts with health care providers and this would allow them to offer lower premiums and sell more health insurance plans. The cost of health plans indeed decreased in 2014, but it is not clear whether this was due to the negotiations or other causes, such as higher (than expected) profits in the previous year or selling cheaper health plans with higher voluntary deductibles.

**Reduction of overspending**

Overspending has been a long-standing problem in both primary and specialized care (see the section on Cost control on pages 67–70). Since 2008, if health care providers exceed the amounts agreed in the contracts, they have had to pay back the amount overspent in the next year. This is done in the form of tariff measures (Table 4.5). Such tariff measures have been applied to care provided by GPs, medical specialists and hospital facilities and to some extent also to pharmaceutical care (claw-backs). Tariff measures applied...
to medical specialist care appear not to be very effective, since the overspending in the area of specialist care remained relatively high in 2009–2011 (at 13–52%; see Table 4.1), whereas overspending on GP care and on the use of hospital facilities remained below 10% of their respective budgets in the same period. More measures to curb overspending have been implemented since the emergence of the crisis.

**Somatic care**

In 2009, the normative times assigned to treatments by medical specialists (that appeared to have been incorrectly calculated; see the section on Cost control on pages 67–70) and the compensation for supporting specialists (such as radiologists, medical specialists who are not the head-responsible physicians and treating physicians) were reconsidered (i.e. recalculated with new assumptions)\(^{17}\) and the NZa formulated measures aimed at recovering overspending. For example, the budget for tariffs for medical specialists was cut by €375 million in 2009 (Table 4.5). The announcement of further cuts in 2010 (€512 million) led to many protests by medical specialists, resulting in an agreement\(^ {18}\) in December 2010, signed between the Association of Medical Specialists (Orde van Medisch Specialisten; OMS), the National Hospital Association (Vereniging van Ziekenhuizen; NVZ) and the Ministry of Health: the budget for specialized care was to be capped at €2 billion per year in 2012, with the growth in budget limited to 2.5% per year until the tariffs of medical specialists become part of the free negotiations between providers of secondary care and insurers, which is assumed will happen in 2015 (Orde van Medisch Specialisten et al., 2010). At present (2014), 70% of hospital care is subject to price negotiations between insurers and hospitals, while the remaining 30% of tariffs is set by the NZa. However, medical specialist care provided in hospitals is currently not included in these negotiations due to the aforementioned budget cap. From 2015 onwards, 70% of hospital care will be subject to price negotiations, including medical specialist care.\(^ {19}\) The NZa will continue to set the remaining 30% of tariffs.

Health care budgets were also reduced in the area of primary care: in 2010, the budget for capitation fees for GPs was reduced by €60 million and GPs were allowed to earn it back by prescribing medicines more efficiently (for example, prescribe cheaper generic drugs; see Table 4.5) and thus reducing the expenditure on pharmaceutical care. In 2012, the Ministry of Health concluded an agreement (implemented in 2013) with the LHV: no tariff reduction would be imposed by the Ministry for the amount overspent in 2011 (€99 million), while at the same time the LHV agreed to realize a saving of €50 million through prescribing cheaper generic drugs in 2012. It was also agreed that the central role of GPs as gatekeepers would be strengthened and GPs would have a more central role in the provision of care in the community (see the section on the Substitution between different types of care on page 81). Therefore, expenditure on GP care was allowed to grow by 2.5% per year between 2014 and 2017. In addition, expenditure on the coordination of community

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17 Treatment times for medical specialists and supporting specialists are difficult to estimate and remain approximations of actual treatment times.

18 Agreements between the Ministry of Health and health care providers or health insurers are concluded by their respective umbrella associations on their behalf. These associations have no means of controlling production of health care services or to sanction any unwanted behaviour of their members. The system of agreements works because there is always the latent threat that the Ministry of Health can impose measures, such as tariff cuts, if the agreed terms are not met (for example, if there is overspending). Since the role of the government in the Dutch health care system is to watch from a distance rather than to be directly involved, the preference is to use agreements negotiated between the parties instead of imposing measures in a one-way fashion by the Ministry of Health. It is assumed that the health purchasing market (insurers purchase care from health care providers) will provide sufficient incentives for both insurers and providers to produce health care of good quality at acceptable prices. It is important to mention that the use of agreements between parties is part of Dutch political culture and such agreements also exist in other sectors, for example, in the education sector.

19 Diagnosis and treatment combination prices are negotiated by hospitals; prices cover the normative working times of medical specialists. These working times are set by scientific associations of medical specialists and cannot be negotiated; however, their price can be. Currently, because of the budget cap for medical specialists, hospitals can no longer negotiate on the price of these working times. This will change in 2015 – hospitals will again be able to negotiate on DBC prices, including the price of working times of medical specialists, with the insurers and will then negotiate on the payments with their medical specialists.
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care (including GPs and other providers) was allowed to grow by an additional 0.5% per year in 2012 and 2013 (LHV & VWS, 2012).

In an agreement signed in 2013 between health care providers (in both primary and specialized care), insurers, patient associations and the Ministry of Health, all stakeholders agreed to a further decrease in the growth in health care expenditure to 1.5% in 2014 and to 1% per year between 2015 and 2017. This decrease is mainly to be achieved through the substitution of secondary care with primary care and by continuing the efforts to prescribe medicines more efficiently. Moreover, public health expenditure is to be monitored closely and reimbursement of treatments, medication and medical devices may be put on hold if the agreed growth in expenditure is exceeded. For GP care, a higher percentage of 2.5% per annum between 2014 and 2017 was maintained, provided that GPs manage to decrease the number of referrals to hospital care (no absolute target was prescribed but GP practices would receive information about referral rates of other practices – practices with relatively high referral rates should reduce the number of referrals). If GPs do not achieve a decrease in the number of referrals, the Ministry of Health may impose new (tariff) measures (LHV et al., 2013).

**Mental health care**

The budget for mental health care was cut by €119 million in 2010. In 2012, reductions of the budget and tariffs on curative mental health care were set with the aim of achieving a saving of €222 million in 2012. To put this in perspective, in 2010, the total turnover of mental health care providers was €3956 million for curative mental care providers and €1431 million for long-term mental care providers. How the reductions affect different providers of mental health care is decided by the NZa. Reductions in both years (2010 and 2012) largely concerned curative mental health care under the Zvw provided by self-employed and institutional mental health care providers.

**Long-term care**

The budget for LTC also experienced cuts, including measures such as a reduction of entitlements for personal budgets and for counselling (see Table 4.3). In 2013, geriatric rehabilitation care was shifted from the AWBZ to the Zvw (see the section on the *Shifting costs between various statutory sources* on pages 79–80). From 2015, a structural yearly budget cut of €50 million is predicted and a major reform of LTC is planned for that year.
Table 4.5 Overview of cost saving initiatives aimed at health care providers\(^{a}\) initiated by the Dutch government and the respective planned savings (if available)

<table>
<thead>
<tr>
<th>Year</th>
<th>Measure</th>
<th>Area affected by the measure</th>
<th>Planned saving in € millions (% of the respective budgets(^{b}))</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>GP tariffs not indexed for inflation (see the section on Cost control on pages 67–70)</td>
<td>Tariffs</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td>Hospitals budget reduced by €160 million with the aim of stimulating efficiency (hospitals had to provide the same amount of care with less money)</td>
<td>Budgets (hospital care)</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td>Tariff agreement(^{c}) with medical specialists</td>
<td>Tariffs</td>
<td>175 (10%)</td>
</tr>
<tr>
<td>2009</td>
<td>Tariff measure(^{d}) for medical specialists</td>
<td>Tariffs</td>
<td>375 (24%)</td>
</tr>
<tr>
<td>2010</td>
<td>Tariff measure(^{d}) for medical specialists</td>
<td>Tariffs</td>
<td>479 (28%)</td>
</tr>
<tr>
<td></td>
<td>Agreement between the Minister of Health and the Association of Medical Specialists and the Netherlands Association of Hospitals to introduce a budget cap for medical specialists between 2012 and 2015 (limiting the growth to 2.5% per year)</td>
<td>Budgets/Tariffs</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td>GPs encouraged to prescribe generics</td>
<td>Pharmaceutical prescribing</td>
<td>130 (6%)</td>
</tr>
<tr>
<td></td>
<td>Capitation fee for GPs lowered</td>
<td>Tariffs</td>
<td>60 (3%)</td>
</tr>
<tr>
<td></td>
<td>Reduction of mental care budget and tariffs</td>
<td>Budgets/Tariffs</td>
<td>119 (3%)</td>
</tr>
<tr>
<td>2011</td>
<td>Tariff measure(^{d}) for pharmacists</td>
<td>Tariffs</td>
<td>74 (1%)</td>
</tr>
<tr>
<td></td>
<td>Tariff measure(^{d}) for hospitals</td>
<td>Tariffs</td>
<td>316 (2%)</td>
</tr>
<tr>
<td></td>
<td>Tariff measure(^{d}) for medical specialists</td>
<td>Tariffs</td>
<td>606 (33%)</td>
</tr>
<tr>
<td>2012</td>
<td>Tariff measure(^{d}) for GPs</td>
<td>Tariffs</td>
<td>98 (5%)</td>
</tr>
<tr>
<td></td>
<td>Reduction of mental care budget and tariffs</td>
<td>Budget/Tariffs</td>
<td>222 (6%)</td>
</tr>
<tr>
<td>2013</td>
<td>Implementation of the agreement between the Minister of Health and GPs (signed in 2012) to cap growth in expenditure on GP care at 2.5% per year between 2014 and 2017; not impose a tariff measure for overspending in 2011; and for GPs to save €50 million on prescriptions of medicines (e.g. by prescribing cheaper generics)</td>
<td>Efficiency</td>
<td>n.a.</td>
</tr>
</tbody>
</table>


Notes: 1. This table is not exhaustive, as only major cost-containment measures are listed.

2. For example, budgets for GP care, medical specialists’ care, hospital care, pharmaceutical care, or mental care.

3. A ‘tariff agreement’ means that medical specialists and the Ministry of Health decided together on the tariff cuts (while a tariff measure is decided unilaterally by the Ministry of Health (see below)).

4. A ‘tariff measure’ means that the Ministry of Health sets an amount (at the national level) that should be saved by health care providers to pay back the overspending in the previous year; the Dutch Health Care Authority decides on how this saving is to be achieved for individual providers.

GP: general practitioner; OMS: Association of Medical Specialists; NVZ: National Hospital Association; n.a. = not available; Zvw: Health Insurance Act; AWBZ: Exceptional Medical Expenses Act.

**Shifting costs between various statutory sources**

Statutory financing has been reorganized with costs being shifted among various statutory sources. For instance, some of the care previously insured under the AWBZ was shifted to the Zvw (geriatric rehabilitation care, in 2013) or to the municipalities (psychological counselling, in 2009), often with decreases in the budgets (see the section on Shifting costs from public to private sources on pages 73–78). In the reform of LTC which is currently (2014) under consideration, there are plans to shift more LTC from the...
AWBZ to other Acts, decentralizing its financing and governance, together with decreases in the respective budgets. As explained previously, the reason for shifting LTC to the municipalities is the idea that they can provide it more efficiently. Personal care, such as assistance with activities of daily living (Algemene dagelijkse levensverrichtingen) and counselling will be removed from the AWBZ and transferred to either the health insurers (Zvw) or the municipalities (Wmo). The exact division of tasks is currently the subject of a political debate. The important difference between shifting care to the municipalities or the Zvw is that care provided by the municipalities is compensation-based (i.e. citizens have to be compensated for their disabilities in such a way that they can participate in society) and care provided under the Zvw is rights-based (there is a list of entitlements). This means that the municipalities have more policy discretion in shaping provision of services formerly provided under the AWBZ, so long as they compensate citizens for their inability to participate in society. For example, municipalities may choose to substitute professional care with other solutions, such as care provided by neighbours or volunteers. The new Act, containing only intensive LTC for older people and people with disabilities, will be called the Long-Term Care Act (Wet Langdurige Zorg) and should come into force in 2015. Personal care (for example, help with washing, dressing, eating) will be removed from the entitlements under the AWBZ, with only nursing care and institutional care to be covered under this Act. The exact content of the new act is still subject to discussion (2014).

The government succeeded in limiting the growth of its own contribution to health care financing since the beginning of the crisis (see Table 4.6). The decrease in AWBZ expenditure in 2007 and 2008 can be attributed to the transfer of home help to the municipalities (see the section on Cost control on pages 67–70). In the following years, a steady growth in AWBZ expenditure has been noted. The decrease in the growth rate of expenditure covered under the Zvw (2009–2011) can mainly be attributed to the lower expenditure on pharmaceuticals. The growth in OOPs can be attributed to the changes in the scope and depth of coverage and the introduction (and subsequent increases) of the compulsory deductible in 2008.

Table 4.6 Health care expenditure in the Netherlands, 2006–2011

<table>
<thead>
<tr>
<th>In € million</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>8,206</td>
<td>10,724</td>
<td>11,328</td>
<td>12,390</td>
<td>12,825</td>
<td>12,915</td>
</tr>
<tr>
<td>% change</td>
<td>n.a.</td>
<td>31%</td>
<td>6%</td>
<td>9%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>AWBZ</td>
<td>23,177</td>
<td>23,007</td>
<td>22,169</td>
<td>23,201</td>
<td>24,187</td>
<td>25,263</td>
</tr>
<tr>
<td>% change</td>
<td>n.a.</td>
<td>-1%</td>
<td>-4%</td>
<td>5%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Zvw</td>
<td>26,727</td>
<td>27,693</td>
<td>32,325</td>
<td>34,143</td>
<td>35,623</td>
<td>36,030</td>
</tr>
<tr>
<td>% change</td>
<td>n.a.</td>
<td>4%</td>
<td>17%</td>
<td>6%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>VHI</td>
<td>2,904</td>
<td>3,146</td>
<td>3,154</td>
<td>3,384</td>
<td>3,429</td>
<td>3,734</td>
</tr>
<tr>
<td>% change</td>
<td>n.a.</td>
<td>8%</td>
<td>0%</td>
<td>7%</td>
<td>1%</td>
<td>9%</td>
</tr>
<tr>
<td>OOP</td>
<td>6,896</td>
<td>7,237</td>
<td>7,913</td>
<td>7,870</td>
<td>8,075</td>
<td>8,565</td>
</tr>
<tr>
<td>% change</td>
<td>n.a.</td>
<td>5%</td>
<td>9%</td>
<td>-1%</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>2,812</td>
<td>2,837</td>
<td>2,866</td>
<td>2,913</td>
<td>3,044</td>
<td>2,874</td>
</tr>
<tr>
<td>% change</td>
<td>n.a.</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
<td>4%</td>
<td>-6%</td>
</tr>
<tr>
<td>Total</td>
<td>70,722</td>
<td>74,644</td>
<td>79,755</td>
<td>83,901</td>
<td>87,183</td>
<td>89,381</td>
</tr>
<tr>
<td>% change</td>
<td>n.a.</td>
<td>6%</td>
<td>7%</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Source: Statistics Netherlands (2013c).

