Health Care Systems in Transition

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Contents

Foreword

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of a health care system and of reform initiatives in progress or under development. The HiTs are a key element of the work of the European Observatory on Health Systems and Policies.

HiTs seek to provide relevant comparative information to support policy-makers and analysts in the development of health care systems in Europe. The HiT profiles are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services;
- to describe the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health care systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries.

The HiT profiles are produced by country experts in collaboration with the Observatory's research directors and staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides the detailed guidelines and specific questions, definitions and examples needed to compile a HiT. This guidance is intended to be flexible to allow authors to take account of their national context.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health

care system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) Health Data and data from the World Bank. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

The HiT profiles provide a source of descriptive information on health care systems. They can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health care systems. This series is an ongoing initiative: material is updated at regular intervals. Comments and suggestions for the further development and improvement of the HiT profiles are most welcome and can be sent to observatory@who.dk. HiTs, HiT summaries and a glossary of terms used in the HiTs are available on the Observatory's website at www.observatory.dk.

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The HiT reflects data available in summer 2004.

Introduction and historical background

Introduction

The Kingdom of the Netherlands (Koninkrijk der Nederlanden, in Dutch) is located in western Europe, bordering the North Sea (451 km of coast) to the west and north, Belgium (450-km border) to the south and Germany (577-km border) to the east (Fig. 1). It covers an area of 41 532 km^2 (33 889 km^2 of land and 7643 km^2 of water. The highest point is Vaalserberg in the south-east corner, near the border with Belgium and Germany (altitude 322.5 m), and the lowest point is near Rotterdam, in Prins Alexanderpolder (Nieuwerkerk aan den Ijssel, 6.74 m below sea level). The climate in the Netherlands is moderate, with an average temperature of 16–17 °C in summer and 2–3 °C in winter.

The total population is 16 258 032 people (2004) 8 045 914 males (49.5%) and 8 212 118 females (50.5%). The capital of the Netherlands is Amsterdam (737 000 inhabitants, 2003), but the seat of government is in The Hague (Den Haag; 464 000 inhabitants, 2003). The Netherlands comprises of 12 provinces and is a very densely populated country, with more than 450 inhabitants per square kilometre. Eighty-one per cent of the population are natives (Natives are persons whose parents were born in the Netherlands, irrespective of their own country of birth), and 19% have a foreign background (Persons are considered to have a foreign background if at least one parent was born abroad), like Moroccan, Surinam and Turkish. Regarding religion, 31% are Roman Catholic, 14% Dutch Reformed, 8% Calvinist, 5.5% Muslim, 0.6% Hindus, 1.9% other and 40% unaffiliated (2002). Of the population, 24.5% are 19 years of age or under, 28% are between 20 and 39 years of age, 33.6% are between 40 and 64 years of age, 10.4% are between 65 and 79 years of age, and 3.4% are 80 years of age or older (2004). The rate of live births is 12.5 births per 1000 inhabitants

Fig. 1. Map of the Netherlands[1]

Source: World Factbook 2004.

(2002), and the death rate is 8.8 deaths per 1000 inhabitants (2002). Forty-three per cent (43%) of the population are married, 45% are single, 5.4% are widowed and 5.8% are divorced (2004).

[1] The maps presented in this document do not imply the expression of any opinion whatsoever on the part of the Secretariat of the European Observatory on Health Systems and Policies or its partners concerning the legal status of any country, territory, city or area or of its authorities or concerning the delimitations of its frontiers or boundaries.

Political system

The formal head of the Netherlands is the King or Queen which, since 30 April 1980, has been Queen Beatrix Wilhelmina Armgard, but only the government has executive power. The head of the government is Prime Minister Jan Peter Balkenende (since 2002). The parliament, called States General (Staten-Generaal), represents the population; it consists of the Second Chamber (Tweede Kamer) and the First Chamber (Eerste Kamer). This bicameral system began in 1815. The First Chamber or Senate has 75 members elected for 6 years by the 12 provincial councils, while the Second Chamber – politically the most important – has 150 members elected directly for 4 years. All major national political parties are represented in the Second Chamber. Since no one party has a majority, a coalition of several parties is necessary to form a cabinet. Together, the two chambers have the power to legislate. The major role of the Second Chamber is to amend and approve bills put forward by the government, while the First Chamber can only approve or reject laws that have already been passed by the Second Chamber.

The constitutional character of the Dutch state is expressed through the *Trias Politica* (separation of powers) and an extensive system of checks and balances. The Trias Politica is most easily on between legislative and executive power is less clear, given that the government makes laws (also in the health care field) in conjunction with parliament and can lay down binding rules upon citizens. Checks and balances come from various sources: the bicameral system, judicial control, administrative supervision, and the right of amendment by the Second Chamber.

Health status

A recent national health status report (Van Oers, 2003) concluded that the vast majority of the Dutch population enjoys good subjective health. Over the past decades Dutch life expectancy at birth has in the year 2002 risen to 76.0 years for men and to 80.7 years for women. The years that have been added over the last decade are generally spent in good health. Major causes of death are cardiovascular diseases and cancers.

Around the year 2000 Dutch men and women experienced roughly the same number of healthy years: 61 years spent in self perceived good health, more than 70 without disabilities, and 68 in good mental health. Consequently, the number of unhealthy years is considerably higher for women than for men.

The positive development of Dutch health has for a large part been associated with a high level of economic development since the Second World War and for a smaller, but probably significant, part to a well-developed health system.

Dutch life expectancy used to be among the highest in the world, but recently the increase has been confined to men and life expectancy at birth has dropped to about EU-15 average for Dutch women. High levels of smoking, unhealthy diets, alcohol abuse and other related risk factors, such as high blood pressure, obesity and physical inactivity are probably responsible for this relatively bad development in recent years. Dutch mortality is still rather low, which is partly caused by relatively low mortality at younger ages due to low rates of traffic accidents. Perinatal mortality, which is often considered an important health system indicator, is also stagnating compared to the EU-15 average. This has been attributed to a number of recently increasing risk factors: a higher percentage of children born to ethnic minority mothers – which is also associated to lower socioeconomic status; the increasing average age of Dutch mothers at birth of their children – now among the oldest at childbirth in Europe – an increasing percentage of twins and triplet births, which is caused by infertility treatments, such as "In Vitro Fertilisation". Finally, a relatively large percentage of Dutch women are still smoking during pregnancy *(1)*. There are no indications, however, that the Dutch health system, which still knows a large percentage of home births, has in any way worse health outcomes than other systems.

Socioeconomic and urban-rural, health differences still exist in the Netherlands and these differences have not decreased in recent years. In the larger Dutch cities a number of health related problems accumulate: drug addiction, alcoholism, sexually transmitted diseases, violence, psychiatric problems, social isolation and homelessness. These problems are more prevalent in lower socioeconomic groups.

According to Statistics Netherlands (Centraal Bureau voor de Statistiek), in 2003, 25.8% of the population described their health status as very good, 54.7% as good and 19.5% as less than good *(2)*. Table 1 gives some demographic and health indicators for the Netherlands for the period from 1980 to 2000.

Economy

The Netherlands' prosperous and open economy is based on private enterprise, with the government's presence felt in many of its aspects. Industrial activity features food processing, petroleum refining, and metalworking. The highly mechanized agricultural sector employs only 4% of the labour force, but provides a large surplus for exports and the domestic food-processing industry. As a result the Netherlands ranks third worldwide in value of agricultural exports. Sharp cuts in subsidies and social security spending since the 1980s helped the Dutch achieve sustained economic growth, combined with falling

Table 1. Demographic and health indicators, 1980–2002

Indicator	1980	1985	1990	1995	2000	2001	2002
Population (x 1000)	14 150	14 492	14 952	15 459	15 926	16 105	16 193
% population 65 years of age or over	11.5	12.1	12.8	13.2	13.6	13.7[a]	13.7[a]
Live births (per 1000 population)	12.8	12.3	13.2	12.3	13.0	12.6[a]	12.5[a]
Crude death rate (per 1000 population)	8.1	8.5	8.6	8.8	8.8	8.7[a]	8.8[a]
Total fertility rate (average number of children per woman)	1.6	–	1.6	1.5	1.7	1.7[a]	1.7[a]
Life expectancy at birth (years)	76.0	76.6	77.2	77.7	78.3	–	–
Female life expectancy at birth (years)	79.5	80.0	80.4	80.6	80.8	80.7[a]	80.7[a]
Male life expectancy at birth (years)	72.6	73.2	73.9	74.7	75.7	75.8[a]	76.0[a]
Infant mortality (per 1000 live births)	8.6	8.0	7.1	5.5	5.1	5.4[a]	5.0[a]
Standardized death rate (all causes per 1000 population)	8.12	7.87	7.49	7.25	6.92	–	–
Standardized death rate (all causes per 1000 population)*	-	-	8.6	8.4	8.0	7.9	7.9

Source: WHO Regional Office for Europe health for all database; [a]Statistics Netherlands (Centraal Bureau voor de Statistiek) 2004.

unemployment and moderate inflation. The economy has been growing by around 3-4% annually during the nineties and slowed down over the last few years. Since 1998, unemployment has been less than 5.0% of the labour force; in the late 1990s, inflation was around 2.0% and rose over the last few years. The Dutch joined the first wave of 11 EU countries, launching the Euro monetary system on 1 January 1999. Table 2 gives some macroeconomic indicators for the Netherlands, for 1980–2002.

Table 2. Macroeconomic indicators (1980-2002)

Indicator	1980	1985	1990	1995	2000	2001	2002
GDP[a] per capita (in US $PPP)[b]	8 860	12 204	16 596	21 251	27 183	27 190	29 000
GDP growth rate (% change)[c]	–	–	–	3.0	3.5	1.2	0.2
Annual average rate of inflation (%)[c]	–	–	–	1.4	2.3	5.1	3.9
Unemployment rate (%)	4.6	10.8	5.0	7.1	2.6	2.0	2.3

Sources: WHO Regional Office for Europe health for all database; [c] Eurostat 2004.

Notes: [a] GDP: gross domestic product; [b] PPP: purchasing power parity.

Historical background

Hospitals

Health care in the Netherlands originated largely through the efforts of voluntary organizations. Assistance was often provided on a charitable basis. In the past, such organizations were run largely along religious or ideological lines, which led to the creation of facilities with a Protestant, Roman Catholic, Jewish or humanistic base *(3)*. The history of health care reflects the changing relationship between the government and the voluntary organizations. Originating largely in private and often charitable initiatives, almost all Dutch hospitals are still private and are all non-profit organizations, but are no longer organized strictly on a denominational basis.

Despite the predominance of private ownership, the government heavily regulates the Dutch health care system. Production and capacity of Dutch hospitals are subject to regulation; the Hospital Provision Act (Wet Ziekenhuisvoorzieningen, WZV) strictly regulates hospital capacity. Before hospital construction may take place, a government licence must be obtained.

In the postwar period, through the 1950s, there was a focus on hospital construction, as part of the overall effort to rebuild the nation. In 1971, a comprehensive planning system for inpatient health facilities was started under the Hospital Provision Act (WZV). The main motive for comprehensive planning was the public perception that facilities were poorly allocated. It was widely felt that too many hospitals were located in the major urban areas and that too few were located in other parts of the nation.

Health insurance – sickness funds and private insurance

The Sickness Fund Act (also known as the Compulsory Health Insurance Act; Ziekenfondswet, ZFW), from 15 October 1964, is one of the Netherlands' most recent pieces of social insurance legislation *(4)*. It came fully into force on 1 January 1966 – but, in fact, insurance covering the cost of medical care is one of the oldest forms of insurance in the Netherlands. Voluntary systems, with contributions based on ability to pay, existe the late Middle Ages. They originate from the system of guilds. Mutual support among guild members included payment for medical treatment: the guilds established funds to which their members contributed and from which the doctors were paid. Such forms of insurance existed even after the abolition of the guilds in 1798 and during the industrial revolution. The terrible conditions of the urban poor in the

mid-nineteenth century led doctors to establish sickness funds in a few of the larger cities. Such voluntary schemes were gradually extended to the whole country, partly thanks to the efforts of the growing trade union movement.

Health insurance remained entirely voluntary until 1941 when, under pressure from the German occupying authorities, the Sickness Fund Decree split the health insurance market into three sub-markets: (1) a compulsory social health insurance scheme for employed people (and their families), (2) a voluntary social health insurance for self-employed people and (3) private health insurance for the rest of the population. The Sickness Fund Decree required sickness funds to include hospital care and specialist treatment in their benefits package. As with the earlier private sickness funds, the Decree also refers to the benefits-in-kind delivered by contracted providers.

From 1941 to 1965, the system of compulsory insurance was further developed gradually, with cover being extended both to new types of benefits and new groups of non-employees. One group that came to be covered by compulsory insurance comprised the elderly population who received benefits under the 1947 pension legislation. When the General Old Age Pensions Act (Algemene ouderdomswet, AOW; covering all elderly) replaced this legislation in 1957, a separate health insurance scheme for the elderly whose income fell below a set ceiling replaced compulsory sickness fund insurance for that group.

Such piecemeal development did not make for a clear and straightforward system, as the substance of the legislation was spread over a broad array of orders, decrees and acts. In addition to introducing various innovations, the new Sickness Fund Act (ZFW) brought together and codified the law in this field. The existing benefits-in-kind system was maintained in the ZFW system. Originally, the Act provided compulsory insurance for people in similar employment and comparable groups, a scheme covering the elderly and a voluntary scheme for those not eligible for cover under the compulsory schemes. In all three cases, eligibility was subject to an income ceiling. The scheme for the elderly and the voluntary scheme were not allowed to turn people away because they were "poor risks". Over the years, a situation evolved where the "good risks" were able to obtain lower-cost cover from private insurers while the so-called poor risks had to rely on the statutory schemes. As a result, these schemes faced ever-worsening financial problems, which eventually led to their abolition on 1 April 1986. Those insured under the scheme for the elderly, together with elderly people insured under the voluntary scheme with reduced contributions, were transferred to the general scheme of compulsory insurance. The scheme was also extended to certain categories of social-benefit recipients. To solve the problem of the disproportionate number of elderly in the sickness fund scheme,

the Act on the Joint Funding of Elderly Sickness Fund Beneficiaries (also known as the Overrepresentation of Elderly Health Insurance Act Beneficiaries Joint Financing Act; Wet Medefinanciering Oververtegenwoordiging Oudere Ziekenfondsverzekerden, MOOZ) was intr oduced at the same time. As a result of this law, the privately insured contribute to the disproportionate high costs of the sickness fund scheme.

The abolition of the insurance scheme for the elderly and the voluntary scheme meant that some of the people formerly covered by these schemes now had to rely on private insurance. In order to guarantee access to the private insurance market, insurers were required to include among their policies one that offered cover as defined in the Health Insurance Access Act (also known as the Medical Insurance Access Act; Wet op de Toegang tot Ziektekostenverzeke ringen, WTZ), known as a WTZ standard policy. Rules governing acceptance, coverage and the premiums payable are defined in the Act.

It became clear, very soon after the new Act came into force, that certain categories of people were finding it hard to pay private medical insurance premiums. These premiums, unlike contributions to the social health insurance schemes, were not related to income. Elderly people with only a state pension to live on, or perhaps a small supplementary pension as well, were particularly hard hit. Although the government acknowledged this problem and, indeed, reduced the premium payable by the elderly under the Act, no structural measures were taken to link premium levels to income, because of the planned reform of the system of health insurance. When these plans stagnated, parliament finally voted unanimously in favour of a bill tabled by the then Member of Parliament, Van Otterloo; this bill amended the health insurance system to help pensioners with no supplementary pension or a very small supplementary pension in addition to their state pension.

With the introduction of the Van Otterloo Act, the state pension became the basis for cover under the Sickness Fund Act (ZFW), provided that income did not exceed a certain level. On 1 January 1997, the ceiling for sickness fund insurance for recipients of state pensions was raised more than proportionally to €15 973, and on 1 July 1997, it was raised to €17 330. These increases meant that more pensioners became eligible for cover under the ZFW. As a result of this increased eligibility, most people insured under the ZFW when they reach the age of 65 years continue to be insured in the same way thereafter (the so-called "stay where you are" principle). The main motive for this legislated protection was that a number of groups of insured people had to spend an unjustifiably large share of their income on premiums. This expense affected the elderly who the Health Insurance Access Act (WTZ) determined had to remain privately insured

after reaching the age of 65 years and also affected insured people whose income was only slightly above the upper limits stipulated in the ZFW. By increasing these upper limits, the Van Otterloo Act expanded the number of people insured by the sickness funds by approximately 162 000.

The Sickness Fund Act (ZFW) was also amended (effective from 1 August 1997) so that new students receiving financial assistance under the Student Finance Act (Wet op de Studiefinanciering, WSF) could no longer be insured as dependants free of charge under their parents' sickness fund. These students are now covered by a private medical insurance scheme. The Student Finance Act provides for a grant to cover the cost of this. Students who had already begun their studies before 1997, who were already eligible for (and are still entitled to) financial assistance, retain the right to insurance as a dependant for the remainder of their studies.

On 1 January 1998, the Health Insurance Restructuring Act (Wet Herstructurering ZFW) came into force. This Act sought to provide a solution to a number of widely regarded unjust situations that followed the enactment of the Van Otterloo Act. The series of measures introduced were primarily aimed at improving the insurance position of people over 65 years of age. Since January 2000, self-employed people below a certain income limit are also insured mandatorily under the Sickness Fund Act (ZFW).

Health insurance – the Exceptional Medical Expenses Act (AWBZ)

The Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, AWBZ) came into force on 14 December 1967, with phased implementation of its content beginning on 1 January 1968. With the introduction of the Health Insurance Bill in 1962 (which later became the Sickness Fund Act), the then Minister of Health also launched the idea of an insurance scheme covering the whole population for serious medical risks. This cover included expenses that anyone faced through serious illness or long-term disability – notably mental illness requiring prolonged nursing and care, and congenital physical or mental handicap – expenses that virtually no one is in a position to bear without help from the state or elsewhere.

In 1966, following consultations with the Sickness Fund Council (Commissie toezicht uitvoeringsorganisatie, CTU; since 2000, the Health Care Insurance Board (College voor zorgverzekeringen, CVZ)) and other bodies, a bill was submitted to parliament that provided everyone in the country with compulsory insurance against the expenses associated with serious medical problems. While

the risk of such problems might not be great, should such a risk materialize, the costs involved would be beyond the ability of virtually anyone to pay; this notion led later to the use of the term "exceptional medical expenses".

The scope of the Act is considerable: Having initially served mainly as a means of funding long-term or high-cost care in various types of institutions, the Act's provisions have been extended over the years to cover more and more elements of health care, of which many are neither prolonged nor expensive. At different times, it was planned to gradually transform the Act into a health insurance scheme encompassing the whole population and covering the great majority of health and social services. The multitude of existing insurance schemes would then have been absorbed, wholly or partially, into the new scheme.

In the 1980s, psychiatric care as well as aids and appliances were taken out of the insurance package covered by the Sickness Fund Act (ZFW) and placed within the scope of the Exceptional Medical Expenses Act (AWBZ). At the beginning of the 1990s, the package of entitlements under the AWBZ was expanded to include pharmaceutical services, the services of a genetic testing centre, rehabilitation and treatment at an audiology centre. The purpose of expanding the cover under this Act was to create a form of basic insurance. The idea was to have a system whereby everyone would be insured by the same basic scheme, covering about 85% of health care costs.

When the Kok government came to power in 1994, the idea of basic insurance was abandoned, because earlier government proposals in this area had come to nothing, as a result of divergent social and political views on the subject. A decision was made to continue to divide the insurance system into three categories, based to a large extent on existing arrangements. As detailed in the section on *Health care reforms*, the issue of whether and how to integrate the health care system remains an extremely complex one.

The so-called first compartment includes care that is funded through the Exceptional Medical Expenses Act (the Sickness Fund Act/private insurance constitutes the second compartment, and voluntary supplementary insurance constitutes the third); specifically, it includes long-term care and treatment and services that cannot be insured by individuals – that is, along the original lines of entitlements under this Act. The target group for services provided under the Act has expanded a great deal and has become much more diverse over the past few years; it presently comprises elderly people, the disabled and mentally ill patients with chronic problems. The Act, however, should be designed to cope with changing demand more effectively. The government's aim in doing so is to create a system that will continue to guarantee a high standard of accessible and affordable care for all.

Other insurance schemes

Civil servants (employees of central government) have traditionally been excluded from the social insurance schemes for employees on account of the special nature of their conditions of service. Civil servants are not employees within the meaning of the Sickness Fund Act (ZFW) and, as such, are not covered by the ZFW.

The Central Government Personnel Act (Ambtenarenwet) of 1929 and the Police Act (Politiewet) include provisions that set out the entitlements of civil servants and officers of the national and municipal police force in case of sickness. These entitlements include not only the continued payment of their salary by the central government in the event of sickness but also include the continuation of their medical benefits. Similar provisions, based on the Central Government Personnel Act, cover provincial and municipal authority personnel.

Since the Second World War, the government has been pressed on a number of occasions to bring public servants within the scope of the Sickness Fund Act (ZFW). Organizations of civil servants and provincial and municipal employees, in contrast, favoured a scheme embracing the employees of all public bodies. In 1968, however, a large majority in the First Chamber rejected a bill with this aim.

