The Dutch health care system: Basic features, coordination and transferal issues, and future policy reforms

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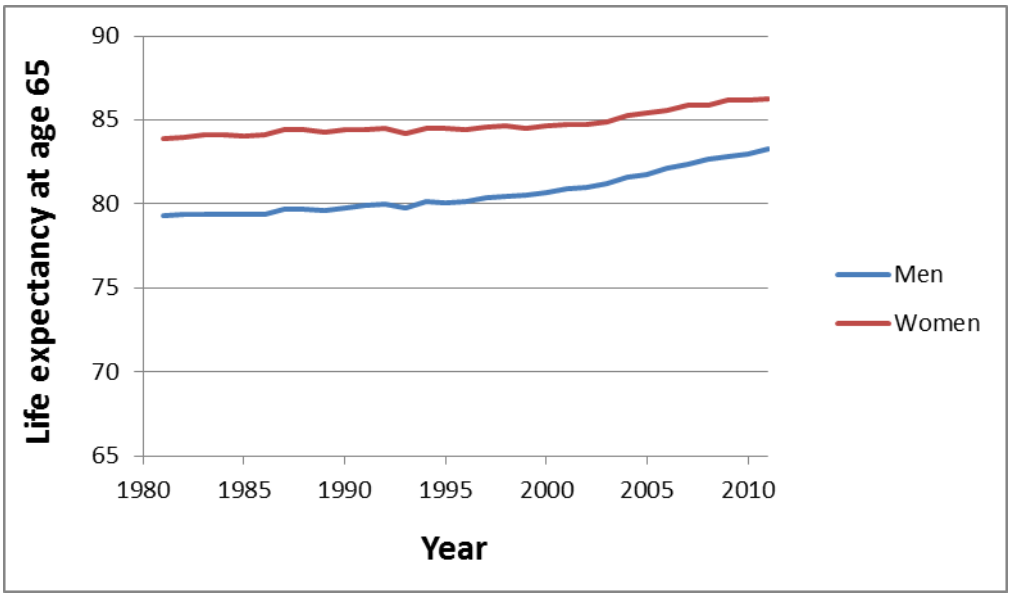
1 Background

Similar to almost all developed countries in the world, the Netherlands is faced with population aging. Of course, improved public health and increasing life expectancy is a blessing (Figure 1 shows how much life expectancy has improved in the last 20 years). However, governments fear overburdening both the working population and the health care system. The number of people age 65 and older is expected to increase from 15% in 2008 to 26% in 2040.[1] Health care expenditure is expected to rise quickly due to population aging, since individual health care expenses increase exponentially after the age of 65 (see figure 2, next page).

Figure 1: Increasing life expectancy in the Netherlands (source: CBS statline).



Indeed, steeply rising health care expenditure in the recent past is already a worrying subject for policy-makers. Health care expenditure expressed as a percentage of GDP has increased from 11.2% in 2000 to 14.8% in 2010.[2] The main causes of this increase are: medical innovations, the Baumol effect, cultural changes, increased supply, health care reforms, and population ageing. Some economists believe the influence of population ageing on health care expenditure is marginal

[1] Van Duin, C. (2009). *Bevolkingsprognose 2008-2050: Naar 17,5 miljoen inwoners [Population forecast 2008-2050: Towards 17.5 million inhabitants]*. The Hague: Central Bureau of Statistics. http://www.cbs.nl/NR/rdonlyres/EB986187-DFD1-4EBA-ABC2-E14A8E9B21B0/0/2009k1b15p15art.pdf.
[2] Central Bureau of Statistics: Statline.

compared to these other factors.[3] These economists argue that population ageing runs parallel with an increase in the overall mortality risk of a nation, and it is this increase in mortality that is the main drive of increased health care expenditure, not ageing itself. It is well-known in literature that health care expenditure increases manifold prior to death, overshadowing slow increases in health care expenditure due to age.[4] Also, these costs of dying decrease when the age at death increases. In short, as life expectancy increases high mortality rates are postponed and the average costs of dying will decrease, leading to the conclusion that current forecasts may overestimate the impact of population ageing on expenditure levels. Another argument is that many countries, including the Netherlands, are planning to downsize supply in the long-term care sector. A final argument is that cultural changes are taking place, and it is possible that the elderly of the future are less dependent on formal care than the elderly are now.

