1. The client visits the GP and shares information on his/her personal data, health and wellbeing.
2. New diagnoses and new treatments are stored in the HIS by the GP or assistant.
3. Important information about the client's diagnoses and treatments are stored in a separate subset of the HIS for the RSP/LSP.
4. If necessary, the GP can give the client a referral note for medication or other forms of medical care.
5. By purchasing medication and giving feedback on any side-effects, the client shares informa-tion with the pharmacist.
6. The pharmacist stores information on medica-tion use and potential side-effects in the AIS.
7. Important information about the client's medication use and side-effects is stored in a separate subset of the AIS for the RSP/LSP.
8. If necessary, the pharmacist can check important information from the GP on the client through the RSP/LSP.
9. If necessary, the GP can check basic and crucial information on medication use and side-effects from the pharmacist through the RSP/LSP.
10. If necessary, the GP can directly refer the client to a specialist.
11. The client visits the specialist and shares information on his health and wellbeing. The hospital collects his personal data.
12. Diagnoses, treatments, and scan and test results are stored in the ZIS.
13. After the consult, the specialist sends a letter to the GP, in which he summarizes the client's visit in terms of new diagnoses, medication, test and scan results, and others.
14. If necessary, the specialist can check important medical information of the client with the GP or pharmacist through the RSP/LSP.
15. In case of emergency, or when the client's GP is unavailable, the client can visit the GP center.
16. If necessary, the substituting GP from the GP center can check important information with the GP or pharmacist through the RSP/LSP.
17. If necessary, the GP can refer the client to an allied health professional (e.g. physiotherapist or psychotherapist). The client usually receives a referral letter for this.
18. The client visits the dentist or an allied health professional and shares information on his/her health and wellbeing.
19. The GP sends individual bills to the health insurer of the client.
20. The pharmacist sends individual bills to the health insurer of the client.
21. The hospital sends individual bills to the health insurer of the client in the form of coded DOTs.
22. The GP center sends individual bills to the health insurer of the client.
23. Other medical care providers sends individual bills to the health insurer of the client.
24. The client is enlisted with a health insurer. The insurer therefore has his/her personal data.
25. The health insurer may send copies of bills to the client, or charge the client with deductibles or client contributions.
26. The health insurer with the highest market share in an AWBZ region is obliged to act as the care office for this region. Legally, the health insurance branch of the company may not exchange client information with the care office branch, but this does happen in practice.
27. If the client requests an AWBZ indication, he/she shares personal data and information on his/her health, wellbeing and social surrounding with the CIZ.
28. If required for the indication, a CIZ employee can request information from the GP. The client first has to give explicit permission.
29. If required for the indication, a CIZ employee can request information from a specialist. The client first has to give explicit permission.
30. If required for the indication, a CIZ employee can request information from a current LTC provider of the client. The client first has to give explicit permission.
31. The CIZ sets an indication for AWBZ care and sends the indication decision the client.
32. The CIZ also sends the indication to the care office.
33. The client informs the care office on his/her LTC preferences and needs.
34. The care office checks if a LTC provider is able to provide the indicated care.
35. If so, the LTC provider commences with LTC provision, collecting information on the client's health, wellbeing and personal preferences to provide the best possible care.
36. The LTC provider sends messages to the care office, containing information on the start and end of LTC provision, and possible changes.
37. These messages on the start, end and changes in LTC are forwarded to the CAK.
38. The CAK receives information on the client's financial status from the tax department.
39. The client has already shared information on his/her financial situation with the tax department by filling in tax declarations.
40. The CAK gives feedback to the client on his/her LTC use, and charges a client contribution.
41. The client applies for WMO services by filling a form, and sending it to the municipal government.
42. The municipal government can second indication-setting to CIZ. In this case, the CIZ sends an official indication to the municipal government.
43. The client receives a letter about the indication decision for WMO support.
44. When the client is eligible for transportation services from the WMO, this is forwarded to the assigned taxi company.
45. When the client is eligible for other services from the WMO (such as instrumental aids), this is forwarded to the assigned service provider.
46. When the client is eligible for domiciliary care services from the WMO, this is forwarded to the assigned domiciliary care provider.
47. Some municipalities ask the assigned taxi com-pany to collect information on the client's use of transportation services for billing purposes.
48. Some municipalities ask the client to collect information on his/her use of transportation services for billing purposes.
49. When the client receives other services from the WMO, he/she shares information on service needs with this service provider.
50. When the client receives domiciliary care services through the WMO, he/she shares information on service needs with the domiciliary care provider.
51. The domiciliary care provider is often asked by the municipal government to share information on the client's use of domiciliary care services with the CAK.
52. The CAK calculates the client contribution for domiciliary care services and charges the client.
53. The collected client contribution is forwarded to the municipal government.