In 1951, the government had four options from which to choose:

1. particular payments to meet the costs of health insurance;
2. a reimbursement scheme for certain medical expenses;
3. a reimbursement scheme for exceptional expenses that exceeded 5% of a person's income; and
4. the extension of the Sickness Fund Decree then in force to all public servants.

At the time, the government opted for what was intended to be a temporary arrangement that provided for regular payments towards the cost of private health insurance (or, in the case of public sector employees with an income below the statutory ceiling, voluntary cover with a sickness fund). This scheme, known as the Provisional Medical Expenses Scheme, covered civil servants and teachers.

In 1955, the supplementary system of special payments was replaced by the 5% scheme, which provided for the reimbursement of any medical expenses (reasonably incurred by a public sector employee and their family and borne by the employer) in excess of 5% of the individual's salary. This scheme was later extended to former employees who received disability or retirement

pensions, and a similar scheme was set up for military personnel. On 1 January 1981, the 5% scheme was replaced by the Public Servants' Medical Expenses Scheme (Regeling Ziektekostenvoorziening Overheidspersoneel, ZVO), which is administered by an autonomous agency. Percentage deductions under the Public Servants' Medical Expenses Scheme are based on the employee's share of the percentage contributions deducted under the sickness fund scheme. The costs of medical care, similar to that available under the Sickness Fund Act (ZFW), are reimbursed.

These schemes, which (from the late 1950s) were the product of various reports issued by the Limburg section of the Association of Dutch Municipalities (Vereniging van Nederlandse Gemeenten, VNG), the public sector employees' organizations, the municipal authorities' national forum for personnel matters and the Association of Provincial Authorities, were modelled on the health scheme for police personnel that had existed since the 1930s; this health scheme was changed into the Police Medical Service (Dienst Geneeskundige Verzorging Politie, DGVP) by Royal Decree in 1949.

Municipal employees and staff employed by the province of Limburg are covered by the Public Servants' Health Insurance Institute (Ziektekostenregeling ambtenaren, IZA)/Netherlands scheme, created by the merger on 1 April 1993 of ten separate IZA schemes, each covering the municipalities in one or more provinces. The Provincial Authorities' Health Insurance Scheme (Interprovinciale Ziektekostenregeling, IZR) covers provincial authority employees outside of Limburg.

Organizational structure and management

Organizational structure of the health care system

In the Netherlands, three parallel compartments of insurance coexist: the *first compartment* is a national health insurance scheme for exceptional medical expenses; the *second compartment* consists of different regulatory regimes – one for compulsory health insurance through sickness funds for those under a certain income, and another for private health insurance, mostly voluntary; and the *third compartment* is voluntary supplementary health insurance. These different compartments and the systems that constitute them are steered and supervised by different ministries and have (at least) partly different relationships to the insured on the one side and the providers on the other side. These three compartments characterize the organizational structure of the Dutch health care system (Fig. 2).

Fig. 2. The health insurance system (2004)

<table>
<tr><td colspan="2">Supplement health insurance
(voluntary)
Third compartment</td></tr>
<tr><td>Sickness funds
(compulsory under a certain income)</td><td>Private health insurance
(mostly voluntary)</td></tr>
<tr><td colspan="2">Second compartment</td></tr>
<tr><td colspan="2">National health insurance for exceptional medical expenses
(compulsory for the entire population)
First compartment</td></tr>
</table>

Government

The revised Constitution of 1848 defines the government as the monarch acting in conjunction with the ministers. The Constitution does not define the monarch's task within the government, but it is tacitly agreed that the monarch has the following rights: the right to be consulted, the right to encourage and the right to advise. The ministers form the Cabinet Council; it is one of the country's main executive bodies, deliberating and deciding upon general policy and stimulating its unanimity. The definition of "general policy" is left to the interpretation of the Cabinet Council. A *cabinet minister* is usually *head* of a ministry. Ministries are separate administrative bodies responsible for certain elements of the general policy. Ministers are accountable to parliament for their specific responsibilities. The Prime Minister, who is the chairman of the Cabinet Council, is responsible for cohesion and coordination of government policy. His position is one of *primus inter pares* (first among equals), which renders him powerless to make any changes in the Cabinet *(5).*

Ministry of Health, Welfare and Sport

The Ministry of Health, Welfare and Sport (Ministerie van Volksgezondheid, Welzijn en Sport, VWS) defines policies that aim to ensure the wellbeing of the population in the Netherlands and that aim to help the populace to lead healthy lives. One of the main objectives is to guarantee access to a system of health care facilities and services of high quality. To foster this, the health ministry has established the social health insurance schemes under the Exceptional Medical Expenses Act (AWBZ) and the Sickness Fund Act (ZFW). Fig. 3 shows the organizational structure of the health ministry, including subordinated institutes and agencies that assume many of the actual tasks.

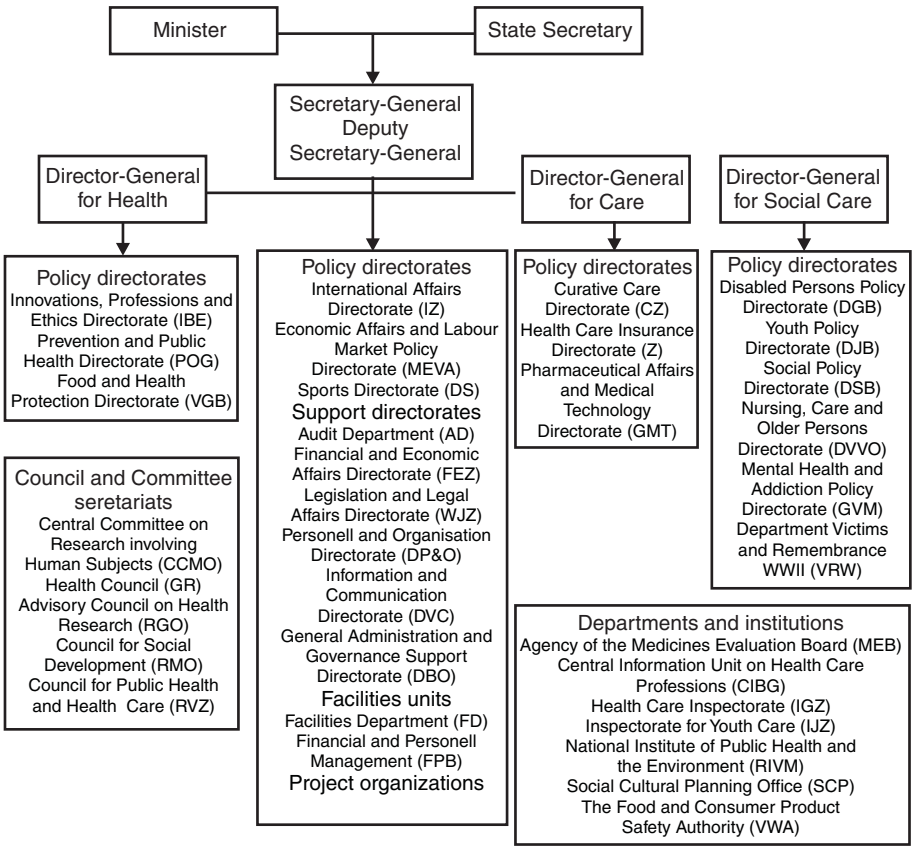
The Ministry of Health, Welfare and Sport and local authorities bear joint responsibility for public health care and play separate complementary roles. The Ministry of Health, Welfare and Sport and the Ministry of Interior and Kingdom Relations (Ministerie van Binnenlandse Zaken en Koninkrijksrelaties, BZK) are also involved in integrated public safety policy, including the implementation of the Medical Assistance (Accidents and Disasters) Act (Wet Geneeskundige Hulpverlening bij Ongevallen en Rampen, WGHOR). The Ministry of Health, Welfare and Sport runs the National Institute of Public Health and the Environment (Rijksinstituut voor de Volksgezondheid en Milieuhygiëne, RIVM), a major knowledge centre for public health care. The Ministry of Interior and Kingdom Relations is responsible for standards in public administration as well as for policy on urban areas and the integration of minorities. It also coordinates integrated public safety and security policy.

Inspectorates monitor and enhance the quality of health and wellbeing of the population. There are three inspectorates: The Food and Consumer Product Safety Authority (Voedsel- en Waren Autoriteit, VWA); the Health Care Inspectorate (Inspectie voor Gezondgeidszorg, IGZ); and the Inspectorate for Youth Care (Inspectie Jeugdzorg, IJZ). In the field of health care, the Health Care Inspectorate is the most important.

Ministry of Social Affairs

The main tasks of the Ministry of Social Affairs and Employment (Ministerie van Sociale Zaken en Werkgelegenheid, SZW) are to stimulate employment, modern labour relations and an active social security policy. To realize these

Fig. 3. The organization chart of the Ministry of Health, Welfare and Sport



Source: Based on Ministry of Health, Welfare and Sport 2004 http://www.minvws.nl/organisatie/organogram, accessed 1 September 2003 *(6)*.

tasks, the Ministry of Social Affairs and Employment collaborates with other ministries, such as the Ministry of Health, Welfare and Sport. Nonetheless, the Ministry of Social Affairs and Employment is responsible for health-related social security schemes covering, among other things, sickness benefits and disabled benefits. These benefits are outside the health insurance scheme, although they are part of the employee insurance scheme which is funded by contributions paid by employers and employees. The implementing bodies of the Sickness Benefits Act (Ziektewet, ZW) and the Disablement Benefit Act (Wet op de arbeidsongeschiktheidsverzekering, WAO) are the social security agencies, as instructed by the National Institute for Social Security (Landelijk Instituut Sociale Verzekeringen, Lisv).

Ministry of Finance
The Ministry of Finance has shared responsibility with the Ministry of Health, Welfare and Sport in supervising changes in the standard insurance scheme – notably, the standard insurance contribution. Private health insurers implement this standard insurance scheme. The legal basis of the standard insurance scheme is the Health Insurance Access Act of 1998 (WTZ 1998).

Third-party payers, associations and supervising organizations

As of 2004, there are 22 sickness funds (*ziekenfondsen*) in the Netherlands. Until recently, the sickness funds were members of a coordinating body, the Association for Sickness Funds (Vereniging van Nederlandse Ziekenfondsen, VNZ). In 1995 this association merged with the Contact Body for Private Health Insurers (Kontaktorgaan Landelijke Organisatie van Ziektekostenverzekeraars, KLOZ) into one central organization called Health Insurers Netherlands (Zorgverzekeraars Nederland, ZN). Membership in this association is voluntary. The sickness funds, however, are under the control of the Sickness Fund Council (Ziekenfondsraad, ZFR). Since January 2000, this Council has been renamed the Health Care Insurance Board (College voor zorgverzekeringen, CVZ).

Health Care Insurance Board (CVZ). Since April 2001, the Board has been made up of nine independent members appointed by the health minister. Previously, the Board consisted of the major health care interests in the Netherlands, including employers, trade unions, health insurers, physicians, consumer groups and the government. The main responsibilities of the Board are to manage the implementation of the Exceptional Medical Expenses Act (AWBZ) and the Sickness Fund Act (ZFW), finance the executive bodies (i.e. sickness funds) and manage the collective resources provided by these laws. In addition, the Board has a number of other tasks. One is to inform the health

minister about all matters concerning insurance under both acts. If the advice relates to policy proposals or proposed statutory regulations, only specific implementation aspects will be considered. The Board has the power to issue insurers instructions about administrative procedures, the registration of people insured, the collection of statistics, annual reports and the conditions of service of staff. It also manages the funds for the AWBZ and the ZFW, into which percentage contributions are paid and from which health services under the acts are financed (via the sickness funds/insurers) and resources are made available for research and publications that relate to health care. The Board is accountable to the health minister, to whom it reports annually on its work. Appeals against decisions by the Board can be taken to the division of administrative jurisdiction of the Council of State (Raad van State), a statutory body that has, among other things, certain administrative juridical competencies.

Supervisory Board for Health Care Insurance (College van toezicht op de zorgverzekeringen, CTZ). Supervision of the implementation of the Exceptional Medical Expenses Act (AWBZ) and the Sickness Fund Act (ZFW) was originally assigned to a committee of the previous Sickness Fund Council (CTU). Since April 2001, the CTU has been transformed into an independent board, the Supervisory Board for Health Care Insurance. The Supervisory Board supervises both the individual executive bodies and the overall implementation of the Exceptional AWBZ and the ZFW. The Supervisory Board consists of five independent members who are not members of the Health Care Insurance Board.

Private health insurers consist of commercial private not-for-profit and for-profit insurance organizations, and private insurance organizations linked with sickness funds.

There has been a tendency towards concentration and cooperation in health insurance. During the period 1985–1993, the number of sickness funds was halved, from 53 to 26, as a result of funds merging. The goals of these mergers were to strengthen the market position of each new fund, to make management and marketing more professional, to achieve economies of scale for administration costs and to pool risk (the law of large numbers). Mergers also occurred among private health insurance funds, as well as between private health insurance and sickness funds. In the latter case, a holding body is used; in this merger, the separate entities are responsible for implementing the sickness insurance programme and private insurance programme. Finally, strategic alliances between sickness funds and private insurers have been developed. These alliances try to benefit from the experience of private insurers in market competition and try to find attractive partners for expanding the package of entitlements. Private insurers see such alliances as a chance to expand their market for insurance products.

The process of concentration cannot be separated from the ongoing process of integration of health insurance into a much broader package of insurance products (for example, travel, life and liability insurance). Marketing an integrated package of insurance products, one that transcends the domain of traditional (social) health insurance, is now considered a strategic necessity if insurers want to be competitive in the health-insurance market. Also, offering a comprehensive package of insurance products is now considered essential for successful contracting with employers.

Despite the overall tendency of the health insurance market towards concentration, an opposing trend is also observable. Between 1994 and 1997, newly established sickness funds were founded by private health insurers (intended to offer employers an integrated package of insurance products), raising the number of sickness funds to 30 in 1997. Between 1997 and 2003 the number decreased again due to of several mergers and since 1 January 2003 there are only 22.

Advisory and administrative bodies

An important aspect of the Dutch health care system is the decision-making process. Guided by a long history of consensual consultation and of policy debate, health policies are now shaped by the interaction between the government and organized groups. Health care during the decades after the Second World War witnessed the rapid development of advisory and administrative bodies. Since the early 1990s, however, a restructuring process was started by the health ministry; it is aimed at reducing the number and improving the transparency of decision-making bodies in health care. The main organizations are:

The Health Council (Gezondheidsraad, GR). This Council is the statutory body that advises the government on the scientific state of the art in medicine, health care, public health and environmental protection. To carry out its responsibility, the council brings together groups of experts on specific topics, at the request of the government. It can also initiate studies on its own. The Council has broad interests, covering most fields in natural sciences and medical research, as well as environmental issues and (lately) nutrition. It has about 160 officially appointed independent members, supported by a small, executive secretariat. Council members (together with outside experts) form ad hoc committees; at any given time, there are 40 to 50 committees with an average of 10 experts each. In this way, a large number of experts from Dutch and foreign scientific communities, representing many different medical specialities and scientific disciplines, can be consulted by the Council.

Health Council committees usually evaluate the effectiveness, efficiency, safety, and availability of health technologies. This mandate is based on the new Special Medical Procedures Act (Wet op bijzondere medische verrichtingen, WBMV; previously the Article 18 programme of the Hospital Provision Act), which is also known as the Exceptional Medical Procedures Act. Some committees also examine epidemiological and economic aspects of health care and – in specific cases – ethical, legal, and social issues. The main research method uses a synthesis of available literature and experts' critical appraisal of conclusions derived from the literature. The Council is also strengthening its "early warning" activities.

Council for Public Health and Health Care (Raad voor de Volksgezondheid en Zorg, RVZ; before 1995 the National Council on Public Health, Nationale Raad voor de Volksgezondheid, NRV). This Council is an independent governmental advisory body, installed by the Minister of Health, Welfare and Sport. The council consists of nine members, including the chairman. They are all appointed by Her Majesty the Queen. Their backgrounds vary considerably, but they all are familiar with the heath care sector and they serve the general interest, independent of their institutions and organizations. The Council advises on health care and welfare policy issues; the main focus now is to stimulate a coherent policy on the quality of health care in the Netherlands. In particular, the Council has given advice on primary health care, care for the elderly and for people with psychological problems, financial matters, medical ethics, rights of patients, cooperation between institutions, information technology in health care, and professionals in health care. To this end, a 5-year task force, called the Committee on Developing Policy for Quality of Care, has been established.

The Council also gives strategic advice on matters such as major governmental problems and political choices. When the government requests advice at an early stage, before political decisions have been made, the Council investigates the pros and cons of possible solutions and describes the long-term and short-term consequences of the various choices. Most of the requests are received from the Minister of Health, Welfare and Sport, although requests are also received from other ministers and members of the First Chamber and Second Chamber. Hence, the Council advises primarily on demand. The Council may occasionally take the initiative and offer unsolicited advice. A secretariat, based in Zoetermeer, supports the Council members.

Board for Health Care Tariffs (also known as the Health Tariffs Authority; College Tarieven Gezondheidszorg, CTG; previously the Central Council for Health Care Charges – Centraal Orgaan Tarieven Gezondheidszorg, COTG). This Board is the independent governmental body that implements the Health

Care Tariffs Act (Wet Tarieven Gezondheidszorg, WTG), which is also known as the Health Care Charges Act. The Board is made up of nine independent members, including the chairman, all appointed by the Minister of Health, Welfare and Sport. The Board's most important statutory tasks are: to determine policy guidelines that provide the framework for tariff negotiations between relevant parties; to approve/set all (maximum) tariffs charged in health care; to perform reviews at the request of the Minister of Health, Welfare and Sport or on its own initiative; and to identify relevant developments in health care that pertain to the implementation of the WTG.

By means of so-called chambers, the Board has structural discussions with relevant parties. These chambers advise the Board on the development of policy guidelines. Chambers I, II and III advise on policy guidelines for various institutions; whereas chambers IV and V focus on independent professionals. Besides health insurers, the most important organizations for institutions and individual professionals are represented in these chambers.

Guidelines are the backbone of health care tariff policy in the Netherlands. The Board sets the guidelines, which are then approved by the health minister. Based on these guidelines, budgets can be drawn up and, in turn, tariffs set.

Medicines Evaluation Board (College ter Beoordeling van Geneesmiddelen, CBG/MEB). The Netherlands has a stringent programme for the evaluation and regulation of pharmaceuticals, including biological substances and vaccines. The responsibility for registration belongs to the Medicines Evaluation Board, which registers drugs on the basis of safety and efficacy (but not cost–effectiveness or societal need). All pharmaceutical products are subject to registration, and the Board generally requires evidence of safety and efficacy (from clinical trials) for new products. The Board has independent authority to grant, refuse, or revoke marketing licences.

The Medicines Evaluation Board Agency, under the supervision of the Ministry of Health, Welfare and Sport, supports the Medicines Evaluation Board and is responsible for preparing and implementing decisions made by the Board.

European Union rules now partially supersede this regulatory programme. Since 1978, new pharmaceuticals already approved elsewhere can be imported under a simplified procedure (parallel imports). More recently, a European pharmaceutical regulatory office, called the European Medicines Evaluation Agency, has been set up in London.

Traditionally, approval of a pharmaceutical product by the Dutch Board led to almost automatic reimbursement by the health insurance agencies. Listing of pharmaceuticals for reimbursement, however, is becoming less automatic, as

a growing number of pharmaceuticals is being assessed for effectiveness (see section on *Pharmaceuticals*).

Netherlands Board for Hospital Facilities (NBHF) (College Bouw Ziekenhuis-voorzieningen). This Board was created after some drastic changes in the health care advisory structure and legislation in 1999. The responsibilities of the Board are regulated by the Hospital Provision Act (WZV), and its main task is to advise the Minster of Health, Welfare and Sport and the provinces on hospital planning policy. It also advises on individual requests from hospitals for licences. One of its most important responsibilities is to monitor infrastructure developments in health care.

National Institute for Public Health and the Environment (Rijksinstituut voor de Volksgezondheid en Milieuhygiëne, RIVM). The RIVM is an independent agency, operating as a one of the main advisors to several Dutch ministries. It advises two ministries on environmental issues and provides policy support to the Ministry of Health, Welfare and Sports (VWS) in several key public health areas. Firstly, it is the central institute for infectious disease surveillance and control, including the quality control of the Dutch national vaccination programme. Secondly, the RIVM operates in various health risk areas, such as integrated assessment of food quality and consumer safety. It has a key role in the regulatory chain for the introduction of new pharmaceuticals on the Dutch market. Finally, the public health branch of the RIVM publishes, every fourth year, a national health report, called the 'Public Health Status and Forecasts'.

Health Care Inspectorate (IGZ). This Inspectorate supervises the quality and accessibility of health care and is autonomous, which means that it is independent of the Ministry of Health, Welfare and Sport. Among other things, it enforces statutory regulations that relate to public health, investigates complaints and calamities in health care and takes appropriate measures (if necessary), and advises the Minister of Health, Welfare and Sport. It is subdivided into three sub-inspectorates: one for preventive and curative health care, one for mental health care, and one for pharmacy and medical technology. The Inspectorate has a headquarters and seven regional offices. An inspector is empowered to submit a complaint about a physician to the Medical Disciplinary Board at any time.

