[xi] In 2009, during the reading of these cards, the rise of rights by billing software caused an error on the date of birth; children born after 31 December 1999 saw a century added. The specifications of SESAM –Vitale Version 1.40 explained: "The software must allow the healthcare provider to change the century of birth, because in some cases the function of reading a Carte Vitale recovered an incorrect date of birth. In effect, the beneficiaries under the age of 16 whose quality Carte Vitale card is different from "child" are considered as adults by the function "Reading Vitale law". In this case, the age of birth is wrong." This bug generates billing. We must systematically correct this date of birth manually to add the specific quotations to increase infant and child (majoration nourrisson (MNO) et enfant (MGE) respectively). In addition, the child is considered out of the "care pathway".

[xii] As of September 30, 2007, some European pensioners living in France had their *Carte Vitale* removed for administrative reasons. The *CPAM Hautes-Pyrénées* stated: "According to the decree of 21 March 2007", under a European directive of 2004, "any non-active community resident located on our territory, and not eligible to receive or continue to receive European rights on presentation forms such as E106 or E121, cannot receive Social Security but must contract with a private insurance. Therefore, kindly return your Carte Vitale."

[xiii] Since 1996, all health insurance plans are obliged to issue an individual smart card to any beneficiary.

[xiv] The EHIC card is valid in all European Economic Area (EEA) countries.

[xv] The Act of 13 August 2004 (Article L.161 -31 of the Code of Public Health) has mandated the presence of a photograph of the insured on the *Carte Vitale 2* to limit fraud. This photograph must meet the same size specifications for identity cards and passports. It must be recent, made by an approved photographer or a photo booth, in color, sized 35mm x 45mm, with a clear and plain background, and with a centered front and bareheaded face.

[xvi] Since 1 December 2007, plans can only issue *Carte Vitale 2* cards with a photograph to their beneficiaries. The photo is printed on the card, but is also inscribed on the chip of the *Carte Vitale 2*. The CNIL banned for now the reading of the scanned image, which is protected by an anti-copy device.

[xvii] In 1998, all patients with long-term diseases (*affection de longue durée*, ALD) had, for technical reasons, their ALD rights ending 31 December 1999 on their *Carte Vitale*. In 1999, faced with the risk of clogging medical services for renewals of exemptions in respect to ALD, *l'Assurance Maladie* decided to make the end date of the entitlement unreadable by modifying the reader software. Lacking updated cards, and the terminals still being rare, health providers had no way to verify that these 7 million cardholders were still benefiting from the ALD exemption. Since it was physically impossible for the doctors of the Medical Service Funds (*Service Médical des Caisses*) to treat all these cases, the rights of all ALD patients were administratively extended several times (with the deadlines of 31 December 1999, 31 December 2000, and 31 December 2002) without verification of their medical condition.

[xviii] Since the publication of the decree of 14 March 2007 "relating to the conditions of issuance and management of health insurance cards."

[xix] According to the law of 13 August 2004, this secure personal record should be generalized to all French beneficiaries on 1 July 2007.

[xx] The decree of 14 February 2007 authorizing the *Carte Vitale 2* refers to a subsequent order setting in action security features. In addition, the Branch of Modernization of the State (*la Direction générale de la modernisation de l'État, DGME*) noted in April 2006 the importance of implanting electronic certificates in *Carte Vitale 2* cards at their issuance, particularly in order to strongly authenticate access to personal medical records. But this study did not start until late 2007, led by CNAMTS and stopped due to the freezing of the site of personal medical records by Roselyne Bachelot in June 2007.

[xxi] This service, born with the law of 13 August 2004, had been "presented in 2004 as almost finalized" and promised by *l'Assurance Maladie* for deployment in April 2005. Finally, after a trial in September 2005 in Yvelines, it was partially deployed in August 2007 and only for *Caisse nationale d'assurance maladie (CNAM)*. In the end of 2007, the MSA, the RSI, the GAMEX, and the CNMSS joined the project. In February 2009, many plans such as Mutuelle Générale were still not connected.

[xxii] The explicit consent of the patient is presumed by the fact that the patient has given his *Carte Vitale* to his doctor, assuming the doctor explains that he is using it to access this history online, and not to open the medical record in his business's software or to make an electronic spreadsheet of care.

[xxiii] In 2004, the *Commission Nationale de l'Informatique et des Libertés (CNIL)* authorized, on an experimental basis for a period of twelve months, for the National Federation of French Mutual (*la Fédération nationale de la mutualité française, FNMF*) to access on behalf of its federated mutuelle, the CIP drug codes and the LPP codes (*Liste des produits et prestations*) of their member's electronic care sheets. These studies were permitted only when the *demandes de remboursement électroniques* (DRE) was anonymous. The identification data of the insured were transformed into an anonymous number and irreversible. Then, these data were aggregated and processed for statistical purposes. In 2006, FNMF was able to recover the first real flow of DRE performed with *Carte Vitale 1b*. By April 2007, FNMF had used the new version of the Administration Chain Cards (la *Chaîne d'Administration des Cartes, CAC*) developed by *GIE SESAM Vitale* for *Carte Vitale 2*.

