のしようがないが、Client は医療サービス提供者の「水増し」をチェックできる(2.5 参照)。これが実施に移されるかはまだ確定していない。

4.3.3 長期療養・介護サービス

AWBZ の支出は 1967 年から増え続けている。高齢化が進むにつれて長期療養・介護サービスの受給資格のある Client 数が増え、AWBZ の支出に大きな影響を与えている。しかし RIVM の試算によると、2001 年から 2010 年までの 10 年間は、高齢化による医療サービス費用への影響はわずか 15% 分に過ぎない。それよりも政治的な政策の方が遥かに AWBZ 支出の増大に影響している。1967 年から 2010 年までの間、政策の変更と共に、AWBZ を通じて健康上の問題や疾患が補償される割合がどんどん上がってきた。去年オランダの政策立案者は、一部の医療サービス給付を AWBZ から外し、また長期療養・介護サービスの受給資格を一部変更しようと試みた。以下にここ数年間の AWBZ への重要な変更を紹介する。

- 2008 年 1 月 1 日から、在宅ケアは AWBZ ではなく WMO を通じて支給されることになった。将来的には、更に施設外サービスが AWBZ から WMO に移管される予定である。施設外長期療養・介護サービスを分散させると以下のようなメリットがある。地方自治体は:
  - ケア受給者に簡単にアクセスできる;
  - 地元の長期療養・介護施設の費用と質の情報を得やすい;
  - Client の社会環境や人的ネットワークの情報を得やすい;
  - 予算が限られているために、場合によっては社会支援や長期療養・介護施設の予算を厳しく削減する。自治体は正式な医療・介護施設にたよるよりも削減によって、Client の人的ネットワークの利用を促進できることを認識している;
  - WMO の他の社会支援活動とのシナジー効果を得る。
- 2009 年以降は軽い障害の Client にはカウンセリングは認定されない。
- 政府は誤用を防ぐために、継続して PGB の受給資格を狭めてきた。メディアは年老いた両親を持つ子供たちが、PGB を両親のケアに使わずに一緒に旅行する、という話題を取り上げた。怪しげな営利企業が PGB の申し込み、使用、管理の援助を申し出て顧客の PGB の一部を他の目的に使用した、というニュースも出た。現在 Client は前もって予算を組み、サービスの使用を正確に報告することを義務付けられている。
- VVD、CDA、及び PVV の連立内閣は、知的障害者にかかる AWBZ サービスの費用を削減するため、受給資格を IQ85 から IQ75 に変更しようとしたが、これは Rutte II により拒否された。

4.3.4 社会支援

WMO については 2007 年の発足以来、主だった変更としては 2008 年に在宅ケアが加わり自治体の責任となったことくらいである。これ以外には WMO には大きな変更は加えられていない。この 5 年間は WMO の始動期間であり、この間、政策を変更しても効果がないと実証されたためである。

4.4 増大する医療・介護費用に対応する将来の政策

ここではまずオランダの政策立案者が、医療・介護制度の質を向上させ、効率化を図るために、どのような視点を掲げているか概要を述べ、その後で2013年以降の政策措置を説明する。

4.4.1 長期的かつ幅広い目的

ここ何年にも渡って実行されてきた数多くの政策措置に基づき、オランダ政府の幅広く長期的な目的は以下2点に集約され、今後も継続してゆく見通しである：

1. 正式な制度ではなく、市民自身と友人、家族、隣人などの人的ネットワークがより大きな責任を負担する。
2. 自己責任、医療・介護サービスの受給、そして身近な解決策の間に明確な境界線を引く。

増大する医療・介護費用を抑制するためにオランダ政府が今後採用する政策は、自己責任と積極的社会参加というコンセプトに基づいている。自己責任は自分自身に責任を持つこと、積極的社会参加はコミュニティに住む他の人々についても責任を負担することである。その目的は、オランダ市民の公的医療・介護制度への依存度を減らすことである。

Clientが独立すれば、セルフケアや自助努力の度合いが高まり、またClient自身がより良い意思決定をするようになり、医療･介護サービスへの要求が少なくなる。政策措置の一つは、医療・介護サービスと住居を完全に切り離そうとしている。例えば、かつての連立内閣Rutte Iは入院した日数分、入院費用を自己負担とする計画を立てた。又､AWBZの長期的目的では、居住費は給付からはずされる(AWBZから支給されるのは長期療養･介護サービスのみであり、住居ではないという考え方である)。優れた医療・介護サービスへのアクセスは権利とみなされるが、居住費の補償はそうではなく、少なくともその一部を支払うのは個人の責任である。

積極的社会参加は主に家族介護者、親戚、友人、隣人からの支援が中心となる。政府は家族介護活動を活発化させることによって、医療・介護サービスの規模を縮小しようと試みている。例えば、治療後の院内リハビリテーションへの給付を縮小し、回復はClient自身の社会的ネットワークを利用した迅速かつ親身な世話に委ねる。入院の平均日数を減らせば、費用を抑えることができる。同様に、在宅ケア給付も受給資格を厳しくし、Clientの友人、隣人、親戚などが生活の基本的活動を支援するように仕向ける。

前頁の2.については、政府はここ何年もの間、医療・介護に関する法律や公的給付が、自己責任と公的医療・介護の受給資格とのバランスを取りながら、財政上も法律上も効率的な制度となることを望んできた。簡潔にいうと、Client自身とその社会的ネットワークが施設、住居、個人サービス、社会支援の形態、その他のケアや援助活動の需要と供給について、**一義的な責任**を担うということである。Clientが財政状況、健康状態、社会的ネットワークの事情によって責任を担うことができない場合のみ、公的枠組みを通じてケアや援助活動を提供すべきである。

