補足資料：法律及び報告書

1. WMCZ：ケア施設へのClient参加に関する法律

第I章：一般的定義

第1条

3 本法律では次の定義を適用する：

a. 我々の大臣：我々の健康厚生スポーツ省（VWS）の大臣；

b. 施設：

1. *Law on Healthcare Institutions Acceptance*（WTZi）の施設；
2. あらゆる協会組織 - 社会で独立した単位として運営され、社会的ケアや公衆衛生を提供し、
   a. 健康保険法（Health Insurance Act（ZVW））、又は特別医療費保険法 Exceptional Medical Expenses Act（AWBZ）に基づき、健康保険委員会 Health Insurance Board（CVZ）から財源を得る；
   b. 法律VWS補助金の枠組みに基づき、我々の大臣から、又は社会支援法（WMO）に基づき、地方自治体から財源を得る；
3. あらゆる協会組織 - 社会で独立した単位として運営され、中毒患者へのケアを提供し、我々の大臣、地方自治体、またはProvinceから財源を得る；

c. 医療サービス提供者：

1. 施設を維持管理する法人または自然人；
2. 施設を共同で維持管理する複数の法人または複数の自然人；

d. Client：施設の機能を享受する自然人

4 協会組織 - 社会で独立した単位として運営され、社会的ケアや公衆衛生を提供し、我々の大臣の法的財源以外を根拠として資金調達している場合、本法律は主務省令に基づく施設と分類する。

5 刑法に定めるとおり、司法機関が行う非自主的なトリートメントについては本法律を適用しない。

第II章：Client Council

第2条

1.医療サービス提供者は運営する全ての施設において、施設が目的とする枠組みの範囲で、特にClient共通の利益を推進するClient Councilを設置する。

2.医療サービス提供者は以下を書面にする。

a. Client Councilのメンバー数、指名方法、どのような個人がメンバーとして選挙されるか、又、メンバーの正式な指名期間：

b. Client Councilの物理的手段。Client Councilは活動の為に何を利用できるか。

3. 上記2.の設定により、Client Councilは、

a. 合理的にClientの代表とみなされる。又、

b. Client の共通利益を推進する能力があると合理的に期待される。

4. Client Council は法的拘束力のあるなしにかかわらず、代表を含めた活動方法を書面にする。
5. 第 10 条の 2.に定める Client Council が行う法的訴訟の費用は、医療サービス提供者にあらかじめ通知されている場合のみ、医療サービス提供者に課せられる。
6. 上記 2. に記載の条件を調えた後、医療サービス提供者は本規定が定める Client Council のメンバーを指名する条件を設定する。医療サービス提供者は、Client Council のメンバーが規定が定める定員に満たない為 2 年間機能しなかった場合には、いつでも条件を設定し直すことができる。

第 3 条

1.医療サービス提供者は以下に関する意図的な決定全てについて、Client Council に対し助言の機会を与える：

a. 目標又は法的根拠の変更；
b. 経営管理の移転、合併、又は他の施設との長期にわたる協業の開始あるいは終了；
c. 施設の全て又は一部の清算、移動あるいは大規模な立て替え；
d. 組織内の重要な変更；
e. 活動の重要な縮小、拡大、その他の変更；
f. 施設内の労務管理について直接的に最も強い管理権限を持つ担当者の指名；
g. 予算および年次決算；
h. Client の一般的受け入れ方針、及び Client の医療サービス給付の終了；
i. Client の一般的な給食、セキュリティ領域での一般的方針、健康、衛生状態、精神保健、社会的サポート、リクリエーション活動；
j. 組織の警備、Client に提供されるケアの品質管理と向上；
l. 第 2 条の 2.に記載の手配の変更、また Client に適用するその他の手配の決定、変更；
m. 施設で長期入所の Client に 24 時間体制のケアを支給する部署の管理責任者

2. 意図的決定に大きな影響を与え得る段階になった場合には、助言を依頼する。
3. Client Council には上記 1.に記載の事項に関し、又、Client に重要な場合にはそれ以外の事項に関し、依頼がなくても医療サービス提供者に助言を与える権限がある。