Selected private organizations

Royal Dutch Medical Association (Koninklijke Nederlandsche Maatschappij ter bevordering van de Geneeskunst, KNMG). This Association is a private organization set up in 1849 to represent doctors in the Netherlands. The objective

of the Royal Dutch Medical Association is "to promote medicine in its broadest sense". Four main professional groups work within the Association; these are the Dutch Association of Medical Specialists (Orde van Medisch Specialisten, OMS), the Dutch National Association of General Practitioners (Landelijke Huisartsen Vereniging, LHV), the National Organization of Salaried Doctors (Landelijke vereninging van Artsen in Dienstverband, LAD) and the Dutch Society of Social Medicine (Landelijke vereniging van Sociaal Geneeskundigen, LvSG). The individual tasks of these organizations are specifically oriented to protect the interests of a certain group of doctors.

Dutch Federation of Patients and Consumers (Nederlandse Patiënten/ Consumenten Federatie, NP/CF). This Federation was founded in 1992 and includes over 45 patient and consumer organizations; it distributes information on health issues to the public. It also runs a telephone service for general information, a library, and an information centre. It publishes its own journal, *Kwartaaluitgave*, which comments (from a consumer point of view) on relevant issues in health care. Also, in the information field, some of the leading national newspapers now have regular sections on medical science and health care issues; they strongly emphasize well-informed and responsible journalism.

Consumer involvement has been strengthened by increased consumer representation. The Dutch Federation of Patients and Consumers is promoting the interests of health care consumers by having representatives on national advisory bodies, such as the Health Care Insurance Board (CVZ) and the Council for Public Health and Health Care.

Dutch Institute for Health Care Improvement (Centraal begeleidingsorgaan voor intercollegiale toetsing, CBO). Established in 1979 as an independent foundation by the Dutch Association of Medical Specialists and the Dutch Association of Medical Directors of Hospitals (Nederlandse Vereniging van Ziekenhuisdirecteuren, NVZD), the Dutch Institute for Health Care Improvement has been active in quality assurance. The institute has four major customer groups: medical specialists, nurses, allied health professionals and health care institutions. Its programmes and products aid these customer groups in improving patient care. These programmes and products include the development of guidelines and indicators, visitation systems, a national registry of quality indicators, improvement models, process redesign, total quality management, implementation of existing knowledge and dissemination of best practices, educational and training programmes, and advice for health care organizations and national organizations of professionals. On the subject of quality assurance, the Institute is considered to be one of the most expert organizations in Europe.

Judiciary

The Judiciary in the Netherlands is independent. Judges are appointed by the government for life by Royal Decree. The idea of separation of powers is most clearly expressed in the administration of justice. In principle, the Constitution assigns judicial power exclusively to an independent judiciary, which includes the ordinary judiciary (concerned with civil and criminal law) and a number of specific administrative courts. An exception to this principle is the delegation of certain forms of public conciliation to government institutions (Article 112, Subsection 2). Under Article 120 of the Constitution, the courts cannot rule on the constitutionality of Acts of Parliament *(wetten)* and treaties. Interpretation of the Constitution is the province of the legislature. In fact, The Dutch Constitution plays a relatively modest role in making (constitutional) laws in the Netherlands. This explains the absence of constitutional case law, except for the review of other statutes and by-laws.

Article 107 of the Constitution makes a clear distinction between civil law, criminal law and procedures on the one hand and administrative law on the other. According to the Constitution, disputes that do not concern relations specified under civil law can be judged by either of the court systems, but – and this is important – the type of case that falls under each system is laid down by Acts of Parliament.

In the Netherlands, the civil courts' right to judge health issues is based on a general provision contained in Article 112, Subsection 1 of the Constitution, which states that "the judgement of disputes on civil rights and obligations shall be the responsibility of the judiciary". In addition, under Article 112, Subsection 2 of the Constitution, administrative courts are provided to give citizens legal protection with regard to specific issues. The statutes for administrative courts dealing with health issues are contained in the Sickness Fund Act (ZFW) and the Exceptional Medical Expenses Act (AWBZ). Finally, Article 115 of the Constitution includes provisions for administrative appeal bodies.

Planning, regulation and management

Under Section 81 of the Constitution, the power to make Acts of Parliament is assigned to the government and the States General, acting jointly. The initiative may come from the government or from one or more members of the Second Chamber (such as Member of Parliament Van Otterloo).

Usually one of the ministries (on the orders of the minister) proposes a bill. The bill is then recorded and its various articles are explained in an explanatory memorandum. First, the bill is presented for criticism to the Cabinet Council; then, it is presented for advice to the Council of State. Together with the Council of State's advice, the bill is sent for parliamentary debate to the Second Chamber. When the Second Chamber has passed the bill, it is sent to the First Chamber for further discussion, which is preceded by a written preparation, as in the Second Chamber. The bill is discussed as it stands, as the First Chamber has no right to amend it. After final approval by the two chambers, the bill is sent to the King/Queen for judgement and approval. In view of the ministerial responsibility, the bill is co-signed by the Minister(s), which is called *contra-seign* (countersign). The Minister of Justice finally proclaims the Act in the *Staatsblad* (*Official journal of the state, Bulletin of acts and decrees*).

The government has ultimate control over the planning of care facilities, the pricing of provisions, and the macroeconomics of health care expenditures. In the 1960s and 1970s, the expansion of health technology and care resulted in a steady increase in health care costs. The Dutch government attributed the main cause of rising costs to the construction of new hospitals and health care institutions.

The Netherlands also has "rule-making" by offices other than parliament, or by parliament and the government together. Delegated rules issued by the government or by a minister are very common. Those issued by the government are usually called Orders in Council or Implementation Regulation (algemene maatregel van bestuur); those issued by a minister are called ministerial rules (ministeriële regelingen). Policy rules (beleidsregels), sometimes called pseudo-legislation, are a special phenomenon. These rules are laid down by an administrative body as a form of self-regulation over the exercise of its administrative powers. Policy rules, therefore, can be delegated, for example, to the Board for Health Care Tariffs (CTG), to the Health Care Inspectorate and to other bodies.

Hospital planning

The Hospital Provision Act (WZV) of 1971 became the government's most important planning tool. The law enables the government to regulate all construction of hospitals and health care institutions and makes the provincial health authorities responsible for implementing this plan.

The Act aims to control the supply of hospitals care, as broadly defined. It also aims to promote efficiency in hospital care. Hospitals may not be constructed or renovated – wholly or partially – without successfully completing

a declaration and licensing process. Project approval is based on a detailed plan for each hospital service affected in a specific geographic area. This includes a description of the existing service capacity, the proposed change of capacity, and a schedule for completing the project.

The formal planning process starts with the issuance of an "instruction" from the Minister of Health, Welfare and Sport to the provincial government. The instruction specifies the categories of hospital facilities for which plans must be developed, the geographical region covered, and the deadline for completing this task. In formulating the plan, provincial governments take into account a number of regulations and guidelines; regulations relate to the planning process itself, and guidelines to the content of the plan. Regulations require the participation of hospitals, patients and consumer organizations, local authorities, and insurance companies in the provincial planning process.

The provincial government initially prepares a draft plan, including such aspects as:

- an inventory of existing capacities
- an evaluation of the existing situation in terms of shortages and weaknesses
- a description of construction, renovation and expansion proposals
- an implementation plan and timetable.

The draft is then submitted to the health minister for approval. The health minister, after receiving advice from the Hospital Provision Board (CBZ), determines whether the draft plan is acceptable. The plan forms the basis for the issuance of so-called acknowledgements. This allows planned hospitals to receive reimbursement for services from health insurers. If a particular hospital is not included in the approved plan, it must close.

The hospital planning process under the Hospital Provision Act (WZV) was criticized for its complexity and lack of flexibility. In January 2000, in order to improve the planning process, a new Act, the Special Medical Procedures Act (WBMZ), came into force. The Act should guarantee a more flexible and effective approach to hospital planning, and it was evaluated in 2001.

Accreditation of institutions

Most institutions that provide services under the Sickness Fund Act (ZFW) must be approved by the Minister of Health, Welfare and Sport. Most hospitals and other institutions need recognition under the Exceptional Medical Expenses Act (AWBZ) in order to provide the treatment and services financed under the auspices of the Act. The Minister of Health, Welfare and Sport

following consultation with the Health Care Insurance Board (CVZ) grants such recognition. In addition, there must be an established need for the kind of services the institution in question is offering, and these services must be compatible with the appropriate, geographical, provisional services. To obtain the care to which they are entitled under the AWBZ, people insured under the Act must apply to the health practitioner or institution of their choice, with whom or with which the insurer has a contract.

Quality assurance

In a letter to the parliament on 4 December 2002, the Minister of Health proclaimed the necessity that healthcare institutions should take rigorous action to implement a structured and programmed quality system to systematically measure, improve/redesign and control the quality of patient care. This is in accordance with the Healthcare Quality Law for Healthcare Institutions of 1996.

Evaluation of this law showed that little progress was made towards implementation of a structured quality system by healthcare institutions. The initiative for the change in focus of the government's quality policy (from supporting health care institutions in building up their quality systems, to commanding and controlling progress in this processes) came from the Minister of Health. Following the recommendations of the Health Care Quality Law evaluation in late 2002, the Minister of Health announced specific measures to make quality management compulsory.

In November 2003, the Minister of Health published a catalogue of kick-off measures (*Sneller Beter*) to be introduced in 2004:

- Benchmarking in primary care for all GPs and ten pilot hospitals
- Introduction of indicators for safer and better care
- Program on quality, innovation and efficiency with priority on patient safety and patient-centered delivery of care.

The Dutch Inspectorate of Health Care will supervise performance with the help of two research institutes. Potential penalties have yet to be defined.

Certification of health professionals

The government regulates physicians and nurses. A new system for enhancing professional standards and quality control in health care, laid out in the Individual Health Care Professions Act of 1993 (*Wet op de Beroepen in de Individuele Gezondheidszorg,* BIG; see the chapter on *Human Resources*), is

now being introduced. This will lead to certification and registration of nurses and physicians, a description of restricted medical activity (that is, restricted to qualified physicians only), and reform of the professional disciplinary law. The number of physicians is regulated in two ways: (1) enrolment in basic medical training is limited by a central government quota at medical schools; (2) professional specialist organizations regulate access to specialized education.

The system of contracts between sickness funds and care providers

The Sickness Fund Act (ZFW) and the Exceptional Medical Expenses Act (AWBZ) have provisions for systems of benefits-in-kind (while AWBZ also provides for cash benefits). In this context, the sickness funds (or health insurers or health care offices they designate in AWBZ) enter into contracts. These fall into two categories, those with institutional providers (such as hospitals) and those with individual providers (such as GPs and specialists). While it is mandatory for the sickness funds to enter into contracts with all accredited institutions, they are – since 1 January 1992 – no longer obliged to enter into contracts with all the individual providers.

Under the Sickness Fund Act (ZFW), health care institutions and individual medical practitioners are paid directly by the funds without any financial involvement on the part of the patient (except in the case of services for which a charge is levied). Under the Exceptional Medical Expenses Act (AWBZ), the insurers (or the health care offices they designate) enter into contracts with care providers under which the latter undertake to provide, and the insurers to fund, health and medical services at set rates and on set terms. Under the Act, the insurers are prohibited from employing personnel that would provide such services themselves, other than in special cases and with the approval of the Health Care Insurance Board (CVZ).

Before a contract between individual parties can be entered into, there first has to be national consultation between the representative organizations of health insurers and health care providers. If the consultation process is successful, a document known as the "consultation outcome" is drawn up, which then has to be approved by the Health Care Insurance Board (CVZ). If the parties cannot work anything out, the CVZ draws up a "model contract". Under the terms of the Sickness Fund Act (ZFW) and the Exceptional Medical Expenses Act (AWBZ), the consultation outcome or model contract must contain certain elements. Any other agreements – for example, concerning fees charged – are set down in the individual contracts with health care providers.

Fees are subject to approval by the Board for Health Care Tariffs (CTG) under the terms of the Health Care Tariffs Act (WTG). As of 1 January 1992, independent medical practitioners and equivalent organizations, such as doctors' partnerships, are subject to a system of maximum fees under which it is possible to charge fees lower than those set or approved by the CTG. Contracts are then determined (other than laying out the matter of fees) by negotiations (based on the consultation outcomes or model contracts) between the representative organizations. The Health Care Insurance Board (CVZ) must then approve them.

Supervision

Under the Sickness Fund Act (ZFW) the task of ensuring that sickness funds carry out their management and administrative duties in a proper manner is entrusted to the Health Care Insurance Board (CVZ), whose other statutory duties include advising the government on matters relating to health insurance. The Board is assisted by a secretariat headed by a general secretary, who is appointed (as is the rest of the secretariat's staff) by the Board.

The Board is accountable to the Minister of Health, Welfare and Sport, to whom it reports annually on its work. The health minister may issue policy rules on how the Board should perform its duties; he/she may also influence its work by exercising their power to reverse its decisions.

The Board's operating costs are met from the Central Fund (Centrale Kas) established by the Sickness Fund Act (different from the Exceptional Medical Expenses Act Fund, which it also manages). The operating costs are partly covered by the Sickness Fund Act (ZFW) Fund and the Exceptional Medical Expenses Act (AWBZ) Fund. The division is based on the time the Board spends on the different acts. For 2000, the percentages were 63% (ZFW) and 37% (AWBZ). Responsibility for ensuring that it does so in a proper manner rests with the health minister. The Board holds the financial resources of the Central Fund in a current account in the name of the Minister of Finance. Central Fund resources are not only used to cover the costs of sickness fund insurance, but are also used in connection with research and publications that relate to health care, and part is used to form a reserve.

The role of the Supervisory Board for Health Care Insurance (CTZ) is to supervise the implementation by the executive agencies of the Sickness Fund Act (ZFW) and the Exceptional Medical Expenses Act (AWBZ). The executive agencies are obliged to report periodically to the Supervisory Board for Health Care Insurance.

Appeals

Under the Sickness Fund Act (ZFW), appeals of decisions made by a sickness fund can be made in various ways. A distinction, however, must be made here between complaints relating to treatment, disputes about registration or contributions, and disputes concerning entitlement to benefits in kind (or to an equivalent payment) under the ZFW. A more or less similar distinction among types of complaints can be found under the Exceptional Medical Expenses Act (AWBZ): In such appeals, a distinction must be made between disputes relating to how bodies that implement the Act treat insured people (or whether the latter are insured under the Act) and disputes concerning entitlement to benefits in kind (or to an equivalent payment under the Act). Under both acts, the most important type of complaint involves disputes over entitlement to benefits.

Different arrangements apply to disputes relating to entitlement to benefits in kind or to an equivalent payment. The insured must submit a formal objection in writing to the sickness fund (or relevant implementing body in the case of the Exceptional Medical Expenses Act). Before considering the objection, the sickness fund (or the relevant Exceptional Medical Expenses Act body) must first seek the advice of the Health Care Insurance Board (CVZ). After obtaining the advice and sending a copy of it to the insured, the sickness fund issues a decision on the objection. If the insured does not agree with the decision, he/she can bring an appeal to the administrative law section of the district court. As supplementary insurance is private insurance, insured people can bring disputes before a civil court.

Under the Health Insurance Access Act (WTZ), private health insurers operating in the Netherlands, with the exception of those exempted from the obligation to offer standard cover, run the standard policy scheme. Implementation of the apportionment scheme is the responsibility of the WTZ Apportionment Scheme Implementation Council.

The job of supervising the private medical insurance sector is entrusted to the Pensions and Insurance Supervisory Authority (Pensioen- en Verzekeringskamer, PVK), a body established under the 1993 Insurance Business Supervision Act (Wet Toezicht Verzekeringsbedrijf, WTV). This supervisory function is limited to monitoring compliance with the requirements that aim to ensure the solvency of insurers and does not, however, extend to the application of the standard policy scheme in individual cases. This is the responsibility of the Minister of Health, Welfare and Sport, whose job it is to ensure that the legislation is properly implemented. Together with the Minister for Economic Affairs and the Minister of Finance, the Minister of Health, Welfare and Sport also monitors trends in the level of premiums of standard policies.

Disputes regarding implementation of the standard policy scheme may be taken before the civil courts. All disputes regarding standard cover may be submitted to the Health Insurance Access Act (WTZ) Appeals Committee. A small sum must be paid before the committee will consider an appeal. If the Committee deems the complaint to be well founded, this sum is then refunded. The Committee's decisions are binding.

Decentralization of the health care system

In the Netherlands, policy traditionally has been prepared and implemented by a massive neocorporate bureaucracy, bringing together government agencies, quasi-governmental organizations (the advisory and executive agencies), the private national organizations of suppliers and providers, and the insurers. This national bureaucracy has developed a grip on the number and distribution of hospital beds and specialist places, and on investment decisions and management costs in health care.

In the 1970s, the concept of centralized government coordination and planning became the leading principle (and model) in health care. The 1974 policy paper *Structuring health care* (*Structuurnota Gezondheidszorg*) *(8)*, however, departed from this concept and contained proposals for decentralized administration by regional and local authorities. In the centralized coordination and planning model, the government would maintain a strong and central steering role. Legislation would then have to be passed to regulate the planning of health care facilities and the tariffs of health care services.

Departing from this model of centralized steering**,** the 1986 coalition government started major reforms – mainly in the field of social health insurance. The integration of different insurance schemes into one social insurance for all (with largely income-related contributions) was widely and seriously debated; this debate aimed to strengthen solidarity in financing. Under these reforms, all insurers would operate as independent and risk-bearing insurers and compete for the insured under the same regulations. One central fund (centrale kas) would provide budgets for all the insurers. While these proposed reforms have been broadly discussed (but yet to be implemented), a crucial element of them was the shift of the insurance risk from the public funding system towards the individual insurance plan. The credo of this shift was "less government, and more market". More precisely, the shift of insurance risk involves a policy of transferring steering competencies from the collective sector to the private sector, such as the providers and insurance agencies. In the Netherlands, this policy

of *delegation* is called "functional decentralization"; it has mainly occurred in the *cure*-sector – that is, acute care and both specialist and general medicine. Through negotiations and contracts, an increasing number of health insurers and providers have become more important participants in defining and interpreting health care, instead of the government and administrative agencies assuming these roles. This point is illustrated by the new role of medical specialists in hospital care; they have acquired an independent coordinating position vis-à-vis both hospital management and sickness funds. Local negotiations and the centralization of negotiating power are the ingredients of the changing power position of medical specialists. Likewise, a greater number of hospital managers take a more pragmatic attitude towards coming to terms with the medical staff than one might expect from the power-driven claims of their umbrella organizations *(9).*

Apart from the shift from government to private enterprise, the Dutch health care system faces *devolution* or "territorial decentralization" – that is, a transfer of competencies from the central government to provincial and local governments. In health care, territorial decentralization has occurred in *care facilities*. Territorial decentralization in steering care facilities includes shifts in financing (such as involvement in project subsidies and reimbursement from general revenues) and planning of care. In the field of planning, an important example is the increased influence of local and provincial governments at the expense of other actors. Among other things, this shift in powers has manifested itself in the use of municipal committees for needs assessment (gemeentelijke indicatiecommissies, GIC). Due to a scarcity of facilities, care must be rationed, which has resulted in establishing and using independent integral needs assessment committees for an increasing number of facilities and disorders. Here, local governments play a major role, given the increasing number of regional assessment bodies – established by (collaborative) local governments.

Health care financing and expenditure

Systems of financing and coverage

Medical care in the Netherlands is largely funded by a system of public and private insurance schemes. Only about 12% of all health care funding is not covered by an insurance scheme (see section on *Other sources of finance*). The insurance system is divided into three compartments, in accordance with the current method of classifying health care (Fig. 4).

The first compartment covers the exceptional medical expenses associated with long-term care or high-cost treatment, where the expense is such that it cannot be borne by individuals or adequately covered by private insurance. This compartment of care is covered under the Exceptional Medical Expenses Act (AWBZ). With a few exceptions, everyone living in the Netherlands (irrespective of nationality) and all non-residents employed in the Netherlands and subject to Dutch income tax are covered by the Act.

The second compartment covers normal, necessary medical care. The costs in this case are largely covered by sickness fund insurance, private medical insurance (including the standard cover provided for under the Health Insurance Access Act), or a health insurance scheme for public servants. Normal medical expenses are covered by a variety of insurance arrangements, the most important of which is that governed by the Sickness Fund Act (ZFW). People with an annual salary below a statutory ceiling (€ 32 600 in 2004) and all recipients of social security benefits are insured up to the age of 65 years under this Act.

Since 1 January 1998, people 65 years old and over who were insured under the Act before they turned 65 will continue to be insured in this way after they reach the age of 65. Their income is no longer a significant factor. This is known as the "stay where you are" principle. In principle, the same arrangement applies

to the private sector. All people privately insured before they turn 65 continue to be insured under that scheme after they reach the age of 65. Only if taxable household income falls below €20 750, may the person concerned register with a sickness fund ("opting in").

Almost 63% (2004) of the Dutch population are covered by the Sickness Fund Act (ZFW), which is about 1% more than in 1998. The health insurance schemes for the various categories of public servants cover around 5% of the total population.

For those covered neither by the Sickness Fund Act (ZFW) nor by the schemes for public servants, there is the option of cover from one of the many private-sector health insurance companies operating in the Netherlands. Approximately 30% of the population are privately insured for medical expenses in the second compartment, and 17% of these (about 4% of the total population) have standard cover under the Health Insurance Access Act (WTZ). In discussing private insurance, this report will mainly concentrate on this group.