These situations can be categorized into roughly four cases:
1. *Force majeur:* Other laws have priority over the duty of confidentiality.
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.
3. Patient consent to sharing information can be reasonably assumed (patient consent is implicit).
4. The patient has explicitly granted the health care professional or institute the authority to share information with specific other professionals or institutes.

After it is assessed that information-sharing is possible, the actual information exchange is hindered by technological issues. For example, some medical specialists send patient information (for example, feedback on consults or newly prescribed medication) to the GP by letter. GPs then sometimes receive this feedback on potentially new diagnoses, prescriptions and treatments after a delay. Currently, new possibilities are researched or followed through to effectuate improved information-sharing between medical care providers. For example, regional collaborations are initiated with a so-called Regional Switching Point (RSP). The RSP offers a web portal 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 authorization card (called an UZI-card) and reader, look for basic medical information in another health care provider's information system. This will make medical care provision more efficient, also promoting timely health care and reducing mistakes due to lack of information. Important for older people in this context is the prevention of unnecessary polypharmacy.

5.3 Coordination issues in the long-term care sector

The AWBZ Care Registration system (AZR) is the information-sharing platform for the different institutions active in long-term 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, including previous and current indications and long-term care utilization. The AZR-system is updated regularly – in accordance with different health insurers (care offices), the CIZ, and the Ministry of Health, Welfare and Sports. Coordination issues in the long-term care sector mainly relate to indication-setting. Illnesses can progress fast and diagnoses can change. Also, indications can be set for a short period of time. Consequently, it is not uncommon that client, or someone from the network of the client, has to continuously apply for new indications. This is problematic, considering that the procedure of indication-setting is a time-consuming administrative process.

5.4 Coordination issues in the social support sector

Municipalities are currently faced with issues in communication and information-sharing, mainly because of the quasi-market system:
- A single information-sharing platform with standardized messaging is missing. This means that, for example, a municipality receives batches of information from the client, an indication-setting organization, and the service providers. This leads to administrative hassle.
- Problems with the delivery and quality of WMO-services are not always known to the institutions involved in the WMO. This is most striking in the case of transportation services. Because of budgetary constraints, the taxi company with the lowest fares is often chosen as the proper candidate for transportation services. This can have detrimental effects on service quality: in some municipal regions, people who are dependent on the WMO for transportation sometimes have to wait hours before their taxi arrives. Municipalities or taxi companies are not always aware that clients are unhappy with service delivery, or discard this information.
- Through the quasi-market system municipalities try to achieve maximum efficiency. This can lead to restraints in information-sharing. Because different service providers compete with

each other, they prefer not to share information about individual clients or about ways to improve quality and efficiency of service provision.

6. Coordination issues between sectors

6.1 The medical and long-term care sector

Coordination between ZVW institutions and AWBZ institutions mainly takes place during indication-setting. After an indication is set, and the client receives AWBZ care, no more information-sharing is usually necessary. For example, when an indication is set for intramural care, all health care is compensated through the AWBZ when the client enters the long-term care institution (including treatment by a nursing home specialist and medication).

The CIZ uses the funnel model to set an indication. The basis of the funnel model is that the CIZ gains knowledge of the specific illnesses and/or handicaps that the client is suffering from. For this purpose, the CIZ usually contacts the client's GP or acting specialist to receive information on the diagnoses and/or prognoses. This can only be done after the client has given consent. When a new medical diagnose is set, or an illness or handicap progresses, it is the responsibility of the client, or someone in the network of the client, to apply for a new indication.

In elderly care, there are instances that a transition of the client from a ZVW to an AWBZ institution takes place. This pertains to a transition from the hospital (or rehabilitation unit) to long-term care unit. When a specialist decides that a long-term care unit is more appropriate for a patient than staying in the hospital, a transfer nurse is usually involved (see paragraph 6.4).