第 4 条

1.医療サービス提供者は、Client Council の書面による助言と異なる決定を採用しない。協議していない場合は、合理的に可能ならば少なくとも一度は協議する。
2. 第 3 条の 1.m.に定める課題に関し、医療サービス提供者は法律に基づいて取られた決定以外、又、Client Council の書面による助言と異なる決定を採用しない。但し、第 10 条に記載の Committee が、医療サービス提供者が全ての利害関係者を交えて合理的に話し合った後に決定に至ったと判断する場合は、この限りではない。
3. 医療サービス提供者は、Client Council が書面により助言した課題について、その決定が異なる場合には Client Council に書面で通知し、議論を提起する。
4. 医療サービス提供者が上記 2.と矛盾した決定を下し、Client Council が書面により医療

サービス提供者に無効を申し立てた場合は無効とする。Client Council は医療サービス提供者が決定を通知してから、1ヵ月以内に無効を申し立てなければならない。Client Council が医療サービス提供者が既にその決定を導入、実行したことに気付いている場合、通知はデフォルトとする。

第5条

1. 医療サービス提供者は、Client Council がその仕事と義務は果たす合理的な目的をもって書面で依頼した場合、タイムリーに全ての情報とデータを Client Council に提供する。
2. 医療サービス提供者は少なくとも年1回、Client Council に口頭もしくは書面で過去の期間に実行された方針、また来年実行する方針を提供する。

第6条

1. 医療サービス提供者は、Client に対して本法律に記載している以外の権限を割り振ることが可能である。かかる決定については Client Council に書面で通知する。
2. 医療サービス提供者は、Client Council に対し上記 1.に記載の決定について、又、かかる決定を変更する場合について助言する機会を与える。第4条も同様の運用とする。

第III章 管理理事会

第7条

1. 医療サービス提供者が民法第2巻第3条に記載の法人の場合には、法律により Client が理事会の総会に影響を与え得る規定があり、それは保護されている。規定により、少なくとも理事の1人は Client Council 又は複数の Client Council の合同の指名を必要とする。但し Client Council 又は複数の Client Council がこの権利を行使しない場合、又はしなかった場合はこの限りではない。
2. 上記 1.は理事会の1人ないしは複数のメンバーが金銭的報酬を伴う雇用契約によって職務を遂行している場合には適用されない。この場合、上記 1.と同等の機能を果たすため、施設の総会が理事会の決議への監視、承認に責任を負う。

第VI章 公表

第8条

医療サービス提供者は本法律が施設に適用する方法により、書面による年次報告書を作成する。

第9条

1. 医療サービス提供者は以下を決定し 10 日後に公表する：
   a. 年次報告書；
   b. 文書化したケア給付の一般的基準を含む方針の出発点
   c. 一般方針に関わる理事会の議事録及び決議リスト
   d. Client の苦情処理に関する規定、及びその他 Client に適用するルール、第2条の 2.に記載の規定。
   e. 第8条に記載の報告書
2. 公表とは書面を閲覧できるようにすること、及び要求に応じてコピーを渡すことである。
3. 公表の通知は Client への通知と同様に行う。

4. コピーを配布する毎に料金を請求するが、原価を超えてはならない。但し、施設に Law on publicity of governance（WOB）が適用できる場合はこの限りではない。

第V章 コンプライアンス

第10条

1. 医療サービス提供者は Client Council 又は複数の Client Council の合意を得て、メンバー3人から構成される受託者委員会を設置する。うち1人は医療サービス提供者が、1人は1つ以上の Client Council が、またもう1人はそのどちらかが指名する。又は医療サービス提供者が、1つ以上の Client 組織と1つ以上の医療サービス提供者組織により設置された受託者委員会を指名する。受託者委員会は調停作業を監督し、以下の場合、必要に応じて合同評決を下す。
   a. 第3条；第4条の1. 及び3.；第5条の1.；及び第9条に関して医療サービス提供者との意見の不一致により Client Council から依頼された場合。
   b. 医療サービス提供者が第3条1. i-m の内容に関して、Client Council からの書面による助言と異なる決議を希望し、依頼した場合。
2. Client Council 及び施設の Client 全員は、医療サービス提供者が拠点を置く地域の郡法廷/州法廷の郡判事/州判事に、医療サービス提供者が第2条、第5条の27、本条の1. に準拠する命令を出すよう書面により申し立てることができる。あらかじめ医療サービス提供者に不服申し立てに従って行動するよう要求せず、又、不服申し立てに従うよう妥当な条件を提示しない申込者は、非許容とみなされる。

Coordination of health care services in the Netherlands

A report by:

Leyden Academy

ON VITALITY AND AGEING

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Foreword

This report is written by the *Leyden Academy*, a knowledge center in the Netherlands with the mission to improve the lives of older people, on a request from the *Institution for Future Welfare*, a knowledge center in Japan. The request by the *Institution for Future Welfare* pertains to an oversight of the Dutch long-term health care system together with questions relating to more specific dynamics of the system. The *Leyden Academy* gives a complete oversight, as well as answers to the questions that were outlined.