Figure 2: Individual health care expenditure by age (2005).[5]

Nonetheless, policy makers are urged to implement changes to accommodate higher numbers of older people. The Dutch government has recently implemented new laws to effectuate these policy changes. In 2006, the new Health Insurance Act (ZVW) came into place, and in 2007 the Social

[3] Barros P. The black box of health care expenditure growth determinants. *Health Economics.* 1998; 7: 533-544. Reinhardt U. Does the aging of the population really drive the demand for health care? *Health Affairs.* 2003; 22(6): 27-39.

[4] Poos, M. J. J. C., Smit, J. M., Groen, J., Kommer, G. J., & Slobbe, L. C. J. (2008). *Kosten van ziekten in Nederland 2005 – Zorg voor euro's-8 [Cost of Illness in the Netherlands 2005]*. Bilthoven: National Institute for Public Health and the Environment. http://www.rivm.nl/bibliotheek/rapporten/270751019.html.

Support Act (WMO) was introduced. Expenditure levels elevated in those years. Now, in 2013, health care is arranged through three major laws: the Health Insurance Act (ZVW); the Exceptional Medical Expenses Act (AWBZ); and the Social Support Act (WMO).

In this paper, we analyze the Dutch health care system by investigating the three laws. In sections 2, 3, and 4 we will provide an overview of the workings and finances of the ZVW, AWBZ, and WMO. Hereafter, section 5 will focus on general coordination issues for older clients, and section 6 deals with coordination issues between health sectors. Section 7 deals with possible solutions for coordination issues, and section 8 with other (possible) future policy reforms in the Dutch health care system to contain ever-rising health care expenditure levels.

2 The Health care Insurance Act (ZVW)

The Dutch health care insurance system is based on a "semi-free market system". Effectively, health care insurers and providers can negotiate about the prices of some health care services. The ultimate goal of this semi-free market system is that health care providers are driven to work as efficiently as possible, and that health care insurers compete with each other on the basis of price, without sacrificing equity, quality and transparency.

2.1 What is provided through the ZVW?

The ZVW arranges how medical care is compensated or provided. This includes medication and health care services from general practices, hospitals, dentists, allied health professionals, and mental care institutions (up to 1 year), as well as some forms of instrumental aids and transportation. This does not include medical treatment provided in care homes and nursing homes, as this is arranged through the AWBZ.

2.2 Who is eligible to receive care or compensation through the ZVW?

All Dutch citizens are obliged to take a basic health insurance package from a private health insurer. The health insurers are not tied to employer constructions or labor sectors, although employers may negotiate for discounts on health insurance premiums for their employees with a health insurer. The contents of the compulsory package are specified by the Ministry of Public Health, Wellbeing and Sports. The Health Insurance Board (CVZ), a semi-governmental body, advises the Ministry on the contents if the compulsory package.

Every Dutch citizen is free to choose an additional package. Every health insurer is free to establish the contents of these voluntary packages. Although health insurers may not discriminate potential clients by the price of their voluntary packages, they may refuse a citizen's application for a voluntary package. They may never refuse a client who applies for a compulsory package.

2.3 Which organizations are involved in executing the ZVW?

-*Health insurers and health care providers.* There are 35 private health insurers active in the medical care sector. These insurers are owned by 10 enterprises. Insurance companies can only compete on the basis of their insurance fees, services, and negotiated contracts with health care providers. Insurers negotiate contracts with health care providers on a yearly basis, and aim to find the best quality of care for their clientele for the lowest prices. Unsatisfied clients can change to another insurer once per year (before the 1st of January).

-*Health Care Inspectorate (IGZ).* The IGZ focuses on the preservation of the quality of care, prevention, and medical products. The inspectorate gives advice to administrators of health care providers, sometimes on the request of the provider, but may also force providers to abort or change damaging or illegal practices.

