

Coordination of health care services in the Netherlands

A report by:

Leyden Academy
ON VITALITY AND AGEING



Rijnsburgerweg 10
2333 AA Leiden, the Netherlands
Rolden@leydenacademy.nl

Foreword

This report is written by the *Leyden Academy*, a knowledge center in the Netherlands with the mission to improve the lives of older people, on a request from the *Institution for Future Welfare*, a knowledge center in Japan. The request by the *Institution for Future Welfare* pertains to an oversight of the Dutch long-term health care system together with questions relating to more specific dynamics of the system. The *Leyden Academy* gives a complete oversight, as well as answers to the questions that were outlined.

The report is divided into different chapters and also offers extensive supplementary material. In the first chapter, an oversight is given of the Dutch health care system. Central in this chapter are three different health care acts – the health care insurance act (ZVW), the exceptional medical expenses act (AWBZ), and the social support act (WMO) – and the institutions involved in fulfilling these acts. The second chapter mainly offers information on the size of the demographic and financial issues related to the health care acts. Also, information about aspects surrounding the three health care acts is given. For example, a paragraph is dedicated to the way health care institutions exchange information about clients. The third chapter offers information about the boundaries of the acts: the three different health care acts (potentially) overlap in certain ways and detailed information is given how rules and regulations are set to separate the different fields. Supplementary material exists of translations of laws surrounding the three health care acts, such as the Law of Client Participation in Health care Institutions is added.

In this report patients, health insurance consumers, and those eligible for AWBZ and WMO will be called clients. If any questions remain unanswered, or the reader is need of further or more detailed information, the Leyden Academy is more than willing to answer them.

Herbert Rolden & Marieke van der Waal

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Important remarks

This introductory paragraph clarifies some potential problems the reader might encounter when reading this report.

First, all abbreviations that are used in this report are summarized in a special section on page 51-52. Second, some terms need to be clarified.

- The term *home care* does not refer to all care that is received in a home situation. It refers to all domiciliary care, encompassing activities such as house cleaning, buying groceries, and cooking. Depending on income of the older person, home care is partly or fully paid by the WMO. Medical and nursing care do **not** fall under the term home care. Activities such as helping with dressing or undressing, with getting in or out of bed, or with bathing or showering is called *personal care*.
- When AWBZ care is delivered at home, and not in an institute, it is called non-residential care. On the other hand, if AWBZ care is delivered at a care home or nursing home, it is called residential care. Home care, personal care and nursing care can be delivered in both residential and non-residential situations.
- In literature, health care services provided through the ZVW are sometimes called *medical* or *cure services* and services provided through the AWBZ are called *welfare* or *care services*. The terms can be confusing as some funding from the ZVW can be spent on care or welfare services. In this report *cure* refers to medical care and is usually compensated through the ZVW. *Care* refers to welfare services and is mostly funded by the AWBZ.
- Different sources are used in this report to clarify the expenses made within certain health care domains or acts. Data are mainly from three sources: the Central Bureau of Statistics (CBS), the System of Health Accounts (used by the Organization for Economic Cooperation and Development, or OECD), and the Dutch national Budget for Care (BKZ) as defined by the Dutch government. Part of the data that is used for the BKZ comes from the Health Insurance Board (CVZ). When expenses are analyzed, the sources for the data are specified. Important to note here is that the definition of health care used by CBS is broader than used by the System of Health Accounts. In contrast to the definition used by the OECD, the definition of

CBS also includes health at work, reintegration services, youth care, social and cultural work, day care centers and boarding schools.

- Expenses made for the WMO are hard to track down, because every municipality defines its own WMO budget. Data about these budgets is not collected centrally. Estimations of expenses made for the WMO were done in the BKZ.

Third and last, the health care system in the Netherlands is changing fast. Since 2006, major reforms have been established on an annual basis. The first version of this report appeared in 2012. It is important to note that new changes have been planned for 2013.

1. Curative and long-term care in the Netherlands

1.1 The Health care Insurance Act (ZVW)

The year 2006 is a focal point in the history of Dutch health care policy. In this year, the new Health care Insurance Act (ZVW) officially came into place. This health care reform obliges all citizens to have a basic health insurance package for curative care with an individually chosen private health care insurer. The specific content of the basic package is established by the Dutch government. Insurance companies can only compete on the basis of their insurance fees, services, and negotiated contracts with health care providers. Insurers negotiate contracts with health care providers on a yearly basis, and aim to find the best quality of care for their clientele for the lowest prices. Unsatisfied clients can change to another insurer once per year (before the 1st of January). Health care insurance is based on a “semi-free market system”. The purpose is that competition between health care providers and insurers is organized without sacrificing equity, quality and transparency of the health care market. Health care insurers and providers can negotiate about the prices of some health care services. The ultimate goal of this semi-free market system is that health care providers are driven to work as efficiently as possible, and that health care insurers compete with each other on the basis of prices.

1.1.1 Equity, quality, and transparency

Equity is ensured by providing everybody with an equal coverage for comparable fees (since there is competition between insurance companies). Persons and households with an income below a certain threshold are eligible to receive a “health care allowance” (*zorgtoeslag*) from the government that covers a part of the insurance fees. The government will decide if a client will get the health care allowance based on the level of income which is based on the yearly household tax payments. To prevent misuse and overuse of health care provision from Dutch citizens, a compulsory deductible is levied over many different health care services (€170 in 2011, €220 in 2012). Clients can voluntarily increase this compulsory deductible to decrease their insurance fee. This can

be done if one expects to use little or no health care in a particular year. Because the chronically ill make more use of health care services, they have an elevated risk of having to pay the full compulsory deductible every year. The Central Administration Office (CAK) offers the chronically ill a compensation to pay for a part of the compulsory deductible. In the near future the compensation will be income-dependent (only low income chronically ill can use the deductible).

People are also allowed to buy more insurance to complement the basic package. Insurers are not allowed to refuse anybody when they apply for a basic insurance, but insurers are allowed to refuse applications for complementary voluntary health insurance (VHI). Each health care insurer offers different VHI packages (ranging from plain to “gold” packages), usually containing additional reimbursements for dental work, and compensation for glasses, alternative medicine, and so on. Since insurers are allowed to refuse applications for VHI, clients feel their freedom of choice is sometimes limited. Clients can be deterred from switching to another insurer, because they are afraid the new potential insurer might refuse their application for a VHI package.^[1]

Quality is ensured by a transformation in the health care purchasing market. To obtain contracts with insurers, health care providers need to provide good quality for an affordable price. Providers who underperform can be left out in negotiations. This relates mainly to the semi-free market where health care insurers and health care providers interact.

Also, since clients can select a health care insurer and provider on their own accord, they are given more freedom of choice. Higher transparency is then reached because health care providers and insurers will want to inform clients about their services and the points in which they outperform others. Independent organizations or web sites offer information about the pros and cons of different services related to health care.

1.1.2 Organization and parties of the health care market

Figure 1 (next page) shows how the ZVW influences the organization of the interrelatedness of health care providers, health insurers and citizens. Different elements of this figure are explained below:

- *Government.* With support of the parliament and after failed reforms in the eighties and nineties, the ZVW entered into force on the 1st of January 2006. Since then, the government issues changes in the contents and deductible fees of the basic packages.
- *Providers.* The general practitioner (GP) is seen as a gatekeeper for other providers. A visit to the GP is usually mandatory before clients can consult with a specialist or when they need medication. Partly due to the introduction of the ZVW, hospitals are stimulated to specialize and divest. Insurance companies will not likely contract a hospital for services in which it has underperformed in previous years. Therefore, it is expected that in the near future hospitals will focus on their competences and relinquish some services and specialties.

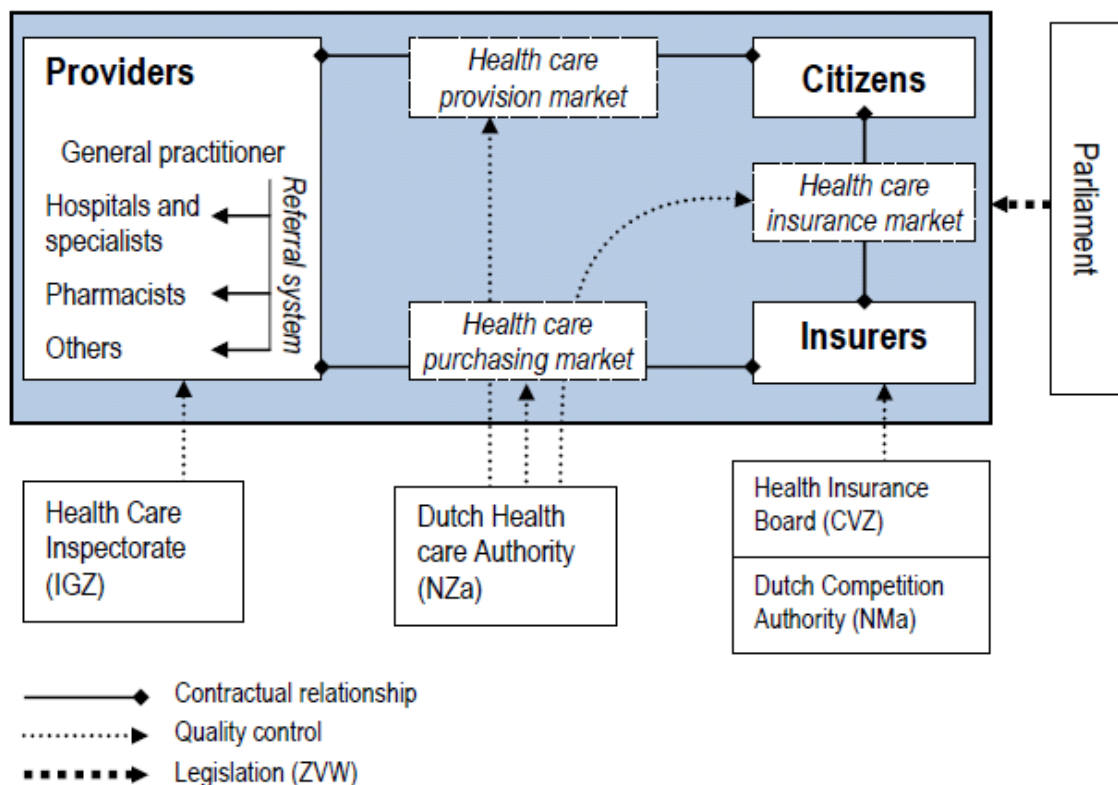


Figure 1: Organizational overview of the Dutch health insurance system (based on figure 2.1, p. 14, source: [2]).

- *Insurers.* Four insurance companies provide services for the majority of the market (88%). Of these four insurers, one is for-profit, the others are not-for-profit. One insurance company can own different brands. There are around 32 brands of health care insurance.
- *Citizens.* An important aim of the health care reform in 2006 was to give the client more power and freedom of choice. The client is seen as an independent and rational decision-maker who can choose for an insurer and compose his or her own insurance package, including content of complementary care and size of the deductible. Also, the patient is free to choose between different health care providers. As of yet, this freedom of choice remains limited with regard to the market of providers where there is low competition, as in the field of general practice. A note of criticism here is that usage of the services of some health care providers might not be fully covered by a health care insurance company. In this case, no contract was negotiated between the insurance company and the health care provider. For example, in 2011 health insurance company Menzis did not establish contracts with one third of all Dutch hospitals regarding hip surgery. These hospitals could not deliver quality services within competitive price ranges. Clients of Menzis could therefore not receive hip surgery in these hospitals. The insurance companies provide information about the contracts they have with health care providers. It is up to the client to find out if there is a contract and coverage of the treatment.
- *Health Insurance Fund (HIF).* Every insurer has a different composition of client group. This means that some insurers may carry more risk concerning medical expenses than others. To ensure that insurers do not suffer from a high risk customer group (such as chronically ill or groups of clients with a low socio-economic status), the Health Insurance Fund is in place to compensate every insurer from elevated risks. The Health Insurance Fund is also in place to compensate for health care provision to people under 18. People under 18 are insured free of charge by a special youth insurance including dental care.

- *Health Care Inspectorate (IGZ)*. The IGZ focuses on the preservation of the quality of care, prevention, and medical products. The inspectorate gives advice to administrators of health care providers, but may also be insistent or even forceful.
- *Dutch Health Care Authority (NZa)*. This administrative body supervises the contractual relationships between clients, insurers, and providers. The NZa investigates if the rules of the ZVW are carried out properly, but can also impose regulations to improve the accessibility, transparency and fairness of the markets.
- *Health Insurance Board (CVZ)*. The CVZ has three core tasks: (1) it gives advice about the content of the basic insurance package to the government; (2) it administers the Health Insurance Fund (HIF) and the AWBZ fund; and (3) it executes and oversees regulations for specific groups – such as people from abroad, or people who conscientiously object to the arrangements of the health care insurance system.
- *Dutch Competition Authority (NMa)*. The NMa sees to it that markets remain competitive and that no cartels, (too) powerful fusions or conglomerates, or monopolies are formed.

1.1.3 How the ZVW is financed

Health insurers are paid a nominal premium by every Dutch person aged 18 or higher. The fees differ between insurers, but a fixed compulsory deductible is set by the government. In 2006 and 2007 there were no compulsory deductibles, but no-claim discounts could be earned if little or no medical care services were used. The average nominal premiums for basic packages, the compulsory deductibles, and other fees for the years 2006 to 2012 are given in table 8 on page 28. Dutch citizens can choose to increase their deductible to lower the fee for their health insurance. The extra voluntary deductible may be increased with €100 up to €500.

In the Netherlands the nominal fees are paid to health insurance companies on a monthly or yearly basis. Health care insurance companies can compensate clients for their health care use in kind or by restitution. If the insurance company pays in kind, any health care expenses are paid by him. When an expense is not covered by the insurance company, or falls under the compulsory or voluntary deductible, the client is billed by the

insurance company. In case of restitution, the client pays for health care expenses itself and bills the insurance company when the expenses are covered in the client's coverage.

Besides these nominal fees, Dutch citizens who receive income through, for example, employment or a pension fund pay an income-dependent contribution to the Health Insurance Fund (HIF). The government also contributes to the HIF. The CVZ calculates and pays out the redistribution by the HIF amongst insurers so that risks are evenly spread out. The *income-dependent employee contribution to the ZVW* is withheld from the employees gross salary. Most employers are obliged by law to compensate the employee for this income-dependent contribution completely through the *employer contribution*. The employer contribution is added to the employee's gross salary: this means the employer contribution is seen as taxable income for the employee. An income-dependent contribution must also be paid over received state pension, private pension, social benefits, and income for self-employed citizens or freelancers.

Two different rates exist concerning this income-dependent contribution: the higher level contribution is paid over gross salary of employees, state pension, and social benefits for those under 65 years old; the lower level contribution is paid over the income of self-employed citizens and freelancers, private pensions, and social benefits for those over 65 years. Table 1 shows the income-dependent contributions for employees and others from 2009 through 2012.

Table 1: The income-dependent contribution to the ZVW, 2009-2012

Year	Income-dependent contribution: high	Income-dependent contribution: low	Maximum yearly amount for which the contribution is imposed
2009	6.90%	4.80%	€32,369
2010	7.05%	4.95%	€33,189
2011	7.75%	5.65%	€33,427
2012	7.10%	5.00%	€50,064

To summarize, the total amount of the HIF depends on these three contributing factors:

1. Fees paid by citizens. These fees should add up to 45% of the total fund.
2. The income-dependent contributions. These contributions should add up to 50% of the total fund.
3. A contribution from the government, which should cover 5% of the fund.