Notes: AWBZ: Exceptional Medical Expenses Act; Zvw: Health Insurance Act; VHI: voluntary health insurance; OOP: out-of-pocket.
Substitution between different types of care

In the 2012 agreement between the Ministry of Health and GPs, the latter agreed to support a reduction in the number of referrals to secondary care and their gatekeeping role was strengthened (see the section on Shifting costs from public to private sources on pages 73–78). For example, mental health care,\(^{20}\) which had always been the responsibility of GPs but was in practice delivered by the mental health care sector, was shifted to primary care for non-complicated cases. In 2008, special practice nurses for mental health care were introduced in primary care and in 2011, the hours for practice nurses were increased from 4 hours per week to over 8. Care for chronic patients was also strengthened at the level of primary care, by introducing practice nurses specialized in cardiovascular diseases, diabetes and chronic obstructive pulmonary disease/asthma within GP practices. (The role of practice nurse for chronic diseases was introduced in 1999. After 10 years, about 75% of GPs employed a practice nurse.)

Substitution between secondary and primary care was also emphasized in the 2013 agreement between GPs and the Ministry of Health, which contained the intention to introduce a new remuneration system for GPs in 2015 (see the section on the Increased focus on improving efficiency and eliminating fraud below). Another agreement, signed in the same year, between health care providers (hospital, medical specialists, providers of mental health care and GPs), insurers, patient associations and the Ministry of Health stipulated that, whenever possible, care should be shifted from secondary to primary care and from primary care to self-care. Quality of care should be improved, for example, by a stricter application of care guidelines.

Increased focus on improving efficiency and eliminating fraud

Improving efficiency

After an initial period of getting accustomed to their new role as health care purchasers,\(^{21}\) health insurers have started to increasingly use selective contracting and other tools to negotiate on price and quality with health care providers. The first attempt at selective contracting was made in 2012 when CZ (an insurer) did not contract with all hospitals for breast cancer surgery. In the same year, a large hospital in Amsterdam (Slotervaart Hospital) was forced to accept lower prices set by Achmea (a large insurer) as most of its patients were insured by this insurer and the loss of contract with Achmea would have led to its bankruptcy. By 2014, the share of health plans using selective contracting had increased, also as a result of the agreement between hospital care providers, health insurers and the government in 2011\(^ {22}\) (Nederlandse Vereniging van Ziekenhuizen et al., 2011) in which health insurers agreed to expand selective contracting starting in 2012. At the same time, in 2014, the basic health care premium has decreased, which is remarkable after years of increases.

There were no major changes in the payment system of health care providers between 2006 and 2012. An experiment with free prices for dental care in 2012 was abolished in 2013 because it led to higher costs instead of cost-containment. For other providers, where the reform of 2006 had led to overspending, mainly reductions in the budgets for tariffs have been introduced (see the section on Shifting costs from public to private sources on pages 73–78).

As already mentioned, in 2012, an agreement was signed between the Ministry of Health and GPs in which the latter agreed to promote prescription of cheaper medicines and a reduction in the number of prescribed

\(^{20}\) Referral rates to specialized mental health care had grown from about 3% of all patients with mental health problems in 1980 to about 12% in 2010 (Wiegert et al., 2011; Verhaak et al., 2000).

\(^{21}\) This role was bestowed on health insurers in the 2006 reform.

\(^{22}\) The 2011 Agreement described in the section on Shifting costs from public to private sources on pages 73–78 is different from the agreement described here. Many agreements are signed each year between various parties and only selected agreements are described in this chapter.
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drugs. It was estimated that this would bring savings of about €50 million in 2013. If the saving was not achieved, the difference between the actual amount saved and the planned savings would have been subject to a tariff measure. (Currently (2014), it is not clear if the saving was achieved and what the next steps will be) (LHV & VWS, 2012).

The 2013 agreement between GPs and the Ministry of Health contained the intention to introduce a new payment system in 2015. The new payment system is to distinguish among three segments: (1) provision of basic GP care; (2) multidisciplinary coordination of care for chronic diseases; and (3) incentivizing innovation and improved performance. The new payment system should take into account population characteristics as determinants of health care needs, emphasize substitution from secondary to primary care and from primary care to self-care, facilitate payment-for-performance through negotiations between GPs and insurers (for example, linking remuneration to health outcomes should be possible), be transparent and as simple as possible, and contribute to control costs at the macro level. It is unclear the level of savings that this measure may generate, but the emphasis on substitution from secondary care to primary care and from primary care to self-care and prevention should be central in generating savings.

In 2014, a new remuneration system for mental health care was introduced. Whenever possible, patients with mental health care problems are to be treated in a GP practice (by a GP assisted by a practice nurse specialized in mental health care) (see the section on the Substitution between different types of care on page 81). If the problems are too severe, the patient is to be referred to basic mental health care (outpatient-based), where four different care products exist: short-term, medium-term, intensive and chronic care. The tariffs are set by the NZa (NVGzP, 2014). Specialist mental health care, which can be both inpatient and outpatient, is paid according to a DBC system. Since 2014, patients no longer have to pay any additional cost-sharing charges.

Other efficiency-improving initiatives, such as connecting information and communication technology (ICT) systems between hospitals and GPs, have been continued and were not triggered by the crisis. Mergers of hospitals, that have been taking place since about the 1960s (Schäfer et al, 2010), was another development that contributed to improving efficiency in the sector. Changes in the delivery of care that have taken place since 2008 contributed to hospital mergers: insurers and professional associations have increasingly set rules for the minimum number of treatments performed by health care personnel that are necessary to ensure sufficient quality in performing these treatments. Complex care is increasingly organized centrally in a few specialist centres.

Elimination of fraud

Since 2010, more attention has been paid to fighting fraud in the health care sector. The need to contain costs, due to the economic crisis, probably increased the awareness of the existence of fraud in the sector and increased attention to fraud is relatively new in this sector. While previously the integrity of health professionals had not been questioned (patients asked for permission by the health insurer before seeking care and this was sometimes checked by a physician employed by the health insurer), currently remuneration claims are subject to much more scrutiny. The implementation of the new case-based payment systems may have increased fraud in the sector as upcoding leads to higher payments. On the other hand, it is not always clear how the procedures should be coded – the regulation of case-based payment is thus in

23 How innovation and performance are to be rewarded is yet to be developed (LHV et al., 2013).

24 Motives for mergers included, among others, providers’ strategic motives: a larger hospital has more possibilities to invest in buildings or new medical technologies, and a merger may enable synergies by eliminating duplicate services; larger hospitals also have more countervailing power against health insurers. Moreover, government policy promoted mergers: the budgets of new large hospitals were higher compared to the sum of budgets of the smaller hospitals before the mergers. Finally, the introduction of market mechanisms and the preceding discussions formed an argument for hospitals to merge in the 1990s. The trend towards consolidation resulted in a reduction in the number of hospitals from 172 in 1982 to 94 in 2005 (Schäfer et al., 2010).

25 A fraudulent practice in which incorrect codes are selected for performed procedures, resulting in a higher payment.
itself a source of much confusion. According to estimates, the monetary value of fraud in health care (i.e., care that was never provided and fraudulent reimbursement claims submitted by health care providers to health insurers) is between €1 and €3 billion (Blokker & Rosenberg, 2013). Exact figures are not available and therefore, on the request of the Ministry of Health, the NZa is currently (2014) conducting research into the magnitude of the problem.

With the exception of initiatives to optimize logistics in the area of pharmaceuticals (taking into account their expiry date) and medical equipment, measures to limit fraud, inefficiencies and waste of resources quickly became the subject of public debate. For instance, measures aimed at further limiting personal budgets in LTC introduced in 2012, introduced as a cost-containment measure but also partly because of fraud, were heavily criticized, as fraud in these cases was debatable and the measures had the potential to harm older people and people with disabilities who were highly dependent on the personal budgets.

**Implications for the health system**

**Impact on health system performance**

**Access to health care**

Few studies are available on the potential effects of the crisis on the financial accessibility of health care. A few recent facts and figures have been documented, but it is difficult to say whether they have been the effect of the crisis or not:

- There has been an increase in the number of defaulters and uninsured: the proportion of defaulters\(^{26}\) has increased from 1.5% in 2006 to 2.4% in 2009. In 2010, a new, stricter definition of defaulter was introduced. According to the new definition, 1.9% of the population defaulted in 2011 and 2.1% in 2012 (Statistics Netherlands, 2013c). The number of uninsured has also likely increased but no data is available to quantify this trend. According to Statistics Netherlands, 0.1% of the population was uninsured in 2012 (Statistics Netherlands, 2013b).

- There has also been an increase in cost-related access problems: a study by The Commonwealth Fund among 1000 Dutch citizens revealed that 22% of respondents experienced cost-related access problems and 9% experienced problems with paying their medical bills in 2013 (Schoen et al., 2013). In 2012, a survey among 854 Dutch respondents revealed that 9% of this population sample stated that they did not go to the GP because of the high deductible, even though the deductible does not apply to GP care (Reitsma-Van Rooijen, Brabers & DeJong, 2012). Since 2012, a decrease in the volume of hospital care has been observed. This is an important break in the trend, since the volume has been increasing for decades. The decrease might have been caused by the economic crisis, but this is not yet fully clear or explained (Heijn, 2013)\(^{27}\). In 2013, a survey among 8500 Dutch GPs showed that 94% were consulted by patients that had difficulties paying for non-refundable medications and other medical aids (24% dealt with such patients on a daily basis). Seventy-seven per cent of the surveyed GPs said that they sought alternative solutions for their patients, such as additional consultations, before referring them to care that was subject to the compulsory deductible (LHV, 2013). Reduction of referrals is also in line with the 2013 agreement with the Ministry of Health (see the section on *Shifting costs from public to private sources* on pages 73–78), but it is not clear what influenced the behaviour of doctors – the crisis, the 2013 agreement or both.

The financial vulnerability of health insurers has grown due to the increase in risk bearing as a result of the abolition of financial safety nets, such as retrospective compensation for large deviations from the budget

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26 Defaulters are people who did not pay their premiums for at least six months.

27 The International Health Policy Surveys conducted by The Commonwealth Fund showed that in 2010 4% of Dutch respondents ‘did not see a doctor when sick or did not get recommended care because of cost’; in 2013 the figure was 20%. In other countries, the percentage of respondents that agreed with this statement remained stable or decreased (for example, from 23% in 2010 to 10% in 2013 in Germany; Schoen et al., 2013).
set by the government (see the section on *Shifting costs from public to private sources* on pages 73–78). Increased competition on premiums might also have contributed to this. Recently, a Dutch newspaper (*De Telegraaf*) reported that in 2013 patients increasingly had trouble paying the compulsory deductible and that health insurers were frequently asked by their clients to come to an insolvency arrangement (Boon & Navis, 2013). If this trend continues, the financial vulnerability of health care providers and even access to health care may be affected in the future.

As noted previously, in 2013 health insurers were for the first time able to lower premiums for the basic package. This might have happened at the expense of reducing the choice of provider and increasing the level of deductibles, but this link needs to be better analysed in the future.28 Lower premiums and the limited choice of health care provider for patients can be only partly related to the crisis as it is also the result of the market regulation introduced in 2006. Health insurers have now become accustomed to their new roles as purchasers of care and have succeeded in achieving a stronger bargaining position vis-à-vis health providers. Whether the limited choice of provider will cause access problems for patients will become clearer in the years to come.

Another important measure, which had been started before the crisis and which may affect access to care, is the substitution of institutional care, mainly for older people and the chronically ill, with home care, provided at the municipal level (with differences in the generosity of care provision among the municipalities; see the section on *Cost control* on pages 67–70 and the section on *Shifting costs between various statutory sources* on pages 79 and 80), and self-care, organized on a voluntary basis. Access to home care services may also become more limited, as applicants must pass a stricter needs assessment test (see Table 4.3).

**Equity in the use of needed health services**

Currently, no specific information is available on equity in the use of health care services. Consumption levels of health care decreased for the first time in decades in 2012, but it is difficult to estimate to what extent this was due to the crisis. Socioeconomic inequalities in access to health care have always been relatively low in the Netherlands, according to several international comparative studies (Westert, 2010) and so far there is not much evidence that this has changed (see the section on *Shifting costs from public to private sources* on pages 73–78).

**Equity in financing**

Interestingly, despite the measures to shift costs from the public purse to citizens, the share of OOP expenditure in health care financing has not increased (Table 4.6 and Figure 4.4). The combined burden of the premiums for both acute care (Zvw) and LTC (AWBZ) also remained rather stable: 68.3% of total health expenditure in 2008 and 68.6% in 2011 (Figure 4.4). However, it should be noted that the effect of the substantial increase in the compulsory deductible from €210 in 2012 to €350 in 2013 is not yet included in these data. Moreover, the net contribution of the government to health care financing (i.e. from taxation, which is a progressive source of financing) grew substantially from 11.6% of total health care expenditure in 2006 to 14.2% in 2008 and 14.4% in 2011 (Statistics Netherlands, 2013c).

**Quality of care and user experience**

There is currently no evidence that quality of care has been affected by the crisis. There has been no increase in waiting times for curative care and they do not seem to be excessive. (In the area of curative care, health insurers are responsible for helping patients to find alternative providers if the waiting lists

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28 The ability to reduce premiums for the basic package might also have been the result of the savings accumulated by insurers. The financial results of health insurers (for the basic package and VHI together) have been positive since 2008 (Nederlandse Zorgautoriteit, 2012).
are long.) In the area of LTC, the percentage of patients waiting for admission to inpatient LTC facilities who waited longer than the normative waiting time increased by 6–11 percentage points between 2010 and 2012 and by 14–21 percentage points for nursing homes. No changes in waiting times were observed for patients in need of inpatient mental health care (93% of patients were admitted within the normative waiting time) (Nederlandse Zorgautoriteit, 2013). However, a periodical survey conducted by the Netherlands Institute for Social Research (Sociaal en Cultureel Planbureau; SCP) among 1307 Dutch citizens in 2013 showed that 11% of respondents see health care and care for older people as the largest social problem and the top priority for the country. Other issues that were considered to be of top priority were the economy and income (17%), social norms and values (17%) and crime. However, it also has to be noted that some measures have been taken to protect the quality of health care. For example, investments in medical education were protected from the cuts until 2013 (see the section on the Health system pressures since the emergence of the crisis on pages 71 and 72).

