
The Dutch health care system

Part 2: Organizations, information-sharing, payment structures, and increasing health care expenditure

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Leyden Academy
ON VITALITY AND AGEING

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

Foreword

Before you lies the second report by the Leyden Academy on Vitality and Ageing on the Dutch health care system, written for the Institute of Future Welfare in Japan. In this report the focus lies on:

- the different institutions supporting the Dutch health care system;
- systems of communication and information-sharing between health care providers;
- systems of payments and incentives in the health care system, and its strengths and weaknesses;
- past, current and (potential) future ways of dealing with population ageing and increasing health care expenditure (cutbacks and increasing efficiency).

Before continuing with these subjects, we first want to clarify some important terms and recent changes in the health care system. We use the term medical care to specify all the care that was delivered within the confounds of the ZVW. Medical care thus pertains to care given by general practitioners, medical specialists (or other hospital care), allied health care, dental care, and others. We use the term long-term care to specify all the care that was delivered within the confounds of the AWBZ. Long-term care can refer to personal care, nursing care, treatment by nursing home doctors and nurses, and residence for the frail elderly, mentally ill, or handicapped. Medical care and long-term care is separated from social support. Social support is officially not a part of the Dutch health care system, but rather a law that ensures the Dutch can be independent, socially active, and that they feel mobile, safe and satisfied in their neighbourhood or village. In the report, social support mainly refers to domiciliary care (housecleaning, grocery shopping, etc.), provision of instrumental aids (wheelchairs, scoot mobiles), adjustments in the house, support to informal care-givers and voluntary workers, and other initiatives to improve the social and personal wellbeing of older clients.

This report is written in a time of economic and political turmoil in the Netherlands. In the last few years, as well as the coming years, many changes will take place in the Dutch health care system. For example, important changes already took place in the AWBZ and more changes have yet to come. AWBZ care no longer includes domiciliary care (from 2008), because it relates more to social support than long-term care. Rehabilitation will be transferred to the ZVV (from 2013), and personal care and counselling will also become part of the WMO (starting from 2015). We anticipate future changes in the AWBZ, since population ageing is expected to cause increasing pressure on available care staff and collective finances. Our new government (installed in November 2012) has announced new changes. These changes mainly entail a decrease in the number of people who are eligible for AWBZ care, as well as a focus on independent living and active citizenship.

The list of abbreviations in the next section might aid the reader in coming to grips with the many laws, systems and institutions, as well as its abbreviations. As in the first report, patients, health insurance consumers, and those eligible for AWBZ and WMO will be called clients in this report. And of course, similar to the first report, if any questions remain unanswered, or the reader needs further information, the Leyden Academy is more than willing to answer them.

Herbert Rolden & Marieke van der Waal

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General abbreviations

AIO	Supplementary Income security for the Elderly	<i>Aanvullende Inkomensvoorziening voor Ouderen</i>
AIS	Information System for Pharmacists	<i>Apotheek Informatiesysteem</i>
AOW	State pension law	<i>Algemene Ouderdomswet</i>
Anw	Surviving relatives pension	<i>Algemene nabestaandenwet</i>
AWBZ	Exceptional Medical Expenses Act	<i>Algemene Wet Bijzondere Ziektekosten</i>
AZR	AWBZ Care Registration	<i>AWBZ-brede Zorgregistratie</i>
BKZ	Budget for Health Care	<i>Budgetair Kader Zorg</i>
BSN	Citizen Service Number	<i>Burgerservicenummer</i>
CAK	Central Administration Office	<i>Centraal Administratiekantoor</i>
CBP	Dutch Data Protection Agency	<i>College Bescherming Persoonsgegevens</i>
CBS	Central Bureau for Statistics	<i>Centraal Bureau voor de Statistiek</i>
CIC	Compliment for Informal Care-givers	<i>Mantelzorgcompliment</i>
CIZ	Centre for Needs Assessment	<i>Centrum Indicatiestelling Zorg</i>
CVZ	Health Insurance Board	<i>College voor Zorgverzekeringen</i>
DBC	Diagnosis Treatment Combination	<i>Diagnose Behandeling Combinatie</i>
DOT	DBC On the way to Transparency	<i>DBC op weg naar Transparantie</i>
GP	General Practitioner	<i>Huisarts</i>
GPC	General Practitioner Center*	<i>Huisartsenpost</i>
GuWA	Data exchange WMO-AWBZ	<i>Gegevensuitwisseling WMO-AWBZ</i>
HIF	Health Insurance Fund	<i>Zorgverzekeringsfonds</i>
HIS	Information System for GPs	<i>Huisartsen Informatiesysteem</i>
LSP	National Switching Point	<i>Landelijk Schakelpunt</i>
NZa	Dutch Health Care Authority	<i>Nederlandse Zorgautoriteit</i>

PGB	Personal Budget (from the AWBZ or WMO)	<i>Persoongebonden Budget</i>
RIO	Regional Indication Office	<i>Regionaal Indicatie Orgaan</i>
RIVM	National Institute for Public Health and the Environment	<i>Rijksinstituut voor Volksgezondheid en Milieu</i>
SSP	SVB Service Center for PGB	<i>SVB Service Centrum voor PGBs</i>
SVB	Social Insurance Bank	<i>Sociale Verzekeringsbank</i>
UZI	Unique Identification of Health care provider	<i>Unieke Zorgverlener Identificatie</i>
VWS	Public Health, Welfare, and Sports	<i>Volksgezondheid, Welzijn en Sport</i>
VZVZ	Alliance of Health care providers For Health care Communication	<i>Vereniging van Zorgaanbieders Voor Zorgcommunicatie</i>
WBSN-Z	Law on the Use of the Citizen Service Number in Health Care	<i>Wet Gebruik Burgerservicenummer in de Zorg</i>
WMG	Law on Market structuring Health care	<i>Wet Marktordening Gezondheidszorg</i>
WMO	Social Support Act	<i>Wet Maatschappelijke Ondersteuning</i>
ZIS	Information System for Hospitals	<i>Ziekenhuis Informatiesysteem</i>
ZVW	Health Insurance Act	<i>Zorgverzekeringswet</i>
ZZP	Care Weight Package	<i>Zorgzwaartepakket</i>

*A GP centre is a central GP practice that is open for emergency doctor visits outside regular clinical hours (regular clinical hours are usually workdays 8.00 – 17.00).

Dutch branch organizations in health care

Actiz	Branch organization for health care entrepreneurs
Federatie Opvang	Branch organization for shelters for the homeless, victims of domestic violence, and other vulnerable population groups
GGZ	Mental Health care association

KNMG	Royal Dutch Corporation for the promotion of Medicine	<i>Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst</i>
KNMP	Royal Dutch Corporation for the promotion of Pharmacy	<i>Koninklijke Nederlandse Maatschappij ter bevordering der Pharmacie</i>
LHV	National General Practitioners' Association	<i>Landelijke Huisartsen Vereniging</i>
NVZ	Dutch Association of Hospitals	<i>Nederlandse Vereniging van Ziekenhuizen</i>
VGN	Association for Handicapped care in the Netherlands	<i>Vereniging voor Gehandicaptenzorg Nederland</i>
VHN	Association of General Practice Centers in the Netherlands	<i>Vereniging Huisartsenposten Nederland</i>
VNG	Association of Dutch Municipalities	<i>Vereniging van Nederlandse Gemeenten</i>
ZN	Health Insurers in the Netherlands	<i>Zorgverzekeraars Nederland</i>

1. Institutions concerned with coordinating and or financing health care

The following institutions are at least in some way concerned with establishing, promoting or organizing health care in the Netherlands. Institutions directly related to health care provision, such as general practices, hospitals or residential homes, are not included. These institutions were described in the first report, but are explained more thoroughly below on request by the Institute of Future Welfare Japan.

1.1 Central Administration Office (CAK)

The CAK has three main tasks:

1. Establishing, imposing and collecting compulsory deductibles for AWBZ care and WMO support. The compulsory deductible for AWBZ care is based on a client's income (wages, state pension, private pension, and/or interest on capital), family situation (living with or without a partner, either intramural or extramural), and the AWBZ indication applicable to the client.
2. Establishing and paying compensatory fees for the chronically ill or handicapped, with the aim to cover part of the compulsory deductible of the ZVW or other expenses. Chronically ill and disabled people can incur exceptionally high health care costs, and almost always pay the full compulsory deductible every year. The reason to levy compulsory deductible is to discourage Dutch citizens to overuse health care facilities, but since the chronically ill and disabled cannot choose to forego health care utilization, the compulsory deductible has no effect on them. Stronger still, without compensatory fees the compulsory deductible would further widen the income gap between disadvantaged and healthy citizens, which is exactly the opposite of what the Dutch government is trying to achieve with the ZVW.
3. Financing health care providers who provide AWBZ care. The CVZ administers the AWBZ fund. Inflow in the AWBZ fund comes from Dutch citizens with a taxable income, outflow goes to the CAK. The CAK disperses the fund to the different health

care organizations, clients, and health care providers (by order of the care offices, who receive the bills from health care providers).

The CAK was founded in 1968, one year after the AWBZ was introduced. The aim with establishing the CAK of the Dutch government was to outsource the effectuation of some laws for which the Ministry of VWS is responsible. Currently, around 1,100 employees work at the CAK.

1.2 Centre for Needs Assessment (CIZ)

The CIZ is the only institution who can set indications for citizens wanting to receive AWBZ care. Without an indication from the CIZ, one cannot receive AWBZ care. Either the client him-/herself, or an employee from a health care provider, may fill in a request for a CIZ indication. The CIZ judges a request on the basis of a “funnel” model, which is explained in detail in the first report.

The CIZ can also be requested by municipalities to set indications for the WMO. Officially, the branch of the CIZ that sets indications for the WMO is called *MO-zaak*. The employees of MO-zaak may use information on a client’s information and indications regarding the AWBZ from the CIZ, but only with the explicit permission from the client. In this report, we will refer to the CIZ as an organization that can set indications for the WMO, rather than MO-zaak.

Its main office is in Driebergen, a village centrally located in the Netherlands. There are 10 regional offices in the Netherlands. These regional offices set the CIZ indications and notify the concerned care offices of a new indication, or a change in a previously set indication. The CIZ has around 1,700 employees and was established in 2005. Before 2005, Regional Indication Offices (RIOs) were responsible for setting indications.

1.3 Health insurance board (CVZ)

The CVZ has three major tasks:

1. Providing money from the Health Insurance Fund (HIF) and the AWBZ fund to health insurance companies, the CAK and care offices. Medical care providers bill health insurers, and long-term care providers bill care offices for provided health care. These expenses are covered by the different fees and premiums that Dutch citizens and employers pay. Employers and government agencies paying social benefits, deposit the income-related fees in the HIF and the AWBZ fund. The CVZ administers the HIF and the AWBZ fund. Health insurers also receive compensation from the HIF if they have more high-risk clients (risk equalization).
2. Advising the Ministry of Health, Welfare and Sports on the specific content of the basic health insurance package. Based on scientific findings and societal developments, the CVZ weighs different arguments from health care, societal and financial perspectives, and produces an advice on the content of the package. The Ministry of Health, Welfare and Sports often follows this advice.
3. Giving standpoints on disputes. For example, on April 2 2012 the CVZ gave its official standpoint on whether or not physiotherapy should be compensated through the ZVV for patients with COPD.

1.4 Dutch Competition Authority (NMa)

The NMa is an independent government institution aimed to promote free market dynamics in different economic sectors, to the benefit of Dutch consumers. It checks whether there are no cartels or instances of market power misuse. It also stimulates free market dynamics in transportation and energy. These are economic sectors where there is no free market system yet. The direct aims of the NMa is to implement and monitor compliance with market legislation originating from the different ministries

(mainly the Ministry of Economic Affairs). To realize these aims, the NMa performs different activities:

- Providing advice for policy-makers and legislators. The NMa also invests in research to remain up to date with changes in different markets.
- Providing information concerning market regulations to companies, mainly with lectures, conferences, and booklets. A company can ask the NMa to issue a provisional statement on a situation, if the company is unsure whether any competition laws are broken.
- Investigating whether any laws are broken by companies. The NMa is watching companies and other market players, to ensure mergers comply with competition laws, and no cartels are formed or market power is misused.
- Ensuring offenders receive a penalty. Offenders will receive a fine dependent on a the company's turnover.

Box 1: An example of NMa activities

2010: NMa inspects hospitals on suspicion of forming a cartel

In the beginning of 2010, the NMa inspected two hospitals in Amsterdam, who where suspected of forming a cartel. Patients reported that they might have been referred from one hospital to the other on the basis of their residential area. When health care providers make agreements to "divide the market" they are overstepping the boundaries of the law. The NMa could not conclude on the basis of these visits that the two hospitals were forming a cartel, but the NMa did find that sensitive information was exchanged between these two and other hospitals. This sensitive information consisted of statistical information on characteristics of the patient population. The NMa found that exchanging such information can lead hospitals to change their market strategies, or to use this information when negotiating contracts with health insurers. Together with the hospitals, the NMa established a set of rules and protocols on the exchange of sensititive information.

1.5 Dutch Health care Authority (NZA)

The core task of the NZa is to regulate the free market system of health care in the Netherlands. It is entitled to issue policy rules – which are lawfully valid – concerning prices for health care services and codes of conduct. The NZa makes sure that the freedom of health care providers and insurance companies within the free market system is used to the benefit of the people. More specifically, the NZa is concerned with the following activities:

- Controlling whether health insurance companies and health care providers comply with three laws: the AWBZ, WMG, and ZVW.
- Controlling whether health insurance companies and health care providers do not attain “considerable market power” (“*aanmerkelijke marktmacht*”). A company reaches such a level of power if it can act against the interest of the Dutch clients without interference from potential competitors. The NZa will issue strict regulations for companies that have attained considerable market power.
- Controlling whether clients are well informed (correctly, clearly, and completely) about financial or health care matters by insurance companies and health care providers.
- Issuing official standpoints on mergers in the health care market to the NMa.
- Effectuating generic rules to ensure competition. In this case, no specific market parties are addressed, but generic rules are applied to benefit multiple parties. For example, the NZa decided that (new) market players may not be obstructed in accessing IT infrastructures or electricity networks.
- Setting budgets and tariffs for that part of the health care sector that does not function as a free market. The NZa sets the maximum tariffs for prices that long-term care providers may bill providers of AWBZ care. For example, in 2012 long-term care providers could charge no more than € 46.65 for one hour of extramural personal care (without extra modules).

Three real-life examples of activities by the NZa are displayed in box column 2 below.

Box 2: Examples of activities by the NZa

November 2 2012: NZa gives an official standpoint on three hospital mergers

The NZa issued the statement that three planned mergers of six hospitals could lead to increased prices for medical care services with freely negotiable fees (DOTS in the B segment, see paragraph 3.2.2). Because the mergers will increase the market power of the hospitals, they can set higher fees for medical services, which is against the interest of Dutch citizens. The hospitals concerned in the three mergers are:

- *Orbis Medical Care Concern and Atrium Medical Centre Parkstad* (South-Limburg). Estimated price increase: 4-9%.
- *Spaarne Hospital and Kennemer Infirmary* (Hoofddorp and Haarlem): 9-18%
- *TweeSteden Hospital and St. Elizabeth Hospital* (Tilburg): 22-33%.

These estimated price increases were calculated by the NZa with simulation models. The Dutch Competition Authority (NMa, see paragraph 1.4) will agree on a “price ceiling” with the hospitals, and it will check if the hospitals comply with these price ceilings. The NZa can intervene when the NMa reports a transgression, or when a hospital misuses attained market power in any other way.

October 3 2012: The NZa improves regulation for diagnostics in primary care

The NZa issued a policy rule for diagnostics in primary care, effective January 1 2013. Through this legislation health insurers and health care providers will be stimulated to improve the quality and cost-effectiveness of diagnostics in primary care. In essence, the policy rule merges different parts of other former policy rules, and offers a new definition of what officially counts as primary care diagnostics. Thereby, the NZa offers health insurers and health care providers a foundation for negotiation procedures. The health insurer is able to ensure quality and cost-effectiveness by rejecting unnecessary diagnostics and being able to negotiate contracts with those providers who offer the best price-quality ratio.

September 27 2012: The NZa establishes rules and prices for DOTs in hospital care for 2013

By issuing regulations for policy, the NZa sets performance criteria and maximum prices for complex university hospital care from medical specialists. This applies to the B segment of hospital care (see paragraph 3.2.2). The main improvement of these new policy rules is that compensation for medical specialists is revised to better reflect daily clinical practice. A sample of medical specialists was asked to adjust average treatment times for complex procedures, if necessary. New compensatory fees were calculated on the basis of these new average treatment times.

1.6 Social Security Bank (SVB)

The SVB pays out benefits to over 5 million Dutch citizens. Benefits that are relevant for older people are summarized and explained below.

State pensions (AOW)

Everybody above 14 years of age, and living in the Netherlands, builds up 2% compensation through the state pension. This means that when someone has lived in the Netherlands throughout life after 14 years, he or she will have built up 100% AOW benefits at the age of 65. In the coming years, the retirement age will slowly increase to 67. The amount of the AOW benefit depends on a person's living situation, and will vary between €587.86 and €1,291.12 (net worth).

