Questionnaire on health care and long-term care for the elderly

TOEGANKELIJKHEID

1.1 GEZONDHEIDSZORG[1]

1.1.1 Mechanismen die de toegang moeten garanderen

Geef een beknopte beschrijving van de algemene structuur en de kenmerken van het gezondheidsstelsel (bv. algemene dekking of verzekering op basis van verplichte aansluiting). Beschrijf de mechanismen die ervoor moeten zorgen dat iedereen toegang heeft tot het stelsel. Beschrijf de doelstellingen van het stelsel op het punt van toepassingsgebied en dekking. Mogelijke vragen in verband met het toepassingsgebied zijn:

- Zijn er beperkingen inzake het type gezondheidszorg dat wordt gedekt, bv. aan de hand van een beoordeling van de meest dringende medische behoeften?
- Dekt het stelsel alle verzorgingskosten of moet de patiënt in de kosten bijdragen?

Mogelijke vragen in verband met de dekking zijn:

- Dekt het stelsel de hele bevolking?
- Welke groepen zijn niet of slechts gedeeltelijk gedekt?
- Verschillen de verstrekkingen naar gelang van inkomen of financiële draagkracht?

Beschrijf eventuele specifieke maatregelen met betrekking tot het toepassingsgebied of de dekking die de toegang van ouderen tot de gezondheidszorg moeten bevorderen[2]. Beschrijf hetzij onder dit punt, hetzij onder punt 1.2.2 hoe de beleidsmaatregelen inzake gezondheidszorg voor ouderen en langdurige zorg gecoördineerd en geïntegreerd worden.

Answer

The objective of the Dutch health insurance system is to guarantee that all insured parties are provided access to good and affordable health care. The Dutch system has an insurance financing structure comprising three compartments in order to realise this objective. In general, the care is subdivided to correspond with these three compartments. The mechanisms guaranteeing access to care can differ per compartment.

The first compartment

The first compartment concerns expensive, uninsurable and long-term care (nursing and care, mental health care, care for the disabled and preventative care). This care is paid out of the *Algemene Wet Bijzondere Ziektekosten* (AWBZ – Dutch General Exceptional Medical Expenses Act). All Dutch citizens are insured by law pursuant to the AWBZ. This means that those who meet the criteria as stipulated in the Act are insured, irrespective of whether

[1] Alle door de overheid verleende of gefinancierde zorg met het oog op de bescherming of handhaving van de gezondheid, revalidatie of herstel.

[2] In deze vragenlijst wordt met ouderen normaliter mensen ouder dan 65 jaar bedoeld. Sommige lidstaten gebruiken echter andere leeftijdsgrenzen voor de toegang tot bepaalde prestaties (in Ierland hebben 70-plussers bijvoorbeeld recht op gratis gezondheidzorg en daarmee samenhangende prestaties). Bovendien is de vraag naar langdurige zorg en gezondheidszorg het hoogst in de hoogste leeftijdscategorieën. De lidstaten mogen dan ook informatie verstrekken over andere leeftijdscategorieën dan 65+, met vermelding van de gebruikte criteria.

they wish to make use of the rights provided through the Act. All insured parties are obliged to pay the statutory premium.

The second compartment

Care provided in the second compartment consists of acute medical care (hospital, general practitioner, chemist's, physiotherapy, dentist, and such). This care is paid out of the *Ziekenfondswet* (Zfw – Dutch National Health Service Act), public schemes for civil servants and private insurance.

Dutch National Health Insurance

The Zfw (Dutch National Health Insurance Act) is originally intended as an insurance for employees. Employees (usually up to the age of 65) and those entitled to a benefit are among those who are insured on the basis of the Zfw if their wages/benefits do not exceed a certain maximum amount (set at € 30,700 for 2002). Further, those who are self-employed, do not exceed 65 years of age and generate operating profits but whose taxable income does not exceed a certain maximum amount (€19,650 for 2002) are insured through the national health service.

In principle, all those who are insured through the national health service by the time they reach the age of 65 remain insured through the national health service (what is referred to as the "stay where you are principle").

Those who are not insured through the National Health Service when they reach the age of 65 may join the National Health Service on a voluntary basis, on the condition that their taxable family income is lower than a certain amount per year (€ 19,550 for the year 2002).

An approximate total of 64% of the Dutch population is insured by law for care in the second compartment through the National Health Service.

Public health insurance schemes

Besides the above-mentioned National Health Insurance, one can be insured for medical expenses on the basis of the public health insurance schemes for civil servants in the employ of local governments (municipality, province or police force). This applies to 5% in total of the Dutch population. The schemes are part of the terms of employment for civil servants and as such have a legal status.

Employees of a municipality, province or the police force who meet the criteria of the relevant official legal status schemes are participants by right, irrespective of whether they wish to make use of the advantages of the health insurance schemes. They are also obliged to pay the established premium.

Private health insurances

Those who are not insured through the National Health Service or on the basis of a public health insurance scheme, need to resort to a private insurance for second compartment care. Although it is not compulsory to have private insurance, approximately 31% of the Dutch population is insured for medical expenses through a private insurance. The private insurance market in the second compartment has two kinds of private insurances - the company policy and the standard package policy.