Around 2% of the population are military personnel, prison inmates or uninsured.

The third compartment covers the supplementary forms of care regarded as being less necessary. The costs here are largely covered by private medical insurance. Supplementary insurance can be taken out to cover the costs of these kinds of care, which are not included in the first or second compartment. This is a voluntary health insurance scheme where the insurers – both sickness funds and private health insurers – themselves determine the content and scope of the package and the conditions under which this type of insurance can be taken out. They also fix the premiums. Possible examples of this kind of insurance include (supplementary) dental insurance and extensions of the insurance package to cover specific items, such as eyeglasses, a higher standard of hospital accommodation, and alternative medicines.

Fig. 4. Population coverage and expenditure in the health insurance system (approx. 2003)

<table>
<tr><td colspan="2">Supplementary health insurance
Third compartment (3% of health expenditure)</td></tr>
<tr><td>Sickness funds
(63% of population)</td><td>Privatre health insurance
(30% of population)</td></tr>
<tr><td colspan="2">Second compartment (53% of health expenditure)</td></tr>
<tr><td colspan="2">National health insurance for exceptional medical expenses
(100% of population covered)
First compartment (41% of health expenditure)</td></tr>
</table>

Finance and coverage under the Exceptional Medical Expenses Act (AWBZ)

Insurance under the Exceptional Medical Expenses Act (AWBZ) is mandatory: everyone meeting the criteria set forth in the Act is insured – whether or not they want to make use of the treatment and services offered – and must pay the relevant contributions. There is one exception to this last requirement: people with a conscientious objection to the principle of insurance are exempted from contributing, paying instead an income tax surcharge in the same amount as the contribution. They are not excluded from the scheme and may make use of its benefits by registering with a sickness fund or recognized insurer when they require assistance.

Eligibility for coverage

As a national insurance scheme, the Exceptional Medical Expenses Act (AWBZ) covers residents and non-residents, as follows:

1. **Residents in the Netherlands**. Whether or not someone is regarded as a resident is decided in light of the circumstances of each case (with Dutch-based ships and aircraft being considered part of the Netherlands for this purpose). Indeed, the courts have determined that under certain circumstances even people currently living abroad may be regarded as residents for the purposes of the Act, provided that their social and economic links make the Netherlands their home. On the other hand, a foreigner with a house in this country may not be considered a resident of the Netherlands for the purposes of the Act.
2. **Non-residents.** They are liable for Dutch wages and salaries in connection with employment in the Netherlands. This category covers mainly cross-border commuters and guest workers.
3. **Non residents covered under the 1999 Decree regulating Admission to the National Insurance Schemes**. This category includes, for example, retired people with national health insurance cover living outside the Netherlands and members of the families of active and post-active national health insurance fund members

The general rule is that everyone residing in the Netherlands is covered by the Exceptional Medical Expenses Act (AWBZ), regardless of nationality. There are exceptions to this rule in the form of both extensions of cover of non-residents and exclusions from cover of residents. This is set down in the 1999 Decree regulating Admittance to National Insurance Schemes *(10).*

Cover for children under the Exceptional Medical Expenses Act (AWBZ) is not linked to the coverage enjoyed by their parents (as under the Sickness

Fund Act); instead, each case is assessed on its merits, and cover also depends on the child's place of residence. Unlike other national insurance schemes, the AWBZ does not lay down any upper and lower age limits for cover.

Registration and administration

Entitlement to services provided under the Exceptional Medical Expenses Act (AWBZ) depends on registration with one of the bodies that implement the Act. It was decided, however, not to opt for a system of individual registration (as under the Sickness Fund Act); instead, anyone covered by the AWBZ who is insured for normal risks by any health insurer is regarded as being registered with that insurer for the purposes of the Act. People covered by the Act who are not insured for normal risks may apply to any sickness fund or to a recognized insurer when they require assistance under the Act.

To be ensured of entitlement to services, insured people residing abroad must register with one of the bodies authorized to implement the Act in the Netherlands. Registration is governed by the same regulations as those applicable to residents.

Registration is based on the individual's existing insurance and is valid for a period of one calendar year at a time, unless the insured party sends written notification stating that he/she does not wish to renew their registration. In such cases, a 2-month notice is required. As individuals are registered with the same insurer for normal risks and for cover under the Exceptional Medical Expenses Act (AWBZ), termination of registration for normal risks, for whatever reason, will also entail termination of registration for exceptional risks.

Individuals requiring the services covered under the Act need only deal with their own insurer, who is responsible for deciding whether to grant, continue or terminate cover, so that patients in any one health care institution – especially if it is a regional or national centre – may be covered by a large number of insurers.

A system has been devised for certain services covered under the Act whereby, as far as possible, institutions only have to deal with one insurer for both financial and medical matters. To this end, part of the administrative work associated with the implementation of the Act and all payments are handled by a Central Administrative Office (Centraal Administratie Kantoor, CAK). The rest of the administrative work is handled wholly or partly by care offices (zorgkantoren). The care office in each of 32 regions performs its tasks under the Exceptional Medical Expenses Act (AWBZ) on behalf of all the bodies that execute the Act, and each office is managed on a concession basis for 5 years (currently 2002–2006) by the regional market sickness fund leader in its area. The responsibilities of the care offices include concluding contracts with

home-care institutions, psychiatric hospitals and other institutions, determining and collecting the charges payable by insured individuals, and participating in discussions about health care services available in the area. Each health care office receives data from insurers and maintains a register of admissions for each institution in its area for the purpose of making monthly settlements and advance payments. Payments to institutions are not made by the health care offices but are made instead by the central administrative office.

Funding

The cost of insurance under the Exceptional Medical Expenses Act (AWBZ) is covered by percentage contributions and government funds. Under the provisions of the National Insurance Financing Act (Wet Financiering Volksverzekeringen, WFV), insured people are liable to pay contributions. This means that people who do not receive wages or a salary but who are liable to tax and social security contributions are issued an assessment for percentage contributions, while contributions are deducted from the earnings of employed people and paid to the tax authorities by their employer. National insurance contributions, which include contributions under the AWBZ, are levied on taxable income, together with the income tax. Under the Act, in 2004, the percentage contribution is 10.25% of taxable income. No contribution is payable for insured people with no taxable income.

Before the Exceptional Medical Expenses Act (AWBZ) was introduced, much of the medical care for which it now provides cover was funded from general revenue – for instance, under the National Assistance Act (Algemene Bijstandswet, ABW) – so that the new Act, being insurance-based, produced considerable savings for the government. It was decided to recycle part of this savings as a structural grant into the AWBZ Fund. Over the years, this government grant has changed many times, due in part to the fact that benefits are added and removed from the scope of the Act. The contributions due under the Act are paid into the AWBZ Fund. The AWBZ Fund is therefore funded by contributions, the government grant and co-payments. From 1992 to 1995, there was also a flat per-person premium of around €59 per year – similar to that under the Sickness Fund Act (ZFW).

The Health Care Insurance Board (CVZ), which manages the Exceptional Medical Expenses Act (AWBZ) Fund, makes payments to the bodies that implement the Act, to cover treatment, services and administrative costs. A macro-administrative cost budget is fixed annually to cover administrative costs under the Act and is allocated to the various implementing bodies according to set guidelines. The details of these arrangements are laid down by decree.

Finance and coverage under the Sickness Fund Act (ZFW)

Insurance under the Sickness Fund Act (also known as Health Insurance Act, Ziekenfondswet ZFW) is statutory: everyone who meets the criteria established by the legislation (of which the most important is that their income must be below a statutory ceiling) is automatically insured and must pay the statutory contributions, whether or not they wish to make use of the benefits offered. An exception to the obligation to pay contributions is only made for those who object on principle. They pay an additional tax instead of contributions.

Eligibility for cover

The same people are covered under the Sickness Fund Act (ZFW) as are covered under the Sickness Benefits Act (ZW), which governs cash benefits payable in connection with sickness and maternity. Broadly speaking, people defined as employees are insured up to the age of 65 years, provided that their annual income is below a statutory ceiling (set at €32 600 for 2004). Coverage also extends to the recipients of social security benefits, again up to the age of 65 years. Earned income and social security benefits are added together to: (1) decide whether an individual's income falls below the ceiling and to (2) determine the total contributions payable (with no contributions due for that portion of the annual income that exceeds a certain figure, which is lower than the threshold). Anyone whose annual income, added up in this way, exceeds the income ceiling for that year ceases to be insured under the ZFW.

From 1 January 1998, a number of new measures have been applied to people 65 years of age or over. These can be summarized as follows:

- Everyone insured under the Sickness Fund Act when they reach the age of 65 years remains insured in principle ("stay where you are" principle).
- For people 65 years of age or over who have private insurance, there is now the option of registering with a sickness fund on a voluntary basis ("opting-in"). The precondition for this is that their annual taxable household income must be below €20 750 (in 2004). A broader definition of income is used here: taxable income also includes interest on savings, dividends, annuities or other income from property. Previously, it was possible for people with a high taxable income, so-called millionaires, to be registered with a sickness fund as a result of tests based solely on income from (former) work. After the definition of income was broadened, this is no longer possible.

Since January 2000, there is a special regulation for the self-employed. Self-employed people with an income of up to €20 800 (in 2004) are insured mandatorily under the Sickness Fund Act (ZFW) and pay a percentage contribution. This contribution is at the rate of 8.0% (in 2004) and is equal

to the percentage of the contributions paid by employers and employees (for employees). In addition to this contribution, the self-employed are also obliged to pay a flat-rate contribution, which is determined separately by each sickness fund.

While coverage under the Sickness Fund Act (ZFW) does not depend on possession of Dutch citizenship, it does normally require residence in the Netherlands. This restriction does not apply, however, if the insured lives in a country where, under the terms of a European Economic Community regulation or a bilateral agreement, he/she is entitled to services normally available under the Act. A person's status as a resident of the Netherlands is based on their actual circumstances: what matters is not where a person happens to be living, but rather whether their social and economic links to the Netherlands are such that it can be regarded as their home.

There are a number of exceptions to this general eligibility rule for cover. The decree designating people insured under the Sickness Fund Act (ZFW) details the categories of insured people referred to in the Act. Another decree, which restricts people insured under the Act, specifies several excluded groups.

Subject to certain conditions, cover is extended to the partner and children (including stepchildren, foster children and the children of the insured party's partner) of the person insured. Legal spouses, registered partners or any person with whom the insured lives on a long-term basis can be entitled to cover, with the exclusion of blood relatives of the first degree, meaning parents. Only people under 65 years of age are entitled to be covered as dependants.

To be entitled, the spouse or other partner must belong to the same household as the insured – that is, they must live together. Entitlement lapses as soon as they split up, even if there is no divorce or legal separation.

Coverage for children claimed as dependants normally depends on their being "1argely maintained" by the person insured. This means that the person insured must contribute at least €29.69 (2004) per week towards the cost of maintaining each child. Children who since 1 August 1997 have been eligible for financial assistance under the Student Finance Act have no entitlement to cover under the Sickness Fund Act (ZFW).

For entitlement to cover as a dependant, the person insured must be the breadwinner – that is, the income assessed for levying contributions must amount to at least half of the couple's joint income. Cover as a dependant is not available for people already insured in their own right, whether under the Sickness Fund Act (ZFW) or under one of the health insurance schemes for public servants.

Registration

Despite the statutory nature of the scheme, individuals must register with a sickness fund to obtain benefits. This does not imply entering into an insurance contract, since insurance cover follows from the legislation itself; rather, it is an administrative procedure that must be gone through to activate the individual's statutory rights and obligations. Since 1 January 1992, when the Health Insurance System Second Phase Amendments Act (Wet stelselwijziging ziektekostenverzekering tweede fase) became law, sickness funds are no longer limited to particular regions, and all of them now may operate throughout the Netherlands. This means that people can choose from a wide variety of funds. By 1997, however, only 8.7% of people insured were insured with sickness funds outside their former catchment.

Certain categories of people, among them seamen and certain people entitled to cover who live outside the country, are required to register with specific funds. The Seamen's Fund (Algemeen Ziekenfonds van Zeelieden, AZVZ) has about 4400 members (2001).

As long as the basis for sickness fund insurance exists, people are insured for one calendar year. The insurance is extended each time it expires by a further calendar year. This notwithstanding, an insured party can terminate their registration if the insurer notifies him/her that the flat-rate contribution has been changed. If an insured party wishes to change from one fund to another, the original fund must be notified in writing before the registration period is due to expire. The sickness fund is authorized to require a period of notice of up to 2 months.

Once an individual is registered, the sickness fund issues a certificate of registration for use as proof of entitlement to services. Provisional certificates may be issued where the fund considers the individual's status to require further investigation.

Where a change of circumstances means that an individual is no longer entitled to insurance or to cover as a dependant, he/she must inform the fund directly. If this is not done, and the individual remains improperly registered as insured or dependant, the fund has the right – when this becomes known – to terminate registration and require compensation for the period of improper registration. This includes compensation for fees paid on a subscription basis to GPs, for administrative costs and for the risk borne by the fund. For 2001, this amounted to €95 per person per month.

On the other hand, where a change of circumstances requires a person with private cover to join a sickness fund, the private cover ends when the insured gives notice of registration with a sickness fund to the private insurer. Where a private policy provides fuller coverage than the fund, the individual may

continue to use private insurance for the additional coverage – providing, for example, for a higher standard of hospital accommodation. Individuals who give notice of registration with a sickness fund, causing their private coverage to lapse, may claim a refund of the premiums paid in advance, subject to a deduction of up to 25% for administrative costs. Where someone privately insured finds that, through changing circumstances, he/she must register with a sickness fund for a period of less than 3 months, he/she may retain entitlement to reimbursement of medical expenses under the private scheme. The private insurance premiums paid for the period in question are repaid by the sickness fund on request.

Funding

The revenue needed to operate the Sickness Fund Act (ZFW) scheme is derived from the following sources: contributions, government grants and special transfer payments for the elderly.

a. Contributions

Insured parties are charged both percentage and flat-rate contributions. The basic rule is that the contributions – payable up to 65 years of age – are related to the insured person's income, whether this is earned income or income in the form of social security benefits. Part of the contribution due for each person insured is payable by their employer (or the body from which he/she receives social security benefits). Until the end of 1988, the amounts paid by employee and employer were the same – that is, they were fixed at the same percentage of the employee's income. From the beginning of 1989, however, contributions ceased to be entirely income related: a part of the contribution is now a flat-rate charge payable by the insured and, reflecting this change, the employer's share of the percentage contribution is now higher than the employee's share.

With regard to income-related contributions, the amount of gross income on which contributions have to be paid by insured people is limited, in 2004, to €29 493 in the case of employees and €20 800 in the case of the self-employed.

All values mentioned – that is, the maximum amount for which Sickness Fund Act (ZFW) insurance is mandatory, the contribution rate with the ratio between employee and employer, and the maximum amount of contributory income – are set yearly by the Ministry of Health, Welfare and Sport (with the contribution rate being proposed by the Health Care Insurance Board).

Table 3 specifies the various income-related rates and employee–employer distribution in the Exceptional Medical Expenses Act (AWBZ) and the Sickness Fund Act (ZFW).

Table 3. Contribution rates and employee–employer distribution in the Exceptional Medical Expenses Act (AWBZ) and the Sickness Fund Act (ZFW), 1990–2004 in percentage of gross income

	1990	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
AWBZ (employee only)	5.4	8.85	7.35	8.85	9.6	10.25	10.25	10.25	10.25	12.3	13.25
ZFW employee	3.05	1.1	1.65	1.35	1.2	1.55	1.8	1.7	1.7	1.7	1.25
ZFW employer	4.85	7.25	5.35	5.55	5.6	5.85	6.3	6.25	6.25	6.75	6.75
ZFW total	7.9	[a]	7.0	6.9	6.8	7.4	8.1	7.95	7.95	8.45	8.0

Note: [a] Because the employers' contribution was not made on the full amount, the percentages cannot be added together.

The contribution rate paid by seamen is lower than that for other employees, since the Commercial Code requires owners to ensure that medical services are available aboard their vessels. For some groups, contributions are set at a particular sum, as their income is so low that calculations of an income-related liability to pay would produce an absurd result; such people are exempted from the flat-rate charge referred to above.

People taking early retirement are also subject to special arrangements, since they have no employer to share in the payment of their contributions. Under these arrangements, the part of their income that is related to their state old-age pension and any further income are both subject to deductions at the full contribution rate of 8.0% (2004), normally paid by the employee and employer together. Similar arrangements exist for those over 65 years of age, who likewise have no employer to share in the payment of their contributions. They also pay a contribution rate of 8.0% (in 2004) on their state old-age pension. Any other income on which health insurance contributions are payable (that is, income derived from employment) is subject to a contribution rate of 6.0% (2004).

With regard to the flat-rate contribution, this had been set by the government at €71 per person per year for 1989 and 1990 and, since 1991, has been set by the individual sickness funds. Since 1 January 1995, no flat-rate contribution has been due for children insured as dependants. In 2003, yearly flat-rate contributions varied between €239 and €390 for the insured person and their partner being insured as a dependant, a sharp increase over 2002. Also, the difference between the cheapest and the most expensive fund has noticeably widened since 1999, when it ranged from €156 to €200 per year. On average,

the flat-rate contributions constitute about 10% of the overall contribution paid to the sickness funds, but for an individual – depending on income, sickness fund and existence of a spouse – this figure can be considerably higher.

The flat-rate contribution is collected in monthly instalments by the sickness fund with which the individual is registered. In the case of over-65-year olds living abroad and receiving a state old age pension, the flat-rate contribution is deducted at the source by the Social Insurance Bank in Amsterdam.

b. Government grants

Until their abolition on 1 April 1986, the health insurance scheme for the elderly and the voluntary health insurance scheme were partially funded by the government. These funds were then diverted to the Central Fund for the sickness fund scheme. When the Health Insurance Access Act (WTZ) and the Act on the Joint Funding of Elderly Sickness Fund Beneficiaries (MOOZ) came into force on the above date, the Sickness Fund Act was amended to the effect that the government would make an annual grant towards the cost of financing the sickness fund scheme. The amount of this grant is determined annually; in 2002, it amounts to about 24% of the Sickness Fund Act (ZFW) expenditure channelled through the Central Fund.

c. Special transfer payments for the elderly

All people covered by the former insurance scheme for the elderly, together with elderly people insured under the voluntary scheme with reduced contributions, were transferred to the Sickness Fund Act (ZFW) scheme when the special schemes were abolished on 1 April 1986. The goal set for the system at the time of the introduction of the Health Insurance Access Act (WTZ) was that only those people covered by the sickness fund scheme before reaching 65 years of age would remain covered thereafter, but the transitional arrangements introduced in connection with the abolition of the special schemes meant that elderly people were over-represented within the ZFW scheme, as compared with the elderly in the private insurance sector. In order to remedy the financially damaging effects of this imbalance on sickness fund insurance, legislation was introduced compelling the private sector to make a contribution towards the cost of sickness fund insurance as long as elderly people remain over-represented within that scheme (the so-called Act on the Joint Funding of Elderly Sickness Fund Beneficiaries, MOOZ).

With the exception of the flat-rate contribution, all these resources are channelled into a central fund for the sickness fund insurance scheme, which is managed by the Health Care Insurance Board (CVZ).

Finance and coverage of private health insurance

Private health insurance falls into two categories, the standard policy provided under the Health Insurance Access Act (WTZ) and other forms of policies. Anyone wishing to be privately insured is not obliged to take out the standard policy, as defined in the Act; all insurance companies are required, however, to offer such a standard policy to anyone requesting it who meets the statutory criteria. For this reason, the term "mixed" cover is used.

Eligibility for cover

In addition to those entitled to a standard policy under the transitional arrangements provided at the time the Health Insurance Access Act (WTZ) came into force, such cover is also available to the following groups:

(a) people residing in the Netherlands who, for whatever reason, have had to leave the sickness fund insurance scheme or one of the schemes for public servants;

(b) people residing in the Netherlands who are uninsured and who do not know, and cannot reasonably be expected to know, that they have an above-average risk of sickness; and

(c) people taking up residence in the Netherlands who have previously had some form of health insurance.

On 1 January 1989, the Act was amended to allow 65-year-olds who previously had some other form of private insurance (generally with high premiums) or none at all to take out a standard policy. Provision was also made for a system of sharing the losses suffered by all insurers on standard policies for the over-65-year olds: these losses are apportioned among private insurance policyholders under 65 years of age through a surcharge on their premiums.

No restrictions may be imposed on the standard coverage afforded to members of any of the groups above on the grounds of higher-than-average risk of sickness. Members of groups (a) and (c) are also guaranteed standard coverage without any age surcharge if they have had any form of health insurance during the preceding 6 months.

A number of additions and exceptions to the above rule are set out in a decree detailing further the categories of people who may or may not be admitted to the Health Insurance Access Act (WTZ) scheme.

Since February 1991, privately insured people who pay more than the maximum standard-policy premium for their age group – excluding co-payments and deductibles – have also been able to take out a standard policy. Their existing policy must be for third-class accommodation and they must have

been insured (other than under the Exceptional Medical Expenses Act) for at least three consecutive years. Losses incurred by insurers due to the low level of premiums paid by this category of people under 65 years of age, however, were not shared among other private policyholders as of 1 March 1994.