**Addressing inefficiencies**

Even before the crisis, the 2006 reform promoted improving the efficiency of health care delivery. The efficiency-improving measures are still being continued and have not been affected by the crisis. For example, the reform included measures such as the programme introducing logistic principles known as ‘faster, better’ (Vos et al., 2008). The reform also promotes delegation of tasks from physicians to less expensive, suitably trained health care professionals, such as nurses (see the section on the Increased focus on improving efficiency and eliminating fraud on pages 81–83). This should improve the multidisciplinary collaboration between different health care professions, leading to less dependency on highly specialized care and lower costs of care. However, delegation of tasks has appeared to be difficult in practice as it requires the adaptation of hierarchies, legal medical responsibilities, competencies and professional domains.

**Transparency and accountability**

Increased focus on improving efficiency and prevention of fraud (see the section on Increased focus on improving efficiency and eliminating fraud on pages 81–83) has likely contributed to increasing attention being paid to the transparency of the health care system. Other measures may have also contributed (indirectly) to increasing transparency, though it has to be noted that they were not driven by the economic crisis. Examples are the application of ICT and innovations to streamline health care processes and (re) design health care organizations to increase their flexibility, efficiency and patient service (for example, enabling email consultations). In the area of specialized care, the financing system based on DBCs (see the section on Payment mechanisms on page 66) was redesigned in 2012 to increase its transparency, with the number of DBCs reduced from over 30 000 to about 3000. This project was named DBCs On the way to Transparency (DOT). Another example of increasing transparency in the system is the increasing publication of comparative information on health care providers on the Internet (for example, through websites such as kiesBeter.nl and Zorgkaart Nederland), enabling patients to choose providers and publish their experiences. Most recently, in January 2014, the organization that governs the DBC system (DBC-Onderhoud), decided to publish a range of prices for specialized care to inform citizens and enable them to compare providers (including hospitals).

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29 Percentage of respondents not available.
30 Percentage of respondents not available.
31 The kiesBeter website can be accessed at http://www.kiesbeter.nl.
32 The Zorgkaart Nederland website can be accessed at http://www.zorgkaartnederland.nl.
Impact on population health

The health status of the Dutch population remains at a high level. In general, it seems safe to state that it has not yet been affected by the crisis. However, some negative signs have been reported recently.

In 2013, the Dutch *Financial Times* reported that doctors and health organizations saw an increase in the number of employees who visit their GP or occupational physician due to mental health problems resulting from fear of job loss (Cats & Olsthoorn, 2013). In the same year, the Netherlands Centre for Occupational Diseases (*Nederlands Centrum voor Beroepsziekten*) reported an increase in the number of burnout cases and depression due to job loss and lowering housing prices (Nederlands Centrum voor Beroepsziekten, 2014). The Trimbos Institute has started a research on the relationship between the economic crisis, depression and suicide (Cats & Olsthoorn, 2013), but no data are available as yet.

Discussion

The nature of the health system’s responses to the crisis and implementation challenges

Drivers of change

The key changes in the Dutch health care system described in this chapter date from before the start of the economic crisis and were mainly affected by the 2006 reform that aimed to increase efficiency and reduce costs. The economic crisis hit the Dutch health care sector relatively late and in an indirect way compared to other countries and other sectors in the economy. The crisis mainly reinforced the measures implemented in earlier years. Some changes are yet to take place (from 2014 onwards) and their effects remain to be seen.

Content and process of change

At the onset of the crisis, the Dutch health care system was still in the process of transition following the 2006 reform. This reform came with many protective measures aimed at preventing financial problems in the health care sector and giving stakeholders the opportunity to become accustomed to their new roles. It is therefore often unclear whether changes in the system that happened after 2008 were the result of the crisis or the result of adjustments to promote good working of the new system and abolishing protective measures.

With the export and financial services sectors hit first and with budget cuts first affecting the defence and arts budgets, it seems that health care is one of the last sectors in the Netherlands to be affected by the economic crisis. Indeed, the cost saving measures implemented in the health care sector between 2009 and 2011 have hardly had an impact on the distribution of health care expenditure among the different financing agents (Figure 4.4) and on the composition of health care expenditure (Figures 4.5 and 4.6) between 2008 and 2011.

Figure 4.4 Breakdown of total health care expenditure by financing agent in the Netherlands at the beginning (2008) and during the crisis (2011)

Source: Statistics Netherlands (2013c).
The deterioration of the economic situation opened up public discussion on fundamental questions, such as what is affordable health care, what should be collectively financed and what are unnecessary treatments and processes in health care. Dutch citizens seem to understand that all public sectors are influenced by the crisis and that a better control of costs is necessary. In 2011, a poll by the SCP showed that 60% of respondents agreed or were neutral towards the statement that the government is right in limiting the basic insurance package to control health care costs (SCP, 2012).

To create support for the measures that were undertaken, the government negotiated a number of agreements with key stakeholders in the sector (see the section on Shifting costs from public to private sources on pages 73-78). The most prominent is the 2013 Health Agreement with all sector stakeholders (medical professionals, hospitals and health insurers). Pressure from the austerity measures was one factor that helped to reach an agreement.

However, controlling growth in health care costs remains difficult, due to the complexity of the system and the determination to maintain high quality of care despite high costs and inefficiencies. Some achievements in cost control have been achieved in recent years, such as those derived from GPs prescribing cheaper drugs or by limiting the income of medical specialists. This might have been supported by other trends, for example, by the fact that a growing number of specialists prefer a salaried hospital position. These can be seen as examples of so-called low-hanging fruit, i.e. easier measures, while the reform of LTC and achieving cost savings in this area are examples of high-hanging fruit.

Finally, the segmentation of health care echelons and occupations remain conservative and pose a barrier to change in times of crises. The slow progress in task delegation and IT use, for instance, can be seen as an expression of these problems. While task shifting and functional/clinical integration are advocated
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throughout the sector, differences in clinical practices and culture, and in the financial regimes, of health care providers in the different sectors between various types of care prevent intersectoral collaboration from actually happening. For example, payment mechanisms for hospitals and medical specialist (DBCs) differ from those used for GPs (capitation and FFS), making the introduction of bundled payments for integrated care difficult. In addition, most policy measures appear to be highly sensitive to the public and political debate, specifically if they could lead to inequality in access to care, as equality in access to care is high and highly valued by the Dutch population.

Resilience

It seems that the Dutch health system was not well prepared at the onset of the crisis, but measures taken in earlier years (to control costs and improve efficiency) are likely to have made the effects of the crisis less severe. Another factor that alleviated the effects of the crisis was the implementation of those easy-to-make changes (low-hanging fruit) described earlier in this chapter. One of the potentially negative consequences of the crisis may be the reduction in the number of home help personnel and nursing assistants, following the shift from institutional care to home care. There are currently signs (Spring 2014) that some nursing homes may need to be closed and home care organizations may need to reduce the number of home help personnel and nursing assistants if they lose contracts with municipalities. It is expected that nurses, nursing assistants and home care employees will be needed in the near future and they should be prevented from leaving the Dutch labour market. If they do, the resilience of the health care system may be reduced.

Conclusion

In retrospect, it can be concluded that the 2006 reform has been the most influential development in the Dutch health care sector in the past decade. Relative to this, the economic crisis has had limited effects on accessibility, quality and affordability of care. However, although the Dutch population accepts that having world-class health care comes at a high cost, the question of affordability of care remains the main topic of concern. This is reflected in the plans for a major reform of LTC that is currently under consideration.

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Acknowledgements

The authors would like to thank Professor JAM (Hans) Maarse from the Department of Health Services Research, School of Public Health and Primary Care, University of Maastricht, for reviewing this case-study chapter and providing numerous constructive comments and suggestions.
Chapter 5
Policy recommendations for the Republic of Korea based on the experiences of three European countries (Belgium, France and the Netherlands)
Seuran Lee

Health financing system in the Republic of Korea
Overview
Like the European countries reviewed in this report (Belgium, France and the Netherlands), the Republic of Korea also has a health financing system based on social health insurance. The majority of the population (97%) is covered by national health insurance (NHI). For the remaining 3%, which lives below the poverty line, the Ministry of Health (MoH) runs a tax-funded medical aid program (MAP) (see Table 5.1). The scope of benefits and provider payment arrangements for MAP are almost identical to those of NHI. In comparison to the benefit package available under the NHI and MAP, which focuses on acute care, long-term care (LTC) for older people is financed through a designated LTC insurance (LTCI) scheme, launched in 2008. When it comes to health promotion and prevention (HPP), major financial responsibility lies with central and local governments rather than with other contribution-based financing schemes such as the NHI and LTCI. These services are provided through local health centres, which are publicly owned facilities. Apart from the public schemes, private health insurance (PHI) covers the health services that are poorly or not provided for by the public schemes. However, the PHI payment system is different from the public scheme in that the reimbursement of costs goes directly to the patient, and does not engage with health providers at all.

In terms of policy authority for the public health financing system, main responsibility rests with the MoH, while the Financial Services Commission (FSC) has responsibility for overseeing and regulating PHI. The MoH formulates policy either through a decision-making committee, made up of representatives from different stakeholders, or by making policy decisions on its own. The Ministry of Finance is another major actor that decides funding levels for the tax-funded health care scheme for the poor (MAP); it also has a say on major health policies through its participation in decision-making committees.

There are two major operational agencies for the NHI scheme, the National Health Insurance Service (NHIS) and the Health Insurance Review Agency (HIRA). The NHIS is in charge of managing NHI entitlement, collecting contributions and managing the NHI Fund. The HIRA is another important agency with responsibility for medical claim reviews and provider payment decisions. In addition to these roles within the NHI scheme, the NHIS and HIRA also undertake management and operational tasks for MAP,

1 At times, the separation of policy authority between two government agencies makes it difficult to design policy to balance the roles of the public scheme and PHI.
according to their areas of expertise. Furthermore, the NHIS is responsible for the operation of the LTCI scheme, including managing entitlement, collecting contributions and paying providers. It is notable that under such operational arrangements, several health financing schemes are centrally managed, using an existing operational agency rather than establishing new ones.

Table 5.1 Overview of health financing schemes in the Republic of Korea

<table>
<thead>
<tr>
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<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage</strong></td>
<td>NHI 97% of population</td>
<td>MAP 3% of population</td>
</tr>
<tr>
<td></td>
<td>LTCl Whole population Beneficiaries</td>
<td>HPP Whole population</td>
</tr>
<tr>
<td></td>
<td>: 5.9% of the elderly</td>
<td>PHI: More than 77% (Voluntary basis)</td>
</tr>
<tr>
<td><strong>Finance</strong></td>
<td>NHI Contribution/ Government subsidy</td>
<td>MAP General Taxation</td>
</tr>
<tr>
<td></td>
<td>LTCl Contribution/ Government subsidy</td>
<td>HPP General Taxation/HPF</td>
</tr>
<tr>
<td></td>
<td>NHI Health care</td>
<td>PHI: Private Premiums</td>
</tr>
<tr>
<td><strong>Service</strong></td>
<td>NHI Health Care</td>
<td>LTCl Long-term care</td>
</tr>
<tr>
<td></td>
<td>NHI Health promotion / prevention</td>
<td>NHI Health services reimbursed in cash</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>Private/Public providers</td>
<td>Private/Public providers</td>
</tr>
<tr>
<td></td>
<td>Local government, NHIS, HIRA</td>
<td>Local government, Public Health centers</td>
</tr>
<tr>
<td><strong>Organization</strong></td>
<td>NHIS HIRA</td>
<td>Local government, NHIS, HIRA</td>
</tr>
</tbody>
</table>

Source: Adapted from Chun et al. (2009:47).

Notes: NHI: national health insurance; MAP: medical aid program; LTCI: long-term care insurance; HPP: health promotion and prevention; PHI: private health insurance; HPF: Health Promotion Fund; LTC: long-term care; NHIS: National Health Insurance Service; HIRA: Health Insurance Review and Assessment; FSC: Financial Services Commission.

Population coverage and revenue collection

The majority of the population (97%) is covered by the mandatory NHI scheme. The NHI is mostly funded by member contributions that normally account for 85% of total NHI revenue (NHIS, 2013a). There are two types of members: the employed and the self-employed. Employees pay their contribution as a proportion of their salary\(^2\) (currently 5.99%) and payment of the contribution is equally split between employers and employees. For the self-employed, since their full income is not easily arrived at, their contribution is calculated based not only on their own salary but also on any property they own and the number of people in their household.

The contribution rates for both types of members are decided by the Health Insurance Policy Committee (HIPC) which is operated by the MoH. Contributions are collected by the NHIS. The NHIS is charged with the implementation of NHI policies, including the management of NHI entitlement and provider payment for the services delivered to NHI members. In addition to contributions, the NHI receives a government subsidy through general taxes and the Health Promotion Fund (KHPF), which collects a tax on tobacco

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\(^2\) From 2012, property income has also been included in the contribution calculation for employees to increase equity between the self-employed and employees (see the section on Increase NHI contribution, pages 101 and 102).
sales. According to legislation, total government subsidies should equal approximately 20% of NHI contribution revenues; in practice, this component only accounts for 15.9% of NHI resources (NHIS, 2013a).

The remaining 3% of the population receive health services through the MAP programme, which is a tax-funded programme. The MAP is fully funded by the government with 80% of funds (50% for the Seoul Capital Area) coming from central government and the remainder from local governments (MOF, 2012). As the MAP aims to target extremely poor people, applicants need to be approved by their local administration office to secure entitlement: means testing is based on income and property. Although MAP funds are set at the metropolitan government level, key policy components, such as eligibility criteria, pooling arrangements and purchasing function principles are set out uniformly across the nation.

Membership of the LTCI scheme is the same as for the NHI, i.e. the entire population, except for MAP beneficiaries, is legally required to be LTCI members. However, given that the LTCI aims to support the daily living activities of older people, service entitlement is extended to citizens aged 65 and older or to those under 65 with geriatric diseases. The LTCI contribution rate is set as a proportion of the NHI contribution and the NHIS collects both the NHI and the LTCI contributions. Apart from contributions, the government transfers general tax revenue to the LTCI, amounting to 20% of its annual projected revenue (NHIS, 2013a).