Medical expenses are calculated with using standard price brackets for each intervention or treatment, called “diagnosis treatment combinations” or DBCs. For example, a knee surgery might involve many aspects (such as anesthesia, MRI scans, pre-surgery consultation etc.), but is defined and billed as one standard product unit. Some DBCs are negotiable, meaning that providers and insurers negotiate about its price.

There were around 30,000 DBCs in 2011. Of these DBCs 34% were negotiable (the so-called B segment), the rest of the prices were defined by the NZa. By the 1st of January 2012, DBCs were replaced by $\pm 4,400$ DOTs (which stands for “DBC On the way to Transparency”). DOTs are based on the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10). Around 70% of the DOTs are negotiable. The more refined classification of DOTs was introduced because since 2012 hospitals no longer receive pre-established budgets, but receive their turnovers from realized performance.

1.1.4 Advantages and disadvantages of the ZVW

The main advantages and disadvantages of the ZVW are given in table 2 below.

Table 2: Advantages and disadvantages of the ZVW (2012)

Advantages	Disadvantages
Pay-by-performance system aims for efficiency and less conflict of interest between health care provider, insurer and client.	Potential conflicts of interests. The values of DOTs are calculated once per year. Underestimation of DOTs makes the related health care services less profitable for health care providers. Overestimation makes the related health care services more profitable for them.
Low out-of-pocket expenses to establish equity; deductibles to safeguard from over-use.	Chronically ill and older people form the bulk of care-users: health care insurers not interested in serving this target group best. ^[3]

Freedom to choose health care insurer and health care provider.	Chronically ill and older people can benefit from VHI packages, but applications can be refused by insurers.
Basic and affordable health care insurance for everyone.	Potential misuse of the system: refusal to take health care insurance or pay health care insurance premium; potential misuse of health care allowance.
Health care insurers ensure low health care insurance fees by negotiating the lowest price possible.	Health care providers are driven to increase their “sales revenue”. More people are treated, and insurance fees are going up.

1.2 The Exceptional Medical Expenses Act (AWBZ)

The Dutch Exceptional Medical Expenses Act (AWBZ) has undergone several changes since its installation in 1967, but the core remained the same: the act is established to provide care for people who cannot provide in their basic care needs independently. This can be the consequence of a physical, psycho-geriatric or psychiatric ailment, or a mental, physical or sensorial handicap. During the seventies and eighties, the coverage of the AWBZ expanded from only including exceptional illnesses to including psychiatric care, rehabilitation, home care services, and more. In this period in time, the AWBZ was developing to become a social insurance scheme since much of the care, instrumental aids, therapeutic tools, and institutes themselves were provided for or arranged by the national government. This was put to a halt in the 1990s when more legislation was put into place to counter rising public expenses and improve the efficiency of the long-term care system by promoting free market dynamics.

In the last decade two major changes have been made concerning the AWBZ. Since 2004, any application for compensation from the AWBZ is scrutinized by the Centre of Needs Assessment (CIZ). Since 2007, some services are no longer provided through the AWBZ, but through the Social Support Act (WMO). Mainly, instrumental assistance (e.g. help with cleaning) and the provision of aiding tools (such as wheel chairs) are provided

through the WMO instead of the AWBZ. The central drive for this change was the expectation that assistance and tools could be delivered more efficiently by offices that are regionally close to clients (municipal offices). Also, municipalities are stimulated to work efficiently, because they can only work within the confines of limited budgets from the national government. More information on the WMO can be found in paragraph 1.3.

1.2.1 Introduction to the AWBZ

The AWBZ is a national insurance scheme for long-term care, mainly for intramural care. Most expenses within the AWBZ are made for (frail) elderly, with or without cognitive limitations or physical/functional limitations. Everyone who works or receives any kind of social benefit,¹ and is obliged to be insured for health care, is also obliged to pay a fee for the AWBZ. The AWBZ funds six main kinds of long-term care:

- Personal care: help with showering, dressing, shaving, going to the toilet, etc.
- Nursing care: wound dressing, injecting, teaching self-care, etc.
- Counseling: help with organizing day-to-day practical matters, such as making coffee or filling in forms.
- Treatment: help with recovering from illnesses or injuries (e.g. learning to walk again after a stroke) or improving skills or behavior (e.g. learning how to deal with panic attacks).
- Long-term residence in a care home or nursing home.
- Short-term residence in certain institutions (maximum of 3 full days in one week).

The first four kinds of AWBZ care defined above – personal care, nursing care, counseling, and treatment – can be provided both at the client's home or any institute the client is residing, except for hospitals. When any kind of personal care, nursing care, counseling and treatment is given in the hospital, care is funded through the ZVW.

The fund for the AWBZ is established through fees paid by employees and the government. The fund for the AWBZ is also called the Exceptional Medical Expenses Fund, or AFBZ (*Algemeen Fonds Bijzondere Ziektekosten*). Figure 2 gives an oversight

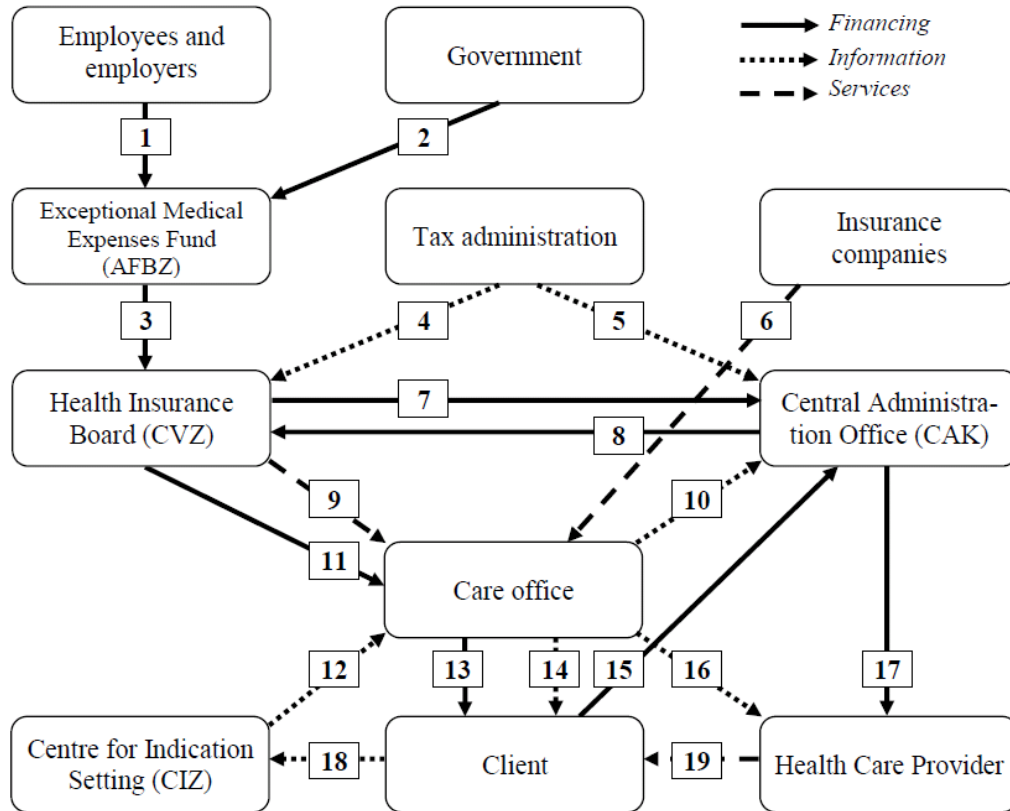
¹ This includes benefits from state pension, called AOW (Algemene Ouderdomswet).

of how administrative and monetary processes are streamed between the patient, health care providers, insurance companies and other institutions that are involved in delivering care services under the AWBZ. The institutions and streams are selected for the purpose of understanding the main administrative processes. Other monetary flows – e.g. how the different institutions such as the CIZ are funded – are excluded to ensure surveyability.

Every person who wants to be eligible for AWBZ funding needs to be assessed by the CIZ. The CIZ assesses the care need of an individual according to a “funneling model” (see paragraph 3.1 for further details). With the use of this model, the care needs of a specific patient are assessed, on which a decision is made. This decision is forwarded to the nearest regional care office. There are 32 care regions in the Netherlands, each with a care office that provides the care that is needed for patients.

Every region in the Netherlands has a care office. Care offices contract health care providers to deliver the care that a client needs on the basis of the indication set by the CIZ. The Central Administration Office (CAK) pays the costs and is billed by the health care provider. The amounts paid by the CAK to health care providers are standardized amounts for every indication setting. It is in the interest of the client as well as the health care provider to keep indication-setting up to date. If the physical or mental condition of a client is progressing, he or she is in need of more care. The health care provider needs to deliver this care and if the provider does not ensure the indication-setting is up to date, he might not get paid enough by the CAK.

Clients who receive an indication from the CIZ for long-term residence in a care home or nursing home, may also receive a personal budget from the care office (or PGB, which stands for *persoonsgebonden budget*) instead of care in kind. Only the client can choose to accept either a PGB or care in kind. A combination of care in kind and a personal budget is also possible. The size of the budget a client may receive is standardized by indication (the kind and the hours of care needed). The specific amounts can be found in table 10 on page 30. In case of personal budgeting, the client directly receives the net worth of the PGB (gross defined PGB minus own deductible) on his or her bank account. More information on the monetary aspects of the AWBZ are given in paragraph 2.1 and 2.3.



Administrative and monetary flows:

1. Employees pay a fee of 12.15% of their yearly income to a maximum of around € 4,000.
2. The government pays the deficit between flow 1 and 3.
3. The Health Insurance Board administers the AWBZ fund.
4. The tax administration gives information to the CVZ on the financial status of the client.
5. The tax administration gives information to the CAK on the financial status of the client.
6. The insurance company with the most clients in a care region delivers the services of a care office.
7. The CVZ pays the CAK from the AWBZ fund for bills from the health care provider.
8. The CAK pays the deductibles received from the clients back to the AWBZ fund administered by the CVZ.
9. The CVZ provides rules and regulations for the functioning of the care offices.
10. The care office bills the CAK for payment of health care provision.
11. The CVZ funds the Care Office for paying out PGBs.
12. The CIZ assesses the care need of the patient, which is sent to the appointed care office.
13. The Care Office pays out the PGB to the client.
14. Care offices provide clients with information, intermediates for the clients, and handles complaints.
15. The client pays a deductible to the CAK, dependent on their financial status.
16. Care offices ask health care providers to deliver the care for a client.
17. The CAK pays providers for the delivered health care.
18. The client provides the CIZ with the necessary information for care need assessment.
19. The health care provider provides care services for the client.

Figure 2: Administrative and monetary streams within the AWBZ

The SVB Service center for Personal budgets (SSP) offers free assistance to clients who receive a PGB. Some PGB holders need help with the administrative processes that are required when applying for a PGB, or maintaining the PGB. SVB stands for Social Insurance Bank (*Sociale Verzekeringsbank*). The SVB is the administrative body that implements national insurance schemes of different types, such as the state pension or child benefits.

Care offices also mediate between patients and health care providers in particular situations, for example when a patient has complaints about his or her health care provider. The services of care offices are provided by the insurance company with the most health care insurance clients in the region. The insurer provides these services regardless of whether the beneficiaries are clients of that particular insurer or not.

The health care providers are paid for by the Central Administration Office (CAK). Clients are obliged to pay a deductible to the CAK for use of health care provision, dependent on their financial status, family situation and age. The tax administration offers information to the CAK and CVZ about the financial status of the patient.

1.2.2 How the AWBZ is financed

For the ABWZ, all Dutch citizens with an income are obliged to pay a fee of 12.15% over a (maximum) part of their yearly taxable income (also those who are younger than 18 years and have a job). The maximized part over 2011 was €33,436. This means that the maximum fee a person had to pay for the AWBZ in 2011 was €4,062.50 (12.15% of €33,436). In case someone is an employee, this fee is subtracted from his or her gross wage or income, and deposited to the tax department by the employer.

The Dutch government aims to fund all AWBZ care by the total bulk of these income-dependent fees alone (including AWBZ care for those under 18 years of age). In some years, the expenses made by the AWBZ fund exceeded the bulk of the incoming fees. In these years, deficits are compensated by the government through contributions by the national treasury. These contributions to the AWBZ fund fall under an expense category, called the *Contribution to Reduction Expenses* (BIKK: *Bijdrage in de Kosten Kortingen*).

1.2.3 Advantages and disadvantages of the AWBZ

The main advantages and disadvantages of the AWBZ are given in table 3 below.

Table 3: Advantages and disadvantages of the AWBZ (2012)

Advantages	Disadvantages
Individually tailored long-term health care and welfare services for every Dutch citizen.	Clients who use AWBZ still pay €145.60 to €2,097.40 per month out-of-pocket (2011), dependent on income.
Clients can choose their own health care or welfare service provider.	Highly bureaucratic administrative processes to establish individually tailored care: high overhead costs; clients confused or underinformed.
Optional personal budgetting increase client autonomy and freedom of choice.	Elderly care needs can change rapidly. The CIZ cannot always keep pace, e.g.: care weight packages are reassessed once a year.

1.3 The Social Support Act (WMO)

1.3.1 Introduction to the WMO

The WMO was introduced in 2007 and replaced other legislation, such as the part of the AWBZ that provided home care assistance before 2007.² Provisions from the social support act are applied for at – and delivered from – the local municipal office. The goals of the WMO are divided into nine “performance fields”, defined by law:

1. Improving social cohesion and livability of villages and neighbourhoods.
2. Support to the youth and parents who experience problems with upbringing (prevention).
3. Giving information, advice, and support to clients.
4. Supporting informal caregivers and volunteers.

² Information in this chapter partly obtained from www.rijksoverheid.nl, <http://wetten.overheid.nl>.

5. Promoting participation of people with chronic psychological or psychosocial problems or a physical limitation in society, as well as their independency.
6. Providing facilities and services for people with a chronic psychological or psychosocial problems or with a physical limitation to promote their independency and societal participation.
7. Offering shelters and implementing policies to combat domestic violence.
8. Improving public mental health care.
9. Improving addiction policies.

Provisions within these fields include:

- help with housekeeping, such as cleaning;
- adjustments in the house, like a stairs lift or a special toilet;
- transport in the region for people who are not capable of travelling with public transport (taxi, compensation for taxi expenses, or scooter);
- support for volunteers and informal caregivers;
- support with raising children;
- wheelchairs;
- delivery of groceries and (warm) meals;
- support to local initiatives, such as community centers and social clubs;
- support to shelters for victims of abuse or homeless people.

WMO provision does **not** include:

- tools for temporary use, such as crutches, or zimmer frames (these are provided by the health care insurer);
- commonly used services or tools (e.g., internet);
- adjustments to a second or other living area (e.g., caravan);
- personal care (provided by AWBZ).

The WMO is a basically a “framework legislation”, which every municipality can realize in its own way. Also, the Dutch social support act is relatively young, so benchmarking and the finding of “best practices” is still in process for many municipalities.

In short, the WMO is mainly focused on providing extramural support, while the AWBZ is focused on intramural care. Those eligible for support from the WMO can receive a personal budget or direct assistance from a person or institution, hired by the municipal office. Municipal offices receive funding for the WMO through the municipal fund from the national government.

1.3.2 Advantages and disadvantages of the WMO

The main advantages and disadvantages of the WMO are given in table 4 below.

