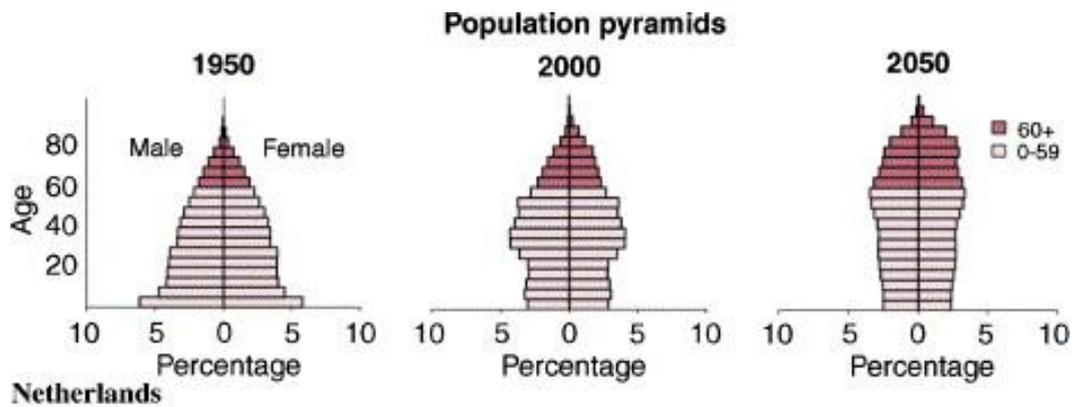
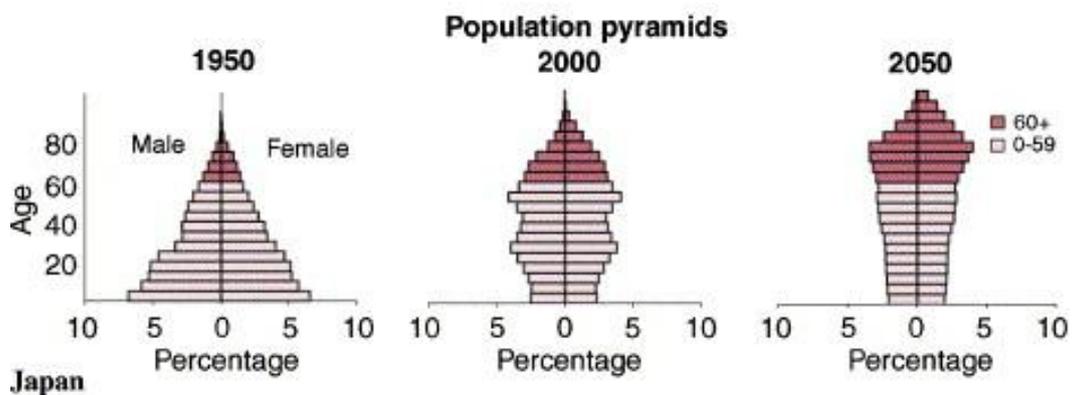


The Dutch health care system

An overview of the three main laws, and potential policy reforms



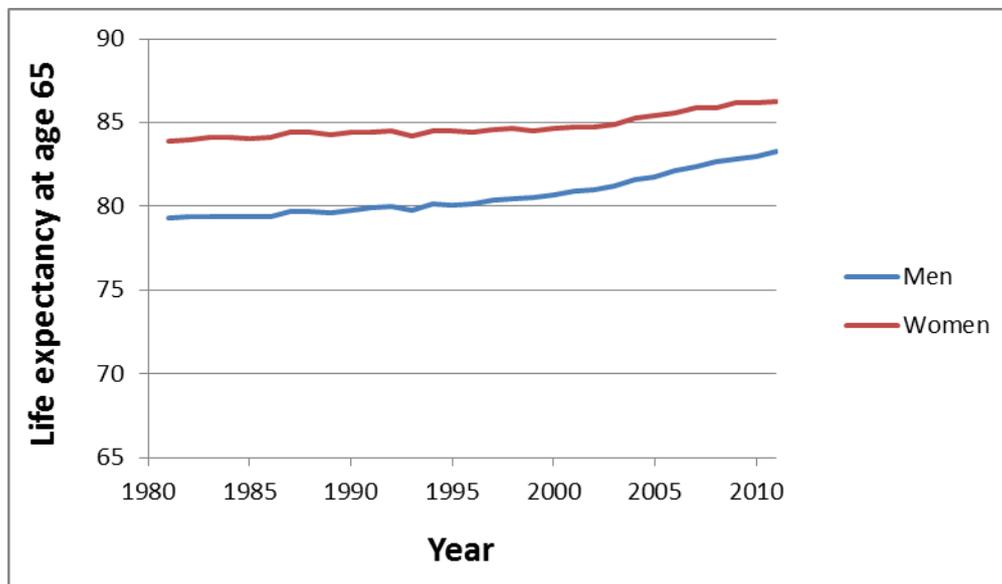
Leyden Academy ON VITALITY AND AGEING



1. Background

Similar to almost all developed countries in the world, the Netherlands is faced with population ageing. 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 of the working population and the health care system. The number of people aged 65 and older is expected to increase from 15% in 2008 to 26% in 2040.¹ Health care expenditure is expected to rise fast due to population ageing, 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 (source: CBS statline). 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 compared to these other factors.^{2,3} 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 Support Act (WMO) was introduced. Expenditure levels elevated in those years. Now, in 2013, health care is arranged through three major laws: (1) the Health Insurance Act (ZVW); (2) the Exceptional Medical Expenses Act (AWBZ); and the Social Support Act (WMO). In the next three chapter, we will provide an overview of the workings and finances of the Dutch health care system by giving structured information on these three laws. Future plans are presented in the last chapter.