As the HPP services are provided through local health centres, the entire population has access to them, with some co-payments associated with services. While PHI is voluntary, more than 77% of households purchased at least one PHI policy in 2009 (KIHSA, 2011a).

**Service coverage and co-payments**

**Service coverage**

Although, according to legislation, the NHI is supposed to cover prevention and treatment of disease as well as health promotion and rehabilitation, its focus is more on curative care. Physician services, hospital care, prescription drugs, medical supplies and some types of traditional medicine are covered in the benefit package. Some services, including spectacles, hearing aids and some rehabilitation services are not included.

As the NHI maintains a so-called negative list system for service coverage, the list of services that are not covered is set out in a MoH regulation. If a particular service is not clearly mentioned in this list, by definition it is assumed to be covered by NHI. However, in practice, there is conflict between insurers and health providers as to whether or not certain services are covered. Usually, health providers tend to label services as excluded from coverage so that they can set the price freely without MoH regulation, while the MoH, along with the HIRA, tend to take the opposite approach. The key problem is that it takes time to resolve such disputes, leading to potential harm to patients in urgent need of the service under discussion.

For services not covered by NHI, prices are set by providers and patients pay the full price out-of-pocket (OOP). Full payment of these services, along with co-payments for those services that are covered leads to high levels of OOP payments in individual households. In 2001, OOPs accounted for 35.2% of total health expenditure in the Republic of Korea (OECD, 2013a). It is notable that service coverage under the MAP scheme is the same as NHI, with a few exceptions where service application is governed more strictly. Because MAP beneficiaries face no or very low levels of co-payments, even when using very expensive services, they are likely to consume more services than NHI members. For this reason, the government

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3 Since 2011, for the purposes of greater efficiency, the NHIS became responsible for the collection all of social insurance contributions, i.e. NHI, LTCI, national pension, employment insurance and industrial accident insurance.
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imposes stricter restrictions on certain services available to MAP beneficiaries.

As mentioned earlier, the main LTCI service coverage aims to support daily living activities. Institutional services are provided by LTC facilities, while home-care services (including bathing, nursing and respite care) are provided by home-care agencies to patients living in their own homes. A special cash benefit and rental services for some equipment to aid daily activities are also available under certain conditions.

**Co-payments**

When using NHI services, patients have to pay co-payments. National Health Insurance reimbursement is organized as a third-party payment system in which the NHIS pays the provider directly and patients are liable only for a certain portion of the total cost as a co-payment. Co-payments vary from 20% (inpatient care) to 100% (special treatments), depending on the type of care provided. All reimbursable services and associated co-payments are listed in MoH regulations.

As a protection mechanism against the financial risk of high co-payments, co-payment rates vary by type of patient. Patients diagnosed with critical, chronic or rare diseases, who are expected to spend more on health services, have reduced co-payment rates. The other protection mechanism is an annual ceiling on total co-payment expenditure (co-payment ceiling). This cap depends on the income level of patients, classified into three percentile bands based on the income levels of NHIS insurees (below 20%, 20–50%, above 50%). Once a patient’s total co-payment spending goes over the annual cap, the NHI covers the difference. Given the low income levels of MAP beneficiaries, they are able to use health services either free of charge (type 1 category) or with very low co-payments (type 2 category).

The co-payment schedule for LTCI services is simpler than that of the NHI. Patients pay 15% of the expenses incurred for home care and 20% for institutional care. However, if patients are beneficiaries of the National Basic Living Security Act, which is an income support programme for vulnerable citizens, they are exempt from co-payments. In addition, low-income patients are entitled to a 50% reduction on co-payments.

**Purchasing scheme and provider payment**

The NHIS is a purchasing agency for its members. All hospitals and clinics, regardless of whether they are public or private, are legally required to provide services to NHI members. Since in the Republic of Korea the majority of providers are private, there is a clear split between purchaser and provider.

With regard to provider payment, fee-for-service (FFS) is the main payment system under the NHI, accounting for 94% of total NHI expenditure in 2010 (MOHW, 2011a). Physicians and hospitals are paid on a FFS basis. The diagnosis-related group (DRG)- or case-based payment, as the other provider payment method, was first introduced in 2002. Although the government has wanted to expand the DRG payment scheme over the past decade, it has not been very successful due to strong resistance from providers. However, in 2012, and taking advantage of the opportunities afforded by the financial crisis, the government made the DRG payment mandatory, but only for seven disease groups (irrespective of whether treatment takes place in hospitals or clinics). Performance-based payment and the per diem payment method have been developed, but are still at an early stage, with application to very limited disease areas or certain provider settings.

To set provider reimbursement rates, the NHIS enters into a contract with a representative of seven types of providers: clinics, pharmacists, dentists, hospitals, traditional medicine practitioners, midwives and public health centres. However, the contract only sets a unit cost (called a conversion factor), which is applied to medical treatment with a resource-based relative value (RBRV). The reimbursement rate for non-RBRV services, such as medical supplies and drugs, are determined by the MoH in consultation with the HIPC. Under this pricing arrangement, there is no tool or way to control NHI expenditure at the macro
level. This contrasts greatly with the situation in the three European countries featured in this report: the Netherlands has a contracting scheme that allows negotiating with hospitals on volume and quality (see Chapter 4, Netherlands case-study, section on Purchasing and purchaser–provider relations, pages 65 and 66), while Belgium and France have a budget cap on their total health budgets (see Chapter 2, section on the Health budget on pages 12–15 and Chapter 3, section on Changes to public funding for the health system on pages 46–48). In order for providers to receive payment for the services supplied, all bills must go through a HIRA review process. The HIRA is in charge of reviewing medical claims and is also responsible for providing the MoH with technical assessments relating to benefit decisions and price setting for services.

The NHIS operates as the purchaser for MAP on behalf of local government and the HIRA reviews medical claims for the services provided to MAP beneficiaries. Because the MAP programme has the same provider payment system as the NHI (with a few exceptions, such as lower fees for mental health care), it is possible, operationally, for the NHIS and HIRA to undertake these task for the MAP.

**Health Expenditure**

Total health expenditure in the Republic of Korea was 91.2 trillion Korean Won (KRW) or €59.2 billion in 2011, representing 7.4% of gross domestic product (GDP) (OECD, 2013b), which is below the OECD average of 9.3%. Along with Estonia at 5.9% and Poland at 6.9%, the Republic of Korea belongs to the group of OECD countries with relatively low health expenditure (Figure 5.1).

Despite the low level of health expenditure, its growth rate has been quite high over the past three decades. Total health expenditure in the Republic of Korea increased rapidly from the second half of the 1980s when the NHI scheme was established. Between 2000 and 2009, the rate of growth in health spending in the Republic of Korea was more than twice the average across OECD countries, reaching 9.8% per year on average in real terms, compared with an OECD average of 4.8%. Although the growth rate decreased to 9.2% in 2010 and 4.7% in 2011, the Republic of Korea is one of the few OECD countries to maintain strong expenditure growth in this sector. The increase in health spending over the last decade has been driven mainly by the increase in public spending on health (OECD, 2013b).

**Figure 5.1 Health expenditure as a share of GDP, OECD countries, 2011**

<table>
<thead>
<tr>
<th>Country</th>
<th>% of GDP</th>
<th>Current Expenditure</th>
<th>Capital Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>17.7</td>
<td>15.3</td>
<td>2.4</td>
</tr>
<tr>
<td>Mexico</td>
<td>11.6</td>
<td>11.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Brazil</td>
<td>11.4</td>
<td>10.9</td>
<td>0.5</td>
</tr>
<tr>
<td>Canada (2010)</td>
<td>11.3</td>
<td>10.4</td>
<td>0.9</td>
</tr>
<tr>
<td>Japan (2010)</td>
<td>12.2</td>
<td>11.2</td>
<td>1.0</td>
</tr>
<tr>
<td>Japan (2011)</td>
<td>11.6</td>
<td>11.2</td>
<td>0.4</td>
</tr>
<tr>
<td>Japan (2012)</td>
<td>11.0</td>
<td>10.3</td>
<td>0.7</td>
</tr>
<tr>
<td>Japan (2013)</td>
<td>10.5</td>
<td>10.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Japan (2014)</td>
<td>10.2</td>
<td>10.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Japan (2015)</td>
<td>8.5</td>
<td>8.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Japan (2016)</td>
<td>7.5</td>
<td>7.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Japan (2017)</td>
<td>7.7</td>
<td>7.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Japan (2018)</td>
<td>7.5</td>
<td>7.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Japan (2019)</td>
<td>7.4</td>
<td>7.4</td>
<td>0.0</td>
</tr>
<tr>
<td>Japan (2020)</td>
<td>6.5</td>
<td>6.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Japan (2021)</td>
<td>6.0</td>
<td>6.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Japan (2022)</td>
<td>5.6</td>
<td>5.6</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Source: OECD (2013b).

Note: GDP: gross domestic product; OECD: Organization for Economic Co-operation and Development.

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4 KRW 1542.42 = €1 (arbitraged exchanges rates of the KRW against the Euro in 2011 based on the Bank of Korea’s Economic Statistics System).
The impact of the global economic crisis on the health care systems of Belgium, France and the Netherlands

However, in terms of the share of public spending, public expenditure on health only represents 55.3% of total health expenditure, which is well below the OECD average of 72.2% (OECD, 2013b). The lower proportion is substantially linked to the high level of OOPs paid by patients, which accounted for 35.2% of total health expenditure in 2011. This is a consequence of maintaining a policy of low contribution and low benefits for the NHI system, which has become one of the key challenges for the health system. Table 5.2 outlines the key health expenditure trends between 1980 and 2011.

Table 5.2. Composition of total health expenditure, as percentages, in the Republic of Korea, 1980–2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government Expenditure</td>
<td>Social Insurance</td>
</tr>
<tr>
<td>1980</td>
<td>9.9</td>
<td>12.3</td>
</tr>
<tr>
<td>1985</td>
<td>7.8</td>
<td>24.4</td>
</tr>
<tr>
<td>1990</td>
<td>8.6</td>
<td>30.9</td>
</tr>
<tr>
<td>1995</td>
<td>7.9</td>
<td>30.6</td>
</tr>
<tr>
<td>2000</td>
<td>11.5</td>
<td>38.9</td>
</tr>
<tr>
<td>2005</td>
<td>12.2</td>
<td>41.0</td>
</tr>
<tr>
<td>2011</td>
<td>11.7</td>
<td>43.6</td>
</tr>
</tbody>
</table>

Source: MOHW (2013a).

Recommendations based on the experience of three country case-studies

Introduction

Impact of financial crisis on the economy of the Republic of Korea

The global financial crisis, which began in late 2007, not only had an impact on European countries but also on those in other parts of the world. The Republic of Korea’s economy was also affected, as testified by an annual growth rate of real GDP of 2.3% in 2008 and 0.3% in 2009, compared to 5.1% in 2007 (Bank of Korea, 2013). As in other countries, to boost the economy, the South Korean government implemented diverse financial measures, such as lowering standard interest rates and providing a supplementary budget in 2008. The monetary value of the economic stimulus package introduced in 2008 amounted to more than 6% of GDP for that year (Seungjae, 2010).

With the rebounding of the world economy and the implementation of diverse stimulus policies, the economy returned almost back to normal with a record growth rate of 6.3% in 2010 compared to 2009 (Bank of Korea, 2013). The Republic of Korea recovered faster and more vigorously from the 2008 global crisis than most OECD countries (OECD, 2012). Apart from the recent decreased trends in economic growth rates (Figure 5.2), it can be said that the Republic of Korea has not struggled as much as European countries with financial pressure coming directly from the financial crisis.


5. Policy recommendation for Korea: based on the experiences of three countries (Belgium, France and the Netherlands)

Financial status of NHI fund

The NHI fund has experienced some fluctuation in financial status, recording deficits and surpluses during the period from 2008 to 2012 (NHIS, 2013a; see also Table 5.3). Like other countries, including the three countries analysed in this report, diverse policy measures were undertaken to reduce NHI expenditure and to increase revenue. The surplus in 2012 can be explained mainly by the huge price cuts on pharmaceuticals that were implemented. However, almost the same level of surplus was achieved in 2013 when there was no policy action to reduce costs. Many factors have been mentioned as possible explanations for NHI surpluses in recent years. The most prevalent assumption is that due to the decline in household disposable income, people reduced their consumption of health services mainly due to the financial burden from co-payments. However, since so far, there has been limited examination of the causes of the financial changes in the NHI fund, deeper analysis is warranted.

Table 5.3 NHI fund financial balances in the Republic of Korea, 2008–2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Revenue (KRW billion) (A)</th>
<th>Expenditure (KRW billion) (B)</th>
<th>Current balance (KRW billion) (C=A-B)</th>
<th>Accumulated balance (KRW billion) (D=C 2008+ C2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>28,908</td>
<td>27,541</td>
<td>1,367</td>
<td>2,262</td>
</tr>
<tr>
<td>2009</td>
<td>31,182</td>
<td>31,185</td>
<td>-3</td>
<td>2,258</td>
</tr>
<tr>
<td>2010</td>
<td>33,561</td>
<td>34,860</td>
<td>-1,299</td>
<td>959</td>
</tr>
<tr>
<td>2011</td>
<td>37,977</td>
<td>37,377</td>
<td>601</td>
<td>1,560</td>
</tr>
<tr>
<td>2012</td>
<td>41,819</td>
<td>38,804</td>
<td>3,015</td>
<td>4,575</td>
</tr>
<tr>
<td>2013</td>
<td>45,173</td>
<td>41,529</td>
<td>3,645</td>
<td>8,220</td>
</tr>
</tbody>
</table>

Source: Kyungrave (2014).

On-going financial threats to the health system

Although the NHI Fund has posted surpluses over the past couple of years, financial pressure on health care has always been, and continues to be, a major issue that needs to be addressed.

Between 1999 and 2003, the NHI experienced significant financial problems. This was a period when major reforms of the health care system took place, namely the insurance fund integration reform (1999), which merged multiple insurance schemes into one single fund, and the reform concerning the separation of pharmaceutical prescribing and dispensing (2000), which prohibited physicians from being able to sell medicines directly to their patients and patients being able to buy a wide range of medicines directly from pharmacies without a prescription. During this period, the NHI had to borrow money from banks to pay medical bills and increased the contribution rate by almost 20%. In addition, in an effort to have a more reliable financing stream from the government NHI Fund subsidy, special legislation was passed to
specify the level of the government transfer. Before this legislation, the subsidy fluctuated, reflecting fiscal capacity or the government’s policy priorities. When the global financial crisis impacted on the economy, the NHIS again ran a short-term deficit in 2009 and 2010 (Table 5.3). To fill the financial gap between revenue and expenditure, a number of policy actions were put in place and some of them are still in effect.