Supplementary Income security for the Elderly (AIO)

The "social minimum" is the lower limit of someone's income, below which a person is not able to sustain him- her herself. If someone is 65 years or older, has not built up a full AOW benefit and does not receive much additional benefits or income, this person may end up with an income below this social minimum. In that case, this person will be eligible for receiving a supplementary benefit, or AIO.

Surviving relative pensions (“Algemene nabestaandenwet”, Anw)

Through the Anw every Dutch citizen is entitled to receive benefits (70% of the minimum wage) when someone next of kin dies (partner, parent, or sister/brother). To be eligible for compensation, the following conditions must apply: the receiver

- was married to the deceased, received alimony from the deceased, or was living together with the deceased;
- does not receive AOW;
- meets one of the following criteria: is either born before 1950, cares for a child under 18 years, or is at least 45% incapacitated to work.

Personal budgets for the AWBZ and WMO

If a person is eligible for care or support through the AWBZ or WMO, he or she may decide to receive a monetary compensation instead of care in kind. Officially, the SVB pays out these personal budgets (PGBs) by order of the care offices or municipalities. To keep it simple, we will keep the SVB out the remainder of this report. Instead, as is common in reports on the Dutch health care system, we will state that care offices or municipalities directly transfer PGBs to clients. The SVB Service Center for PGB (SSP) can help PGB-receivers with their administration free of charge.

Compliment for informal care-givers (CIC)

If someone provides intensive care for a long duration to another person or other persons, he or she may be eligible for receiving a “compliment”. This compliment was €200 in 2012. An informal care-receiver has to nominate the informal care-giver for this compliment.

Benefits for people below 65 years of age

- Child benefits
- Compensation for parents of a handicapped child living at home
- Compensation for asbestos victims

2. Information-sharing in the Dutch health care system

2.1 Information-sharing within the Zvw

Especially in the medical care sector, quality of care is greatly dependent on health care providers' timely reception of crucial and complete information concerning clients. However, the use of information systems to obtain and sustain such effective information-sharing between health care providers may not conflict with privacy rules and regulations. When legislation for the national electronic patient file was put to a halt by the senate in 2011, privacy concerns played a major role. Also, since competition between health care providers is stimulated, they might not be inclined to share information. It is therefore of utmost importance to establish solid legislation as well as an efficient infrastructure to manage information-sharing between medical care providers. Here, current and potential future information flows and information-sharing platforms in the health care market of the Netherlands are defined and explained.

2.1.1 Legislation concerning information-sharing¹

Legislation basically stipulates that sharing information about personal data, health status and health care utilization is illegal, unless certain conditions apply. This is a consequence of the “duty of confidentiality” that every health care professional and institute has. The premise of this duty of confidentiality is that health care professionals and institutes cannot share private information of clients (in particular their health status), health related matters that have been discussed in the consultation room, as

¹ Two major laws apply to privacy regulation in health care: the “Law on treatment relationships in health care” (Wgbo: *Wet inzake geneeskundige behandelingsovereen-komst*) and the “Law on protection of personal data” (Wpb: *Wet bescherming persoonsgegevens*). For the use of citizen service numbers (BSNs) by health care professionals, the WBSN-Z is applicable (see also paragraph 2.2 of the first year report). Other laws are: the “Law on quality of health care institutes” (*Kwaliteitswet zorginstellingen*) and the “Law on professions in individual health care” (*Wet op de beroepen in de individuele gezondheidszorg*).

well as (medical) treatments that have been prescribed. However, the duty of confidentiality may be overruled, but only in certain situations. These situations can be categorized into roughly four cases:

1. *Force majeur*: Other laws have priority over the duty of confidentiality. When no consent has been given by the patient to share information, but a threat to the patient or others exist, a health care professional may be obliged to serve a greater cause and overrule the duty of confidentiality. The following five conditions must all apply in this case²:
 - Upholding the duty of confidentiality causes harm to one or more people.
 - All means to receive consent from the patient have been used to no avail.
 - The health care professional is struggling with a moral dilemma by upholding the duty of confidentiality.
 - No other means than overruling the duty of confidentiality are available to face the threat or problem in question.
 - Overruling the duty of confidentiality will almost certainly solve the threat or problem.
2. The information that is shared is required by other health care professionals directly involved in the treatment relationship with the patient, such as colleagues, nurses, and assistants.
3. Patient consent to sharing information can be reasonably assumed, since the receivers of patient information are automatically involved in the treatment process, and the patient is almost certainly aware of this. In this case, patient consent is implicit. For example, when a GP refers a patient to a medical specialist, the patient may reasonably assume that a referral letter will be sent, containing information on the patient's health status and current/past (medical) treatments.
4. The patient has explicitly granted the health care professional or institute the authority to share information with specific other professionals or institutes.

² These conditions are based on protocols issued by the KNMG.

In short, if a third party needs information from an institute or a health care professional on a client's health status or medical treatments, but there is (1) no imminent threat characterized by the five conditions described above, (2) no direct treatment-relationship between the professional/institute, the client and the third party, and (3) one cannot reasonably assume that a patient gave implicit consent to information-sharing, the only legal way to share information is to receive explicit patient consent. Regardless of which of the four situations applies, when medical information is shared it is crucial that only the **minimum required information** is shared. The sharing of information which any professional or employee should deem irrelevant, is also illegal.

Although the importance of privacy protection is clear, there are two major downsides to the application of these laws:

- Legal boundaries are not always clear, especially concerning point 3 about reasonable assumptions. For example, when a client applies for a CIZ-indication, it might be reasonable to assume that the client gave implicit permission to a CIZ-employee to receive information from one or more health care professionals that he/she has a treatment-relationship with. However, CIZ-employees are not allowed to acquire this information without explicit patient consent.
- Patients might not be fully aware of the consequences of giving their consent. Currently, some medical care providers are working with national and regional switching points, for which explicit patient consent is required (see 2.1.3 and 2.1.4). Opponents of these initiatives claim that although patients may easily consent to be included in these platforms, they are not able to grasp the dangers of cybercrime or unscrupulous personnel.

2.1.2 AIS, HIS and ZIS

The AIS, HIS and ZIS stand for information system used by pharmacists, general practices and hospitals respectively. In principle, every health care provider collects its own individual client data. Collected are: the client's name, BSN (citizen service number),

address, date of birth, health insurer, possibly a specific health insurance number, and possibly other important personal data. Medical data about a client is linked to this personal data. Only authorized personnel of a health care provider may log into the information system to track individual client data.

The pharmacist collects information about medication history, current medication use, and allergy information. The hospital collects data about visits and results from tests, such as scans or lab work. In most hospitals medical information is collected as a paper file and archived, and only some medical information is stored electronically. For example, scan images are not saved in an information system in all hospitals, although this is changing fast. The GP collects data about patients' illnesses and somatic/psychological ailments, prescribed medication, lab results, and so on.

When a medical specialist starts a new treatment or finds important new test results, the GP is usually informed by letter. Unfortunately, these letters can arrive late or even not at all. Also, if a GP needs more (specific) information, communication back and forth has to be established, which can cause further delays. It is not uncommon that a GP is not up-to-date with his/her patient's health and treatment status. In the Netherlands, the GP plays a central role in health care; he is called the "gate-keeper to expensive specialist care" and is expected to be fully informed about his patient's health status and wellbeing. This is why discussions currently take place on more effective communication or information-sharing between different kinds of health care providers in the ZVW.

In April 2011, the Dutch senate voted against the implementation of a national electronic patient file (EPD). See the first report for more details. Since then, better communication within the ZVW is expected to come from regional EPDs and/or an alternative national infrastructure, called the National Switching Point (LSP). These two initiatives are explained below.

2.1.3 National Switching Point (LSP)

Before the law for a national EPD was rejected, an IT infrastructure was already put into place to bring the national EPD into effect. After the law was rejected, the Ministry of VWS withdrew from the EPD project. In January 2012, the newly established *Alliance of Health care providers For Health care Communication* (VZVZ) brought different health care institutions together for a renewal of the project. The VZVZ is an alliance of four umbrella organisations in health care provision and Nictiz, and is supported by the Dutch Patient and Consumer Organisation (NPCF). Nictiz is the National ICT Institute for Health care in the Netherlands. The four umbrella organisations are the branch organizations for general practitioners (LHV), general practice centers (VHN), pharmacists (KNMP), and hospitals (NVZ). Exchanging medical information through the LSP is in accordance with privacy legislation and laws concerning the relationship between health care provider and patient. The start of the LSP-project in October 2012 was approved by the Dutch Data Protection Agency (CBP).

The LSP makes instant access to basic and important medical information possible, mainly in emergency cases. GPs and pharmacists who collaborate with the LSP ask for written permission by their patients to include their personal information in the national information system. **This personal information concerns only the patient's BSN, and the identity of the patient's treating GP and pharmacist. Medical information on treatments, medication use, allergies, and so on, are not stored in the LSP.** This is why the installment of the LSP is not called an electronic patient file (EPD), but can, instead, be called a shared health care IT infrastructure.

Only a substituting GP, GP center, pharmacist or a medical specialist who is currently seeing the patient, may track a patient's personal information (BSN and treating GP and pharmacist). When the patient's personal information is retrieved, the medical care professional may log into the information system of the patient's GP or pharmacist and retrieve the medical information that is separately stored there. This separately stored medical information consists of a basic summary of the most important aspects of the patient's medical history, and does not comprise the complete

patient file. If a client has not given explicit permission to be opted in, the substituting professional or medical specialist cannot see this medical information.

A health care professional may only log into the LSP with an UZI-card, an UZI-card reader, and with the right certifications. The UZI-card is used in the following way:

1. The medical professional tries to locate his or her patient in the LSP search engine on the basis of the patient's BSN.
2. The medical professional logs in with a password and the use of a UZI-card, a card that looks like a credit card. The UZI-card grants the user authority to access patient information, depending on the region and the profession of the user.
3. When the identity of the client and the user of the LSP is confirmed, the user may access the database of other health care providers. The user may than only see a summary of medical information about the selected patient.

2.1.4 Regional IT infrastructures for medical care communication

Different forms of regional collaborations already exist, and the Minister of Health, Welfare and Sports has issued the statement that further investigation in the systematic legislation of regional collaborations should be encouraged. An important objection to a national EPD for members of the senate was that thousands of medical professionals could retrieve extremely sensitive information about any person in the Netherlands.

With a regional collaboration, only a couple of involved medical professionals can retrieve sensitive information, decreasing the chance of misuse by medical professionals or cybercriminals.

Regional collaborations on information-sharing can use a so-called Regional Switching Point (RSP). Similar to the LSP, the RSP offers a webportal where a medical professional can find a patient's personal information. On the basis of this information, the professional can, with the use of an UZI-card and -reader, look for basic medical information in another health care provider's information system. The difference with the LSP is that the RSP only offers personal information about patients from cooperating

health care providers in a certain region, and not from all cooperating health care providers in the country.

Regional collaborations can also take other forms. In this case, no RSPs with UZI-cards are used, but other agreements are made.

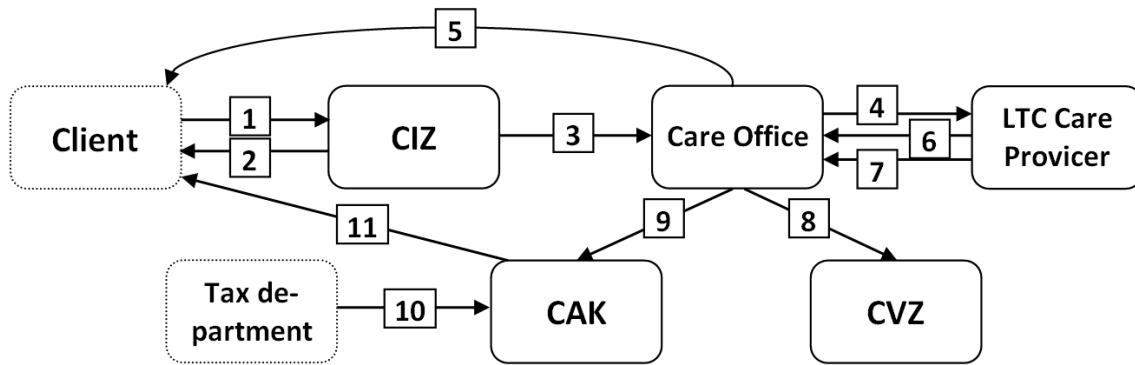
- Electronic File for Substituting GPs (EWH): If an EWH is active in a region, only a substituting GP will have access to the patient's medical records, or a basic summary of the medical records, if the patient is visiting. A substituting GP can be an assigned substitute or a GP from an emergency medical centre in the region. When a patient has a GP who is a part of an EWH, he or she is automatically included in this system, unless the patient signs a form in which he objects to information-sharing of this nature (opt-out system). In the province of Friesland, a broad EWH is used by 63 GPs (2008), giving GP centres in towns/cities like Heerenveen, Drachten, Leeuwarden and Dokkum the opportunity to access important patient information.
- Electronic Medication File (EMD): An EMD shows a patient's medication history. All pharmacists who are part of the regional collaboration may record medication provision to the patient, and look into the medication file. Because specialists also prescribe medication and patients don't always take their prescribed medication, the GP also has access to the EMD in some cases. In some instances specialists in regional hospitals may have access to the medication file, but only if the specialist is actually treating the patient. To give an example, GPs in Zoetermeer and Benthuizen have access to an EMD. Some specialists in a hospital closeby (*'t Lange Land*), also have access to this EMD.

2.2 Information sharing within the AWBZ

The AWBZ Care Registration system (AZR) is the information-sharing platform for the different institutions active in AWBZ care. The CIZ, the CVZ, the CAK, the different care offices, and long-term care providers have access to AZR. AZR is an information system

that displays client-level information regarding AWBZ care. Figure 1 shows how the information flows through AZR. The numbered information flows in the figure, are explained below the figure.

*Figure 1: Information-sharing between the different institutions active in the AWBZ**
 (Source: Plexus)



* The client and the tax department in this figure are circled with a dotted line, which means they are not allowed to access AZR.

The different information flows in figure 1 are:

1. The client, or someone acting on behalf of the client, makes a request for an indication at CIZ. A request can be made digitally, or by letter or telephone. Most often, a form is sent to the client when a request has been made. After filling in the form, a CIZ employee can call or visit the client, or contact a health care professional treating the client, to receive a more detailed picture of the client's situation.
2. The CIZ sets an indication and sends the indication decision in a letter to the client.
3. The indication decision is also sent to the care office that is responsible for arranging AWBZ care in the region where the client lives.
4. The care office appoints a long-term care provider to the client, dependent on the care demands and personal preferences of the client.
5. The care office sends a letter to the client, in which the appointed long-term care provider is mentioned.

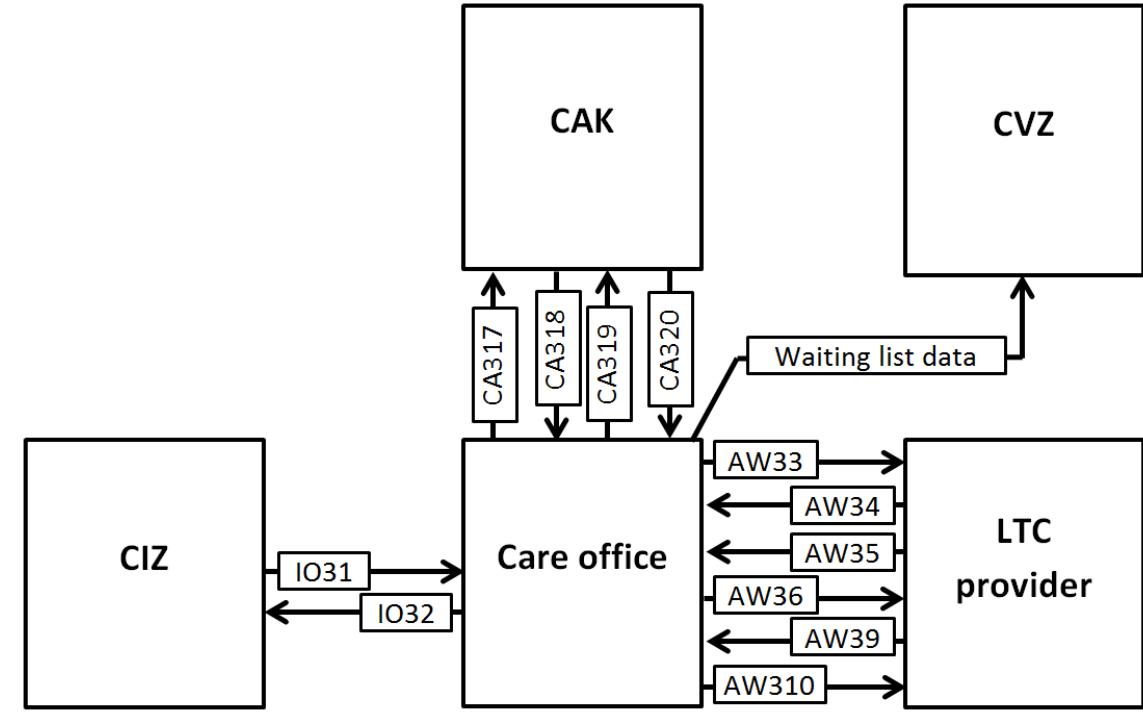
6. The long-term care provider reports the date that long-term care started, changed or ended in the AZR system.
7. At the end of the year, or when care for the client has ended, the long-term care institution bills the care office.
8. The care office sends information on the (potential) waiting lists at different long-term care providers to the CVZ.
9. The care office redirects information concerning the start, change or end of long-term care provision (see point 6) to the CAK.
10. The CAK receives information on the client's income status from the tax department.
11. The CAK calculates the compulsory client contribution for received AWBZ care on the basis of the information from the care office and the tax department.

