

*Administrative and monetary flows:*

1. Employees pay a fee of 12.15% of their yearly income to a maximum of around € 4,000.
2. The government pays the deficit between flow 1 and 3.
3. The Health Insurance Board administers the AWBZ fund.
4. The tax administration gives information to the CVZ on the financial status of the client.
5. The tax administration gives information to the CAK on the financial status of the client.
6. The insurance company with the most clients in a care region delivers the services of a care office.
7. The CVZ pays the CAK from the AWBZ fund for bills from the health care provider.
8. The CAK pays the deductibles received from the clients back to the AWBZ fund administered by the CVZ.
9. The CVZ provides rules and regulations for the functioning of the care offices.
10. The care office bills the CAK for payment of health care provision.
11. The CVZ funds the Care Office for paying out PGBs.
12. The CIZ assesses the care need of the patient, which is sent to the appointed care office.
13. The Care Office pays out the PGB to the client.
14. Care offices provide clients with information, intermediates for the clients, and handles complaints.
15. The client pays a deductible to the CAK, dependent on their financial status.
16. Care offices ask health care providers to deliver the care for a client.
17. The CAK pays providers for the delivered health care.
18. The client provides the CIZ with the necessary information for care need assessment.
19. The health care provider provides care services for the client.

*Figure 2: Administrative and monetary streams within the AWBZ*

The SVB Service center for Personal budgets (SSP) offers free assistance to clients who receive a PGB. Some PGB holders need help with the administrative processes that are required when applying for a PGB, or maintaining the PGB. SVB stands for Social Insurance Bank (*Sociale Verzekeringsbank*). The SVB is the administrative body that implements national insurance schemes of different types, such as the state pension or child benefits.

Care offices also mediate between patients and health care providers in particular situations, for example when a patient has complaints about his or her health care provider. The services of care offices are provided by the insurance company with the most health care insurance clients in the region. The insurer provides these services regardless of whether the beneficiaries are clients of that particular insurer or not.

The health care providers are paid for by the Central Administration Office (CAK). Clients are obliged to pay a deductible to the CAK for use of health care provision, dependent on their financial status, family situation and age. The tax administration offers information to the CAK and CVZ about the financial status of the patient.

### *1.2.2 How the AWBZ is financed*

For the ABWZ, all Dutch citizens with an income are obliged to pay a fee of 12.15% over a (maximum) part of their yearly taxable income (also those who are younger than 18 years and have a job). The maximized part over 2011 was €33,436. This means that the maximum fee a person had to pay for the AWBZ in 2011 was €4,062.50 (12.15% of €33,436). In case someone is an employee, this fee is subtracted from his or her gross wage or income, and deposited to the tax department by the employer.

The Dutch government aims to fund all AWBZ care by the total bulk of these income-dependent fees alone (including AWBZ care for those under 18 years of age). In some years, the expenses made by the AWBZ fund exceeded the bulk of the incoming fees. In these years, deficits are compensated by the government through contributions by the national treasury. These contributions to the AWBZ fund fall under an expense category, called the *Contribution to Reduction Expenses* (BIKK: *Bijdrage in de Kosten Kortingen*).

### 1.2.3 Advantages and disadvantages of the AWBZ

The main advantages and disadvantages of the AWBZ are given in table 3 below.

Table 3: Advantages and disadvantages of the AWBZ (2012)

Advantages	Disadvantages
Individually tailored long-term health care and welfare services for every Dutch citizen.	Clients who use AWBZ still pay €145.60 to €2,097.40 per month out-of-pocket (2011), dependent on income.
Clients can choose their own health care or welfare service provider.	Highly bureaucratic administrative processes to establish individually tailored care: high overhead costs; clients confused or underinformed.
Optional personal budgetting increase client autonomy and freedom of choice.	Elderly care needs can change rapidly. The CIZ cannot always keep pace, e.g.: care weight packages are reassessed once a year.

## 1.3 The Social Support Act (WMO)

### 1.3.1 Introduction to the WMO

The WMO was introduced in 2007 and replaced other legislation, such as the part of the AWBZ that provided home care assistance before 2007.<sup>2</sup> Provisions from the social support act are applied for at – and delivered from – the local municipal office. The goals of the WMO are divided into nine “performance fields”, defined by law:

1. Improving social cohesion and livability of villages and neighbourhoods.
2. Support to the youth and parents who experience problems with upbringing (prevention).
3. Giving information, advice, and support to clients.
4. Supporting informal caregivers and volunteers.

<sup>2</sup> Information in this chapter partly obtained from [www.rijksoverheid.nl](http://www.rijksoverheid.nl), <http://wetten.overheid.nl>.

5. Promoting participation of people with chronic psychological or psychosocial problems or a physical limitation in society, as well as their independency.
6. Providing facilities and services for people with a chronic psychological or psychosocial problems or with a physical limitation to promote their independency and societal participation.
7. Offering shelters and implementing policies to combat domestic violence.
8. Improving public mental health care.
9. Improving addiction policies.