6.2 The medical and social support sector

A municipality may, just like the CIZ, ask for information about a client's medical status to be able to make an informed decision on an indication. The client has to give explicit permission for this. Some municipalities require all clients who request for a WMO-indication to give permission for medical information retrieval from a treating health care professional. In this case, clients have to sign for this permission in their application form. Transfer nurses may also assist clients with regard to WMO support (see paragraph 6.4).

Other health care professionals may also assist the client with requesting a WMO indication. Experiments have been done whereby GPs act as indication-setters for WMO support, but these experiments were deemed unsuccessful. The main reason for abandoning the experiments is a conflict of interest: a general practitioner might benefit from a WMO-indication. A WMO indication can divert some expenditure for the GP to the municipality. Currently, the GP does inform his patients when a service is not compensated through the ZVW, but when they can benefit from social support.

6.3 The long-term care and social support sector

Currently, there is no client-level information-sharing between institutions active in the AWBZ and WMO. This has three major consequences:

1. Clients with multiple care and support needs, often have to tell the same story about their physical and personal circumstances to different institutions. Also, if a client moves from one municipal region to another, the process of requesting WMO support, setting indications and arranging support services starts all over again. If municipalities, care offices, long-term care providers, and social support providers could gain access to one database, where the CIZ reports indication decisions and the client's care and support needs, the client would only have to tell his/her story once to the CIZ.

2. Some service providers deal with multiple municipalities and care offices. This means that these providers have to deal with different ways in which indications are communicated and compensated. Because communication and billing procedures are unstandardized, service providers suffer from administrative hassle.
3. Every municipality sets its own client contribution fees. The CAK deals with many different contribution fees and arrangements, and communication between municipalities and the CAK doesn't always occur smoothly. Some clients receive numerous recalculations of the CAK because of these reasons, leading to administrative hassles to both the CAK and the clients.

A common information-sharing platform with standardized messaging is needed within the WMO. Further still, developing such a common platform for both the WMO and AWBZ could greatly reduce administrative hassles for different parties in the long-term care and social support market.

6.4 Specific roles in improved care and care coordination

Some health care professionals in the Netherlands specifically fill the role of coordinator. There are basically three of these professionals – each with their different function – and they are described below. First, some medical care providers offer the assistance of a *transfer nurse*. By her knowledge and expertise, this health care professional is able to inform the client of all possible provisions he or she may receive, as well as the processes that are involved in applying for these provisions. The transfer nurse has different responsibilities:

- Requesting an indication from the CIZ.
- Informing the patient and relatives on the progress in requesting social support or admission to a long-term care unit, as well as legal and financial matters that are important.
- Contacting the provider after an indication is approved.
- After the patient is admitted in a long-term care unit, the transfer nurse stays in contact with the care unit to stay informed about the patient's state.

The role and responsibilities of the transfer nurse are clear, and her expertise can greatly benefit the timeliness and quality of care for patients. Besides the GP, the transfer nurse is the only health care professional who can apply for an AWBZ indication with urgency. The transfer nurse is employed by hospitals or rehabilitation units.

Second, the *case manager* helps clients who are no longer independent and have complex care needs. The role of case manager is in a developmental stage and case managers are currently only installed to aid elderly who are suspected of dementia. The case manager has a broader focus than the transfer nurse, and can assist clients with (suspected) dementia in the following ways:

- Counseling before or after the diagnosis.
- Mapping the care needs of the client.
- Providing information and advise on the diagnosis, prognosis and consequences.
- Coordinating care by offering information on possible provisions and on administrative requirements and processes for these provisions.
- Stimulating elderly who avoid care to accept some care provisions.
- Emotional and practical support to the client and informal care-givers.

Case managers are employed by long-term care providers, and are therefore paid through the AWBZ. Research shows that clients are very satisfied with the help from case managers, and it is forecasted that installing case managers nation-wide could reduce admission rates to care homes and nursing

homes. Consequently, investments in case managers are expected to be cost-effective due to a reduction in AWBZ expenditure.[5]