結論を述べると、現在の政府はAWBZを10年かそれ以上の長い時間をかけて完全に撤廃したいと考えている。それには一段一段ステップを踏んでゆく必要がある。第一に、現在AWBZが支給している個人サービス、カウンセリング、デイケア・サービス、その他のサービスをWMOに移管する。これらはより社会支援に近く、Clientの社会的ネットワークから供

給できるはずである。つまり国やAWBZの官僚制度よりも、地方自治体の方がこれらのサービスの手順や支給に適している。このことは、**身近な解決策を持っている**とみなされるClientは、このような形でケアや援助を得る**資格**がなくなることを意味する。第二に、短期・長期入所の施設、設備(“hotel costs”)の準備や補償は本来Clientの責任とみなされ、公的資金からははずされる。第三に、ナーシング・ケアは長期療養・介護サービスや社会支援よりも医療サービスに近いため、ZVWを通じて支給される。

4.4.2 2013年の政策措置

ここでは、2013年以降の医療・介護保険制度における政府方針の変更について述べる。政府は短期的な政策措置については、徹底的に検討している。まず、長期的な変更について述べてから、医療・介護保険制度で最も重要な変更を定義する。以下は2013年に発効される医療・介護方針の変更である：

- 2013年から、保険会社のCare OfficeはClientが住む地域に関係なく、その保険会社の全てのClientに対して責任を持つ。2013年以前は、保険会社は最も大きなシェアを持つ地域においてCare Officeを設置し、在住する全てのClientに対して法的責任を負っていた。2013年はその過渡期である：今までのCare officeは2013年以前に活動した地域もカバーする。保険会社は自分たちがCare Officeとして機能できるようになるまで、2013年以前にAWBZサービスに責任を持っていたCare Officeにその機能を委託する。
- 新規の認定の場合、2012年以前では低レベルのAWBZ施設サービス(ZZPレベル 1か2)の受給資格が得られたケースでも、これからは施設外サービスしか利用できなくなる。但し、2013年以前に低レベルの施設サービスの認定を受けている場合には、近い将来それが消滅することはない。
- AWBZ (ZZP 9)のリハビリテーション・サービスは、ZVWに移管される。リハビリテーション・サービスはその本質からいって短期的であり、ケア・セクターよりも治療セクターが相応しい。
- AWBZサービスのClientの自己負担金額は値上げされる。
- AWBZにおいて、PGBの受給資格者が増える。政府は、Clientの家族と民間の長期療養・介護仲介業者がPGBを誤用した報告を受け、2011年と2012年に受給資格を一旦厳しくした。
- 医療サービスの免責額が ± 60% (€220から €350)値上げされる。
- ZVW、AWBZ、WMOの医療保険基本パッケージでは歩行器、zimmerframes、松葉杖、杖は補償されず、またAWBZを通じて用具を借りることはできない。

4.4.3 2013年以降の施策(暫定)

医療サービス

- 2014年には、Clientが救急救命科に連絡しても実際には救急措置が必要でない場合には、€50の負担金が課されることになる。この政策措置はClientの自己主張からくる余分な医療給付を削るのが目的である。
- Rutte IIが当初計画した、医療保険料を所得比例にする構想は見送られた。現在の長期的計画は、保険料ではなく免責額を所得比例にするという構想である。

長期療養・介護サービス

- 長期的にはCare Officeは廃止され、保険会社がClientの医療及び長期療養・介護サービス(ZVWとAWBZ)を補償する責任を担う。ClientにとってはZVWとAWBZサービスの受付デスクが一つになる利便性がある。また保険会社にとっても、Clientが既に自分の情報システムに登録されているため、彼らがAWBZに申し込んだ時も新しい情報を集めずに済む。新しい制度では、保険会社がCare Officeの代わりに長期療養・介護サービス提供者となる。
- 4.4.2で述べたように、低レベルの施設外サービス(ZZP 1及び2)は2013年に廃止される。低レベルの施設サービスの受給資格者は、施設外サービスの認定のみとなる。2014年と2015年には、それぞれZZP 3と4にも同様の措置が取られる。
- 2014年からデイケア・サービス(カウンセリングの一部)はAWBZでは補償されなくなる。
- 2014から期間が6ヵ月以下の個人サービスは認定から外される。
- 2015年には全ての施設外個人サービスとカウンセリングは地方自治体に移管される。4.4.1で述べたとおり、全ての社会支援はAWBZの手を離れ、WMOの管轄となる。自治体の財政は厳しいため、Clientが施設を含む社会支援給付の受給資格を得ることが少なくなり、医療サービス費用を圧縮することができると予想されている。政策立案者は、個人サービスとカウンセリングをWMOに移管することにより、AWBZの費用を25%削減しようと考えている。考え方のベースとなるのは、ナーシング・ケアは長期療養・介護セクターや社会支援セクターよりも治療セクター(医療サービス)に適しているというものである。

社会支援

- 2014年以降、在宅ケアの受給資格は完全な所得比例となる。自治体はこのようなサービスを比較的低所得者にしか提供せず、それ以外のClientは自分で掃除や食料品の買い出し等の方法を見つけることになる。この削減は2014年に在宅ケア受給資格を得た者のみに適用される。但し2015年には、既に在宅ケアを受給している全てのClientに適用される。

The Dutch health care system

Part 2: Organizations, information-sharing, payment structures, and increasing health care expenditure

Report for the Institute of Future Welfare Japan 2012/2013, by

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ON VITALITY AND AGEING

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Foreword

Before you lies the second report by the Leyden Academy on Vitality and Ageing on the Dutch health care system, written for the Institute of Future Welfare in Japan. In this report the focus lies on:

- the different institutions supporting the Dutch health care system;
- systems of communication and information-sharing between health care providers;
- systems of payments and incentives in the health care system, and its strengths and weaknesses;
- past, current and (potential) future ways of dealing with population ageing and increasing health care expenditure (cutbacks and increasing efficiency).