Provisions within these fields include:

- help with housekeeping, such as cleaning;
- adjustments in the house, like a stairs lift or a special toilet;
- transport in the region for people who are not capable of travelling with public transport (taxi, compensation for taxi expenses, or scooter);
- support for volunteers and informal caregivers;
- support with raising children;
- wheelchairs;
- delivery of groceries and (warm) meals;
- support to local initiatives, such as community centers and social clubs;
- support to shelters for victims of abuse or homeless people.

WMO provision does **not** include:

- tools for temporary use, such as crutches, or zimmer frames (these are provided by the health care insurer);
- commonly used services or tools (e.g., internet);
- adjustments to a second or other living area (e.g., caravan);
- personal care (provided by AWBZ).

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

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

### 1.3.2 Advantages and disadvantages of the WMO

The main advantages and disadvantages of the WMO are given in table 4 below.

Table 4: Advantages and disadvantages of the WMO

Advantages	Disadvantages
Free for everyone (besides a relatively low deductible).	The act is relatively young: every municipality realizes the WMO in a different way; budget differs per community; WMO provisions change every year.
Easily accessible (geographically close reception desk, non-discriminatory).	Some municipalities have more older generations than others, and funding from the national government does not account for this.
Less bureaucracy than in the AWBZ.	Sometimes it is unclear for clients when to apply at the CIZ, the health care insurer or the municipality for moveable aids.

## 2. The scope of the Dutch cure and care sector

### 2.1 Use and expenditure within the AWBZ, ZVW and WMO

Total health care expenses made in the Netherlands were around 87 billion euros in 2010, which amounts to 14.8% of Dutch gross domestic product in 2010. These total expenses can be divided into different sources of finance (ZVW, AWBZ etc.) or different health care domains (cure, care etc.). This is done for the years 2000 and 2006-2010 in table 5a below. Table 5b shows the expenses per capita, and table 5c shows health care expenses as a percentage of gross domestic product (GDP).

*Table 5a: Sources and domains of health care expenditure, in millions of euro's (source: CBS)*

Source of finance	2000	2006	2007	2008	2009	2010
Government	6,585	8,206	10,724	11,328	12,215	12,484
ZVW	13,138	26,727	27,693	32,322	34,191	35,413
AWBZ	14,580	23,177	23,007	22,169	23,201	24,286
Other	12,616	12,612	13,220	13,933	14,446	14,923
Domains	2000	2006	2007	2008	2009	2010
Expenses for cure	26,801	40,688	43,306	46,550	48,851	50,525
Expenses for care	18,080	27,026	28,262	30,175	32,200	33,583
Policy & overhead	2,039	3,007	3,074	3,026	3,001	2,998
<b>Total expenses</b>	<b>46,919</b>	<b>70,722</b>	<b>74,643</b>	<b>79,752</b>	<b>84,053</b>	<b>87,106</b>

Important to notice is that health care expenditure per Dutch citizen has risen with almost 1,000 euro's in 5 year time. As a percentage of GDP, health care expenditure has also risen, which economists deem problematic for economic growth.

Table 5b: Sources and domains of health care expenditure per capita (source: CBS)

Source of finance	2000	2006	2007	2008	2009	2010
Government	413	502	655	689	739	751
ZVW	825	1,635	1,690	1,965	2,068	2,132
AWBZ	915	1,418	1,404	1,348	1,404	1,462
Other	792	772	807	847	874	898
Domains	2000	2006	2007	2008	2009	2010
Expenses for cure	1,683	2,489	2,643	2,830	2,955	3,041
Expenses for care	1,135	1,654	1,725	1,835	1,948	2,021
Policy & overhead	128	184	188	184	182	180
<b>Total expenses</b>	<b>2,946</b>	<b>4,327</b>	<b>4,556</b>	<b>4,849</b>	<b>5,085</b>	<b>5,243</b>

Table 5c: Sources and domains of health care expenditure as % of GDP (source: CBS)

Source of finance	2000	2006	2007	2008	2009	2010
Government	1.6	1.5	1.9	1.9	2.1	2.1
ZVW	3.1	5.0	4.9	5.4	6.0	6.0
AWBZ	3.5	4.3	4.0	3.7	4.1	4.1
Other	3.0	2.3	2.3	2.3	2.5	2.5
Domains	2000	2006	2007	2008	2009	2010
Expenses for cure	6.4	7.5	7.6	7.8	8.5	8.6
Expenses for care	4.3	5.0	5.0	5.1	5.6	5.7
Policy & overhead	0.5	0.6	0.5	0.5	0.5	0.5
<b>Total expenses</b>	<b>11.2</b>	<b>13.1</b>	<b>13.1</b>	<b>13.4</b>	<b>14.7</b>	<b>14.8</b>

The Central Bureau of Statistics (CBS) has given health care expenditure for different categories of health care providers in 2008, 2009, and 2010. These statistics are summarized in table 6.