[xxiv] Following an initial authorization of the *Commission nationale de l'informatique et des libertés (CNIL)* dated May 30, 2007, the pilot phase began in June 2007 in some pharmacies in six departments (Doubs, Meurthe-et-Moselle, Nièvre, Pas-de-Calais, Rhone, Seine -Maritime). Then in February 2008, following a further decision of the CNIL, the experiment was expanded to the departments of Yvelines and Hauts-de-Seine, as well as 2,000 other pharmacies across the country. On 22 July 2008 the CNIL authorized the continuation of the experiment until 15 November 2008. Finally, on 2 December 2008, the CNIL gave permission for the generalization of the Pharmaceutical Record throughout France.

[xxv] After testing in the second half of 2003 with 2,000 pharmacies (in Provence-Alpes-Cote d'Azur, Corsica, Gironde and Ardennes regions).

[xxvi] The software version 1.31.4 or higher automatically blocks cards whose numbers are on the list of opposition; with version 1.31.5 and higher, the pharmacist cannot use a secure electronic care sheet for third-party payments. A degraded electronic care sheet - without use of the Carte Vitale - can be done, but in this case the pharmacist may not be refunded in case of third-party payment.

[xxvii] The national convention of pharmacists signed on 29 March 2006 an Addendum No. 4 to the specifications published in March 2009.

[xxviii] According to Article L. 162-1-14 in the code of Sécurité Sociale.

[xxix] According to Article 8 of Ordinance No. 96-345 of 24 April 1996 "relating to the control of medical care expenses,"..."This card has a medical component to receive relevant information necessary for the continuity and coordination of care." The content and function of this health component was officially registered in Article 36 of the Law of 30 June 1999 establishing Universal Health Coverage (CMU).

[xxx] This part has replaced the health component "intended to receive only the necessary information for the urgent intervention as well as the elements of continuity and coordination of care" under the law of 27 July 1999 and was not implemented anymore under the medical component provided by the order of April 25, 1996.

[xxxi] Article 3 of the Decree of 14 March 2007 states that the card may include data indicating "the existence of an attending physician and the information needed to identify him."

[xxxii] The NETC@RDS project is coordinated in France by *GIE SESAM –Vitale.*

韓国における医療と療養との連携の現状

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1. 韓国の高齢者医療・介護の基本的な特徴

韓国では日本のような前期高齢者医療制度や後期高齢者医療制度など、高齢者を別立てにした制度は存在しない。国民健康保険法に基づいて年齢区分のない一元化された医療保険制度を保険者である国民健康保険公団が管理している。

そのため、医療保険の中に高齢者に対する特徴といえるものがあまりないが、65歳以上の高齢者に対して「外来本人負担定額制度」というものがある。これは65歳以上の高齢者が診療所で診察を受けた場合、かかった医療費の総額が1万5千ウォン以下であれば、本人が1,500ウォンを負担する定額制度である。医療費が1万5千ウォンを超えた場合には、他の年齢と同様の3割の本人負担となる。

こうした「外来本人負担定額制度」が自己負担額ではなく、医療費総額であるため、その水準が非常に低いこともあって、本人負担定額制度の基準金額の引き上げを求める声が高い。ちなみに、2012年度の65歳以上の外来の平均医療費（診療所）は17,803ウォンである。しかし、これはあくまでも診療所の平均医療費であり、病院や大学病院などの医療費は含まれていない。

一方、「外来本人負担定額制度」のほかに、65歳以上の高齢者のための老人長期療養保険制度がある。65歳以上の身体的または認知的機能の障害状態にあると判断される者は国民健康保険公団（以下、公団）、または自治体に認定申請できる。その際に医師の所見書を添付して申請することになっている。

公団は申請者の機能状態等を把握するため、申請者の家庭、または居住場所を訪問し調査する。その際に調査に用いるのは身体機能（ADL項目）、認知機能、行動変化状態、看護及びリハビリ措置状態などを総合的に判断した後に、等級判定委員会に送付する。長期療養等級は1等級から3等級に分かれており、施設報酬が適用される老人療養施設と老人療養共同生活家庭に入所できるのは1等級と2等級のみである。

長期療養保険から等級判定を受けていない入院高齢者の殆どは医療的な対応ができる療養病院に移送されるのが通例。すなわち、一般病院から療養病院へ、療養病院から療養施設か在宅へという流れである。但し、医療的対応が不十分な療養施設への不安があり、療養病院を選択せざるを得ない場合も多い。病院から療養病院に移送される場合はリハビリや療養のための「診療依頼書」の中に医師の所見書が伝達される。

療養病院、または療養施設に入所できるほどの支払い能力を持たない低所得者の場合は、在宅に戻らざるを得ないが、その際には主に訪問療養サービスとデイケアセンターが投薬管理や生活援助などは担う。等級外の高齢者の場合は、療養施設に入所できないため、多くは療養病院に入院している。

表1　韓国と日本の介護保険制度の比較

	韓国	日本
名称	老人長期療養保険法	介護保険法
法律制定年月	2007年4月	1997年12月
法律施行期日	2007年10月（要介護認定等）、2008年7月（給付開始）	2000年4月
2008年7月（給付開始）	医療保険活用型	独立型・地域保険型
制度の建て方	国民健康保険公団（全国で1）	市町村（施行時点では約3000）
保険者	国民健康保険の加入者	40歳以上の医療保険被保険者（65歳の境に第1号・第2号被保険者に区分）
被保険者	原則として高齢者	原則として高齢者
給付対象者	3段階（1等級（最重症）、2等級（重症）、3等級（中等症））	7段階（要支援と要介護。施行時は6段階）
要介護度	在宅・施設・特別現金給付	在宅給付・施設給付
保険給付種類	在宅給付（15%）、施設給付（20%）	10%
利用者負担	利用者負担と保険料負担。保険料負担の20%相当額は国庫負担	公費50%と保険料50%
財源	利用者負担と保険料負担。保険料負担の20%相当額は国庫負担	公費50%と保険料50%