- *Company policy*

The company policy is purely a private insurance for medical expenses in which the government may not be involved. Based on the third European Non-life Directive, the government is prohibited from interfering in acceptance conditions, insurance coverage and premiums. This enables insurers to compete with other – foreign – insurers who are not confronted with government interference in their operations.

Approximately 60% of all privately insured individuals have a company policy. It is noteworthy that many of these individuals are insured through a collective contract that employers close for their employees. The other 40% has a private insurance on the basis of the standard package policy.

- *Standard package policy*

When the Dutch government decided, in 1986, to cancel the voluntary National Health Insurance and the National Health Insurance for the elderly, several categories of people that had been eligible for these insurances had to resort to private health insurance. To guarantee access for those who have to resort to the private market, the *Wet op de toegang tot ziektekostenverzekeringen 1998* (WTZ – 1998 Access to Health Insurances Act) stipulates that private health insurance companies must include the standard insurance agreement (also referred to as standard package insurance) in their portfolio. There are statutory regulations for this insurance concerning the acceptance of insured parties, the volume of the risk to be insured and the maximum premium that may be charged for this. In contrast to the company policy, the government may interfere in the terms for acceptance, the coverage and the premium price of the standard package insurance because the WTZ 1998 is outside the scope of the third European Non-life Directive.

Insured or uninsured parties are not obliged to conclude an insurance agreement for a standard package insurance. Insurance companies, on the other hand, are obliged to accept someone who meets all statutory conditions for a standard package insurance upon his/her request. Incidentally, most of those insured via a standard package insurance are 65 or older.

Explanatory notes on the insurance system in the second compartment

The duality of national health service-private insurance in the second compartment has a historical background which has now lost its social significance. The National Health Insurance was originally an insurance for people with low incomes. Doctors and other care providers accepted lower rates for aid to those insured through the National Health Service than for aid to 'private' patients. The professional associations in the care industry, however, required, , that citizens who could afford private rates would not be granted access to the National Health Insurance.

This introduced the phenomenon of income limits and maximum wage levels into the insurance system.

Today, there is no longer any difference in the fees charged by care providers for providing care to those insured through the national health service and privately insured patients, with a few exceptions such as the fees charged by general practitioners. This has diminished the income limit and maximum wage level ratio.

One can conclude from the above that everyone is assured of access to health care in the first and second compartments.

The third compartment

The third compartment comprises other types of care (class insurance, alternative medicine, dentist and such). The third compartment concerns private (supplementary) insurances which are not compulsory and which have no acceptance duty.

Coverage of the health insurances

Under the AWBZ, Zfw, public schemes and standard package policy as mentioned previously the insurance coverage is determined on the basis of a statutory insured package. Under the company policy, the coverage is determined by means of the private-law terms of the insurance policy.

When deciding whether a service should be part of the statutory insured package, the following questions must be answered:

1. Is the service essential for reasons of health?
2. If so, has the effect of the service been established in sufficient measure?
3. If so, is it also an efficient service (cost/benefit ratio)?
4. If so, can this service, in all reasonableness, be at the expense and for responsibility of the insured party?

Only when questions 1 through 3 have been answered in the affirmative and question 4 has been given a negative answer, will the service be included or will it remain in the statutorily insured package.

So the statutory package comprises types of essential care. The composition of the statutory package for essential care must be subject to a verification of the scientifically evident effect of the cost effectiveness and of the necessity for collective financing while taking any negative effects (such as unwanted substitution) into account.

The services do not differ according to income or financial means. However, there are specific schemes enabling insured parties to purchase more expensive services by paying them from their own means. The most obvious example of this is the *Geneesmiddelen Vergoedingen Systeem* (GVS – Drug Reimbursement System). The GVS divides the medicine as contained in the Zfw package into groups of interchangeable therapeutic drugs. The reimbursement limit for these groups is determined on the basis of the average price of the drugs in a particular group. If an insured party opts for a drug that exceeds the limit, he/she must pay the difference.

Contribution by the individual towards the costs

In principle, the above-mentioned insurances cover the costs of the services included in the statutory package. Parties insured through the above-mentioned insurances – except for the private insurance – may nevertheless be obliged to pay a contribution in certain instances.

For instance, insured parties of 18 years of age and older residing in (psychiatric) hospitals, care homes, nursing homes, etc., must pay a contribution towards the costs. There are three kinds of contribution by the individual in the AWBZ, two of which depend on income (the high contribution and the low contribution). The third is a fixed contribution.

The Zfw has no general contribution by the individual, however those insured through the national health service may be obliged to pay a contribution for provisions such as wigs or orthopaedic shoes if the costs for such provisions exceed the statutory amount.

Private insurance systems have no general contribution by the individual but a (voluntary) excess as a basis.

The insured parties can select insurance in which they themselves pay part of the services that are covered by the insurance up to a certain maximum. Opting for a contribution by the individual reduces the insurance premium.

1.1.2 Beoordeling

Zijn er prestatie-indicatoren voor de toegang tot gezondheidszorg, bv.
- wachtlijsten;
- ongelijke toegang tot bepaalde geavanceerde of nieuwe behandelingen;
- regionale of inkomensgebonden verschillen;
- specifieke groepen die waarschijnlijk niet volledig gedekt zijn?