-*Dutch Health Care Authority (NZa).* This administrative body supervises the contractual relationships between clients, insurers, and providers. The NZa investigates if the rules of the ZVW are carried out properly, and can impose regulations to improve the accessibility, transparency and fairness of the markets.

-*Health Insurance Board (CVZ).* The CVZ has three core tasks: (1) it gives advice about the content of the basic insurance package to the government; (2) it administers the Health Insurance Fund (HIF) and the AWBZ fund; and (3) it executes and oversees regulations for specific groups – such as people from abroad, or people who conscientiously object to the arrangements of the health care insurance system.

-*Dutch Competition Authority (NMa).* The NMa sees to it that markets remain competitive and that no cartels, (too) powerful fusions or conglomerates, or monopolies are formed.

2.4 How is the ZVW financed?

Health insurers are paid a nominal fee by every Dutch person aged 18 or higher. The fees differ between insurers, but a fixed compulsory deductible is set by the government. This deductible is €350 in 2013, but citizens can choose to increase this deductible up to €850 to lower the fee for their health insurance. Besides nominal fees, Dutch citizens who receive income pay an income-dependent contribution to the Health Insurance Fund (HIF). The HIF is used to compensate health insurers for "unfairness": some health insurers may have clients with higher risk profiles in their clientele, and need financial compensation for this to remain competitive. The government also contributes to the HIF. The total amount of the HIF depends on these three contributing factors:

- Fees paid by citizens. These fees should add up to 45% of the total fund.
- The income dependent contributions (50% of the fund).
- A contribution from the government (5% of the fund).

Most employers are obliged by law to compensate the employee for the income-dependent contribution completely through the *employer contribution*. The employer contribution is added to the employee's gross salary: this means the employer contribution is seen as taxable income for the employee. An income dependent contribution must also be paid over received state pension, private pension, social benefits, and income for self-employed citizens or freelancers.

Health care insurance companies can compensate clients for their health care use in kind or by restitution. If the insurance company pays in kind, any health care expenses are paid by him. When an expense is not covered by the insurance company, or falls under the compulsory or voluntary deductible, the client is billed by the insurance company. In case of restitution, the client pays for health care expenses itself and bills the insurance company when the expenses are covered in the client's coverage. Besides health insurance coverage, there is also out-of-pocket expenditure in the medical care market: for some forms of care and medication, clients pay the whole or a share themselves through the client contributions. The client contribution for the basic package is set by the government. Client contributions in the voluntary package are set by the health insurer.

Medical care providers calculate their required compensations for supplied services by using standard price brackets for each intervention or treatment, called "diagnosis treatment combinations" or DBCs. For example, a knee surgery might involve many aspects (such as anesthesia, MRI scans, pre-surgery consultation etc.), but is defined and billed as one standard product unit. Some DBCs are negotiable, meaning that providers and insurers negotiate about its price.

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

3 **The Exceptional Medical Expenses Act (AWBZ)**

The Dutch Exceptional Medical Expenses Act (AWBZ) has undergone several changes since its installation in 1967, but the core remains the same: the act is established to provide long-term care for people who cannot provide for their basic care needs independently. In the 1970s and 1980s, long-term care expenditures started to rise quickly, as more and more forms of care and instrumental aids were made available. This was put to a stop in the 1990s when more legislation was put into place to counter rising public expenses and improve the efficiency of the long-term care system by promoting free market dynamics.

In the last decade, two major changes have been made concerning the AWBZ. Since 2004, any application for compensation from the AWBZ is scrutinized by the Centre of Needs Assessment (CIZ). Since 2007, some services are no longer provided through the AWBZ, but through the Social Support Act (WMO). Mainly, instrumental assistance (e.g. help with cleaning) and the provision of aiding tools (such as wheelchairs) are provided through the WMO instead of the AWBZ. The central drive for this change was the expectation that assistance and tools could be delivered more efficiently by offices that are regionally close to clients (municipal offices). Also, municipalities are stimulated to work efficiently, because they can only work within the confines of limited budgets from the national government.

3.1 What is provided through the AWBZ?

The AWBZ is a national insurance scheme for long-term care, mainly for intramural care. The AWBZ funds six main kinds of long-term care:

-Personal care: help with showering, dressing, shaving, going to the toilet, etc.