Table 4: Advantages and disadvantages of the WMO

Advantages	Disadvantages
Free for everyone (besides a relatively low deductible).	The act is relatively young: every municipality realizes the WMO in a different way; budget differs per community; WMO provisions change every year.
Easily accessible (geographically close reception desk, non-discriminatory).	Some municipalities have more older generations than others, and funding from the national government does not account for this.
Less bureaucracy than in the AWBZ.	Sometimes it is unclear for clients when to apply at the CIZ, the health care insurer or the municipality for moveable aids.

2. The scope of the Dutch cure and care sector

2.1 Use and expenditure within the AWBZ, ZVW and WMO

Total health care expenses made in the Netherlands were around 87 billion euros in 2010, which amounts to 14.8% of Dutch gross domestic product in 2010. These total expenses can be divided into different sources of finance (ZVW, AWBZ etc.) or different health care domains (cure, care etc.). This is done for the years 2000 and 2006-2010 in table 5a below. Table 5b shows the expenses per capita, and table 5c shows health care expenses as a percentage of gross domestic product (GDP).

Table 5a: Sources and domains of health care expenditure, in millions of euro's (source: CBS)

Source of finance	2000	2006	2007	2008	2009	2010
Government	6,585	8,206	10,724	11,328	12,215	12,484
ZVW	13,138	26,727	27,693	32,322	34,191	35,413
AWBZ	14,580	23,177	23,007	22,169	23,201	24,286
Other	12,616	12,612	13,220	13,933	14,446	14,923
Domains	2000	2006	2007	2008	2009	2010
Expenses for cure	26,801	40,688	43,306	46,550	48,851	50,525
Expenses for care	18,080	27,026	28,262	30,175	32,200	33,583
Policy & overhead	2,039	3,007	3,074	3,026	3,001	2,998
Total expenses	46,919	70,722	74,643	79,752	84,053	87,106

Important to notice is that health care expenditure per Dutch citizen has risen with almost 1,000 euro's in 5 year time. As a percentage of GDP, health care expenditure has also risen, which economists deem problematic for economic growth.

Table 5b: Sources and domains of health care expenditure per capita (source: CBS)

Source of finance	2000	2006	2007	2008	2009	2010
Government	413	502	655	689	739	751
ZVW	825	1,635	1,690	1,965	2,068	2,132
AWBZ	915	1,418	1,404	1,348	1,404	1,462
Other	792	772	807	847	874	898
Domains	2000	2006	2007	2008	2009	2010
Expenses for cure	1,683	2,489	2,643	2,830	2,955	3,041
Expenses for care	1,135	1,654	1,725	1,835	1,948	2,021
Policy & overhead	128	184	188	184	182	180
Total expenses	2,946	4,327	4,556	4,849	5,085	5,243

Table 5c: Sources and domains of health care expenditure as % of GDP (source: CBS)

Source of finance	2000	2006	2007	2008	2009	2010
Government	1.6	1.5	1.9	1.9	2.1	2.1
ZVW	3.1	5.0	4.9	5.4	6.0	6.0
AWBZ	3.5	4.3	4.0	3.7	4.1	4.1
Other	3.0	2.3	2.3	2.3	2.5	2.5
Domains	2000	2006	2007	2008	2009	2010
Expenses for cure	6.4	7.5	7.6	7.8	8.5	8.6
Expenses for care	4.3	5.0	5.0	5.1	5.6	5.7
Policy & overhead	0.5	0.6	0.5	0.5	0.5	0.5
Total expenses	11.2	13.1	13.1	13.4	14.7	14.8

The Central Bureau of Statistics (CBS) has given health care expenditure for different categories of health care providers in 2008, 2009, and 2010. These statistics are summarized in table 6.

Table 6: Health care expenditure by type of provider, 2008-2010 (source: CBS)*

	2008		2009		2010	
	Total in million €	% of GDP	Total in million €	% of GDP	Total in million €	% of GDP
Hospitals & specialist practices ¹	20,259	3.41	21,629	3.79	22,390	3.81
Mental health care ^{1,2}	4,899	0.82	5,273	0.92	5,435	0.92
General practices ¹	2,444	0.41	2,470	0.43	2,528	0.43
Dental practices ¹	2,418	0.41	2,558	0.45	2,642	0.45
Paramedical practices ¹	1,610	0.27	1,720	0.30	1,838	0.31
Municipal health service (GGD) ³	686	0.12	707	0.12	734	0.12
Health at work ⁴ & reintegration ⁵	1,211	0.20	1,224	0.21	1,224	0.21
Pharmaceutics ^{1,2}	6,098	1.03	6,204	1.09	6,366	1.08
Therapeutic instruments ^{1,2}	2,929	0.49	2,670	0.47	2,754	0.47
Supporting services	1,587	0.27	1,785	0.31	1,873	0.32
Other	2,409	0.41	2,611	0.46	2,741	0.47
Total medical expenses (cure)	46,550	7.83	48,851	8.55	50,525	8.59
Providers of elderly care ²	14,775	2.49	15,211	2.66	15,974	2.71
Providers of care for the disabled ²	7,138	1.20	7,802	1.37	7,902	1.34
Providers of youth care ^{2,6}	1,441	0.24	1,819	0.32	1,955	0.33
Social and cultural work ³	1,101	0.19	1,173	0.21	1,225	0.21
Day care centers ⁷	3,602	0.61	3,943	0.69	4,187	0.71
Boarding schools ⁶	541	0.09	576	0.10	580	0.10
Other	1,577	0.27	1,677	0.29	1,758	0.30
Total welfare expenses (care)	30,175	5.08	32,200	5.64	33,583	5.71
Policy and management organizations	3,026	0.51	3,001	0.53	2,998	0.51
Total health care expenditure	79,752	13.42	84,053	14.72	87,106	14.80

*The reference numbers in the brackets shows from which act or institution the provider is compensated:

1 = ZVW.

2 = AWBZ.

3 = Municipal budget (large municipalities have their own Municipal Health Service (GGD), which promotes public health by focusing on prevention, town and country planning to promote health etc.).

4 = Law on Labor Conditions (ARBO), financed by the Ministry of Social Affairs and Employment.

5 = Municipal Budgets and the Ministry of Social Affairs and Employment (mainly by the Law on Working in line with Capabilities (WWNV)).

6 = Government budgets invest in institutes that provide services for youth showing problematic behavior, besides the AWBZ fund.

7 = Dutch citizens may receive subsidies from the tax department for payments made to daycare centers.

The national Budget for Care (BZK) is defined by the Ministry of Health, Welfare and Sport. The data used to analyze the realization of this budget shows slightly different numbers. However, the BZK does specify expenses made for the WMO and specifies what part of the AWBZ fund is spent on care in kind and on PGBs. This information can be found in table 7 on the next page.

Figure 3 (page 27) shows the average per capita health care expenses for different age categories. These average expenses include all expenses related to health care and welfare, including the ZVW, AWBZ and WMO. Important to note here is that figure 3 may be misleading. On an individual level, health care expenses rise exponentially before time of death. Since older people have a higher risk of dying, the chance increases that they will make higher health care expenses. Older people who are relatively healthy and will not die within the next few years, do not make significant higher health care expenses compared to younger people. This is known in health economics literature as the “red herring debate”.

The health care expenses made for palliative care are unknown. When a client is diagnosed with a terminal illness, he or she may receive palliative care at home, but palliative care can also be given in a hospice, hospital, nursing home, or care home. Also, palliative care can be financed through the ZVW, AWBZ and WMO. Insight into these expenses cannot be attained. Figure 4 (page 27) offers an insight into how health care expenses made in hospitals in 2000 differ between ages, but mainly between clients who died in 2000 and clients who didn't die in 2000. Age does not seem to play a significant role for costs of hospitalization, unless a client dies in the same year that the health care expenses are made.

Table 7: Health care expenses (in millions of euros) by domain in 2008-2010, defined by the BZK.

Domain	Subdomain	2008	2009	2010
Public health ¹		108	100	95
Medical health care ²	Total	31,526	33,971	34,893
	<i>Inpatient</i>			17,708
	<i>Outpatient</i>			3,931
	<i>Patient transportation</i>			554
	<i>Medicine & tools</i>			6,908
	<i>Mental health care (medical)</i>			3,532
	<i>Health care abroad</i>			467
	<i>Other</i>			1,793
Long-term care	Total	21,537	22,931	23,983
	<i>AWBZ care in kind</i>			21,380
	<i>AWBZ PGB</i>			2,158
	<i>Other</i>			446
MEE institutions ³		172	178	180
WMO ⁴		1,475	1,533	1,541
Educational fund ⁵		783	824	839
WTCG ⁶		–	–	488
Total		55,600	59,537	62,019

1 = Includes mainly preventive health care, such as vaccinations.

2 = Inpatient medical health care is hospital and specialist health care. Outpatient health care includes general practice, dental health care, etc.

3 = MEE institutions offer free information, advice and support to people with disabilities.

4 = Subdomains of the WMO fund not defined in BZK, therefore unknown.

5 = Fund for training of specialists.

6 = Law on Compensation for Chronical Illness.

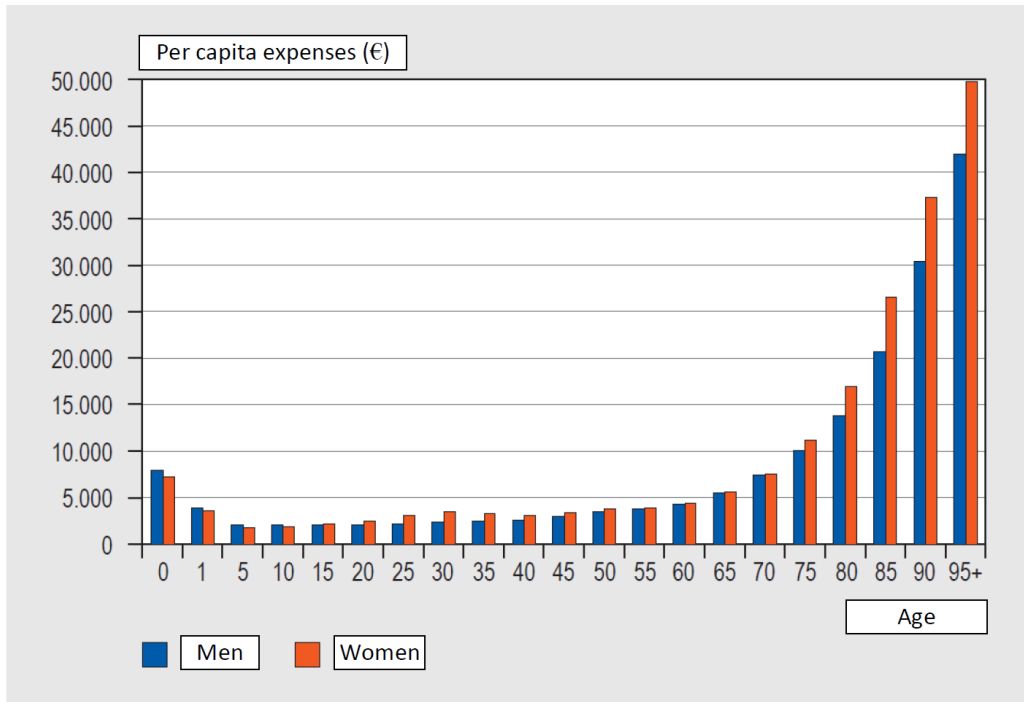


Figure 3: Per capita health care expenses in the Netherlands by age and gender, 2009 (Source: [4])

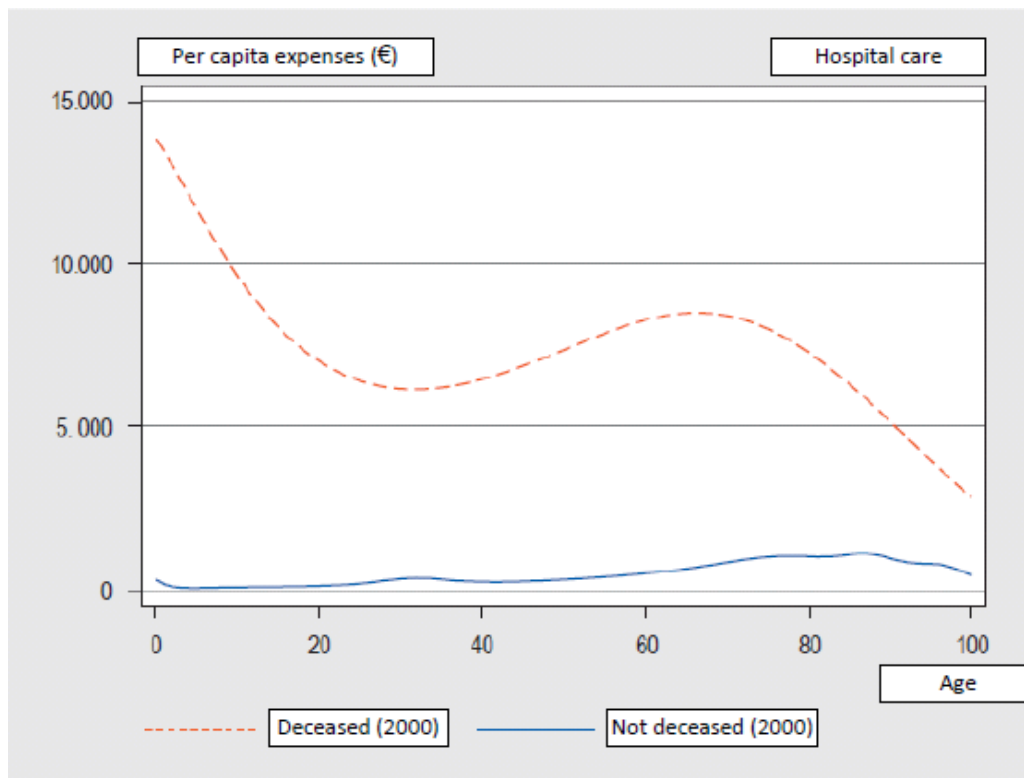


Figure 4: Per capita health care expenses made in hospitals in the Netherlands, by age and divided into deceased and not-deceased, 2000 (Source: [4])

2.1.1 Use and expenditure: ZVW

Table 8 shows the average health care fees from 2006 to 2012, as well as other expenses made for the ZVW by Dutch citizens. Per capita expenses on fees and deductibles have increased with almost 50% from 2006 to 2012. At the same time, compensation for some medical services has been lowered or removed from the basic packages. This sharp rise in expenses together with a downsizing in compensation, can be related to different dynamics in the health care market. Major contributing factors are population ageing, “expensive” medical innovations that increase the demand for medical services, and an autonomous increase in demand for medical services. The rise in expenses for the ZVW can also be related to unexpected detrimental effects of introducing free market mechanism in the health care sector. Research is currently undertaken to find out if these effects exist.

Table 8: Average expenditure in euros for nominal and voluntary premiums, compulsory deductibles and compensation for the compulsory deductible, 2006-2010, (source: www.zorgkiezer.nl)

	2006	2007	2008	2009	2010	2011	2012
Average health care premiums of basic packages (annual)	1027	1091	1040	1056	1082	1211	1239
Average expenses for voluntary health insurance package	290	307	334	362	370	375	412
No-claim discount	255	255	-	-	-	-	-
Compulsory deductible	-	-	150	155	165	170	220
Average no-claim earned or deductible paid*	-98	-102	103	106	111	114	135
Compensation for compulsory deductible chronically ill	-	-	47	50	54	56	**
Average annual expenses incl. average no-claim / deductible	1,219	1,296	1,477	1,524	1,563	1,700	1,786

* Includes voluntary deductible. Average expenses were calculated with an assumption of average health care use.