注：筆者作成

2.　医療費及び介護費の大きさ（対GDP比）

韓国での医療費と長期療養費の将来推計については信頼できる資料は見当たらない。韓国では「混合診療」が認められており、いわゆる「自由診療」についての正確な情報が把握できないためと思われる。その理由から、ここでは国民健康保険の給付費と老人長期療養保険の給付費の将来推計を提示する（表2参照）。

3.　医療と療養との連携

（1）　医療と療養施設の連携状況

1）　嘱託医師

韓国の療養施設は「嘱託医」と呼ばれる「公衆保健医師」や「提携医療機関」と連携することで医療と療養との連携を図り、「ケアの連続性」を維持している。まず、「公衆保健医師」は、公衆保健に関する業務に従事させるため、兵役法第34条第1項の規定により公衆保健医師として編入された医師、歯科医師、漢方医師の資格を有し、保健福祉部の長官に公衆保健医師として従事することを命じられた者であり、医師が不足している地域の保健所か保健支所などで3年間兵役の代わりに診療業務を担当する医師を指す。

療養施設はこの公衆保健医師を嘱託医として契約し月2回程度の往診を行うことで、入所者の健康管理や予防事業を実施している。しかし、嘱託医師に対する報酬は健康保険や長期療養

表２　医療費と長期療養費の将来予測（単位：対 GDP、%）

年度	健康保険	老人長期療養保健
2010	3.06	0.23
2015	3.49	0.35
2020	3.96	0.42
2025	4.48	0.53
2030	5.00	0.67
2035	5.48	0.87
2040	5.91	1.10
2045	6.27	1.39
2050	6.53	1.65

出所：박형수 / 홍승현 (2011) 高齢化及び人口減少が財政に与える影響，한국조세연구원、p. 288

保険から支払われているわけではないため、現場では嘱託医の往診は非常に形式的なものとして評価している。

こうした問題は制度発足当時から指摘されており、国民健康保険公団は協約医療機関及び嘱託医師運営規定(2008 年 6 月)を制定して、老人療養施設などが診察、処方、応急時の移送対策など、医療的な側面からの弱点を補うことで入所老人に対する適切な医療的サービスを提供するために療養施設と医療機関等の連携を図ろうとした。

＜嘱託医師運営規定の主な内容＞

・提携医療機関の医師は入所者ごとに２週に１回以上診察を行う
・できる限り家庭医学科、内科、リハビリ医学科、神経科、精神科または漢方神経精神科が担当
・診療記録簿を作成・保管
・看護(助務)士は入所者の意識状態、呼吸様相、消化器機能、日常生活能力などについて記録し、医師が訪問した際に、活用できるようにする
・看護(助務)士は入所者の病歴、投薬、情緒状態など、患者の看護記録を作成・保管
・看護(助務)士は、入所者の毎日の健康状態をチェック
・入所者の健康状態の悪化など、応急状況に対処するために提携医療機関などと協議し、応急移送システムを整えておく。

しかし、療養施設で提供される嘱託医師による医療サービスに対する評価は非常に低い。そのため、入所者に医療的処置や応急状況が発生した場合には、嘱託医師の勤務する保健所などに移送するか、嘱託医の判断を待つことなく、施設長の個人的な判断で移送病院(チャートがある病院、または保護者が希望する病院など)を決めるのが現状である。その際の情報伝達は施設長(看護師)が口頭で病院に直接伝達するか看護助務士(准看護士)が病院まで同行し、簡単なメモの形で伝達している。このため、社会保険の標準化のためにも医療と療養の連携のための公式的なチャンネル、連携システムを必要とする声が一部から上がっている。

では、なぜ連携が進んでないか。それには主に2つの理由があると考えられる。

① 嘱託医師(公衆保健医師)に対する社会的な評価がない

嘱託医師は兵役義務を行っている医師であるため、往診も兵役義務の一種としか認識していないため、積極的な関与ができなく、さらに往診に対する対価(診療報酬や療養報酬による評価)がない。療養施設側が個別的な謝礼をすることもあるが、これが入所者と保護者の負担増につながらないようにするために、提携病院の医師の「ボランティア」に多く依存しているのが現状である。このため、往診の際の主な仕事もこれまで服用していた薬の処方箋を出すか、病院への移送の助言を行うほどにとどまっている。

② 療養施設の施設長は看護士が多い

看護士が経営する療養施設は「医療的サービスが優秀」との評判が高く、実際に多くの入所者の家族から信頼されている。「チューブ交換」などの簡単な医療行為は医師の指示なく看護士が担当するのが応急措置としても有用な場合が多い。費用も安いという理由から入所者及びその家族からの満足度が高いため、看護士の経営する施設に入所者が集まる傾向がある。この医療行為には医師の指示が必要である場合が多いが、実際には看護士の判断で医療行為がなされており、これに対する別途の診療報酬や療養報酬が支払われるわけでもない。施設側としては材料代だけ入所者に請求している。