-Nursing care: wound dressing, injecting, teaching self-care, etc.

-Counseling: help with organizing day-to-day practical matters, such as making coffee or filling in forms.

-Treatment: help with recovering from illnesses or injuries (e.g. learning to walk again after a stroke) or improving skills or behavior (e.g. learning how to deal with panic attacks).

-Long-term residence in a care home or nursing home.

-Short-term residence in certain institutions (maximum of 3 full days in one week).

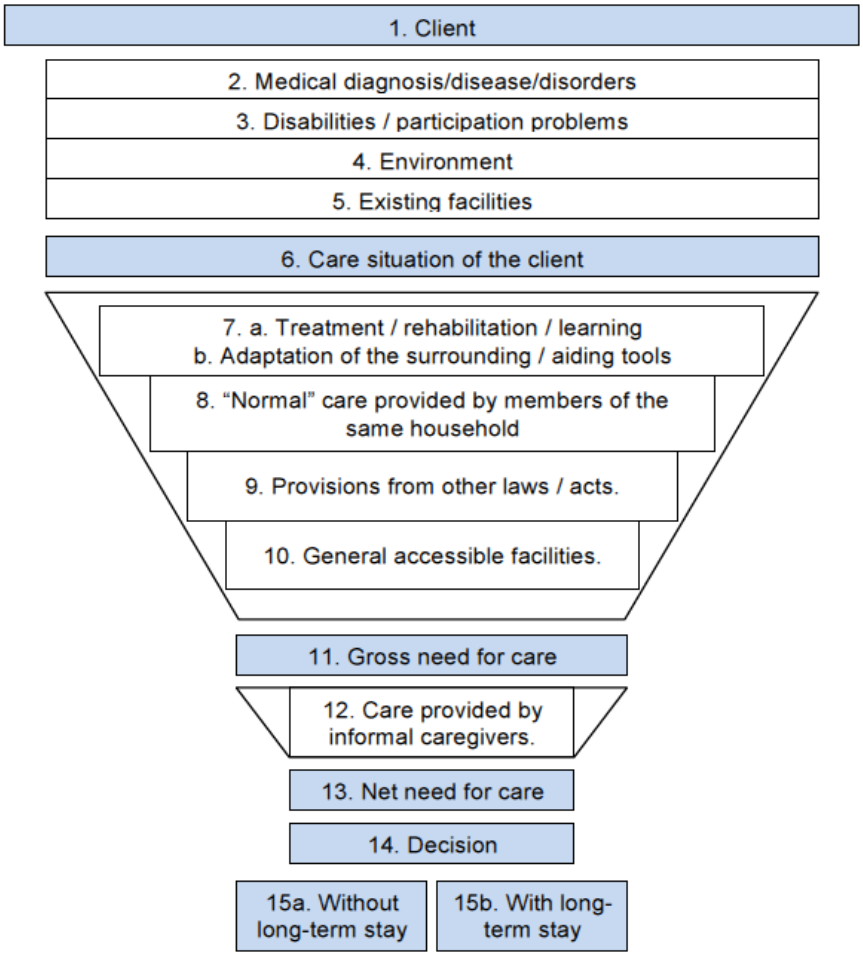
The first four kinds of AWBZ care defined above – personal care, nursing care, counseling, and treatment – can be provided both at the client's home or any institute the client is residing, except for hospitals. When any kind of personal care, nursing care, counseling and treatment is given in the hospital, care is funded through the ZVW. In the intramural elderly care sector, the AWBZ compensates the residence and care in care homes, nursing homes, long-term rehabilitation units, and hospices.

3.2 Who is eligible to receive care or compensation through the AWBZ?

As mentioned before, the AWBZ aims to provide long-term care to all who cannot provide in their basic care needs independently, such as people with a handicap or the frail elderly. More specifically, to be eligible for AWBZ care or compensation, a Dutch citizen has to suffer from a long-lasting physical, psycho-geriatric or psychiatric ailment, or a mental, physical or sensorial handicap. Most expenses within the AWBZ are made for (frail) elderly, with or without cognitive limitations or physical/functional limitations. Before AWBZ care or compensation may be received, one needs to be assessed by the Centre of Indication-setting in Health care (CIZ). The CIZ assesses the care need

of an individual according to a "funneling model", as shown in figure 3. With the use of this model, the care needs of a specific patient are assessed, on which a decision is made.