Third, the role of the *neighbourhood nurse* is also to prevent early admission to care homes or nursing homes. But where the case manager provides assistance and information, the neighbourhood nurse offers basic nursing activities, such as preparing and giving medication, dressing wounds, performing injections, providing intravenous therapy, inserting catheters, and so on. The neighbourhood nurse also fills a social role, making conversation, advising the patient on self-care issues or (psychological or social problems) and by keeping a close eye on the patient. She provides feedback to family members or the GP when the client's illness progresses or when situations change. Currently, the municipalities employ neigbourhood nurses, but from 2015, health insurers will become responsible for providing these services. Research has shown that neighbourhood nurses can prove to be cost-effective, as they realize cost savings (€18,000 per nurse per year) in other health care services.[6]

7. Improving coordination in the Dutch health care system

Figure 4 shows that the Dutch health care system has a highly bureaucratic structure. An important reason for this bureaucracy is that information-sharing is regarded as an exception, rather than a standard way of working. This means that many forms of information-sharing may not take place at all. For example, CIZ-employees would greatly benefit from access to information systems of medical care providers. This way, a CIZ-employee can quickly get a complete picture of a client's health status. For privacy reasons, access to these systems is heavily restricted by law.

When information-sharing does take place, laws, regulations and protocols are in place to ensure that it occurs in a secure setting and all precautions have been taken. Medical care professionals need authorization, an authorization card and a password, to access just a subset of another information system. Ways to improve efficiency of information-sharing without sacrificing the privacy of clients are discussed by policy-makers and academics in the Netherlands. The most important (possible) developments to diminish bureaucratic problems can roughly be divided in three categories, explained below:

1. *A more central role for the client, and more financial transparency for the client.* Letting the client arrange many of his/her own required services is a way to decrease information-sharing "backstage" and diminish overhead costs. In the AWBZ and WMO policies can become more oriented towards personal budgets. This way, municipalities and care offices are only concerned with paying out personal budgets and monitoring the use of personal budgets, rather than arranging all the long-term care or social support for the client. However, the frail elderly and elderly with a cognitive disability or psychogeriatric illness are usually not able to make effective use of personal budget due to their lack of independence. A care manager or family member can then play a role.
2. *Improved system of information-sharing within the ZVW.* The introduction of regional or even national collaborations between medical care providers (mainly GP, substituting GP, pharmacist, and hospitals) can reduce administrative hassles and delays in information-sharing between them.
3. *Improved system of information-sharing within the AWBZ and WMO, and between the AWBZ and WMO.* In the beginning of 2012, a discussion and innovation platform, called Platform IZO has been initiated by the Ministry of VWS. Besides the ministry, different organizations are

[5] http://www.nivel.nl/sites/default/files/bestanden/Rapport-casemanagement-dementie.pdf
[6] http://www.bmc.nl/expertisegebieden/bedrijfsvoering-in-het-sociale-domein/mediatheek/rapport-de-zichtbare-schakel-wijkverpleegkundige-een-hele-zorg-minder/

involved in this project, namely: Actiz, the CAK, the CIZ, the CVZ, Federatie Opvang, the GGZ, the VGN, the VNG, and ZN. The aim of Platform IZO is to find the most important bottlenecks in information-sharing regarding the ZVW, AWBZ and WMO, and to define a common goal to improve information-sharing in the long-term. Part of Platform IZO are the following initiatives:

- A "think tank" called iAWBZ. In iAWBZ, health care professionals are asked to define the most important bottlenecks in the administrative burden of the AWBZ and come up with solutions. The iAWBZ has led to an update from AZR 3.0 to 3.1, in which "quick wins" were gained: messages can be simplified and may be sent less often, changing personal data from clients is simplified, LTC providers can view the initial indication-decision from the CIZ, and so on.
- Since October 2012 different organizations in the health care sector are working on an information-sharing platform for both the AWBZ and WMO. The project is called GuWA (Data exchange WMO-AWBZ), and is now in the first phase. Flows of existing platforms and flows of information- and data-sharing are now thoroughly analyzed. Possible scenarios to improve information-sharing are researched, as well as any legal restraints. As of yet, it remains unclear what form an information-sharing platform for the AWBZ and WMO will look like. A new system of standardized and coded messages could be developed, but it could also be possible that municipalities will be included in the AZR.
- The long-term goal from Platform IZO currently entails three ambitions for 2016: (1) more simplicity for the client, (2) less administrative burden for organizations in health care and social support, and (3) modernization of data management. They hope to achieve these ambitions by developing an information system with standardized messaging, that can be used by many organizations, while preventing misuse of this system. This way, the CIZ, the CAK, municipalities, care offices, long-term care providers, other service providers, etc. can quickly gain access to clear information for which they are authorized.