Table 6: Health care expenditure by type of provider, 2008-2010 (source: CBS)\*

	2008		2009		2010	
	Total in million €	% of GDP	Total in million €	% of GDP	Total in million €	% of GDP
Hospitals & specialist practices <sup>1</sup>	20,259	3.41	21,629	3.79	22,390	3.81
Mental health care <sup>1,2</sup>	4,899	0.82	5,273	0.92	5,435	0.92
General practices <sup>1</sup>	2,444	0.41	2,470	0.43	2,528	0.43
Dental practices <sup>1</sup>	2,418	0.41	2,558	0.45	2,642	0.45
Paramedical practices <sup>1</sup>	1,610	0.27	1,720	0.30	1,838	0.31
Municipal health service (GGD) <sup>3</sup>	686	0.12	707	0.12	734	0.12
Health at work <sup>4</sup> & reintegration <sup>5</sup>	1,211	0.20	1,224	0.21	1,224	0.21
Pharmaceutics <sup>1,2</sup>	6,098	1.03	6,204	1.09	6,366	1.08
Therapeutic instruments <sup>1,2</sup>	2,929	0.49	2,670	0.47	2,754	0.47
Supporting services	1,587	0.27	1,785	0.31	1,873	0.32
Other	2,409	0.41	2,611	0.46	2,741	0.47
<b>Total medical expenses (cure)</b>	<b>46,550</b>	<b>7.83</b>	<b>48,851</b>	<b>8.55</b>	<b>50,525</b>	<b>8.59</b>
Providers of elderly care <sup>2</sup>	14,775	2.49	15,211	2.66	15,974	2.71
Providers of care for the disabled <sup>2</sup>	7,138	1.20	7,802	1.37	7,902	1.34
Providers of youth care <sup>2,6</sup>	1,441	0.24	1,819	0.32	1,955	0.33
Social and cultural work <sup>3</sup>	1,101	0.19	1,173	0.21	1,225	0.21
Day care centers <sup>7</sup>	3,602	0.61	3,943	0.69	4,187	0.71
Boarding schools <sup>6</sup>	541	0.09	576	0.10	580	0.10
Other	1,577	0.27	1,677	0.29	1,758	0.30
<b>Total welfare expenses (care)</b>	<b>30,175</b>	<b>5.08</b>	<b>32,200</b>	<b>5.64</b>	<b>33,583</b>	<b>5.71</b>
Policy and management organizations	3,026	0.51	3,001	0.53	2,998	0.51
<b>Total health care expenditure</b>	<b>79,752</b>	<b>13.42</b>	<b>84,053</b>	<b>14.72</b>	<b>87,106</b>	<b>14.80</b>

\*The reference numbers in the brackets shows from which act or institution the provider is compensated:

1 = ZVW.

2 = AWBZ.

3 = Municipal budget (large municipalities have their own Municipal Health Service (GGD), which promotes public health by focusing on prevention, town and country planning to promote health etc. ).

4 = Law on Labor Conditions (ARBO), financed by the Ministry of Social Affairs and Employment.

5 = *Municipal Budgets and the Ministry of Social Affairs and Employment (mainly by the Law on Working in line with Capabilities (WWNV)).*

6 = *Government budgets invest in institutes that provide services for youth showing problematic behavior, besides the AWBZ fund.*

7 = *Dutch citizens may receive subsidies from the tax department for payments made to daycare centers.*

The national Budget for Care (BZK) is defined by the Ministry of Health, Welfare and Sport. The data used to analyze the realization of this budget shows slightly different numbers. However, the BZK does specify expenses made for the WMO and specifies what part of the AWBZ fund is spent on care in kind and on PGBs. This information can be found in table 7 on the next page.

Figure 3 (page 27) shows the average per capita health care expenses for different age categories. These average expenses include all expenses related to health care and welfare, including the ZVW, AWBZ and WMO. Important to note here is that figure 3 may be misleading. On an individual level, health care expenses rise exponentially before time of death. Since older people have a higher risk of dying, the chance increases that they will make higher health care expenses. Older people who are relatively healthy and will not die within the next few years, do not make significant higher health care expenses compared to younger people. This is known in health economics literature as the “red herring debate”.

The health care expenses made for palliative care are unknown. When a client is diagnosed with a terminal illness, he or she may receive palliative care at home, but palliative care can also be given in a hospice, hospital, nursing home, or care home. Also, palliative care can be financed through the ZVW, AWBZ and WMO. Insight into these expenses cannot be attained. Figure 4 (page 27) offers an insight into how health care expenses made in hospitals in 2000 differ between ages, but mainly between clients who died in 2000 and clients who didn't die in 2000. Age does not seem to play a significant role for costs of hospitalization, unless a client dies in the same year that the health care expenses are made.

Table 7: Health care expenses (in millions of euros) by domain in 2008-2010, defined by the BZK.

Domain	Subdomain	2008	2009	2010
Public health <sup>1</sup>		108	100	95
Medical health care <sup>2</sup>	Total	31,526	33,971	34,893
	<i>Inpatient</i>			17,708
	<i>Outpatient</i>			3,931
	<i>Patient transportation</i>			554
	<i>Medicine &amp; tools</i>			6,908
	<i>Mental health care (medical)</i>			3,532
	<i>Health care abroad</i>			467
	<i>Other</i>			1,793
Long-term care	Total	21,537	22,931	23,983
	<i>AWBZ care in kind</i>			21,380
	<i>AWBZ PGB</i>			2,158
	<i>Other</i>			446
<i>MEE institutions</i> <sup>3</sup>		172	178	180
WMO <sup>4</sup>		1,475	1,533	1,541
Educational fund <sup>5</sup>		783	824	839
WTCG <sup>6</sup>		–	–	488
<b>Total</b>		<b>55,600</b>	<b>59,537</b>	<b>62,019</b>

1 = Includes mainly preventive health care, such as vaccinations.