Before continuing with these subjects, we first want to clarify some important terms and recent changes in the health care system. We use the term medical care to specify all the care that was delivered within the confounds of the ZVW. Medical care thus pertains to care given by general practitioners, medical specialists (or other hospital care), allied health care, dental care, and others. We use the term long-term care to specify all the care that was delivered within the confounds of the AWBZ. Long-term care can refer to personal care, nursing care, treatment by nursing home doctors and nurses, and residence for the frail elderly, mentally ill, or handicapped. Medical care and long-term care is separated from social support. Social support is officially not a part of the Dutch health care system, but rather a law that ensures the Dutch can be independent, socially active, and that they feel mobile, safe and satisfied in their neighbourhood or village. In the report, social support mainly refers to domiciliary care (housecleaning, grocery shopping, etc.), provision of instrumental aids (wheelchairs, scoot mobiles), adjustments in the house, support to informal care-givers and voluntary workers, and other initiatives to improve the social and personal wellbeing of older clients.

This report is written in a time of economic and political turmoil in the Netherlands. In the last few years, as well as the coming years, many changes will take place in the Dutch health care system. For example, important changes already took place in the AWBZ and more changes have yet to come. AWBZ care no longer includes domiciliary care (from 2008), because it relates more to social support than long-term care. Rehabilatition will be transferred to the ZVW (from 2013), and personal care and counselling will also become part of the WMO (starting from 2015). We anticipate future changes in the AWBZ, since population ageing is expected to cause increasing pressure on available care staff and collective finances. Our new government (installed in November 2012) has announced new changes. These changes mainly entail a decrease in the number of people who are eligible for AWBZ care, as well as a focus on independent living and active citizenship.

The list of abbreviations in the next section might aid the reader in coming to grips with the many laws, systems and institutions, as well as its abbreviations. As in the first report, patients, health insurance consumers, and those eligible for AWBZ and WMO will be called clients in this report. And of course, similar to the first report, if any questions remain unanswered, or the reader needs further information, the Leyden Academy is more than willing to answer them.

Herbert Rolden & Marieke van der Waal

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General abbreviations

AIO	Supplementary Income security for the Elderly	*Aanvullende Inkomensvoorziening voor Ouderen*
AIS	Information System for Pharmacists	*Apotheek Informatiesysteem*
AOW	State pension law	*Algemene Ouderdomswet*
Anw	Surviving relatives pension	*Algemene nabestaandenwet*
AWBZ	Exceptional Medical Expenses Act	*Algemene Wet Bijzondere Ziektekosten*
AZR	AWBZ Care Registration	*AWBZ-brede Zorgregistratie*
BKZ	Budget for Health Care	*Budgetair Kader Zorg*
BSN	Citizen Service Number	*Burgerservicenummer*
CAK	Central Administration Office	*Centraal Administratiekantoor*
CBP	Dutch Data Protection Agency	*College Bescherming Persoonsgegevens*
CBS	Central Bureau for Statistics	*Centraal Bureau voor de Statistiek*
CIC	Compliment for Informal Care-givers	*Mantelzorgcompliment*
CIZ	Centre for Needs Assessment	*Centrum Indicatiestelling Zorg*
CVZ	Health Insurance Board	*College voor Zorgverzekeringen*
DBC	Diagnosis Treatment Combination	*Diagnose Behandeling Combinatie*
DOT	DBC On the way to Transparency	*DBC op weg naar Transparantie*
GP	General Practitioner	*Huisarts*
GPC	General Practitioner Center*	*Huisartsenpost*
GuWA	Data exchange WMO-AWBZ	*Gegegevensuitwisseling WMO-AWBZ*
HIF	Health Insurance Fund	*Zorgverzekeringsfonds*
HIS	Information System for GPs	*Huisartsen Informatiesysteem*
LSP	National Switching Point	*Landelijk Schakelpunt*
NZa	Dutch Health Care Authority	*Nederlandse Zorgautoriteit*
PGB	Personal Budget (from the AWBZ or WMO)	*Persoongebonden Budget*
RIO	Regional Indication Office	*Regionaal Indicatie Orgaan*
RIVM	National Institute for Public Health and the Environment	*Rijksinstituut voor Volksgezondheid en Milieu*
SSP	SVB Service Center for PGB	*SVB Service Centrum voor PGBs*
SVB	Social Insurance Bank	*Sociale Verzekeringsbank*
UZI	Unique Identification of Health care provider	*Unieke Zorgverlener Identificatie*
VWS	Public Health, Welfare, and Sports	*Volksgezondheid, Welzijn en Sport*
VZVZ	Alliance of Health care providers For Health care Communication	*Vereniging van Zorgaanbieders Voor Zorgcommunicatie*
WBSN-Z	Law on the Use of the Citizen	*Wet Gebruik Burgerservicenummer in*

	Service Number in Health Care	*de Zorg*
WMG	Law on Market structuring Health care	Wet Marktordening Gezondheidszorg
WMO	Social Support Act	*Wet Maatschappelijke Ondersteuning*
ZIS	Information System for Hospitals	*Ziekenhuis Informatiesysteem*
ZVW	Health Insurance Act	*Zorgverzekeringswet*
ZZP	Care Weight Package	*Zorgzwaartepakket*

*A GP centre is a central GP practice that is open for emergency doctor visits outside regular clinical hours (regular clinical hours are usually workdays 8.00 – 17.00).