Answer
The Dutch public sector (and also the care sector) is working towards changing from indicators to performance indicators.

There are indicators for access to health care. There are standard times for physical accessibility of ambulances or hospitals, for example, on the basis of which a distribution policy has been developed for these facilities. There are waiting periods for various ailments, for which the hospital sector has developed its own standards concerning medical and social acceptability (called Treek standards).

The distribution policy provides for differences in accessibility; there are more hospitals in large cities than, for instance, in the most sparsely populated part of the Dutch countryside where one must travel several kilometres. In that sense there are regional differences.

There is no formal distinction in access to health care. In principle, all care – even certain sophisticated or new treatments – is available to all citizens. So there is no distinction by income, by region, or by other specific features (insofar as medically irrelevant).

1.1.3 Uitdagingen

Wat zijn de voornaamste uitdagingen waarmee u wordt geconfronteerd met betrekking tot het verlenen van toegang?

Answer

Currently there are waiting periods for various ailments, even though several are within the limits of what can be deemed medically and socially acceptable.

This indicates that there is a discrepancy between supply and demand. It is a considerable challenge to organise the provision of care in such a way that the demand for care can be met with quality care service on a timely basis with the most efficient use of the available means.

1.1.2 Geplande beleidswijzigingen

Beschrijf in voorkomende geval welke wijzigingen in het algemene stelsel of in de beleidsmechanismen worden overwogen.

Answer

An important change is the development towards a more liberalised and more demand-driven care system. A precondition for this is that the requestors, patients and consumers, have relevant information at their disposal in order to effectuate their demand for care as best as possible. The various care sectors must function and perform in a transparent way to realise this. Various initiatives have been developed for this purpose, including a new control system for hospitals, a new financing system based on *Diagnose Behandeling Combinaties* (DBCs – Diagnosis Treatment Combinations) as of 1 January 2003 and a statutory requirement to provide information.

As of 1 January 2003, hospitals will be funded on the basis of DBCs. A DBC gives a diagnosis with corresponding actions to be carried out by specialists and hospital personnel to treat the patient along with a corresponding cost price. A starting point with respect to the DBC system is to create transparency. Transparency makes demands on the way in which information is provided. This applies not only at local levels where agreements are made on volume, price and quality based on a nationally established product structure, but also at a national level where agreements are made on supervision (quality, inspection), maintenance and national registration systems. Besides the fact that the DBC system induces production (through the implemented principle of ‘performance-based wages’) each DBC gives an estimate of the average capacity required . This can be used to help reduce waiting lists.

1.2 LANGDURIGE ZORG

1.2.1 Toegang tot langdurige zorg

Geef een beknopte beschrijving van de structuren en mechanismen ter ondersteuning van langdurige zorgverlening (bv. rechtstreekse verlening via sociale diensten, voorziening in de behoeften via universele dekking, sociale verzekering, sociale bijstand en/of particuliere verzekering, steun voor informele zorg). Hoe groot is de dekkingsgraad (de hele bevolking die behoefte heeft aan zorg of alleen diegenen die anders geen zorg kunnen ontvangen)? Hoe groot is het toepassingsgebied (alle soorten zorg en alle kosten of alleen sommige soorten zorg en een deel van de kosten)?

Answer

Long-term care (nursing and care, mental health care, care for the disabled and preventative care) is funded through the *Algemene Wet Bijzondere Ziektekosten* (AWBZ – Dutch General Exceptional Medical Expenses Act).

Please refer to 1.1.1 above for a description of the structures and mechanisms that support long-term care services as well as the extent of coverage and their field of application.

The *Wet Voorziening Gehandicapten* (Wvg – Dutch Disabled Services Act) focuses specifically on the disabled

Field of application

The Wvg helps local authorities to provide facilities to people with limitations to enable them to live an independent life. These facilities are special provisions in the home, transportation facilities and wheelchairs.

Extent of coverage

The Wvg is aimed at people with limitations, i.e. people with ergonomic, sensory, mental or psychological limitations, as well as the elderly who suffer limitations as a result of sickness or ailments.

Regional differences

The Wvg has a decentralised regime within which local authorities have been given the responsibility to provide 'customised care'. This can – and may – result in differences between municipalities both in terms of provisions to be provided and in the quality of the care provision. The Wvg has no waiting list.

Planned policy change

The policy on provisions for the disabled is currently under discussion. It is necessary for the long term to place the Wvg in a broader perspective and to also look at its connection with care, housing and transport. Several variants for future Wvg policy are outlined in the *Bouwstenennotie Wvg* (Wvg Building Block Document), as it is called, which was recently submitted to the Dutch parliament.

1.2.2 Beoordeling

Zijn er prestatie-indicatoren voor de toegang tot langdurige zorg, bv.

- wachtlijsten voor zorginstellingen;
- regionale of inkomensgebonden verschillen;
- specifieke groepen die waarschijnlijk niet volledig gedekt zijn?