2 = Inpatient medical health care is hospital and specialist health care. Outpatient health care includes general practice, dental health care, etc.

3 = MEE institutions offer free information, advice and support to people with disabilities.

4 = Subdomains of the WMO fund not defined in BZK, therefore unknown.

5 = Fund for training of specialists.

6 = Law on Compensation for Chronical Illness.

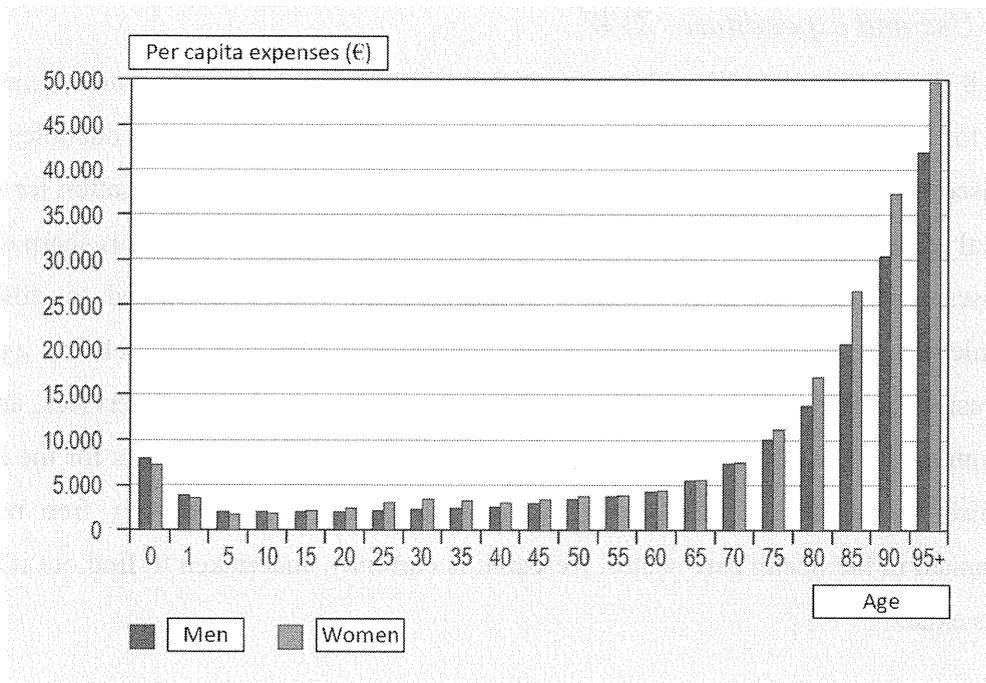


Figure 3: Per capita health care expenses in the Netherlands by age and gender, 2009 (Source: [4])

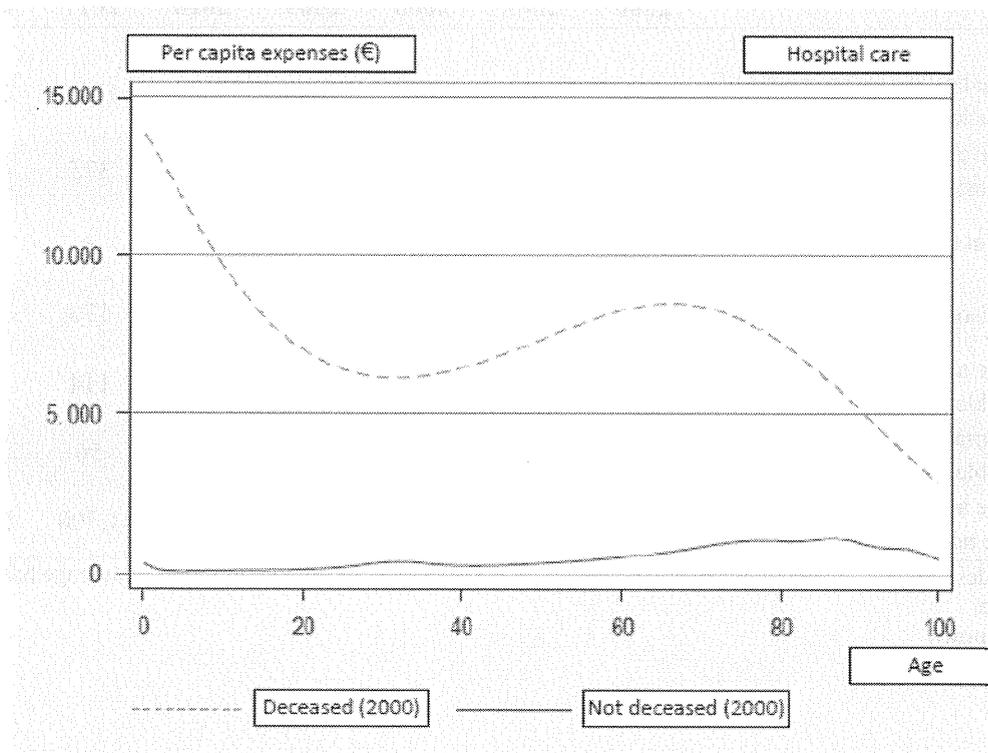


Figure 4: Per capita health care expenses made in hospitals in the Netherlands, by age and divided into deceased and not-deceased, 2000 (Source: [4])