Dutch branch organizations in health care

Actiz	Branch organization for health care entrepeneurs
Federatie Opvang	Branch organization for shelters for the homeless, victims of domestic violence, and other vulnerable population groups

GGZ	Mental Health care association	*Geestelijke Gezondheidszorg*
KNMG	Royal Dutch Corporation for the promotion of Medicine	*Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst*
KNMP	Royal Dutch Corporation for the promotion of Pharmacy	*Koninklijke Nederlandse Maatschappij ter bevordering der Pharmacie*
LHV	National General Practitioners' Association	*Landelijke Huisartsen Vereniging*
NVZ	Dutch Assocation of Hospitals	*Nederlandse Vereniging van Ziekenhuizen*
VGN	Association for Handicapped care in the Netherlands	*Vereniging voor Gehandicapten-zorg Nederland*
VHN	Association of General Practice Centers in the Netherlands	*Vereniging Huisartsenposten Nederland*
VNG	Association of Dutch Municipalities	*Vereniging van Nederlandse Gemeenten*
ZN	Health Insurers in the Netherlands	*Zorgverzekeraars Nederland*

1. Institutions concerned with coordinating and or financing health care

The following institutions are at least in some way concerned with establishing, promoting or organizing health care in the Netherlands. Institutions directly related to health care provision, such as general practices, hospitals or residential homes, are not included. These institutions were described in the first report, but are explained more thoroughly below on request by the Institute of Future Welfare Japan.

1.1 Central Administration Office (CAK)

The CAK has three main tasks:

1. Establishing, imposing and collecting compulsory deductibles for AWBZ care and WMO support. The compulsory deductible for AWBZ care is based on a client's income (wages, state pension, private pension, and/or interest on capital), family situation (living with or without a partner, either intramural or extramural), and the AWBZ indication applicable to the client.
2. Establishing and paying compensatory fees for the chronically ill or handicapped, with the aim to cover part of the compulsory deductible of the ZVW or other expenses. Chronically ill and disabled people can incur exceptionally high health care costs, and almost always pay the full compulsory deductible every year. The reason to levy compulsory deductible is to discourage Dutch citizens to overuse health care facilities, but since the chronically ill and disabled cannot choose to forego health care utilization, the compulsory deductible has no effect on them. Stronger still, without compensatory fees the compulsory deductible would further widen the income gap between disadvantaged and healthy citizens, which is exactly the opposite of what the Dutch government is trying to achieve with the ZVW.
3. Financing health care providers who provide AWBZ care. The CVZ administers the AWBZ fund. Inflow in the AWBZ fund comes from Dutch citizens with a taxable income, outflow goes to the CAK. The CAK disperses the fund to the different health care organizations, clients, and health care providers (by order of the care offices, who receive the bills from health care providers).

The CAK was founded in 1968, one year after the AWBZ was introduced. The aim with establishing the CAK of the Dutch government was to outsource the effectuation of some laws for which the Ministry of VWS is responsible. Currently, around 1,100 employees work at the CAK.

1.2 Centre for Needs Assessment (CIZ)

The CIZ is the only institution who can set indications for citizens wanting to receive AWBZ care. Without an indication from the CIZ, one cannot receive AWBZ care. Either the client him-/herself, or an employee from a health care provider, may fill in a request for a CIZ indication. The CIZ judges a request on the basis of a "funnel" model, which is explained in detail in the first report.

The CIZ can also be requested by municipalities to set indications for the WMO. Officially, the branch of the CIZ that sets indications for the WMO is called *MO-zaak*. The employees of MO-zaak may use information on a client's information and indications regarding the AWBZ

from the CIZ, but only with the explicit permission from the client. In this report, we will refer to the CIZ as an organization that can set indications for the WMO, rather than MO-zaak.

Its main office is in Driebergen, a village centrally located in the Netherlands. There are 10 regional offices in the Netherlands. These regional offices set the CIZ indications and notify the concerned care offices of a new indication, or a change in a previously set indication. The CIZ has around 1,700 employees and was established in 2005. Before 2005, Regional Indication Offices (RIOs) were responsible for setting indications.

1.3 Health insurance board (CVZ)

The CVZ has three major tasks:

1. Providing money from the Health Insurance Fund (HIF) and the AWBZ fund to health insurance companies, the CAK and care offices. Medical care providers bill health insurers, and long-term care providers bill care offices for provided health care. These expenses are covered by the different fees and premiums that Dutch citizens and employers pay. Employers and government agencies paying social benefits, deposit the income-related fees in the HIF and the AWBZ fund. The CVZ administers the HIF and the AWBZ fund. Health insurers also receive compensation from the HIF if they have more high-risk clients (risk equalization).
2. Advising the Ministry of Health, Welfare and Sports on the specific content of the basic health insurance package. Based on scientific findings and societal developments, the CVZ weighs different arguments from health care, societal and financial perspectives, and produces an advice on the content of the package. The Ministry of Health, Welfare and Sports often follows this advice.
3. Giving standpoints on disputes. For example, on April 2 2012 the CVZ gave its official standpoint on whether or not physiotherapy should be compensated through the ZVW for patients with COPD.