Through these measures, the different institutions and organizations hope to make gains in efficiency by reducing:

- overhead costs;
- delays in information exchange;
- hours spent on administrative tasks by health care professionals;
- frequency of uninformed decisions by doctors;
- occurrence of overlapping, similar activities done by different professionals (for example, indication-setting by the municipalities and the CIZ).

8. Future measures to deal with rising health care costs

8.1 Broad scope

Two broad and long-term aims of the Dutch government can be distilled that are the basis of the many policy measures that were taken in the last years, and are expected in the feature:

1. A focus on higher responsibility for citizens themselves and their surrounding network of friends, family and neighbors, rather than the formal system;
2. A sharp distinction between individual responsibility, entitlements to health care, and practical solutions.

Many of the future measures of the Dutch government to regulate rising health care costs are related to the concepts of *independence* and *active citizenship*. Independence relates to taking responsibility for oneself, and active citizenship relates to taking responsibility for others in your community. One tool for the government to promote independence and network support is to

downsize supply. In the future, care and support activities should only be provided through collective means if a client's financial means, health status and social network does not allow him/her to take this responsibility.

All in all, the current government wants to totally abolish the AWBZ in the very long run (10 years or longer). This long-term aim will pursued in steps. First, personal care, counseling, daytime activities, and other activities currently or formerly provided through the AWBZ should be provided through the WMO. These activities relate more to social support and can potentially be provided through a client's social network, meaning that municipalities might be better equipped to coordinate and provide these services than the national and bureaucratic system of the AWBZ. Second, arranging and compensating for short-term or long-term residence and facilities ("hotel costs") are thought to be the client's responsibility, and will no longer be provided through public resources. Third, nursing care should be provided through the ZVW, as this relates more to medical care than long-term care or social support.

8.2 (Potential) measures after 2013

Medical care

- In 2014, a client contribution of €50 will be charged when a client reports at the emergency ward in a situation where emergency care is uncalled for.
- The compulsory deductible might become income dependent in the long term.

Long-term care

- In the long term, care offices will be abolished. Health insurers will then become responsible for compensating medical as well as long-term care for their clients. This will benefit clients, since they now have one "reception desk" for both forms of care services. In the new system, long-term care providers will bill health insurers instead of care offices for their provided services.
- Lower-level intramural care (ZZP 1 and 2) disappeared in 2013. Instead, those who were eligible for lower-level intramural care will now only receive indications for extramural care. In 2014 and 2015, the same will count for ZZP 3 and 4 respectively.
- From 2014, daytime activities (part of counseling) will no longer be compensated through the AWBZ.
- From 2014, indications for personal care for a duration of 6 months or less, will no longer be set.
- In 2015 all extramural personal care and counseling will be the responsibility of the municipality.
- In 2015 extramural nursing care will be provided and compensated through the ZVW. The underlying argument for this transfer is that nursing care better suits the curative sector (medical care) than the long-term care or social support sector.

Social support

- From 2014 onward, eligibility for domiciliary care will become entirely income dependent. Municipalities will only provide such services for those with a relatively low income, other clients will have to find their own means to acquire help with housecleaning, grocery shopping etc. These cutbacks will only count for those applying for domiciliary care in 2014. However, in 2015 these changes will also count for all those already receiving domiciliary care.

付録

2013年度 研究会名簿（2014年3月1日現在）

磯部 文雄　城西国際大学教授、福祉未来研究所代表
井深 陽子　東北大学
大森 正博　お茶の水女子大学
庄司 啓史　衆議院事務局
府川 哲夫　福祉未来研究所代表、武蔵野大学教授
堀田 聰子　労働政策研究・研修機構
松田 典子　文教大学

2013年度 研究会開催状況等

5月10日　第1回研究会：2013年度研究プラン
6月7日　Leyden Academyと基本合意
8月1日　第2回研究会：Workshopの最終打合せ
10月26日　早稲田大学においてWorkshop
10月29日　東京財団においてフォーラム（Marieke van der Waal、大森正博）
12月1日　月刊「統計」2013年12月号特集“これからの医療・介護－オランダに学ぶ－”
1月30日　Workshop Papersのnative check完了
2月4日　第4回研究会：2013年度報告書の議論
3月末　報告書取りまとめ