### 2.1.1 Use and expenditure: ZVW

Table 8 shows the average health care fees from 2006 to 2012, as well as other expenses made for the ZVW by Dutch citizens. Per capita expenses on fees and deductibles have increased with almost 50% from 2006 to 2012. At the same time, compensation for some medical services has been lowered or removed from the basic packages. This sharp rise in expenses together with a downsizing in compensation, can be related to different dynamics in the health care market. Major contributing factors are population ageing, “expensive” medical innovations that increase the demand for medical services, and an autonomous increase in demand for medical services. The rise in expenses for the ZVW can also be related to unexpected detrimental effects of introducing free market mechanism in the health care sector. Research is currently undertaken to find out if these effects exist.

Table 8: Average expenditure in euros for nominal and voluntary premiums, compulsory deductibles and compensation for the compulsory deductible, 2006-2010, (source: [www.zorgkiezer.nl](http://www.zorgkiezer.nl))

	2006	2007	2008	2009	2010	2011	2012
Average health care premiums of basic packages (annual)	1027	1091	1040	1056	1082	1211	1239
Average expenses for voluntary health insurance package	290	307	334	362	370	375	412
No-claim discount	255	255	-	-	-	-	-
Compulsory deductible	-	-	150	155	165	170	220
Average no-claim earned or deductible paid*	-98	-102	103	106	111	114	135
Compensation for compulsory deductible chronically ill	-	-	47	50	54	56	**
Average annual expenses incl. average no-claim / deductible	1,219	1,296	1,477	1,524	1,563	1,700	1,786

\* Includes voluntary deductible. Average expenses were calculated with an assumption of average health care use.

\*\* Unknown

### 2.1.2 Use and expenditure: AWBZ & WMO

The estimated expenses from the AWBZ in 2010 are €24.4 billion (€23.4 billion in 2009). Expenses for AWBZ care were €1,400 per capita in 2009. On the income side, around €21 billion was collected from premiums and government input in 2010. The more than €1 billion rise in expenses from 2009 to 2010 were mainly attributable to increased expenses on nursing care (€600 million) and higher demand on personal budgets (€240 million). Expenses from the AWBZ exceeded its financial budget every year since 2008. These deficits are compensated by contributions of the national treasury through a fund called the *Contribution to Reduction Expenses* (BIKK: *Bijdrage in de Kosten Kortingen*). More specific statistics about the PGBs can be found in table 9.

Table 9: Statistics about AWBZ-PGBs 2009-2010 (source: [5])

Subject	2009	2010
Number of PGB holders	118,284	120,572
Fund allocated to PGB holders	€ 2,175 million	€ 2,397 million
Part of allocated PGB actually spent	88.3%	90.4%
PGB spent by PGB holders	€ 1,920 million	€ 2,116 million
PGB spent per PGB holder	€ 16,232 (€44 p/day)	€ 17,550 (€48 p/day)
Users of SVB Service Center PGB (SSP)	24,128	26,610

The amount of the PGB received is dependent on the kind and hours of care that is indicated by the CIZ. Table 10 (next page) shows the possible amounts of PGB. How these individual budgetary compensations relate to compensation from the care in kind is unknown. The indication-dependent amounts that health care providers receive through the AWBZ for delivered care is not offered to the public.

Clients receiving AWBZ care will have to pay a compulsory deductible to the CAK. The height of this compulsory deductible is individually tailored, based on income, age, and family environment.

Table 10: Amounts of PGB received, dependent on type and hours of care indicated, 2012 (source: [www.pgb.nl](http://www.pgb.nl))

<b>Personal care</b>			<b>Nursing care</b>		
<i>Level</i>	<i>Hours/week</i>	<i>PGB/year (€)</i>	<i>Level</i>	<i>Hours/week</i>	<i>PGB/year (€)</i>
1	0 - 1.9	1,483	0	0 - 0.9	1,279
2	2 - 3.9	4,450	1	1 - 1.9	3,819
3	4 - 6.9	8,155	2	2 - 3.9	7,633
4	7 - 9.9	12,606	3	4 - 6.9	13,992
5	10 - 12.9	17,054	4	7 - 9.9	21,628
6	13 - 15.9	21,504	5	10 - 12.9	29,258
7	16 - 19.9	26,693	6	13 - 15.9	36,892
8	20 - 24.9	33,366	7	16 - 19.9	45,798
<b>Counseling</b>					
<i>Hours</i>			<i>Day-parts</i>		
<i>Level</i>	<i>Hours/week</i>	<i>PGB/year (€)</i>	<i>Level</i>	<i>PGB (without transportation)</i>	<i>PGB (with transportation)</i>
1	0 - 1.9	1,967	1	2,432	2,724
2	2 - 3.9	5,903	2	4,865	5,447
3	4 - 6.9	10,823	3	7,297	8,172
4	7 - 9.9	16,726	4	9,731	10,893
5	10 - 12.9	22,630	5	12,163	13,620
6	13 - 15.9	28,534	6	14,595	16,051
7	16 - 19.9	35,420	7	17,028	18,485
8	20 - 24.9	44,276	8	19,460	20,917
			9	21,893	23,350
Short-term residence: € 101 for every 24 hours					