Since January 1992, students with private medical insurance who are entitled to financial assistance under the provisions of Chapter 11 of the Student Finance Act have been able to take out a standard policy at a reduced premium. A partner and children for whom the student receives a partner or single-parent allowance are also entitled to a standard policy at a reduced contribution rate.

Registration

People who meet the statutory criteria for the standard policy may apply to any private health insurer providing standard cover in the Netherlands for standard cover within 4 months of the date on which they first fulfil these criteria. Insurers are normally obliged to accept such applications. Full or partial exemption from the requirement to offer standard cover may be made, however; a number of insurers who serve only the employees of a particular firm or group of firms have used this provision.

Unlike the sickness fund insurance scheme, standard policies do not provide cover for dependants. Since standard cover is an individual form of insurance, it does not extend to the insured's partner or children.

Funding

Premiums for private health insurance are subject to two statutory surcharges (Table 4): the Act on the Joint Funding of Elderly Sickness Fund Beneficiaries (MOOZ) and the Health Insurance Access Act (WTZ) surcharges. The former finances the transfer of funds from private health insurance to the sickness funds to make up for the higher percentage of older people covered by the sickness funds. In 2004, insured people under the age of 20 years pay €60 per year, those between 20 and 64 years of age pay €120 per year, those 65 years of age and older pay €96 per year; and students are exempted. The WTZ surcharge covers the difference between expenditures and premiums; in 2004, insured people under 20 years of age pay €196.80 per year; those between 20 and 64 years of age pay €393.60 per year, and students and the elderly are exempted.

Standard policies are therefore funded from the premiums paid by policyholders and the so-called Health Insurance Access Act (WTZ) apportionment charges. The premiums are set at a fixed sum per month per person insured; in 2004, the monthly charges are €152 (and €36.70 for students) per month per person. Children under the age of 18 years and children between the ages of

18 and 27 years who are studying and who are included in the policy of the principal policyholder pay only half the amount paid by the main policyholder. Premiums are payable for no more than two or three children. If policyholders have children who have a standard policy or are included in their policy, only the apportionment contribution of €21.40 per month is payable.

Table 4. Simplified tariff structure for private health insurance in 2004 (monthly values)

	Premium	Act on the Joint Funding of Elderly Sickness Fund Beneficiaries (MOOZ) surcharge	Health Insurance Access Act (WTZ) surcharge
Up to 20 years	Regular premium or standard police premium (€152.00)	€5	€16.40
20–64 years		€10	€32.80
65 years and older		€8	–
Students	€36.70	–	–

Other sources of financing

Besides the three major sources of finance mentioned (statutory insurance under the Exceptional Medical Expenses Act and the Sickness Fund Act as well as private health insurance), taxes, out-of-pocket payments and voluntary supplementary health insurance are the main complementary sources of health care financing (Tables 5a and 5b).

The tables show the changing relative shares of the funding sources. In 1986, after the cabinet decided to end the voluntary sickness fund scheme, a large number of insured elderly gained access to sickness fund insurance, decreasing the share of private health insurance. The Van Otterloo Act expanded access to the Sickness Fund Act (ZFW) scheme for low-income elderly in the mid-1990s. In the early 1990s, as part of then ongoing health reforms, some entitlements shifted from the sickness fund and from private health insurance to the long-term care insurance scheme, the Exceptional Medical Expenses Act (AWBZ); from 1996, however, this step was reversed. From 1997 on, nursing homes and homes for the elderly have been included in the AWBZ benefits package. As they were previously financed by taxes, funding shares again changed noticeably.

Table 5a. Structure of the main sources of finance (in million €), 1980–2002

Source of finance	1980	1990	1995	2000	2001	2002
Total health expenditure	17 220	21 782	26 974	34 640	38 450	43 041
Public						
– Taxes	1 567	2 292	2 709	1 673	2 015	2 394
– Statutory insurance (Exceptional Medical Expenses Act)	6 388	7 088	11 488	12 936	14 511	16 733
– Statutory insurance (Sickness Fund Act)	3 893	6 805	7 397	12 736	13 877	15 319
Private						
– Private insurance	4 197	3 470	3 251	4 664	5 301	6 137
– Out- of- pocket	1 174	2 128	2 053	2 369	2 555	2 459
Other	–	–	77	262	190	–

Source: Ministry of Health, Welfare and Sport, various years.

Table 5b. Percentage of main sources of finance, 1980–2002

Source of finance	1980	1990	1995	2000	2001	2002
Public						
– Taxes	9	11	10	4.8	5.2	5.6
– Statutory Insurance (Exceptional Medical Expenses Act)	37	33	42.6	37.3	37.7	38.9
– Statutory Insurance (Sickness Fund Act)	23	31	27.4	36.8	36.1	35.6
Private						
– Private insurance	24	16	12.1	13.5	13.8	14.3
–Out- of- pocket	7	10	7.6	6.8	6.7	5.8
Other	–	–	0.3	0.8	0.5	–

Source: Ministry of Health, Welfare and Sport, various years.

Taxes

Tax-financed government expenditure is composed of that of the Kingdom, the provinces and the municipalities. Tax expenditure is mainly used for research in health and, to a certain extent, public health. As these figures do not include the government subsidies to the Sickness Fund Act (ZFW) and, to a lesser degree,

the Exceptional Medical Expenses Act (AWBZ) funds, total tax expenditure is estimated to be around 13–14%.

Out-of-pocket payments

The Care Memorandum of 2001 estimated that up to 9% of total health care costs are covered out of pocket: 4% as co-payments in the *first compartment* (the Exceptional Medical Expenses Act), 2% as co-payments/deductibles in the second compartment (the Sickness Fund Act and private insurance) and 3% as direct payments/private supplementary insurance in the *third compartment*.

Co-payments in the first compartment cover nursing home costs. In determining cost-sharing of admission to an Exceptional Medical Expenses Act (AWBZ) institution, the individual's circumstances are taken into account, notably whether he/she is married or cohabiting, or lives alone: the last type of person faces higher charges, since their household expenses are reduced to a greater extent than those of someone living with a spouse or partner. The maximum amount was fixed at €1631 per month in 2001.

In the second compartment, from 1 January 1997, all those insured under the Sickness Fund Act (ZFW) faced a co-insurance of 20% of medical costs up to a maximum of €90. No co-insurance was charged for GP visits, basic dental care and hospital costs of pregnancy. For other hospitalization services, there was a fixed co-payment of €3.62 per day. From 1 January 1999, these general cost-sharing requirements were abolished in the ZFW. Certain deductibles remain in force: these are €180 per year for artificial breasts, €51 per year or €102 per year (for up to 16 years of age and above 16 years, respectively) for orthopaedic shoes, €454 per year for hearing aids and €252 per year for wigs. Many privately insured people have to pay a deductible on their health care costs in their contracts.

The third compartment covers health care for which citizens have complete financial responsibility. This compartment includes expenditures no longer covered for such areas as physical therapy, dental surgery and unnecessary cosmetic surgery.

Voluntary supplementary health insurance

Almost all sickness funds offer the possibility of voluntary supplementary health insurance to their policyholders. More than 90% of all people insured under the Sickness Fund Act (ZFW) have supplementary health insurance. Each sickness fund makes its own supplementary insurance policy. Most commonly, these cover the costs of dental care, prosthesis, hearing aids and alternative treatment, and costs incurred in foreign countries.

Health care benefits and rationing

The Exceptional Medical Expenses Act (AWBZ)

Entitlement to care

Registration with one of the bodies that implements the Exceptional Medical Expenses Act (AWBZ) provides a person with entitlement to preventive care, medical treatment, nursing and care, services aimed at maintaining, restoring or enhancing capacity for work or improving quality of life, and social services. To claim entitlement to care, the consent of the insurer has to be obtained.

Since January 1992, people coming from abroad to reside in the Netherlands, and thus falling within the scope of the Act, are not entitled to certain forms of inpatient care for up to a maximum of 12 months after their arrival if there was already a medical indication that such care was necessary or if the state of health of the person in question might reasonably indicate that such care would be necessary. This applies to admission to a nursing home, institution for the mentally handicapped and institute for the hearing impaired, attendance at a day care centre for the disabled, outpatient treatment in a nursing home, and the like. To avoid a misunderstanding, it must be noted that the above restrictions do not mean that the people involved are excluded from the services in question; it only means that these services are not covered under the Act for the first 12 months after they arrive in the country.

The Regional Indication Bodies (RIOs) are responsible for assessing whether care is really required. RIOs are independant organizations that determine which kind of care is required, what type of care and how much care is needed. After the 'indication' the client knows what he or she is entitled to. Once the indication has been made, the client has the choice between benefits-in-kind or a Personal Budget (Persoonsgebonden Budget, PGB). Benefits-in-kind are the traditional way in which indicated care is directly provided by a health care provider that is contracted to provide such care and do the necessary administration. The PGB is an option that is available only for certain functional forms of care (see below). The PGB is a sum of money that enables the client to purchase care independently. In this system, the client has full responsibility over his own PGB. However, a Personal Budget is only available for Nursing, general care and guidance. Treatment and Accommodation is only provided as Benefits-in-kind.

Benefits

The Exceptional Medical Expenses Act (AWBZ) specifies the basic forms of health care to which those covered are entitled. The remainder are detailed in the Exceptional Medical Expenses (Entitlement to Care) Decree and the additional rules for entitlement to care under the AWBZ. The range of benefits has changed several times during the 1990s (see section on *Health care reforms*). Since 1 April 2003, entitlements under the AWBZ have been defined not in terms of categories or providers, but in *functional* terms. These *functions* should make it easier for clients to choose the care they wish. This change is part of a gradual process of modernising the AWBZ scheme. Instead of simply being managed by the government, the supply side of the market is increasingly demand-induced. The focus is less on the available supply of care and more on the needs of clients who are entitled to care. This change in philosophy is expected to pave the way for the provision of customised care and a broader range of products and suppliers. To stimulate this, the government broke down barriers for starting care providers and allowes existing providers to expand their product range. The AWBZ scheme works on the principle that people should continue living in their own homes for as long as possible, whether they receive their care at home or in an institution (Ministry of Health, Welfare and Sports 2004).

Seven functionally distinct functions of care are defined:

1. **Domestic help**, e.g.: tidying up, cleaning, tending houseplants, preparing meals.
2. **Personal care**, e.g.: help with taking a shower, bed baths, dressing, shaving, skin care, going to the toilet, eating and drinking.
3. **Nursing**, e.g.: dressing wounds, administering medication, giving injections, advising on how to cope with illness, showing clients how to self-inject.
4. **Supportive guidance**, e.g.: helping the client organise his/her day and manage his/her life better, as well as day-care or provision of daytime activities, or helping the client to look after his/her own household.
5. **Activating guidance**, e.g.: talking to the client to help him/her modify his/her behaviour or learn new forms of behaviour in cases where behavioural psychical problems exist.
6. **Treatment**, e.g.: care in connection with an ailment, for example, rehabilitation following a stroke.
7. **Accommodation.**

Grants scheme

In addition to the above-mentioned entitlements provided under the Exceptional Medical Expenses Act (AWBZ), under certain circumstances insured individuals

can also claim treatment and services paid for by a government grant scheme. The basis for rendering these services is stipulated in Section 39, Subsection 3 of the National Insurance Financing Act (WFV). The Health Care Insurance Board (CVZ) has the authority to arrange for services to be financed this way. A number of criteria have to be met in order to qualify for the scheme, such as whether the service to be provided is medically indicated and the number of treatments. The types of services and treatments that are paid for under a grant scheme include:

- children's hostels for the mentally handicapped
- individualized care for the mentally handicapped
- abortion clinics
- prenatal and perinatal tests, to determine blood group/type factor and check for gonorrhoea
- supervised independent housing
- family counselling for families with children with a serious hearing impairment
- national influenza prevention programme.

Claiming entitlement to treatment and services

If necessary, insurers can authorize individuals to obtain the kind of care covered under the Exceptional Medical Expenses Act (AWBZ) from a practitioner or institution with which they do not have a contract. The Exceptional Medical Expenses (Entitlement to Care) Decree provides for a person insured under the AWBZ to be reimbursed for the cost of care received abroad that is insured under the Act, provided that this care could not reasonably be postponed until the person's return to the Netherlands. If there is no legal maximum, the amount generally charged will be reimbursed, taking into account the level of costs for health care in that country. Any cost sharing incurred by the person insured under the Act will be deducted from the amount reimbursed. Insured people are entitled to payment, provided that the costs involved are not reimbursed under any other scheme.

Since 1 January 2004, insured above 18 years are required to make a contribution towards the received care. Detailed rules are laid down in the Decree on Personal Contributions to the Cost of Care and the associated Regulations on Personal Contributions to the Cost of Care. Relevant factors include taxable income, marital status and cohabiting. The personal contribution is deducted from the PGB. Insured receiving benefits-in-kind receive a bill for the personal contribution.

If insurers are unable to conclude any contracts with care providers or if these contracts are inadequate, the Minister of Health, Welfare and Sport may decide that entitlement to benefits in kind be replaced by benefits in cash to insured people for the costs incurred by them in obtaining non-contracted care.

Sickness Fund Act (ZFW)

Entitlement to treatment and services

Cover under th e Sickness Fund Act (ZFW) gives entitlement to benefits in kind in the form of medical treatment and care.

Benefits

The Sickness Fund Act (ZFW) provides the statutory basis for the medical care to which insured people are entitled; the details are set out in the Health Insurance (Treatments and Services) Decree. The range of benefits has been changed several times during the 1990s (see section on *Health care reforms*). Treatment and services available under the ZFW are as follows:

a. Medical and surgical treatment

This coverage comprises treatment by GPs and specialists, physiotherapy for both adults and children (including Mensendieck and César physiotherapy), and speech therapy. Entitlement to physiotherapy is limited to a maximum of nine treatments per indication per calendar year, except for specific complaints that require longer treatment. César or Mensendieck physiotherapy treatment can be continued for a further nine sessions if the patient's GP or specialist considers it necessary – and provided that prior consent of the sickness fund has been obtained. Since 1996, specialist care includes screening for cervical cancer.

b. Obstetric care

Obstetric care is normally provided by a midwife, but may be provided by a GP or specialist when no midwife is available, or when medically indicated.

c. Dental care

Since 1 January 1995, dental cover has been limited to dental care for children and preventive dental care for adults, in addition to specialist surgical treatment and, in certain cases, the fitting of dental implants and related X-rays. This step was taken because it was felt that the Dutch population was able to be responsible for their own dental hygiene. Regular

visits to the dentist have become commonplace in the Netherlands, so the average person's teeth are well cared for and the cost of dental treatment for the individual is generally affordable. Dental care for children includes preventive maintenance work, fluoride applications up to twice a year from the age of 6 years, sealing, periodontal care and surgical treatment. At the age of 2 years, children receive (under the Sickness Fund Act) a dental card that is valid for a year at a time. Children over the age of 13 years who have no dental card have to pay 50% of the cost of treatment, up to a maximum of €226.89 a year. Adults are entitled to preventive care provided that they go for a check-up at least once a year. Since 1 January 1997, insured individuals have once again been entitled to dentures. People with a specific dental complaint, or a physical or mental handicap resulting from medical treatment, are entitled (under specific circumstances and if required) to integral dental care.

d. Pharmaceuticals

This benefit includes the provision of medicine, special dietary products and dressings. Individuals are entitled to a high-quality, varied choice of medication. In addition to a charge amounting to 20% of the costs, the costs of drugs are normally reimbursed up to the limit imposed for alternative drugs of a similar type ("reference price", see section on *Pharmaceuticals*). The insured person must pay any difference.

e. Admission to and stay in a hospital (other than in a psychiatric hospital or the psychiatric ward of a general or teaching hospital)

A stay in a hospital includes all medical, surgical and obstetric treatments required by the patient, including examinations by specialists, and all related nursing and other care for part or all of the day and night. Admission to the hospital (in the lowest class of accommodation) must be authorized by the sickness fund with which the patient is registered. Authorization is given wherever inpatient care (both treatment and nursing) is reasonably indicated by the individual's medical condition or where obstetric care and treatment can be provided only in the hospital. Where continued hospital care is not indicated on strictly medical grounds but the individual concerned has no choice other than to remain in the hospital (for example, pending admission to a nursing home), then inpatient care is still considered to be indicated.

Hospital care is covered under the Sickness Fund Act (ZFW) for up to 365 days; thereafter, care is provided under the Exceptional Medical Expenses Act (AWBZ). The cover provided also includes certain types of tissue and organ transplantations, and reimbursement of the costs of obtaining suitable transplant material.

f. Aids and appliances

The services provided include the supply of medical aids, such as prostheses. Not only are medical indications taken into account in supplying such aids, but also an individual's work situation is taken into account. Aids may be supplied to people as their own property, or they may be borrowed. This service is provided on medical prescription, normally with the prior permission of the insurer implementing the Act. Under certain conditions, alterations and repairs to aids and the supply of reserves are also covered. The insured is responsible for the costs of normal use and maintenance.

g. Transport

Transport of patients by ambulance, taxi or private car is covered (provided that it is certified by the attending physician), as well as is reimbursement of the cost of public transport (in the lowest class) from or to a hospital or clinic. In certain cases, sickness funds will authorize transport by other means, like a helicopter. The cost of (medically indicated) transport from abroad is reimbursed only from the border crossing or domestic airport; when, however, patients have been receiving treatment abroad with authority from their sickness fund, the cost of the whole journey is covered. Sickness fund patients living abroad who have received treatment in the Netherlands have the cost of their return journey paid only as far as the border crossing or domestic airport; for cross-border commuters who work in the Netherlands and are insured with a Dutch sickness fund, the whole homeward journey is covered.

h. Maternity care

This service, comprising postnatal care and help given to mother and baby, may be provided at home (under the guidance of a maternity centre), in a maternity clinic or in a hospital. In the case of care at home, it is provided by maternity help and supplied by a maternity centre, which also performs household chores. Maternity care is provided by a maternity centre for as long as mother and baby require it, for a minimum period of 24 hours up to a maximum of 80 hours – spread over a period of up to 10 days. A request for maternity care must be submitted 5 months before the due date to the maternity centre located nearest to the residence of the insured.

i. Care provided by an audiology centre

These services include testing the patient's hearing and advising on the purchase and use of a hearing aid. If necessary, psychosocial counselling can be given to help a person deal with their hearing impairment as well as possible. Patients must be referred to an audiology centre by a GP, paediatrician, or ear, nose and throat specialist. Consent by the sickness fund must be obtained if these services are to continue for more than 6 weeks.

j. The services of a genetic testing centre

These services include tests for hereditary defects, genetic counselling and psychosocial guidance, and are provided on referral by a GP or medical specialist. Genetic counselling includes issuing advice to (or on behalf of) people other than those covered. Tests are carried out at a centre for genetic testing or by a medical specialist who has a contract with such a centre.

k. Haemodialysis

Insured persons are entitled to the use of kidney dialysis equipment at home or in a dialysis centre, subject to sickness fund authorization. In the case of home dialysis, cover includes the cost of training users and helpers, servicing and maintaining the equipment, and obtaining the necessary chemicals and fluids. The costs involved in adapting the home (for example, putting in extra bathrooms) and of additional heating are also met, where appropriate.

l. Services for patients with chronic recurring respiratory problems

An insured person may use the services of a respiratory unit either in their own home or in a location where it can be used by a number of people. Also included are associated medical and pharmaceutical services provided by (or on behalf of) the respiratory unit. Authorization from the sickness fund is required.

m. Rehabilitation

This consists of examinations, treatment and counselling by medical specialists, paramedical staff, and behavioural or rehabilitation therapists. Rehabilitation may be accompanied by care, nursing, and full- or part-time accommodation in an appropriate establishment. The aim of rehabilitation is to prevent or reduce any handicap resulting from motor disorders, thus providing the patient with the degree of independence that is feasible, given the nature of the condition.

n. Services of a thrombosis prevention unit

This covers regular blood sampling and its laboratory testing to determine coagulation time, together with advice to the patient's GP on anticoagulant therapy. Though patients must be referred by their doctor, sickness fund authorization is not required.

Grant scheme

In addition to the treatment and services provided under the Sickness Fund Act (ZFW), under certain circumstances, insured individuals can also claim health care that is paid for by a Health Care Insurance Board (CVZ) grant scheme. As a result of progressive sickness fund budgeting, the sickness funds are bearing more and more financial risk. In principle, they should cope with this risk by

using the powers given to them under statutory legislation to keep it under control. In addition to this, however, there is a need for capacity for substitution and individualized care, so that budget funds can be used more effectively. This requires a different interpretation of treatment and services than that allowed under the current regulations. This is referred to as making the range of benefits more flexible. The health insurance budgets do not pay for this care, since it is not covered by regulation. In order to provide financial cover for the costs involved, the Minister of Health, Welfare and Sport, under certain conditions, can ask the CVZ to set up a subsidy scheme, under which the cost of this special care can be defrayed from statutory contributions. Specifically, these conditions may involve provisions for medical indications, the number of treatments, and other necessary items. This applies, for example, to the following:

- in vitro fertilization
- intensive home care.

