Long-term care in the Netherlands
The Exceptional Medical Expenses Act

Ministry of Health, Welfare and Sport

1. Background

History

In 1962, Health Minister Gerard Veldkamp put forward a plan for an insurance scheme to cover the whole population against major medical risks. This scheme was intended to provide for the considerable financial consequences of serious long-term sicknesses or disorders, in particular the cost of caring for disabled people with severe congenital physical or mental disorders and psychiatric patients requiring long-term nursing and care. The risk of incurring such costs is in fact not particularly great, but virtually nobody that does incur them can bear such costs themselves; hence the term "exceptional medical expenses". The Exceptional Medical Expenses Act ("AWBZ") became law on 14 December 1967 (Bulletin of Acts, Orders and Decrees 1967, 655) and came into effect in stages, starting on 1 January 1968.

Facts and figures[1]

Traditionally there are three targets groups in the long-term care of the Netherlands: elderly persons (somatic and demented), disabled persons (the vast majority of them being mentally disabled) and persons with psychiatric disorders.

Target groups	Number of users
Elderly (somatic and demented) Disabled Persons with psychiatric disorders	391.000 113.000 84.000
Total (till up 18 years of age) Percentage of total of inhabitants of the Netherlands	588.000 (63.000) 3,6%

[1] November 2008

People who are in need for long-term care are – due to the nature of their problems and disorders – often living in residential settings. However a majority of those who are in need for long-term care manage to stay at home.

Target group	Residential care	Home care
Demented elderly	55.000	17.000
Elderly with somatic disorders	109.000	210.000
Disabled	66.000	47.000
Persons with psychiatric disorders	23.000	61.000
Total	253.000	335.000

Since the introduction of personal budgets in the nineties the number of clients with personal budgets did increase. However the number of those who are entitled to "care in kind" did not decrease.

Target group	Care – in - kind	Personal budgets	Both
Demented elderly	70.000	1.000	1.000
Elderly with somatic disorders	295.000	19.000	5.000
Disabled	85.000	19.000	9.000
Persons with psychiatric disorders	50.000	32.000	2.000
Total	500.000	71.000	18.000

The increase of the cost of long-term care has a cumulative character.

	1968	1998	2008
costs AWBZ-care (milliard €'s)	< € 1	€ 12,8	€ 20,5
Number of clients	Circa 55.000	almost 900.000 or almost 500.000 excl. psychiatric care-extramural	almost 600.000
Premium AWBZ	0,41 %	9,60%	12,15%

2. Nature of the scheme

Insurance under the Act is statutory: everyone who meets the criteria spelled out in the legislation is automatically insured and consequently obliged to pay the statutory contribution, irrespective of whether the individual wants to make use of the benefits provided by the legislation. People who object to insurance as a question of personal principle ('conscientious objectors') may obtain exemption from the insurance obligations under the Act. Instead, they pay amounts under income tax or payroll tax to replace the insurance premiums.

3. Insured persons

The Exceptional Medical Expenses Act is a national insurance scheme. Generally speaking this means that the following persons are insured:

- Residents of the Netherlands. Residents are people who live in the Netherlands. This primarily means people who live on Dutch territory, but also people living elsewhere can sometimes qualify as residents of the Netherlands. In various cases, the courts have ruled that someone living beyond the national borders can be considered to be a resident of the Netherlands in certain circumstances. Generally speaking, a person's place of residence depends on the community into which he or she is integrated. So, for example, someone who can demonstrate that his or her economic and social ties are primarily with the Netherlands may be considered resident in the Netherlands.

- Non-residents who are employed in and therefore liable for payroll tax in the Netherlands. This category covers primarily cross-border commuters and expatriates.

Under these basic rules, it makes no difference whether a person is a Dutch national or not. However, someone who is not a Dutch national must be legally resident in the Netherlands to qualify for cover under the Act.

There are a number of exceptions to the basic rules set out above. On the one hand, some people are covered even though they are residents of other countries. On the other, some people who are residents of the Netherlands are not actually covered. These exceptions are explained in the 1999 Decree regulating Admission to the National Insurance Schemes. Among those who are insured are Dutch civil servants and their family members who are stationed in foreign countries.

The insurance of children under the Act is not pegged to the insurance of the parents. A child's place of residence is determined by his or her own circumstances. The Act also differs from other social insurance schemes in that there is no age limit on the insurance obligation.

Important considerations for application of the Exceptional Medical Expenses Act are the arrangements that exist under the Council Regulation, the EEA agreement, the agreement between the European Community and its Member States on the one hand and the Swiss Confederation on the other on the free movement of persons and bilateral social security agreements that the Netherlands has concluded with other countries and include arrangements for the provision of medical care (refer to chapter 4).