The content of the AZR-system consists only of basic client information (BSN, address, date of birth) and a record of all the coded messages that have been sent. What the AZR-system can offer to authorized administrative personnel or health care professionals is an oversight of these messages. Personnel are only authorized to see the messages that are relevant for them. For example, personnel from the CIZ can only see their sent and received messages (IO31 and IO32). CIZ employees cannot see when the long-term care provider started or ended its activities, or how high the client contribution is. As can be deduced from figure 2 (next page), authorized personnel of care offices may see all messages. Figure 2 specifies which coded messages are used.

The basic content of the messages are explained below.

- IO31: The CIZ sends an indication decision to the care office. This decision comprises a kind and level of extramural care, and the time period for which the decision is valid (for example, personal care level 4, from 14/07/2011 to 14/07/2016).
- IO32: The care office sends a confirmation that the decision is received to the CIZ.

Figure 2: Coded messages in the AZR-system (Source: CVZ)



- AW33: The care office reports to the long-term care provider which kind and period of long-term care is appointed to the client.
- AW34: The long-term care provider sends a confirmation to the care office.
- AW35: The long-term care provider reports the start of long-term care provision to the care office.
- AW36: The care office sends a confirmation to the long-term care provider.
- AW39: A mutation in, or the end of, long-term care provision is reported to the care office.
- AW38: The care office sends a confirmation to the long-term care provider.
- CA317: The care office reports the start of long-term care provision to the CAK.
- CA318: The CAK sends a confirmation to the care office.
- CA319: The care office reports a mutation in, or the end of, long-term care provision to the CAK.

- CA320: The CAK sends a confirmation to the care office.
- Waiting list data: The care office sends data on waiting times of clients (the time difference between IO31 and AW33, and between AW33 and AW35). No confirmation is sent back.

2.3 Information sharing within the WMO

2.3.1 The WMO: The role of the municipality

The WMO is a law that aims to provide services that improve the opportunities and capabilities of citizens that are socially “disadvantaged” due to a handicap, an addiction, a mental illness, social isolation or abuse. The WMO fits into the broader aim of the government to reach social equality. This aim of social equality is reflected in WMO-policy. For example, when citizens of a municipality are unable to take a bus, for example due to a handicap, a municipality can decide to compensate other means of transportation for these citizens. This compensation is usually equal to the costs of taking a bus. Transportation costs that exceed the average bus fare are at the expense of the client him-/herself.

As mentioned in the first report, WMO provision can be categorized into nine “performance fields”. These are:

1. Social cohesion, “livability” of villages and neighbourhoods.
2. Support to youth and their parents.
3. Information, advice, and support to (potential) WMO clients.
4. Support to informal caregivers and volunteers.
5. Promotion and stimulation of societal participation.
6. Promotion and stimulation of independency.
7. Shelters and policies against domestic violence.
8. Improving public mental health care.
9. Improving addiction policies.

Unlike care or compensation for exceptional health care expenses (AWBZ), social support (WMO) is not a right. As such, municipalities are obliged to help disadvantaged people participate in society and the community, but they are essentially free to make and effectuate WMO policy. This means that the nature and quality of social support can differ between municipalities. Please see table A2.1 in the appendix for more details on the sort of support that is provided through the WMO, and how many municipalities provide these different services. An example of how client contributions are arranged differently in municipalities, can be found in 3.4.

WMO-services can be seconded to commercial organisations or other institutions. Municipalities often employ domiciliary care providers, taxi companies, volunteers, and other institutions to efficiently provide these services.

The responsibilities of the municipality regarding the WMO include:

- Setting the criteria for WMO eligibility, as well as the fees of clients' compulsory contributions. Some municipalities have stricter criteria for WMO support than others, and some municipalities demand higher contributions from their clients than others.
- Indication-setting, or seconding the practice of indication-setting to the CIZ or another qualified organization. When the municipality takes responsibility for setting indications, they must use the International Classification of Functioning, Disability and Health (ICF).
- Provision of services (provision of personal budgets and social support services in kind), or seconding of service provision to a commercial service provider.
- Handling of complaints and requests. Requests for indication-setting from a client, or someone helping the client, can be seconded to the CIZ.
- Budget decisions: Municipalities receive money through municipal taxes (mainly real estate tax) and the municipal fund, administered by the national government. The executive board of the municipality, consisting of the mayor and aldermen, allocates the municipal budget. The municipal council, elected by the municipal

population once every four years, decides on the municipal policies in the broad sense, and controls whether these policies are implemented by the executive board.

In short, municipalities have two main responsibilities regarding enactment of the WMO: policy-making and policy-implementation. To improve effective implementation of the WMO, policy-makers need to know the quality of their policy-implementation, and where the current strengths, weaknesses, opportunities and threats lie. This means that policy-makers and other municipal employees need to be embedded in a policy network where outcomes and financial, technical, and ethical issues are discussed. Such a policy network consists of the executive board, the municipal council, municipal employees, third parties to which WMO-services are procured, and other institutions and municipalities. As the social support act is relatively young, the best practices in sustaining a broad and effective policy network are not yet distilled.

It is clear, however, that municipalities are currently faced with issues in communication and information-sharing, mainly because of the quasi-market system. This is portrayed in figure 3, where information flows in the WMO for a fictional municipality are given in the case of a client needing transportation services and domiciliary care services. Other WMO-services, such as adjustments in the house or provision of wheelchairs, are left out to keep the figure clear, but delivery of these services could be organized in a similar manner.

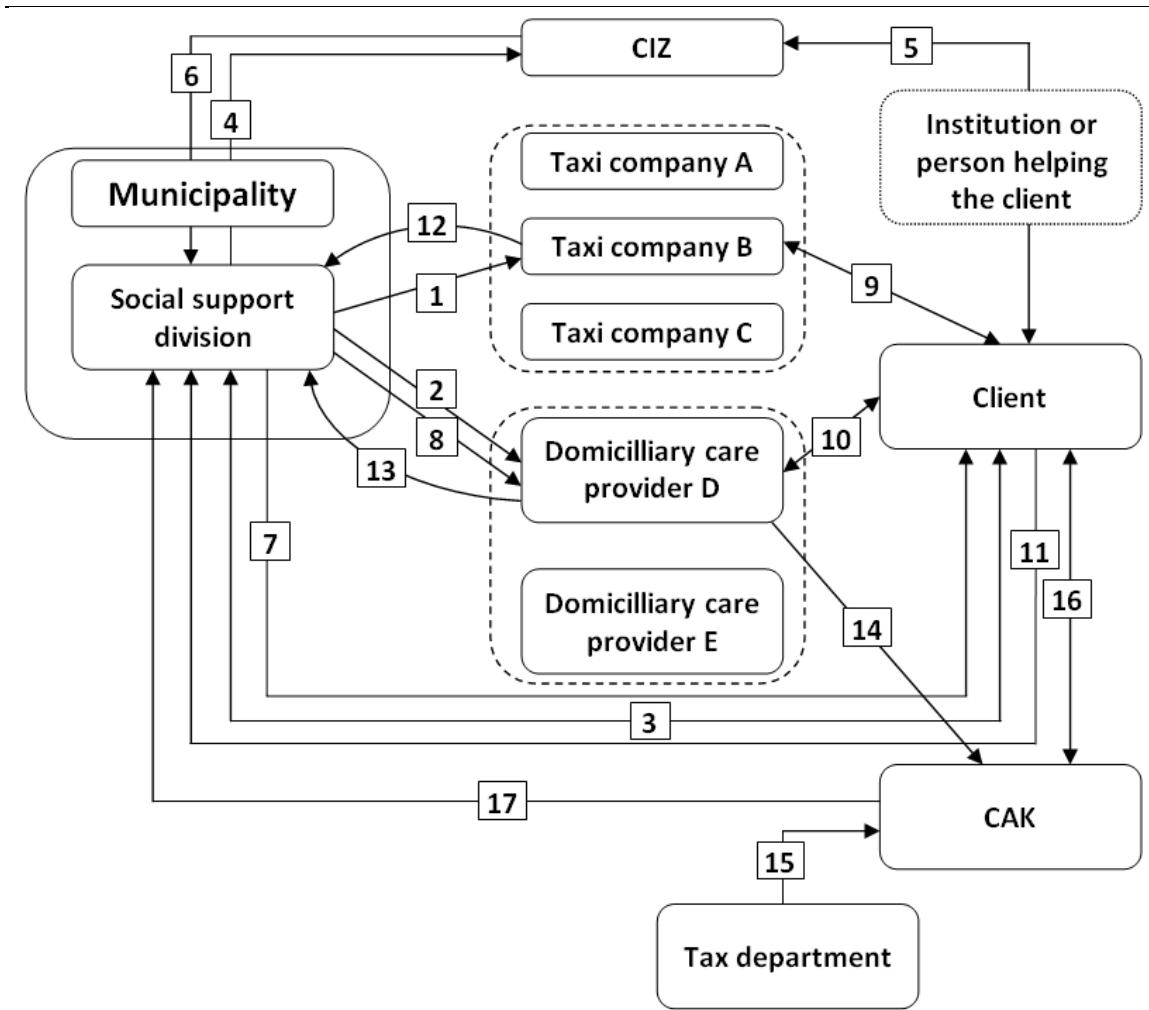
Implementation of WMO support is usually done by a separate division of the municipality that is concerned with implementing the WMO. For example, the municipal government of The Hague has nine major divisions:

- [1] *Governing affairs*: governance, and press information.
- [2] *Public affairs*: tax affairs, and management of different city districts.
- [3] *Urban management*: sewage, water supplies, parking, cemeteries, etc.
- [4] *Education, culture and wellbeing*: sports, culture, public health, etc.
- [5] *Social affairs and employment*: help with job applications, unemployment benefits, etc.

- [6] *Urban development*: construction and building projects.
- [7] *Public libraries*.
- [8] *Accounting*.
- [9] *Internal affairs*.

Policy-making for, and implementation of, the WMO in The Hague is at the responsibility of division 4.

Figure 3: Information-sharing between different parties in the WMO (Source: Leyden Academy)



1. The municipality negotiates a contract for transportation services in the WMO with a taxi company.

2. The municipality negotiates a contract for domiciliary care services in the WMO with one or more companies offering these services. In the example of figure 2, one company is chosen as the provider of domiciliary services in the WMO.
3. The client applies for WMO support by filling in a form from the front desk of the municipality. Most municipalities have a separate “WMO-reception”. Some municipalities offer a “digital front office”: the necessary forms can then be downloaded and send through the municipality’s website. After a request has been made, either an employee from the municipality or the CIZ will meet the client in question to assess his/her needs for social support.
4. Some municipalities second the practice of indication-setting to the CIZ. In this example, the municipality seconds indication-setting to the CIZ.
5. If indication-setting is seconded, the CIZ will meet the client and assess his/her needs to set an indication. Sometimes, a friend or family-member, the general practitioner, the domiciliary care organization, or other organizations help the client with requesting for a WMO-indication. In the Netherlands, MEE is such an organization, giving advice and assistance to people with a disability.
6. After the CIZ assessed the client’s situation and need for social support, the advised indication is sent to the municipality.
7. The municipality sends a letter about the indication decision to the client.
8. The municipality sends a notification to the domiciliary care company that the client is in need of services, and provides the company with the data that is further required.
9. The client calls the taxi company to agree on a time and place. The taxi company then provides transportation services for the client.
10. The domiciliary care company provides the client with basic help and household services.
11. The client might give feedback on the quality of the received WMO-services.

12. The taxi company bills the municipality for transportation services provided by him for the WMO (not all municipalities arrange client contributions for transportation services this way, also see 3.4).
13. The domiciliary care company bills the municipality for domiciliary care services provided by him for the WMO.
14. For calculating the client contribution for domiciliary care, the domiciliary care company sends client data about provided hours to the CAK. Municipalities can choose to calculate and charge the client contributions, but this is often seconded to the CAK.
15. The CAK receives information on the client's financial status from the tax department.
16. The CAK calculates the compulsory client contribution for received domiciliary care on the basis of the information from the domiciliary care company and the tax department. The CAK then bills the client for the client contribution.
17. The CAK sends the received client contribution to the municipality.

2.3.2 Information-sharing in the WMO

Multiple problems with information-sharing can take place in the communication structure of the WMO. The different problems are described below:

- A single information-sharing platform with standardized messaging is missing. This means that, for example, a municipality receives uncoordinated batches of information from the client, an indication-setting organization, and the service providers. This leads to administrative hassle. A system like AZR could lead to an improved synchronization of services, less administrative strains, and better insight to costs of social support for more organizations. For these reasons a new information-sharing platform is developed for the WMO, called GuWA. More detailed information on GuWA can be found in paragraph 2.5.
- Problems with the delivery and quality of WMO-services are not always known to the institutions involved in the WMO. This is most striking in the case of

transportation services. Because of budgetary constraints, the taxi company with the lowest fares is often chosen as the proper candidate for transportation services. This can have detrimental effects on service quality: in some municipal regions, people who are dependent on the WMO for transportation sometimes have to wait hours before their taxi arrives. Municipalities or taxi companies are not always aware that clients are unhappy with service delivery, or discard this information as trivial. For this reason some municipalities are experimenting with a “regional taxi-card”. With this card, the client verifies to the taxi-company that a part of the costs is compensated by the municipality. The rest needs to be paid by the client him- or herself. This gives WMO-clients the opportunity to use their preferred taxi company, even if additional payments are required.

- Through the quasi-market system municipalities try to achieve maximum efficiency. This can lead to restraints in information-sharing. Because different service providers compete with each other, they prefer not to share information about individual clients or about ways to improve quality and efficiency of service provision.

2.4 Information sharing between institutions in the ZVW, AWBZ and WMO

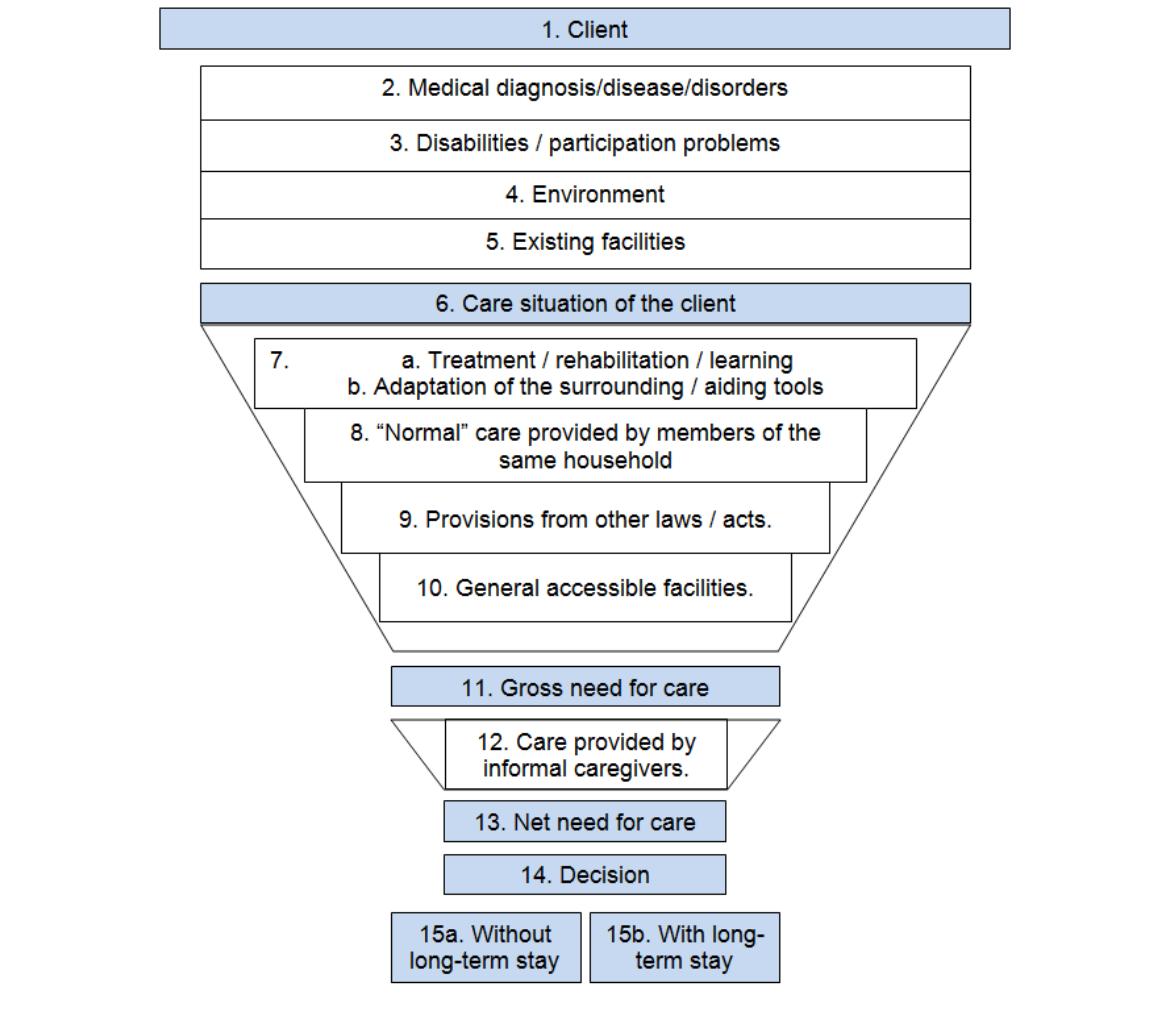
2.4.1 ZVW and AWBZ

The CIZ sets an indication on the basis of a funnel model. This funnel model is explained in the first report. A graphic summary of the model is depicted in figure 4 (next page). The first task of the CIZ, when making an indication decision, is to get a full picture of the client's medical status. Information about medical diagnoses, diseases and disorders that are important for developing a sound indication decision can be requested from a health care professional treating the client. The CIZ may do this only after the client has given explicit permission for this.