Private insurance under the Health Insurance Access Act (WTZ)

The Health Insurance Access Act (WTZ) and the Private Medical Insurance (Reimbursements) Decree regulate the medical costs reimbursed under standard policies. The amount reimbursed, profits, and charges payable by the insured are detailed in the Private Medical Insurance (Reimbursements) Implementation Decree. The risks covered by standard policies coincide more or less with those covered under the sickness fund insurance scheme, although the costs payable by the insured for treatment and services are somewhat different. For example, standard cover provides not only for fixed charges for specific services (as happens under the sickness fund scheme) but also for an excess charge – that is, a specified amount below which all costs for certain types of medical care are paid by the insured. One essential difference between the standard policy and sickness fund insurance or cover under the Exceptional Medical Expenses Act (AWBZ) is that with the last two options the insured is entitled to medical care, whereas with the standard policy the insured is entitled to be reimbursed for any costs he/she has paid for medical care. For this reason, sickness fund insurance and cover under the AWBZ are referred to as health insurance schemes, while the standard policy is considered indemnity insurance.

Policyholders have a free choice of general practitioner, specialist, hospital, dentist, orthodontist, midwife/obstetrician, maternity help, physiotherapist, remedial gymnast/masseur, exercise therapist and speech therapist; they must, however, have with them a letter of referral from a specialist, doctor or dentist to have the cost of claims reimbursed for non-clinical specialist treatment, physiotherapy, exercise therapy or speech therapy.

At the earliest opportunity, the insured is required to give the insurer prior written notice of admission to a hospital and of impending hospital stays and maternity care. Notice of emergency admissions must be given in writing within 3 days. The original bills must be forwarded to the insurer for reimbursement within 6 months of their date of issue.

Health care expenditure

Health care expenditure, estimated in terms of US $ purchasing power parity (PPP), has more than tripled since 1980, in line with the EU-15 development. During the 1980s, expenditure as a percentage of GDP was up to half a percentage point higher than the EU average. It rose from 7.5% in 1980 to a high of 8.6% in 1993. After 1993 it decreased to 8.1% in 1998. Since 2001, it has risen to 9.1% – that is about the same level as the EU-15 average (Table 6, Fig. 5). The public share of total expenditure rose in the early 1990s but has fallen back to values below 70% (Table 6), relatively low value in comparison with most of Europe (Fig. 6). The noticeable jumps are related to either benefits moved from one compartment to another or new groups of beneficiaries added to one of the public insurance schemes (see section on *Health care reforms*).

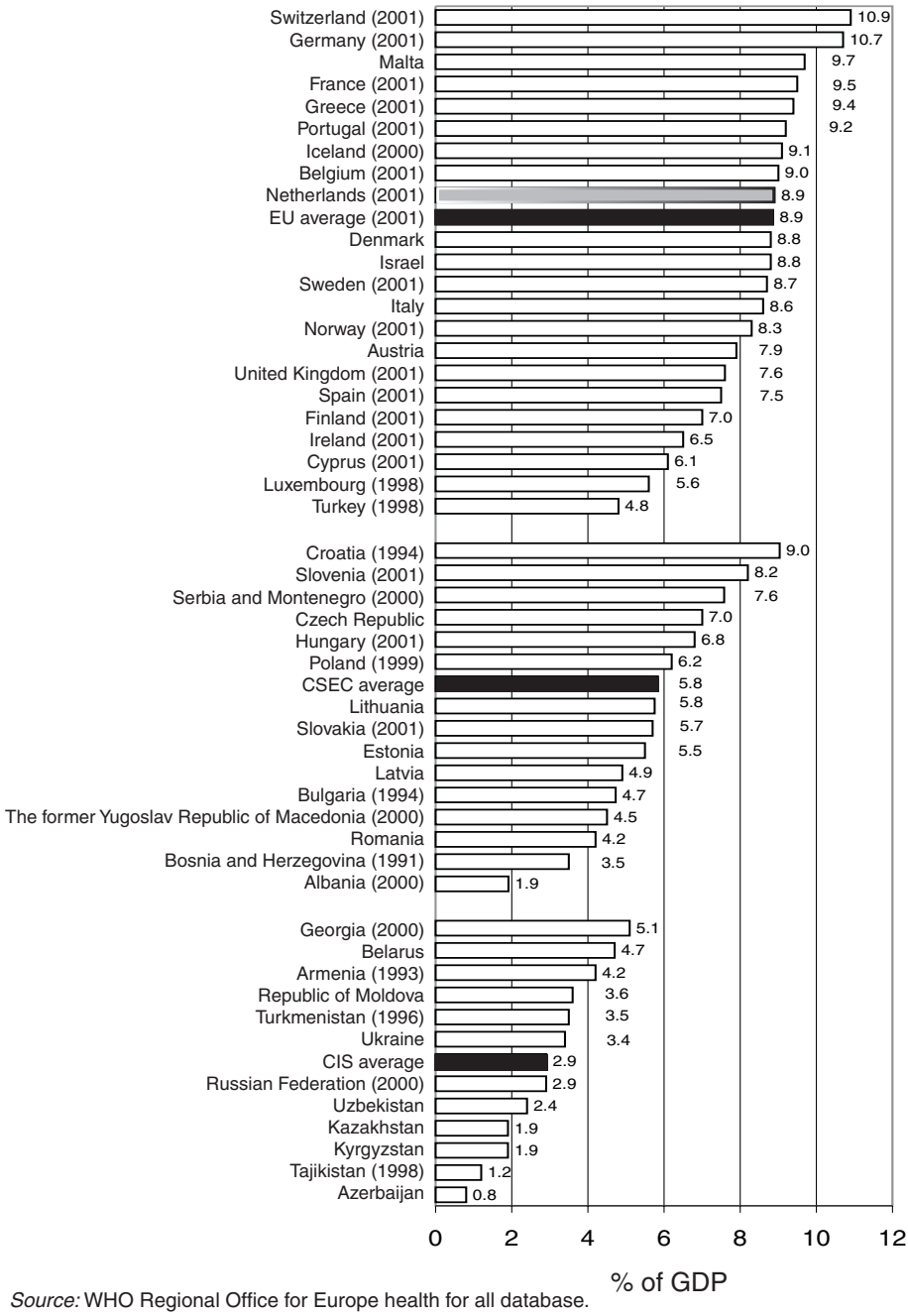
If compared with neighbouring social insurance countries since 1993, the Dutch expenditure trend differs. While in that year, the percentage of GDP spent on health was only one percentage point lower than in France, 1.5% lower than in Germany and about 0.5% higher than in Belgium, it was the lowest of these group by the year 2001 (Fig. 7). In 2002, however, it increased sharply and is now at the same level as Belgium, 0.6% lower than France and 1.8% lower than Germany. In absolute terms, health care expenditure per person in the Netherlands is above the EU-15 average and about as high as in Belgium (Fig. 8).

Table 6. Trends in health care expenditure, 1980–2002

Total expenditure on health care	1980	1985	1990	1995	2000	2001	2002
Total expenditure (in US $ PPP per person)	668	896	1 419	1 827	2 196	2 455	2 643
Share of GDP (%)	7.5	7.3	8.0	8.4	8.2	8.5	9.1
Public share of total expenditure on health care (%)	69.4	71.0	67.1	71.0	63.4	63.3	-

Source: WHO Regional Office for Europe health for all database.

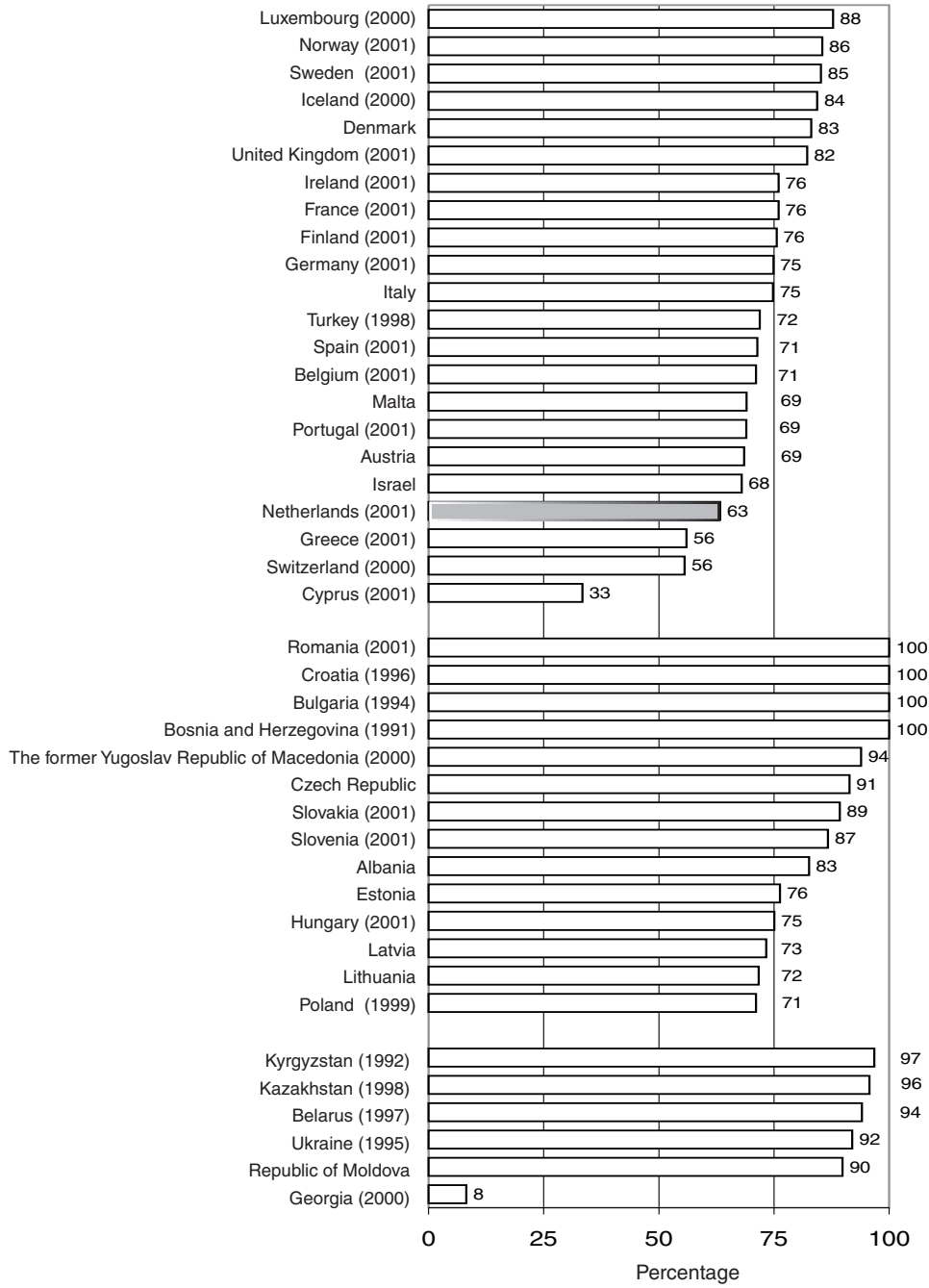
Fig. 5. Total expenditure on health as a % of GDP in the WHO European Region, 2002 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

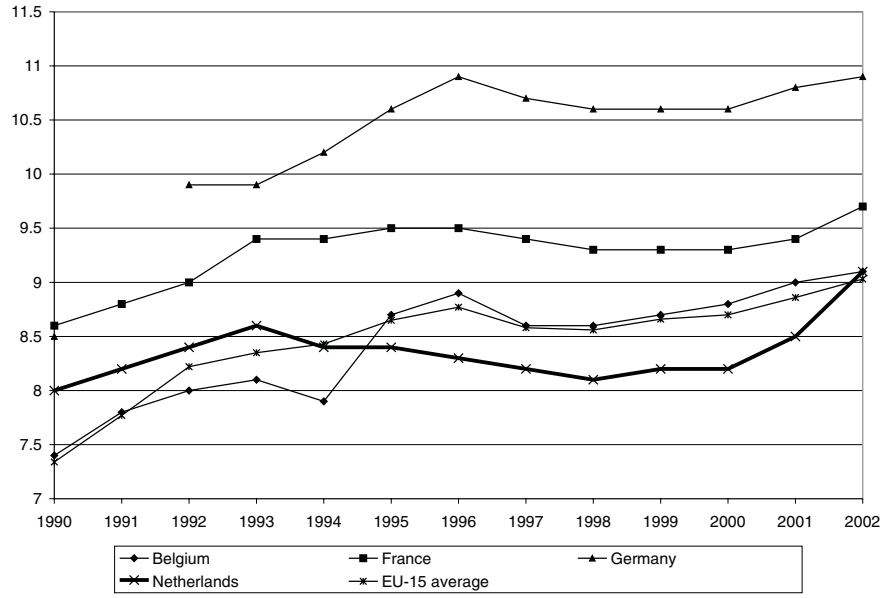
Notes: CIS: Commonwealth of independent states; CSEC: Central and south-eastern European countries; EU: European Union.

Fig. 6. Health care expenditure from public sources as a percentage of total health care expenditure in countries in the WHO European Region, 2002 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

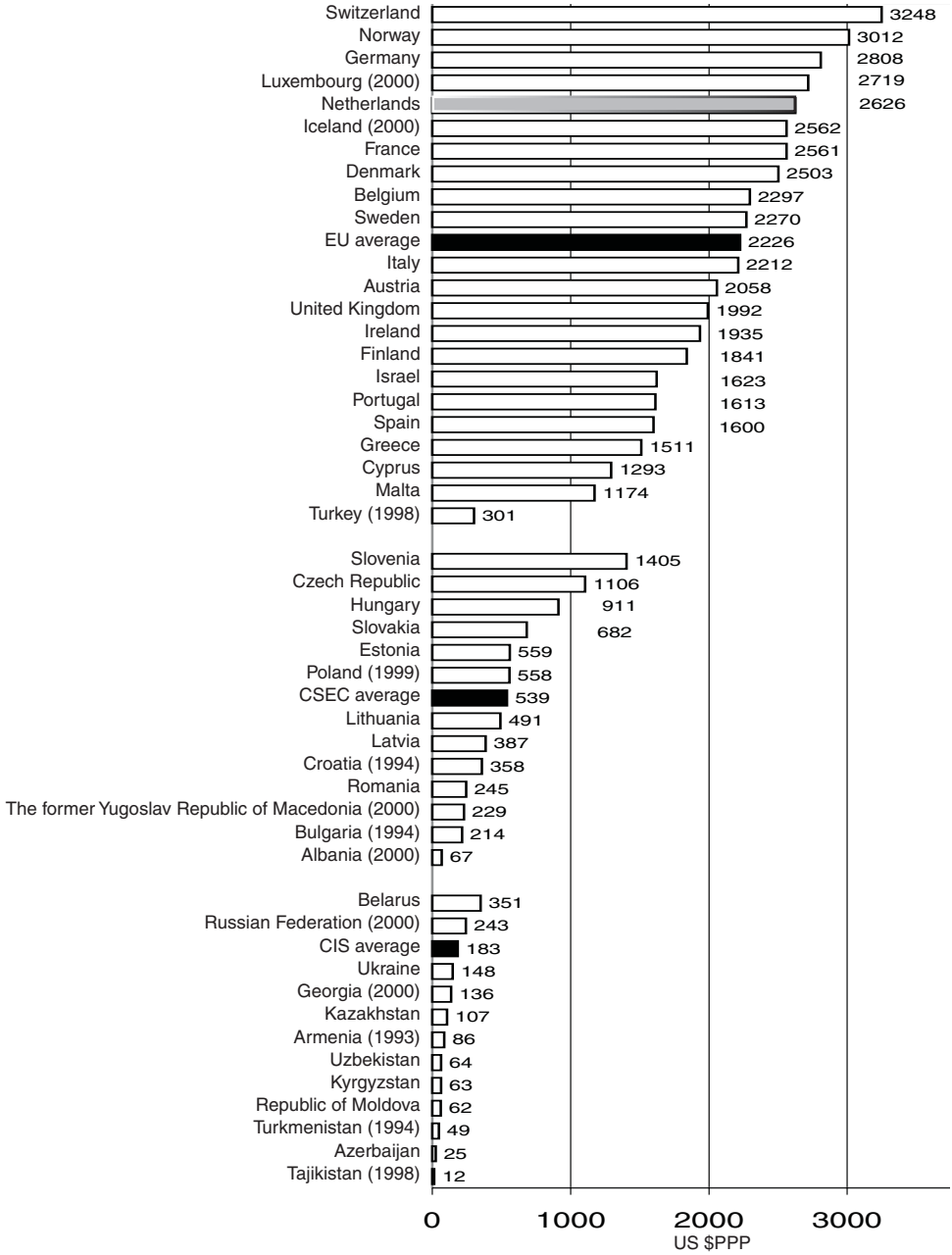
Fig. 7. Trends in health care expenditure as a share of GDP (%) in the Netherlands and selected countries, 1990–2002



Source: WHO Regional Office for Europe health for all database.

In the breakdown of the country's national health expenditure since 1998, hospitals accounted for a quarter of total expenditure, and expenditure on nursing homes, home care for the elderly and home care institutions is about 30% as well (Table 7). All health care categeories display a rise in absolute expenditures but as percentage of total expenditure they were relatively stable. In contrast to this social care expenditure has both increased in relative as well as in absolute terms.

Fig. 8. Health care expenditure in US $PPP per capita in the WHO European Region, 2001 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

Notes: CIS: Commonwealth of independent states; CSEC: Central and south-eastern European countries; EU: European Union.

Table 7. Health care expenditure by category (in billion €[a]) and percentage of total (in parentheses), 1990– 2002

Expenditure category	1990	1995	1997	1998	1999	2000	2001	2002
Providers of health care								
Hospitals	6.0 (30.8%)	7.8 (30.6%)	8.5 (30.7%)	8.7 (23.6%)	9.3 (23.1%)	9.9 (23.5%)	11.4 (24.3%)	12.8 (24.4%)
Providers of mental health care	[b]	[b]	2.1 (7.6%)	2.3 (6.3%)	2.5 (6.3%)	2.6 (6.2%)	2.9 (6.2%)	3.3 (6.3%)
General practitioners	0.7 (3.7%)	0.9 (3.6%)	1.0 (3.6%)	1.3 (3.5%)	1.4 (3.6%)	1.5 (3.6%)	1.6 (3.4%)	1.8 (3.4%)
Medical specialists	1.1 (5.8%)	1.3 (5.0%)	1.3 (4.6%)	1.3 (3.5%)	1.4 (3.6%)	1.4 (3.3%)	1.4 (3.0%)	1.6 (3.1%)
Dentists	0.9 (4.6%)	1.0 (3.9%)	1.1 (4.1%)	1.2 (3.3%)	1.2 (3.0%)	1.3 (3.1%)	1.5 (3.2%)	1.7 (3.2%)
Midwives and paramedics	0.6 (3.0%)	0.7 (2.7%)	0.7 (2.5%)	0.8 (2.2%)	0.9 (2.3%)	0.9 (2.1%)	1.0 (2.1%)	1.1 (2.1%)
Municipal health services	–	–	–	0.4 (1.1%)	0.4 (1.0%)	0.5 (1.2%)	0.5 (1.1%)	0.6 (1.1%)
Occupational health serices	–	–	–	0.6 (1.6%)	0.7 (1.8%)	0.8 (1.9%)	0.9 (1.9%)	0.9 (1.7%)
Suppliers of pharmaceuticals	–	–	–	3.3 (9.0%)	3.6 (9.1%)	3.9 (9.2%)	4.3 (9.1%)	4.7 (9.0%)
Suppliers of therapeutic appliances	–	–	–	1.6 (4.3%)	1.8 (4.6%)	1.8 (4.3%)	2.1 (4.5%)	2.2 (4.2%)
Providers of ancillary services	–	–	–	0.4 (1.1%)	0.4 (1.0%)	0.4 (0.9%)	0.5 (1.1%)	0.5 (1.0%)
Other providers of health care	–	–	–	1.4 (3.8%)	1.5 (3.8%)	1.6 (3.8%)	1.7 (3.6%)	1.9 (3.6%)
Providers of social care								
Nursing homes	1.9 (9.7%)	2.5 (9.9%)	2.8 (10.2%)	2.9 (7.9%)	3.0 (7.6%)	3.2 (7.6%)	3.6 (7.7%)	4.1 (7.8%)
Homes for the elderly	–	–	–	2.7 (7.3%)	2.8 (7.1%)	3.0 (7.1%)	3.1 (6.6%)	3.4 (6.5%)
Home care institutions	–	–	–	2.0 (5.4%)	2.1 (5.3%)	2.4 (5.7%)	2.8 (6.0%)	3.3 (6.3%)
Providers of care for the handicapped	–	–	–	2.8 (7.6%)	3.1 (7.9%)	3.4 (8.1%)	3.7 (7.9%)	4.4 (8.4%)
Providers of day nursery	–	–	–	0.6 (1.6%)	0.8 (2.0%)	1.0 (2.4%)	1.1 (2.3%)	1.3 (2.5%)
Other providers of social care	–	–	–	0.9 (2.4%)	1.0 (2.5%)	1.1 (2.6%)	1.2 (2.6%)	1.3 (2.5%)
Administration and management institutions	1.0 (4.9%)	1.1 (4.4%)	1.2 (4.3%)	1.5 (4.1%)	1.5 (3.8%)	1.5 (3.6%)	1.6 (3.4%)	1.7 (3.2%)
Total expenditure	19.6	25.5	27.6	36.8	39.4	42.2	47.0	52.4

Source: Statistics Netherlands (Centraal Bureau voor de Statistiek) *(11)*; Statistics Netherlands (Centraal Bureau voor de Statistiek) 2004 (http://www.cbs.nl/en/publications/articles/General/statistical-yearbook/a-3-2004.pdf accessed 1 September 2004) *(12)*.