The report is divided into different chapters and also offers extensive supplementary material. In the first chapter, an oversight is given of the Dutch health care system. Central in this chapter are three different health care acts – the health care insurance act (ZVW), the exceptional medical expenses act (AWBZ), and the social support act (WMO) – and the institutions involved in fulfilling these acts. The second chapter mainly offers information on the size of the demographic and financial issues related to the health care acts. Also, information about aspects surrounding the three health care acts is given. For example, a paragraph is dedicated to the way health care institutions exchange information about clients. The third chapter offers information about the boundaries of the acts: the three different health care acts (potentially) overlap in certain ways and detailed information is given how rules and regulations are set to separate the different fields. Supplementary material exists of translations of laws surrounding the three health care acts, such as the Law of Client Participation in Health care Institutions is added.

In this report patients, health insurance consumers, and those eligible for AWBZ and WMO will be called clients. If any questions remain unanswered, or the reader is need of further or more detailed information, the Leyden Academy is more than willing to answer them.

Herbert Rolden & Marieke van der Waal

Contents

Important remarks

This introductory paragraph clarifies some potential problems the reader might encounter when reading this report.

First, all abbreviations that are used in this report are summarized in a special section on page 51-52. Second, some terms need to be clarified.

- The term *home care* does not refer to all care that is received in a home situation. It refers to all domiciliary care, encompassing activities such as house cleaning, buying groceries, and cooking. Depending on income of the older person, home care is partly or fully paid by the WMO. Medical and nursing care do **not** fall under the term home care. Activities such as helping with dressing or undressing, with getting in or out of bed, or with bathing or showering is called *personal care.*
- When AWBZ care is delivered at home, and not in an institute, it is called non-residential care. On the other hand, if AWBZ care is delivered at a care home or nursing home, it is called residential care. Home care, personal care and nursing care can be delivered in both residential and non-residential situations.
- In literature, health care services provided through the ZVW are sometimes called *medical* or *cure services* and services provided through the AWBZ are called *welfare* or *care services.* The terms can be confusing as some funding from the ZVW can be spent on care or welfare services. In this report *cure* refers to medical care and is usually compensated through the ZVW. *Care* refers to welfare services and is mostly funded by the AWBZ.
- Different sources are used in this report to clarify the expenses made within certain health care domains or acts. Data are mainly from three sources: the Central Bureau of Statistics (CBS), the System of Health Accounts (used by the Organization for Economic Cooperation and Development, or OECD), and the Dutch national Budget for Care (BKZ) as defined by the Dutch government. Part of the data that is used for the BKZ comes from the Health Insurance Board (CVZ). When expenses are analyzed, the sources for the data are specified. Important to note here is that the definition of health care used by CBS is broader than used by the System of Health Accounts. In contrast to the definition used by the OECD, the definition of

CBS also includes health at work, reintegration services, youth care, social and cultural work, day care centers and boarding schools.

- Expenses made for the WMO are hard to track down, because every municipality defines its own WMO budget. Data about these budgets is not collected centrally. Estimations of expenses made for the WMO were done in the BKZ.

Third and last, the health care system in the Netherlands is changing fast. Since 2006, major reforms have been established on an annual basis. The first version of this report appeared in 2012. It is important to note that new changes have been planned for 2013.

1. Curative and long-term care in the Netherlands

1.1 The Health care Insurance Act (ZVW)

The year 2006 is a focal point in the history of Dutch health care policy. In this year, the new Health care Insurance Act (ZVW) officially came into place. This health care reform obliges all citizens to have a basic health insurance package for curative care with an individually chosen private health care insurer. The specific content of the basic package is established by the Dutch government. 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 insurance is based on a "semi-free market system". The purpose is that competition between health care providers and insurers is organized without sacrificing equity, quality and transparency of the health care market. 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.