If a client moves from the hospital to a long-term care institution, the client essentially moves from the ZVW to the AWBZ. In this case, the client, a family member,

or someone from the hospital staff may request an indication from the CIZ (with urgency or not). A CIZ employee will assess the client's situation according to the funnel model, and information from a health care professional may be required. The CIZ employee may need further information to judge the situation, in which case the client may be telephoned or visited.

Figure 4: The “funnel model” with which the CIZ estimates a client’s care needs for indication-setting (Source: CIZ).



As portrayed in figure 1, care offices mediate between long-term care providers, clients, the CIZ and the CAK. As mentioned in the first report, the health insurer with the highest market share in an AWBZ-region fulfills the duties of the care office. However, the care

office branch of an insurance company may not exchange client information with the health insurance branch. This would violate privacy regulations in the medical care sector, and would give the health insurer a competitive advantage (as they can collect client information that competitors cannot). The only institutions that may share client information within the confounds of the AWBZ are the CIZ, the CAK, the care office, and the long-term care providers. As mentioned before, AZR is the information-sharing platform for these institutions.

2.4.2 ZVW and WMO

A municipality may, just like the CIZ, ask for information about a client's medical status from a health care professional to be able to make an informed decision on an indication. The client has to give explicit permission for this. Some municipalities require all clients who request for a WMO-indication to give permission for medical information retrieval from a treating health care professional. In this case, clients have to sign for this permission in their application form.

As mentioned in point 5 in figure 3, a health care professional may assist the client with requesting a WMO indication. Experiments were also running, in which general practitioners were acting as indication-setters for WMO support, but these experiments were deemed unsuccessful. The main reason for abandoning the experiments is a conflict of interest: a general practitioner might benefit from a WMO-indication. A WMO indication can divert some expenditure for the GP to the municipality.

2.4.3 AWBZ and WMO

Currently, there is no client-level information-sharing between institutions active in the AWBZ and WMO. This has three major consequences:

1. Clients with multiple care and support needs, often have to tell the same story about their physical and personal circumstances to different institutions. Also, if a client moves from one municipal region to another, the process of requesting WMO support, setting indications and arranging support services starts all over again. If

municipalities, care offices, long-term care providers, and social support providers could gain access to one database, where the CIZ reports indication decisions and the client's care and support needs, the client would only have to tell his/her story once to the CIZ.

2. Some service providers deal with multiple municipalities and care offices. This means that these providers have to deal with different ways in which indications are communicated and compensated. Because communication and billing procedures are unstandardized, service providers suffer from administrative hassle.
3. Every municipality sets its own client contribution fees. The CAK deals with many different contribution fees and arrangements, and communication between municipalities and the CAK doesn't always occur smoothly. Some clients receive numerous recalculations of the CAK because of these reasons, leading to administrative hassles to both the CAK and the clients.

A common information-sharing platform with standardized messaging is needed within the WMO. Further still, developing such a common platform for both the WMO and AWBZ could greatly reduce administrative hassles for different parties in the long-term care and social support market.

2.5 Improving information-sharing in the Dutch health care system

Figure 5 at the end of this paragraph is a graphic summary of the information-sharing flows described above. Please note that the information flows pertain only to private information on individual client level. For example, the CVZ is not added to the figure for this reason. The CVZ receives data on waiting lists from care offices (for more information, see figure 1 or 2 with explanation). These data do not comprise individual level client data, but rather aggregate levels of client data. Also, information-sharing between staff members of one institute is not depicted. For example, information exchange between specialists and nurses or administrative staff members working in

the same hospital is not added to the figure. Referrals between specialists is also not depicted, since they work in similar institutions.

Figure 5 shows that the Dutch health care system has a highly bureaucratic structure. An important reason for this bureaucracy is that information-sharing is regarded as an exception, rather than a standard way of working. This means that many forms of information-sharing may not take place at all. For example, CIZ-employees would greatly benefit from access to information systems of medical care providers. This way, a CIZ-employee can quickly get a complete picture of a client's health status. For privacy reasons, access to these systems is heavily restricted by law.

When information-sharing does take place, laws, regulations and protocols are in place to ensure that it occurs in a secure setting and all precautions have been taken. Medical care professionals need authorization, an UZI-card and a password, to access just a subset of another information system. Ways to improve efficiency of information-sharing without sacrificing the privacy of clients are discussed by policy-makers and academics in the Netherlands. The most important (possible) developments to diminish bureaucratic problems can roughly be divided in three categories, explained below:

1. *A more central role for the client, and more financial transparency for the client.*

Letting the client arrange many of his/her own required services is a way to decrease information-sharing "backstage" and diminish overhead costs. In the AWBZ and WMO policies can become more oriented towards personal budgets. This way, municipalities and care offices are only concerned with paying out personal budgets and monitoring the use of personal budgets, rather than arranging all the long-term care or social support for the client.

The NZa is currently researching how the malpractice of "upcoding" by hospitals can be countered. Because health insurers only receive coded bills (DOTs), they have no insight into what treatments or tests were actually carried out. There have been reports of hospital departments finding ways to purposefully charge the wrong DOTs to receive a higher return on treatments. Upcoding can be discovered

by wary clients who receive a copy of the bill from the health insurer, and find out that the bill does not match with the procedures that were actually performed.

2. *Improved system of information-sharing within the ZVW.* The introduction of the LSP or RSPs can reduce administrative hassles and delays in information-sharing between medical care providers. Also, complete digitalization of (1) patient files, (2) storage of test and scan results, and (3) communication between GP and specialists can be innovations that can decrease information-sharing issues in the near future.
3. *Improved system of information-sharing within the AWBZ and WMO, and between the AWBZ and WMO.* In the beginning of 2012, a discussion and innovation platform, called Platform IZO has been initiated by the Ministry of VWS. Besides the ministry, different organizations are involved in this project, namely: Actiz, the CAK, the CIZ, the CVZ, Federatie Opvang, the GGZ, the VGN, the VNG, and ZN. The aim of Platform IZO is to find the most important bottlenecks in information-sharing regarding the ZVW, AWBZ and WMO, and to define a common goal to improve information-sharing in the long-term. Part of Platform IZO are the following initiatives:
 - A “think tank” called iAWBZ. In iAWBZ, health care professionals are asked to define the most important bottlenecks in the administrative burden of the AWBZ and come up with solutions. The iAWBZ has led to an update from AZR 3.0 to 3.1, in which “quick wins” were gained: messages can be simplified and may be sent less often, changing personal data from clients is simplified, LTC providers can view the initial indication-decision from the CIZ, and so on.
 - Since October 2012 different organizations in the health care sector are working on an information-sharing platform for both the AWBZ and WMO. The project is called GuWA (Data exchange WMO-AWBZ), and is now in the first phase. Flows of existing platforms and flows of information- and data-sharing are now thoroughly analyzed. Possible scenario’s to improve information-sharing are researched, as well as any legal restraints. As of yet, it remains unclear what form an information-sharing platform for the AWBZ and WMO

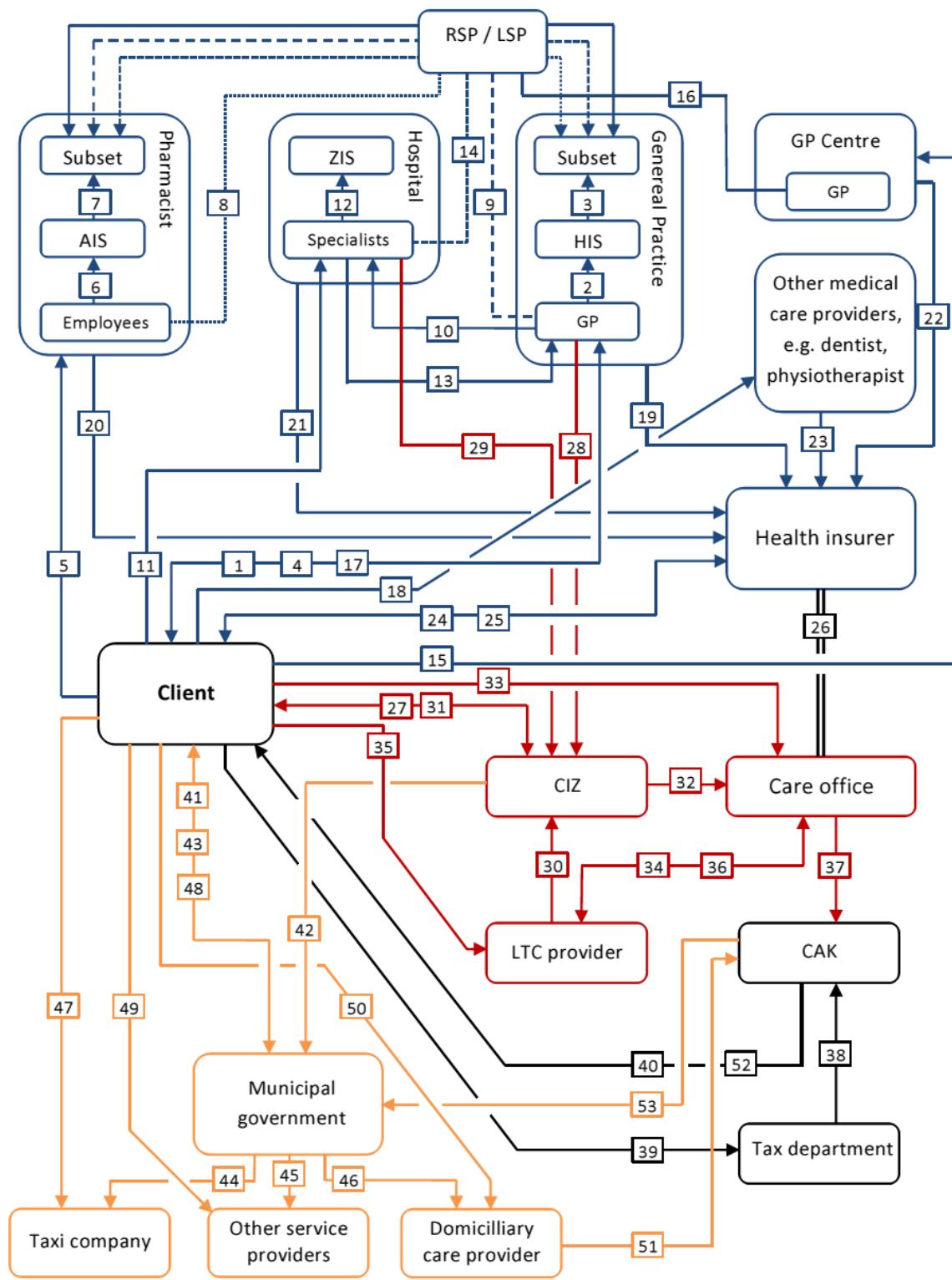
will look like. A new system of standardized and coded messages could be developed, but it could also be possible that municipalities will be included in the AZR.

- The long-term goal from Platform IZO currently entails three ambitions for 2016: (1) more simplicity for the client, (2) less administrative burden for organizations in health care and social support, and (3) modernization of data management. They hope to achieve these ambitions by developing an information system with standardized messaging, that can be used by many organizations, while preventing misuse of this system. This way, the CIZ, the CAK, municipalities, care offices, long-term care providers, other service providers, etc. can quickly gain access to clear information for which they are authorized.

Through these measures, the different institutions and organizations hope to make gains in efficiency by reducing:

- overhead costs;
- delays in information exchange;
- hours spent on administrative tasks by health care professionals;
- frequency of uninformed decisions by doctors;
- occurrence of overlapping, similar activities done by different professionals (for example, indication-setting by the municipalities and the CIZ).

Figure 5: All possible information-sharing flows between health care institutes and/or professionals in the Dutch health care system (Source: Leyden Academy).



Flows in figure 5

1. The client visits the GP and shares information on his/her personal data, health and wellbeing.
2. New diagnoses and new treatments are stored in the HIS by the GP or assistant.
3. Important information about the client's diagnoses and treatments are stored in a separate subset of the HIS for the RSP/LSP.
4. If necessary, the GP can give the client a referral note for medication or other forms of medical care.
5. By purchasing medication and giving feedback on any side-effects, the client shares information with the pharmacist.
6. The pharmacist stores information on medication use and potential side-effects in the AIS.
7. Important information about the client's medication use and side-effects is stored in a separate subset of the AIS for the RSP/LSP.
8. If necessary, the pharmacist can check important information from the GP on the client through the RSP/LSP.
9. If necessary, the GP can check basic and crucial information on medication use and side-effects from the pharmacist through the RSP/LSP.
10. If necessary, the GP can directly refer the client to a specialist.
11. The client visits the specialist and shares information on his health and wellbeing. The hospital collects his personal data.
12. Diagnoses, treatments, and scan and test results are stored in the ZIS.
13. After the consult, the specialist sends a letter to the GP, in which he summarizes the client's visit in terms of new diagnoses, medication, test and scan results, and others.
14. If necessary, the specialist can check important medical information of the client with the GP or pharmacist through the RSP/LSP.
15. In case of emergency, or when the client's GP is unavailable, the client can visit the GP center.
16. If necessary, the substituting GP from the GP center can check important information with the GP or pharmacist through the RSP/LSP.
17. If necessary, the GP can refer the client to an allied health professional (e.g. physiotherapist or psychotherapist). The client usually receives a referral letter for this.
18. The client visits the dentist or an allied health professional and shares information on his/her health and wellbeing.
19. The GP sends individual bills to the health insurer of the client.
20. The pharmacist sends individual bills to the health insurer of the client.
21. The hospital sends individual bills to the health insurer of the client in the form of coded DOTs.
22. The GP center sends individual bills to the health insurer of the client.
23. Other medical care providers send individual bills to the health insurer of the client.
24. The client is enlisted with a health insurer. The insurer therefore has his/her personal data.
25. The health insurer may send copies of bills to the client, or charge the client with deductibles or client contributions.
26. The health insurer with the highest market share in an AWBZ region is obliged to act as the

- care office for this region. Legally, the health insurance branch of the company may not exchange client information with the care office branch, but this does happen in practice.
27. If the client requests an AWBZ indication, he/she shares personal data and information on his/her health, wellbeing and social surrounding with the CIZ.
 28. If required for the indication, a CIZ employee can request information from the GP. The client first has to give explicit permission.
 29. If required for the indication, a CIZ employee can request information from a specialist. The client first has to give explicit permission.
 30. If required for the indication, a CIZ employee can request information from a current LTC provider of the client. The client first has to give explicit permission.
 31. The CIZ sets an indication for AWBZ care and sends the indication decision the client.
 32. The CIZ also sends the indication to the care office.
 33. The client informs the care office on his/her LTC preferences and needs.
 34. The care office checks if a LTC provider is able to provide the indicated care.
 35. If so, the LTC provider commences with LTC provision, collecting information on the client's health, wellbeing and personal preferences to provide the best possible care.
 36. The LTC provider sends messages to the care office, containing information on the start and end of LTC provision, and possible changes.
 37. These messages on the start, end and changes in LTC are forwarded to the CAK.
 38. The CAK receives information on the client's financial status from the tax department.
 39. The client has already shared information on his/her financial situation with the tax department by filling in tax declarations.
 40. The CAK gives feedback to the client on his/her LTC use, and charges a client contribution.
 41. The client applies for WMO services by filling a form, and sending it to the municipal government.
 42. The municipal government can second indication-setting to CIZ. In this case, the CIZ sends an official indication to the municipal government.
 43. The client receives a letter about the indication decision for WMO support.
 44. When the client is eligible for transportation services from the WMO, this is forwarded to the assigned taxi company.
 45. When the client is eligible for other services from the WMO (such as instrumental aids), this is forwarded to the assigned service provider.
 46. When the client is eligible for domiciliary care services from the WMO, this is forwarded to the assigned domiciliary care provider.
 47. Some municipalities ask the assigned taxi company to collect information on the client's use of transportation services for billing purposes.
 48. Some municipalities ask the client to collect information on his/her use of transportation services for billing purposes.
 49. When the client receives other services from the WMO, he/she shares information on service needs with this service provider.