Notes: [a] billion = 1000 million. [b] Data since 1998 comes from the Statictical Yearbook 2004, which displays data in different categories than before. Therefore data before 1998 might not always be comparable.

Health care delivery system

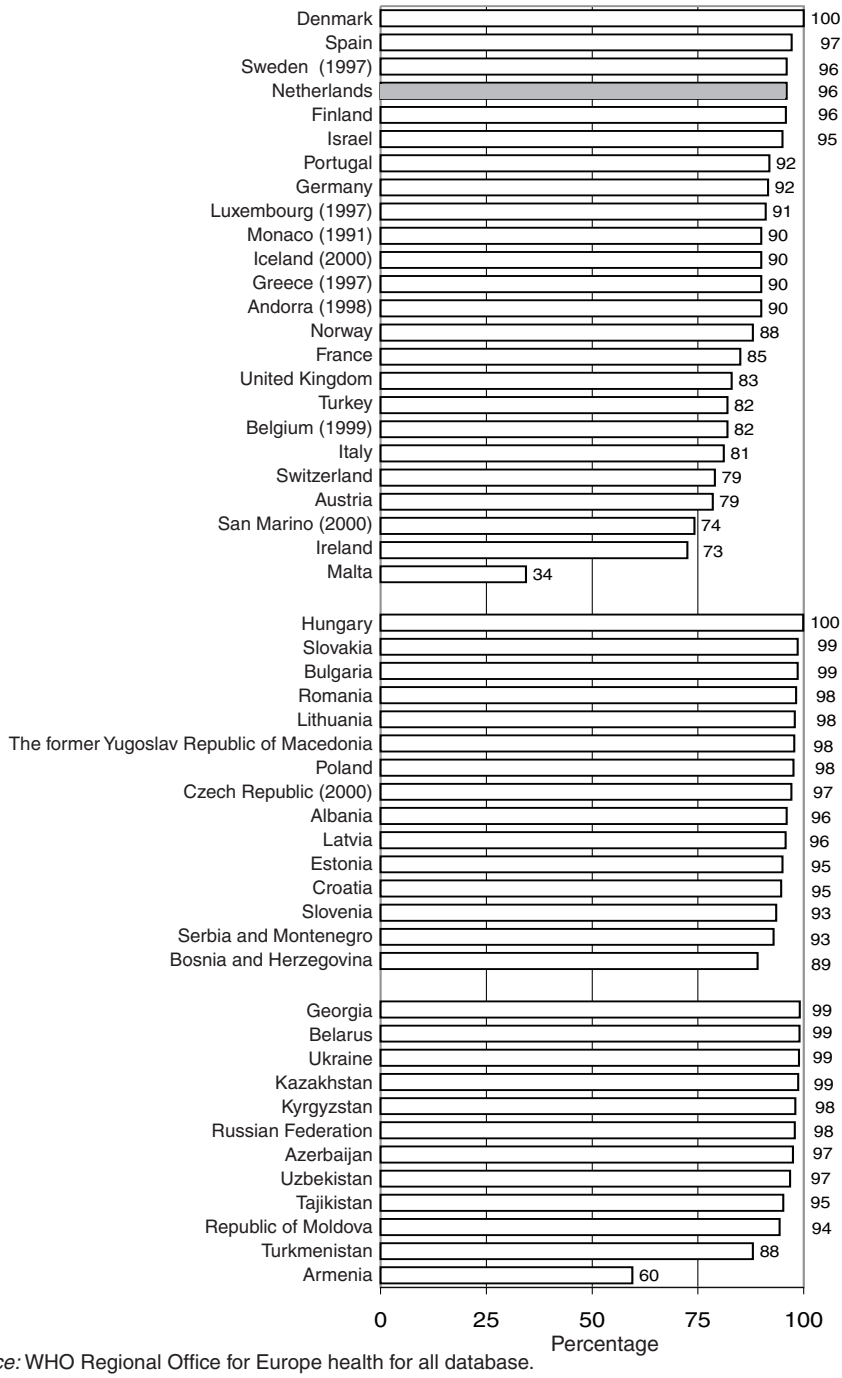
Public health services, primary care and secondary care are separate modalities. Basic health care is provided through a rather restricted public health system with local offices throughout the country. Primary health care is well developed and is provided by family physicians, district nurses, home care givers, midwives, physiotherapists, social workers, dentists and pharmacists. Each patient is supposed to be on a GP patient list and must be referred to specialist physicians or the hospital by the family physician. Secondary and tertiary care in hospitals is largely provided in private not-for-profit institutions.

Public health services

Public health system

The Netherlands has a regional network of municipal public health services, which take care of child health examination, vaccinations, environmental health, health protection and health promotion activities. Local public health includes all aspects of infectious disease control, general hygiene, school health and public health education, and the dissemination of information on rearing children. Traditionally, the local Health Care Service (Gemeentelijke Gezondheidsdienst, GGD) has covered the immunization programmes. When compared with other countries in the WHO European Region, the Netherlands ranks high on its immunization levels (see Fig. 9 for a comparison of immunization levels for measles). On a regional and national level, the function of the Health Care Inspectorate (IGZ) is to advise, supervise and monitor.

Fig. 9. Levels of immunization for measles in the WHO European Region, 2002 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

The primary care system supports the public health tasks as does a series of national institutes and university departments in the various public health areas. This includes institutes that focus on health care areas with important public health implications, such as mental health and addiction and primary health care.

Most of these organizations and institutions are funded or facilitated by the government, especially by the Ministry of Health and its Health Inspectorate. The Inspectorate has important controling and supervising tasks in the area of health care quality and health protection, the latter a.o. together with the new food safety organization. Infectious disease surveillance is under tight government control as well and supported by research, e.g. from the National Institute for Public Health and the Environment (RIVM). Institutes in other relevant areas also receive funding for public health related purposes, i.e. in the consumer safety area, the area of demographics, the socio-cultural, welfare and youth policy area and other specific areas, such as STD control, AIDS and sexual health.

All these institutional efforts contribute to Dutch health policy development, and to its implementation and evaluation and these institutes interact in various ways with the health education system and contribute to the advancement of international health sciences. To support academic prevention research, a prevention research programme, funded by the government and organized by the Netherlands Organisation for Health Research and Development (ZON-MW), an independent research organization to support Dutch prevention research. Public health policy in the Netherlands is additionally guided by advisory councils, such as the Health Council (GR), a Council for Public Health and Health Care (RVZ) and the Advisory Council on Health Research (RGO) and the Social Cultural Planning office (SCP).

A public health planning report *(13)* was issued in 1988, based on World Health Organization guidelines: Health for all by the year 2000. The plan enumerated national goals and policies to improve the public's state of health. The physical and social environment as well as lifestyle factors that contribute to health received particular attention. The plan focused on involving the public in health education and promotion of healthy living. This included, for instance, efforts to reduce alcohol consumption and tobacco use (especially among younger people), while promoting good nutrition, exercise, and stress reduction. The state of health of the elderly was also emphasized. Among other achievements, these efforts have resulted in a substantial decline in smoking, as indicated by periodic national health interview survey results. However there are several critical reports maintaining that there still is a lack of implementation regarding the proposed Health for all strategy *(14,15)*.

The development and management of Dutch public health policy used to be rather centralized in the past, but currently the responsibility for the implementation of prevention and health promotion is shifted more and more towards the municipalities. Some controversy has arisen in the public health field, however, as to the potential lack of coordination and inspiration that this approach may coincide with. Still, a number of national and centralized public health efforts are kept in place, such as a comprehensive childhood vaccination effort (National Vaccination Programme), widely implemented national screening programmes for breast and cervix cancer and the national screening for congenital metabolic defects (such as PKU, CHT). The breast cancer screening programme was approved by parliament for women between 50 and 70 years of age. It was fully implemented in 1997.

The public health perspective

A number of pecularities have arisen within Dutch society and the Dutch public health and health care system which may be communicated to provide some depth and perspective to the above organizational picture. Although abortion has been legalized the actual rates of abortion for Dutch women are among the lowest in the world, as are Dutch teenage pregnancy rates, although both are currently rising somewhat, mainly in women that belong to ethnic minority groups. Dutch drug abuse policy has 'harm reduction' as a leading theme and some actually forbidden possession, use and sales of low amounts of soft drugs is not actively prosecuted. From an international public health perspective Dutch hard drug abuse is not really high and the number of drug related deaths is relatively low. Smoking prevention has largely been 'working against the mainstream' as the Dutch, and especially Dutch women, still have a rather high smoking prevalence. This probably contributes to the recent stagnation in life expectancy at birth of Dutch women. The Dutch health care and prevention system, however, has been very quick in adopting and implementing preventive measures against cot death, which led to an early, fast and large decline in SIDS. The collection, quality control and distribution of blood and blood products are run through a single organization (Sanquin) in the Netherlands. Under certain conditions euthanasia by Dutch doctors is not punishable. Legal regulations have been put in place to carefully guide and examine each instance. Recently, free influenza vaccination has been expanded from just covering high risk groups to covering every citizen over the age of 65 as well *(16)*.

Perinatal and infant mortality rates have been among the lowest in the world in the early eighties, reflecting a high quality public health and health care system. A further decline, as was observed for instance in the Scandinavian

countries, has stagnated in the Netherlands however. This is probably due to a number of increasing risk factors, such as an increasing percentage of birth to mothers from ethnic minorities, increasing age of Dutch mothers at birth (among the highest in Europe), and increasing numbers of twins and triplets, caused by the increasing rates of hormone treatment and in vitro fertilisation *(1).*

Screening during pregnancy for congenital anomalies, such as spina bifida, has a rather low uptake in the Netherlands, which cannot be easily explained. A rather careful approach in deciding or having to decide to have an abortion could play a role here. Health care and prevention around childbirth is still largely taken care for by midwives, although the fraction of in-hospital births is rising steadily.

Future course

With the continued ageing of the population, the proportion of health care devoted to the elderly will increase. Subsequently, there will be increasing pressure to concentrate on more cost-effective interventions. As stated in the *Report on health and wellbeing (17),* the future course of health policy in the Netherlands will be expressed in more concrete terms – that is, more quantitative terms and fewer qualitative terms. Since unequal distribution of health care among various socioeconomic groups is the most widespread problem, emphasis will be placed on reducing socioeconomic differences, as well as on attempting to reduce morbidity in old age – most likely by influencing lifestyle.

Primary health care

Primary care is well developed and is provided largely by family physicians. The family physician is the gatekeeper and dominant figure in the primary health care system. The *gatekeeping* principle is one of the main characteristics of the system and denotes that patients do not have free access to specialists or hospital care. Patients covered by sickness funds require a referral card, and the privately insured must have a letter of referral. Consequently, the Dutch health care system is considered effective and efficient: when care is needed, the doctor who is best equipped to deal with the specific health problem provides it. Family physicians "specialize" in common and minor diseases, in care for patients with chronic illnesses and in addressing the psychosocial problems related to these complaints. Complicated non-comprehensive (and expensive) specialist care is reserved for patients who require specific expertise and highly technical skills *(18).*

The impact of gatekeeping is illustrated by the low referral rate: the vast majority of medical problems are treated by family physicians. Patients are referred to specialists in only 6% of contacts. Referral rates to surgical specialists are relatively high. Referrals for common conditions, such as hypertension, lower back pain and upper respiratory tract infections, are very low; nearly all cases are treated by family doctors. On the other hand, medical conditions such as myocardial infarction, lower back pain with radicular symptoms and chronic tonsillitis account for a relatively high percentage of referrals. Specialists, therefore, are responsible for a very select and limited segment of the total spectrum of morbidity (Table 8).

Table 8. Gatekeeping principle illustrated

Almost exclusively treated by family doctors	Low referral (%)	Often treated by specialists	High referral (%)
Hypertension	1	Myocardial infarction	60
Lower back pain	2	Lower back pain with radicular symptoms	16
Otitis media, acute tonsillitis	3	Chronic tonsillitis	35

Source: Groenewegen et al. *(19).*

Family physicians maintain independent and largely individual practices in each community. The average number of patients per family physician is 2300. The number of group practices and health centres (staffed by family physicians, social workers, physiotherapists and, sometimes, midwives) is increasing rapidly. While in 1970 91% of GPs worked in individual practises, this percentage had decreased to 43% in 2000 *(20)*. In rural areas, some family physicians also have their own pharmacy. During the past decade, the average number of annual patient contacts has increased and is higher for sickness fund patients than for privately insured patients (Table 9).

Physician–patient contacts, including specialist care, were around 5.7 contacts in the 1990s (about 0.5 contact higher than in the 1980s), and primary care constitutes about two thirds of all contacts in ambulatory care. (According to the European Community Household Panel, the figures for 1996 were 2.9 contacts with GPs and 1.8 contacts with specialists.) As a yardstick, the overall figure of 5.8 contacts in 2001 is slightly less than the EU-15 average (Fig. 10).

Table 9. Annual contacts between family physicians and patients (by insurance type), 1983, 1988 and 1994

Year	Sickness fund (capitation)	Private (fee for service)	Average for total population
1983	3.8	2.7	3.4
1988	4.1	2.9	3.6
1994	4.3	3.1	3.8

Source: Dutch Association of Family Physicians *(21).*

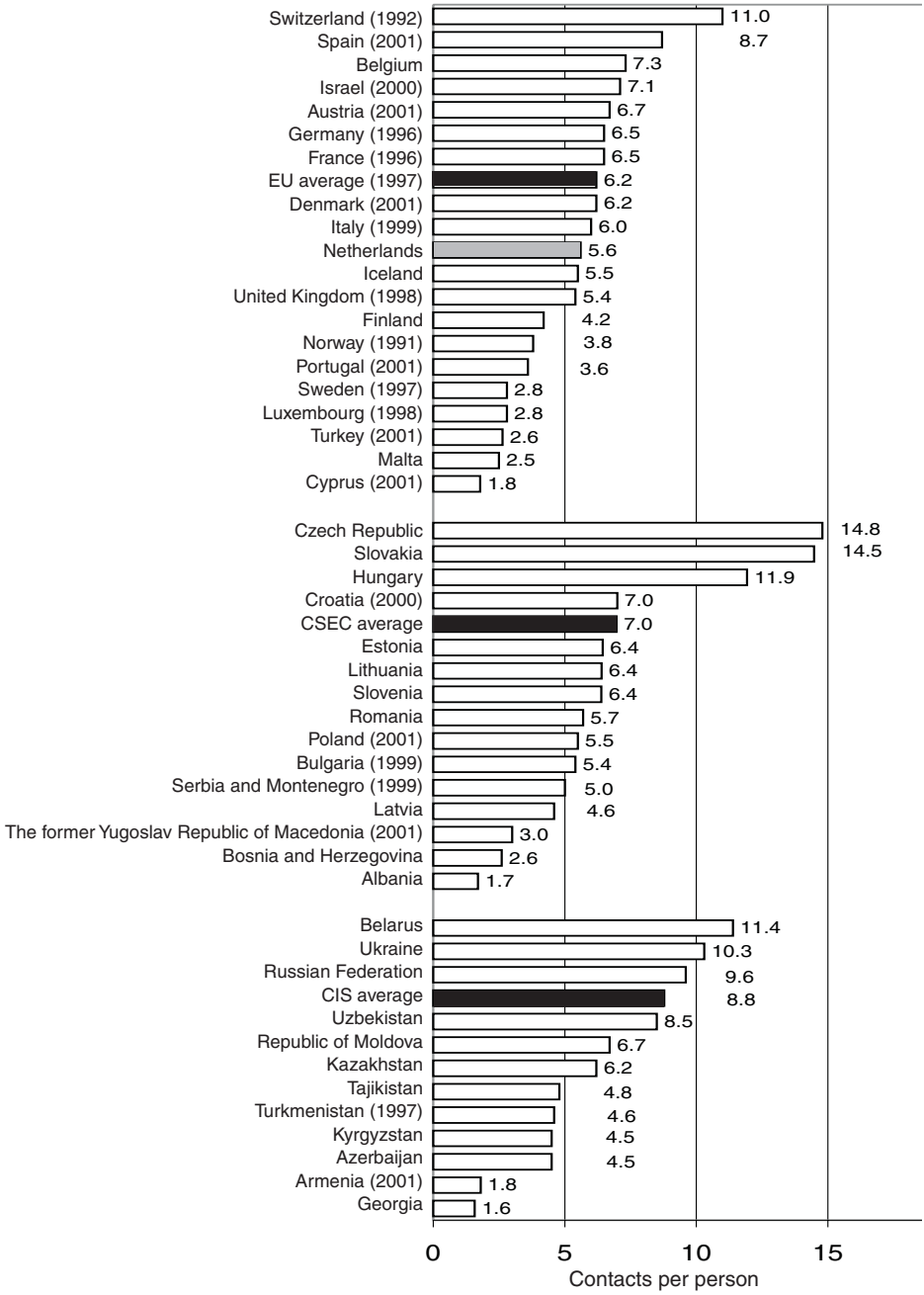
A striking aspect of Dutch health care is the low prescription rate; a prescription is given in only two thirds of contacts. Moreover, drugs are prescribed for only slightly more than half of all diagnoses – compared with 75– 95% in other European countries. The importance of this low rate is well illustrated by the selective prescribing of antibiotics, for instance, for upper respiratory tract infections *(18).*

In the Dutch system, family physicians do not have hospital privileges: they cannot admit their patients to, nor treat them in, the hospital. They may, however, use the hospital for diagnostic procedures, such as blood tests, X-rays, endoscopies and lung tests. Although some family physicians visit their hospital patients, this is not common in practice. This illustrates one of the disadvantages of the existing health care system: a gap between outpatient and hospital care.

Family physicians spend a great deal of time talking with patients. This helps explain the previously mentioned low prescription rate. In addition to giving advice, doctors take the time to explain the nature of medical problems and to discuss various psychological aspects. During medical training, much attention is paid to developing communication skills, counselling, and clarifying the reason for the medical encounter. The latter is especially useful because of the type of complaints seen in the family physician's office. In many cases, the reason for an encounter is related to anxiety, concern over the possibility of serious disease and events in the patient's life *(22).*

Registering as a family doctor is possible only after the required vocational training in one of the eight university departments of family medicine. In family medicine, much attention is given to epidemiology, morbidity, clinical skills, clarifying the reasons for a doctor–patient encounter, counselling, and personal development of trainees. Family doctors are assessed for registration every 5 years, based on their practice experience and the postgraduate courses they have taken.

Fig. 10. Outpatient contacts per person in the WHO European Region, 2002 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

Note: CIS: Commonwealth of independent states; CSEC: Central and south-eastern European countries; EU: European Union.

Secondary and tertiary care

Secondary and tertiary care is predominantly provided by medical specialists in hospitals. Nearly all hospitals have outpatient and inpatient facilities. Outpatient services are provided primarily by specialists who carry out pre-admission diagnostic examinations and outpatient treatment. Unlike in other countries, the specialists who provide both inpatient and outpatient care are not employed by the hospitals but rather are formally self-employed and work on a contract basis for (and in) the hospitals.

Except in case of emergency, patients are not allowed to go directly to an outpatient department or polyclinic of an acute care hospital. About 40% of the population contact a medical specialist each year; those who do have around 4.8 contacts with them, making the average number of consultations per insured person about 1.9 contacts per year or a third of all physician–patient contacts in ambulatory care.

The well-developed hospital system in the Netherlands consisted of 136 hospitals in 1999 (excluding psychiatric hospitals). More than 90% of the hospitals are private and non-profit; the rest are public (university) hospitals. Hospitals may be classified as teaching, general and specialist hospitals. In the Netherlands, eight university hospitals are spread throughout the country. The university hospitals are attached to universities with a faculty of medicine. They have several responsibilities, including patient care, education, research and training. They provide the faculties of medicine with a "workplace" for education and research, allowing effective interaction between patient care, education and research. Within the health care system, the university hospitals occupy a special place as leading hospitals with general specialist functions, advanced clinical functions and final referral functions.

Around 100 general hospitals provide various forms of specialist treatment. Within the category of general hospitals, there are considerable differences from hospital to hospital, with some smaller hospitals providing only basic specialist care. The other hospitals are specialty hospitals, which limit their care to selective illnesses or patient groups.

Hospitals have increased their capacity through mergers and expansion despite the required decrease in beds within each region, which lowered the number of acute care beds by over a third since 1980 (Table 10) to 3.1 beds per 1000 population – a value well below the EU-15 average (Fig. 11). Despite the already low initial numbers, the decrease in the number of beds has been in line with the EU-15 average and with numbers for most neighbouring countries (Fig. 12). In international comparisons, admissions to acute care hospitals are equally low, while the occupancy rate is extremely low – that is, around

20 percentage points lower than in other EU-15 countries and also lower than in all central and eastern European (CEE) countries with (typically) rather low rates (Table 11).