Figure 3: Assessment steps by the CIZ to decide on an individual's AWBZ care needs (funnel model)



3.3 Which organizations are involved in executing the AWBZ?

-*Centre of Indication-setting Health care (CIZ).* Every request for AWBZ care is sent to the CIZ first. The client, or someone acting on behalf of the client, can make a request digitally or by telephone. After the client has filled 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. The CIZ issues a legally binding indication, sent to both the client and the care office.

-*Care offices (health insurers).* In 2013, health insurers act as care offices for all their ZVW-clients. In prior years, the health insurer with the highest market share in one of 32 AWBZ regions acted as a care office. Care offices are responsible for arranging long-term care for the client, usually after consulting the client. Long-term care providers send their bills to the care office.

-*Central Administration Office (CAK).* The CAK calculates the client contributions, on the basis information on income from the tax department. The CAK compensates the long-term care providers by request of the care office.

-*Health Insurance Board (CVZ).* The CVZ administers the AWBZ fund.

-*SVB Service center for Personal budgets (SSP)*. The SSP offers free assistance to clients who receive a personal budget. Some personal budget holders need help with the administrative processes that are required when applying for a budget, or maintaining the budget. SVB stands for Social Insurance Bank (*Sociale Verzekeringsbank*).

3.4 How is the AWBZ financed?

All Dutch citizens with income are obliged to pay a fee of 12.15% over a (maximum) part of their yearly taxable income (also those who are younger than 18 years and have a job). The maximized part over 2013 is €33,363. This means that the maximum fee a person can pay for the AWBZ is €4,053.60. The Dutch government aims to fund all AWBZ care by the total bulk of these income dependent fees alone (including AWBZ care for those under 18 years of age). In some years, the expenses made by the AWBZ fund exceed the bulk of the incoming fees. In these years, deficits are compensated by the government through contributions by the national treasury. These contributions to the AWBZ fund fall under an expense category, called the Contribution to Reduction Expenses (BIKK: Bijdrage in de Kosten Kortingen).

Clients can choose to receive care in kind, arranged by the care office, or to receive a personal budget. With a personal budget, a client is free to choose his or her own long-term care provider. However, when a client makes use of a personal budget, the client, or someone acting in behalf of the client, needs to administer care use and payments. Besides compensation from the AWBZ fund, clients are required to pay a contribution dependent on their income.

4 The Social Support Act (WMO)

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

- Improving social cohesion and livability of villages and neighborhoods.
- Support to youth and parents who experience problems with upbringing (prevention).
- Giving information, advice, and support to clients.
- Supporting informal caregivers and volunteers.
- Promoting the participation of people with chronic psychological or psychosocial problems or a physical limitation in society, as well as their independency.

- Providing facilities and services for people with chronic psychological or psychosocial problems or with a physical limitation to promote their independency and societal participation.
- Offering shelters and implementing policies to combat domestic violence.
- Improving public mental health care.
- Improving addiction policies.

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

4.1 What is provided through the WMO?

Provisions within the nine performance fields described above include:

-help with housekeeping, such as cleaning;

-adjustments in the house, like a stairs lift or a special toilet;

-transport in the region for people who are not capable of travelling with public transport (taxi, compensation for taxi expenses, or scooter);

-support for volunteers and informal caregivers;

-support with raising children;

-wheelchairs;

-delivery of groceries and (warm) meals;

-support to local initiatives, such as community centers and social clubs;

-support to shelters for victims of abuse or homeless people.

WMO provision does **not** include:

-tools for temporary use, such as crutches, or zimmer frames (these are provided by the health care insurer);

-commonly used services or tools (e.g., internet);

-adjustments to a second or other living area (e.g., caravan);

-personal care (provided by AWBZ).