** Unknown

2.1.2 Use and expenditure: AWBZ & WMO

The estimated expenses from the AWBZ in 2010 are €24.4 billion (€23.4 billion in 2009). Expenses for AWBZ care were €1,400 per capita in 2009. On the income side, around €21 billion was collected from premiums and government input in 2010. The more than €1 billion rise in expenses from 2009 to 2010 were mainly attributable to increased expenses on nursing care (€600 million) and higher demand on personal budgets (€240 million). Expenses from the AWBZ exceeded its financial budget every year since 2008. These deficits are compensated by contributions of the national treasury through a fund called the *Contribution to Reduction Expenses* (BIKK: *Bijdrage in de Kosten Kortingen*). More specific statistics about the PGBs can be found in table 9.

Table 9: Statistics about AWBZ-PGBs 2009-2010 (source: [5])

Subject	2009	2010
Number of PGB holders	118,284	120,572
Fund allocated to PGB holders	€ 2,175 million	€ 2,397 million
Part of allocated PGB actually spent	88.3%	90.4%
PGB spent by PGB holders	€ 1,920 million	€ 2,116 million
PGB spent per PGB holder	€ 16,232 (€44 p/day)	€ 17,550 (€48 p/day)
Users of SVB Service Center PGB (SSP)	24,128	26,610

The amount of the PGB received is dependent on the kind and hours of care that is indicated by the CIZ. Table 10 (next page) shows the possible amounts of PGB. How these individual budgetary compensations relate to compensation from the care in kind is unknown. The indication-dependent amounts that health care providers receive through the AWBZ for delivered care is not offered to the public.

Clients receiving AWBZ care will have to pay a compulsory deductible to the CAK. The height of this compulsory deductible is individually tailored, based on income, age, and family environment.

Table 10: Amounts of PGB received, dependent on type and hours of care indicated, 2012
(source: www.pgb.nl)

Personal care			Nursing care		
<i>Level</i>	<i>Hours/week</i>	<i>PGB/year (€)</i>	<i>Level</i>	<i>Hours/week</i>	<i>PGB/year (€)</i>
1	0 - 1.9	1,483	0	0 - 0.9	1,279
2	2 - 3.9	4,450	1	1 - 1.9	3,819
3	4 - 6.9	8,155	2	2 - 3.9	7,633
4	7 - 9.9	12,606	3	4 - 6.9	13,992
5	10 - 12.9	17,054	4	7 - 9.9	21,628
6	13 - 15.9	21,504	5	10 - 12.9	29,258
7	16 - 19.9	26,693	6	13 - 15.9	36,892
8	20 - 24.9	33,366	7	16 - 19.9	45,798
Counseling					
<i>Hours</i>			<i>Day-parts</i>		
<i>Level</i>	<i>Hours/week</i>	<i>PGB/year (€)</i>	<i>Level</i>	<i>PGB (without transportation)</i>	<i>PGB (with transportation)</i>
1	0 - 1.9	1,967	1	2,432	2,724
2	2 - 3.9	5,903	2	4,865	5,447
3	4 - 6.9	10,823	3	7,297	8,172
4	7 - 9.9	16,726	4	9,731	10,893
5	10 - 12.9	22,630	5	12,163	13,620
6	13 - 15.9	28,534	6	14,595	16,051
7	16 - 19.9	35,420	7	17,028	18,485
8	20 - 24.9	44,276	8	19,460	20,917
			9	21,893	23,350
Short-term residence: € 101 for every 24 hours					

We can see from table 11a (next page) and 11b (page 33) that, although the expenses for AWBZ care are rising sharply, the percentage of clients who use care from the AWBZ is decreasing. These tables show the number of clients using AWBZ care, grouped according to gender and 5-year age categories, with and without residence respectively, in 2009 and 2010. Care with residence refers to both long-term and short-term residence, and is always compensated by AWBZ funding. Care without residence can be compensated by either the AWBZ or the WMO.

Currently, governmental and non-governmental different institutes are offering advice on how to downsize spending from the AWBZ. On the 1st of January 2012 expenses on personal budgets (PGB) were downsized by reducing the number of clients who are eligible for these personal budgets. Since 2012, only those who have an indication including extramural care may receive a PGB (although those receiving a PGB before 2012, will receive their PGB until 2014).

Every client pays a compulsory deductible for the AWBZ, which is dependent on age, individual income, family situation, and type of care needed. The CAK collects the deductible and gathers information on the current situation from the CIZ and the national tax department. Figure 5 (page 34) shows the size of the monetary flows involved with the AWBZ.

Table 11a: Use of AWBZ/WMO by age-gender group (%) – 65-85 years (source: CBS)

		Use of care as % of age and gender group								
			65-70		70-75		75-80		80-85	
Type of care*	Year	M	F	M	F	M	F	M	F	
Care with residence	Nursing care	2004	1.06	1.14	2.46	3.24	5.52	8.16	12.2	18.44
		2009	1.10	1.24	2.34	2.93	5.37	7.55	11.23	17.01
	Care for the handicapped	2004	0.34	0.30	0.29	0.25	0.23	0.19	0.15	0.12
		2009	0.35	0.30	0.33	0.28	0.26	0.22	0.19	0.15
	Mental health care	2004	0.18	0.19	0.18	0.21	0.15	0.22	0.15	0.19
		2009	0.19	0.18	0.17	0.19	0.13	0.17	0.09	0.15
	Total care with residence	2004	1.56	1.62	2.92	3.68	5.88	8.54	12.48	18.71
		2009	1.62	1.7	2.82	3.38	5.74	7.91	11.49	17.29
Care without residence	Home care help	2004	1.96	6	4.24	13.34	8.88	25.21	15.99	35.77
		2009	1.69	5.28	3.42	10.86	7.28	22.02	13.5	34.44
	Personal care	2004	2.00	4.1	4.25	8.83	8.71	16.85	16.16	26.21
		2009	2.00	2.93	3.99	5.95	8.28	12.62	15.85	22.66
	Nursing care	2004	2.55	3.21	4.77	6.23	8.56	11.41	14.75	18.48
		2009	1.84	2.15	3.09	3.72	5.43	6.69	9.04	10.77
	Total care without residence	2004	4.08	8.07	7.99	16.73	15.18	30.56	26.06	43.39
		2009	3.73	7.2	7.06	14	14.03	27.51	25.06	42.83

*Types of care overlap. For example, people who receive nursing care may also receive care for the handicapped. That is why total care with or without residence is less than the sum of the parts.

Table 11b: Use of AWBZ/WMO by age-gender group (%) – 85+ & 18+ years (source: CBS)

Type of care*		Use of care as % of age and gender group							
		85-90		90-95		95+		18+**	
		Year	M	F	M	F	M	F	
Care with residence	Nursing care	2004	24.63	35.7	41.27	54.05	56.41	69.8	2.67
		2009	22.07	32.45	38.15	50.77	51.74	65.72	2.71
	Care for the handicapped	2004	0.11	0.08	0.08	0.04	0.03	0.04	0.36
		2009	0.12	0.1	0.09	0.08	0.11	0.04	0.42
	Mental health care	2004	0.11	0.15	0.08	0.12	0.11	0.07	0.12
		2009	0.07	0.1	0.07	0.07	0.04	0.08	0.14
	Total care with residence	2004	24.82	35.9	41.4	54.18	56.55	69.91	3.15
		2009	22.25	32.64	38.29	50.9	51.89	65.84	3.26
	Home care help	2004	22.37	36.51	24.72	29.1	21.43	18.78	5.29
		2009	20.47	38.35	23.93	32.81	23.56	23.45	5.07
Care without residence	Personal care	2004	24.97	31.8	30.2	30.7	30.74	23.71	3.96
		2009	25.46	31.24	32.63	33.37	34.51	28.8	3.30
	Nursing care	2004	21.79	23.6	25.96	23.96	27	19.44	2.80
		2009	13.53	14.69	17.53	16.47	18.99	15.62	1.86
	Total care without residence	2004	36.27	46.01	39.56	39.33	36.86	27.7	6.81
		2009	37.29	49.08	43.17	44.44	41.45	34.06	6.59

*Types of care overlap. For example, people who receive nursing care may also receive care for the handicapped. That is why total care with or without residence is less than the sum of the parts.

**18+ includes all age categories above 18 years old (not 18-65).

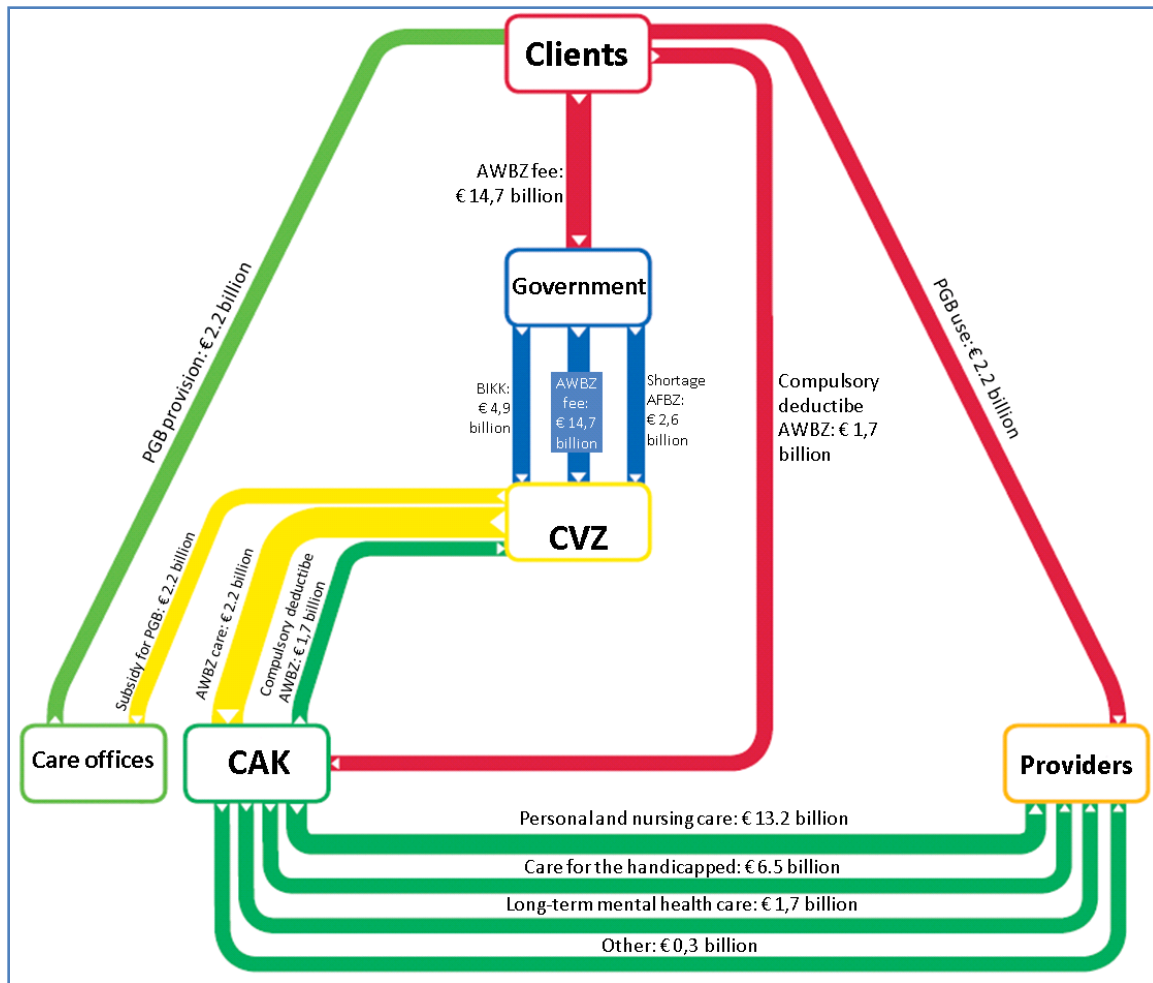


Figure 5: Monetary flows involved with the AWBZ in 2010 (from www.cvz.nl³)

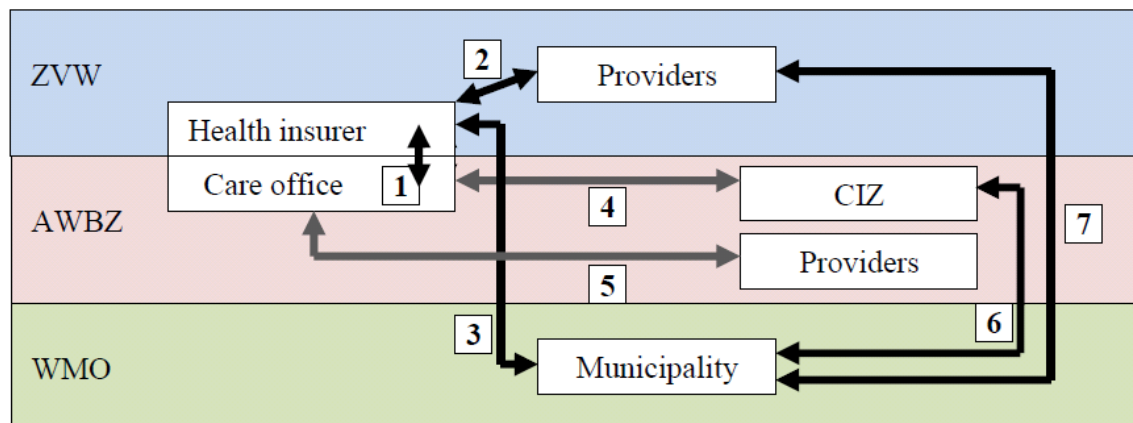
2.2 Coordination of health care: the electronic patient file

Figure 1, 2, and 5 (pages 9, 17, and 34 respectively) show administrative and monetary flows of the ZVW and AWBZ. This paragraph focuses on information exchange between different health care institutions and care givers concerning patients.

Currently, all health care providers have their own information database concerning their patients. Information exchange between health care providers takes place on request. If, for example, a cardiologist in one city needs information about a patient from another hospital, he or she sends a request to this hospital. Patient

³ http://www.cvz.nl/binaries/live/cvzinternet/hst_content/nl/documenten/rubriek+zorgcijfers/geldstromenkaart-awbz.pdf

information can then be sent by mail or by e-mail. Information exchange between GPs and medical specialists concerning a patient is standardized. A GP almost always receives feedback from medical specialists when a patient was referred. An oversight of information exchange between different health care parties regarding individual client information is given in figure 6. This figure does not include general information exchange. For example, municipalities may ask GPs for general advice on WMO provisions or consult a care office for budgetary advice.



1. Legally, the insurance division and the care office of a health insurance company may not exchange information on individual clients. This does happen in practice sometimes. Information exchange can be necessary to check if some providers are not requesting for compensation from both the care office and the insurance division at the same time (on purpose or by accident). Information exchange for this purpose and others will become legal on January 1 2013.
2. Providers request for compensation regarding individual clients on the basis of DBCs (2006-2011) or DOTs (2012). More detailed information than the DBC- or DOT-codes are not given, such as client's risk of chronic illness.
3. The municipality may not request for individual client information from the health insurer. Four municipalities were investigated in 2011 for requesting too much personal information from clients, such medicine use or the name of his/her specialist.
4. The CIZ sends an indication decision, together with the necessary client information to the care office.
5. The care office sends a request for care in kind, together with the indication, to the relevant provider.
6. When a client applies for services from the WMO, he or she needs to send an official document regarding indication-setting from the CIZ for AWBZ care.
7. When a WMO application is filed by a client, he or she has to give permission to the municipality to collect client information from some other providers.