We can see from table 11a (next page) and 11b (page 33) that, although the expenses for AWBZ care are rising sharply, the percentage of clients who use care from the AWBZ is decreasing. These tables show the number of clients using AWBZ care, grouped according to gender and 5-year age categories, with and without residence respectively, in 2009 and 2010. Care with residence refers to both long-term and short-term residence, and is always compensated by AWBZ funding. Care without residence can be compensated by either the AWBZ or the WMO.

Currently, governmental and non-governmental different institutes are offering advice on how to downsize spending from the AWBZ. On the 1<sup>st</sup> of January 2012 expenses on personal budgets (PGB) were downsized by reducing the number of clients who are eligible for these personal budgets. Since 2012, only those who have an indication including extramural care may receive a PGB (although those receiving a PGB before 2012, will receive their PGB until 2014).

Every client pays a compulsory deductible for the AWBZ, which is dependent on age, individual income, family situation, and type of care needed. The CAK collects the deductible and gathers information on the current situation from the CIZ and the national tax department. Figure 5 (page 34) shows the size of the monetary flows involved with the AWBZ.

Table 11a: Use of AWBZ/WMO by age-gender group (%) – 65-85 years (source: CBS)

Type of care*		Use of care as % of age and gender group								
		65-70		70-75		75-80		80-85		
		Year	M	F	M	F	M	F	M	F
Care with residence	Nursing care	2004	1.06	1.14	2.46	3.24	5.52	8.16	12.2	18.44
		2009	1.10	1.24	2.34	2.93	5.37	7.55	11.23	17.01
	Care for the handicapped	2004	0.34	0.30	0.29	0.25	0.23	0.19	0.15	0.12
		2009	0.35	0.30	0.33	0.28	0.26	0.22	0.19	0.15
	Mental health care	2004	0.18	0.19	0.18	0.21	0.15	0.22	0.15	0.19
		2009	0.19	0.18	0.17	0.19	0.13	0.17	0.09	0.15
	<b>Total care with residence</b>	2004	1.56	1.62	2.92	3.68	5.88	8.54	12.48	18.71
		2009	1.62	1.7	2.82	3.38	5.74	7.91	11.49	17.29
Care without residence	Home care help	2004	1.96	6	4.24	13.34	8.88	25.21	15.99	35.77
		2009	1.69	5.28	3.42	10.86	7.28	22.02	13.5	34.44
	Personal care	2004	2.00	4.1	4.25	8.83	8.71	16.85	16.16	26.21
		2009	2.00	2.93	3.99	5.95	8.28	12.62	15.85	22.66
	Nursing care	2004	2.55	3.21	4.77	6.23	8.56	11.41	14.75	18.48
		2009	1.84	2.15	3.09	3.72	5.43	6.69	9.04	10.77
	<b>Total care without residence</b>	2004	4.08	8.07	7.99	16.73	15.18	30.56	26.06	43.39
		2009	3.73	7.2	7.06	14	14.03	27.51	25.06	42.83

\*Types of care overlap. For example, people who receive nursing care may also receive care for the handicapped. That is why total care with or without residence is less than the sum of the parts.

Table 11b: Use of AWBZ/WMO by age-gender group (%) – 85+ & 18+ years (source: CBS)

Type of care*		Use of care as % of age and gender group									
		Year	85-90		90-95		95+		18+**		
			M	F	M	F	M	F	M	F	
Care with residence	Nursing care	2004	24.63	35.7	41.27	54.05	56.41	69.8	1.06	2.67	
		2009	22.07	32.45	38.15	50.77	51.74	65.72	1.18	2.71	
	Care for the handicapped	2004	0.11	0.08	0.08	0.04	0.03	0.04	0.47	0.36	
		2009	0.12	0.1	0.09	0.08	0.11	0.04	0.56	0.42	
	Mental health care	2004	0.11	0.15	0.08	0.12	0.11	0.07	0.17	0.12	
		2009	0.07	0.1	0.07	0.07	0.04	0.08	0.25	0.14	
	<b>Total care with residence</b>	2004	24.82	35.9	41.4	54.18	56.55	69.91	1.70	3.15	
		2009	22.25	32.64	38.29	50.9	51.89	65.84	1.97	3.26	
	Care without residence	Home care help	2004	22.37	36.51	24.72	29.1	21.43	18.78	1.46	5.29
			2009	20.47	38.35	23.93	32.81	23.56	23.45	1.47	5.07
Personal care		2004	24.97	31.8	30.2	30.7	30.74	23.71	1.51	3.96	
		2009	25.46	31.24	32.63	33.37	34.51	28.8	1.64	3.30	
Nursing care		2004	21.79	23.6	25.96	23.96	27	19.44	1.55	2.80	
		2009	13.53	14.69	17.53	16.47	18.99	15.62	1.17	1.86	
<b>Total care without residence</b>		2004	36.27	46.01	39.56	39.33	36.86	27.7	2.64	6.81	
		2009	37.29	49.08	43.17	44.44	41.45	34.06	2.84	6.59	