1.4 Dutch Competition Authority (NMa)

The NMa is an independent government institution aimed to promote free market dynamics in different economic sectors, to the benefit of Dutch consumers. It checks whether there are no cartels or instances of market power misuse. It also stimulates free market dynamics in transportation and energy. These are economic sectors where there is no free market system yet. The direct aims of the NMa is to implement and monitor compliance with market legislation originating from the different ministries (mainly the Ministry of Economic Affairs). To realize these aims, the NMa performs different activities:

- Providing advice for policy-makers and legislators. The NMa also invests in research to remain up to date with changes in different markets.
- Providing information concerning market regulations to companies, mainly with lectures, conferences, and booklets. A company can ask the NMa to issue a provisional statement on a situation, if the company is unsure whether any competition laws are broken.
- Investigating whether any laws are broken by companies. The NMa is watching companies and other market players, to ensure mergers comply with competition laws, and no cartels are formed or market power is misused.
- Ensuring offenders receive a penalty. Offenders will receive a fine dependent on a the company's turnover.

Box 1: An example of NMa activities

2010: NMa inspects hospitals on suspicion of forming a cartel
In the beginning of 2010, the NMa inspected two hospitals in Amsterdam, who where suspected of forming a cartel. Patients reported that they might have been referred from one hospital to the other on the basis of their residential area. When health care providers make agreements to "divide the market" they are overstepping the boundaries of the law. The NMa could not conclude on the basis of these visits that the two hospitals were forming a cartel, but the NMa did find that sensitive information was exchanged between these two and other hospitals. This sensitive information consisted of statistical information on characteristics of the patient population. The NMa found that exchanging such information can lead hospitals to change their market strategies, or to use this information when negotiating contracts with health insurers. Together with the hospitals, the NMa established a set of rules and protocols on the exchange of sensititive information.

1.5 Dutch Health care Authority (NZa)

The core task of the NZa is to regulate the free market system of health care in the Netherlands. It is entitled to issue policy rules – which are lawfully valid – concerning prices for health care services and codes of conduct. The NZa makes sure that the freedom of health care providers and insurance companies within the free market system is used to the benefit of the people. More specifically, the NZa is concerned with the following activities:

- Controlling whether health insurance companies and health care providers comply with three laws: the AWBZ, WMG, and ZVW.
- Controlling whether health insurance companies and health care providers do not attain "considerable market power" ("*aanmerkelijke marktmacht*"). A company reaches such a level of power if it can act against the interest of th Dutch clients without interference from potential competitors. The NZa will issue strict regulations for companies that have attained considerable market power.
- Controlling whether clients are well informed (correctly, clearly, and completely) about financial or health care matters by insurance companies and health care providers.
- Issuing official standpoints on mergers in the health care market to the NMa.
- Effectuating generic rules to ensure competition. In this case, no specific market parties are addressed, but generic rules are applied to benefit multiple parties. For example, the NZa decided that (new) market players may not be obstructed in accessing IT infrastructures or electricity networks.
- Setting budgets and tariffs for that part of the health care sector that does not function as a free market. The NZa sets the maximum tariffs for prices that long-term care providers may bill providers of AWBZ care. For example, in 2012 long-term care providers could charge no more than € 46.65 for one hour of extramural personal care (without extra modules).

Three real-life examples of activities by the NZa are displayed in box column 2 below.

Box 2: Examples of activities by the NZa

November 2 2012: NZa gives an official standpoint on three hospital mergers
The NZa issued the statement that three planned mergers of six hospitals could lead to increased prices for medical care services with freely negiotable fees (DOTS in the B segment, see paragraph 3.2.2). Because the mergers will increase the market power of the hospitals, they can set higher fees for medical services, which is against the interest of Dutch citizens. The hospitals concerned in the three mergers are:

- *Orbis Medical Care Concern* and *Atrium Medical Centre Parkstad* (South-Limburg). Estimated price increase: 4-9%.
- *Spaarne Hospital* and *Kennemer Infirmary* (Hoofddorp and Haarlem): 9-18%
- *TweeSteden Hospital* and *St. Elizabeth Hospital* (Tilburg): 22-33%.

These estimated price increases were calculated by the NZa with simulation models. The Dutch Competition Authority (NMa, see paragraph 1.4) will agree on a "price ceiling" with the hospitals, and it will check if the hospitals comply with these price ceilings. The NZa can intervene when the NMa reports a transgression, or when a hospital misuses attained market power in any other way.

October 3 2012: The NZa improves regulation for diagnostics in primary care
The NZa issued a policy rule for diagnostics in primary care, effective January 1 2013. Through this legislation health insurers and health care providers will be stimulated to improve the quality and cost-effectiveness of diagnostics in primary care. In essence, the policy rule merges different parts of other former policy rules, and offers a new definition of what officially counts as primary care diagnostics. Thereby, the NZa offers health insurers and health care providers a foundation for negotiation procedures. The health insurer is able to ensure quality and cost-effectiveness by rejecting unnecessary diagnostics and being able to negotiate contracts with those providers who offer the best price-quality ratio.