50. When the client receives domiciliary care services through the WMO, he/she shares information on service needs with the domiciliary care provider.
51. The domiciliary care provider is often asked by the municipal government to share
- information on the client's use of domiciliary care services with the CAK.
52. The CAK calculates the client contribution for domiciliary care services and charges the client.
53. The collected client contribution is forwarded to the municipal government.
-

3. Payment and incentives in the Dutch health care system

3.1 Payment structures and incentives

In the first report, monetary flows from different organizations in the health care system, such as clients, providers, insurers, and state institutions, were specified. Here, we go further into detail about the payment flows between or by the different parties. Of specific importance is how payment structures influence incentives. First, different payment structures are defined broadly, as well as their positive and negative effects on health care provision. Taken into account here are only economic incentives. Fortunately, many health care professionals do not have or follow such incentives.

In theory, there are four different basic payment structures. Descriptions of these payment structures are given below:

- **Capitation fee:** The health care provider is compensated for the number of clients that are assigned to him. In this structure, health care providers are not paid for services directly. The benefit is that they are not rewarded for overtreatment. A downside of this structure is that providers are stimulated to attract healthy clients, or work in regions with relatively more healthy people. Healthy people require less treatment. Providers with a higher number of healthy clients can increase their clientele (and thus their received capitation fees) while offering the same number of treatments as providers with less healthy people in their database.
- **Budget system:** The health care provider and a governing body agree on a budgetary limit of health care costs within a certain time range. Just like in the capitation fee system, providers in a budget system are not rewarded for providing unnecessary care. Providers are forced to prioritize clients. A downside to this system is that waiting lists are created.
- **Pay-per-performance:** The health care provider receives compensation for time spent on a patient, medical equipment used, and so on. The benefit of this pay-as-

you-go system is that no agreements or arrangements on expenses have to be made in advance, (long) waiting lists are avoided, and providers are not stimulated to attract healthy clients. A major downside is that providers are enticed to treat, rather than to wait or decline care. This can increase health care expenditure in a health care system due to higher volume levels.

- **Bundled payments or diagnosis-related groups:** The health care provider receives compensation in the form of a standard fee for a “package of care”, based on the diagnosis and/or treatment. For example, a hospital admitting a patient with pneumonia receives a standard fee for this diagnosis. If the diagnosis seems to be incorrect, or the patient has a complex form requiring additional treatments, the bundle is changed into another bundle with an agreed fee. Some patients with pneumonia require more treatment than others, but the aim is that average cost of treatment per pneumonia patient is in accordance with the bundle fee.
Overtreatment is avoided without the side-effect of increased waiting lists or patient selection. The downside is that providers are enticed to increase the volume of admittance (number of diagnoses), in combination with undertreatment. This way, increasing the number of received payments elevates turnover, and the undertreatment limits the costs. Another benefit of bundled payments is that health care providers have to make a detailed estimation of the expenses they make per treatment for negotiation and business administration purposes. They thereby gain insight into the costs of the different treatments they offer.

3.2 Payments within the ZVW

3.2.1 From client to health insurer and medical care provider

Every Dutch citizen is obliged to have a basic health insurance package at one of the competing private health insurers. These health insurers receive their funding in different ways, which are explained below.

- Health insurers receive premium fees for the basic packages, and the additional voluntary packages, from clients above the age of 18. These premium fees are paid directly from the client's bank account to the administration office of a health insurer.
- Clients pay an income-related fee to the Health Insurance Fund (HIF). If a client is an employee, the employer deposits a percentage of the employee's income through the employer's bank account to the account of the HIF (in 2012, this is 7.1% of an employee's income up to €34,055). If a person owns a company or is a freelancer, he pays the income-related fee directly to the HIF when paying taxes. If a client's income is earned through other means, such as the AOW, private pension, divorce alimony or other, the institution providing the (social) benefit deposits the income-dependent fee to the HIF.
- Clients pay a compulsory deductible for a first amount of medical care they received. This deductible was €220 in 2012, and €350 in 2013. If medical care was provided, and the deductible, or a part of the deductible, has to be paid, the client owes this to the health insurer. In this case, the health insurer already paid the bill. This compulsory deductible is installed to deter clients from requesting unnecessary consultation or treatment. To prevent the client from avoiding decent screening and basic health care altogether, the deductible does not apply to health care received from the GP.
- For some forms of care, the health insurer will demand a contribution from the client. Client contributions in the obligatory basic health care package relate to:
 - Instrumental aids
 - Some medication
 - Maternity services
 - Patient transportation without medical staff on board
 - In-hospital childbirth without medical indication
 - Psychological therapies in the primary care sector
 - Forms of mental health care

- Forms of dental care

Client contributions in voluntary health care packages depend on the health insurer's policy.

3.2.2 From health insurer to medical care provider

Medical care providers are compensated in different ways, as explained below:

- General practitioners receive a combination of capitation fees and pay-per-performance fees: they receive a standard amount per enrolled client four times per year, as well as a standard amount (€9) per consult. If certain treatments or special equipments are used (in the case of, for example, minor surgery, bloodtests or scans) additional compensation will be paid by the health insurer. To prevent GPs from selecting regions or clients with low-risk profiles – to benefit financially from the capitation fee system – the size of the capitation fee per client is dependent on the client's living area.
- Hospitals, allied health providers, dental service providers, and other medical care providers are paid by bundled payments. Since 2012, bundled payments are called DOTs. From 2006 to 2011, they were called DBCs. There are two main differences between DOTs and DBCs:
 - There were around 30,000 DBCs, some hospital specific. There are around 4,400 DOTs based on the International Classification of Diseases 10 (ICD10).
 - DBCs were billed directly. A so-called “grouper” system is used to bill DOTs. This means that providers need to record the diagnosis, tests, and treatments into a web application. The application groups these data and finds the DOT that fits these provided medical care services the best. The application “validates” this DOT. The DOT can be charged from the health insurer only after this validation.

There are roughly two segments in the DOT-structure: (1) the A-segment ($\pm 30\%$), in which the NZa establishes the annual fee, and (2) the B-segment ($\pm 70\%$), in which health insurer and provider are free to bargain the fee. A DOT mainly exists of two parts: expenses coverage for the hospital (including personnel) and a compensation

for the medical specialist. Medical specialists can be employees, or private practitioners (see next paragraph).

- The CVZ administers the HIF. Through the HIF health insurers are compensated for clients under 18 years, and clients with high-risk profiles in health care utilization.

3.2.3 From medical care provider to personnel

Health care professionals are either owners of a private practice, or hired staff members.

Private practitioners receive their money directly from health insurers, and are responsible for paying the facilities, instruments and potentially staff members that are needed to provide the services. Hired staff members (usually) receive hourly wages.

In many hospitals in the Netherlands, medical specialists work as private practitioners. In Dutch, they are called “freely established specialists” (FE specialists). Specialists working in the same hospital and specialism (e.g., cardiology) can act as FE specialists under the umbrella of a cooperation. Every FE specialist is then a partner within a cooperation that is nestled in a hospital. These cooperations receive payments for medical services directly from health insurers, and profits are divided amongst the partners. Cooperations pay hospitals for using their facilities and instruments.

Currently, the use of FE specialists by hospitals is disputed in the Netherlands. The main reason is that they are said to be more expensive than their hired counterparts. Because their income is dependent on the number of treatments they perform, they might be stimulated to increase their production rate to earn more money. On the other hand, others argue that specialists might not be stimulated enough to work efficiently when they receive hourly wages.

3.3 Payments within the AWBZ

Every Dutch citizen with an income (either wages, profits, pensions or other social security benefits) pays 12.15% of his/her income up to €34,055 (2012, annually) for the AWBZ. This payment is made to the tax department of the national government.

The national government transfers these finances to the CVZ, who administers the AWBZ fund. The CVZ pays funding for PGBs to care offices. Finances that are required for care in kind are transferred to the CAK, who disperses the fund to the different health care providers.

Care offices negotiate contracts with long-term care providers (homecare organizations, care homes, nursing homes) in their region on an annual basis. These contracts state the kind, size, price and quality of long-term care that such a provider may provide in the region. Every long-term care provider receives a starting fund at the beginning of the year from the CAK, who received a payment order for this transfer from the care office. At the end of the year, the care office calculates what payments to long-term care providers are remaining, and a new payment order is sent to the CAK.

The CAK calculates (on the basis of information of the tax department) the client contribution for AWBZ care. The client is obliged to pay this contribution from the first day he/she receives long-term care. In the first six months that the client receives AWBZ care, he/she has to pay the low contribution (maximum of € 715 per month). If the client was transferred from a hospital, the days/months spent in hospital count as a part of these first six months of institution. After six months, the client has to pay the high contribution (maximum of € 1773.40 per month). The client will receive a letter with information on the size and background of their client contribution. The client is usually billed every month, or the contribution is subtracted from the state pension.

The PGBs are paid by the SVB, also by order of the care office. For simplicity's sake, it is often said that care offices pay the PGBs. Clients who receive a PGB need to clarify to the care office how they spent the PGB. The SSP can help clients with requesting, administering and clarifying the use of PGBs. Client contributions for PGBs are calculated by the care offices. Client contributions are subtracted from the initial (gross) PGB, after which a net PGB is paid out.

All staff members of long-term care providers receive their income as wages.

3.4 Payments within the WMO

Municipalities receive their finances from the municipal fund from the national government and from municipal taxes. A municipality sets the budget for the WMO on an annual basis. Most often, the municipality seconds the provision of social support services to commercial organizations. Contracts with these providers are negotiated on an annual basis.

Every municipality decides whether client contributions are required, and if so, how they are calculated. Municipal workers can calculate and bill these contributions themselves, or these tasks can be seconded to the CAK. If the CAK is made responsible for administering the client contributions, the required information on service usage is delivered by the municipality or the service company and information on income is delivered by the tax department. Client contributions are usually installed for domiciliary care, instrumental aids, adjustments in the house and personal budgets. Some municipalities ask client contributions for transportation services. There are different ways in which client contributions are paid for transportation services if a commercial taxi company is involved. First, client contributions can be directly charged by the taxi company, independent of income. For example, a taxi company can charge a fee per kilometer from the municipality, charging the remaining fees to the client. Second, a municipality can pay taxi companies for all their services, calculating and charging client contributions afterwards on the basis of information provided by the taxi company. Third, clients can be asked to submit the receipts of their taxi rides to the municipality. Clients are then compensated, dependent on their income.

4. Measures to contain costs or increase efficiency

In the first paragraph of this chapter, the broad dynamics that underly the increase in health care costs in the Netherlands will be described. A more detailed analysis of trends in health care provision, efficiency and outcomes will be discussed. In the last two paragraphs, past and future changes in policy to counter the steeply rising health care costs will be discussed.

4.1 Rising health care expenditure in the Netherlands

Expenses in the Dutch health care sector are continuously on the rise. Health care expenditure is rising for many different reasons:

- *Medical innovations* increase the availability of treatments. Some illnesses and other health problems that could not be treated in the past, can be treated now. These developments are of course beneficial for clients, but increase their average expenditure levels.
- Clients are becoming *more aware and assertive* regarding their own health. In the Netherlands, clients are becoming better informed about their health status and their health risks, and are more demanding. These trends push the number of treatments upwards. Doctors are also becoming less willing to let small risks go untreated, as they also bear responsibility for negative health outcomes.
- *Population ageing*. Ageing populations are seen as a major contributor to the rise in national health care expenditure. In 2010 the Netherlands counted 16,6 million inhabitants, including 2,5 million people at age 65 and older. The Dutch bureau of statistics (CBS) estimates that the amount of people at age 65 and older will increase to 3,4 million in 2020 and 4,1 million in 2030. The total amount of the inhabitants will increase with a lower percentage: 2,6% (in the period of 2010-2020) and 2,2% (in the period of 2020- 2030). This implies that the share of people aged 65 and above increases from 15% in 2009 to 24% in 2040. When considering that

Dutch people make around 72% of their individual lifetime health care expenses above the age of 65³, it becomes clear that population ageing will have an impact on rising health care expenditure in the Netherlands.

- *The Baumol effect.* This economic theory states that in the health care sector, like other public sectors, there is a steady decrease in “productivity : price ratio” if the economy is growing. Innovation stimulates economic growth as people will become more labour productive. When a worker’s productivity grows, his/her wage will increase simultaneously. The Baumol effect refers to a dynamic where employees who cannot increase their labour productivity (mainly in the public sector), demand higher wages because people who do increase their labour productivity receive higher wages. This means that health care expenditure grows due to higher wages, while the “output” – in terms of number of patients treated – does not keep up with this growth of average wages.
- *Health care reforms.* In the Netherlands, the focus has shifted from a system of state budgeting and planning to a free market system. The goal of this shift in focus is to let competition drive health care providers’ search for efficiency, and get rid of the bulk of waiting lists. On the other side, there is now an incentive for many health care providers to increase their volume. For example, if a hospital is not restrained in tonsil operations by a state budget, this hospital can stimulate specialists to perform as many tonsil operations as possible to increase turnover.
- *Supply-dependent demand.* If long-term care activities are provided on a free basis through the AWBZ and WMO, people tend to arrange their informal care activities around these formal activities (see box 3 for an example). Especially long-term care and social support is highly institutionalized when compared with other countries. This means that Dutch citizens rely (at least partially) on services in health care and wellbeing provided by the government. This is a consequence of the Dutch culture, as well as the broad spectrum of available services through public means.

³ Source: RIVM

Box 3: An example of supply-dependent demand.

Mister A receives care from his spouse, mrs. B. Mr. A. is in the beginning stages of Alzheimer's and has lost some of his mobility. Together with her son and daughter, mrs. B finds out that mr. A is entitled to domiciliary care through the WMO and extramural personal care (level 3) and nursing care (level 2) through the AWBZ. Mrs. B and her children decide to request for these formal care activities, pay a small compulsory deductible, and plan their care activities to complement the WMO support and AWBZ care for mr. A. This way, mrs. B. is free to spend some time away from home, and her children are not pressured to visit mr. A.

4.2 Current trends in health care

The key variable to evaluate the effectiveness of the Dutch health care system on a macro-level is (healthy) life expectancy. Variables to measure the performance level of health care provision on a micro-level (institutional level) are, for example, health care expenditure, the average days spent in the institution, the mortality risk, and the satisfaction of patients. Examples of markers of health outcomes for older people are bedsores and fall incidents. Below trends in different variables reflecting the effectiveness (quality) and costs of the Dutch health care system are explained.

4.2.1 Macro-level: Life expectancy⁴

Life expectancy is a key demographic figure as it reflects overall mortality and can be validly compared between countries and periods. Life expectancy is a sign of the net health outcomes of current medical, societal, and political structures of all age groups. With continuing socio-economic development, life expectancy has increased

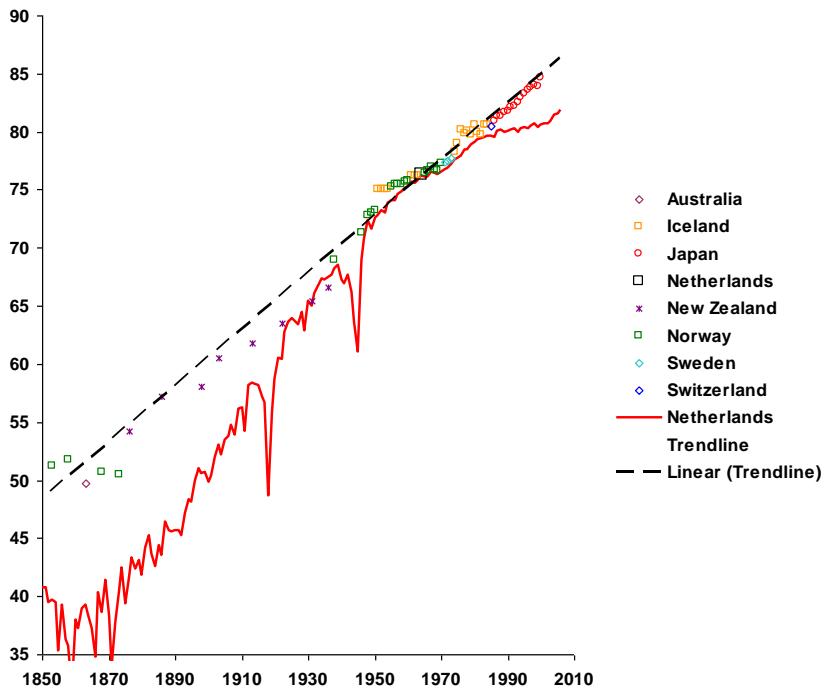
⁴ More information can be read in the report "Dutch life expectancy from an international perspective" by D. van Bodegom L. Bonneux, F. M. Engelaer, J. Lindenberg, J. J. Meij, R. G. J. Westendorp, Leyden Academy on Vitality and Ageing 2010. Web address:
http://lava.test.yellowcat.nl/UserFiles/file/Onderzoek%20levensverwachting_okt_2010/rapport_2010_in_boekvorm_definitief_30_9_2010.pdf

spectacularly in all developed countries over the past 150 years. In 2010 the life expectancy at birth in the Netherlands is 81 years for women, and 77 years for men. Figure 6 shows the ‘best-performance life expectancy’, i.e. the countries with the highest life expectancy from 1850 to 2010 including The Netherlands. A first observation is that in 1850 life expectancy in the Netherlands was far below the linear trend line. As in developed countries mortality at young and middle age has come to a minimum, differences in life expectancy are now mainly caused by mortality differences in old age. It is therefore vital to examine life expectancy at age 65, i.e. the number of years people can expect to live when they have reached the age of 65. The life expectancy in 2010 at age of 65 for women is 21.2 years and for men 18 years.