Answer

The Treek standards are a performance indicator for access to long-term care. These standards were established by the parties in the *Sector Verpleging en Verzorging* (V&V-sector – Nursing and Care Sector) (health insurance companies, care providers). The parties in the V&V sector are now associated in what are called the Treek consultations. In this association the parties reached an agreement in the year 2000 concerning maximum delivery times for home care, nursing-home care and care-home care. The underlying idea is that some care cannot or need not be provided immediately and that therefore a certain waiting period is acceptable. *Zorgverzekeraars Nederland* (Netherlands Health Insurance Companies) has taken the initiative to draw up standards. According to these standards, home care and nursing-home care should be provided within 4 weeks of the indication decision to 80% of those marked down for this care and within 6 weeks of the indication decision to 100% of those marked down for this care. A standard of 80% within 8 weeks and 100% within 13 weeks has been set for care-home care. In practice, a standard of 6 weeks for nursing-home care and home care and 13 weeks for care-home care applies after the indication decision has been drawn up. In acute situations, care must be provided immediately and the acceptable delivery times do not apply. Just what an acceptable waiting period is for a client depends on his or her individual situation established when making the indication decision and is included in terms of urgency in the indication decision.

Furthermore, the *Landelijke Vereniging voor Indicatieorganen* (LVIO – National Association for Indication Bodies – March 2002) has issued guidelines enabling the regional indication bodies to mark down quickly and conscientiously with the customer in mind. Given the statutory period of 6 weeks for issuing an indication decision, this guideline contains procedures for emergency indications within 24 hours and procedures for settling indication requests immediately.

Data on waiting lists is available for the V&V sector. The waiting lists have been measured three times in the sector. The last reference date is 1 October 2001. The waiting list data provides insight into the number of patients waiting for nursing home care, care-home care and home care. It is also known whether those waiting are getting care during their waiting period. The waiting list data is broken down by care office and region, allowing insight into regional differences as well.

The AWBZ is an insurance to which all citizens (residents of the Netherlands with legal status) are entitled. This means that residents of the Netherlands who do not pay premium are entitled to AWBZ care. Those who reside illegally in the Netherlands are not entitled to AWBZ care.

The AWBZ is carried out by the health insurance companies and the national health service, which have authorised the Care Offices. There are 32 care offices in the Netherlands with a regional structure. The care offices are autonomous in their region. This means that they may differ in what they select or emphasise within their region.

1.2.3 Uitdagingen

Wat zijn de voornaamste uitdagingen waarmee u wordt geconfronteerd met betrekking tot het verlenen van toegang?

Answer

The Netherlands suffers from what is called "double ageing", i.e., a large group of Dutch citizens becomes old and at the same time more and more people are becoming increasingly advanced in years. This will cause an exponential growth in the demand for care in the scope of the AWBZ.

So there is increasing pressure on existing services.

This also means that the current policy for reducing waiting lists is an extra challenge in order to be able to provide care for future generations. One of the crucial points in the policy is providing care on an extramural basis – to the elderly as well. Encouraging the elderly to remain independent and manage for themselves is at the top of the policy agenda. By means of modified rules and regulations and together with the Ministry for Housing, a lot of effort has been put into enabling the elderly to continue to live independently for as long as possible. This approach will be continued over the next few years.

1.2.4 Geplande beleidswijzigingen

Beschrijf eventuele geplande wijzigingen in het stelsel.

Answer

As of 1 January 2003 the AWBZ will be modernised in a legal sense. The planned changes to the AWBZ and many related laws and regulations are all grafted onto the basic principle that the supply-driven system will be changed into a demand-oriented system. Freedom of choice for insured parties (choice between care in kind and the *Persoon Gebonden Budget* (pgb – Personal Budget) and a greater freedom of choice in effectuating their entitlement (more room for customised care in consultation between the insured party and the client) served as the starting point in designing a new system of entitlements. They are no longer formulated according to the institute; the type of care that the insured party needs is key in what he/she is entitled to. The agreements are described by function. The insured party is free to select, in consultation with his/her insurer, one of the contracted providers that have been approved for providing the care he/she requires. This also means that the customer can opt for more than one provider if two or more different functions have been indicated. As from 1 January 2002 all providers were allowed to provide all extramural care within a sector of the AWBZ (e.g., the care home supplied home care products at home) but as from next year the sector boundaries will also be lifted.

From that date on, the elderly will be free to obtain their personal care from a "former" facility for the disabled that has been explicitly approved for providing that function.

To realise functional claims it is necessary that patients are marked down in functional terms. Each insured party needs a decision of a regional indication body in order to receive AWBZ care. If that care is described functionally, the preparatory examination as to whether care is required must be reflected in functions. That will also be structured by 1 January 2003. Furthermore, the use of a statutory protocol and a newly designed set of forms will simplify matters considerably.

The personal budget will also be modernised by the time the new year commences. Only one regulation will apply instead of the five separate, sectoral regulations today. This new regulation also needs to be considerably simplified. This new Personal Budget scheme also requires a functionally-oriented mark-down system.

The specifications for the modernisation of the AWBZ in a number of areas will be settled in the next few years. For instance, a new funding system for care in kind will not be implemented immediately on 1 January 2003. The system of contribution by the individual will be adapted to the new functional situation only where necessary and will not be changed entirely until one year later.