September 27 2012: The NZa establishes rules and prices for DOTs in hospital care for 2013
By issuing regulations for policy, the NZa sets performance criteria and maximum prices for complex university hospital care from medical specialists. This applies to the B segment of hospital care (see paragraph 3.2.2). The main improvement of these new policy rules is that compensation for medical specialists is revised to better reflect daily clinical practice. A sample of medical specialists was asked to adjust average treatment times for complex procedures, if necessary. New compensatory fees were calculated on the basis of these new average treatment times.

1.6 Social Security Bank (SVB)

The SVB pays out benefits to over 5 million Dutch citizens. Benefits that are relevant for older people are summarized and explained below.

State pensions (AOW)
Everybody above 14 years of age, and living in the Netherlands, builds up 2% compensation through the state pension. This means that when someone has lived in the Netherlands throughout life after 14 years, he or she will have built up 100% AOW benefits at the age of 65. In the coming years, the retirement age will slowly increase to 67. The amount of the

AOW benefit depends on a person's living situation, and will vary between €587.86 and €1,291.12 (net worth).

Supplementary Income security for the Elderly (AIO)
The "social minimum" is the lower limit of someone's income, below which a person is not able to sustain him- her herself. If someone is 65 years or older, has not built up a full AOW benefit and does not receive much additional benefits or income, this person may end up with an income below this social minimum. In that case, this person will be eligible for receiving a supplementary benefit, or AIO.

Surviving relative pensions ("Algemene nabestaandenwet", Anw)
Through the Anw every Dutch citizen is entitled to receive benefits (70% of the minimum wage) when someone next of kin dies (partner, parent, or sister/brother). To be eligible for compensation, the following conditions must apply: the receiver

- was married to the deceased, received alimony from the deceased, or was living together with the deceased;
- does not receive AOW;
- meets one of the following criteria: is either born before 1950, cares for a child under 18 years, or is at least 45% incapacitated to work.

Personal budgets for the AWBZ and WMO
If a person is eligible for care or support through the AWBZ or WMO, he or she may decide to receive a monetary compensation instead of care in kind. Officially, the SVB pays out these personal budgets (PGBs) by order of the care offices or municipalities. To keep it simple, we will keep the SVB out the remainder of this report. Instead, as is common in reports on the Dutch health care system, we will state that care offices or municipalities directly transfer PGBs to clients.The SVB Service Center for PGB (SSP) can help PGB-receivers with their administration free of charge.

Compliment for informal care-givers (CIC)
If someone provides intensive care for a long duration to another person or other persons, he or she may be eligible for receiving a "compliment". This compliment was €200 in 2012. An informal care-receiver has to nominate the informal care-giver for this compliment.

Benefits for people below 65 years of age

- Child benefits
- Compensation for parents of a handicapped child living at home
- Compensation for asbestos victims

2. Information-sharing in the Dutch health care system

2.1 Information-sharing within the ZVW

Especially in the medical care sector, quality of care is greatly dependent on health care providers' timely reception of crucial and complete information concerning clients. However, the use of information systems to obtain and sustain such effective information-sharing between health care providers may not conflict with privacy rules and regulations. When legislation for the national electronic patient file was put to a halt by the senate in 2011, privacy concerns played a major role. Also, since competition between health care providers is stimulated, they might not be inclined to share information. It is therefore of utmost importance to establish solid legislation as well an efficient infrastructure to manage information-sharing between medical care providers. Here, current and potential future information flows and information-sharing platforms in the health care market of the Netherlands are defined and explained.

2.1.1 Legislation concerning information-sharing[1]

Legislation basically stipulates that sharing information about personal data, health status and health care utilization is illegal, unless certain conditions apply. This is a consequence of the "duty of confidentiality" that every health care professional and institute has. The premise of this duty of confidentiality is that health care professionals and institutes cannot share private information of clients (in particular their health status), health related matters that have been discussed in the consultation room, as well as (medical) treatments that have been prescribed. However, the duty of confidentiality may be overruled, but only in certain situations. These situations can be categorized into roughly four cases:

1. *Force majeur:* Other laws have priority over the duty of confidentiality. When no consent has been given by the patient to share information, but a threat to the patient or others exist, a health care professional may be obliged to serve a greater cause and overrule the duty of confidentiality. The following five conditions must all apply in this case[2]:
   - Upholding the duty of confidentiality causes harm to one or more people.
   - All means to receive consent from the patient have been used to no avail.
   - The health care professional is struggling with a moral dilemma by upholding the duty of confidentiality.
   - No other means than overruling the duty of confidentiality are available to face the threat or problem in question.
   - Overruling the duty of confidentiality will almost certainly solve the threat or problem.
2. The information that is shared is required by other health care professionals directly involved in the treatment relationship with the patient, such as colleagues, nurses, and assistants.

[1] Two major laws apply to privacy regulation in health care: the "Law on treatment relationships in health care" (Wgbo: *Wet inzake geneeskundige behandelingsovereen-komst)* and the "Law on protection of personal data" (Wpb: *Wet bescherming persoons-gegevens).* For the use of citizen service numbers (BSNs) by health care professionals, the WBSN-Z is applicable (see also paragraph 2.2 of the first year report). Other laws are: the "Law on quality of health care institutes" (*Kwaliteitswet zorginstellingen*) and the "Law on professions in individual health care" (*Wet op de beroepen in de individuele gezondheidszorg*).

[2] These conditions are based on protocols issued by the KNMG.

3. Patient consent to sharing information can be reasonably assumed, since the receivers of patient information are automatically involved in the treatment process, and the patient is almost certainly aware of this. In this case, patient consent is implicit. For example, when a GP refers a patient to a medical specialist, the patient may reasonably assume that a referral letter will be sent, containing information on the patient's health status and current/past (medical) treatments.
4. The patient has explicitly granted the health care professional or institute the authority to share information with specific other professionals or institutes.