入所者が移送される病院側にとっても施設長が看護士である施設と提携を取れば、病院に移送される前の応急措置ができ、よりスムーズな連携ができるという。

現在、療養施設の経営において「看護士経営」が売り物になっている現状がかえって医療との連携を妨げ、連携サービスの標準化が進まない理由の一つとなっているように思われる。現場では入所者と家族の要求レベルが高くなるにつれて、施設自ら医療との連携に対するマニュアルを作成するなど、療養施設での医療行為と療養サービスの整備が求められている。看護士が療養施設で行う医療行為には自ずと限界があり、長期的にはナースプラクチショナーが必要だという意見もある。

③ 訪問看護の形骸化

嘱託医とあわせて医療と在宅療養の連携の柱として期待されたのは訪問看護サービスであったが、利用率が非常に低い。2011年度老人長期療養保険統計によると、在宅給付サービスの中で利用されているのは「家事援助サービス」が殆どで、訪問看護サービスの利用率は1.9%にすぎない。医療現場での看護士不足現象が療養ではサービス利用率の低下につながっており、看護士を中心としたケアマネジャー制度の導入による「ケアの連続性」が必要という意見がある。

2) 急性期病院と療養施設(在宅)との連携状況

地域拠点病院と療養病院、療養施設、デイケアセンターとの公式的な連携システムは存在しない。病院の家庭医学科の課長が療養施設を訪問し、かぜ予防などの簡単な診療活動を行っており、これもあくまで「ボランティア」活動に過ぎない。

療養施設から地域拠点病院に入院すれば、10日間まで療養施設は療養報酬の1/2を受けられるが、10日が過ぎると療養報酬が受けられなくなる。したがって、病院と療養施設のシス

テムをよく知っている場合は、10日以内に再び療養施設に戻すなどといった「調整」を行う。

地域拠点病院には療養施設から入院した高齢者らを担当する社会福祉士が配置されているが、その業務の殆どは、医療費を支払えない高齢者の医療費支援問題の相談か付添い看護による看病費用の問題である。

特に問題なのは在宅から入院する場合である。在宅から入院する場合、療養保護士が記録した高齢者の一般的な状態を病院の社会福祉士に提供する義務もなく、得られる情報も殆どないという。仮に、ケアマネジメントが導入されれば、地域のケアマネジャーを中心に連携体制を取り、病院の社会福祉士との間で高齢者の情報の連携ができると思われる。

3) 医療とデイケアセンターとの情報連携

在宅療養サービスの一種であるデイケアセンターと周辺の医療サービスの利用現況がスムーズではない。デイケアセンターの主な仕事は薬物過多服用および誤乱用を防ぎ、また、リハビリの低下に繋がる恐れがあることを把握することであり、姉妹関係の病院の院長らが1ヶ月に1回程度の往診を行っているが、あくまでも「かぜの予防」のためだという。こうした提携病院の医師の訪問診療は長期療養保険制度の診療報酬に含まれていない。診療報酬として請求できるのは、病院移送と簡単な処置のみである。したがって、病院とデイケアセンターとの連携はあくまでかぜや薬物誤乱用など、限られた「予防的」措置にすぎない。

デイケアセンターで応急状況が発生したら、とりあえず、119コールと同時に保護者に電話(保護者から事前に同意をもらっている)して対応する。看護助務士が病院に移送された老齢者のチャートを記録・管理しており、病院に手渡すのは普通である。

家族の依頼により療養病院を紹介する場合には、主に療養病院の費用と評判などを館長や看護助務士が調べて紹介している。実際に療養病院に紹介する場合、A4用紙1枚程度の簡略な情報を提供することもあるが、医療と療養との連携加算などは存在しないため、あくまで「無料サービス」である。

但し、急性期病院と連携した場合、総合福祉館の総合評価項目(機関評価と呼ぶ)に連携記録紙の作成有無を書く欄があり、これがB等級以上であれば、インセンティブが受けられる。総合福祉館の総合評価は2年に1度行われる「義務評価」で判断される(但し、これまでこの評価を受けて退出された個人事業や株式会社などは1つもない)。従って、医療と療養を連携する公式ツールやシステムは存在しない(長期的には換算より、評価の際に減算を考慮しているという)

また、病院や施設から戻った高齢者に対する情報については、デイケアセンターにとって必要な情報は薬の処方と注意事項などであり、電話、もしくは口頭によって把握している(現場では、これによってお互いに顔知りになるという)。

健康保険ではICTやEDI請求などを活用した効率化がなされているが、医療と療養との連携には活用されていないのが現状である。長期療養保険制度が社会保険方式を採用して、サービスの標準化を目指したといわれる割には、医療と療養の連携に対する現場での対応は本来の趣旨からは相当の距離がある。これは、結局、ケアマネジャーのような連携者、調整者と呼ぶべき存在の不在が大きいと思われる。地域を中心とした保険者、サービス適用者、要介護者とその家族などが総合的に連携作業に係わる必要があるが、現在の連携は個人的な能力や人材プールを使って行われているのが現状である。医療と療養との連携をよりスムーズに行うため

に長期療養保険制度の保険者である国民健康保険公団の支部が関与することも考えられるが、現場では、等級判定などに影響を与えかねず、ケアマネジャーを導入して独立的な活動を保障したほうがよいという意見が多い。

* shiwa general hospital（キム・ミキョン社会福祉チーム長とのインタビュー）
* union hospital 社会事業室チャン・デシック(社会福祉士)とのインタビュー
* nursing home（キム・ミウァ代表(看護士出身)とのインタビュー）
* geomo 総合社会福祉館(デイケアセンター)キム・キョンミ館長とのインタビュー）
*リ・ウォンピル(老人長期療養保険公団　課長とのインタビュー）

第4部

The Dutch health care system

Basic features, coordination and transferal issues, and future policy reforms

Leyden Academy

ON VITALITY AND AGEING

Author: Herbert Rolden

Executive summary

This report summarizes the information in the two reports made previously for the Institute of Future Welfare Japan and was presented at the meeting organized by this institute on October 26th at Waseda University in Tokyo. The structure and core content of the report is given below.