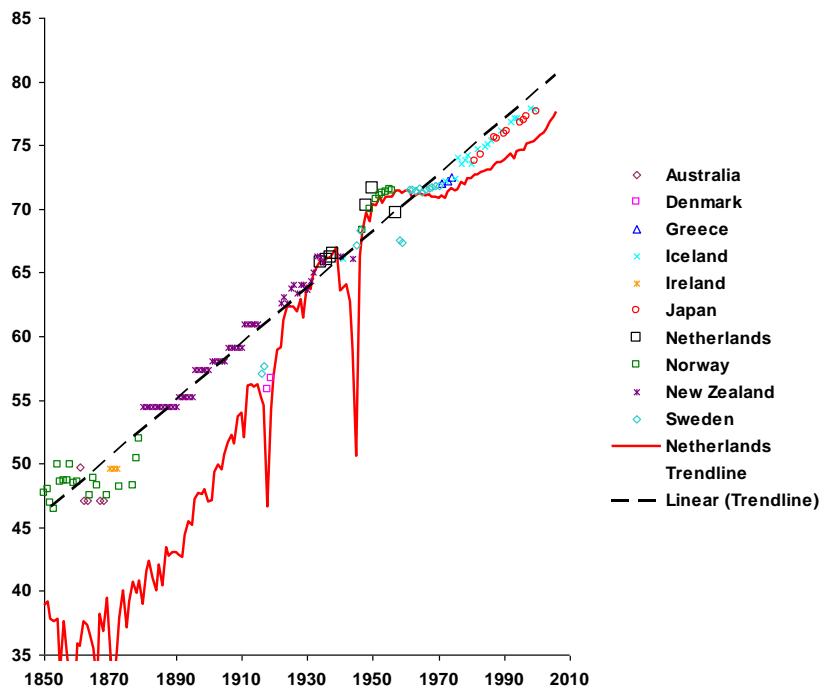
Life expectancy at age 65 (figure 7) in particular reflects outcomes of the socio-medical systems to prevent and cope with chronic, age-associated diseases. Over the past decennia, the number of years without chronic diseases is decreasing. This is mainly because chronic diseases include high blood pressure, but also because active and passive case detection is moving diagnoses to an earlier age. Added to this is the effect of the lowering of clinical thresholds of disease, often caused by available treatment (e.g. hip replacement). At least part of our longer lives is therefore exactly brought about by increased case detection and increased medical treatment of risk factors.

There are various ways to live a longer healthier life. First, it is essential to prevent chronic, age-associated diseases such as atherosclerosis, diabetes and dementia. Here is an important role for public health strategies to prevent smoking, hypertension and obesity, by improving the quality of our diet, and by increasing the level of exercise. Second, it is important that there are screening and diagnostic strategies for chronic age-associated diseases to minimize persistent complications and disabilities at the earliest time. Third, it is important to optimize the structure and finance of cure and care. The positive effects can be seen in the increase in life expectancy.

Figure 6: Life expectancies at birth, men and women, from 1850 to 2010. Country with the best performance versus the Netherlands.

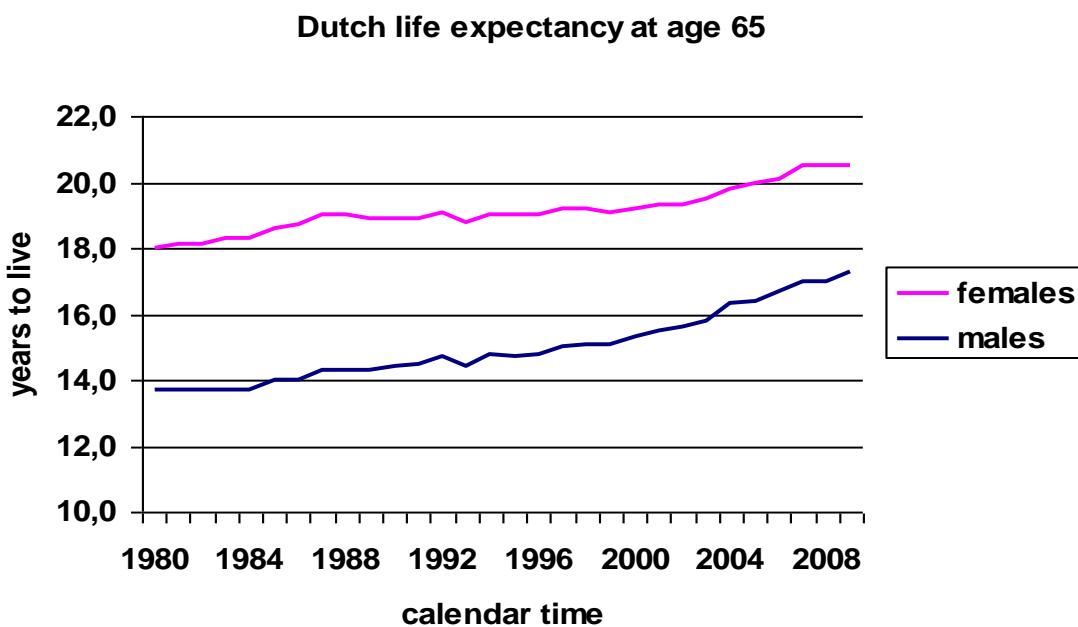


Women



Men

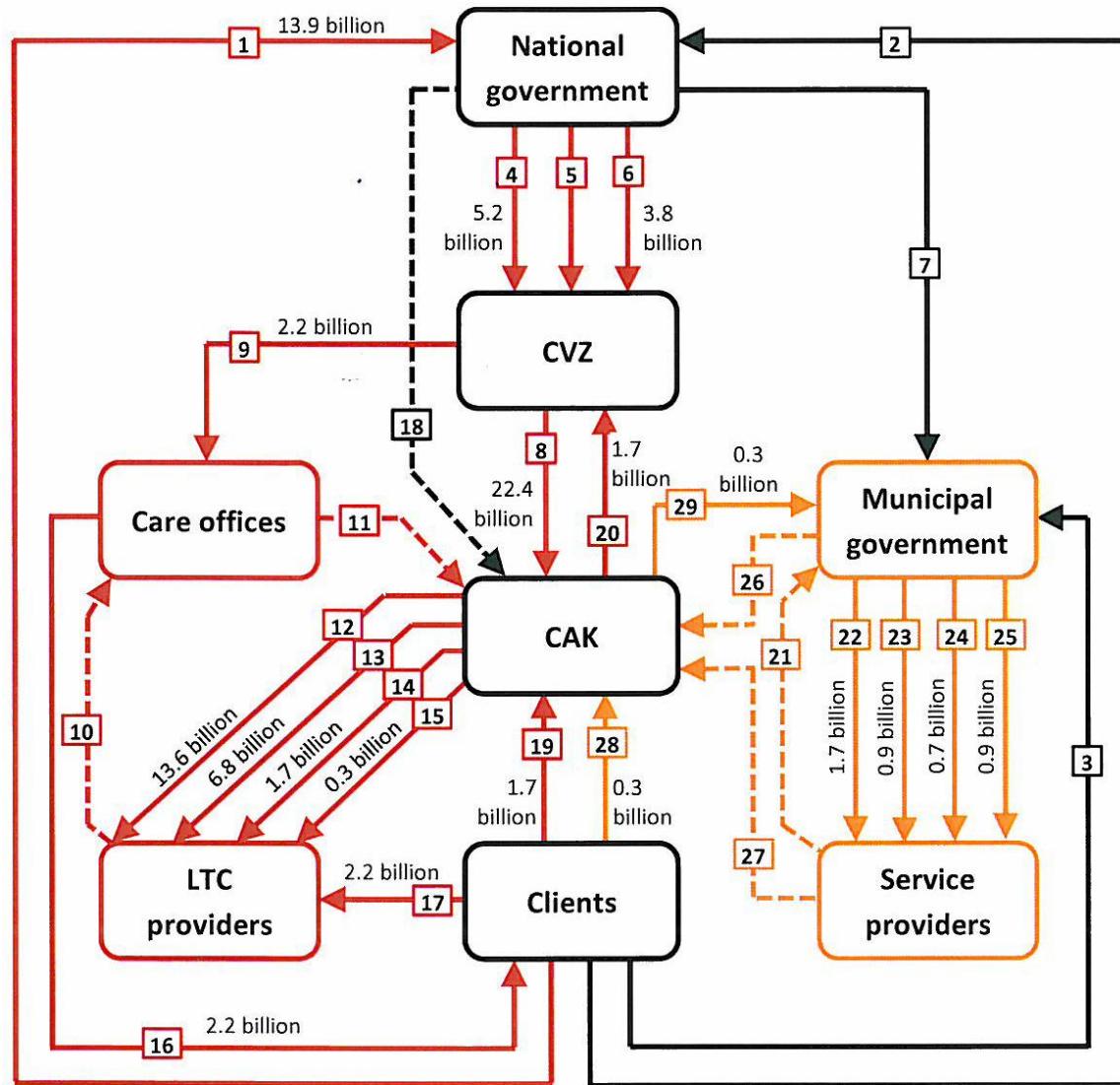
Figure 7: Dutch life expectancy for males and females at birth and at age of 65 from 1980 to 2008 (source: CBS).



4.2.2 Macro-level: Health care expenditure

Information on health care expenditure on the macro-level can be found in tables A1.1 and A1.2 in the appendix. Figure 9 (next page) shows the monetary flows in the long-term care and social support sector on a national scale. Expenditure in the social support sector is estimated on the basis of data from the SGBO from 123 municipalities in the Netherlands in 2011.

Figure 8: Monetary flows in the AWBZ and WMO, 2011 (Source: Leyden Academy)⁵



⁵ Data of the levels of AWBZ expenditure are from the CVZ. Data on the levels of WMO expenditure are estimated from the data in a report by the SGBO ("Benchmark WMO 2012: Results of the Year 2011"). Data on personal budgets for instrumental aids and home adjustments (WMO) were unavailable. Therefore, flows of expenditure through PGBs are not reported for the WMO, and instead subsumed under flows 22, 23, 24, and 25.

Explanation of flows in figure 8:

1. All Dutch citizens with an income pay a fee of 12.15% of a first part of their income.
2. All Dutch citizens with an income pay different kinds of taxes to the national government.
3. All Dutch citizens with an income pay different kinds of taxes to their municipal government.
4. The national government adds a monetary amount to the AWBZ fund (the BIKK).
5. The national government lets the CVZ administer the funds received from AWBZ fees.
6. Shortages in the AWBZ fund are compensated by the national government.
7. The national government transfers a part of the national taxes to the municipal governments through the municipal fund.
8. The CVZ transfers the part of the AWBZ fund that is destined for long-term care in kind to the CAK.
9. The CVZ transfers the part of the AWBZ fund that is destined for personal budgets to the care offices.
10. Long-term care providers report the start, end and changes in provided care to clients to the care offices.
11. Care offices calculate the compensations long-term care providers are entitled to, and orders the CAK to pay the bills of the long-term care providers.
12. The CAK pays out the providers of nursing care, personal care and counselling.
13. The CAK pays out the providers of care for the handicapped.
14. The CAK pays out the providers of long-term mental health care.
15. The CAK pays out the providers of other forms of AWBZ care.
16. The care offices pay out the personal budgets to the clients.
17. Clients use their personal budgets to pay long-term care providers for their services.
18. The CAK receives information on the financial situations of all the clients (AWBZ and WMO) from the national government through the tax department.
19. The CAK calculates the client contributions of the AWBZ on the basis of the information from (11) and (18), and charges the clients.
20. The client contributions of the AWBZ go back to the AWBZ fund, administered by the CVZ.
21. When service providers deliver WMO support to clients, they charge or inform municipal governments for these services.

- 22. The municipal governments pay out the providers of domiciliary care.
- 23. The municipal governments pay out the providers of instrumental aids and other assistance to the handicapped.
- 24. The municipal governments pay out the providers of social counselling and advice.
- 25. The municipal governments pay out the providers of social and cultural work (0.7 billion), and other social support services (0.2 billion).
- 26. The municipal governments deliver the utilization figures of social support services by their clients to the CAK.
- 27. Domiciliary care providers deliver the utilization figures of their clients to the CAK.
- 28. The CAK calculates the client contributions of the WMO on the basis of the information from (18), (26), and (27), and charges the clients.
- 29. The client contributions of the WMO go back to the municipal governments.

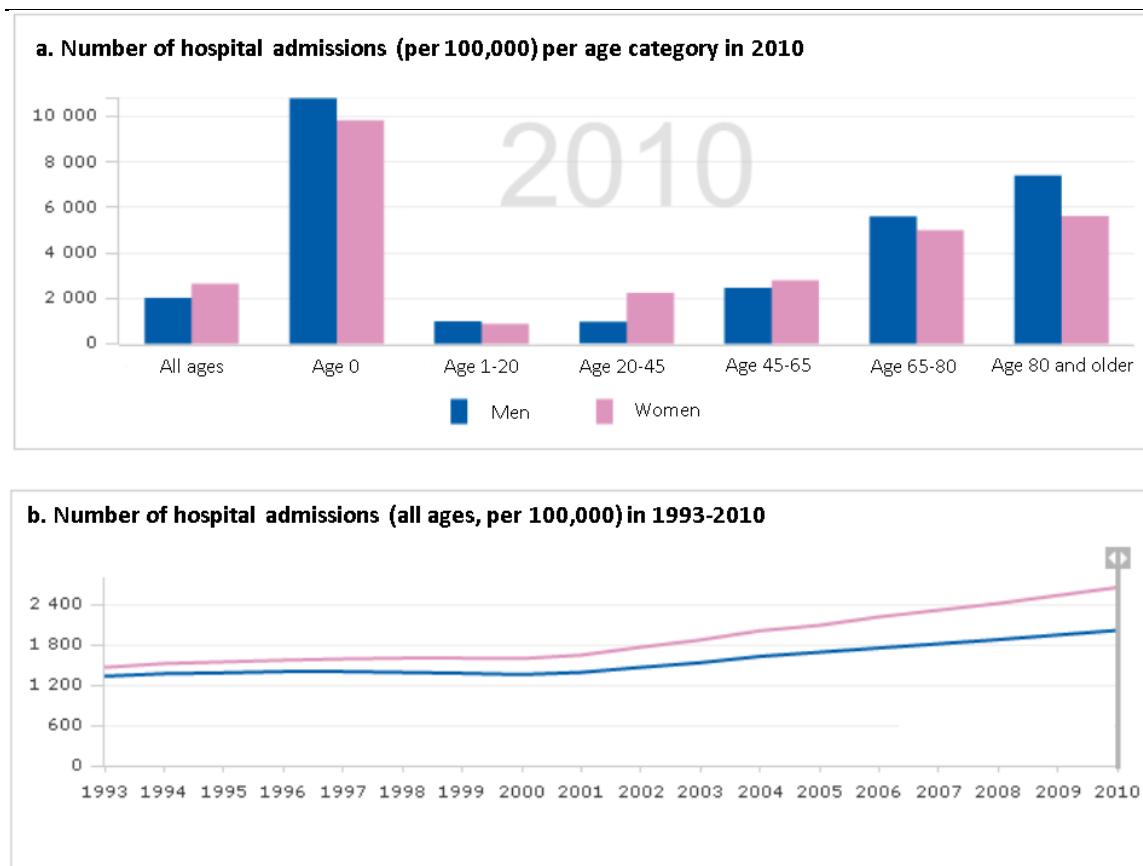
4.2.3 Institutional level: hospitals

In the Netherlands, the number of hospital admissions increased throughout the last two decades, but the average number of hospital beds and days spent in hospital decreased. In the period 1976-2006, the number of beds in both general and university hospitals decreased with 30%. From 1993 to 2010, the number of hospital admissions increased with almost 50%. This can be seen in the lower panel (b) of figure 9. In the upper panel (a), it is visible that both newborns and people over 65 are admitted most often. Like the number of beds, the number of days spent in hospital also decreased. This can be seen in figure 10.

Compared to surrounding countries (Austria, Belgium, Denmark, France, Germany, Spain, Switzerland, United Kingdom), the admission rate and length of stay in the Netherlands was a little below average in 2009.⁶

⁶ Based on *Health at a Glance*, 2011: OECD.