\*Types of care overlap. For example, people who receive nursing care may also receive care for the handicapped. That is why total care with or without residence is less than the sum of the parts.

\*\*18+ includes all age categories above 18 years old (not 18-65).

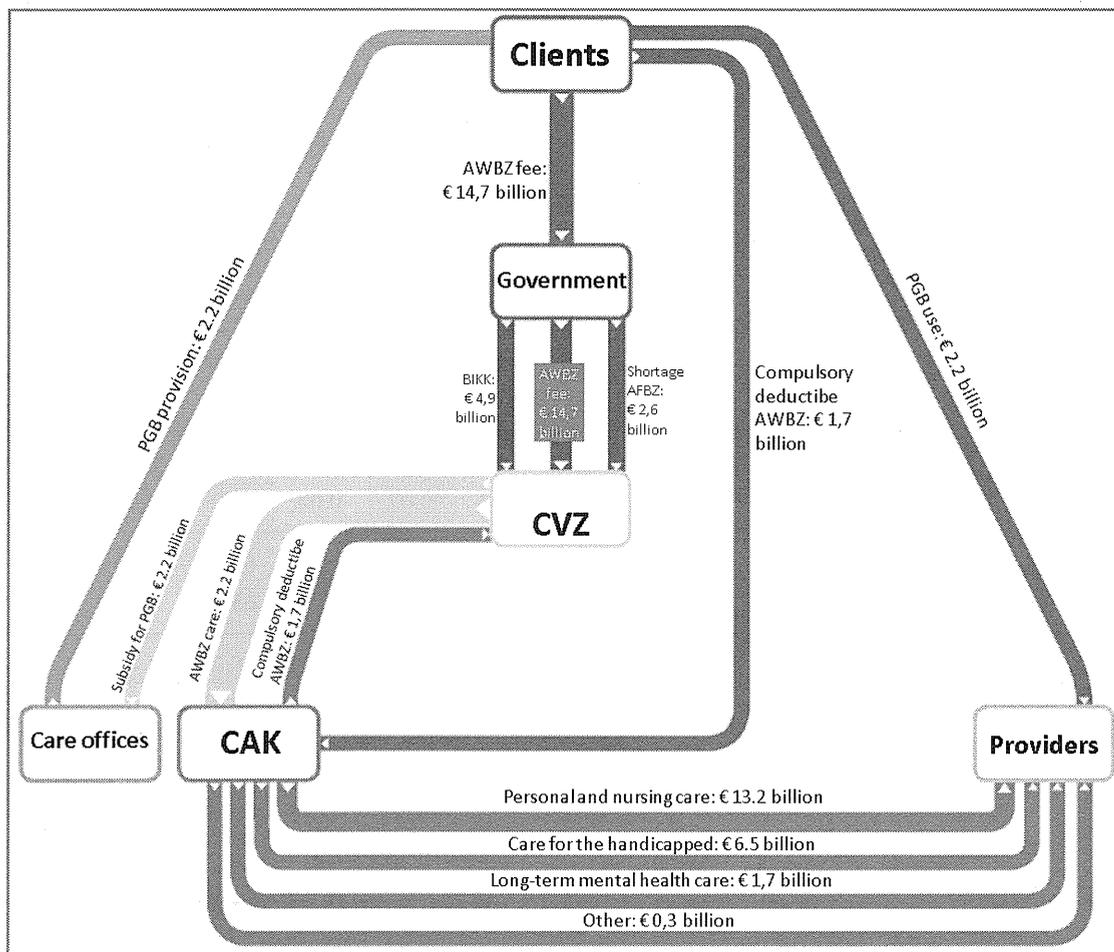


Figure 5: Monetary flows involved with the AWBZ in 2010 (from [www.cvz.nl](http://www.cvz.nl)<sup>3</sup>)