Since the start of President Park Geun-hye’s administration in 2013, the MoH has been under considerable pressure to secure more resources for health care. The Park administration's major policy priority for the NHI scheme is to improve financial protection for four critical disease areas (cancer, cardiovascular disease, cerebrovascular disease and orphan/rare diseases). The other major priority for the NH is to expand the NHI benefits to three major non-covered services: extra charges for a luxury room in an inpatient setting; nursing care for inpatient care; and high fees for treatment by experienced physicians. In fact, these three areas have long been identified as representative, imposing a financial burden on households while also being a major income source for hospitals. These policies were part of the president's electoral commitments and implementation has been pushed through during her presidential term.

In addition to current financial challenges, a number of future threats are expected to impose financial pressure on health expenditure. The decline of potential economic growth associated with a rapidly ageing population needs to be taken into account. Moreover, slow economic growth is likely to constrain public resources for health. An ageing population is another factor that will drive up the financial burden on health spending. According to projections of NH expenditure for the next decade, the proportion of the population aged over 65 will reach 20.8%; accordingly, health spending for this group will take up 53.2% of total NH expenditure in 2026 (Kyungrae, 2014).

Three types of policy responses

During the crisis, the three European countries featured in this report (Belgium, France and the Netherlands) have responded with diverse policy measures to relieve financial pressure on health care. However, it is notable that there had been ongoing reforms and policy changes in these countries that started before the economic crisis. Mobilizing more resources and improving efficiency of health spending have always been challenges in health policy. Reflecting this, the policy recommendations for the Republic of Korea in this report derive not only from examples of policy responses to the crisis but also from existing reforms or policy actions which started before and continued after the crisis, if relevant. In order to identify policy suggestions that are most relevant for the context of the Republic of Korea, the focus will be on policies which the country shares (or has similar experience) with the three case-study countries or policies that the population has a strong interest in introducing or developing. Diverse policy suggestions will be described according to three categories:

- Mobilizing more resources to meet current or future expenditure;
- Reducing health spending by changing coverage while also ensuring financial protection;
- Managing health care costs more efficiently.

As these categories are not mutually exclusive, some policies, which aim to achieve multiple purposes, can be covered under more than one category.

5 Although these three services are major factors driving increases in the financial burden on individual households, there is a debate as to whether they should be covered by the NH immediately, given some of them are not medically necessary services.

6 These three categories have been used in a current analysis study of European countries' policy responses to the economic crisis (Jowett, Thomson & Evetovits, in press).
Policy options to mobilize more resources

Increase NHI contribution

In countries where social health insurance plays a major role in financing health care, and where contributions are the main financial source, increasing the contribution rate should be the first policy option to be considered as a way of mobilizing more resources.

In France, a new social security contribution (for the earmarked social security budget) was introduced in 2009 at 2%. It was increased to 4% in 2010, then to 8% in January and 20% in August in 2012. Currently, 25% of these revenues are allocated to health. The French government also allocated some additional resources to the social security system by reducing the tax shelter of this earmarked tax in 2012. In addition, in 2013, an increased rate of this tax was levied on those with annual earnings over €150 000 (see Chapter 3, France case-study, section on Changes to public funding for the health system, pages 46–48). However, vulnerable population groups with an income under a certain threshold are exempt from compulsory social security contributions that also cover statutory health insurance under the State’s universal medical coverage (couverture maladie universelle; CMU) scheme. Moreover, in the case of VHI to cover co-payments for public services, the State introduced public complementary insurance (couverture maladie universelle complémentaire; CMU-C) for lower-income groups, on a voluntary basis, to ensure that their access to services is not hindered by high co-payments/coinsurance. Finally, those who are at the margin of the income ceiling for CMU eligibility are helped to access VHI through the aide pour une complémentaire santé (ACS) voucher scheme financed by the CMU Fund. From 2011 to 2013, eligibility for these programmes has been expanded (see Chapter 3, France case-study, section on Changes to coverage, page 48).

In the Netherlands, in 2013, the income ceiling for income-dependent social health insurance contributions paid by employers was increased from €33 427 to €50 853 per year and the contribution cap was increased accordingly from €2591 to €3941 (the contribution rate is 7.75%). This is aligned with the policy direction towards ensuring equity in health financing across income levels (see Chapter 4, Netherlands case-study, section on Shifting costs from public to private sources, pages 48 and 49).

Looking at the experience of the Republic of Korea in this area in relation to the economic crisis, in 2009 the government decided to freeze the NHI contribution rate for 2010. As a result, the NHIS recorded a deficit of more than KRW 1299 billion (€847 million) for 2010, which was equivalent to 3.8% of total NHIS health care expenditure (see Table 5.2).

In addition, in 2012, the MoH took action to broaden the revenue base for NHI contributions from the employed to mobilize more resources. Under the existing arrangements, employees paid their contributions based only on their salaries or wages (payroll), whereas the self-employed paid contributions based on a wider income base, including property and the number of people in their household. Thus, an equity issue arose over the level of contributions of employees who owned a lot of property and other financial assets. This issue had been a prolonged one and attracted a great deal of public attention, particularly from the self-employed. In response, the government took the decision to broaden the basis of assessment and include other income deriving from property, such as rental income and capital gain if these additional incomes exceed a certain level when calculating the contribution rate for employees. Although the increase in revenue from this measure is not sizable, estimated to account for less than 0.1% of total NHI contribution revenue in 2011 (MoH, 2012a), this measure has been perceived by the public as improving equity in NHI contributions to some extent.

As an extension to this policy measure, focus has now turned to how NHI contribution calculations affect retired older citizens. Currently, for the purposes of calculating contributions, retired people belong to the same group as the the self-employed and thus their income, as well as any property and other revenue,
are taken into account. This method is likely to impose a greater financial burden on the retired as they have no regular income from employment but often own their own homes and perhaps other assets. Therefore, it is worth exploring whether the NHI contribution scheme could be redesigned to treat older citizens as a separate category from the self-employed and to differentiate the mix of income sources that apply to both groups to calculate their respective contributions.

Having said that, given the demands for equitable treatment by the different groups (employees, the self-employed and the retired), this equity issue may need to be addressed definitively, in the longer term, by imposing a uniform contribution scheme applicable to everyone, based on earned income; for any solution to be successfully implemented by the NHIS, a well-established data infrastructure on income reporting would need to be developed and accompanied by adequate investigation capacities by the tax authorities.

Overall, the Republic of Korea has a relatively low NHI contribution rate for employees, at 5.99%, in comparison to 7.75% in the Netherlands and 8% in France. In relation to this, the Republic of Korea has a low share of public spending on health (53%) compared to the OECD average (72.2%) along with high levels of OOPs (35.2%) compared to the OECD average of 19.4% (OECD, 2013b). Considering this financial structure, increasing the NHI contribution rate should be considered. However, since ensuring equity is an important policy aspect in health financing, some protection measures for low-income groups also need to be considered. Reflecting this point, it is worthwhile examining in greater detail the case-study on France, where selective contribution increases for high-income brackets were implemented and the Netherlands case-study where premiums for children under 18 are paid by the government along with the establishment of a public fund to ensure health care access for vulnerable groups.

**New or increased taxes on unhealthy products**

The health financing scheme, which is heavily reliant on wages, is vulnerable to fluctuations in the economy, with economic downturns resulting in less revenue. In addition, an increase in the NHI contribution rate is likely to make the labour market less competitive. Thus, introducing new taxes or increasing existing tax on unhealthy food or products is often used as an alternative financing method to secure resources for health care while lessening the burden on the labour market.

France has taken diverse measures in this area. An increase of the share of tobacco tax revenues earmarked for health care was enacted in 2007, leading to a 98.76% increase in 2009. Moreover, in 2013 a new tax on beer was introduced, generating an expected €480 million; and since 2012, a new tax of €0.04 per litre has been levied on sugary soft drinks. These taxes earmarked for health care (as well as taxes on pharmaceutical companies’ turnover) account for around 13% of total revenue for health care (see Chapter 3, France case-study, section on the *Health care financing system in France* on pages 40–42, and section on *Changes to public funding for the health system* on pages 46–48). In Belgium, the share of value added tax and tobacco tax revenue earmarked for social security has increased since 2008, and collectively accounted for almost 9.4% of the health care budget in 2012 (see Chapter 2, Belgium case-study, section on *Health Budget*, pages 12–15).

In the Republic of Korea, tobacco is the only unhealthy product on which tax is levied. A tobacco tax earmarked for health care was introduced in 1997: the tax was KRW 2 per pack of cigarettes in 1997, jumping significantly to KRW 150 in 2002 and again to KRW 354 in 2005 (though it has not increased since). This is the main resource for the Health Promotion Fund (HPF). Although 60% of the HPF’s annual revenue is transferred to the NHIS in the form of a government subsidy, this only covers 3% of total NHIS revenue because of the small size of the HPF. Moreover, in the Republic of Korea the funding share from alternative sources for health financing is very low in comparison to Belgium and France.

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7 In France, capital gains tax revenue, which is earmarked for health care, also increased from 12.3 to 13.5% in 2011.
With regard to tobacco consumption of the population over 19, the trend has been decreasing over the past few years from 35.1% in 1998 to 27.0% in 2011 (MOHW & KCDC, 2011). During this period, the considerable drop was associated with increased tobacco surcharges (KERI, 2007). Nevertheless, the smoking rate for men over 15 is 40.8%, which is the highest rate among OECD countries (OECD, 2012). This high rate can be partially attributed to the relatively lower tax rates on tobacco in comparison to other countries (WHO, 2011). Thus, increasing the tax on tobacco should be considered as a measure to help not only reduce smoking rates, but also to contribute to increases in public revenue for health.

In addition to the low rate, the taxing mechanism underlying the tobacco tax should be re-examined. The current mechanism levies a fixed amount on tobacco (currently KRW 354 (€0.28) per pack), not a percentage of its price. With this taxing mechanism, it is hard to keep track with inflation and maintain real income without regular amendment to the tobacco tax regulation. Thus, modification of the taxation formula to a percentage of the cigarette pack price will contribute to generating revenue while minimizing the need to amend the regulation (which may also mitigate opposition from interest groups).

In addition to tobacco, taxes on sugary food and alcohol, which also cause health problems, should be considered. Like other public health taxes, these taxes can function as a means to change people’s behaviour towards healthier lifestyles and also as a means to generate more public resources for health care. These two objectives cannot be achieved together, however, in the sense that if people reduce their consumption of taxed unhealthy products or even stop consuming them altogether, eventually less or no revenue will be generated. When it comes to an alcohol tax, there has been a fierce debate in the Republic of Korea over the possible introduction of a tax on ‘soju’. The main thread of the debate is that because soju is one of the population’s favourite drinks, imposing a tax on this alcoholic product would lead to a greater financial burden on the poor, worsening tax equity and making the tax system more regressive. Although policies such as these cannot be put into place without taking into account the specific country context, imposing a tax on alcohol should be reconsidered in light of its potential impact on health promotion.

**Raise government transfers to health care**

It is common in many countries with contribution-based social health insurance schemes that a considerable amount of general tax revenue goes into the social health insurance fund. Generally speaking, general tax captures more diverse sources of revenue and it is likely to be more progressive than social health insurance contributions. Thus, putting more general tax revenue into resources for health helps to improve equity in health financing while increasing available funds.

In the Netherlands, the government provides tax transfers by subsidizing vulnerable people, including older people and children. The nominal SHI premium for children under the age of 18 is paid by the government. For people with low incomes, a so-called health care allowance, which is funded from general tax has supported them to ensure access to basic health insurance since 2006. In 2013, 6 out of 10 households received a health care allowance. In addition, the government also protects people with chronic diseases from the compulsory deductible set at €350 per year (in 2013) by providing a health allowance of €99 (see Chapter 4, Netherlands case-study, section on the Basic health insurance scheme, pages 64 and 65).

In Belgium, a government subsidy from general taxes closes the gap between the revenue obtained from the social security contribution and the fixed total health budget. In 2012, about 82.2% of the total health care budget was covered by social security contributions, while taxes on tobacco accounted for 9.4%. The remainder of the health care budget comes from other fiscal transfers, for example, taxes on pharmaceutical products and transfers from general taxes (see Chapter 2, Belgium case-study, section on Financing, pages 6 and 7).

**5. Policy recommendation for Korea: based on the experiences of three countries (Belgium, France and the Netherlands)**

In addition to tobacco, taxes on sugary food and alcohol, which also cause health problems, should be considered. Like other public health taxes, these taxes can function as a means to change people’s behaviour towards healthier lifestyles and also as a means to generate more public resources for health care. These two objectives cannot be achieved together, however, in the sense that if people reduce their consumption of taxed unhealthy products or even stop consuming them altogether, eventually less or no revenue will be generated. When it comes to an alcohol tax, there has been a fierce debate in the Republic of Korea over the possible introduction of a tax on ‘soju’. The main thread of the debate is that because soju is one of the population’s favourite drinks, imposing a tax on this alcoholic product would lead to a greater financial burden on the poor, worsening tax equity and making the tax system more regressive. Although policies such as these cannot be put into place without taking into account the specific country context, imposing a tax on alcohol should be reconsidered in light of its potential impact on health promotion.
In the Republic of Korea, the NHI receives a government subsidy through general tax revenue. When the government subsidy was introduced in 1988, when coverage was extended to the self-employed, it was mainly conceived of as providing 50% of the health care cost incurred by the self-employed. At the time, it was considered to be equivalent to the 50% share that employers contribute to the NHI for their employees; therefore, the government transfer was only provided on behalf of the self-employed. However, as time went by, the share of the government subsidy as a percentage of total NHI costs decreased because the health care costs of the self-employed increased faster than the government subsidy. After the health insurance fund integration reform in 2000, the NHI system experienced a financial crisis. To meet this crisis, special legislation on NHI financing was enacted in 2002, with an explicit provision on the level of the government subsidy to secure greater predictability of NHI revenue derived from the State. With the NHI Act (passed in 2002), NHIS receives 14% as a share of total projected NHI contribution revenue from general tax revenue. Another 6% comes from the HFP Fund.