Figure 9: Trends in hospital admission in the Netherlands (Source: CBS)

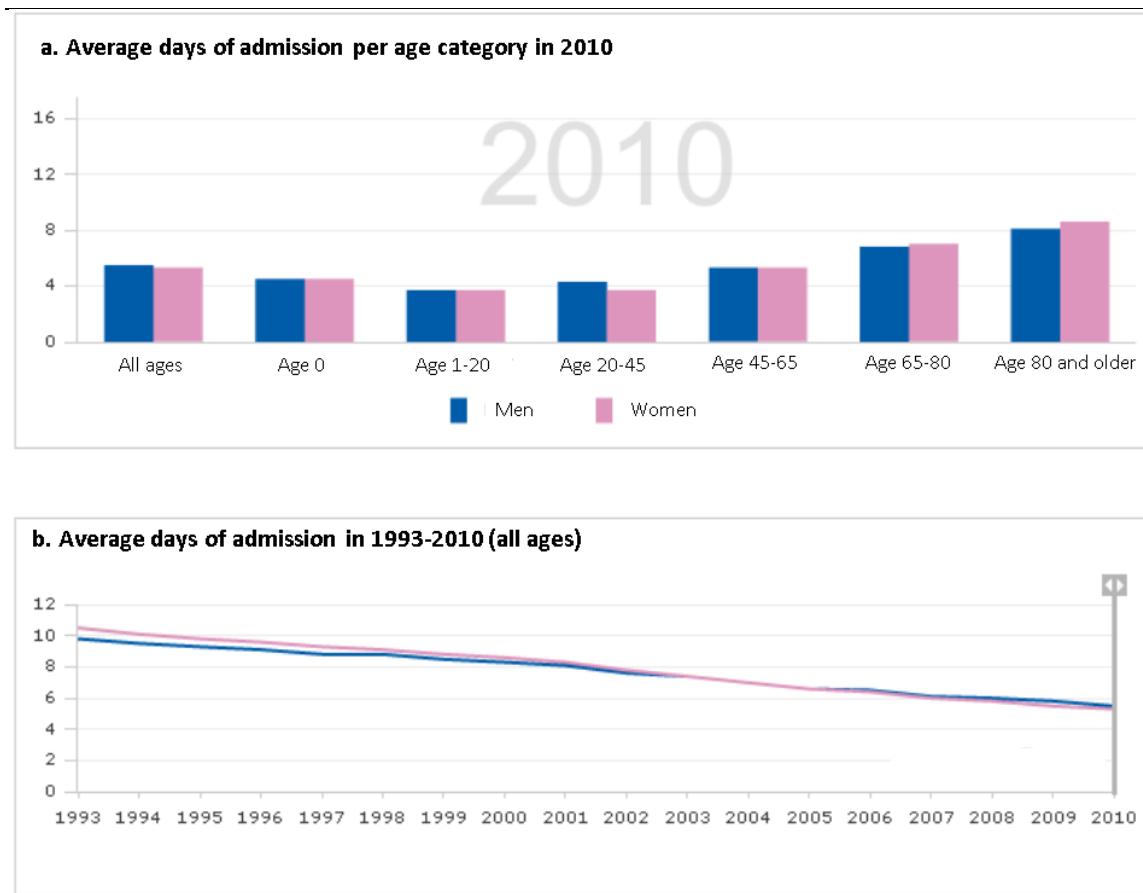


The number of hospital beds is low in the Netherlands (2.8 per 1,000 inhabitants, compared to an average of 3.7), and the number of doctors is even the lowest of the eight selected countries (1.6 per 1,000 inhabitants, compared to an average of 2.4). The number of surgical procedures is lower in the Netherlands than the average of other seven countries (except for tonsil removals and cataract surgeries), and the 5-year survival rate after surgery is higher.

It is perhaps not surprising then, that the Netherlands spends the lowest share of its GDP on general practices and hospitals of these countries (3.7% , adjusted for gender and age differences). Also, according to the Euro Health Consumer Index 2012, the Netherlands scores the highest on hospital performance. This score is based on five categories: patient rights and information, accessibility, outcome measures, prevention,

and pharmacy. From these scores, one can conclude that the Netherlands has a highly efficient medical care system.

Figure 10: Trends in admission days in the Netherlands (Source: CBS)



On the other hand, other expenses in health care (other than general practices and hospitals) is the highest in the Netherlands, compared to the other seven European countries. The costs of long-term care provision, social support, mental health care, overhead costs, and of other health care providers add up to 7.4% of GDP (adjusted for gender and age differences). All in all, to deal with the rising health care costs effectively, policy-makers in the Netherlands need to focus on health care sectors, other than general practice and hospitals.

4.2.4 Institutional level: long-term care

From 2006 to 2010, the number of extramural care providers has been increasing from ±700 to over 1200. The number of intramural care providers has been decreasing.

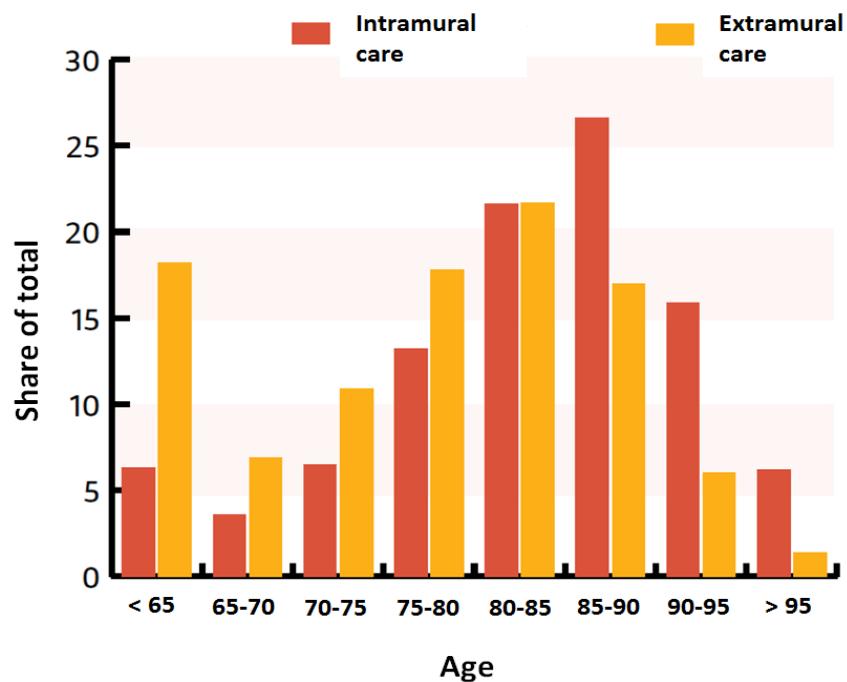
Especially the number of care homes has decreased (from ±500 to ±400). The number of nursing homes has remained stable. These trends have two reasons: (1) mergers in the care home sectors has decreased the total number of care homes; (2) more long-term care is provided extramural rather than intramural. The second reason relates to an increase in efficiency in the long-term care sector, since intramural care is more expensive than extramural care.

Not only has the number of care homes decreased between 2006 and 2010, the days spent in care or nursing homes per client have also decreased. If a long-term care institution has a capacity of 100 clients, the average number of clients that were admitted to this institution in 2006 were 152. This number increased to 160 in 2009, meaning that the average period of admittance decreased with 5% between 2006 and 2009. While the relative use of intramural long-term care has decreased over the last years, the total number of informal care-givers has increased.⁷ This could be a direct effect of population ageing, but it is also possible that long-term care becomes less institutionalized in the Netherlands. This runs parallel with the broad aim of the Dutch government to expect more effort from informal care-givers, the social network and the community, rather than the formal long-term care system. Figure 11 (next page) shows what shares different age categories of clients had in long-term care utilization in 2009.

As stated below figure 11, extramural care includes domiciliary care through the WMO, but no other WMO-services. The effectiveness (quality) and costs of the WMO are discussed in the next paragraph.

⁷ Source: Social and Cultural Planning Bureau

Figure 11: What share do clients have in long-term care utilization by age, 2009?⁸



The monetary flows in long-term care and social support (AWBZ and WMO) are given in figure 10 (next page). This figure shows that expenditure levels in the AWBZ are much higher than the estimated levels in the WMO: 24.6 billion versus 4.2 billion. Care in the AWBZ is much more intensive than WMO support (including Care Weight Packages with full-time residence and 24 hours supervision, and nursing and personal care). However, policy-makers are planning to move substantial parts of the AWBZ to the WMO, because it is assumed less intensive long-term care activities are much more efficiently arranged through local governments with restricted budgets than through a large national system (see also paragraph 4.3 and 4.4).

⁸ Figure from: www.actiz.nl, extramural care includes domiciliary care from the WMO

4.2.3 Institutional level: social support

Table 1 (next page) shows the per capita costs of the WMO in 124 municipalities from 2008 to 2012, also for three performance fields that are specifically important for the elderly. These figures were collected by SGBO, a commercial research institute providing benchmarking services for public organizations. Because data on utilization and expenditure of WMO services are dispersed over 415 municipalities (2012) and every municipality defines a different spectrum of WMO services, coherent information on the expenditure levels in the social support sector is hard to find, and not available through regular means (e.g. from the Ministry of VWS, the CBS, or the SCP). Although the figures from table 1 offer an insight into expenditure levels of the WMO, it remains unclear what share the elderly have in the costs.

Per capita expenditure levels of domiciliary care have risen sharply in 2010, while the number of new applications have decreased between 2009 and 2011. The average expenditure per client receiving domiciliary care has risen from €2,929 to €3,234 from 2009 to 2010 (€3,370 in 2011). It is assumed that the criteria for indication-setting have been made stricter, while the costs of service providers have risen. Also notable from the SGBO reports is that per capita expenditure on WMO is much higher in bigger municipalities than smaller ones: €334.91 versus €237.11. It could be that bigger municipalities offer more WMO services, or that the share of WMO dependent inhabitants is higher in these regions. However, the difference in expenditure levels is almost €100 (29%), and other factors are probably contributing to this difference. Levels of voluntary work, informal support and informal care are higher in smaller communities, substituting for formal care and support.

Table 1: Annual costs and outcomes of the WMO (2008-2011, 124 municipalities)⁹

	2008	2009	2010	2011
Per capita expenditure (€)				
Total	208.77	230.07	233.16	252.17
Performance fields 5 & 6	-	140.71	154.73	157.25
<i>Domiciliary care (±)¹⁰</i>	78.00	77.00	91.00	96.00
(% receiving PGB)	-	(16%)	(17%)	(18%)
<i>Adjustments to home</i>	13.60	12.60	12.60	11.10
<i>Collective transportation</i>	11.10	10.30	11.80	11.70
<i>Wheel chairs</i>	9.40	9.20	9.00	8.40
<i>Scooters</i>	-	7.60	8.10	8.10
<i>Individual transportation</i>	-	6.60	4.70	4.20
<i>Overhead costs</i>	18.89	17.41	17.53	17.75
<i>(Client contributions)</i>	(11.24)	(11.64)	(13.85)	(16.93)
Performance field 4	-	-	4.71	4.45
<i>Informal care</i>	-	-	2.05	1.95
<i>Voluntary work</i>	-	-	2.66	2.50
Other performance fields	-	-	73.72	90.47
Outcome measures (average scores, 0-10)				
Social quality	-	6.6	6.6	6.7
Environmental deprivation	-	3.9	3.8	3.4
Satisfaction: domiciliary care	7.8	7.8	7.8	7.8
New applications (per 1,000)				
Information and advice: field 3	-	126.0	145.0	108.0
Domiciliary care: field 5/6	-	12.0	10.9	9.2
Other provisions in field 5 & 6	-	23.2	21.9	19.2

⁹ Source: SGBO, Benchmark WMO 2012.

¹⁰ Average expenditure levels per client receiving domiciliary care were €2,638 in 2008, €2,929 in 2009, €3,234 in 2010, and €3,370 in 2011.

4.3 Past measures to deal with rising health care costs

4.3.1 Political environment

Before defining the recent and most important transformations in the Dutch medical and long-term care sector to curtail the rising health care expenditure, the political situation in the Netherlands is sketched. In 2010, national elections were organized after the government resigned. In these elections, the VVD (conservative-liberal party) had received most seats of government by votes (31 of 150 seats), followed by the PvdA (social-democratic or “labour” party) with 30 seats, the PVV (party of Geert Wilders) with 24 seats, and the CDA (Christian-democratic party) with 21. The VVD, PVV and CDA formed a coalition, called Rutte I, in which the PVV offered only cooperation through support. This government resigned again on April 21st 2012, when the PVV withdrew this support. Many decisions were made during the time of Rutte I, which affected the Zvw, AWBZ and WMO. These decisions could not be realized, as the government had lost its acting power.

New elections were held in October 2012 and a new coalition was formed in November 2012. The new coalition, called Rutte II, consists of the VVD and the PvdA. Rutte II was planning to make the health insurance premium income dependent, and to discard the health care allowance completely. This would mean that Dutch citizens with a middle or high income would pay a higher premium to their health insurers, and that the lower income population would pay less. This led to many protests, and the plans to make health insurance premiums income dependent were abolished. Serious cutbacks in the AWBZ were also on the agenda of Rutte II. Although people and health care professionals protested against these cutbacks, they are likely to be followed through. More information on this can be found in paragraph 4.4.2.

4.3.2 Medical care

Medical care costs have increased steeply in the last decade, especially in 2005-2006, when the ZVV was introduced. Measures have been taken from the start of the ZVV in 2006 to contain growing costs in the medical care sector.

- Mainly to curtail the increasing assertiveness and demands of patients, the compulsory deductible has been raised to refrain people from overusing health care facilities.
- To prevent the health insurance premiums from increasing steeply, the government has diminished the coverage of the basic health insurance package. For example, coverage for physiotherapy has been decreased consistently throughout the last few years. The first twenty physiotherapy sessions are no longer covered by the basic package in 2013 (and after twenty physiotherapy sessions, still only some treatments are compensated by basic insurance).
- To counter the effects of a volume increase due to free market incentives, so-called “volume norms” are being researched and issued by the Dutch Health Care Inspectorate (IGZ). Volume norms signify a minimum of complex surgeries or treatments per year a hospital must perform to sustain the right to perform these surgeries or treatments. Examples are pancreatic cancer, rectal carcinoma's or elective surgeries for an aneurysmatic aorta. Scientific committees in health care were asked to give their viewpoint on the number of surgeries or treatments that were required to reach such a norm.
- Volume norms and quality standards have been issued by health insurers. For example, health insurer CZ has stopped compensating breast cancer surgeries in six hospitals in the Netherlands in 2011. These hospitals scored too low on quality indicators – the most important one being survival rates after surgery. Because CZ is one of the biggest players in the Dutch health care sector, these hospitals were forced to increase their quality levels or stop providing these surgeries. Volume norms and quality standards, controlled by the IGZ or health insurers, force hospitals to specialize in certain disciplines.

- Rutte I was planning to charge client contributions for hospitalization (around €7.50 per day) in 2012. Rutte II discarded these plans.
- On November 4 2011, the liberal party (VVD) suggested that clients should also receive health care providers' bills, besides their health insurer. They offered two arguments: (1) people could then see how expensive health care can be, creating more support for necessary future cutbacks on health care expenditure; (2) people could check whether health care providers are "upcoding", since health insurers cannot check whether a health care provider has booked the right DOT (see 2.5). It is unclear whether these plans will be effectuated in the future.

4.3.3 Long-term care

Expenditure in the AWBZ has been growing steadily since 1967. Population ageing has an impact on expenditure in the AWBZ, as the number of clients eligible for long-term care increases. However, the RIVM estimated that only 15% of the total rising health care costs in the Netherlands could be attributed to population ageing between 2001 and 2010. Political decision-making had a more significant impact on rising AWBZ expenses. Through changes in policy, more and more health problems and ailments were covered through the AWBZ between 1967 and 2010. In the last years, policy-makers in the Netherlands have removed some forms of health care provision from the AWBZ and tried to change eligibility criteria for some forms of long-term care. The most important changes in the AWBZ in the last few years are given below.

- Starting from January 1st 2008, domiciliary care is provided through the WMO rather than the AWBZ. In the future, more extramural care is going to be transferred from the AWBZ to the WMO. The aim is to decentralize extramural long-term care, which has several advantages. Municipal offices:
 - are easier to access for care-receivers;
 - are better informed about the costs and quality with regard to local long-term care facilities;
 - are better informed about a client's social environment and network;

- have tight budgets and are forced to make rigorous cuts in social support and long-term care facilities if that is necessary. Municipalities can realize these cuts by trying to stimulate utilization of a client's social networks rather than formal care facilities;
 - can reach synergy effects with the other social support activities in the WMO.
- In 2009, counselling was no longer indicated for clients with only slight limitations.
- To prevent misuse, the Dutch government has steadily narrowed the eligibility criteria for PGBs. Stories appeared in the media on children of older people who used the PGBs of their parents to go on holiday, rather than to provide their parent(s) with the necessary care. News items were also published on dodgy commercial organizations offering help with requesting, using and administrating PGBs, but using (parts of) their customers' PGBs for other purposes instead. Clients now also have to set up a budget in advance, and accurately report their service utilization.
- To cut costs in AWBZ care for the mentally handicapped, the former coalition of Rutte I of VVD, CDA and PVV were planning to increase the IQ-threshold for eligibility from 85 to 70. These plans were discarded by Rutte II.