In short, if a third party needs information from an institute or a health care professional on a client's health status or medical treatments, but there is (1) no imminent threat characterized by the five conditions described above, (2) no direct treatment-relationship between the professional/institute, the client and the third party, and (3) one cannot reasonably assume that a patient gave implicit consent to information-sharing, the only legal way to share information is to receive explicit patient consent. Regardless of which of the four situations applies, when medical information is shared it is crucial that only the **minimum required information** is shared. The sharing of information which any professional or employee should deem irrelevant, is also illegal.

Although the importance of privacy protection is clear, there are two major downsides to the application of these laws:

- Legal boundaries are not always clear, especially concerning point 3 about reasonable assumptions. For example, when a client applies for a CIZ-indication, it might be reasonable to assume that the client gave implicit permission to a CIZ-employee to receive information from one or more health care professionals that he/she has a treatment-relationship with. However, CIZ-employees are not allowed to acquire this information without explicit patient consent.
- Patients might not be fully aware of the consequences of giving their consent. Currently, some medical care providers are working with national and regional switching points, for which explicit patient consent is required (see 2.1.3 and 2.1.4). Opponents of these initiatives claim that although patients may easily consent to be included in these platforms, they are not able to grasp the dangers of cybercrime or unscrupulous personnel.

2.1.2 AIS, HIS and ZIS

The AIS, HIS and ZIS stand for information system used by pharmacists, general practices and hospitals respectively. In principle, every health care provider collects its own individual client data. Collected are: the client's name, BSN (citizen service number), address, date of birth, health insurer, possibly a specific health insurance number, and possibly other important personal data. Medical data about a client is linked to this personal data. Only authorized personnel of a health care provider may log into the information system to track individual client data.

The pharmacist collects information about medication history, current medication use, and allergy information. The hospital collects data about visits and results from tests, such as scans or lab work. In most hospitals medical information is collected as a paper file and archived, and only some medical information is stored electronically. For example, scan images are not saved in an information system in all hospitals, although this is changing fast. The GP collects data about patients' illnesses and somatic/ psychological ailments, prescribed medication, lab results, and so on.

When a medical specialist starts a new treatment or finds important new test results, the GP is usually informed by letter. Unfortunately, these letters can arrive late or even not at all. Also, if a GP needs more (specific) information, communication back and forth has to be established, which can cause further delays. It is not uncommon that a GP is not up-to-date with his/her patient's health and treatment status. In the Netherlands, the GP plays a central role in health care; he is called the "gate-keeper to expensive specialist care" and is expected to be fully informed about his patient's health status and wellbeing. This is why discussions currently take place on more effective communication or information-sharing between different kinds of health care providers in the ZVW.

In April 2011, the Dutch senate voted against the implementation of a national electronic patien file (EPD). See the first report for more details. Since then, better communication within the ZVW is expected to come from regional EPDs and/or an alternative national infrastructure, called the National Switching Point (LSP). These two initiatives are explained below.

2.1.3 National Switching Point (LSP)

Before the law for a national EPD was rejected, an IT infrastructure was already put into place to bring the national EPD into effect. After the law was rejected, the Ministry of VWS withdrew from the EPD project. In January 2012, the newly established *Alliance of Health care providers For Health care Communication* (VZVZ) brought different health care institutions together for a renewal of the project. The VZVZ is an alliance of four umbrella organisations in health care provision and Nictiz, and is supported by the Dutch Patient and Consumer Organisation (NPCF). Nictiz is the National ICT Institute for Health care in the Netherlands. The four umbrella organisations are the branch organizations for general practitioners (LHV), general practice centers (VHN), pharmacists (KNMP), and hospitals (NVZ). Exchanging medical information through the LSP is in accordance with privacy legislation and laws concerning the relationship between health care provider and patient. The start of the LSP-project in October 2012 was approved by the Dutch Data Protection Agency (CBP).

The LSP makes instant access to basic and important medical information possible, mainly in emergency cases. GPs and pharmacists who collaborate with the LSP ask for written permission by their patients to include their personal information in the national information system. **This personal information concerns only the patient's BSN, and the identity of the patient's treating GP and pharmacist. Medical information on treatments, medication use, allergies, and so on, are not stored in the LSP.** This is why the installment of the LSP is not called an electronic patient file (EPD), but can, instead, be called a shared health care IT infrastructure.

Only a substituting GP, GP center, pharmacist or a medical specialist who is currently seeing the patient, may track a patient's personal information (BSN and treating GP and pharmacist). When the patient's personal information is retrieved, the medical care professional may log into the information system of the patient's GP or pharmacist and retrieve the medical information that is separately stored there. This separately stored medical information consists of a basic summary of the most important aspects of the patient's medical history, and does not comprise the complete patient file. If a client has not given explicit permission to be opted in, the substituting professional or medical specialist cannot see this medical information.

A health care professional may only log into the LSP with an UZI-card, an UZI-card reader, and with the right certifications. The UZI-card is used in the following way:

1. The medical professional tries to locate his or her patient in the LSP search engine on the basis of the patient's BSN.
2. The medical professional logs in with a password and the use of a UZI-card, a card that looks like a credit card. The UZI-card grants the user authority to access patient information, depending on the region and the profession of the user.
3. When the identity of the client and the user of the LSP is confirmed, the user may access the database of other health care providers. The user may than only see a summary of medical information about the selected patient.