2 KWALITEIT

2.1 GEZONDHEIDSZORG

2.1.1 Normen

Zijn er nationale kwaliteitsnormen? Zijn er streefcijfers voor de toegang tot medische verzorging en ziekenhuisbedden? Zijn de patiëntenrechten vastgesteld?

Answer

Zijn er nationale kwaliteitsnormen?

Quality is a result of the (weighed) outcome of the results on the following 6 fields:

- safety
- effectiveness
- patient orientation
- efficiency
- timeliness
- uniformity

The government has not formulated any goals and standards. The *Kwaliteitswet Zorginstellingen* (Dutch Care Institute Quality Act) stipulates that in first instance the care providers themselves are responsible for formulating standards for quality care (field standards). The statutory norm is the term 'responsible care', which means that care must be provided in an effective, efficient and patient-oriented manner. The organisations of the providers (umbrella organisations) have drawn up field standards in consultation with those requiring care and insurers (tripartite). These field standards have been translated into standards that can be verified and certified for an increasing number of professional groups and sectors and form the basis for a professional study, organisational recognition, external certification and verification by the *Inspectie voor de Gezondheidszorg* (IGZ – Dutch Health Care Inspection).

Zijn er streefcijfers voor de toegang tot medische verzorging en ziekenhuisbedden?

Access to medical care and hospital beds can be approached from two different views, namely from a capacity standard point of view and from a waiting list or waiting period point of view.

Planning hospital facilities is checked against the *Wet ziekenhuisvoorzieningen* (Dutch Hospital Services Act) in which guidelines have been established. These guidelines provide a more detailed description of the beds allowed and the distribution of functions or specialisms over the hospitals in a health region. This framework does not apply to the nursing and care homes that are subject to regional decisions through jointly drawn-up spending proposals.

In the second case, insurers and organisations for providers (hospitals, care homes, nursing homes) and patients have drawn up standards in joint consultation for various kinds of care (ambulance services, obstetrics, emergency first aid, etc.) that are to serve as the maximum value and target value for waiting periods.

Zijn de patiëntenrechten vastgesteld?
There are three Acts that safeguard patients' rights, namely the *Wet Geneeskundige Behandelingsovereenkomst* (WGBO – Dutch Medical Treatment Act) which deals with rights and obligations of patients and care providers); the *Wet Medezeggenschap Cliënten Zorginstellingen* (WMCZ – Dutch Act for Participation of Patients of Care Institutes) which deals with the structural participation in the policy of the institute; and the *Wet Klachtrecht Cliënten Zorgsector* (WKCZ - Dutch Act for the Right of Complaint for Clients of the Care Sector) which deals with the possibility to appeal through official complaints committees.

Quality in the Wvg (Dutch Disabled Services Act)
The Wvg stipulates that local authorities provide responsible services, i.e., services that are effective, efficient and customer-oriented. The protocol that was recently agreed upon by the SZW (Ministry for Social Affairs and Employment), the interest groups and the VNG (Association of Netherlands Municipalities), provides a more detailed interpretation of the term "responsible services". The purpose of the protocol is to arrive at a more uniform application of the law, giving the disabled greater legal security.

2.1.2 Beoordeling

Beschrijf de mechanismen voor de beoordeling van de kwaliteit van de behandeling en voor de vaststelling van en het toezicht op kwaliteitsnormen voor gezondheidszorg en langdurige zorg.

Answer
The quality of the health care and long-term care is assessed on the basis of:

- Standards in legislation and regulations including jurisprudence
- Field standards determined by, for instance, umbrella organisations of care institutes (standards, guidelines, protocols)
- The state of the art as indicated in the professional literature

How is the quality of medical treatments assessed? Which criteria apply?

The quality of the medical treatments is assessed on the basis of:

- Field standards determined by the professional associations (standards, guidelines, protocols)
- The state of the art as indicated in the professional literature
- Standards in legislation and regulations including jurisprudence concerning compulsory treatment and disciplinary sentences

The quality of both the preconditions for responsible care (in accordance with the Quality Act) and the quality of the provided care is assessed by means of:

- Investigation into reports and calamities in care
- Investigation into mandatory reports of compulsory admissions, the application of means or measures and compulsory treatments
- Investigation into mandatory reports on medical treatments under duress
- General preventative supervision. Points of particular attention are selected as much as possible based on risk assessment of processes and sub-processes such as drug management and drug distribution, pharmacotherapy, internal evaluation errors, accidents and near-accidents, complaints handling, etc., but also on reserved procedures and high-risk procedures such as fixation, separation, etc. This type of supervision can be a continuous process but can also be carried out in the form of a campaign.
- Thematic supervision. Parts of the care process are investigated thoroughly and systematically in a short period of time and result in an aggregated report.
- Evaluation of statutory documents: Annual Report, Annual Quality Report (Dutch Care Institute Quality Act), Annual Complaints Committee Report
- Evaluation of mandatory registrations

2.1.3 Kwaliteitsbevordering

Hoe wordt kwalitatief hoogstaande zorg ontwikkeld, bevorderd en vlot toegankelijk gemaakt? Wordt er bijzondere aandacht besteed aan de ontwikkeling, bevordering en toegankelijkheid van kwalitatief hoogstaande gezondheidszorg voor ouderen?