4. Management, administration and contracts between insurers and health care providers

The health insurers operate the Exceptional Medical Expenses Act scheme on their clients' behalf. The bodies that implement the provisions of the Act delegate various responsibilities – in particular the contracting of health care providers, the collection of patient contributions and the organisation of regional consultations – to regional health care offices. These offices receive a budget to pay for their running costs. The Health insurance Board sets the budget and it is subject to the approval of the Minister of Health, Welfare and Sport.

Each health care office carries out tasks in a particular region for the implementing bodies. The health care office, which receives its data from the implementing bodies, keeps records of the monthly accounts and advance payments for each institution.

Where certain health care entitlements are concerned, it has been arranged that, as far as possible, an institution only has to deal with one implementing body for both financial settlement and medical supervision. To this end, the implementing bodies have handed responsibility for administration and payments to a central administration office ("CAK-BZ"), which makes payments to the relevant institutions.

Contracts between insurers and health care providers

The bodies that implement the Exceptional Medical Expenses Act have a "duty of care" in that they are required to ensure that their clients can obtain the health care to which they are entitled to. To this end, the bodies or the health care offices they engage enter into contracts with health care providers and institutions. These contacts regulate the volumes of health care services that will be provided, the charges and other such matters.

5. Registration and validation of health care entitlements

Under the Exceptional Medical Expenses Act, a person must be registered with one of the implementing bodies to be entitled to health care. A care insurer that has registered with the Health insurance Board to carry out the Act's provisions represents its insured clients as an implementing body under the Act. Consequently, people who are insured under the Act and have taken out insurance with a care insurer are registered automatically for entitlements under the Act. Persons insured under the Act who for any reason do not hold health insurance (like members of the armed forces) are able to sign up with a care insurer for cover confined to the Act's provisions. The same applies to people covered by the Act who live outside the Netherlands. Registration is for one calendar year at a time and is renewed at the end of each year unless the individual concerned gives written notice in good time that he or she does not wish to renew. A health insurance fund may require a period of notice of up to two months. Insured persons who end their health insurance to take out cover with a different care insurer have their registrations for entitlements under the Act transferred to their new insurer.

Validation of health care entitlements

Someone from abroad who settles in the Netherlands and thus comes within the scope of the Exceptional Medical Expenses Act is not actually entitled to certain types of inpatient health care covered by the scheme for a period of up to twelve months from the time that he or she takes up residence. This rule applies if the care in question was already indicated when the person took up residence in the Netherlands or if his/her medical condition at that time was such that it would have been clear that the care would be needed within six months. The waiting period applies in relation to expensive forms of care, such as nursing-home care. A person to whom this rule applies is not necessarily unable to obtain care, but he or she cannot claim for the cost of such care through the Act's provisions.

Before a person can qualify for care under the Exceptional Medical Expenses Act, it is necessary to establish whether care is really required and, if so, what type of care and how much care is needed. This 'indication' is issued by an organisation called CIZ. CIZ is an independent organisation responsible for determining impartially, objectively and thoroughly what care is required. The client then has the choice of receiving his/her entitlement as care in kind, or in the form of a personal care budget; a combination of the two is also possible.

Care in kind is the provision of indicated care directly to the client by a health care provider (e.g. a home care organisation) that is contracted to provide such care. The care provider arranges the provision of care and its administration in consultation with the patient. A person who is entitled to care does not have to obtain all his/her care from the same provider; he or she may receive some of his/her care in kind from one provider and some (also in kind) from another provider.

A person who is entitled to care under the Exceptional Medical Expenses Act can opt not to take care in kind, but to receive a personal care budget. In principle, anyone who requires care under the Act for more than three months can qualify for such a budget. The budget is a sum of money awarded to the client to enable him/her to purchase care independently. However, the budgets are available only for certain functional forms of care, such as nursing, general care and guidance; they are not available for treatment or institutional accommodation (see below under entitlements). The latter forms of care are always made available in kind.

Someone who has been awarded a budget is free to choose when and from whom they obtain care. The budget provides freedom of choice alongside services a client prefers to receive in kind. Many budget recipients like receiving assistance from a particular carer whom they choose themselves and who does not change from day to day. In many cases the carer will be a personal acquaintance, such as a neighbour or friend, but the client is also free to use the services of a health care organisation. In other words, the budget gives clients considerable freedom of choice.

Obligations are also attached to the budget. Requirements include procurement of a responsible standard of care and the discharge of regular financial accountability to the care office.