1.1.1 Equity, quality, and transparency

Equity is ensured by providing everybody with an equal coverage for comparable fees (since there is competition between insurance companies). Persons and households with an income below a certain threshold are eligible to receive a "health care allowance" (*zorgtoeslag*) from the government that covers a part of the insurance fees. The government will decide if a client will get the health care allowance based on the level of income which is based on the yearly household tax payments. To prevent misuse and overuse of health care provision from Dutch citizens, a compulsory deductible is levied over many different health care services (€170 in 2011, €220 in 2012). Clients can voluntarily increase this compulsory deductible to decrease their insurance fee. This can

be done if one expects to use little or no health care in a particular year. Because the chronically ill make more use of health care services, they have an elevated risk of having to pay the full compulsory deductible every year. The Central Administration Office (CAK) offers the chronically ill a compensation to pay for a part of the compulsory deductible. In the near future the compensation will be income-dependent (only low income chronically ill can use the deductible).

People are also allowed to buy more insurance to complement the basic package. Insurers are not allowed to refuse anybody when they apply for a basic insurance, but insurers are allowed to refuse applications for complementary voluntary health insurance (VHI). Each health care insurer offers different VHI packages (ranging from plain to "gold" packages), usually containing additional reimbursements for dental work, and compensation for glasses, alternative medicine, and so on. Since insurers are allowed to refuse applications for VHI, clients feel their freedom of choice is sometimes limited. Clients can be deterred from switching to another insurer, because they are afraid the new potential insurer might refuse their application for a VHI package.[1]

Quality is ensured by a transformation in the health care purchasing market. To obtain contracts with insurers, health care providers need to provide good quality for an affordable price. Providers who underperform can be left out in negotiations. This relates mainly to the semi-free market where health care insurers and health care providers interact.

Also, since clients can select a health care insurer and provider on their own accord, they are given more freedom of choice. Higher transparency is then reached because health care providers and insurers will want to inform clients about their services and the points in which they outperform others. Independent organizations or web sites offer information about the pros and cons of different services related to health care.

1.1.2 Organization and parties of the health care market

Figure 1 (next page) shows how the ZVW influences the organization of the interrelatedness of health care providers, health insurers and citizens. Different elements of this figure are explained below:

- *Government.* With support of the parliament and after failed reforms in the eighties and nineties, the ZVW entered into force on the 1st of January 2006. Since then, the government issues changes in the contents and deductible fees of the basic packages.
- *Providers.* The general practitioner (GP) is seen as a gatekeeper for other providers. A visit to the GP is usually mandatory before clients can consult with a specialist or when they need medication. Partly due to the introduction of the ZVW, hospitals are stimulated to specialize and divest. Insurance companies will not likely contract a hospital for services in which it has underperformed in previous years. Therefore, it is expected that in the near future hospitals will focus on their competences and relinquish some services and specialties.