Chapter 1 deals with the background on developments in health care worldwide and serves as a short introduction. Although the effects of population ageing in the Netherlands are sometimes overestimated, we find that investigation into future prospects and current developments in the Dutch health care system are needed.

Chapters 2,3 and 4 offer a summary of the Dutch health care system by providing insight into the three main laws that govern the system: The Health Insurance Act (ZVW), the Exceptional Medical Expenses Acts (AWBZ), and the Social Support Act (WMO). Information is provided on the basic provisions and financial system for the three related sectors: The medical care, long-term care, and social support sector respectively.

Chapter 5 deals with general coordination issues. These issues mainly relate to legislation (privacy protection), bureaucracy (the older patient easily loses oversight) and diffuse information collection (every organization collects its own patient information, and information exchange is scarce). An oversight is given of the information flows within and between the three sectors.

Chapter 6 then specifically deals with coordination issues between the three sectors. Usually, information exchange between the medical care sector and the other two sectors relates to indication-setting procedures. Issues between the long-term care and social support sectors mainly relate to the lack of a common information-sharing platform. Special attention is given to the transfer nurse, the case manager and the neighbourhood nurse; relatively new professions that offer great potential for the elderly segment of the Dutch health care system.

Chapters 7 and 8 focus on current and future developments (mainly policy decisions) that promise to make the Dutch health care system more efficient and robust. Finally, if any questions remain unanswered, or the reader needs further information, I am more than willing to answer them.

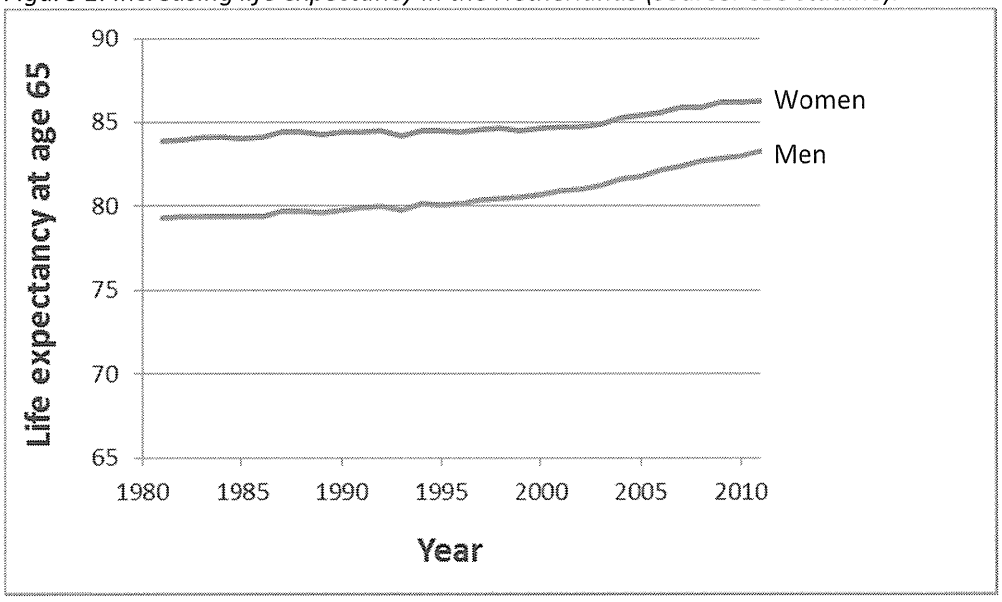
Herbert Rolden
Leyden Academy on Vitality and Ageing

1. Background

Similar to almost all developed countries in the world, the Netherlands is faced with population ageing. Of course, improved public health and increasing life expectancy is a blessing (figure 1 shows how much life expectancy has improved in the last 20 years). However, governments fear overburdening of the working population and the health care system. The number of people aged 65 and older is expected to increase from 15% in 2008 to 26% in 2040.[1] Health care expenditure is expected to rise fast due to population ageing, since individual health care expenses increase exponentially after the age of 65 (see figure 2).

[1] Van Duin, C. (2009). *Bevolkingsprognose 2008-2050: Naar 17,5 miljoen inwoners [Population forecast 2008-2050: Towards 17.5 million inhabitants].* The Hague: Central Bureau of Statistics. http://www.cbs.nl/NR/rdonlyres/EB986187-DFD1-4EBA-ABC2-E14A8E9B21B0/0/2009k1b15p15art.pdf.

Figure 1: Increasing life expectancy in the Netherlands (source: CBS statline).