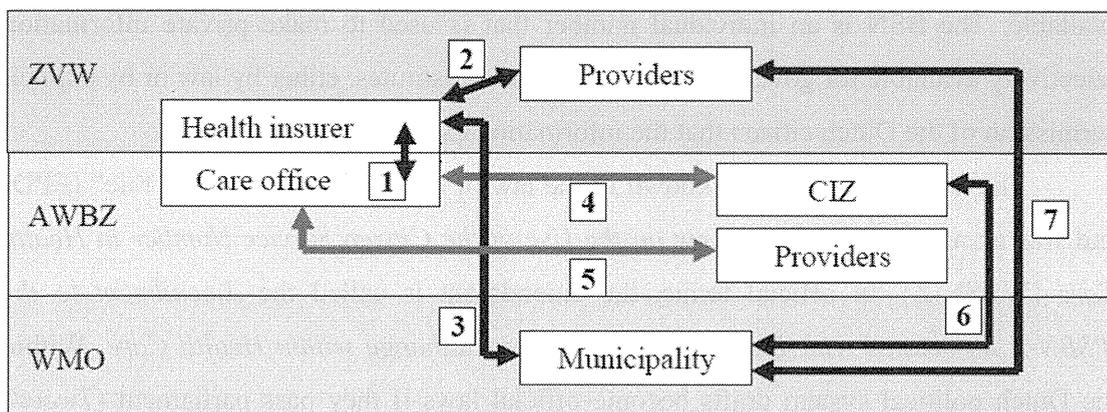
## 2.2 Coordination of health care: the electronic patient file

Figure 1, 2, and 5 (pages 9, 17, and 34 respectively) show administrative and monetary flows of the ZVW and AWBZ. This paragraph focuses on information exchange between different health care institutions and care givers concerning patients.

Currently, all health care providers have their own information database concerning their patients. Information exchange between health care providers takes place on request. If, for example, a cardiologist in one city needs information about a patient from another hospital, he or she sends a request to this hospital. Patient

<sup>3</sup> [http://www.cvz.nl/binaries/live/cvzinternet/hst\\_content/nl/documenten/rubriek+zorgcijfers/geldstromenkaart-awbz.pdf](http://www.cvz.nl/binaries/live/cvzinternet/hst_content/nl/documenten/rubriek+zorgcijfers/geldstromenkaart-awbz.pdf)

information can then be sent by mail or by e-mail. Information exchange between GPs and medical specialists concerning a patient is standardized. A GP almost always receives feedback from medical specialists when a patient was referred. An oversight of information exchange between different health care parties regarding individual client information is given in figure 6. This figure does not include general information exchange. For example, municipalities may ask GPs for general advice on WMO provisions or consult a care office for budgetary advice.



1. Legally, the insurance division and the care office of a health insurance company may not exchange information on individual clients. This does happen in practice sometimes. Information exchange can be necessary to check if some providers are not requesting for compensation from both the care office and the insurance division at the same time (on purpose or by accident). Information exchange for this purpose and others will become legal on January 1 2013.
2. Providers request for compensation regarding individual clients on the basis of DBCs (2006-2011) or DOTs (2012). More detailed information than the DBC- or DOT-codes are not given, such as client's risk of chronic illness.
3. The municipality may not request for individual client information from the health insurer. Four municipalities were investigated in 2011 for requesting too much personal information from clients, such medicine use or the name of his/her specialist.
4. The CIZ sends an indication decision, together with the necessary client information to the care office.
5. The care office sends a request for care in kind, together with the indication, to the relevant provider.
6. When a client applies for services from the WMO, he or she needs to send an official document regarding indication-setting from the CIZ for AWBZ care.
7. When a WMO application is filed by a client, he or she has to give permission to the municipality to collect client information from some other providers.

Figure 6: Information exchange between different parties regarding client information (2012).

On November 1<sup>st</sup> 2008, an initiative for centralizing patient information was launched. An amendment was prepared to promote easy access to a patient's history for general practitioners, pharmacists, and medical specialists. Basically, the drafted amendment would make it possible for GPs, pharmacists and medical specialists to use the patient's Citizen Service Number (BSN) to locate the patient in the information system of another medical professional, after which the patient information in that system would be made available. The BSN is an individual number that is used to make private information selectively available for governmental agencies and institutes, either by law or by explicit permission of the Dutch citizen that the information exchange concerns.

The amendment became known as the law of the "Electronic Patient File" (EPD) and was an amendment to the *Law on the Use of the Citizen Service Number in Health Care* (WBSN-Z). In official terms, the amendment is called the *Amendment to the WBSN-Z Associated with Electronic Information Exchange within Health Care*. Within the Dutch political system drafts become official laws if they pass parliament (*Tweede Kamer*), and the senate (*Eerste Kamer*). The WBSN-Z passed parliament and the senate, and came into force June 1<sup>st</sup> 2008. Starting June 1<sup>st</sup> 2009 the WBSaAN-Z obligated every health care provider, health care insurer and the CIZ to exchange client information using the BSN. The amendment to the WBSN-Z passed parliament on February 19<sup>th</sup> 2009, but was rejected by the senate on April 4<sup>th</sup> 2011.

It is important to note that the amendment to the WBSN-Z would **not** make it possible for nurses, therapists, managers, policymakers, health insurance companies, municipalities, the CAK, the CIZ, or other medical professionals or institutions to access patient information from other information systems than their own. Only general practitioners, pharmacists, and medical specialists would be able to access this information. These medical professionals could only log into other information systems after they identified themselves with a so-called Unique Health Care Provider Identification pass (UZI). Opposed to what is commonly thought, the purpose of the amendment was thus not to establish one centrally administered patient record that is accessible for many different parties within the health care sector.