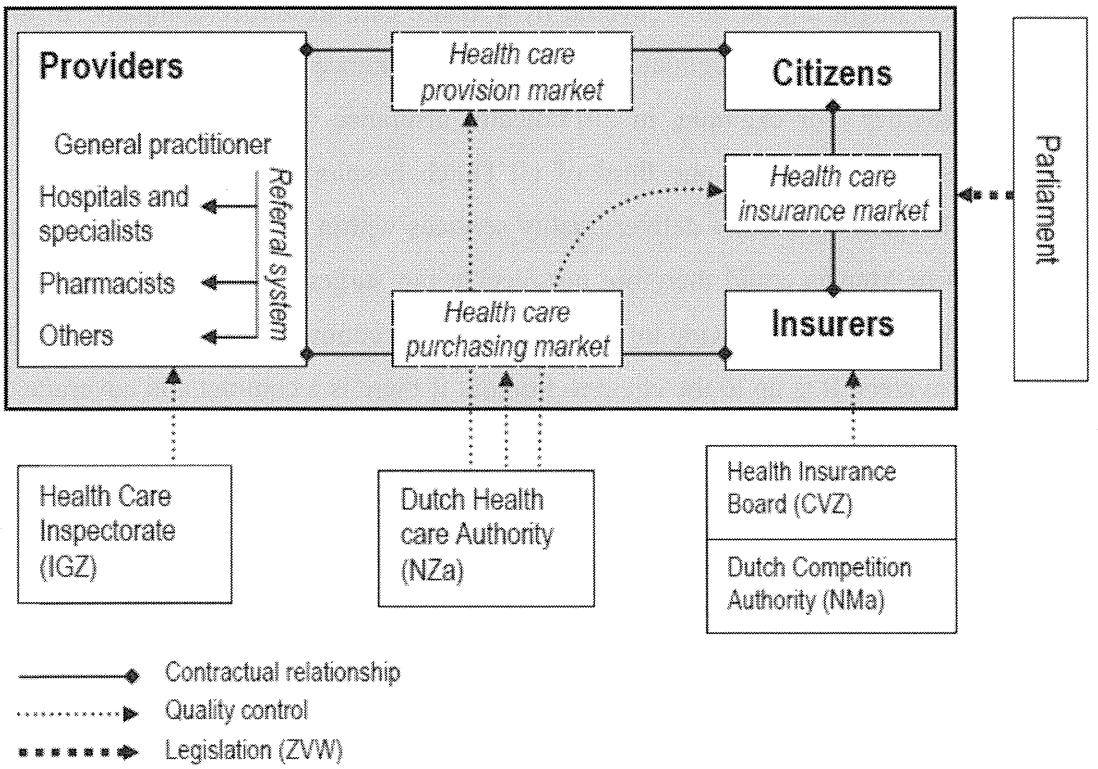

Figure 1: Organizational overview of the Dutch health insurance system (based on figure 2.1, p. 14, source: [2]).

- *Insurers.* Four insurance companies provide services for the majority of the market (88%). Of these four insurers, one is for-profit, the others are not-for-profit. One insurance company can own different brands. There are around 32 brands of health care insurance.
- *Citizens.* An important aim of the health care reform in 2006 was to give the client more power and freedom of choice. The client is seen as an independent and rational decision-maker who can choose for an insurer and compose his or her own insurance package, including content of complementary care and size of the deductible. Also, the patient is free to choose between different health care providers. As of yet, this freedom of choice remains limited with regard to the market of providers where there is low competition, as in the field of general practice. A note of criticism here is that usage of the services of some health care providers might not be fully covered by a health care insurance company. In this case, no contract was negotiated between the insurance company and the health care provider. For example, in 2011 health insurance company Menzis did not establish contracts with one third of all Dutch hospitals regarding hip surgery. These hospitals could not deliver quality services within competitive price ranges. Clients of Menzis could therefore not receive hip surgery in these hospitals. The insurance companies provide information about the contracts they have with health care providers. It is up to the client to find out if there is a contract and coverage of the treatment.
- *Health Insurance Fund (HIF).* Every insurer has a different composition of client group. This means that some insurers may carry more risk concerning medical expenses than others. To ensure that insurers do not suffer from a high risk customer group (such as chronically ill or groups of clients with a low socio-economic status), the Health Insurance Fund is in place to compensate every insurer from elevated risks. The Health Insurance Fund is also in place to compensate for health care provision to people under 18. People under 18 are insured fee of charge by a special youth insurance including dental care.

- *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, but may also be insistent or even forceful.
- *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, but can also 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.

1.1.3 How the ZVW is financed

Health insurers are paid a nominal premium by every Dutch person aged 18 or higher. The fees differ between insurers, but a fixed compulsory deductible is set by the government. In 2006 and 2007 there were no compulsory deductibles, but no-claim discounts could be earned if little or no medical care services were used. The average nominal premiums for basic packages, the compulsory deductibles, and other fees for the years 2006 to 2012 are given in table 8 on page 28. Dutch citizens can choose to increase their deductible to lower the fee for their health insurance. The extra voluntary deductible may be increased with €100 up to €500.

In the Netherlands the nominal fees are paid to health insurance companies on a monthly or yearly basis. 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 these nominal fees, Dutch citizens who receive income through, for example, employment or a pension fund pay an income-dependent contribution to the Health Insurance Fund (HIF). The government also contributes to the HIF. The CVZ calculates and pays out the redistribution by the HIF amongst insurers so that risks are evenly spread out. The *income-dependent employee contribution to the ZVW* is withheld from the employees gross salary. Most employers are obliged by law to compensate the employee for this 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.

Two different rates exist concerning this income-dependent contribution: the higher level contribution is paid over gross salary of employees, state pension, and social benefits for those under 65 years old; the lower level contribution is paid over the income of self-employed citizens and freelancers, private pensions, and social benefits for those over 65 years. Table 1 shows the income-dependent contributions for employees and others from 2009 through 2012.

Table 1: The income-dependent contribution to the ZVW, 2009-2012

Year	Income-dependent contribution: high	Income-dependent contribution: low	Maximum yearly amount for which the contribution is imposed
2009	6.90%	4.80%	€32,369
2010	7.05%	4.95%	€33,189
2011	7.75%	5.65%	€33,427
2012	7.10%	5.00%	€50,064

To summarize, 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. These contributions should add up to 50% of the total fund.
3. A contribution from the government, which should cover 5% of the fund.