Indeed, steeply rising health care expenditure in the recent past is already a worrying subject for policy-makers. Health care expenditure expressed as a percentage of GDP has increased from 11.2% in 2000 to 14.8% in 2010.[2] The main causes of this increase are: medical innovations, the Baumol effect, cultural changes, increased supply, health care reforms, and population ageing. Some economists believe the influence of population ageing on health care expenditure is marginal compared to these other factors.[3] These economists argue that population ageing runs parallel with an increase in the overall mortality risk of a nation, and it is this increase in mortality that is the main drive of increased health care expenditure, not ageing itself. It is well-known in literature that health care expenditure increases manifold prior to death, overshadowing slow increases in health care expenditure due to age.[4] Also, these costs of dying decrease when the age at death increases. In short, as life expectancy increases high mortality rates are postponed and the average costs of dying will decrease, leading to the conclusion that current forecasts may overestimate the impact of population ageing on expenditure levels. Another argument is that many countries, including the Netherlands, are planning to downsize supply in the long-term care sector. A final argument is that cultural changes are taking place, and it is possible that the elderly of the future are less dependent on formal care than the elderly are now.

[2] Central Bureau of Statistics: Statline.

[3] Barros P. The black box of health care expenditure growth determinants. *Health Economics.* 1998; 7: 533-544. Reinhardt U. Does the aging of the population really drive the demand for health care? *Health Affairs.* 2003; 22(6): 27-39.

[4] Poos, M. J. J. C., Smit, J. M., Groen, J., Kommer, G. J., & Slobbe, L. C. J. (2008). *Kosten van ziekten in Nederland 2005 – Zorg voor euro's-8 [Cost of Illness in the Netherlands 2005].* Bilthoven: National Institute for Public Health and the Environment. http://www.rivm.nl/bibliotheek/rapporten/270751019.html.

Figure 2: Individual health care expenditure by age (2005).[5]

Nonetheless, policy-makers are urged to implement changes to accommodate higher numbers of older people. The Dutch government has recently implemented new laws to effectuate these policy changes. In 2006, the new Health Insurance Act (ZVW) came into place, and in 2007 the Social Support Act (WMO) was introduced. Expenditure levels elevated in those years. Now, in 2013, health care is arranged through three major laws: (1) the Health Insurance Act (ZVW); (2) the Exceptional Medical Expenses Act (AWBZ); and the Social Support Act (WMO).

In this report, we analyze the Dutch health care system by investigating the three laws. In chapters 2,3 and 4 we will provide an overview of the workings and finances of the ZVW, AWBZ, and WMO. Hereafter, chapter 5 will focus on general coordination issues for older clients , and chapter 6 deals with coordination issues between health sectors. Chapter 7 deals with possible solutions for coordination issues, and chapter 8 with other (possible) future policy reforms in the Dutch health care system to contain ever rising health care expenditure levels.

2. The Health care Insurance Act (ZVW)

The Dutch health care insurance system is based on a "semi-free market system". Effectively, 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, without sacrificing equity, quality and transparency.

2.1 What is provided through the ZVW?

The ZVW arranges how medical care is compensated or provided. This includes medication and health care services from general practices, hospitals, dentists, allied health professionals, and mental care institutions (up to 1 year), as well as some forms of instrumental aids and transportation. This does not include medical treatment provided in care homes and nursing homes, as this is arranged through the AWBZ.

2.2 Who is eligible to receive care or compensation through the ZVW?

All Dutch citizens are obliged to take a basic health insurance package from a private health insurer. The health insurers are not tied to employer constructions or labor sectors, although employers may negotiate for discounts on health insurance premiums for their employees with a health insurer. The contents of the compulsory package are specified by the Ministry of Public Health, Wellbeing and Sports. The Health Insurance Board (CVZ), a semi-governmental body, advises the Ministry on the contents if the compulsory package.

Every Dutch citizen is free to choose an additional package. Every health insurer is free to establish the contents of these voluntary packages. Although health insurers may not discriminate potential clients by the price of their voluntary packages, they may refuse a citizen's application for a voluntary package. They may never refuse a client who applies for a compulsory package.

2.3 Which organizations are involved in executing the ZVW?

- *Health insurers and health care providers.* There are 35 private health insurers active in the medical care sector. These insurers are owned by 10 enterprises. 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 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, sometimes on the request of the provider, but may also force providers to abort or change damaging or illegal practices.
- *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, and can 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.

2.4 How is the ZVW financed?

Health insurers are paid a nominal fee by every Dutch person aged 18 or higher. The fees differ between insurers, but a fixed compulsory deductible is set by the government. This deductible is €350 in 2013, but citizens can choose to increase this deductible up to €850 to lower the fee for their health insurance. Besides nominal fees, Dutch citizens who receive income pay an income dependent contribution to the Health Insurance Fund (HIF). The HIF is used to compensate health insurers for "unfairness": some health insurers may have clients with higher risk profiles in their clientele, and need financial compensation for this to remain competitive. The government also contributes to the HIF. 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 (50% of the fund).
3. A contribution from the government (5% of the fund).

Most employers are obliged by law to compensate the employee for the 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.

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 health insurance coverage, there is also out-of-pocket expenditure in the medical care market: for some forms of care and medication, clients pay the whole or a share themselves through the client contributions. The client contribution for the basic package is set by the government. Client contributions in the voluntary package are set by the health insurer.

Medical care providers calculate their required compensations for supplied services by 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.

3. 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 long-term care for people who cannot provide in their basic care needs independently. In the 1970s and 1980s, long-term care expenditures started to rise fast, as more and more forms of care and instrumental aids were made available. 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.

3.1 What is provided through the AWBZ?

The AWBZ is a national insurance scheme for long-term care, mainly for intramural care. 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. In the intramural elderly care sector, the AWBZ compensates the residence and care in care homes, nursing homes, long-term rehabilitation units, and hospices.