4.3.4 Social support

The main change since the start of the WMO in 2007, is the addition of domiciliary care to the responsibility of municipalities in 2008. Other than this, no important changes have taken place in the WMO. This is mainly because the WMO has been in its start-up phase in the last 5 years, and major policy changes in this phase could prove ineffective.

4.4 (Potential) Future measures to deal with rising health care costs

In this chapter, we begin with explaining the broad viewpoints of Dutch policy-makers in health care to improve the quality and efficiency of the system. After this, the specific policy measures for 2013 and after are discussed.

4.4.1 Broad and long-term aims

Two broad and long-term aims of the Dutch government can be distilled that are the basis of the many policy measures that were taken in the last years, and are expected in the future:

1. A focus on higher responsibility for citizens themselves and their surrounding network of friends, family and neighbours, rather than the formal system;
2. A sharp distinction between individual responsibility, entitlements to health care, and practical solutions.

These two aims are discussed in more detail below. First, many of the future measures of the Dutch government to regulate rising health care costs are related to the concepts of *independence* and *active citizenship*. Independence relates to taking responsibility for oneself, and active citizenship relates to taking responsibility for others in your community. The central aim is to make Dutch citizens less dependent on the formal health care system.

Improving clients' independence could lead to lower levels of health care demand due to higher levels of self-care and self-support, as well as better decision-making by clients. Some policy measures, have the goal to separate health care from residence. One example is that the former coalition Rutte I was planning to charge client contributions for days spent in the hospital. Another example is that a long-term aim within the AWBZ is to abolish compensation for housing costs (this means that only long-term care is provided through the AWBZ, and not residence). The central motivation is that the availability of good health care is a right, but compensation for housing is not. Instead, paying for residence is (at least partly) the responsibility of the person him-/herself.

Active citizenship relates mainly to the provision of informal care and social support from relatives, friends and neighbours. The main instrument of the government to stimulate such informal care activities, is to downsize the supply of health care. For example, provision of in-hospital recovery from treatment can be reduced, making a

speedy and good recovery more dependent on a client's social network. This way, costs are reduced because the average days spent in hospital are decreased. Similarly, eligibility for domiciliary care provision is made more strict to stimulate friends, neighbours and relatives of the client to provide these basic activities.

Second, in many years time the Dutch government wants health care legislation and provision to overlap with current ideas on responsibility and entitlements in health care, and to be arranged in efficient systems of finance and legislation. In short, this implies that a client and his/her social networks have the **first responsibility** to acquire or provide facilities, residence, personal care, forms of social support, and other care and support activities. Care and support activities should only be provided through collective means if a client's financial means, health status and social network does not allow him/her to take this responsibility.

All in all, the current government wants to totally abolish the AWBZ in the very long run (10 years or longer). This long-term aim will pursued in steps. First, personal care, counselling, daytime activities, and other activities currently or formerly provided through the AWBZ should be provided through the WMO. These activities relate more to social support and can potentially be provided through a client's social network, meaning that municipalities might be better equipped to coordinate and provide these services than the national and bureaucratic system of the AWBZ. This means that clients are no longer **entitled** to receive these forms of care/support, but that these services are seen as **potential practical solutions**. Second, arranging and compensating for short-term or long-term residence and facilities ("hotel costs") are thought to be the client's responsibility, and will no longer be provided through public resources. Third, nursing care should be provided through the ZVV, as this relates more to medical care than long-term care or social support.

4.4.2 Policy measures for 2013

The policy measures in this paragraph relate to changes in government policy in the health care system from 2013 onwards. Policy measures in the short-term are

thoroughly worked out by the government. Here, the most important changes in the health care system are defined, after which the changes planned for the long term are described. The following changes in health care policy become effective in 2013:

- From 2013, care office branches of health insurers become responsible for all the clients of the health insurer, regardless in which region they live. Before 2013, health insurers were legally obligated to have a care office branch for all clients in the regions in which they have the highest market share. The year 2013 is a transition year: care offices are still going to cover the regions in which they were active before 2013. Health insurers will then second care office activities to the care office that was responsible for AWBZ services before 2013, until they are ready to perform these activities themselves.
- Clients that were eligible for low-level intramural AWBZ care (ZZP level 1 or 2) in 2012 and before, will now be eligible for extramural care only. This only counts for new indications. Clients with indications from before 2013 for low-level intramural care will not lose them in the near future.
- Rehabilitation in the AWBZ (ZZP 9) will be transferred to the ZVW. Rehabilitative care is found to be short-term by nature, and related more to the curative sector than the care sector.
- The client contribution for AWBZ care is going to be raised.
- More people will become eligible for PGBs in the AWBZ. The government made eligibility criteria more strict in 2011 and 2012, because there were reports of misuse by relatives of clients and commercial long-term care intermediaries.
- The compulsory deductible for medical care is raised with ± 60% (from €220 to €350).
- Walkers, zimmerframes, crutches, and kanes are no longer compensated through the basic health insurance package of the ZVW, the AWBZ or the WMO. Renting instrumental aids through the AWBZ is no longer possible.

4.4.3 (Potential) measures after 2013

Medical care

- In 2014, a client contribution of €50 will be charged when a client reports at the emergency ward in a situation where emergency care is uncalled for. This policy measure aims to reduce redundant medical provision due to client assertiveness.
- The initial plans of Rutte II to make health insurance premiums income dependent were abolished. The current long-term plan is to make the compulsory deductible income dependent, instead of the premiums.

Long-term care

- In the long term, care offices will be abolished. Health insurers will then become responsible for compensating medical as well as long-term care (ZVW and AWBZ) for their clients. This will benefit clients, since they now have one “reception desk” for both ZVW and AWBZ services. Also, health insurers don’t have to collect new information on a client, when he or she applies for AWBZ care, since this client is already in the information system of the health insurer. In the new system, long-term care providers will bill health insurers instead of care offices for their provided services.
- As stated in the beginning of this paragraph lower-level intramural care (ZZP 1 and 2) will disappear from 2013. Instead, those who were eligible for lower-level intramural care will now only receive indications for extramural care. In 2014 and 2015, the same will count for ZZP 3 and 4 respectively.
- From 2014, daytime activities (part of counselling) will no longer be compensated through the AWBZ.
- From 2014, indications for personal care for a duration of 6 months or less, will no longer be set.
- In 2015 all extramural personal care and counselling will be the responsibility of the municipality. As was mentioned in paragraph 4.4.1, all social support activities are

going to be detached from the AWBZ, becoming part of the WMO. As municipalities have tighter budgets, it is expected that less clients will be eligible for institutional social support provision, decreasing health care costs. Policy-makers hope to decrease the costs within the AWBZ with 25%, by transferring personal care and counselling to the WMO.

- In 2015 extramural nursing care will be provided and compensated through the ZVV. The underlying argument for this transfer is that nursing care better suits the curative sector (medical care) than the long-term care or social support sector.

Social support

- From 2014 onward, eligibility for domiciliary care will become entirely income-dependent. Municipalities will only provide such services for those with a relatively low income, other clients will have to find their own means to acquire help with housecleaning, grocery shopping etc. These cutbacks will only count for those applying for domiciliary care in 2014. However, in 2015 these changes will also count for all those already receiving domiciliary care.

Appendix

1. Figures of health care expenditure¹¹

Given below are three tables with global figures of health care expenditure in the Netherlands. These tables form an update to table 5-7 of the first report.

Table A1.1a: Source and domains of health care expenditure, millions of euro's (source: CBS)

	2006	2007	2008	2009	2010	2011
Source of finance						
Government	8,206	10,724	11,328	12,390	12,739	13,147
ZVW	26,727	27,693	32,325	34,143	35,625	36,394
AWBZ	23,177	23,007	22,169	23,201	24,409	25,128
Other	12,612	13,220	13,933	14,150	14,506	15,043
Domains						
Expenses for cure	40,688	43,306	46,553	48,688	50,741	51,926
Expenses for care	27,026	28,262	30,175	32,195	33,521	34,628
Policy & overhead	3,007	3,074	3,026	3,001	3,016	3,158
Total	70,722	74,643	79,755	83,884	87,279	89,712

¹¹ The CBS, CVZ, OECD, and BKZ use different approaches to measuring health care expenditure. The CBS retrieves its data from health care providers through questionnaires, checking their annual accounts and other means. The CVZ receives its data from health insurers and care offices. The OECD uses primary CBS data but does not use the same definitions of medical and long-term care. Sometimes the OECD adjusts their figures for age and gender differences to improve inter-country comparison. The government publishes data on health care expenditure through the BKZ. Shown in the BKZ are expenses made by the government and government institutions. Information comes from internal budgets and accounts.

*Table A1.1b: Source and domains of per capita health care expenditure, millions of euro's
(source: CBS)*

	2006	2007	2008	2009	2010	2011
Source of finance						
Government	502	655	689	750	767	788
ZVW	1,635	1,690	1,965	2,066	2,144	2,180
AWBZ	1,418	1,404	1,348	1,404	1,469	1,506
Other	772	807	847	856	873	901
Domains						
Expenses for cure	2,489	2,643	2,830	2,946	3,054	3,111
Expenses for care	1,654	1,725	1,835	1,948	2,018	2,075
Policy & overhead	184	188	184	182	182	189
Total	4,327	4,556	4,849	5,075	5,253	5,375

Table 1.1c: Source and domains of health care expenditure as the share (%) of gross domestic product (source: CBS)

	2006	2007	2008	2009	2010	2011
Source of finance						
Government	1.5	1.9	1.9	2.2	2.2	2.2
ZVW	5.0	4.9	5.4	5.9	6.0	6.1
AWBZ	4.3	4.0	3.7	4.0	4.2	4.2
Other ¹²	2.3	2.3	2.3	2.5	2.5	2.5
Domains						
Medical care	7.5	7.6	7.8	8.5	8.6	8.7
Long-term care	5.0	5.0	5.1	5.6	5.7	5.8
Policy & overhead	0.6	0.5	0.5	0.5	0.5	0.5
Total	13.1	13.1	13.4	14.6	14.8	15.0

¹² Other sources of finance encompass: out-of-pocket expenditure (although made within the confounds of the ZVW and AWBZ) and financing from institutions and companies.

Table A1.2: Health care expenditure by type of provider, 2009-2011 (source: CBS)*

Provider	2009		2010		2011	
	Total in million €	% of GDP	Total in million €	% of GDP	Total in million €	% of GDP
Hospitals & specialist practices ¹	21,436	3.73	22,702	3.85	22,811	3.81
Mental health care ^{1,2}	5,273	0.92	5,401	0.92	5,665	0.95
General practices ¹	2,470	0.43	2,494	0.42	2,697	0.45
Dental practices ¹	2,558	0.45	2,637	0.45	2,743	0.46
Paramedical practices ¹	1,720	0.30	1,807	0.31	1,940	0.32
Municipal health service (GGD) ³	707	0.12	752	0.13	772	0.13
Health at work ⁴ & reintegration ⁵	1,260	0.22	1,279	0.22	1,266	0.21
Pharmaceutics ^{1,2}	6,204	1.08	6,340	1.08	6,418	1.07
Therapeutic instruments ^{1,2}	2,670	0.46	2,727	0.46	2,867	0.48
Supporting services	1,769	0.31	1,878	0.32	1,903	0.32
Other	2,620	0.46	2,725	0.46	2,845	0.48
Total medical care expenditure	48,688	8.47	50,741	8.60	51,926	8.68
Providers of elderly care ²	15,211	2.65	15,807	2.68	16,386	2.74
Providers of care for the disabled ²	7,802	1.36	8,088	1.37	8,293	1.39
Providers of youth care ^{2,6}	1,819	0.32	1,960	0.33	2,077	0.35
Social and cultural work ³	1,168	0.20	1,221	0.21	1,277	0.21
Day care centers ⁷	3,943	0.69	4,138	0.70	4,336	0.72
Boarding schools ⁶	576	0.10	549	0.09	481	0.08
Other	1,677	0.29	1,758	0.30	1,778	0.30
Total long-term care and social support expenditure	32,195	5.60	33,521	5.68	34,628	5.79
Policy and management organizations	3,001	0.52	3,016	0.51	3,158	0.53
Total health care expenditure	83,884	14.59	87,279	14.79	89,712	14.99

*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.

Table A1.3: Health care expenditure as budgetted by the government, per sector, in millions of euros, 2010-2011 (Source: BKZ).

Domain	Subdomain	2010	% of total	2011	% of total
Public health		95	0,2%	109	0,2%
Medical care	Total	35,417	56,6%	36,167	56,1%
	Hospital	19,191	30,7%	19,273	29,9%
	Medication	5,215	8,3%	5,460	8,5%
	Mental health care	3,897	6,2%	4,095	6,4%
	General practice	2,219	3,5%	2,310	3,6%
	Instrumental aids	1,394	2,2%	1,475	2,3%
	Dental care	877	1,4%	788	1,2%
	Allied health care	731	1,2%	725	1,1%
	Other	1,893	3,0%	2,041	3,2%
Long-term care	Total	23,983	38,3%	24,645	38,3%
	Nursing & personal care ¹³	7,447	11,9%	7,637	11,9%
	Care for handicapped ¹²	4,333	6,9%	4,437	6,9%
	Mental health care ¹²	1,246	2,0%	1,281	2,0%
	Extramural care	3,595	5,7%	3,603	5,6%
	Daytime act. & transport.	1,159	1,9%	1,181	1,8%
	Personal budgets	2,157	3,4%	2,279	3,5%
	Capital fees	2,608	4,2%	2,593	4,0%
	Other	1,438	2,3%	1,634	2,5%
Social support	Total	1,721	2,8%	1,642	2,5%
	Budgetting for WMO	1,541	2,5%	1,456	2,3%
	MEE	180	0,3%	186	0,3%
Other¹⁴		1,327	2,1%	1,850	2,9%
Total		62,543	100%	64,413	100%

¹³ These long-term care sectors designate intramural care

¹⁴ Other expenses are mainly for education in medicine, and the Wtgc.

2. Benchmark results regarding WMO services of 123 municipalities (Source: SGBO)

*Table A2.1: Information on WMO activities in a study population of 123 municipalities, 2011**

Size of municipal region	Share of study population	Share in the Netherlands
0 – 20,000	18%	37%
20,000 – 50,000	52%	45%
50,000 – 100,000	20%	11%
100,000 and more	10%	6%

Performance field:	“Yes” in share of municipalities:
1.	
Promoting liveability (NH = neighbourhood):	
Promoting citizen participation of local activities	98%
Stimulating initiatives from citizens	98%
Promoting citizen platforms	79%
Promoting networks for specific groups	77%
Providing information concerning NHs	93%
Providing mediation for conflicts in NHs	70%
Promoting NHs watchers and coordinators	72%
Promotion of citizens developing behavioral codes in NHs	29%
Promoting activities to improved citizen contact in NHs	90%
Agreements with housing cooperations on:	
Vacancies	59%
Appropriate supply of social housing projects	95%
Illegal renting / residence	58%
Storage and garbage	67%
Maintenance of plants and trees	66%
Investments in play grounds	48%
“Neighbour days”	34%
Providing mediation for conflicts in neighbourhoods	64%
Neighbourhood cleaning projects	54%
Safety issues in the neighbourhood	81%

3.

Switched to a client-oriented approach**	22%
Switched to a client-oriented approach in a pilot	29%

4.

Support to informal care-givers:

Activities to suspend informal-care activities at home	91%
Activities to suspend informal-care activities outside the home	69%
Daycare for children of informal care-givers	15%
Courses	88%
Facilities	21%
Dispensation for obligation to apply for jobs when unemployed	31%
Contact platforms for informal care-givers	96%
Support after death of the informal care-receiver	83%
Counselling	99%
Recreational activities for informal care-givers	88%

Support to voluntary workers:

Daycare for children of voluntary workers	7%
Promoting professional skills of voluntary workers	88%
Facilities (parking cards, discount cards, etc)	7%
Dispensation for obligation to apply for jobs when unemployed	20%
Insurance	97%
Awards and nominations for voluntary workers	86%
Courses for employees working in voluntary work organizations	84%
Information on legislation	89%
Courses for voluntary workers	70%
Platform with vacancies for voluntary workers	93%
Recruitment campaigns for voluntary workers	78%
Travel allowance	20%
Support for administrative tasks	26%
Financial means for support	38%
Help with organizing	64%

7, 8 & 9.

Agreements with housing cooperations on housing and support for:

Homeless people	95%
Women from shelters	63%
Patients in long-term mental health care	63%
Addicts	58%
Former prisoners	50%

Activities with regard to:

Housing rehabilitation	58%
Employment rehabilitation	63%
Education rehabilitation	55%
Social rehabilitation	60%
Financial rehabilitation	57%
Other daytime activities in rehabilitation	54%
Physical recovery	39%
Psychological rehabilitation	48%

* Please note that this is not the complete lists of WMO activities provided by municipalities in the Netherlands, but only those activities for which data was collected.

** Municipalities are switching to a more client-oriented approach ("De Kanteling"). This client-oriented approach aims at keeping citizens independent and active by actively approaching and stimulating them. WMO provisions should be a last resort.