Medical expenses are calculated with 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.

1.1.4 Advantages and disadvantages of the ZVW

The main advantages and disadvantages of the ZVW are given in table 2 below.

Table 2: Advantages and disadvantages of the ZVW (2012)

Advantages	**Disadvantages**
Pay-by-performance system aims for efficiency and less conflict of interest between health care provider, insurer and client.	Potential conflicts of interests. The values of DOTs are calculated once per year. Underestimation of DOTs makes the related health care services less profitable for health care providers. Overestimation makes the related health care services more profitable for them.
Low out-of-pocket expenses to establish equity; deductibles to safeguard from over-use.	Chronically ill and older people form the bulk of care-users: health care insurers not interested in serving this target group best.[3]

Freedom to choose health care insurer and health care provider.	Chronically ill and older people can benefit from VHI packages, but applications can be refused by insurers.
Basic and affordable health care insurance for everyone.	Potential misuse of the system: refusal to take health care insurance or pay health care insurance premium; potential misuse of health care allowance.
Health care insurers ensure low health care insurance fees by negotiating the lowest price possible.	Health care providers are driven to increase their "sales revenue". More people are treated, and insurance fees are going up.

1.2 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 care for people who cannot provide in their basic care needs independently. This can be the consequence of a physical, psycho-geriatric or psychiatric ailment, or a mental, physical or sensorial handicap. During the seventies and eighties, the coverage of the AWBZ expanded from only including exceptional illnesses to including psychiatric care, rehabilitation, home care services, and more. In this period in time, the AWBZ was developing to become a social insurance scheme since much of the care, instrumental aids, therapeutic tools, and institutes themselves were provided for or arranged by the national government. 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 confounds of limited budgets from the national government. More information on the WMO can be found in paragraph 1.3.

1.2.1 Introduction to the AWBZ

The AWBZ is a national insurance scheme for long-term care, mainly for intramural care. Most expenses within the AWBZ are made for (frail) elderly, with or without cognitive limitations or physical/functional limitations. Everyone who works or receives any kind of social benefit,[1] and is obliged to be insured for health care, is also obliged to pay a fee for the AWBZ. 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.

The fund for the AWBZ is established through fees paid by employees and the government. The fund for the AWBZ is also called the Exceptional Medical Expenses Fund, or AFBZ (*Algemeen Fonds Bijzondere Ziektekosten*). Figure 2 gives an oversight

[1] This includes benefits from state pension, called AOW (Algemene Ouderdomswet).

of how administrative and monetary processes are streamed between the patient, health care providers, insurance companies and other institutions that are involved in delivering care services under the AWBZ. The institutions and streams are selected for the purpose of understanding the main administrative processes. Other monetary flows – e.g. how the different institutions such as the CIZ are funded – are excluded to ensure surveyability.

Every person who wants to be eligible for AWBZ funding needs to be assessed by the CIZ. The CIZ assesses the care need of an individual according to a "funneling model" (see paragraph 3.1 for further details). With the use of this model, the care needs of a specific patient are assessed, on which a decision is made. This decision is forwarded to the nearest regional care office. There are 32 care regions in the Netherlands, each with a care office that provides the care that is needed for patients.

Every region in the Netherlands has a care office. Care offices contract health care providers to deliver the care that a client needs on the basis of the indication set by the CIZ. The Central Administration Office (CAK) pays the costs and is billed by the health care provider. The amounts paid by the CAK to health care providers are standardized amounts for every indication setting. It is in the interest of the client as well as the health care provider to keep indication-setting up to date. If the physical or mental condition of a client is progressing, he or she is in need of more care. The health care provider needs to deliver this care and if the provider does not ensure the indication-setting is up to date, he might not get paid enough by the CAK.

Clients who receive an indication from the CIZ for long-term residence in a care home or nursing home, may also receive a personal budget from the care office (or PGB, which stands for *persoonsgebonden budget*) instead of care in kind. Only the client can choose to accept either a PGB or care in kind. A combination of care in kind and a personal budget is also possible. The size of the budget a client may receive is standardized by indication (the kind and the hours of care needed). The specific amounts can be found in table 10 on page 30. In case of personal budgeting, the client directly receives the net worth of the PGB (gross defined PGB minus own deductible) on his or her bank account. More information on the monetary aspects of the AWBZ are given in paragraph 2.1 and 2.3.