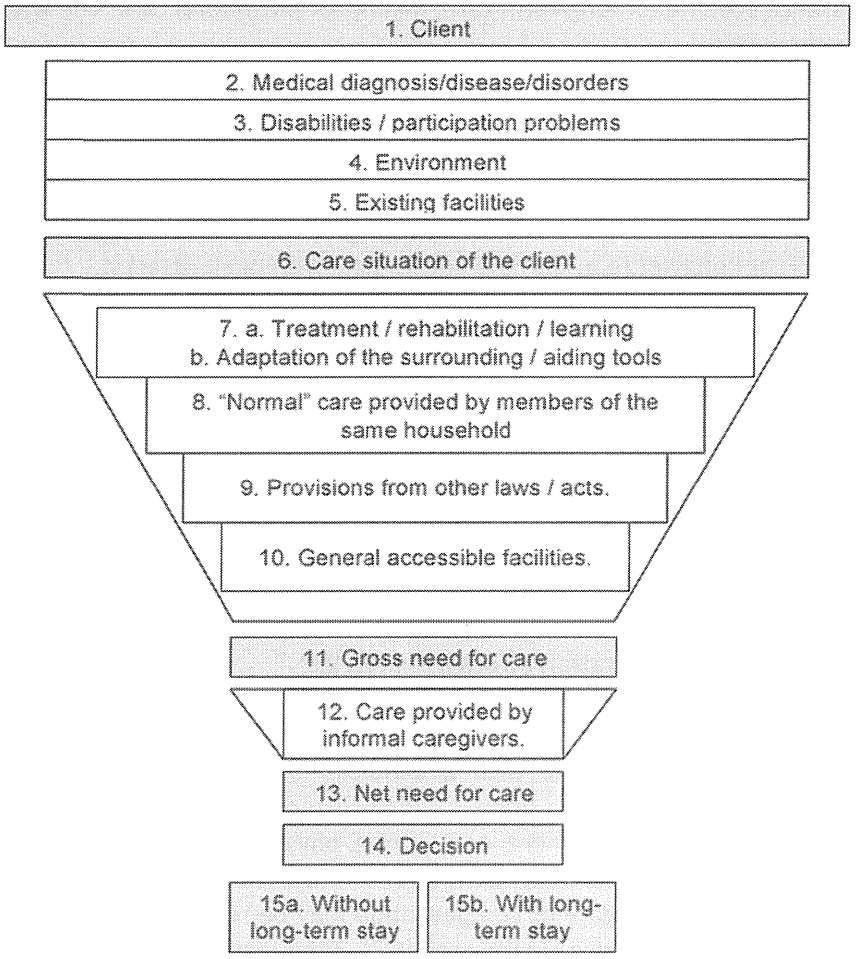
3.2 Who is eligible to receive care or compensation through the AWBZ?

As mentioned before, the AWBZ aims to provide long-term care to all who cannot provide in their basic care needs independently, such as people with a handicap or the frail elderly. More specifically, to be eligible for AWBZ care or compensation, a Dutch citizen has to suffer from a long-lasting physical, psycho-geriatric or psychiatric ailment, or a mental, physical or sensorial handicap. Most expenses within the AWBZ are made for (frail) elderly, with or without cognitive limitations or physical/functional limitations. Before AWBZ care or compensation may be received, one needs to be assessed by the Centre of Indication-setting in Health care (CIZ). The CIZ assesses the care need of an individual according to a "funneling model", as shown in figure 3. With the use of this model, the care needs of a specific patient are assessed, on which a decision is made.

3.3 Which organizations are involved in executing the AWBZ?

- *Centre of Indication-setting Health care (CIZ).* Every request for AWBZ care is sent to the CIZ first. The client, or someone acting on behalf of the client, can make a request digitally or by telephone. After the client has filled 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. The CIZ issues a legally binding indication, sent to both the client and the care office.
- *Care offices (health insurers).* In 2013, health insurers act as care offices for all their ZVW-clients. In prior years, the health insurer with the highest market share in one of 32 AWBZ regions acted as a care office. Care offices are responsible for arranging long-term care for the client, usually after consulting the client. Long-term care providers send their bills to the care office.
- *Central Administration Office (CAK).* The CAK calculates the client contributions, on the basis information on income from the tax department. The CAK compensates the long-term care providers by request of the care office.
- *Health Insurance Board (CVZ).* The CVZ administers the AWBZ fund.

Figure 3: Assessment steps by the CIZ to decide on an individual's AWBZ care needs (funnel model)



- *SVB Service center for Personal budgets (SSP).* The SSP offers free assistance to clients who receive a personal budget. Some personal budget holders need help with the administrative processes that are required when applying for a budget, or maintaining the budget. SVB stands for Social Insurance Bank (*Sociale Verzekeringsbank*).

3.4 How is the AWBZ financed?

All Dutch citizens with 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 2013 is €33,363. This means that the maximum fee a person can pay for the AWBZ is €4,053.60. 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*).

Clients can choose to receive care in kind, arranged by the care office, or to receive a personal budget. With a personal budget, a client is free to choose his or her own long-term care provider. However, when a client makes use of a personal budget, the client, or someone acting in

behalf of the client, needs to administer care use and payments. Besides compensation from the AWBZ fund, clients are required to pay a contribution dependent on their income.

4. The Social Support Act (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. 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.
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.

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.

4.1 What is provided through the WMO?

Provisions within the nine performance fields described above 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).