Since the appropriate level of government subsidy should be determined in the context of each country, it is hard to make a judgement on whether or not 20% is the appropriate level in the Republic of Korea. However, one can raise the policy issue as to whether the government subsidy meets financial sustainability objectives and whether it helps to improve equity in health financing. From this perspective, the current formula used to derive the government subsidy, which is linked to NHI revenue, has no countercyclical function. In other words, when the economy experiences a downturn, both NHI contributions and government subsidy decrease, resulting in a widening of the gap between NHI revenue and expenditure. In particular, this will be more problematic in the longer term, when the proportion of the older population grows. In addition, as the government subsidy is pooled within the NHI Fund with other NHI revenues, there is no specific mechanism to target and support vulnerable groups (Youngsoo, 2011). Thus, it is recommended that policy consideration be given to developing a better formula to determine the government NHI subsidy to serve diverse purposes, such as health financing (including equity), counterbalancing functions and long-term sustainability, which can be achieved mainly through general tax revenue.

**Automatic safety mechanism**

It is very difficult to predict economic crises. Furthermore, there is a time lag between periods of financial crisis and the impact of policies taken in response to such crises. In this context, an automatic mechanism to secure health care funding is a critical means of preparing for the changing economic environment. In particular, countercyclical financing is worth considering.

Among the three European countries studied in this report, Belgium has a reserve fund (Fund for the Future), but was not able to transfer social health insurance money to this fund in 2011 due to financial constraints. Lithuania and Estonia (not included in this report) also have well-known reserve funds designed to reduce fluctuations in annual social health insurance revenue. Looking at the case of Lithuania, the country’s health insurance fund is required to accumulate reserves to cover expenditure if annual revenues decline. In addition, transfers from the State are made to cover the economically inactive and unemployed, and since 2007, the basis for calculating the State budget contribution for the unemployed has changed to the gross average salary during the preceding two years, which reflects the wages of the economically active population during that period. These adjustment mechanisms provide a highly effective countercyclical mechanism to avoid sudden drops in health insurance revenue (Jowett, Thomson & Evetovits, in press).

Within the Republic of Korea’s NHI scheme, a legal provision (NHI Act, Article 38) states that the NHIS has to reserve an amount that is equivalent to 5% of total annual NHI costs until the reserve reaches at least 50% of total annual costs. However, this regulation on creating a reserve has never been enforced. The main question is whether the target of 50% of total health care cost for the reserve fund is an appropriate level and moreover whether this high target can be enforced in practice. Given the importance of having an automatic stabilizing mechanism, revising the NHI reserve fund legislation, along with better enforcement, need to be addressed.
Policy options to reduce health spending

Streamline the benefit package

Generally speaking, changes to benefit package, particularly reductions to services coverage, are a relatively easy way to generate savings. Notably, the three European countries analysed in this report did not rely heavily on reducing population coverage to make savings in health care funding. Rather, policy decisions aimed to streamline service coverage. Given that such policies can be implemented in different ways, it is necessary to assess them by focusing on policy design and implementation mechanisms.

In France, some drugs with low therapeutic value were delisted from the drug reimbursement list in 2010 and 2011, based on effectiveness criteria. In contrast, some services (abortion and contraception for girls aged 15–18) have been fully covered since 31 March 2013, leading to an increase in overall costs (see Chapter 3, France case-study, section on Changes to coverage, pages 48 and 49).

In Belgium, the entire population has been covered for the same health services since 2008. This was accomplished by expanding the benefit package for the self-employed and their dependents to include small health risks, such as ambulatory care, pharmaceuticals for outpatient care, home care and dental care. Although this decision had already been made before the start of the crisis, it is notable that it was implemented during the crisis. In Belgium, no measures were taken to exclude or reduce services covered by compulsory health insurance; the only exception was a health technology assessment (HTA)-determined reduction to certain eligibility conditions for reimbursement of oxygen therapy (see Chapter 2, Belgium case-study, section on Coverage of services, page 18).

In the Netherlands, several changes to the benefit package with regard to treatments and pharmaceuticals have been implemented since 2007. Dental care for people aged 18–21 was included in 2008 but removed in 2011. Dietary advice was very limited in 2012 and extended in 2013 (with restricted conditions) due to research that revealed that abolishing dietary advice would lead to higher use of services in secondary care (see Chapter 4, Netherlands case-study, section on Shifting costs from public to private sources, pages 73–78).

Across the three countries, the principle behind these responses is that policy decisions are made based on evidence. If a particular treatment or drug was not cost–effective or not medically necessary, they were removed from coverage and vice versa.

In the Republic of Korea, before the crisis, the Pharmaceutical Review Plan (2007–2011) for listed drugs reimbursed under the NHI was established to reduce pharmaceutical spending and improve resource efficiency. Between 2001 and 2005, pharmaceutical costs took up around 29% of the total NHI expenditure and its average growth rate was around 14% during this period (MOHW, 2006). Given the restrictive financial conditions of the time, the government needed to implement a plan to control this sizable cost.

In the implementation of the pharmaceutical review, the prices of more than 3,500 drugs were reduced and around 500 drugs were de-listed, leading to a reduction in pharmaceutical expenditure (MOHW, 2012a). These decisions were based on economic evaluation, including cost-effective technical assessments. However, some issues raised by providers have put obstacles in the way of realising the full impact of the review plan. First of all, there were many disagreements from provider regarding the evaluation criteria and methods used. In addition, due to opposition from pharmaceutical companies, price reductions have been carried out gradually over three years, in order to minimize the impact on the pharmaceutical market. As a result, despite of small drop in pharmaceutical expenditure, its share as a proportion of NHI expenditure remained high, at about 27% in 2012, while its share of THE is 20.2%, relatively high in comparison to the OECD average of 16.4% in 2012 (OECD, 2013).
Other than pharmaceuticals, there was no decision to reduce or limit medical treatments listed in the NHI benefit package. Partly, this is because there is no periodic review system equipped with a mechanism to determine the cost–effectiveness of services provided under the NHI scheme. As services that are covered under the NHI have not been reviewed, so far, on a regular basis, it is realistic to assume that some services may be outdated and should be excluded following an economic assessment process. For the longer term, it is worth considering the introduction of a periodic review system to streamline the NHI benefit package. The case of the Netherlands, where new treatments are introduced into the benefit package and obsolete treatments are removed, is worth examining further (see Chapter 4, Netherlands case-study, section Service coverage (benefits package), pages 73–75). However, some related prerequisite work, such as developing clinical pathways and evidence-based analysis of services, needs to be addressed in advance to design implementation arrangements for a review system.

**Refine user charges**

Adjusting user charges is another way to make savings on public health expenditure. However, a user charge policy should be carefully shaped given that such OOP payments can easily restrict patients’ access to services.

Looking at the Netherlands case-study, a number of measures have been taken to shift costs from public to private sources by increasing patient co-payments. The compulsory deductible has increased every year from €150 in 2008 to €350 in 2013. The extent of cost-sharing for mental health care has also changed almost every year since 2007. However, at the same time, some protection measures were implemented to protect vulnerable population groups from the increased financial burden of user charges. For example, GP care, maternity care and children services were excluded from the compulsory deductible. Also, in 2012, the care allowance was adjusted so that lower-income groups were protected more than higher-income groups (see Chapter 4, Netherlands case-study, section on the Basic health insurance scheme, pages 64 and 65).

In France, overall, user charges have increased since 2004. The purpose of the 2004 reform was to improve coordination of care and raise patients’ awareness of their health care consumption. For this purpose, a coordinated care pathway was implemented, with higher coinsurance for patients who consume services off the pathway. In 2009, the penalty (coinsurance) for patients not following an agreed medical pathway was increased from 40 to 70%. With regard to the delisting of certain drugs (see Chapter 3, France case-study, section on User charges, pages 48 and 49), coinsurance rates for certain less effective drugs increased from 65 to 70% in 2010 (see Chapter 3, France case-study: section on the Health care financing system in France on pages 40–42, and section on Changes to coverage on pages 48 and 49).

The policy responses put in place in Belgium were a little different from the other two countries and aimed more at minimizing financial barriers to access to services, particularly targeted at vulnerable lower-income groups and chronic disease patients. Certain designated groups (for example, the long-term unemployed) or those with a household income below a certain threshold, are entitled to increased reimbursement. People eligible for increased reimbursement can also be eligible for lower co-payments for some drugs, specialist medical services and GP services. In addition, since 2002, a maximum billing system imposes a ceiling on the total amount of co-payments that are payable, set as a proportion of the total net taxable household income (this varies from 2.4 to 3.9%). Lastly, since 2013, chronically ill patients face a lower maximum billing ceiling and are entitled to third-party payment arrangements (see Chapter 2, Belgium case-study, section on Maximum billing, page 20).8

8 In contrast to a direct payment system where patients pay all the costs upfront and obtain reimbursement from the insurer later, the third-party payment system allows patients to pay only the coinsurance rate and the rest of the cost is paid directly by the insurer (see Chapter 2, Belgium case-study, section on Payment mechanisms, page 8). This payment system was only applied to inpatient and pharmaceutical care and was later extended to ambulatory care for some vulnerable groups in July 2011.
When it comes to the context of the Republic of Korea, the OOP level in 2011 was 35.2% of total health expenditure (MOHW, 2013a), which is very high by international comparison. Of these OOPs, co-payments for covered services represent approximately 64%, while the remaining 36% comes from full payment for services not covered by the NHI (NHIS, 2011). Thus, given the already high level of OOPs, in principle, increasing user charges cannot be regarded as a good option.

However, in 2011, the co-payment for pharmaceuticals was raised selectively. Patients with minor or chronic diseases that can be treated in primary care settings have to pay a higher co-payment for medicines when they use services in a higher setting (such as secondary care). The MoH has specified 52 diseases where these higher co-payments apply. In general, the co-payment for drugs for a patient is 30% across all settings. However, if the disease falls into the higher co-payment category, the co-payment for medicines is differentiated by health facility level: 30% for primary care, 40% for hospitals and 50% for tertiary hospitals. The rationale behind this policy is that these types of diseases can be treated more efficiently within the primary care setting with fewer resources (MOHW, 2011a). This policy is similar to the French experience of imposing higher co-payments on pharmaceuticals for patients who do not follow the agreed clinical pathway. As these policies have been implemented only for a short time in the Republic of Korea, it is too early to make a judgement on their impact on the quality of CDM and on health care costs. According to the NHIS internal monitoring data, although some side effects, such as distortions in disease coding, have been found, the number of visits by patients with diseases in the higher co-payment category declined by 45.5% at tertiary hospitals and by 22.4% at other hospitals in 2012, compared to 2011 (NHIS, 2013b). Reflecting this result, selective application of higher co-payments, based on effectiveness criteria, can be considered for certain areas.

Facilitate the role of private health insurance

On a voluntary basis, PHI can play a role in relieving financial pressure on the public budget by protecting people from user charges and OOPs. However, in practice, it has not been a useful policy tool in an economic crisis based on the experience of European countries (Thomson et al., 2014). France was the only country to try to promote PHI by providing vulnerable groups (the very poor) with free access to PHI. Moreover, the scope of the population entitled to the CMU-C and the ACS voucher scheme to give the poor greater access to PHI has been extended. Currently, in France, PHI covers 88% of the population and accounts for 13% of all health care expenditure, which is a larger share than other European countries (Thomson, Foubister & Mossilaos, 2009). In general, PHI in France provides reimbursement for co-payments and better coverage for medical goods and services that are poorly covered under the benefits package. However, some deductibles (for doctor’s visits, and certain drugs and procedures) that were introduced as part of the 2004 reform, are not to be covered by PHI. The rationale behind this was to link the role of PHI with the purpose of the reform, i.e. to raise patients’ awareness of their health care consumption. If PHI providers do not comply with the restrictions, a double premium has to be charged as a financial penalty (see Chapter 3, France case-study, section on the Health care financing system in France on pages 40–42, and the section on Changes to coverage, pages 48 and 49).

In the case of the Republic of Korea, more than 77% of households purchased at least one PHI policy in 2009 (KIHSA, 2011a). Like France, PHI covers services that are poorly covered or not covered by the public scheme and also reimburses patient co-payments for publicly covering the services. The high population coverage rate for PHI is mainly attributable to the high level of OOPs, approximately 35%, which result from co-payments for covered services and full payment of the costs for services that are not covered by

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9 According to an analysis of NHIS expenditure in 2009, NHI fully covered 64% of total health care cost while 36% was paid by patients.

10 This policy measure was part of the policy package to facilitate the role of primary care. Under this co-payment schedule, patients are inclined to visit a primary care physician rather than a higher-level care setting as long as it has the same quality of services (see the section on how to Strengthen pharmaceutical policy on pages 108–111).
NHI. There has always been debate in the Republic of Korea over the role of PHI in health care financing. However, regardless of the pros and cons of the role of PHI, its growth has been remarkable in terms of paying for health care over the past decade, rising from US$ 345 million in 2000 to US$ 4122 million in 2009 (Shin, 2012). In this context, it is necessary to identify how to balance the respective roles of PHI and NHI in promoting financial sustainability of the health care financing system. Unlike the NHI, which pays providers directly for the services used by patients, PHI reimburses claims directly to the insured. Under this reimbursement structure, PHI reimbursement goes to patients in the form of an income subsidy. Consequently, one of the controversial concerns is whether PHI has an impact on service use of public NHI services because in theory, people with PHI are likely to increase demand for health care services due to the reduced financial burden of co-payments stemming from the income support received from PHI. However, there has not been much policy discussion or research on this topic.

A recent study has revealed that patients with PHI use more outpatient services (due to the fact that they are reimbursed for this expenditure), and consequently increase NHI expenditure (Jeon & Kwon, 2013). The thrust of this study implies that some policy intervention to balance the roles of NHI and PHI needs to occur, such as designating a clear definition of the coverage boundary between the two schemes. When it comes to designing the function of PHI, it is worth reviewing the French example where some services cannot be covered by PHI to ensure that patients remain aware of health care costs.

Policy options to manage health care costs efficiently

Strengthen pharmaceutical policy

Containing spending on pharmaceuticals has long been an important policy area in the European region. Around 30 countries in the European region have made policy changes in the pharmaceutical sector during the financial crisis, aiming to either reduce pharmaceutical prices or promote the greater use of generic drugs, or both (Thomson et al., 2014).

Focusing on the three European countries in this report, Belgium took a wide variety of measures to control the cost of pharmaceuticals. First of all, Belgium has made changes to prices and the pricing system over the past 15 years. In 2001, a reference price for drugs was introduced with the pricing mechanism based on a simple linear reduction (percentage) in the original ex-factory price of a brand drug, fixed at 16%. Since 2011, the price reduction on drugs increased to 31%, with additional reductions associated with the length of time that a drug has been listed. In 2012, drugs in category A (which incur no co-payment) attracted a reduction of 41%, rather than 31%, with further increases in the price cut linked to the number of years that they have been listed (7% further cut rather than 5%). In addition, a 1.95% price cut on all drugs came into force in 2012 (with a few exceptions) and resulted in more than 2500 drugs having their prices reduced in 2013.