Most care under the Exceptional Medical Expenses Act is provided by institutions. Before it is allowed to provide care under the Act an institution must have received approval and concluded an agreement with a body that implements the provisions of the Act.

6. Funding

The Exceptional Medical Expenses Act insurance scheme is funded by premiums paid by the people whom the scheme covers, by the State Subsidy and by personal contributions from care recipients.

Contributions due under the Act are collected through the income and payroll tax systems, along with the contributions for the other national insurance schemes. Every year the government sets the contribution payable under the Act as a percentage of taxable income in the lowest two income tax bands. The premium percentage in 2005 was 13.45%. People in paid employment have their contributions deducted at source by their employers, who pay the money to the tax authorities. People who are not in paid employment but are liable to pay income tax and social insurance contributions receive tax assessments that include their contributions and thus pay their contributions straight to the tax authorities. Insured persons below age 15 and those older than 15 without their own taxable income do not owe any premiums.

An insured party pays the excess for using certain facilities like admission to a nursing home. The excess amounts payable are usually linked to the level of a person's income.

The Inland Revenue Service remits collected premiums to the Health insurance Board (hereafter: the board) that deposits the money in the Exceptional Medical Expenses Fund. The board manages and administers the fund. The implementing bodies that collect excess amounts from insured persons similarly remit this money to the fund. Each year central government pays an amount into the Exceptional Medical Expenses Fund to compensate for the financial effects caused by the modified levying system that accompanied introduction of the Income Tax Act 2001. The government adjusts this payment from year to year.

Personal contribution

For most types of care under the Act, clients above the age of eighteen are required to make personal contributions towards the costs. The size of this contribution depends partly on the client's taxable income and domestic circumstances (whether he or she lives at home or in an institution). Other relevant factors include whether the client is older than sixty-five and whether he or she is married or cohabits. If the client is receiving a personal care budget, his/her personal contribution is deducted directly from the budget. An insured person who pays a personal contribution towards in-kind care will either receive a bill or the amount owed will be set off against state allowances like social assistance benefits. The detailed rules are laid down in the Decree on Personal Contributions to the Cost of Care and the associated Regulations on Personal Contributions to the Cost of Care.

Government grants

The basic provisions for awarding subsidies chargeable to the General Exceptional Medical Expenses Fund have been embodied in the Exceptional Medical Expenses Act as a result of introduction of the Health Insurance Act on 1st January 2006. As with the Health Insurance Act, the number of purposes for which the government may provide subsidies is limited. In principle, a subsidy may be provided only for care or other services that are likely to be brought into the package of insurable care. For that reason, the government decided that the subsidy should be of a temporary nature.

In contrast with the Health Insurance Act, the Exceptional Medical Expenses Act defines two other purposes for which subsidies may be given. They are a personalised healthcare budget and the termination of pregnancies by abortion clinics. The principle remains that pregnancy terminations are not financed through premium revenues but from tax revenues that the government allocates to the Exceptional Medical Expenses Fund.
The Minister of Health, Welfare and Sport has the power to set a ceiling for each category of subsidies. The Health Insurance Board may lay down supplementary rules. These include, for example, an elaboration of the rules issued by ministerial decision if such is necessary to regulate the practical side of awarding subsidies. These supplementary rules are subject to the minister's approval. Approval is not always possible on account of conflicts with written or unwritten law. Similarly, the minister may occasionally withhold approval because the rules are counter to the general interests of public health.

7. Care entitlements under the Act

The Act and related legislation govern the entitlements to care that exist under the Exceptional Medical Expenses Act. Procedural rules have been laid down under this legislation for such matters as invoking certain rights to care or obtaining the implementing body's prior permission. Assistance is available only if the CIZ has decided that the insured person is in need of a particular type of care.

The entitlements that exist under the Exceptional Medical Expenses Act have been defined in terms of functions. The focus is now on the needs of people entitled to care rather than on the available supply of care. This change in emphasis is expected to pave the way for providing customised care. The need to switch from a supply-side approach to a demand-side one came about as a result of a changing society in which people increasingly voice their wishes and want to organise their lives in the way they see fit. Another basic principle of the Exceptional Medical Expenses Act is that people should continue to live at home for as long as possible. They can receive care either in the home or at a healthcare institution.

Six broadly-defined functions create considerable freedom for arranging indicated care in consultation with a care provider. They are:

1. Personal care: e.g. help with taking a shower, bed baths, dressing, shaving, skin care, going to the toilet, eating and drinking.

2. Nursing: e.g. dressing wounds, administering medication, giving injections, advising on how to cope with illness, showing clients how to self-inject.