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.

4.2 Who is eligible to receive care or compensation through the WMO?

The WMO is a law that aims to provide services that improve the opportunities and capabilities of citizens that are socially "disadvantaged" due to a handicap, an addiction, a mental illness, social isolation or abuse. The WMO fits into the broader aim of the government to reach social equality. This aim of social equality is reflected in WMO-policy. For example, when citizens of a municipality are unable to take a bus, for example due to a handicap, a municipality can decide to compensate other means of transportation for these citizens. This compensation is usually equal to the costs of taking a bus. Transportation costs that exceed the average bus fare are at the expense of the client him-/herself. The main difference between the AWBZ and WMO is that citizens are **entitled** to receive AWBZ care when they meet the criteria, whereas citizens are never entitled to receive WMO support. Instead, they can make use of social support activities that are offered by their municipality. Although municipalities are obliged to help disadvantaged people participate in society and the community, they are essentially free to make and effectuate WMO policy.

4.3 Which organizations are involved in executing the WMO?

- *Municipalities.* Although municipal offices are responsible for providing WMO support, they can second service provision, indication-setting and billing to other organizations.
- *MO-zaak.* De MO-zaak is a commercial division of the CIZ, performing indication-setting for WMO support for many municipalities. If the client gives his or her consent, MO-zaak has access to AWBZ data on previous and current indications and care utilization of the client.
- *Service providers.* Many municipalities establish contracts with commercial service providers on a yearly basis to ensure providers remain efficient through competition. Service providers include volunteers, domiciliary care providers, taxi companies, companies providing instrumental aids (such as wheel chairs), and more.
- *Central Administration Office (CAK).* Municipalities often second the calculation of client contributions to the CAK.

4.4 How is the WMO financed?

Municipalities receive their finances from the municipal fund from the national government and from municipal taxes. A municipality sets the budget for the WMO on an annual basis. Most often, the municipality seconds the provision of social support services to commercial organizations. Every municipality decides whether client contributions are required, and if so, how they are calculated. Municipal workers can calculate and bill these contributions themselves, or these tasks can be seconded to the CAK. Client contributions are usually installed for domiciliary care, instrumental aids, adjustments in the house and personal budgets.

5. Information sharing in the Dutch health care system

5.1 Background

Coordination is considered to relate to two concepts: (1) information-sharing, and (2) definition of roles and responsibilities. Through good coordination of care, the client is guided through the many difficult pathways in health care in an effective and timely manner, ensuring that the patient is kept informed and satisfied. Details on information-sharing and the definition on roles in the medical

care, long-term care, and social support sector in Dutch health care system are provided in the next paragraphs. Details on coordination between these sectors are explained in chapter 6.

Overall, coordination of care in the Dutch health care system is hindered by bureaucracy, diffuse information collection (due to the existence of multiple information systems) and legislation.

- *Bureaucracy.* Because of the many organizations active in the Dutch health care market, and because of legislation to prevent misuse of health care, clients have to collect information, fill in forms, collect formal evidence, and wait for response when they apply for health care. This bureaucratic system makes health care time-consuming and more expensive. Box 1 (next page) offers an example of the bureaucratic nature of the Dutch health care system.
- *Diffuse information collection.* Many different information systems are used in the Dutch health care system. In the medical care sector, every health care provider collects its own information of clients. The AIS, HIS and ZIS stand for information system used by pharmacists, general practices and hospitals respectively. Only authorized personnel of a health care provider may log into the information system of the health care provider to track individual client data. In the long-term care sector, organizations share a common information system on client data, called AZR. In the social support sector, every municipality collects data in its own manner. Information-sharing between the different information systems is thwarted by legislation (next page) and competition. Also, because of the competitive nature of the semi-free market system of Dutch health care, providers are not inclined to easily share information with each other.
- *Legislation.* The use of information systems to obtain and sustain effective information-sharing between health care providers may not conflict with privacy rules and regulations. A famous example of such a conflict is the failure to install a national electronic patient information-sharing platform (EPD) in the medical care sector. A proposed law that would make instant data-sharing between medical care providers possible in certain situations, was put to a halt by the senate in 2011, mainly because of privacy concerns.

Box 1: An example of bureaucracy in the Dutch health care system
Mrs. X is terminally ill and receives domiciliary care and home care. She fell on Wednesday April 10, and had to wait for 2 hours before a family member coincidentally found her lying on the floor. Her children decide she needs an alarm that can be worn around the neck. After browsing the internet, they find that such an alarm is compensated by the health insurer. They apply for an alarm at a domiciliary care provider on the next day. The provider informs the children that they need a proof by letter from the acting physician. They call her GP, who sends the proof to the provider on Friday April 12. On Tuesday April 16, the provider calls and informs the children that it has no contract with the health insurer of Mrs. X. They need to pay for this alarm out of pocket, or apply at a different provider. They decide to apply at another provider, who has a contract with the health insurer. They have to ask the GP to send a new letter of proof, and finally receive the alarm on Monday April 22. Unfortunately, mrs. X passed away on that same day.

An oversight of information-sharing flows in the Dutch health care sector is given in figure 4.

5.2 Coordination issues in the medical care sector

Information exchange between the many different providers in the medical sector is relatively slow and incomplete in the Dutch health care system. This is mainly due to legislative and technological issues. 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.

Figure 4: All possible information-sharing flows between health care institutes and/or professionals in the Dutch health care system (Source: Leyden Academy).