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

4.2 Who is eligible to receive care or compensation through the WMO?

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. The main difference between the AWBZ and WMO is that citizens are **entitled** to receive AWBZ care when they meet the criteria, whereas citizens are never entitled to receive WMO support. Instead, they can make use of social support activities that are offered by their municipality. Although municipalities are obliged to help disadvantaged people participate in society and the community, they are essentially free to make and effectuate WMO policy.

4.3 Which organizations are involved in executing the WMO?

-*Municipalities.* Although municipal offices are responsible for providing WMO support, they can second service provision, indication-setting and billing to other organizations.

-*MO-zaak.* De MO-zaak is a commercial division of the CIZ, performing indication-setting for WMO support for many municipalities. If the client gives his or her consent, MO-zaak has access to AWBZ data on previous and current indications and care utilization of the client.

-*Service providers.* Many municipalities establish contracts with commercial service providers on a yearly basis to ensure providers remain efficient through competition. Service providers include volunteers, domiciliary care providers, taxi companies, companies providing instrumental aids (such as wheel chairs), and more.

-*Central Administration Office (CAK).* Municipalities often second the calculation of client contributions to the CAK.

4.4 How is the WMO financed?

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. 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. Client contributions are usually installed for domiciliary care, instrumental aids, adjustments in the house, and personal budgets.

5 Information sharing in the Dutch health care system

5.1 Background

Coordination is considered to relate to two concepts: (1) information sharing, and (2) definition of roles and responsibilities. Through good coordination of care, the client is guided through the many

difficult pathways in health care in an effective and timely manner, ensuring that the patient is kept informed and satisfied. Details on information sharing and the definition on roles in the medical care, long-term care, and social support sector in the Dutch health care system are provided in the next paragraphs. Details on coordination between these sectors are explained in chapter 6.

Overall, coordination of care in the Dutch health care system is hindered by bureaucracy, diffuse information collection (due to the existence of multiple information systems), and legislation.

- *Bureaucracy.* Because of the many organizations active in the Dutch health care market, and because of legislation to prevent misuse of health care, clients have to collect information, fill in forms, collect formal evidence, and wait for a response when they apply for health care. This bureaucratic system makes health care time-consuming and more expensive. Box 1 (next page) offers an example of the bureaucratic nature of the Dutch health care system.
- *Diffuse information collection.* Many different information systems are used in the Dutch health care system. In the medical care sector, every health care provider collects its own client information. The AIS, HIS and ZIS stand for information system used by pharmacists, general practices and hospitals respectively. Only authorized personnel of a health care provider may log into the information system of the health care provider to track individual client data. In the long-term care sector, organizations share a common information system on client data, called AZR. In the social support sector, every municipality collects data in its own manner. Information sharing between the different information systems is thwarted by legislation (next page) and competition. Also, because of the competitive nature of the semi-free market system of Dutch health care, providers are not inclined to easily share information with each other.
- *Legislation.* The use of information systems to obtain and sustain effective information sharing between health care providers may not conflict with privacy rules and regulations. A famous example of such a conflict is the failure to install a national electronic patient information sharing platform (EPD) in the medical care sector. A proposed law that would make instant data sharing between medical care providers possible in certain situations was put to a halt by the senate in 2011, mainly because of privacy concerns.

5.2 Coordination issues in the medical care sector

Information exchange between the many different providers in the medical sector is relatively slow and incomplete in the Dutch health care system. This is mainly due to legislative and technological issues. 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 the private information of clients (in particular their health status), health related matters that have been discussed in the

consultation room, as 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:

- Force majeur: Other laws have priority over the duty of confidentiality.
- 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.
- Patient consent to sharing information can be reasonably assumed (patient consent is implicit).
- The patient has explicitly granted the health care professional or institute the authority to share information with specific other professionals or institutes.

After it was assessed that information sharing is possible, technological issues have hindered any actual information exchange. For example, some medical specialists send patient information (for example, feedback on consultations or newly prescribed medication) to the GP by letter. GPs then sometimes receive this feedback on potentially new diagnoses, prescriptions, and treatments after a delay. Currently, new possibilities are researched or followed through to effectuate improved information sharing between medical care providers. For example, regional collaborations are initiated with a so-called Regional Switching Point (RSP). The RSP offers a web portal 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 authorization card (called an UZI-card) and reader, look for basic medical information in another health care provider's information system. This will make medical care provision more efficient, also promoting timely health care and reducing mistakes due to a lack of information. Important for older people in this context is the prevention of unnecessary polypharmacy.