With regard to supply-side mechanisms, in Belgium, since 2012, pharmacists must dispense a drug which is among the group of cheapest drugs in the same category for every prescription that is issued by the international non-proprietary name (INN). Moreover, while physicians are not required to prescribe drugs by their INN, they are incentivized to do so by being subject to quotas, first introduced in 2005, whereby GPs and other medical specialists are required to prescribe a minimum percentage of low-cost drugs, including drugs prescribed by INN. In addition, since 2012 pharmaceutical companies are required to submit the ex-factory prices of drugs under patent on the Belgian market, for six European Union countries, to facilitate price comparisons; price cuts are implemented in Belgium if significant reductions have also occurred in the other countries. Pharmaceutical companies also pay an additional tax on the

11 The INN identifies the pharmaceutical substance or active pharmaceutical ingredients. Each INN is a unique name that is globally recognized and is public property. A non-proprietary name is also known as a generic name. The INN system was established in 1953; currently, the cumulative list of INNs stands at 7000 names. (For further information and guidance on the INN system, see the appropriate World Health Organization web pages: http://www.who.int/medicines/services/inn/inn guidance/en/, accessed 20 November 2014.)
5. Policy recommendation for Korea: based on the experiences of three countries (Belgium, France and the Netherlands)

turnover of reimbursed pharmaceuticals from 1% in 2010 to 0.13% in 2013, which was implemented in response to the economic crisis (see Chapter 2, Belgium case-study, section on the Policies to make drug prescribing, use and pricing more rational, on pages 22 and 23).

The Netherlands has had a preferred pharmaceuticals policy since 2005, which is mentioned in the case-study as its most successful cost containing measure. This policy allows health insurers to identify a preferred pharmaceutical for the most often used substances and to reimburse them at almost the cheapest price (mostly similar to the price of equivalent generic drugs). In other words, if a patient chooses a non-preferred medicine, they do not get reimbursed by the insurer for the extra cost of that drug compared to the preferred drug. As a result of this policy, considerable cost savings have been realized, estimated at €389 million in 2008. The preferred pharmaceuticals system was extended to include more generic drugs in 2009. In addition, since 2010, dispensing pharmacists only receive a predefined fee for each service rather than a percentage of the drug price (see Chapter 4, Netherlands case-study, section on Cost control, pages 67–70).

In France, under the 2013 Social Security Financing Law, price cuts on drugs, together with price cuts on medical supplies, were implemented to make savings of €1 billion. To control pharmaceutical costs on the delivery side, two measures were put in place: first, to encourage the dispensing of cheaper drug alternatives, pharmacists’ remuneration was made independent of sales volume in 2011; second, pay-for-performance (P4P) components, incentivizing increases in generic usage were included within the payment scheme for physicians in 2012 (see Chapter 3, France case-study, section on Changes to purchasing and delivery, pages 49–51).

In Republic of Korea, both the sizable proportion and the rapid increase of pharmaceutical costs have long been one of the challenges of health expenditure control. From 2001 to 2010, the average annual rate of increase was 13.2%. In 2010, pharmaceutical expenditure took up 29.3% of NHI’s total expenditure and accounted for up to 22.5% of total health expenditure. In 2011, this figure was 20.2%, higher than the OECD average of 16.4% (OECD, 2013a). This high level of pharmaceutical costs was mainly driven by growth in the number of patients with chronic diseases, more usage of drugs than in other countries and a higher proportion of expensive original drugs. Moreover, a comparative study on generic drugs highlighted that in the Republic of Korea higher generic drug prices is one of the factors pushing up pharmaceutical costs, and that in the Republic of Korea has the highest prices among 16 countries (Soonman, 2010).

In recognition of the need to control pharmaceutical costs, the government of the Republic of Korea has developed and implemented diverse policy measures since 2006. First, the five-year Pharmaceutical Review Plan (2007–2011) was initiated before the onset of the financial crisis (see the section on how to Streamline the benefit package on pages 105 and 106). Moreover, in 2006, the NHI drug registration system was changed from a negative list system to a positive list system. In contrast to a negative list, where all drugs approved by the Ministry of Food and Drug Safety (MFDS, formerly the Korea Food and Drug Safety) can be listed in the NHI benefit package (unless they are specifically put on the negative list), a positive list requires a set of processes for drugs to be covered by the NHI, including an assessment process based on cost-effectiveness and a price negotiation process with the NHIS (MOHW, 2006). Since 2006, the average annual increase in pharmaceutical costs has decelerated to 9%, but it is still high.

12 The average number of drugs prescribed per prescription varied from 3.2 (for tertiary hospitals) to 4.2 (for primary care) in Korea, while 69% of prescriptions in the USA contain only one or two drugs (National Ambulatory Medical Care Survey in 2005).
13 The 16 countries included are: Australia, Austria, Belgium, England, France, Germany, Italy, Japan, Korea, the Netherlands, Norway, Spain, Sweden, Switzerland, Taiwan, and the USA.
In 2011, the government of the Republic of Korea decided to change the pricing mechanism for generic drugs covered by the NHI scheme. Previously, the price of generic drugs was determined based on their listing date in the NHI benefit package, meaning that earlier listed medications would be assigned higher prices. The price varied from 68 to 80% of the price of the original branded drug. Thus, not surprisingly, pharmaceutical companies competed with each other to get their drug listed as soon as possible, rather than concentrating on improving the quality of medicines, resulting in decreased competitiveness in the pharmaceutical market. In addition, there was widespread public recognition that drugs were overpriced.

According to the new generic pricing system introduced in 2011, only one price – 53.55% of the price of the original brand – is given to all generic drugs regardless of when they are listed; orphan drugs and some essential medicines are exempt from this pricing system. In addition, there are several policy measures, such as special tax treatment for research and development of new drugs, to facilitate investment in the pharmaceutical market, aiming to enhance market competitiveness (MOHW, 2011c). Owing to the introduction of the new pricing system for generic drugs, pharmaceutical expenditure went down by KRW 448 900 million (€310 million) in 2012, recording a negative growth rate for the first time since 2000 (HIRA, 2013). Accordingly, pharmaceuticals’ share of total NHI expenditure went down to 26.45% in 2012, from 28.53% in the previous year (MOHW, 2013b). As shown by these data, the magnitude of the price cut was tremendous, and it was not surprising that the government faced huge resistance from pharmaceutical companies.

In contrast to the more severe approach of price cuts, other policy tools with embedded incentive schemes have also been tried to reduce pharmaceutical expenditure. In 2010, a policy was introduced whereby if health facilities purchased drugs at a lower price than the listed (reimbursement) price (due to successful negotiations with the pharmaceutical company) and reported the purchase price to the NHI, they would receive a monetary incentive (bonus) equal to a certain proportion of the gap (70% maximum) between the listed price and the purchase price (called the lower price purchasing incentive). The following year, the price of the medication would go down to reflect the previous year’s purchasing price and the purchased volume. A second incentive tool was aimed at prescribers: if primary care physicians reduce pharmaceutical costs by prescribing fewer and lower-cost drugs to patients, they will receive a bonus of between 10 and 50% of the reduced pharmaceutical cost paid by the NHI (called the outpatient prescription incentive). In addition, if individual primary care physicians maintain pharmaceutical costs consistently at a certain level over a period of more than 1.5 years, they can obtain an exemption from the NHI on-site regulatory visits for one year (‘green clinics’ non-monetary incentive) (MOHW, 2013c).

In theory, policies containing monetary incentives would work for health providers when the incentives gained from following the policy are greater than the expected gain from not following it. In this sense, the impact on pharmaceutical expenditure of the incentive polices outlined previously has not been positive due to the fact that the commissions physicians receive from pharmaceutical companies that are linked to the prescription of expensive drugs are greater than the incentives provided by the NHI. Furthermore, the current brand-based prescription system restricts the role of pharmacists in substituting cheaper drugs, resulting in a much more limited usage of generic drugs. This policy environment is very different from the other countries examined in this report where drugs are prescribed by INN, which makes it easier to design policies to shift to more generic drugs.

Another point to consider is that, according to a policymaker in the MoH, the focus of pharmaceutical policy measures taken over the past decade has been mainly on price control while volume control has

14 The price cut associated with the lower purchasing price was supposed to have been implemented in 2011, but did not go ahead due to the other policy discussions that were taking place on the very large price cuts that were to be implemented in 2012. Given this, pharmaceutical companies successfully pushed for a suspension of the Lower Price Purchasing Incentive to minimize the impact on their revenue. The Lower Price Purchasing Incentive was resumed in February of 2014.
been neglected. However, given that the number of drugs prescribed per prescription is higher in the Republic of Korea than in other countries, it is necessary to develop policies that focus on the control of volume and mix (for example, branded versus generic).

Changes to provider payment

This section looks at the policies taken to reduce the reimbursement of providers, including cuts in the prices of medical goods and services. Needless to say, this is a more direct way to generate savings. However, payment reductions can have different impacts on the efficiency of health spending depending on the way they are designed.

In the Netherlands, a rapid increase in GPs’ remuneration, which has caused budget overruns since 2006, led to a decision to freeze their fees for two consecutive years (2007 and 2008), and the freeze continued until 2009. In 2010, the budget for GP capitation fees was reduced, but GPs were allowed to compensate for this by taking part in incentive schemes to prescribe drugs more efficiently. In 2012, following an agreement between the MoH and the National Association of GPs on a more enhanced role for GPs in the provision of care in the community, the total expenditure for GPs was allowed to grow by 2.5% annually from 2014 to 2017.

In the area of specialist care, even greater budget overruns than those for GPs were recorded; consequently, the budget for medical specialists’ tariffs was cut in 2009 as well. After continuous tariff cuts, the MoH, the Association of Medical Specialists and the National Hospital Association eventually reached an agreement which resulted in a budget cap for specialists with an annual growth rate of 2.5% until 2015.

Beyond the changes in individual practice areas, changes were also made in the Netherlands to control overall health care costs. As overspending has been a long-standing problem, not only in primary but also in specialized care, in 2008, a pay-back system was introduced that requires health care providers to pay back any amount overspent over the agreed (contractual) level in the next year. This pay-back system is operationalized via tariff measures in which the Ministry of Health sets a national savings amount for the specific group of health care providers so that they pay back the overspending from the previous year. In addition, in the agreement signed in 2013 between health care providers, insurers, patient associations and the MoH, all stakeholders have committed to further decreasing the total health expenditure growth rate to 1.5% in 2014 and 1% from 2015 to 2017. This decrease is to be made by shifting care to lower levels and by continuing to make prescriptions more cost-efficient. Moreover, closer monitoring of public expenditure was agreed and reimbursement for services can be put on hold if expenditure exceeds the agreed growth rates. Notably, a growth rate of 2.5% for GP services until 2017 (already agreed in 2012) will be maintained given the importance of the role of GPs in managing referrals to hospital care (see Chapter 4, Netherlands case-study: section on Shifting costs from public to private sources on pages 73–78).

In Belgium, GPs experienced changes in payment arrangements. Within the payment system, which is mainly based on FFS, the share of lump sum payments (which are paid for GPs to manage global medical files (disease management programme (DMP) for patients with chronic diseases) and for being on call increased from 2.6% in 2000 to 20% in 2010. The purpose of this policy is to reinforce the role of GPs in the treatment and follow-up of chronically ill patients. For hospital payment, stricter compliance came into force, with a claw-back system in place since 2002, whereby a reference amount is set for standard interventions in inpatient settings. If hospital expenditures go over the set amount, the hospital has to pay back the difference to the National Institute for Health and Disability Insurance. In terms of growth caps on annual health budgets, these were set at 4.5% from 2005 to 2012, which was a generous level, and absorbed the impact of tighter fiscal measures during these years.

According to research conducted by HIRA in 2005 comparing the number of drugs prescribed per prescription for children under 18 years, Korea had 4.56, much higher than other countries such as Australia (1.31), the USA (1.64) and Japan (2.02).
years (see Chapter 2, Belgium case-study, sections on: the Health care budget, pages 12–15; Cost coverage, page 18; and Provider payment reforms, pages 23 and 24).

To meet EU fiscal targets, the French government reduced the 2014 health budget by €2.4 billion, focusing on the areas of ambulatory care (€1.75 billion) and hospital care (€0.65 billion). These reductions were to be achieved by cutting the prices of drugs and medical devices and by eliminating inappropriate and unnecessary care. As a means to using resources better, P4P for GPs was introduced in an agreement between the social health insurance and GPs in 2012. Pay-for-performance was also included in the social health insurance agreement with cardiologists in 2012. Fee-for-service rates for radiologists and pathologists were decreased for three years (2011–2013) and official tariffs for laboratory and other diagnostic tests were also reduced (see Chapter 3, France case-study, section on Changes to purchasing and delivery on pages 49–51).

In response to the financial pressure, the government of the Republic of Korea cut fees for computed tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography diagnostic tests by 15.9, 24 and 10.7%, respectively, in 2012. The expected result was a reduction in the revenue of health specialists working in related areas, such as nuclear medicine. However, in the Republic of Korea’s provider payment system, where there is no strict control mechanism for the volume of services; theoretically, it is possible to increase the number of tests to compensate for price cuts. However, due to a lack of analysis or evaluation of the impact of the reduction of fees so far, it is difficult to make a judgement on how well this policy meets its objectives.

With regard to policy tools to control health expenditure at the macro level, none exists in the Republic of Korea. The NHI scheme’s provider payment system is heavily based on the FFS payment system. Moreover, NHI contract arrangements with health providers only regulate the price, not the quantity of services. Looking back at policy practices over the past few years, only prices have been changed or adjusted. However, in using the FFS payment system, ironically, price cuts that are implemented to reduce health system input costs might induce increases in the volume of services, motivated by providers’ desire to maintain a similar level of revenue.

In an effort to control health care costs more efficiently, the use of activity-based payment/DRGs has long been a policy that the government has wanted to implement. While it was first discussed and tried in the early 2000s, in practice, there was not much progress, with only some providers participating on a voluntary basis. In 2012, using financial pressure as a policy momentum, mandatory DRGs came into force for clinics (including small facilities that undertake day surgery) in the first place. The system will be gradually applied to higher level health care settings, such as tertiary hospitals. However, the issue is that the current DRG system is very limited and is only applied to seven diagnostic disease groups that have relatively low variation in treatment. Although a plan has been publicly announced to expand the application of DRGs to all health care settings for the seven diagnostic disease groups, based on past experience, the government will face many implementation challenges.