Figure 6: Information exchange between different parties regarding client information (2012).

On November 1st 2008, an initiative for centralizing patient information was launched. An amendment was prepared to promote easy access to a patient's history for general practitioners, pharmacists, and medical specialists. Basically, the drafted amendment would make it possible for GPs, pharmacists and medical specialists to use the patient's Citizen Service Number (BSN) to locate the patient in the information system of another medical professional, after which the patient information in that system would be made available. The BSN is an individual number that is used to make private information selectively available for governmental agencies and institutes, either by law or by explicit permission of the Dutch citizen that the information exchange concerns.

The amendment became known as the law of the "Electronic Patient File" (EPD) and was an amendment to the *Law on the Use of the Citizen Service Number in Health Care* (WBSN-Z). In official terms, the amendment is called the *Amendment to the WBSN-Z Associated with Electronic Information Exchange within Health Care*. Within the Dutch political system drafts become official laws if they pass parliament (*Tweede Kamer*), and the senate (*Eerste Kamer*). The WBSN-Z passed parliament and the senate, and came into force June 1st 2008. Starting June 1st 2009 the WBSaAN-Z obligated every health care provider, health care insurer and the CIZ to exchange client information using the BSN. The amendment to the WBSN-Z passed parliament on February 19th 2009, but was rejected by the senate on April 4th 2011.

It is important to note that the amendment to the WBSN-Z would **not** make it possible for nurses, therapists, managers, policymakers, health insurance companies, municipalities, the CAK, the CIZ, or other medical professionals or institutions to access patient information from other information systems than their own. Only general practitioners, pharmacists, and medical specialists would be able to access this information. These medical professionals could only log into other information systems after they identified themselves with a so-called Unique Health Care Provider Identification pass (UZI). Opposed to what is commonly thought, the purpose of the amendment was thus not to establish one centrally administered patient record that is accessible for many different parties within the health care sector.

The aim of the law of the EPD was to make (crucial) medical information rapidly available for medical professionals who were responsible for a patient's health. This would ensure that many avoidable medical mistakes could be prevented. The EPD would prove especially useful for (emergency visits by) older patients, who have a higher risk of co-morbidity, are less well-informed about their own condition, and who have a higher risk on poly-pharmacy. The main objection of the senate to support the amendment was that it held a potential threat for private and sensitive patient information. In a survey, many physicians were worried that private patient information was not sufficiently secured. If the system was hacked or the UZI codes of a medical professional were cracked, personal information of many Dutch citizens could potentially be available to unauthorized persons in an instance. Also, it would be a daunting task to train the thousands of medical professionals involved to gain more knowledge about the different ICT-systems, relevant privacy laws and – potentially – new codes of ethics.

The senate also expressed their discontent with the fact that the Ministry of Public Health, Welfare, and Sports had already sent a letter to all Dutch citizens over 18 in November 2009, explaining to them the what the Law of EPD would mean for them, and giving them the chance to opt out (meaning citizens had a right to refuse information sharing by GPs, pharmacists, and medical professionals).

3. Demarcating the Dutch cure and care services

3.1 Assessment for AWBZ⁴

Everybody who wants to be eligible for funding from the AWBZ has to be assessed by the CIZ. The CIZ works with a funnel model to assess the care needs of an individual. This funnel model is given in figure 7.

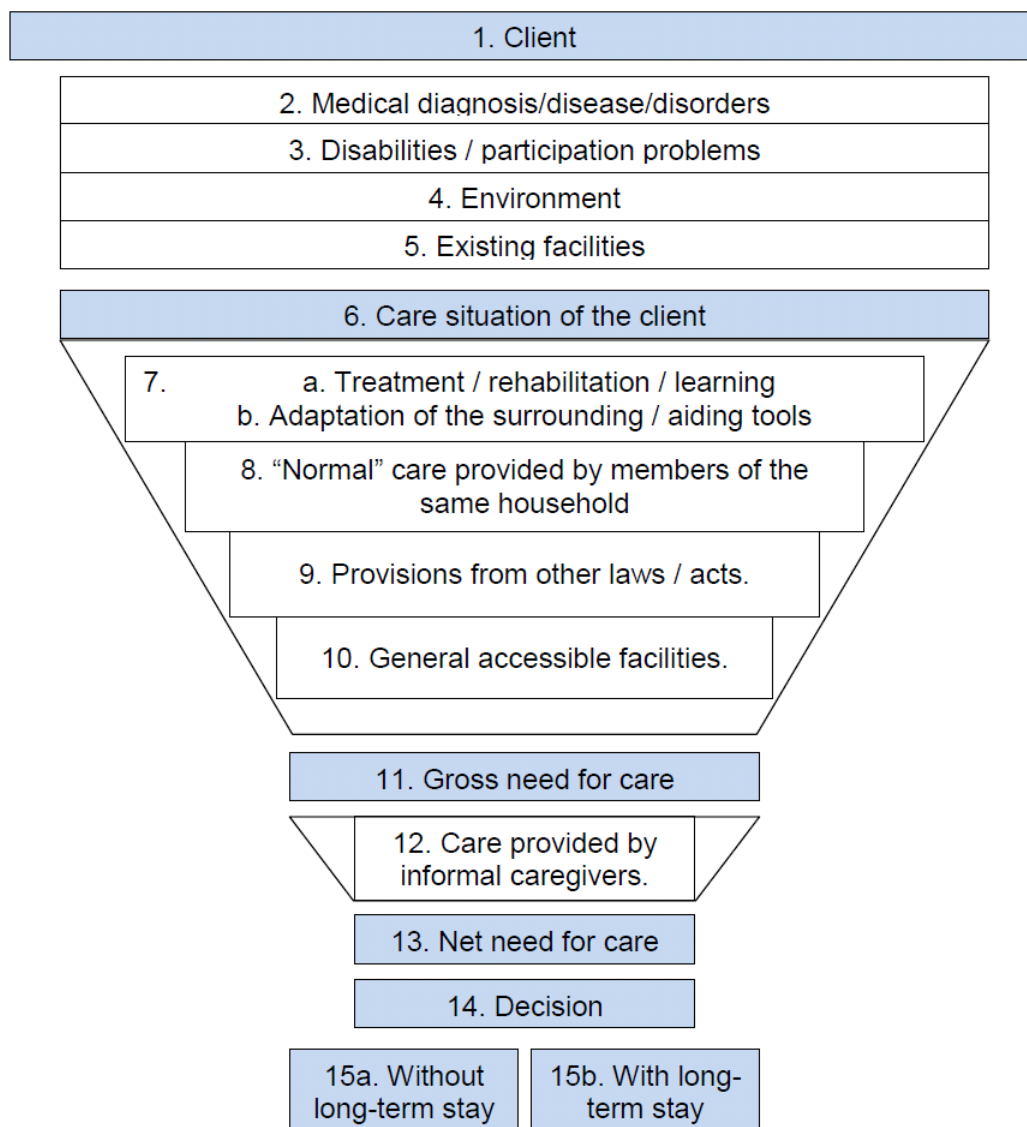


Figure 7: The CIZ funnel model.

⁴ Mainly based on [6].

The steps described in the CIZ funnel model are explained below.

1. The client can file in an application for AWBZ funding, but a health care professional may also do this by the client's request. An emergency application can only be filed in by a health care professional.
2. The CIZ assesses whether there are sufficient grounds for care from the AWBZ. There are two main grounds for care, divided into six parts: (1) a somatic, psycho geriatric or psychiatric ailment / limitation; (2) a mental, physical or sensorial handicap. Function disorders are scored on a scale from 0 to 3:
 0. No problems / no help required from another person.
 1. Problems / needs help, supervision or guidance occasionally.
 2. Problems / needs help, supervision or guidance often.
 3. Problems / needs help, supervision or guidance continuously.
3. Disabilities and participation problems are also scored from a scale from 0 to 3:
 0. Can pursue this activity him- or herself / no help required from another person.
 1. Can pursue this activity him- or herself / needs supervision or stimulation from another person.
 2. Can barely pursue this activity / help required from another person.
 3. Cannot do this activity independently / another person needs to take over.
4. The environment is defined by three main factors:
 - The nature and size of the care activities that are provided by other care facilities and informal caregivers. Within AWBZ indication-setting family-members, neighbors and friends can be deemed informal caregivers.
 - The health, burden and future care possibilities of other care facilities and informal caregivers.
 - The current living situation of the individual, his/her possible problems with the home, surroundings and living behavior, and his/her possible need/desire to move.
5. These are provisions the client can already use through regulations or acts in the fields of living, public health, health care, labor and education.

6. The care situation of the patient is described as a clear “picture” by the CIZ of the client in his/her surroundings.
7. In this step, the CIZ weighs if there are existing and adequate or new solutions to the problems in the care situation through treatment, rehabilitation or learning. Treatment cannot be enforced when the integrity of the body can be harmed (e.g. surgery). Besides these solutions, there might be other possibilities to improve the client’s situation that have priority over care from the AWBZ (see point 8, 9, 10).
8. Normal care is the care that partners, parents, children or other co-residents are deemed to give each other on a “normal” basis. Possible overburdening of these co-residents is taken into account.
9. If a person needs care, the AWBZ will only provide the care that is not financed by other laws. Therefore, the AWBZ is also called the “law for risks that cannot be insured”. If other acts, mainly the ZVW, are in place to offer certain health care or welfare services needed by the client, these services have precedence over potential AWBZ services.
10. General provisions are not regulated by law and can also offer solutions to the client’s needs, such as shopping services, child support facilities, et cetera.
11. Determining the need for care concerning the nature, size, duration and terms of delivery, without a decision concerning accommodation.
12. Here, the compensating opportunities by voluntary informal caregivers are assessed. Also assessed is the care that those informal caregivers are willing and able to give in the future.
13. After the subtraction of informal care giving from the gross need for care, the net need for care is hereby defined. Six weeks after the application was filed, the client is informed of the indication. In principle, an indication is valid for 15 years. Adult clients with a stabile disability sometimes have an indication that remains unchanged for many years, maybe even up to 15 years. Often, diseases or disabilities that require long-term care and demand exceptionally high expenses, are progressing. This means that an indication usually changes much sooner than 15 years, sometimes even multiple times per year. This is usually the case for the

elderly receiving AWBZ care, since they become more fragile, ill or disabled in a relatively rapid manner.

14. If the indicated care of the client is necessarily paired with the need for a protective or therapeutic living environment or permanent supervision, the decision is paired with an indication for long-term stay. Otherwise, no long-term stay is deemed necessary by the AWBZ.

As defined in paragraph 1.2.1 care from the AWBZ can be divided into six major categories: (1) personal care, (2) nursing care, (3) counseling (individual or group), (4) treatment (individual or group); (5) long-term residence, (6) short-term residence. If no long-term stay is indicated, care needs are defined according to different levels. The following kinds of levels are possible:

- Levels on the basis of an average amount of hours of care per week. These levels are defined for personal care, nursing care and counseling (individual).
- Levels on the basis of “day-parts” (period with a maximum of 4 hours) for counseling (group) and treatment (group).
- Treatment (individual) is not defined by levels.

The CIZ bases its indication partly on the information and diagnoses from related professionals. Table 11 shows which health care professional is involved for which of the six grounds (one professional may offer the diagnosis, but multiple professionals may also be involved, either separately or as a multidisciplinary team). A decision about indication by the CIZ is valid for no more than 15 years, although in almost all individual cases indications change much sooner. Some younger clients with (relatively stable) mental or physical handicaps might receive an indication-setting that remains unchanged for years. Older clients usually suffer from progressive illnesses or handicaps, implying that indications will change often for them.

Table 12: Professionals who are involved with diagnosing the clients health status for the AWBZ.

	General practitioner	Specialist	GZ-psychologist*	Medical educationist
Somatic ailment / limitation	X	X		
Psycho-geriatric ailment / limit.	X	X	X	
Psychiatric ailment / limitation	X	X	X	
Physical handicap	X	X		
Mental handicap	X	X	X	X
Sensorial handicap	X	X		

**GZ-psychologist is a “health care psychologist”: a specialized psychologist, who is entitled to make diagnoses.*

3.2 Compensation from the AWBZ fund

When an indication for a client does not include residence for more than three full days, his or her care needs are defined according to function and level. Table 13 (next page) shows how levels are defined for the different functions of AWBZ care without residence (> 3 days).

When an indication for a client includes residence for more than three full days, his or her care needs are defined according to care weight packages or ZZPs. AWBZ care providers receive standard compensation fees for each level of function or ZZP. These standard compensation fees are established by the NZa. These fees are “maximum” fees, and care offices have the ability to negotiate lower compensation fees with providers. These fees may not be lower than 94% of the standard compensation fee concerning residential care, and not lower than 85% for non-residential care.

Table 10 on page 30 shows how the different functions and levels are defined. This table also shows the compensation from the personal budget for each function and level: please note that the compensations mentioned in table 10 do not equal compensations made for care in kind to AWBZ institutions.

Table 13: AWBZ-care with no residential care for more than 3 full days per week is defined and compensated by function and level according to this table.

Function	Levels are defined by:
Personal care	Average number of hours/week
Nursing care	Average number of hours/week
Counseling (individual)	Average number of hours/week
Counseling (group)	“Dayparts”/week
Treatment (individual)	“Dayparts”/week
Treatment (group)	Not expressed in levels
Transportation	Related to the level of group counseling and group treatment

[Following text until “!!” moved from 3.3.6] A ZZP is a total package of care that fits the individual circumstances of the client, which concerns living, nursing care, treatment and daytime activities. Different gradients of ZZPs exist for different types of care. The different kinds of care weight packages can be categorized according to the grounds of AWBZ care. Table 14 shows the grounds and its set of ZZPs.

Compensation for transportation is offered, dependent on the amount of group counseling and group treatment. Clients who need care with long-term residence more than three full days are classified into so-called “care weight packages” (ZZPs). A long-term health care institution – such as a nursing home – that admits a client, receives a monetary compensation from the AWBZ fund via the CAK on the basis of the client’s ZZP level. ~~The concept of ZZPs is further clarified in paragraph ??.~~ When a client is appointed one, two or three full days of stay with care (short-term residence), care is defined by function and level.

The VV-ZZP is explained here, to give an example of how care weight packages are used and demarcated. As can be seen in table 15 (next page), the ten VV care weight packages can be categorized according to seven factors. Interpretation of the symbols can roughly be done as follows: 0 = not applicable, ++ = supervision and/or stimulation, ++++ = help, ++++++ = complete take-over. The ninth and tenth VV-ZZP apply to short-term care for specific client groups. The ninth VV-ZZP applies to clients in rehabilitation. The tenth VV-ZZP applies to palliative care for terminally ill clients, who can no longer live in their own home.