3. Supportive guidance: helping the client organise his/her day and manage his/her life better, as well as day-care or provision of daytime activities, or helping the client to look after his/her own household.

4. Activating guidance: e.g. talking to the client to help him/her modifying his/her behaviour or learn new forms of behaviour in cases where behavioural or psychological problems exist.

5. Treatment: e.g. care in connection with an ailment, e.g. rehabilitation following a stroke.

6. Living, services and care/treatment: some people are not capable of living independent lives, but require, for example, sheltered housing or continuous supervision in connection with serious absent-mindedness. In other cases, a client's care requirements may be too great to address in a home environment, making admission to an institution necessary.

Care is provided in the form of 'products'. So, for example, home care, psychiatric care and admission to a residential care home, nursing home or institution for people with physical or mental disabilities are all Exceptional Medical Expenses Act products. A product consists of one or more functionally defined forms of care. Illustration: Mr B has suffered a brain haemorrhage. He is convalescing and is temporarily in need of nursing and general care. His indication therefore covers four functionally defined forms of care: "general care", "nursing", "treatment" and "accommodation". The combination of these functions is delivered by admission to a nursing home.

Besides the care functions, people are entitled to such facilities as nursing articles, hospital care after one year, rehabilitation (after one year), pre-natal care, examination of certain hereditary metabolic diseases and vaccinations under the national vaccination programme.

8. The Netherlands Health Care Inspectorate

The Netherlands Health Care Inspectorate protects and promotes health and healthcare by ensuring that care providers, care institutions and companies comply with laws and regulations. The inspectorate makes impartial decisions and reports on request and at its own initiative to the Minister of Health, Welfare and Sport.

The Health Care Inspectorate acts in the public interest and concentrates mostly on problems that members of the public are unable to assess or influence themselves. People must be able to rely on the quality and safety of care and products.

The mission focuses on patient safety, effective care and care that is patient orientated.

9. Management and supervision

The Health Care Insurance Board (CVZ) co-ordinates the implementation and funding of the Cure Insurance Act (Zvw) and the Exceptional Medical Expenses Act. The CVZ adopts an independent position: in between policy and practice, in between central government on the one hand and the health insurers, care-providers and citizens on the other.

The tasks of the CVZ are laid down in statutes. The most well-known of these are:

- Providing advice on the sum of the contributions and the budgets for health insurers;
- Managing contribution funds and distributing them over the health insurers;
- Providing guidelines for carrying out new and existing legislation;
- Monitoring adherence to the regulations of international conventions;
- Keeping care-insurers, care providers and citizens informed;
- Monitoring feasibility and efficiency of government plans;
- Detecting and reporting bottlenecks in the practice of implementation.

10. Disputes

Complaints

Clients with complaints about how they have been treated by an Exceptional Medical Expenses Act implementing body must first lodge their complaint with the body in question. Under the General Administrative Law Act, an Exceptional Medical Expenses Act implementing body has an obligation to deal satisfactorily with such complaints. If the complainant is not satisfied with the response, he or she can then submit a complaint to the National Ombudsman.

The National Ombudsman assesses complaints on the basis of accepted standards of conduct. The Ombudsman considers whether the implementing body has acted in breach of the statutory code of conduct and whether its actions were reasonable, equitable, justified and duly careful.

An aggrieved client also has the option of submitting a complaint about an implementing body to the Health insurance Board. The board can then take action if appropriate, for example by issuing directives to implementing bodies. In the event of several complaints about the same subject, the board may inform the Minister about the problems. This may in turn give grounds for policy changes or amendments to legislation and regulation. An insured person has the right to lodge an objection with the body that implements the Exceptional Medical Expenses Act or with CIZ (an organisation that assesses and issues medical indications) in response to a medical indication. The implementing body is legally bound to reconsider its decision and to make known its findings on each lodged objection. If the objection relates to a decision regarding entitlement to care under the Act or a related reimbursement, the implementing body is obliged, if it does not entirely accept the objection, to ask the Health insurance Board for its advice before responding to the objection. This obligation does not apply to objections concerning personal contributions, the size of which does not depend on medical factors. If the objector is unhappy with the implementing body's response to his/her objection, he or she may lodge an appeal with an administrative court.

11. Recent and future developments

In 1999 it was recognised in the document: *View on Care, approach for modernising the Exceptional Medical Expenses Act* (Zicht op Zorg, plan van aanpak modernisering AWBZ, 18 juni 1999) that the demand and the supply for care did not match.