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 prices, 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 EMEA.

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) is a semi-governmental body advising the Ministry in this matter.

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:

1. Fees paid by citizens. These fees should add up to 45% of the total fund.
2. The income dependent contributions (50% of the fund).
3. 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), 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 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 remained the same: the act is established to provide long-term care for people who cannot provide in their basic care needs independently. In the 1970s and 1980s, long-term care expenditures started to rise fast, as more and more forms of care and instrumental aids

were made available. This was put to a halt in the 1990s when more legislation was put into place to counter rising public expenses and improve the efficiency of the long-term care system by promoting free market dynamics.

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

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:

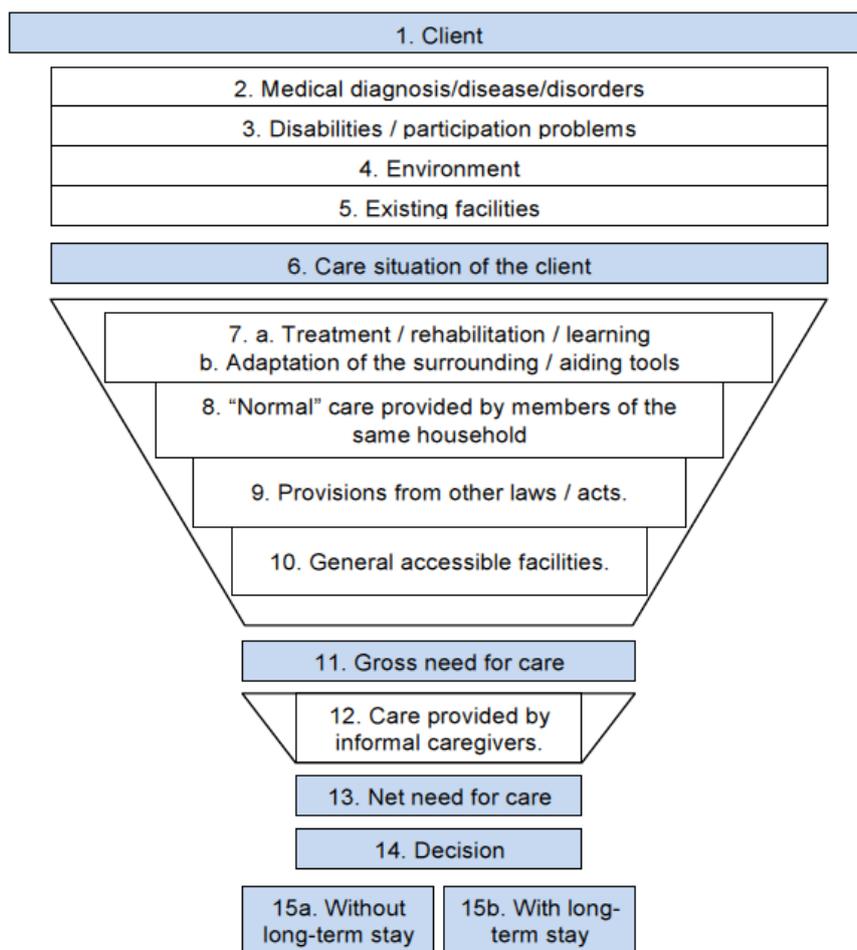
- Personal care: help with showering, dressing, shaving, going to the toilet, etc.
- Nursing care: wound dressing, injecting, teaching self-care, etc.
- Counseling: help with organizing day-to-day practical matters, such as making coffee or filling in forms.
- Treatment: help with recovering from illnesses 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 exceeded the bulk of the incoming fees. In these years, deficits are compensated by the government through contributions by the national treasury. These contributions to the AWBZ fund fall under an expense category, called the *Contribution to Reduction Expenses* (BIKK: *Bijdrage in de Kosten Kortingen*).

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:

1. Improving social cohesion and livability of villages and neighbourhoods.
2. Support to the youth and parents who experience problems with upbringing (prevention).
3. Giving information, advice, and support to clients.
4. Supporting informal caregivers and volunteers.
5. Promoting participation of people with chronic psychological or psychosocial problems or a physical limitation in society, as well as their independency.
6. Providing facilities and services for people with a chronic psychological or psychosocial problems or with a physical limitation to promote their independency and societal participation.
7. Offering shelters and implementing policies to combat domestic violence.
8. Improving public mental health care.
9. Improving addiction policies.

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. Future measures to deal with rising health care costs

5.1 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:

1. A focus on higher responsibility for citizens themselves and their surrounding network of friends, family and neighbors, rather than the formal system;
2. 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 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 be 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. 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.

5.2 (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 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 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.

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