Table 14: Grounds for AWBZ care and their care weight packages

Ground	Special circumstance	ZZP series
Somatic ailment/limitation	-	VV
Psycho-geriatric ailment/limit.	-	VV
Mental handicap	-	VG
	Slight mental handicap	LVG
	Strong behavioral disorder / slight mental hand.	SGLVG
Physical handicap	-	LG
Sensory handicap	Hearing disorder and communication handicap	ZGaud
	Visual handicap	ZGvis
Psychiatric ailment/limitation	-	GGZ

Table 15: VV-ZZPs

ZZP	Counseling		Care			Nursing care	Problem behavior
	Social self-reliance	Psycho-soc. funct.	Personal care	Mobility	Motor funct.		
VV1	+	0	+	+	0	0	0
VV2	+++	+	++	+	+	+	0
VV3	++++	++	++++	+++	++	+	0
VV4	++++	+++	++	+	+	+	+
VV5	+++++	++++	++++	++++	++	+	+
VV6	++++	+++	+++++	+++++	+++	++	0
VV7	++++++	+++++	++++	+++	++	++	+++
VV8	+++++	+++	+++++	+++++	+++++	++++	+
VV9	+++	++	+++	+++	++	++	0
VV10	+++++	++++	+++++	+++++	++++	+++	+

Central to the first eight VV-ZZPs is that the higher the level of ZZP the higher the compensation from the AWBZ via the Central Administration Office (CAK). Every VV-ZZP includes different classified illnesses and limitations. For example, clients in VV-ZZP 7 have a relatively higher score on problems with social self-reliance, psycho-social functioning, and problem behavior, than clients in VV-ZZP 8. This means that VV-ZZP 7 includes many psycho-social or psycho-geriatric elements, or other psychologically classifiable problems, and VV-ZZP 8 more problems or illnesses concerning physical instead of psychological problems. VV-ZZP 8 is on a higher level because illnesses with this character involve higher health care expenditure, not because the illnesses or problems are more serious or detrimental. !!

Table 16 shows the compensation fees for VV-ZZPs in 2011. The 10 VV-ZZPs can be given with or without treatment, and they all include daytime activities.

Table 16: (Maximum) compensation fees for VV-ZZPs in 2011, set by the NZa.

Care weight package	Compensation fee in euros/day (no treatment)	Compensation fee in euros/day (including treatment)
VV1	58,55	-
VV2	74,77	-
VV3	90,49	113,18
VV4	103,27	125,96
VV5	141,51	165,38
VV6	141,55	165,42
VV7	166,62	197,39
VV8	194,20	224,97
VV9	137,76	196,15
VV10	212,42	243,20

3.3 Types of long-term care institutions

The two most important institutions delivering long-term (AWBZ) care are nursing homes and care homes. Other homes are also defined in this paragraph.

3.3.1 Nursing homes

Nursing homes have two main functions. First, they house and provide care for seriously ill and/or disabled clients who have lost so much of their independence and mobility that they need intensive personal and nursing care. Second, they offer personal and nursing care to clients who are housed in other institutions, such as care homes or hospices. Residence, medication, tools and all forms of care (including specialist care) that is provided in a nursing home is compensated through the AWBZ. If a client leaves a nursing home for care in a hospital, all care is compensated through the ZVW.

There were 479 nursing homes in the Netherlands in 2009. In that same year, the capacity of all nursing homes in the Netherlands totaled 74,430 persons.

3.3.2 Care homes

Care homes provide care for clients who can no longer live in their own home. Clients can receive home care, personal care, and some basic nursing care (e.g. wound dressing, help with medication intake) in care homes. So-called “regular” care homes are controlled by the government and receive most of their compensation for residence and care from the AWBZ fund (besides out-of-pocket expenditure). Private care homes are not compensated through the AWBZ fund, but by clients themselves. Clients may use their PGB to pay for residence and care in a private care home. A care home was usually called a care home, but this term is not used often anymore.

There were 1,131 care homes in the Netherlands in 2009. There were 290 homes combining services of care and nursing homes. In that same year, the capacity of all care homes totaled 96,170 persons. Table 17 shows the usage of care and nursing homes by gender, age and marital status in 2008 and 2009.

Table 17: Share of users (%) in care homes and nursing homes by gender, age and marital status, 2008-2009 (source: SCP).

Category	Level	Share of users (%) in:		
		Care home	Nursing home (somatic)	Nursing home (psychogeriatric)
Gender	Male	23	29	23
	Female	77	71	77
Age	55-64	1	8	3
	65-69	2	5	3
	70-74	3	11	6
	75-79	10	18	14
	80-84	23	20	25
	85-89	32	22	27
	90+	30	15	22
	Average age	85.8	80.5	83.4
Marital status	Married	9	25	23
	Divorced	5	7	5
	Widowed	76	57	65
	Never married	10	11	6

3.3.3 Related institutions

Other different forms of elderly homes and care institutions exist in the Netherlands. These are defined below:

- Care farms are agricultural or horticultural companies that offer daytime activities for people with mental or physical disabilities and (demented) elderly. These daytime activities can be compensated through the AWBZ.
- Home care organizations. Home care organizations deliver home care for clients living at home or in long-term care institutions. Home care organizations can be from the municipality or privately owned. Home care can be funded by the client or through the WMO.
- Hospices. Anyone who is diagnosed with a terminal illness and will (probably) live no longer than 3 months, may be moved to hospices, where only palliative care is given. There are also “almost home” institutions, where there are volunteers working to improve the well-being of the terminally ill. “High-care hospices” offer medical services comparable to hospital services for the terminally ill.

3.4 Staff working in the context of the AWBZ

The different types of staff that work within the confines of AWBZ care are given in this paragraph.

3.4.1. Nursing staff

Basically, there are five levels of nursing and caring staff in the Netherlands. Level 5 is the highest level and attained by earning a *Bachelor of Nursing* after studying and practicing this occupation in an institute for *Higher Occupational Education* (HBO). Students following a Bachelor of Nursing may specialize in geriatrics, pediatrics, psychiatry, hospital care, and “social nursing” (related to prevention, vaccination, and health advice).

Level 4 nurses finished the highest level in a *Secondary Occupational Education* (MBO) school. The main difference between level 4 and 5 nurses is that level 5 nurses focus on coordinating and managing in their studies, and are prepared to bring scientific findings into practice. Both level 4 and 5 nurses may become a nursing specialist after following a master. Nursing specialists may treat patients (e.g. give injections, prescribe medication) and have the authority to work more independently. Five specialisms are protected within the Law on BIG for nursing specialists: preventive, acute, intensive, chronic, and mental care.

Level 5 nurses can also become a *nurse practitioner* after following a *Master of Advanced Nursing Practice*. Nurse practitioners (NPs) can see patients in the polyclinic, make diagnoses, and prescribe medication. They often work besides a general practitioner. The target group of NPs exist mostly of chronic patients. By treating chronic patients, nurse practitioners help in preventing these patients from intensively visiting the more “expensive” medical specialists.

Members of caring staff with level 1, 2 or 3 are officially not nurses, but fall under the category of home care staff.

3.4.2 Home care staff

Home care staff are not qualified to give medical care, and only assist in domiciliary tasks, such as cleaning, bathing, and dressing. Home care helpers with a level 1 training may prepare meals and help in other domiciliary tasks. These tasks may be performed at the client's home, but also in care homes or nursing homes. Level 2 home care helpers may also provide personal care, such as helping people in and out of bed, getting dressed or undressed, and showering or bathing. Level 3 home care helpers receive additional training in preparing schedules, making individually tailored domiciliary- and personal care plans, and making reports. They may also qualify for a degree in *Individual Health care* (IG), for which they must learn basic nursing tasks such as assisting with taking medication or injecting oneself.

3.5 Separating AWBZ care from care from the ZVW and WMO

When a client receives care, it is not always distinctly clear from which health care act compensation for expenses is provided. The focus of this paragraph lies on the AWBZ and how care from the AWBZ fund can be separated from compensation from the ZVW and the WMO. Point 9 of the CIZ funnel model stipulates that care is not funded by AWBZ insofar a client is entitled to comparable care services from other legal care provisions. This means that – if possible – care from the ZVW or WMO precedes care from the AWBZ. If care services are not provided through the ZVW or WMO, it is provided through the AWBZ. How AWBZ funding is separated from funding from the ZVW and WMO is explained below. This is explained on the basis of the six types of AWBZ care; for each type of care a different paragraph. The next paragraph clarifies what health care services are provided by the AWBZ in an institution.

3.5.1 Provisions

Most expenses for care and residence in a regular care home or nursing home are paid for by the AWBZ. These regular institutions are therefore also called AWBZ-institutions. The client will have to pay for care and residence when he or she is staying in a private care home or nursing home. The client may use money from a PGB in this case.

Personal care, nursing care, home care, counseling and other products and services are provided through the AWBZ when a client is staying in a regular institution. The client partly pays for these services and products he or she is receiving through the compulsory AWBZ deductible. The other products and services mentioned here refer to, for example, toilet paper and foot care. These products and services are also called *provisions*. Most provisions are only paid for by the client himself if they are medically speaking not a necessity. Examples of provisions that the client may receive through AWBZ financing are given below:

- Three meals a day, sufficient drinks (such as coffee, tea or soft drinks), fruit and some (healthy) snacks. Alcoholic beverages and other snacks are not paid for.
- Certain care products, such as plastic gloves, wet towels or toilet paper. More “general” care products such as shower gel, soap, shaving equipment, toothpaste a toothbrush, et cetera are not paid for.
- Washing, drying, ironing and dry-cleaning of clothing. Clothing that needs extra washing for medical reasons is not paid for.
- Personal care services that are a medical necessity or cannot be done by the client him- or herself. An example is nail clipping in case the client has a certain disability, or foot care in case of diabetes or a disability.
- A cable connection for television. The television and a TV-membership is not provided.

3.5.2 Limits of the AWBZ: Personal care

Clients who need moveable living provisions for the short term (less than six months), such as a shower stool, may receive them from a lending service from the AWBZ. If a client requires provisions for the longer term (more than six months), he or she will receive this from the municipality through the WMO. If clients apply for personal care provisions from the WMO, they may receive them from the lending service from the AWBZ first, because the WMO cannot always directly provide them. When adjustments to the client’s home are required, the AWBZ can also bridge the gap between the application for – and the realization of – these adjustments. The ZVW also provides for personal care services. These services concern:

- Aiding tools (e.g. for putting on and taking off support stockings). The AWBZ provides for professional help, when the use of such aiding tools has become too problematic.
- Request for patient-specific distribution and dose-preparation of medication is done by the pharmacist (formerly by home care). A health care professional may assist a patient with the preparation or taking of medication when medication cannot be systematically pre-dosed by the pharmacist (e.g., when medication intake changes often or fluids or ointments are prescribed).
- Teaching of self-care or learning specific skills that result from a prescribed treatment or action by a medical specialist (e.g., using a stoma or preparing tube feeding), unless the client is unable to learn or implement the skills.

3.5.3 Limits of the AWBZ: Nursing care

The demarcation of nursing care delivered by the AWBZ and the ZVW is complex. The essence of how nursing care is separated remains the same though: if nursing care is necessary with regard to a medical specialism – whether there it concerns nursing care in combination with hospital stay or not – it is arranged through the ZVW; otherwise it is provided by the AWBZ. The Health Insurance Board (CVZ) separates ZVW from AWBZ with regard to nursing care according to three factors:

- The seriousness of the ailment or treatment (Life-threatening? Risk?).
- The complexity of the situation (Stabile? Predictable?).
- The amount of interference by a medical specialist (Instructions? Supervision? Interference? Control?).

The CVZ has defined four categories to demarcate nursing care from AWBZ or ZVW:

1. Complex nursing care, which is assigned and supervised by a medical specialist, and for which he or she is available for intervention, and of which he or she needs feedback, is arranged through the ZVW. An example is intra-venal therapy at home.
2. Less complex nursing care directly connected to a medical specialism, for which supervision and intervention are not necessary, and which the client may reasonably

expect to receive in a hospital is also arranged through the ZVW. An example is periodical injections under the responsibility of the medical specialist.

3. Less complex nursing care directly connected to a medical specialism, for which supervision and intervention are not necessary, and of which the client may not reasonably expect to receive in a hospital, is arranged through the AWBZ. An example is frequent treatment or treatment for an immobile client.
4. Nursing care assigned by the GP of which the client may reasonably expect to receive in a GP's office belongs to the ZVW. Nursing care assigned by the GP of which the client may not reasonably expect to receive in a GP's office belongs to the AWBZ. An example is repetitive wound dressing at home or at a long-term care institution.

Nursing care under direct management and responsibility (assign, instruct, receive feedback) of the medical specialist belongs to the ZVW. This also applies to instruction and information that necessarily goes together with the act or treatment, such as the instruction how to use a catheter or how to perform an injection. When it is established from these categories that nursing care is not directly under the responsibility of the ZVW, other factors should also be taken into account. These are given in figure 8 (next page). The administration of a health care provider is responsible for demarcating the care that is delivered, so compensation can be retrieved from either the health care insurer or the AWBZ budget they receive.

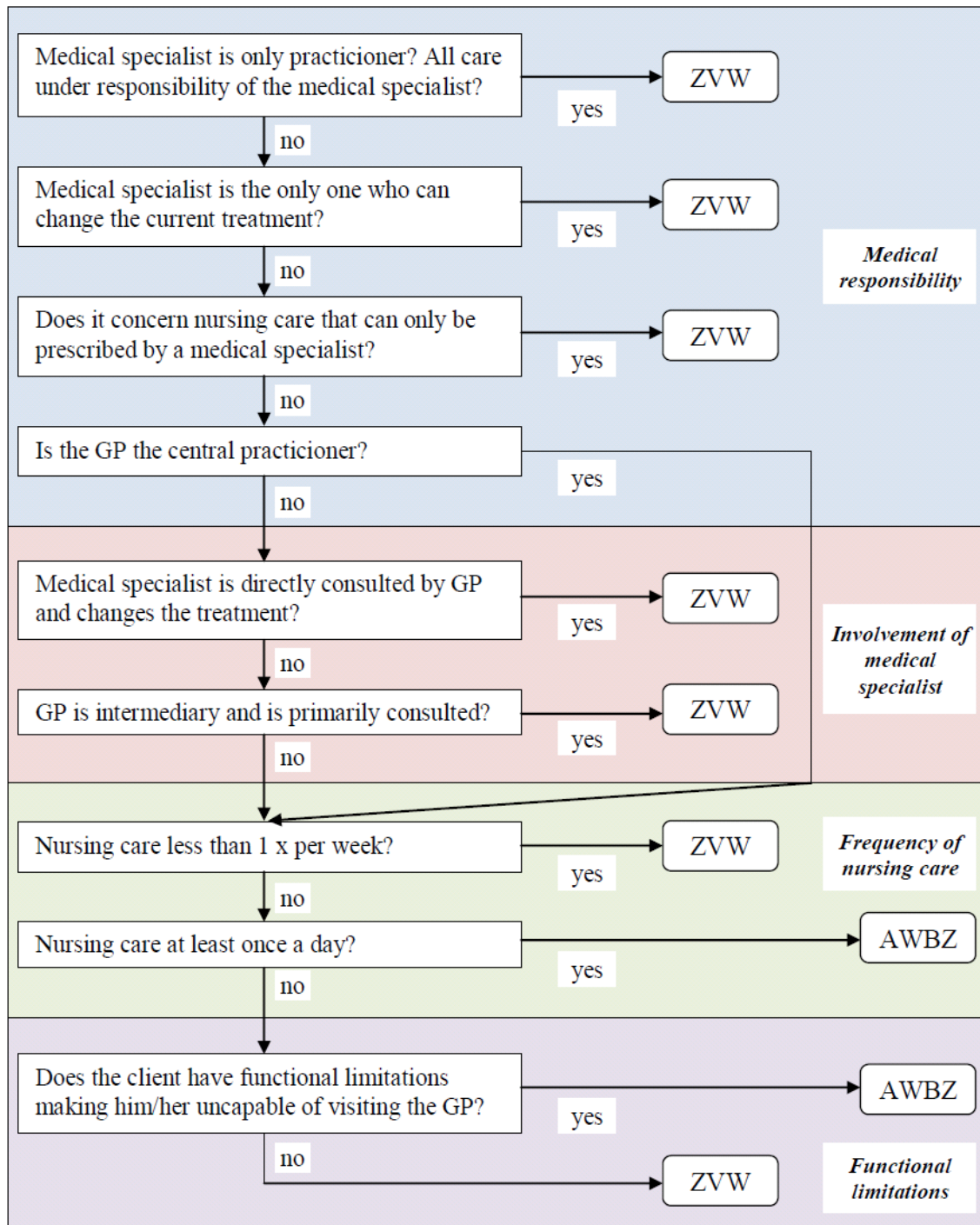


Figure 8: Schedule of demarcation nursing care ABWZ from ZVW (source: [6] page 102).