2.1.4 Regional IT infrastructures for medical care communication

Different forms of regional collaborations already exist, and the Minister of Health, Welfare and Sports has issued the statement that further investigation in the systematic legislation of regional collaborations should be encouraged. An important objection to a national EPD for members of the senate was that thousands of medical professionals could retrieve extremely sensitive information about any person in the Netherlands. With a regional collaboration, only a couple of involved medical professionals can retrieve sensitive information, decreasing the chance of misuse by medical professionals or cybercriminals.

Regional collaborations on information-sharing can use a so-called Regional Switching Point (RSP). Similar to the LSP, the RSP offers a webportal where a medical professional can find a patient's personal information. On the basis of this information, the professional can, with the use of an UZI-card and -reader, look for basic medical information in another health care provider's information system. The difference with the LSP is that the RSP only offers personal information about patients from cooperating health care providers in a certain region, and not from all cooperating health care providers in the country.

Regional collaborations can also take other forms. In this case, no RSPs with UZI-cards are used, but other agreements are made.

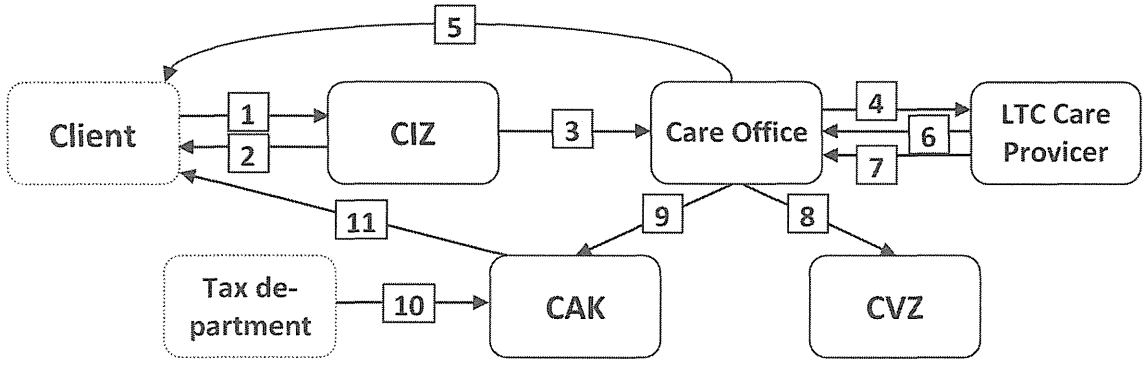
- Electronic File for Substituting GPs (EWH): If an EWH is active in a region, only a substituting GP will have access to the patient's medical records, or a basic summary of the medical records, if the patient is visiting. A substituting GP can be an assigned substitute or a GP from an emergency medical centre in the region. When a patient has a GP who is a part of an EWH, he or she is automatically included in this system, unless the patient signs a form in which he objects to information-sharing of this nature (opt-out system). In the province of Friesland, a broad EWH is used by 63 GPs (2008), giving GP centres in towns/cities like Heerenveen, Drachten, Leeuwarden and Dokkum the opportunity to access important patient information.
- Electronic Medication File (EMD): An EMD shows a patient's medication history. All pharmacists who are part of the regional collaboration may record medication provision to the patient, and look into the medication file. Because specialists also prescribe medication and patients don't always take their prescribed medication, the GP also has access to the EMD in some cases. In some instances specialists in regional hospitals may have access to the medication file, but only if the specialist is actually treating the patient. To give an example, GPs in Zoetermeer and Benthuizen have access to an EMD. Some specialists in a hospital closeby (*'t Lange Land*), also have access to this EMD.

2.2 Information sharing within the AWBZ

The AWBZ Care Registration system (AZR) is the information-sharing platform for the different institutions active in AWBZ care. The CIZ, the CVZ, the CAK, the different care offices,

and long-term care providers have access to AZR. AZR is an information system that displays client-level information regarding AWBZ care. Figure 1 shows how the information flows through AZR. The numbered information flows in the figure, are explained below the figure.

Figure 1: Information-sharing between the different institutions active in the AWBZ (Source: Plexus)*



** The client and the tax department in this figure are circled with a dotted line, which means they are not allowed to access AZR.*

The different information flows in figure 1 are:

1. The client, or someone acting on behalf of the client, makes a request for an indication at CIZ. A request can be made digitally, or by letter or telephone. Most often, a form is sent to the client when a request has been made. After filling in the form, a CIZ employee can call or visit the client, or contact a health care professional treating the client, to receive a more detailed picture of the client's situation.
2. The CIZ sets an indication and sends the indication decision in a letter to the client.
3. The indication decision is also sent to the care office that is responsible for arranging AWBZ care in the region where the client lives.
4. The care office appoints a long-term care provider to the client, dependent on the care demands and personal preferences of the client.
5. The care office sends a letter to the client, in which the appointed long-term care provider is mentioned.
6. The long-term care provider reports the date that long-term care started, changed or ended in the AZR system.
7. At the end of the year, or when care for the client has ended, the long-term care institution bills the care office.
8. The care office sends information on the (potential) waiting lists at different long-term care providers to the CVZ.
9. The care office redirects information concerning the start, change or end of long-term care provision (see point 6) to the CAK.
10. The CAK receives information on the client's income status from the tax department.
11. The CAK calculates the compulsory client contribution for received AWBZ care on the basis of the information from the care office and the tax department.