Even if the DRG payment system were to be expanded as planned, it will still have only a limited influence on inpatient settings. Thus, development of a cost-containment policy tool at the macro level should be considered. In this context, the Dutch agreement arrangement which aims to control the health care expenditure at the macro level has policy relevance for the Republic of Korea. Likewise, the Belgian

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16 The price cut on the three diagnostic tests was imposed in May 2011, but was annulled by the courts following an action brought about by the Hospital Association. The government retook the policy decision, reflecting the verdict of the court, and imposed the price cuts again in 2013.

17 The revision of provider payment mechanisms, including the introduction of DRGs was part of The Vision for Health 2020 which was announced in 2011 by the Committee for the Future for Health, together with the MoH, in recognition of the health system’s structural problems. This plan is very comprehensive, covering all critical issues categorized by 10 sectors and 28 policy issues (MOHW, 2011d).
system which uses a growth cap for the health budget is worth reviewing in more depth; in particular, the aspect of the growth cap that functions as a countercyclical measure during the financial crisis should be examined (see Chapter 2, Belgium case-study, section on Priority given to the health sector, on pages 15 and 16).

**Strengthening primary care access and quality**

It cannot be stressed enough that good quality primary care can play a critical role in treating patients efficiently. Strong primary care can generate saving and improve efficiency by preventing ill health and avoiding the use of more expensive resources. This is particularly important for patients with chronic conditions. In this context, some policies were undertaken to strengthen the role of the primary care setting in the three countries studied in this report (Belgium, France and the Netherlands).

First of all, in France, more efficient spending was sought by seeking to shift care from hospital to primary and community care settings with the enforcement of the Social Security Financing Law in 2013 (see Chapter 3, France case-study, section on Changes to purchasing and delivery, pages 49–51). In addition, the P4P payment component, which was intended to strengthen the role of GPs in CDM, was introduced in 2009 and became part of the agreement with GPs in 2012. According to this agreement, GPs can receive an additional 5% of their regular income if they follow up on chronic disease patients with a range of chronic conditions (mainly hypertension and diabetes), reflecting the policy priority set by parliament (see Chapter 3, France case-study, section on Changes to purchasing and delivery: payment to providers, page 49).

In Belgium, like France, the payment of GPs has included financial incentives to reinforce their role in following up patients with chronic illnesses (mainly those with type 2 diabetes and chronic kidney failure). Moreover, the payment system for pharmacists contains a new remuneration structure (introduced in 2010) to strengthen their role in providing detailed information to patients treated for chronic diseases when dispensing their first prescription (see Chapter 2, Belgium case-study, section on Provider payment reforms, page 23).

In the Netherlands, the 2013 agreement between the MoH and GPs included a new payment system with a focus on reinforcing primary care (see Chapter 4, Netherlands case-study, section on Shifting costs from public to private sources, pages 73–78; see also section on Policy options to manage health care costs efficiently on pages 108–111). Major components include: provision of basic GP care, multidisciplinary coordination of care for chronic diseases and incentivizing innovation and improved performance (see Chapter 4, Netherlands case-study, section on Increased focus on improving efficiency and eliminating fraud, pages 81–83).

In recognition of the rapid growth in the number of chronic disease patients, the Republic of Korea also introduced a chronic DMP (mainly for type 2 diabetes and hypertension) within the NHI scheme in 2012. In fact, the NHIS provided an education programme for chronic disease patients prior to 2012. The difference represented by this new management programme is the linkage to the co-payment for a doctor’s visit and the strong engagement of primary care physicians. The program offers a 33% reduction on the co-payment (i.e. a reduced co-payment from 30 to 20% of the total cost) to patients who see a doctor in a primary care setting. General practitioners can also obtain a financial incentive if they provide regular follow-ups and care to patients. With these two components, the DMP aims to provide continuous service to chronically ill patients through the primary care setting and, simultaneously, to generate saving with more efficiency in health spending.

Along with this chronic DMP, the co-payment for pharmaceuticals for chronic disease patients was adjusted in 2011 to encourage patients to visit a primary care setting (see section on Refine user charges...
on pages 106 and 107). These two policy measures were discussed at the same time. However, as the introduction of the DMP was delayed, mainly due to delays in the policy discussions with the Korean Medical Association (on behalf of GPs), the modification of the pharmaceutical co-payment framework was put in place in advance. The MoH specified 52 diseases which can be treated within a primary care setting. Patients with one of these diseases have to pay higher co-payments for prescribed drugs if they choose to receive care at facilities located in other care settings (40% for secondary hospitals and 50% for tertiary hospitals).

Generally, under health care delivery systems where functional divisions are not clear among the different levels of health providers, it is difficult to design policies to strengthen primary care. Within this arrangement, it is normally expected that health care providers compete with each other to attract more patients. Thus, to reinforce the role of primary care, it is necessary to consider the introduction of a more fundamental policy that includes a clearer definition of the different roles of providers. Furthermore, a clear incentive scheme for the better coordination of services should be embedded in the payment scheme because effective service coordination among competing providers is not likely to happen without financial benefits derived from collaboration with other providers. In this regard, the Dutch agreement arrangement should be reviewed in detail, particularly the linkage between GPs practices and their payment to reinforce the role of GPs in coordinating services in the community.

**Cost effective investment in technologies and quality improvement**

As a means to enhance the efficiency of services, the case-studies in this report highlight a few policy measures, such as increasing investment in e-health and expanding the use of care protocols. These policies make more sense when longer-term savings are desired since they require investment in the short term.

In Belgium, the e-health digital platform, which was set up in 2008 to permit all health actors to exchange electronic data, has been developed gradually. In 2009, the federal government invested in MyCareNet to improve the monitoring of patients. Along with this investment, GPs are paid a fixed amount per year to use a software package for the global medical file (see Chapter 2, Belgium case-study, section on Provider payment reforms: general practitioners, page 18). Another policy attempting to use resources more efficiently was the development of clinical guidelines for health care providers, albeit currently limited to two diseases (see Chapter 2, Belgium case-study, section on Content and process of change, page 33).

France established a five-year hospital sector investment plan from 2008 to 2012 (called Hôpital 2012). The aim was to maintain the previous level of hospital investment to support regional planning goals, the development of information technology (IT) systems and the updating of safety standards. In 2009, in a move towards enhancing efficiency, a national agency (Agence Nationale d’Appui à la Performance) was established, with the mission to modernize management and optimize the real estate of health care facilities. In practice, pooled procurement of hospital supplies to achieve lower prices was introduced. To improve the efficiency of resources used in patient treatment, economic evaluations, as part of the HTA process, became mandatory in October 2013. In addition, the National Health Authority (Haute autorité de santé) introduced care pathways for certain chronic diseases (for example, chronic obstructive pulmonary disease, Parkinson’s disease, chronic kidney failure, chronic heart failure) in 2012 and introduced a plan to improve care coordination for older people in 2013 (see Chapter 3, France case-study, section on Changes to purchasing and delivery, pages 49–51).

Since its major health system reform in 2006, the Netherlands has attempted to achieve savings in hospital spending by empowering health insurers to advise hospitals on how to obtain lower prices in purchasing. In addition, investment in ICT connections between hospitals and GPS can be regarded as an

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18 There are four levels of health care settings in Korea: clinics, hospitals, secondary hospitals and tertiary hospitals. However, there is no clear distinction between the roles of these four levels, giving patients the freedom to choose their health provider. In other words, health care providers compete with each other to attract more patients.
efficiency-improving initiative. Furthermore, attempts to improve the quality of service are also reflected in the agreement between the government and health care providers. The agreement, signed in 2013, states that, where clinically appropriate, care should be shifted from secondary to primary care and from primary to self-care; moreover, quality of care should be improved through the application of care guidelines (Section 3.3 of The Netherland case study).

In the Republic of Korea, IT-based systems are highly used in the health care sector; examples include electronic payment systems and an e-medical claims review system within the NHI scheme. With regard to patient-centred management, the Drug Utilization Review (DUR) system was established in 2010 to improve patient safety in drug usage. This system aims to prevent misuse of drugs and is designed to provide information on appropriate dosage, non-compatibility of drugs and other necessary information to physicians and pharmacists at the prescribing and dispensing levels, respectively. Another example is the chronic DMP which was established in 2012 to support CDM (outlined under the section on how to *Strengthen pharmaceutical policy*, pages 108–111). This system was developed to implement a chronic DMP by mainly monitoring whether GPs provide chronic disease patients with regular follow-ups and whether patients periodically visit physicians as advised.

However, the Republic of Korea is little behind in terms of development and use of clinical pathways in comparison to other countries where they are commonly used. Academic activities in this area were not very vigorous until 2006. In order to facilitate related work more systematically, the Medical Guideline Information Center (KoMGI) was established in conjunction with the Academy of Medical Science. Despite the fact that clinical pathways for more than 21 diseases have been developed, their uptake, in practice, has been very limited (Kookki et al., 2010). The low use of clinical pathways is not surprising given the nature of the payment system under the NHI scheme. In other words, since physicians receive payment from the NHI for every service they provide based on FFS, there is no motivation for them to follow care pathways, which usually aim to ensure quality treatment with a minimum level of treatment.

Currently, the policy environment has become slightly more favourable to the adoption of care pathways due to the policy of introducing mandatory DRGs as a payment system in some areas of the health system: the application of DRGs makes it necessary to develop quality assurance criteria, including clinical pathways, at least for the seven disease areas subject to DRG payment. However, given that health providers are still very against the mandatory DRG policy, there will be many challenges to develop mutually agreed quality criteria and implement them.

**Conclusion: Implications for implementation**

From the experience of the three countries featured in this report (Belgium, France and the Netherlands), it is notable that the financial crisis has affected society overall, including the health care system. Therefore, many fiscal austerity measures have been implemented in the health financing area. However, as the overall direction of health policy has mainly aimed to increase the long-term sustainability of the health financing system, many actions can be seen as the continuation of policy measures that started before the onset of the financial crisis. In other words, the structural problems of the health care system are reflected in the policy measures implemented during the economic downturn. Similarly, the policy recommendations for the Republic of Korea are not limited to policy responses designed solely to meet financial pressure: they are more comprehensive suggestions that have relevance to the country’s health care system as a whole. Thus, for proper and timely implementation it is necessary to prioritize policies with different focuses, reflecting the context of the Republic of Korea.

**Mobilizing more public resources**

In the area of mobilizing more resources for health care, revenue policy, with a focus on public resources, should be the first area to be assessed, given that the Republic of Korea currently has high levels of OOPs.
Considering that the health financing system in the Republic of Korea is a contribution-based system, the policy option of increasing contributions, including widening the income base for contributions, should be the primary item on the agenda for discussion. However, according to a national survey (KIHSA, 2011b), only 18% of respondents expressed a willingness to pay more contributions to expand the benefit package. This implies that to achieve social consensus on the financing plan for health, there should be more policy discussion open to the public and a better understanding of the structure of health financing among the population.

On the other hand, around 92% of the survey’s respondents claimed that budget transfers should be increased to improve the financial protection of the NHI. With regard to the budget transfer to the NHI, the current method, which links the transfer amount with NHI revenue, is not likely to work well in the future given the rapid increase in the older population and a commensurate decline in the proportion of the economically active population. The determination of the government subsidy based on NHI revenue is understandable given that, currently, there is no policy tool to control expenditure. In order to mobilize more government resources, eventually, a revision of the provider payment system needs to be addressed to ensure more predictability and better control over health care costs. This is connected with the continued calls by the MoH to expand the DRG payment system during policy discussions to increase the level of the government transfer to the NHI.

**Cost control mechanism**

Although many policies have been implemented to reduce financial spending in response to financial pressure in other countries, policies to control expenditure are particularly suitable to the context of the Republic of Korea. At micro level, services that are not covered by NHI should be tackled first. The prices of non-covered services are not regulated by the government. In addition, these services are outside of any protection mechanism, and consequently, have become the main sources of the financial burden on individual households.

At macro level, a cost containment tool should be developed. ‘The Vision for Health 2020’ included a mid-term plan to revise the NHI provider payment system by expanding the application of the DRG payment system and taking research initiatives to develop a global cap system for total NHI expenditure, reflecting the Korean context (MOHW, 2011b) However, when the plan was publicly announced in 2011, it was not welcomed by health providers. In fact, it is almost impossible to expect that the plan would be welcomed by stakeholders whose remuneration will be affected by the new policy. The difficulty of dealing with provider opposition has already been illustrated in the past when the government tried to introduce the mandatory DRG policy. Currently, the government is in the middle of formulating policies in detail to implement ‘The Vision for Health 2020’. It remains to be seen whether the policies will be able to be developed consensually with providers.

**Essential components for improving efficiency**

Like the Netherlands, lack of coordination of services is one of the structural problems of the health system in the Republic of Korea. Recognizing that well-functioning primary care is a very important factor in improving the efficiency of services, some policies have been implemented to achieve better coordination. However, these policies have not been successful due to segmentation of health professionals who compete for patients and a lack of high-enough financial incentives to encourage collaboration among providers. Another consideration is that restricting access to health facilities as a consequence of giving a greater role to primary care is less likely to be supported by patients, who have long enjoyed freedom in choosing whatever health facility they would like to visit. Moreover, patients

19 In March 2011, the MoH announced The Restructuring Plan for the Roles of Health Care Providers. However, there has not been much progress and some specific measures have been moved to the Vision for Health 2020.
do not seem to be convinced about the quality of services in primary care to shift their choices from the hospital setting. Therefore, policies aimed at improving quality of care, including payment based on performance, particularly for primary care providers, should be deliberated.

**Final remarks**

There are many policy issues which should be addressed to achieve better performance of the HFS in the Republic of Korea. However, above all, policy tools to control expenditure, particularly mechanisms relating to how providers are paid, should be the first priority. This is why the provider payment system crops up consistently during the analysis of all three categories of policies that are suggested for implementation in this report. Since provider payment is a politically sensitive issue and is likely to face oppositions from providers (as demonstrated in the past), it requires a greater leadership role on the part of the government to try to coordinate the interests of providers. The success or failure of improving the provider payment system will largely determine the future performance of the Republic of Korea’s health financing system.

When it comes to benchmarking the experiences of other countries, it is necessary to review them in depth before adopting them. As mentioned in many parts of this report, there are many policies in Belgium, France and the Netherlands that have potential implications for the Republic of Korea. However, since such policies have emerged from the political, historical and cultural background of each country, they should be considered with these aspects in mind and need to be modified to reflect the context of the Republic of Korea.

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