Answer

Hoe wordt kwalitatief hoogstaande zorg ontwikkeld, bevorderd en vlot toegankelijk gemaakt?

Views on high-quality care ensue from research into the effectiveness or efficiency of procedures in daily care practice. This is called evidence-based guidelines, procedures or techniques. Optimal care is also pursued by means of good experiences and examples (‘best practices’). The implementation of such guidelines and best practices requires attention. The quality institute CBO contributes significantly to distributing ‘best practices’ with its RANGE and BREAK-THROUGH programmes.

Wordt er bijzondere aandacht besteed aan de ontwikkeling, bevordering en toegankelijkheid van kwalitatief hoogstaande gezondheidszorg voor ouderen?

The point of departure for the Dutch government is that the required care is of good quality, accessible, and affordable for all citizens. The government sets frameworks within which care providers, insurers and clients/patients can made their choices and take responsibility. Besides providing care at home for elderly citizens who require care, specific facilities (nursing homes and care homes, home care centres) are being built for them. Considering that the Netherlands has high-quality health care, there is no need for special attention for the elderly.

2.1.4 Uitdagingen

Wat zijn de voornaamste uitdagingen waarmee u wordt geconfronteerd met betrekking tot kwaliteitsbevordering?

Answer

The Netherlands ranks among the best in the world in the development of knowledge and top-level clinical research. The problem is not in the development of new knowledge but in the distribution and implementation of that knowledge. The main challenge lies in both fields. In the near future, the emphasis well be on monitoring and improving the distribution and implementation of guidelines, techniques and 'best practices'.

2.1.5 Geplande beleidswijzigingen

Beschrijf eventuele geplande wijzigingen in het stelsel.

Answer

With the "Supply and Demand" memorandum, the course has been set for changing from a centrally controlled supply system to a decentralised demand-oriented care system. The care system will be modernised through steering care by means of dividing responsibilities and changing the related instruments.

2.2 LANGDURIGE ZORG

2.2.1 Normen

Zijn er nationale kwaliteitsnormen? Zijn de rechten van de zorgontvangers vastgesteld?

Answer

The government has not formulated any goals and standards. The Kwaliteitswet Zorginstellingen (Dutch Care Institute Quality Act) stipulates that in first instance the care providers themselves are responsible for formulating standards for quality care (field standards). The statutory norm is the term 'responsible care', which means that care must be provided in an effective, efficient and patient-oriented manner. The organisations of the providers (umbrella organisations) have drawn up field standards in consultation with those requiring care and the insurers (tripartite). These field standards have been translated into standards that can be verified and certified for an increasing number of professional groups and sectors and form the basis for a professional study, organisational recognition, external certification and verification by the Inspectie voor de Gezondheidszorg (IGZ – Dutch Health Care Inspection).

One sought to structure the basis for quality in the field of care by establishing a number of enabling legislations. These are:

- Wet BIG: Beroepen individuele gezondheidszorg (Dutch Individual Health Care Professions Act);
- WMCZ: Wet medezeggenschap cliënten zorginstellingen (Dutch Act for Participation of Patients of Care Institutes);
- WKCZ : Wet klachtrecht cliënten zorginstellingen (Dutch Act for the Right of Complaint for Clients of the Care Sector);
- WGBO: Wet geneeskundige behandelovereenkomst (Dutch Medical Treatment Act).

These are the main Acts which define the position and the rights of those requesting care and which determine the role and position of the health professional/care provider and the individual or body providing the treatment.

The IGZ and branch organisation Arcares are currently working together on 10 criteria which define the minimum care in the V&V (Nursing and Care Sector). The required quality of care can be determined by establishing the minimum care and staffing..

2.2.2 Kwaliteitstoezicht en kwaliteitsbevordering

Is er een systeem voor de beoordeling en erkenning van zorgverleners en zorginstellingen? Indien informele zorg wordt gesteund, zijn er maatregelen voor kwaliteitsbevordering (bv. financiële steun voor infrastructuur en aanpassingen aan huizen, scholing van informele zorgverleners)?

Answer

Care institutes are evaluated and recognised prior to being accepted into the AWBZ. Care providers have two routes they can follow before being eligible for acceptance. If a care provider wishes to be accepted without it having a (new) building, this care provider must register with the CvZ (Netherlands Health Insurances Authority) that will then evaluate its acceptance into the AWBZ.

If a care provider wishes to be accepted and also wants to erect a new building, it must first submit a request for building permission to the Building Board on the basis of the Wet Ziekenhuisvoorzieningen (Dutch Hospital Facilities Act), after which acceptance into the AWBZ must be arranged via the CvZ.

Care institutes are evaluated on the one hand by means of a check carried out by the Inspection and on the other hand by means of Benchmark. The first pilot with the tools for Benchmark V&V took place in 2001 (this tool had already been used before in home care). The report on this pilot was forwarded to the Dutch Lower Chamber in May 2002. A follow-up for this Benchmarch is currently being considered at administrative level.

Health professionals are evaluated and recognised by means of rules for qualification and competence as stipulated in the BIG Act. Nurses require to be registered in the BIG register.

Occupations are not protected in the Netherlands, however titles/degrees are protected.