5.3 Coordination issues in the long-term care sector

The AWBZ Care Registration system (AZR) is the information sharing platform for the different institutions active in long-term 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, including previous and current indications and long-term care utilization. The AZR system is updated regularly, in accordance with different health insurers (care offices), the CIZ, and the Ministry of Health, Welfare and Sports. Coordination issues in the long-term care sector mainly relate to indication-setting. Illnesses can progress fast and diagnoses can change. Also, indications can be set for a short period of time. Consequently, it is not uncommon that client, or someone from the network of the client, has to continuously apply for new indications. This is problematic, considering that the procedure of indication-setting is a time-consuming administrative process.

5.4 Coordination issues in the social support sector

Municipalities are currently faced with issues in communication and information sharing, mainly because of the quasi-market system:

- A single information sharing platform with standardized messaging is missing. This means that, for example, a municipality receives batches of information from the client, an indication-setting organization, and the service providers. This leads to administrative hassle.
- 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.
- 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.

6 Coordination issues between sectors

6.1 The medical and long-term care sector

Coordination between ZVW institutions and AWBZ institutions mainly takes place during indication setting. After an indication is set, and the client receives AWBZ care, no more information sharing is usually necessary. For example, when an indication is set for intramural care, all health care is compensated through the AWBZ when the client enters the long-term care institution (including treatment by a nursing home specialist and medication).

The CIZ uses the funnel model to set an indication. The basis of the funnel model is that the CIZ gains knowledge of the specific illnesses and/or handicaps that the client is suffering from. For this purpose, the CIZ usually contacts the client's GP or acting specialist to receive information on the diagnoses and/or prognoses. This can only be done after the client has given consent. When a new medical diagnosis is set, or an illness or handicap progresses, it is the responsibility of the client, or someone in the network of the client, to apply for a new indication.

In elderly care, there are instances where a transition of the client from a ZVW to an AWBZ institution takes place. This pertains to a transition from a hospital (or rehabilitation unit) to long-term care units. When a specialist decides that a long-term care unit is more appropriate for a patient than staying in the hospital, a transfer nurse is usually involved (see paragraph 6.4).

6.2 The medical and social support sector

A municipality may, just like the CIZ, ask for information about a client's medical status to be able to make an informed decision on an indication. The client must give explicit permission for this. Some municipalities require all clients who request a WMO indication to give permission for retrieving medical information from their primary health care professional. In this case, clients have to sign for this permission in their application form. Transfer nurses may also assist clients with regard to WMO support (see paragraph 6.4).

Other health care professionals may also assist the client with requesting a WMO indication. Experiments have been done whereby GPs act 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 from the GP to the municipality. Currently, the GP does inform his patients when a service is not compensated through the ZVW, but when they can benefit from social support.

6.3 The long-term care and social support sector

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

- 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 their story once to the CIZ.
- 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 not standardized, service providers suffer from administrative hassles.
- 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 does not always occur smoothly. Some clients receive numerous recalculations of the CAK because of these reasons, leading to administrative hassles for 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.

6.4 Specific roles in improved care and care coordination

Some health care professionals in the Netherlands specifically fill the role of coordinator. There are basically three types of these professionals – each with a different function – and they are described below. First, some medical care providers offer the assistance of a *transfer nurse*. With her knowledge and expertise, this health care professional is able to inform the client of all possible provisions he or she may receive, as well as the processes involved in applying for these provisions. The transfer nurse has different responsibilities:

- Requesting an indication from the CIZ.
- Informing the patient and relatives on the progress in requesting social support or admission to a long-term care unit, as well as important legal and financial matters.
- Contacting the provider after an indication is approved.
- After the patient is admitted in a long-term care unit, the transfer nurse stays in contact with the care unit to stay informed about the patient's state.