In the last ten years the financial growth of the Exceptional Medical Expenses Act was immense, far greater than could be expected based on demographic developments, leading immediately to the question of affordability and maintaining solidarity. A Dutch person on an average income now pays about €320 a month as his or her Exceptional Medical Expenses Act premium. Since sustainability is clearly at stake, changes are necessary in order to achieve that long-term care can remain accessible, of high quality, and affordable.

Measures to guarantee the sustainability of long-term care have been taken in two ways.

The first is to increase the insight in what care is provided under the Exceptional Medical Expenses Act. In the course of time under the Act all kinds of care, welfare and other means were provided that had little to do with the original intention of the Exceptional Medical Expenses Act. A major disadvantage being that it was taken for granted, by society and family, that care was taken up by the government or off spin institutions, where it used to be communities and family who would help out. By making transparent on quite a detailed level what was provided for which groups, the choices could be made when people were entitled to Exceptional Medical Expenses Act care and the government would step in. Currently a rearrangement of what care people are entitled to is made by redefining the responsibilities between government and the individual and his family on the basis of principles as autonomy" and "participation".

A second way to ensure the sustainability of the Exceptional Medical Expenses Act is to make the system more efficient. To get rid of the stimulus of budget maximising by care-foundations and to go to an output-based system in which there is not too big a gap between supply and demand for care. That means redirecting the financial system and its incentives. Pay for demand, not supply.

This way the growth of the Exceptional Medical Expenses Act should be in line with demographic expectations and partly there should be a relative decline, seen the cut back on what people are entitled too. It is estimated that the measures will save 800 billion Euros in 2010. However on balance the growth of the Exceptional Medical Expenses Act will still increase by 3 % due to demography. In 2008 an expenditure of € 21 billion will be expected. In 2012 this will be € 23 billion. These growth will be spend preferably for demography-related extra long-term care, the quality and the intensiveness of the care, including personal budgets.

Short term

The three current functions (supportive guidance, activating guidance and treatment) will be rearranged under two new functions: support and treatment. The new 'support' function will be limited. The current supportive and activating guidance functions have two aims at present: "autonomy" and "participation". The new support function will only address the first aim (autonomy).

People with psychosocial problems will now no longer be able to make claims for the other Exceptional Medical Expenses Act functions that were still available for them, particularly supportive guidance for sections of a day and personal care. The psychosocial principle will be eliminated from all Exceptional Medical Expenses Act claims as from 1 January 2009. Local authorities will be compensated for this so that they can continue to deal with helping and reintegrating homeless people.

Long term

A number of starting points has been formulated to create a future-proof Exceptional Medical Expenses Act which would have wide support. This must be an Exceptional Medical Expenses Act that has returned more closely to its original objectives. The following lines of policy are traced out.

1. *Improving the client's position*
   This long-term perspective must include a more central focus on the client. They are individuals who rely on the Exceptional Medical Expenses Act and are often vulnerable. And there is also a group of people who may well be physically or mentally vulnerable but who are increasingly articulate and independent-minded. In both cases respect for autonomy and the dignity of each individual are essential.

2. *Freedom of choice and variety of options for living*
   There is no wish to bring the market any further into the situation in the sense of competition between providers on the basis of unregulated prices. Diversity is to be encouraged. Clients must be able to choose how and from whom they receive their care. Care providers must have the space and encouragement to work effectively in this situation. Clients must be able to choose how they want to live. In an increasingly diverse society, not everyone wants to live in the same way. Care provision must take account of this, while ensuring that everyone has equal entitlement to care.

3. *Improving the quality of care and encouraging innovation*
   The cabinet regards quality of life as an important principle. The client's perception is paramount: the human dimension and respect for clients' dignity. 'Normal' life must continue as far as possible, even for people who are heavily reliant on care. It is important that state-of-the-art care is available, that clients can easily and quickly access innovations provided by sufficiently well-trained staff.

4. *Guaranteeing solidarity/financial sustainability*
   The way in which high-quality care is to be assured not only now but in the future needs to be clarified. This could involve tightening up the system by making changes to packages of care. Only then will members of society be prepared to fund mutual solidarity in the long term.

5. *Reducing bureaucracy by improving the quality and simplicity of provision*
   Care provision and the relationship between clients and professionals must be as free from bureaucracy as possible. Organisations under the Exceptional Medical Expenses Act, such as the claim assessment agency (CIZ), care offices and care institutions still have to spend

far too much time, money and energy on coordinating different processes. Providing care to people who are vulnerable precisely because they are in need of care must be a personal process, based on trust. Care must be returned to the people. There is far too much bureaucracy burden at the moment. Simplicity and quality of implementation and decisions on care arrangements are the key to improving the system.