This means that everyone may in principle carry out care activities but they may not claim to be nurses or ‘carers’ if they do not have the necessary diploma.

Informal care is supported, volunteer aid was a specific spearhead of the second Kok cabinet (1998-2002). This means that in 2002 VWS (Ministry of Heath, Welfare and Sports) invested € 4,848,000 in developments as to volunteer aid and informal care, on the one hand for policy development and on the other hand for support by means of conferences and education.

Financial support for modifications to the home is covered by the Wvg (Dutch Disabled Services Act) which provides the possibility for adapting one’s residence.

2.2.3 Uitdagingen

Wat zijn de voornaamste uitdagingen waarmee u wordt geconfronteerd met betrekking tot kwalitatief hoogstaande langdurige zorgverlening?

Answer

Demand-oriented care instead of supply-driven care is a major development of the past few years whereby the client's own free choice ranks first. The change in the approach and the organisation of care has been initiated but it will remain a challenge for the future.

Intramural care must make increasingly more room for extramural care; people wish to continue to live at home longer, leading independent lives while everything that can be done must be done. Giving shape to this extramural care without approaching it from an institutional point of view is a major development for the future.

Another major challenge is recruiting sufficient and sufficiently qualified personnel. The labour market has been problematic for some years now and does not have enough supply to recruit new staff.

2.2.3 Geplande beleidswijzigingen

Beschrijf eventuele geplande wijzigingen op dit vlak.

Answer

Policy changes are planned for the above-mentioned developments. These developments were initiated some time ago but will continue in the next few years and have also not yet been fully fleshed out.

3 BETAALBAARHEID

3.1 GEZONDHEIDSZORG

3.1.1 Uitgaven en financiering

Beschrijf het huidige niveau van de uitgaven voor gezondheidszorg en de extrapolaties voor de toekomst. Geef zo mogelijk afzonderlijke cijfers voor gezondheidszorg voor ouderen. Beschrijf de wijze van financiering (sociale-verzekeringspremies, algemene belastingen, vrijwillige verzekering met eventuele belastingvoordelen, patiëntenbijdragen). [NB: eventueel kan worden verwezen naar de beknopte beschrijving van het stelsel onder punt 1.1.1.]

Answer

Care expenditure[3] in the Netherlands for the year 2002 amounts to approximately € 40.7 billion. This is € 2,358 per capita and 10.1% of GNP (Gross National Product). Approximately 23% is available for the care of the elderly.

The new government aims to increase actual care expenditure[4] by 4¼% per year during its period of office from 2002 through 2006. According to the most recent macro-economic estimates, expenditure in 2006 will thus amount to € 51 billion. It is not yet clear how much of the total available budget will be reserved for the care of the elderly.

Paragraph 1.1.1. describes the financing.

3.1.2 Uitgavenontwikkeling

Geef een beoordeling van de ontwikkeling van de uitgaven en de financieringsbehoeften. Hoe kan deze ontwikkeling, in het licht van de vergrijzing van de bevolking, in overeenstemming worden gebracht met andere beleidsdoelstellingen, zoals evenwichtige openbare financiën?

Answer

The new government based the amount to be reserved for care expenditure for 2003-2006 on the results of a study carried out by the Central Planning Bureau (CPB) which indicates that to cover this expenditure the care sector requires a 2½% increase in volume per year besides the higher price movements. Of this, 1.1% point is the result of the increase in volume (population growth) and composition (ageing) of the population. The rest is required to meet socio-economic, epidemiological and technological developments.

Because the effect of ageing will be felt most strongly in the long-term, the budget policy is now entirely aimed at clearing away the national debt in 20 to 25 years.

[3] Care expenditure is meant in the sense of expenditure in the first and second compartments.
[4] Actual increase is defined as the increase over and above the price movement of the GNP.

3.1.3 Kostenbeheersing

Beschrijf hoe de uitgaven worden beheerst:

- de rol van de prijs bij de beheersing van de vraag;
- beheersing van de kosten van de zorgverlening door financiële stimulansen en marktmechanismen;
- mechanismen om verzorgingsinstellingen en gezondheidswerkers kostenbewuster te maken bij het kiezen van een behandeling;
- beheersing van de kosten van materiaal en producten (bv. farmaceutische producten);
- de rol van gezondheidsbevordering, ziektepreventie en met name de bevordering van een gezonde levenswijze bij ouderen.

Answer

Control of the costs for providing care through financial incentives and market mechanisms

Expenditure is currently largely controlled through supply regulation. Policy rules are established centrally by the College tarieven gezondheidszorg (Ctg – National Health Tariff Authority) which determines how the budgets for care institutes and tariffs for care institutes and other care providers are fixed. These policy rules must be approved by the Minister of Health as to changes in the capacity of institutes according to the Wzv (Dutch Care Services Act).

The amount for hospital budgets is determined partially through agreements between hospitals and health insurance companies. Insurance companies are benefited by limiting production agreements as lower production leads to lower expenditure for the insurers. Both private insurers and the National Health Services can translate lower expenditure into a lower premium and thus strengthen their market positions.