The roles and responsibilities of the transfer nurse are clear, and her expertise can greatly benefit the timeliness and quality of care for patients. Besides the GP, the transfer nurse is the only health care professional who can apply for an AWBZ indication with urgency. Transfer nurses are employed by a hospital or a rehabilitation unit.

Second, the *case manager* helps clients who are no longer independent and have complex care needs. The role of case manager is in a developmental stage, and case managers are currently only installed to aid elderly who are suspected of dementia. The case manager has a broader focus than the transfer nurse, and can assist clients with (suspected) dementia in the following ways:

- Counseling before or after diagnosis.
- Mapping the care needs of the client.
- Providing information and advice on the diagnosis, prognosis, and consequences.
- Coordinating care by offering information on possible provisions and on administrative requirements and processes for these provisions.
- Stimulating elderly who avoid care to accept some care provisions.
- Emotional and practical support to the client and informal caregivers.

Case managers are employed by long-term care providers, and are therefore paid through the AWBZ. Research shows that clients are very satisfied with the help from case managers, and it is forecasted that installing case managers nationwide could reduce admission rates to care homes and nursing homes. Consequently, investments in case managers are expected to be cost-effective due to a reduction in AWBZ expenditure.[5]

Third, the role of the *neighborhood nurse* is also to prevent early admission to care homes or nursing homes. But where the case manager provides assistance and information, the neighborhood

[5] http://www.nivel.nl/sites/default/files/bestanden/Rapport-casemanagement-dementie.pdf

nurse offers basic nursing activities, such as preparing and giving medication, dressing wounds, performing injections, providing intravenous therapy, inserting catheters, and so on. The neighborhood nurse also fills a social role by making conversation, advising the patient on self-care issues (or psychological or social problems) and by keeping a close eye on the patient. She provides feedback to family members or the GP when the client's illness progresses or when situations change. Currently the municipalities employ neighborhood nurses, but from 2015, health insurers will become responsible for providing these services. Research has shown that neighborhood nurses can prove to be cost-effective, as they realize cost savings (€18,000 per nurse per year) in other health care services.[6]

7 Improving coordination in the Dutch health care system

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 they occur in a secure setting and all precautions have been taken. Medical care professionals need authorization, an authorization 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 into 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 their own required services is a way to decrease "backstage" information sharing 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. However, the frail elderly and elderly with a cognitive disability or psychogeriatric illness are usually not able to make effective use of personal budget due to their lack of independence. A care manager or family member can then play a role.

[6] http://www.bmc.nl/expertisegebieden/bedrijfsvoering-in-het-sociale-domein/mediatheek/rapport-de-zichtbare-schakel-wijkverpleegkundige-een-hele-zorg-minder/

2. *Improved system of information sharing within the ZVW.* The introduction of regional or even national collaborations between medical care providers (mainly GP, substituting GP, pharmacist, and hospitals) can reduce administrative hassles and delays in information sharing between each other.
3. *Improved system of information sharing within and between the AWBZ and WMO.* In the beginning of 2012, a discussion and innovation platform called Platform IZO was 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 pressing 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 clients' personal data 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 its first phase. Flows of existing platforms and flows of information and data sharing are now thoroughly analyzed. Possible scenarios 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, and occurrences of overlapping similar activities done by different professionals.

8 Future measures to deal with rising health care costs

8.1 Broad scope

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:

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

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. One tool for the government to promote independence and network support is to downsize supply. In the future, 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 them to take this responsibility.

All in all, the current government wants to totally abolish the AWBZ in the very long run (10 years or beyond). This long-term aim will be pursued in steps. First, personal care, counseling, 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. 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 ZVW, as this relates more to medical care than long-term care or social support.

8.2 (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.

-The compulsory deductible might become income dependent in the long term.

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 for their clients. This will benefit clients, since they now have one "reception desk" for both forms of care services. In the new system, long-term care providers will bill health insurers instead of care offices for their provided services.
-Lower-level intramural care (ZZP 1 and 2) disappeared in 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 counseling) 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 counseling will be the responsibility of the municipality.
-In 2015 extramural nursing care will be provided and compensated through the ZVW. 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.