3.5.4 Limits of the AWBZ: Counseling

In this paragraph counseling activities from the AWBZ are separated from those of the WMO. First, what counseling entails within the framework of the AWBZ is defined, after which counseling activities within the WMO are given. Within the AWBZ counseling roughly consists of the following activities:

- supporting with or rehearsing of skills or actions;
- supporting with or rehearsing of bringing structure into one's life or managing one self;
- taking over of supervision of client.

Counseling from the AWBZ relates to activities to clients in the domain of:

- social self-reliance;
- mobility;
- mental functioning;
- memory and orientation;
- moderate or severe behavioral problems.

These five domains are further specified here. The five domains are labeled as slightly, moderately or severely limited on the basis of these specifications.

Social self-reliance:

- understanding what others are saying;
- making conversation;
- making oneself understandable;
- initiating and executing simple tasks;
- reading, writing, calculating;
- using communication aids;
- daily routines and activities;
- solving problems and taking decisions;
- arranging daily routine;

- controlling budget and arranging monetary tasks;
- initiating and executing complex tasks;
- keeping up with administrative tasks.

Mobility:

- maintaining bodily position;
- making crude hand and arm movements;
- making fine hand and arm movements;
- lifting lighter objects;
- making coordinated movement with legs and feet;
- changing bodily position;
- going up and down the stairs without aid;
- moving with aids;
- moving within the house without aids;
- using public transport;
- using own transportation;
- walking short distances;
- lifting heavier objects.

Mental functioning:

- concentration;
- memory and reasoning;
- perception of surroundings.

Orientation:

- orientation as a person;
- orientation in space;
- orientation in time;
- orientation to a place.

Behavioral problems:

- destructive behavior towards oneself and/or the other, literally and figuratively speaking;
- obsessive behavior;
- physically aggressive behavior;
- manipulative behavior;
- verbally aggressive behavior;
- self-harming or self-damaging behavior;
- sexual behavior transgressing certain borders.

Care that can be provided through the WMO precedes potential AWBZ care. With regard to counseling the WMO provides care by offering clients help with regard to participating in society. Municipalities are responsible for this help and every municipality can decide how to compensate for the client's limitations. As described in paragraph 1.3.1 on pages 18-20 there are nine performance fields. How municipalities organize and conduct aid for elderly clients with limitations are given in table 17 below.

Table 17: Performance fields within the WMO and examples concerning elderly welfare

<i>Performance field</i>	<i>Examples</i>
Improving social cohesion and livability of villages and neighborhoods.	Club houses, 'drop-in centres', neighbourhood activities, sports, park benches, social/cultural activities, contact networks for people in vulnerable positions, contact stimulation, safety, social work.
Support to the youth and parents who experience problems with upbringing.	<i>No example with regard to older people.</i>
Giving information, advice, and support to clients.	One desk policy (the goal is to have on reception desk for all provisions), client and civil participation, handling of complaints.
Supporting informal caregivers and	Voluntary services, chore aid, service point informal

volunteers.	care, organising suspension of care, informal care broker, voluntary courses, 'buddy projects' (buddies are voluntary workers who accompany the vulnerable and lonely).
Promoting participation of people with chronic psychological or psychosocial problems or a physical limitation in society, as well as their independency.	This consists mostly of general facilities and projects, such as: Social work, debt assistance, elderly provisions, accessibility of public space, buildings and public transport, adjustments to residences.
Providing facilities and services for people with a chronic psychological or psychosocial problems or with a physical limitation to promote their independency and societal participation.	This consists mostly of individually tailored facilities and projects, such as: Home help assistance, wheelchairs, scooters, transport provisions, provisions for residence, assistance in independent living, daytime activities, meal provisions. Aid can be provided in kind or with a personal budget.
Offering shelters and implementing policies to combat domestic violence.	Offering temporary sheltering, guidance, information, and advice for persons who have left their home situation and are not capable of supporting themselves.
Improving public mental health care.	Hotline for crises, reaching and helping socially vulnerable people.
Improving addiction policies.	<i>No example with regard to older people.</i>

Any forms of counseling that can be provided through the ZVW precede counseling through AWBZ. Some forms of individual counseling or daytime activities for psychiatric patients can be part of psychiatric treatment and under the responsibility of a medical specialist. In this case, counseling is funded through the ZVW. If the necessity of psychological counseling comes into existence in a time period after diagnosis or treatment, the counseling activities are no longer part of medical treatment and AWBZ-funding will be provided. Some insurers offer substitutive informal care-giving in their additional VHI packages.

3.5.5 Limits of the AWBZ: Treatment

AWBZ treatment consists mostly of continuous, systematic, long-term and multidisciplinary care for complex care problems that requires specifically trained professionals. Care from the ZVW is usually not continuous, systematic, and long-term, but can be multidisciplinary. An example is care that is needed for a client with a multiple handicap, who might need behavioral therapy, and medical and paramedical assistance.

A main practitioner – in charge of the coordination of care – is appointed for the client in case of AWBZ treatment; this main practitioner may essentially be from any discipline. Treatment is aimed at preventing the worsening of consequences and/or complications of the ailment or the coming into existence of a disorder or limitation that is associated with the ailment, and at learning new skills and/or behavior.

3.5.6 Limits of the AWBZ: Long-term residence⁵

As stated in paragraph 3.1, indication setting for long-term stay – four full days per week or more – is done in the form of care weight packages or ZZPs. [Text ZZPs removed!] Formally, any care or compensation from the voluntary health insurance, such as informal care suspension of care-givers, is not obligatory by the ZVW and therefore no precedence from other arrangement exists. Instead, when care-givers have this option, the CIZ can alter their indication on the basis of point 12 of the CIZ funnel. Also, the first 365 days of sequential residence in a psychiatric institution is compensated by the ZVW.

3.5.7 Limits of the AWBZ: Short-term residence

No legal provisions precede short-term residence care from the AWBZ. Some general accessible facilities do precede this type of AWBZ care, such as alarms, volunteers, client support through MEE (organization offering support to people with functional limitations), voluntary health insurance or forms of informal care-giver support.

⁵ Information from <http://zorgzwaarte-pakket.nl>.

Index of abbreviations

- AFBZ = Exceptional Medical Expenses Fund (*Algemeen Fonds Bijzondere Ziektekosten*)
- AOW = State pension law (*Algemene Ouderdomswet*)
- AWBZ = Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*)
- BIKK = Contribution to Reduction Expenses (*Bijdrage in de Kosten Kortingen*)
- BKZ = Budget for Health Care (*Budgetair Kader Zorg*)
- BSN = Citizen Service Number (*Burgerservicenummer*)
- CAK = Central Administration Office (*Centraal Administratiekantoor*)
- CBS = Central Bureau for Statistics
- CIZ = Centre for Needs Assessment (*Centrum Indicatiestelling Zorg*)
- CVZ = Health Insurance Board (*College voor Zorgverzekeringen*)
- DBC = Diagnosis Treatment Combination (*Diagnose Behandeling Combinatie*)
- DOT = DBC on the way to Transparency (*DBC op weg naar Transparantie*)
- HBO = Higher Occupational Education (*Hoger Beroepsonderwijs*)
- HIF = Health Insurance Fund (*Zorgverzekeringsfonds*)
- IGZ = Health Care Inspectorate (*Inspectie voor de Gezondheidszorg*)
- GP = General Practitioner
- MBO = Secondary Occupational Education (*Middelbaar Beroepsonderwijs*)
- NZa = Dutch Health Care Authority (*Nederlandse Zorgautoriteit*)
- PGB = Personal Budget from the AWBZ (*Persoongebonden Budget*)
- SSP = SVB Service Center
- SVB = Social Insurance Bank (*Sociale Verzekeringsbank*)
- UZI = Unique Health Care Provider Identification (*Unieke Zorgverlener Identificatie*)
- VHI = Voluntary Health Insurance
- VWS = Ministry of Public Health, Welfare, and Sports (*Ministerie van Volksgezondheid, Welzijn en Sport*)

- WBSN-Z = *Law on the Use of the Citizen Service Number in Health Care (Wet Gebruik Burgerservicenummer in de Zorg)*
- WMCZ = *Law on Client Participation in Care Institutions (Wet Medezeggenschap Cliënten Zorginstellingen)*
- WMO = *Social Support Act (Wet Maatschappelijke Ondersteuning)*
- ZVW = *Health Insurance Act (Zorgverzekeringswet)*
- ZZP = *Care Weight Package (Zorgzwaartepakket)*

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- <http://www.hetcak.nl>
- <http://www.pgb.nl>
- <http://www.rijksbegroting.nl>
- <http://www.rijksoverheid.nl/ministeries/vws>
- <http://www.rivm.nl>
- <http://wetten.overheid.nl/>
- <http://www.zorgkiezer.nl>
- <http://zorgzwaarte-pakket.nl>

Supplementary material: Laws & Reports

1. WMCZ: Law on client participation in care institutions

Chapter I. General definitions

Article 1

1. In this law the next definitions apply:
 - a. Our Minister: Our Minister of Public Health, Welfare, and Sports (VWS);
 - b. institution:
 1. an institution in the sense of the *Law on Healthcare Institutions Acceptance* (WTZi);
 2. every organizational association – operating as an independent unit in society – where societal care or public health is delivered and which is financed:
 - a. by the Health Insurance Board (CVZ) on the ground of the Health Insurance Act (ZVW) or Exceptional Medical Expenses Act (AWBZ);
 - b. by Our Minister on the ground of the framework Law VWS Subsidies or a municipality on the ground of the Social Support Act (WMO);
 3. every organizational association – operating as an independent unit in society – where care for the addicted is delivered and which is financed by Our Minister, a municipality or a province;
 - c. health care provider:
 1. a legal person or natural person, maintaining an institution;
 2. the legal persons or natural persons, maintaining an institution together;
 - d. client: a natural person for whom the institution functions.
2. Organizational associations – operating as an independent unit in society – where societal care or public health is delivered, and which are financed other than on the ground of a legal funding arrangement by Our Minister, can be classified as an institution in the sense of this law by ministerial regulation.
3. This law is not applicable to judicial institutions for treatment of the involuntary committed, as is specified in the penal code.

Chapter II. Client councils

Article 2

1. The healthcare provider establishes a client council for every institution maintained by him, that within the framework of the goals of the institution particularly promotes the common interests of the clients.
2. The healthcare provider provides in written form:
 - a. the number of members of the client council, the method of appointment, which persons can be elected as a member, and the legislative period of appointment;
 - b. the material means of the client council, which the client council can use for their activities.
3. The arrangement described in the second paragraph is such that the client council:
 - a. can reasonably be deemed representative for the clients, and
 - b. can reasonably be expected to be capable to promote their common interests.
4. The client council arranges its working method in written form, including representation inclusive and exclusive to the law.
5. The expenses of conducting legal suits by the client council, as meant in article 10, paragraph 2, are only charged to the healthcare provider in the case the healthcare provider was notified by the expenses in advance.
6. After providing the arrangement referred to in paragraph 2 the health care provider establishes the provisions that are necessary by this regulation for appointing the members of the client council. The healthcare provider establishes the provisions anew at any time when the client council has not functioned for two years due to a lack of members, of which the number is determined by the regulation.

Article 3

1. The healthcare provider provides for the opportunity of the client council to give advice about every intended decision concerning the institution with regard to:
 - a. a change in the goal or the ground;
 - b. transfer of control, a merger, or the start or breakdown of a long-term collaboration with another institution;
 - c. the liquidation of the whole or a part of the institution, a migration or substantial rebuilding;
 - d. an important alteration within the organization;
 - e. an important reduction, expansion or other alteration of the activities;
 - f. the appointment of person who directly attain highest control with the management of labor in the institution;
 - g. the budget and annual account;

- h. general policy with regard to admission of clients and the termination of health care provision to clients;
 - i. feedings affairs of a general nature, general policy in the domains of the security, the health, the hygiene, the mental healthcare, societal assistance to and recreational activities for clients;
 - j. the systematic guarding, controlling or improving the quality of the care that is to be provided to the clients;
 - k. the determination or alteration of a arrangement with regard to the treatment of complaints of clients and the appointment of persons charged with the treatment of complaints of clients;
 - l. alteration of the arrangement, referred to in article 2, paragraph 2, and the determination or alteration of other arrangements applicable to clients;
 - m. charging persons with the management of a part of the institution where 24 hours care is provided to clients who stay in the institution for the long term.
2. The advice is requested at such a point in time that it can be of essential influence on the intended decision.
 3. The client council is authorized to give unrequested advice to the healthcare provider with regard to the subjects referred to in paragraph 1, or other subjects that can be of importance to the clients.

Article 4

1. The healthcare provider does not take a decision that is different than a written advice of the client council, if no deliberation, if reasonably possible, was done with the client council at least once.
2. With regard to the subjects referred to in article 3, paragraph 1i-m, the healthcare provider does not take a decision, excluding any decision that has to be taken according to the law, that is different from the written advice of the client council, unless the committee referred to in article 10, has determined that the healthcare provider has reached the intended decision after reasonably consideration of all the interests involved.
3. The healthcare provider provides a written notification to the client council of a decision concerning a subject of which the client council has filed written advice, and provides arguments if the decision is different from the advice.
4. A decision from the healthcare provider taken in contradiction with paragraph 2 is void, in the case the client council has filed a written annulment with the healthcare provider. A client council can only file an annulment within a month after the healthcare provider has informed

the client council about the decision, or, in case of default of notification, the client council has noticed that the healthcare provider has implemented or executed the decision.

Article 5

1. The healthcare provider provides timely, and if requested written, all the information and data to the client council that the client council reasonably needs to fulfill its tasks and duties.
2. The healthcare provider provides the client council at least once a year with oral or written information concerning the policy that is executed in the passed time span, and that shall be executed in the coming year.

Article 6

1. The healthcare provider can assign the client additional competencies than the in this law states competencies. Such a decision is to be notified to the client council in written form.
2. The healthcare provider provides opportunity for the client council to give advice about an intention to take a decision as referred to in paragraph 1, and about an intention to alter such a decision. Article 4 is of similar appropriation.

Chapter III. Governance board of directors

Article 7

1. If a healthcare provider is a legal person as is referred to in article 3 of book 2 of the Civil Code, the statutes provide for regulations, safekeeping that clients can influence the assembly of the board of directors. The regulation at least includes that one member of the board is appointed by a binding nomination of the client council or client councils, unless the client council or client councils did or does not make use of this possibility.
2. Paragraph 1 is not applicable when the board of directors includes one or more persons who execute or executes this function on the basis of an employment contract on which rests a monetary reward. In this case paragraph 1 is of similar application on the assembly of the institute that is charged with the supervision or approval of decisions made by the board of directors.