Cost control by institutes

The budget for care institutes and their corresponding tariffs are established centrally, but the institutes are free to determine how their budgets are spent. So care institutes can profit from cost conscious behaviour and are therefore benefited by cost awareness among their employees. A tool in this respect is benchmarking.

Although care institutes are autonomous in the use of their budgets, a part of the budget is based on the (waiting list) production as agreed with the health insurers. If this (waiting list) production is not realised, the budget is subsequently cut: the “cash on the nail” principle.

The role of the price in controlling demand

Privately insured parties, some of whom have opted for a considerably high contribution for their own account, will have an obstructive effect on the demand for care so long as the costs for care are for their own account. This mechanism does not apply to those insured through the National Health Service, however some drugs and medical supplies are subject to reimbursement limits. The patient must pay the amount that exceeds the limit for the costs of a remedy. In the case of drugs, this would apply, e.g., to remedies that are more expensive than other remedies with the same therapeutic effect.

A ‘Contribution by the individual’ does apply in the AWBZ but its purpose is not so much to influence demand as to acquire reasonable financing from the applicant. However, the AWBZ requires an indication by the independent RIO (Regional Indication Body) to honour demand.

3.1.4 Uitdagingen

Beschrijf de voornaamste uitdagingen met betrekking tot betaalbare gezondheidszorg.

Answer

The main challenge is changing from a system in which demand is the first matter of importance to a system in which patient demand determines the volume and the variety of the care supplied. The starting point is competition between care providers and between health insurers combined with a strong position of clients and patients. The first step in this direction has been made with the "Vraag aan Bod" ("Give Demand a Chance) memorandum.

3.1.5 Geplande beleidswijzigingen

Beschrijf eventuele geplande wijzigingen, met name initiatieven inzake gezondheidszorg voor ouderen.

Answer

The next steps include the implementation of a new insurance system in the second compartment, the implementation of a funding system based on performance and the updating of the AWBZ. Deregulation and reduction of administrative costs is also being considered in order to keep costs under control.

3.2 LANGDURIGE ZORG

3.2.1 Uitgaven en financiering

Geef een raming van de huidige kosten voor langdurige zorg. Houd voor zover mogelijk rekening met het effect op andere beleidsgebieden.

Beschrijf eventuele specifieke financieringsmechanismen voor langdurige zorg (bv. gerichte sociale-verzekeringspremies).

Answer

Long-term care is funded through the AWBZ. AWBZ expenditure in 2002 is expected to amount of € 18 billion, of which € 1.8 billion is funded through own payments.

Supplementary benefit

The supplementary benefit is a scheme that is included in the Algemene bijstandswets (Dutch Social Securities Act) and enables local governments to give citizens a financial contribution towards costs that are necessary but that in connection with their individual circumstances cannot be paid out of their own income or any financial means they might have. They are costs ensuing from the individual circumstances of the party concerned. These costs may also include costs for care services. One is not entitled to supplementary benefit if a provision is available at hand for the costs which is considered to be sufficient

and appropriate considering its nature and purpose. Examples are the Wvg, AWBZ and the Zfw.

The scheme is intended for all individuals as of 21 years of age with an income equal to or approximating minimum wage. Individuals up to the age of 21 must first appeal to their parents. The target group has no other special characteristics; after all, the individual special circumstances and the necessary costs ensuing from those circumstances are already qualifying.

The State has left the interpretation of the conditions for supplementary benefit within the scope of the Algemene bijstandswets (Dutch Social Securities Act) to the local authorities. The municipality in which the applicant lives has therefore worked out the conditions in further detail. In general, the income limit is determined on the basis of the social security norm and a contribution (financial means) is charged to the individual as the income increases. Capital is generally left clear up to a certain amount. Local authorities may also charge a threshold amount.

3.2.2 Kostenbeheersing

De rol van de prijs bij de beheersing van de vraag naar formele zorg.

Hoe wordt voor een kostenbewuste planning en zorgverlening gezorgd? Worden de verschillende benaderingen (zorginstelling/thuiszorg, formele/informele zorg) onderling vergeleken? Zijn er mechanismen om zorgverleners en beleidsmakers (bv. sociaal werkers) kostenbewuster te maken?

Zijn er mechanismen om de kosten voor langdurige zorg en gezondheidszorg integraal te beoordelen?

Answer

A ‘contribution by the individual’ does apply in the AWBZ but its purpose is not so much to influence demand as to acquire reasonable financing from the applicant. So accessibility is the first matter of importance. However, the AWBZ requires an indication by the independent RIO (Regional Indication Body) to honour demand.

The costs for long-term care and health care fall within the scope of the care budget, a framework for the care expenditure for which the Minister of Health is responsible.

For more information please refer to paragraph 3.1.3.

Affordability

Local authorities receive financing for implementing the Wvg (Dutch Disabled Services Act) from the Municipalities Fund. The municipality determines how to interpret its statutory tasks within the limits of its finances.

The total Wvg net expenditure amounted to NLG 1,779 million in the year 2000.

3.2.3 Uitdagingen

Beschrijf de voornaamste uitdagingen met betrekking tot betaalbare langdurige zorg.

Answer

See 3.1.4

3.2.4 Geplande beleidswijzigingen

Beschrijf eventuele geplande wijzigingen.

Answer

See 3.1.5