Chapter IV. Publicity

Article 8

The healthcare provider assembles an annual written report in the way this law is applicable to the institution.

Article 9

1. The healthcare provider makes public 10 days after installation:

- a. the annual report;
 - b. written starting points for policy, including the general criteria that are employed by care provision;
 - c. the minutes and the decision list of the meetings of the board of directors, insofar these consist of general policy affairs;
 - d. a regulation of the handling of complaints of clients and other rules that apply to clients, as well as a regulation referred to in article 2, paragraph 2;
 - e. the report referred to in article 8.
2. The publication occurs by making the documents available for viewing, and by providing copies if so demanded by them.
 3. Notification of publication will occur by way that is common for notifying clients.
 4. A price can be placed on the dispensing of copies by request, no higher than the cost price, unless the Law on publicity of governance (WOB) is applicable to the institution.

Chapter V. Compliance

Article 10

1. The healthcare provider installs a three member committee of trustees in consensus with the client council or client councils, of which one can be appointed by the healthcare provider, one by the client council or client councils, and one by either parties, or appoints a committee of trustees installed by one or more client organizations and one or more healthcare provider organizations, that oversees the task of mediation and, if necessary, giving a binding verdict:
 - a. on the request of the client council, about disagreements with the healthcare provider concerning execution of article 3; 4 paragraph 1 and 3; 5 paragraph 1; and 9.
 - b. on the request of the healthcare provider, in the case the healthcare provider wishes to make a decision different from the written advice of the client council, relating to a subject referred to in article 3, paragraph 1i-m.
2. The client council and every client of the institution can file a written request with the cantonal judge of the court of the arrondissement in which the residential area of the healthcare provider lies, to command the healthcare provider to comply to article 2; 5 paragraph 2 7; 8; and paragraph 1 of this article. An applicant who did not request in advance from the healthcare provider to act in accordance with that which is requested in an appeal, and who did not give a reasonable term to comply to the appeal, is deemed non-admissible.

2. BIG: Law on the professions in individual healthcare

Chapter I. Definitions

Article 1

1. In this law and the on this law resting provisions the term individual healthcare refers to, besides the in paragraph 2 described actions, all other actions – including researching and giving of council – directly affecting a person, thereby covering the promotion and safekeeping of that person's health.
2. In this law and the on this law resting provisions is considered under the name of acts in the domain of medicine:
 - a. all actions – including researching and giving of council – directly affecting a person and to cure the person from disease, to guard the person from the origination of disease, or to judge the person's health condition, or to give obstetric assistance;
 - b. the taking of blood or tissue for other purposes referred to in a;
 - c. the taking of tissue from a deceased person and the performance of autopsy.

Article 2

1. In this law and the on this law resting provisions is considered under Our Minister the Minister of Health, Wellbeing, and Sports.
2. In the chapter VII and VIII and the on these chapters resting provisions is considered under Our Ministers the Minister of Health, Wellbeing, and Sports and the Minister of Justice.
3. In this law is considered under other deal-making states a state, not a member of the State of the European Economic Society, which is a party from the Deal regarding the European Economic Space or Switzerland.
4. In this law and the on this law resting provisions is considered under register a register installed according to article 3, paragraph 1.
5. In this law and the on this law resting provisions is considered under recognized specialist register a register of specialists on which article 14, paragraph 1 applies, or a specialist register that is installed in accordance with article 16.

Chapter II. Registration and protection of title

§ 1. General

Article 3

1. Registers will be installed, in which those who comply to the therefore installed prerequisites by this law will be subscribed, distinguished as:

- physician,
 - dentist,
 - pharmacist,
 - healthcare psychologist,
 - psychotherapist,
 - fysiotherapist,
 - midwife,
 - nurse.
2. The last name, first name, gender, date of birth, nationality, address, and number and date of registration of the person subscribed will be mentioned in the register.
 3. Every register will be installed and controlled by Our Minister.
 4. The registers will be installed to comply to a request for information as referred to in article 12, and to facilitate supervision of implementation of articles 4 and 17.

Article 4

1. To those that are subscribed in the register is given the right to use the term in which they are subscribed as referred to in article 3, paragraph 1.
2. To those who do not receive the right to use a title as referred to in paragraph 1, forbidden to use this title, a similar denomination, or a signature that refers to this title, declared with application of article 93 or mainly similar to this.
3. As long as a subscription to the register is suspended, the person involved is equated to a non-subscripted.
4. In this law and the on this law resting provisions is considered under the titles as referred to in article 3, paragraph 1, insofar there is no contradictory argument, as those who are subscribed in the register as such.

Article 5

1. Our Minister is authorized to decide to subscription in the register by request.
2. By general decree of the board of directors rules will be installed about the amount to be paid for handling of request, as well as the way of submission of the request, and the thereby to provide information and documents that are needed to judge the request. The amount referred to in the first sentence is determined in such a way that the expenses of the handling of this request are paid for.
3. By general decree of governance an amount can be established that is charged in the period referred to in the decree to the professionals for being subscribed in the register. The amount

referred to in the first sentence is determined such that the expenses of being subscribed in the register are covered.

Article 6

Subscription is refused:

- a. if the requestor does not comply to the prerequisites of education referred to in chapter III;
- b. if the requestor is put under legal constraint by judicial verdict for a mental disorder;
- c. if the requestor is deprived of the right to perform a profession by judicial verdict;
- d. if this results from a decree taken on the basis on the grounds of this law for the requestor.

Article 7

Subscription is stricken out:

- a. in case of death of the requestor;
- b. on the request of the subscribed;
- c. if the subscribed is under the circumstance referred to in article 6, paragraph b or c;
- d. if this results from a decree taken on the basis on the grounds of this law for the requestor.

Article 8

1. By general decree by the board of director is decided that the subscription to a register referred to by the decree is stricken out if after the in the paragraph 2 referred to date has passed with a time period referred to in the decree.
2. The in paragraph 1 referred to date is the most recent of the next dates:
 - a. the date on which the subscribed has received a certificate referred to by chapter III or VI a statement referred to by article 41, paragraph 1, section b, or a recognition of professional qualifications referred to in the EU law governing recognition of professional qualifications.
 - b. in the register assigned date following from a request by the subscribed, preceded by successful education which is completed in the period referred to in paragraph 1 and consistent with the by Our Minister installed rules;
 - c. in the register assigned date following from a request by the subscribed, preceded by the professional practice by the subscribed in the involved domain which complies in duration and spread to the in paragraph 1 referred to period by the to be regulated general decree of the board of directors.

3. With deviation from paragraph 1, the subscription of a specialist, for which an arrangement applies as referred to article 15, paragraph 1, in the in paragraph 1 referred to register will not be stricken as long as the specialist is subscribed in an acknowledged specialist register.
4. To a request as referred to in paragraph 2, section b or c, is article 5 similarly applicable.
5. The striking out is omitted as long as a decision is not made on an already filed request for annotation of a date as is referred to in paragraph 2, under b or c.
6. [This paragraph is not applicable yet.]
7. Our Minister can:
 - a. set prerequisites by which the nature of the practices, referred to in paragraph 2, section c, has to comply for the application of this article.
 - b. appoint practices, either within or outside the domain of individual healthcare, that are equated to practices on the involved domain of professional practices for application of this article.

Article 9

1. In the register a note, when it follows from a decree or decision based on this law, shall be made:
 - a. the suspension of a subscription;
 - b. the restrictions that have been imposed the subscribed;
 - c. the partial denial of the authority to execute the in the register notified profession;
 - d. the ending of a suspension, other than a consequence of the expiring of a time period settled by a decree;
 - e. the loss of applicability of the restrictions referred to in section b, other than the result of the expiring of the trial period, and of the denial referred to in section c.
2. With a note as referred to paragraph 1 is mentioned:
 - a. the date of the notification of a suspension, together with the duration of the suspension if that is already known;
 - b. the date on which the restriction or denial referred to in paragraph 1 is applicable, together with, when the restrictions are limited to the trial period, the duration of it, or;
 - c. the data on which the suspension is ended or since when the restrictions or denial, as referred to in paragraph 1, is no longer applicable.

Article 10

1. Every subscription to, notation in, or striking from a register occurs on the grounds of a befitting, dated and signed ordinance.

2. Our Minister sends a transcription of an ordinance as referred to in paragraph 1 to the administrator of the register of health care providers, as referred to in article 14 of the *Law on use of citizen service number in healthcare*.

Article 11

1. Our Minister provides for public announcement of:
 - a. that which is noted and mentioned in the register on the ground of article 9, considering that the conditions imposed on the subscribed are only notified in the case it needs to be reported by general decree of the board of directors;
 - b. the striking from the register by implementation of a taken measure on the ground of this law, with notification of the ground on which the striking rests;
 - c. the subscription of a person in case the preceding subscription of that person is stricken out by implementation of a taken measure on the ground of this law.
2. The name and place of residence is mentioned in the public announcement. The public announcement occurs in a by general measure of governance arranged manner, which should at least occur in the *Staatscourant*.

Article 12

1. On the request of a person involved, all information applicable to him in the register should be notified to him.
2. For everybody who so desires is notified:
 - a. if a person is subscribed in a register;
 - b. if the subscription of a person is suspended in a register;
 - c. if, with regard to the subscribed, a measure is taken concerning a partial denial of authority to practice the involved profession, with, if this is the case, a description of the content of the measure;
 - d. in case this is to be reported by general measure of governance: if with regard to a subscribed person conditions are given, with, if this is the case, a description of these conditions and, if these are limited to a probationary period, a notification of the duration thereof.
3. The providing of notifications, referred to in paragraph 2, other than to governing bodies or governed services, occurs, insofar it takes place in writing, against payment according to a by general decree of governance applied tariff.

Article 13

The data from registers can also be used for implementation of the Law on physicians in emergency situations, the Law on market planning of health care, and the sending of information

from governing bodies concerning public health, appointed by State supervision on public health or by other by our Minister appointed governing bodies, to the in the register subscribed persons.

§ 2. Specialisms

Article 14

1. When an organization of practitioners of a profession as referred to in paragraph 3 has a specialist register for the subscription of professionals who have gained a special expertise with regard to the practicing of a domain in their profession, and a title is connected to that subscription, our Minister can decide that this title is recognized as a specialist title by law. An application for this is done by the governance of an organization; the governance can also pass this authority onto the organizational body referred to in paragraph 2d.
2. Such a decision will only be taken by our Minister if that is desirable to promote a good practice of individual health care, and if the next conditions are met:
 - a. the organization is, to the judgment of Our Minister, sufficiently representative for the practitioners of the involved profession;
 - b. the organization is an lawfully competent association;
 - c. the organization makes rules in which is recorded
 - the procedure for the decision-making context within the organization with regard to the installation of a specialist register,
 - the tasks and composition of the different bodies and
 - the tariff which, to cover expenses, applies to the handling for the request for subscription as a specialist and for the acknowledgement of educational institution, respectively trainer.
 - d. the organization has an organizational body that
 - is charged with the decision to install a specialist register, and
 - established rules with regard to the demands that are given for subscription as a specialist and for acknowledging educational institutions, respectively trainers for a specialism.
 - e. the organizations also has an organizational body that is charged with
 - the subscription of specialists,
 - the recognition of educational institutions, respectively the trainers, and
 - the supervision on the execution of the rules by the acknowledged educational institutions, respectively trainers.

3. A regulation established by an organizational body as referred to in paragraph 2d is in accordance with the rules established by or by virtue of *Trb. 2000, 16 and 86*.
4. The regulations referred to in paragraph 2c and 2d require the approval of Our Minister; the approval can be withheld when in conflict with the law or common interest.
5. Subscription in an acknowledged specialist register is not dependent on the membership with the organization.
6. Subscription in an acknowledged specialist register is solely possible for persons subscribed in the BIG register.
7. To everyone who so desires the administrator of an acknowledged specialist register notifies if that person is subscribed in the specialist register.
8. Our Minister can give directions of a general nature to an organizational body as referred to in paragraph 2d with regard to the in this article referred to tasks in connection with binding decisions of the European Community as well as for improvement of a good practice of the individual health care. Before initiating this, he hears the organizational body. A direction cannot mean that a specialist register is established for a specific domain.
9. Our Minister can revoke a decision that is based on paragraph 1 if that what is decided in this article is not fulfilled.
10. The organizational body as referred to in paragraph 2d will provide to Our Minister, if so desired, the information needed for the execution of his tasks. Our Minister can claim to inspect formal information and documents insofar that is reasonably needed to fulfill his tasks.
11. The Outline law on independent governing bodies is applicable to an organizational body as referred to in paragraph 2e, insofar this organizational body is exercising activities with regard to an acknowledged specialist register. In contrast to the first sentence, article 22 of the Outline law on independent governing bodies is not applicable, insofar this relates to matters of subscription.
12. In the *Staatscourant* is reported:
 - a. the decisions of Our Minister under paragraph 1, 4, 8, and 9;
 - b. establishment and amendment of a regulation as is referred to in paragraph 2c and 2d.

Article 15

1. A regulation as referred to in article 14, paragraph 2d, can also mean that a person who has completed the training as a specialist is subscribed as a specialist for a certain period, established by regulation, and that a sequential renewed subscription only takes place if the specialist has been practicing regularly on the involved domain of the profession in a, with

that regulation established, time period, or will practice the profession under the with renewed subscription indicated educational conditions.

2. If a regulation as referred to in paragraph 1 is applied, within that regulation:
 - a. requirements can be placed in which the activities, as referred to in paragraph 1, need to be fulfilled for the appropriation of that paragraph;
 - b. activities can be appointed, not necessarily in the domain of individual health care, that are aligned with activities within the involved domain of professional practice for application of paragraph 1;
 - c. requirements can also be made for participation in expertise improving activities during the in paragraph 1 referred to period of activity.
3. A regulation as referred to in paragraph 1 offers to a person for whom subscription is not renewed as a specialist for not meeting the requirements, the possibility to be subscribed again as a specialists as soon as the requirements are met by receiving training that is appropriate for the knowledge and skill level of the person involved.
4. In cases article 14 paragraph 1 is appropriate, the professional organization is deemed to notify Our Minister for every subscription to or striking from the register. For every subscription to and striking from the register, a dated notification is placed in the register. If a subscription is stricken from the register on the ground of a regulation as referred to in paragraph 1, the tasks as referred to in the first and second sentence, respectively note, solely take place if the involved person is not subscribed again as a specialist within four weeks.
5. Without prejudice to what applies to the subscribed, as referred to article 12, paragraph 2, to anyone who so desires is notified if the involved person is registered.
6. Striking from the register or suspension of a subscription in the register brings with it, by law, that the subscription of the involved as specialist is expired, respectively is suspended accordingly. Of every striking from the register or suspension of subscription in the register is given notification to the involved organization.

Article 16

If no acknowledged specialist register exists in a certain domain of profession as referred to in article 3, and such is necessary according to binding decisions of the European Community, or promotion of good practice of individual health care is desired, rules can be established by general decree of governance. Article 15 applies to a specialist register that is installed in such a manner.

Article 17

1. The right to claim a specialist title is reserved to those that are subscribed in the involved acknowledged specialist register.
2. It is forbidden for a person to claim a specialist title acknowledged by this law, when he has no right to claim the title on the ground of paragraph 1.

Chapter III. Provisions with regard to the professions

This will be described in the next year of this project, if requested.