Table 10. Inpatient utilization and performance, 1980–2001

Indicator category	1980	1985	1990	1995	2000	2001
Beds per 1000 population, all hospitals	–	6.4	5.8	5.3	4.8	4.7
Beds per 1000 population, acute care	5.2	4.7	4.0	3.5	3.3	3.1
Beds per 1000 population, psychiatric	1.7	1.7	1.8	1.7	1.6	1.5
Admissions per 100 population, all hospitals	11.7	11.4	9.9	10.0	9.4	9.3
Admissions per 100 population, acute care	11.2	10.9	9.6	9.6	9.0	8.8
Average length of stay (days), all hospitals	-	-	16.0	14.3	12.9	12.5
Average length of stay (days), acute care	14.0	12.5	10.0	8.8	7.7	7.4
Occupancy rate (%), acute care	83.5	79.1	66.1	65.5	58.4	58.4

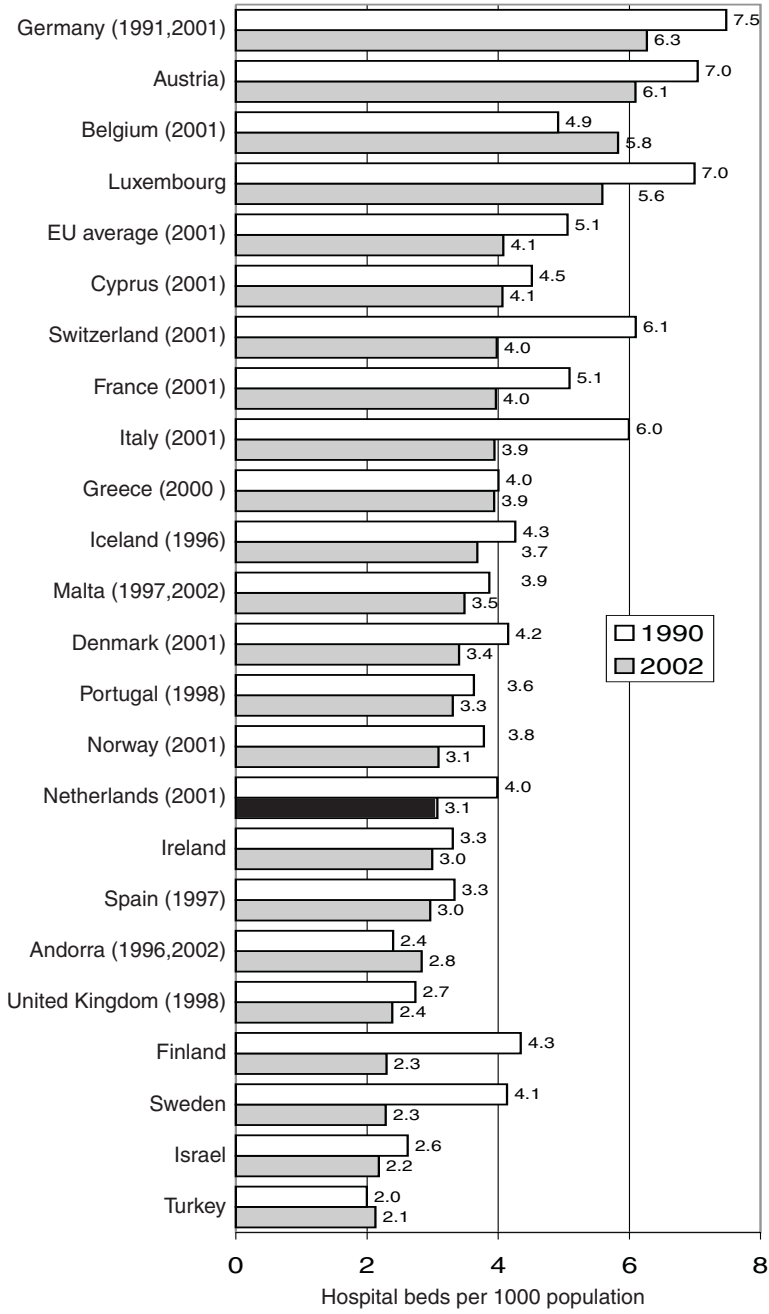
Source: WHO Regional Office for Europe health for all database.

Hospital management has been streamlined, with middle management gaining responsibility for departmental functions at the expense of central managers. A greater integration of medical specialists into the hospital administrative structure has also occurred, somewhat at the expense of the influence of physicians as a distinct group within the hospital. Also, administrators with broader roles have replaced directors of nursing.

Top management has gained overall power and professionalism (compared with physicians) as a result of the changes. Specialist medical personnel continue to have great influence over hospital operations but are more dependent on executive leadership than they used to be. Hospital trustees currently play more of a supporting role in decisions, and major policy responsibility is delegated to administrators.

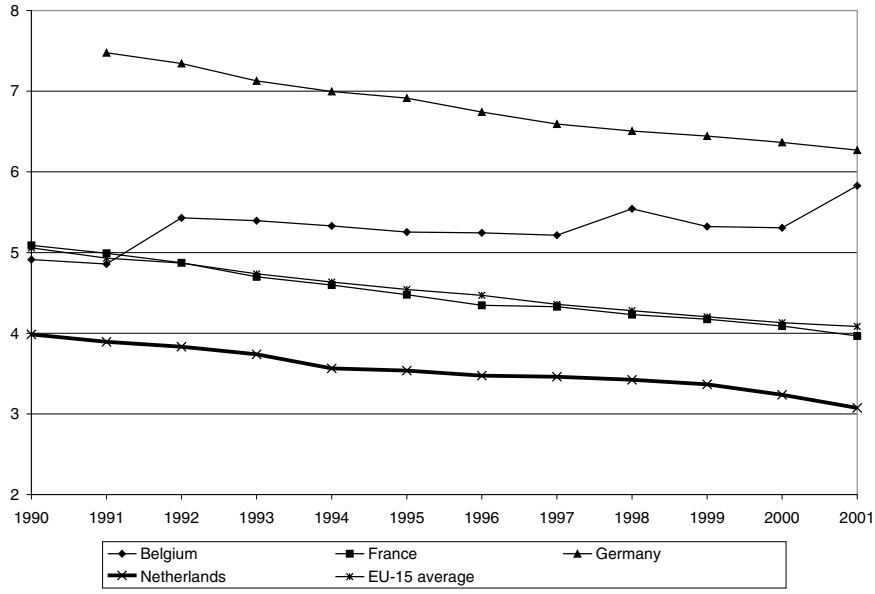
The system of input financing, with more or less fixed hospital budgets since the late 1980s, was intended to contribute to macro-cost control (see subsection on *Payment of hospitals*). Gradually, it has led to an increased sense of interdependence between hospital management and medical professionals who mostly work as independent entrepreneurs within the hospital. The financing system provoked a real shift in the organization of the hospitals. Traditionally, the organizational structure of hospitals was based on grouping

Fig. 11. Hospital beds in acute hospitals per 1000 population in western Europe, 1990 and 2002 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.
EU: European Union.

Fig. 12. Hospital beds in acute care hospitals per 1000 in the Netherlands and selected western European countries, 1990–2001



Source: WHO Regional Office for Europe health for all database.

activities by function. The traditional hospital organization consisted of separate, strong, functional departments, which were linked together only at the top of the organization. Under rising external pressure and increasing mutual interdependence between specialists and hospital management, another type of hospital organization was required.

What followed is described as an organizational development facing two major tendencies: decentralization and management participation of the medical specialists. The more complex the environment and the more increased the organizational size, the more decentralized the organizational structure of hospitals. The mutual dependence between hospital and medical specialist has assumed the form of an integrated operation for specialized medical care. An essential aspect of the integrated hospital is a decentralized organization within which authority and responsibility are transferred to the operational units. As such, decentralization shifts responsibility and accountability to specialists in the clinical departments. Decentralization also enhances organizational flexibility and responsiveness. The concept of decentralization is most effective when the medical specialists participate in the management of the decentralized operational units, which have their own budgets. Almost all

Table 11. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2002 or latest available ye ar

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Western Europe				
Andorra	2.8	10.1	6.7[c]	70.0[c]
Austria	6.1	28.6	6.0	76.4
Belgium	5.8[a]	16.9[c]	8.0[c]	79.9[d]
Cyprus	4.1[b]	8.1[a]	5.5[a]	80.1[a]
Denma rk	3.4[a]	17.8[a]	3.8[a]	83.5[b]
EU average	4.1[a]	18.1[c]	7.1[c]	77.9[d]
Finland	2.3	19.9	4.4	74.0[g]
France	4.0[a]	20.4[c]	5.5[c]	77.4[c]
Germany	6.3[a]	20.5[a]	9.3[a]	80.1[a]
Greece	3.9[b]	15.2[d]	–	–
Iceland	3.7[f]	15.3[d]	5.7[d]	–
Ireland	3.0	14.1	6.5	84.4
Israel	2.2	17.6	4.1	94.0
Italy	3.9[a]	15.6[a]	6.9[a]	76.0[a]
Luxembourg	5.6	18.4[h]	7.7[d]	74.3[h]
Malta	3.5	11.0	4.3	83.0
Netherlands	3.1[a]	8.8[a]	7.4[a]	58.4[a]
Norway	3.1[a]	16.0[a]	5.8[a]	87.2[a]
Portugal	3.3[d]	11.9[d]	7.3[d]	75.5[d]
Spain	3.0[e]	11.5[d]	7.5[d]	76.1[d]
Sweden	2.3	15.1	6.4	77.5[f]
Switzerland	4.0[a]	16.3[d]	9.2[a]	84.6[a]
Turkey	2.1	7.7	5.4	53.7
United Kingdom	2.4[d]	21.4[f]	5.0[f]	80.8[d]
CSEC				
Albania	2.8	–	–	–
Bosnia and Herzegovina	3.3[d]	7.2[d]	9.8[d]	62.6[c]
Bulgaria	–	14.8[f]	10.7[f]	64.1[f]
Croatia	3.7	13.8	8.7	89.6
CSEC average	5.2	17.6	8.1	72.5
Czech Republic	6.3	19.7	8.5	72.1
Estonia	4.5	17.2	6.9	64.6
Hungary	5.9	22.9	6.9	77.8
Latvia	5.5	18.0	–	–
Lithuania	6.0	21.7	8.2	73.8
Slovakia	6.7	18.0	8.8	66.2
Slovenia	4.1	15.7	6.6	69.0
The former Yugoslav Republic of Macedonia	3.4[a]	8.2[a]	8.0[a]	53.7[a]
CIS				
Armenia	3.8	5.9	8.9	31.6[a]
Azerbaijan	7.7	4.7	15.3	25.6
Belarus	–	–	–	88.7[h]
CIS average	8.2	19.7	12.7	85.4
Georgia	3.6	4.4	7.4	82.0[a]
Kazakhstan	5.1	15.5	10.9	98.5
Kyrgyzstan	4.3	12.2	10.3	86.8
Republic of Moldova	4.7	13.1	9.7	75.1
Russian Federation	9.5	22.2	13.5	86.1
Tajikistan	5.7	9.1	12.0	55.1
Turkmenistan	6.0[e]	12.4[e]	11.1[e]	72.1[e]
Ukraine	7.2	19.2	12.3	89.2[d]
Uzbekistan	–	–	–	84.5

Source: WHO Regional Office for Europe health for all database.
Notes: [a] 2001, [b] 2000, [c] 1999, [d] 1998, [e] 1997, [f] 1996, [g] 1995, [h] 1 994.
CIS: Commonwealth of Independent States; CSEC: Central and south eastern countries.

large hospitals and academic hospitals have already installed (or are going to install) a form of decentralization and management participation. In the case of Utrecht University Hospital, a triad consisting of a medical manager, a nursing manager and an administrative manager manages these decentralized units. As such, decentralization and management participation of medical specialists may contribute to solving the problems between professional autonomy and budgetary constraints.

In the second half of the 1990s, the Netherlands recognized that it had a problem with waiting lists. Intensive action on the waiting lists started in 1997. Since then, the government made additional money available (around €7 million) in order to reduce unacceptable waiting times for inpatient care. In 1998, a waiting list committee was established, which decided on twelve measures to solve the problem. The main components of the strategy are:

- improvement and publication of figures on waiting lists: health insurers use waiting lists for their marketing strategy, and they promise their insured a guaranteed treatment within a limited period of time;
- inputting extra financial resources into health care: health care providers receive extra resources only if they can demonstrate that they have produced extra health care services (performance related payment);
- improving the organization of health care delivery – for example, according to the principles of business administration;
- increasing the number of medical students; and
- campaigning to increase the number of nurses and other care givers.

In March 2000, around 150 000 patients were waiting for treatment in general hospitals, with more than 92 000 of them waiting for longer than a month *(23)*. By October 2001, the number – excluding psychiatry and paediatrics – had increased to 185 000. The specialities of orthopaedics (35 000), general surgery (35 000), ophthalmology (34 000) and plastic surgery (24 000) had the largest waiting lists; plastic surgery had the longest waiting time: 12 weeks for diagnosis and 23 weeks for treatment (both figures about twice as high as the average).

At the end of 2001, a report put the total social costs of waiting lists at €3.2 billion per year. These included €1.9 billion due to loss of welfare, €0.6 billion due to loss of income and productivity, €0.7 billion due to long-term disability and €8.1 million due to bureaucracy *(24)*.

To counter the problem of waiting lists, the Dutch government implemented a policy of providing extra funding where waiting lists were cleared. This had some success: According to the ministries' *Jaarbeeld Zorg 2002* and *2003* accounting reports, the waiting lists were reduced over the full range compared to the previous year. As a result however, this led to huge exceedance of the

budget up to €2.2 billion (€1.5 billion of this for AWBZ care) in 2003, mainly due to increased productivity. Writing to parliament on 27 January 2004, the State Secretary of Health reported that as of October 2003, in comparison to November 2002, the waiting list for nursing homes, care institutions and home care decreased by 27% from 74 382 to 54 244 persons.

In May 2004, a new report *(25)* issued by the Ministry of Health Welfare and Sport showed that the Netherlands has shorter waiting lists for hospitals than previously assumed. 95 000 (68 %) of 139 000 people, currently on waiting lists for hospitals, can be treated within four to five weeks. According to the ministry this is an acceptable amount of time. Twenty per cent (28 000) of people on waiting lists cannot be treated due to capacity problems in hospitals and nearly 17 000 people (12 %) cannot or do not want to be treated because of personal or for medical reasons. The report advises that hospitals should use different categories of patients, in order to be able to concentrate on the people who really need or want to be treated.

Transmural care

Transmural care – care given "across the walls" of the existing system – was introduced in the early 1990s and has been growing rapidly since then. Transmural care encompasses many different forms of care directed towards bridging the organizational and financial gap between general primary care (outpatient care) and specialized hospital care (inpatient care). In 1994, the National Council on Public Health (Nationale Raad voor de Volksgezondheid, NRV) defined "transmural care" as "care, geared to the needs of the patient, provided on the basis of cooperation and co-ordination between general and specialized providers of care, with shared responsibility and specifications of delegated responsibilities" *(18).*

This definition encompasses a wide variety of initiatives where home- and hospital-based providers, traditionally working separately, join together to improve quality and efficiency in care delivery. Transmural care projects utilize specialized nurses, guidelines, home care technology, discharge planning and other methods. Transmural care is often geared towards specific groups of patients, such as chronic patients with intermittent acute care needs – for example, patients with cancer, chronic obstructive pulmonary disease, diabetes or rheumatoid arthritis *(26).*

Despite certain successes in improving quality and efficiency in care delivery, incorporation of the concept of transmural care as a new modality in the Dutch health care structure has faced some difficulties, and a "true comprehensive approach that includes all medical components – from first contact to discharge

from medical care and covering peoples' social and housing needs as well as their medical ones – has not been achieved as yet, anywhere in the Netherlands" *(26).*

These unresolved problems concern cooperation, capacity management, and financing. Here, the inflexibility of the financial structure of the Dutch health care system is considered to be a major implementation barrier. The reimbursement system as it exists today contains few, if any, financial incentives for transmural care (see section on *Financial resource allocation*). Several possible measures have been proposed to overcome these financial barriers. These proposals are geared either to changing incentives or to providing compensation for time spent on transmural care. Subsidies and grants at either the local level or national level fund most of the current transmural projects. Many of these face difficulties in obtaining permanent funding after the conclusion of an experimental phase. Recently, a government committee was established for the purpose of stimulating and coordinating research in the field of transmural care. It is hoped that such research will contribute to finding solutions to the problems identified in the implementation process.

Social care

Mental health care

In the Netherlands, mental health care encompasses a range of organizations and practising professionals, all pursuing the common goal of treating mental health problems. Mental health care both includes mental illness such as depressions and psychiatric patients, mentally retarded or handicapped persons. On a regional level there exist the regional institutes for ambulatory mental health (Regionaal Institut voor Ambulante geestelijke gesondheidszorg, RIAGG), sheltered housing schemes (Regionale Instelling voor Beschermende Woonvormen, RIBW) and institutions where psychiatric hospitals (Algemeen Psychiatrisch Ziekenhuis, APZ) merged with RIAGGs and partially with RIBWs. Besides, there exist centers formed by an APZ, RIAGG and a psychiatric department of a general hospital (Psychiatrische Afdeling Algemeen Ziekenhuis, PAAZ). They are responsible for the psychiatric and psychosocial care of the population within a specified catchment area.

In principle, mental health care is only accessible to people referred by their GP. In both acute and crisis situations, however, a direct appeal is made to the mental health care services for assistance. Community mental health care is structured by the provisions offered for diagnosis, treatment and supervision, but

without nursing care. In the community, there are the facilities of the regional institutes for ambulatory mental health care, outpatient clinics connected to psychiatric hospitals, outpatient clinics attached to general and university hospitals, health centres for drug and alcohol abuse (Consultatiebureau voor Alcohol en Drugs, CAD) and numerous private practices run by independent established psychiatrists and psychotherapists.

Mental health care services stem from the general psychiatric hospitals (APZ), which currently constitute the core of hospital mental health care with 1.7 beds per 1000 population – that is, almost a third of all hospital beds in the Netherlands. A whole catalogue of possibilities for assistance is hidden under the blanket term "psychiatric hospital". These possibilities vary from outpatient clinics to housing units for long-term residents, from psychiatric departments for the elderly (psychogeriatric) to therapeutic communities, and from admission wards to specialized units for groups with special needs, such as addicts and forensic patients.

The psychiatric departments of general hospitals (PAAZ) and of university hospitals (Psychiatrische Universiteitsklinieken, PUK) are on average not very large (approximately 30 beds each), and the average length of stay is also relatively short (on average 5–6 weeks).

Included in the category of hospital mental health care are the following: child and youth psychiatric clinics, centres for care and treatment of drug addicts, convalescent homes catering to those with serious problems of neurosis, and clinics for forensic psychiatry. In general, the overall capacity of these facilities is small.

Nursing care

In the Netherlands, the most important social services consist of nursing homes and homes for the elderly (residential homes). Compared with other European countries, the Netherlands has almost the highest rate of residential care for the elderly in nursing homes and psychiatric and medical hospitals. People in residential homes have disabilities, a lack of social contacts and/or feel unsafe in an independent house. Residential homes offer a daily programme with courses. A GP is responsible for medical care, and each resident has a GP. The Exceptional Medical Expenses Act (AWBZ) finances the residential homes, and residents pay only a small, income-related share of the costs. People can only choose a residential home if they are willing to cover all the costs themselves. In all other cases, a person is referred and applies for a place to a branch office of the Municipal Committees on Need Assessment (Gemeentelijke Indicatiecommissie). A social worker or a nurse starts the admission process.

Disabled people who cannot live alone reside in a somatic nursing home. They need continuous multidisciplinary (nursing, medical, paramedical and psychological) treatment and monitoring. During the night, patients live in a four- or six-bed room and, during the day, they live in a day room. The branch office of the Municipal Committees on Need Assessment decides about admission. The costs of a stay in a nursing home are paid by social insurance, regulated by the Exceptional Medical Expenses Act (AWBZ). The 32 regional health care offices (regionaal verbindingskantoor), managed by sickness funds on a concession basis, are responsible for the budget and the payments.

The psychogeriatric nursing home is geared to patients with mental deterioration, most of them with dementia. Admission is done mostly by a multidisciplinary team from a facility of the regional institutes for ambulatory mental health care. The multidisciplinary approach and the financing system are comparable to those of the somatic nursing homes.

Table 12 shows statistical data on residential homes and nursing homes from 1989 and 2001. Although the prevalence of 168 600 (59 600 + 109 000) beds in both types of institutions in 2001 is small in comparison to the total of about 2 230 000 senior citizens above 65 years, these institutions consume most of the financial resources of the government and of social insurance. Because the inflow of psychogeriatric patients is increasing, the switch in resources is noticeable. Previously, residential and somatic nursing homes included psychogeriatric units. An explanation for the expected declining inflow of healthy elderly people is a change in demand and supply for care among the elderly. Twenty to thirty years ago, residential homes had a good reputation. Healthy people applied for a place in one of them long before they were in need of it. Currently, the elderly want to stay in their own home, environment and social network as long as possible and are stimulated to do so by the Municipal Committees on Need Assessment. Also, people with a higher pension are willing to pay out of pocket for home help, supporting equipment and house adaptations. Consequently, the residential homes have become less popular, especially those with shared rooms and without a private bathroom.

On the supply side, home care and ambulatory care grew quickly during the last 20 years. Until recently, community nursing grew at 4% a year. Then home care organizations became more efficient and supplied more productive hours with the same number of staff. The residential and nursing homes themselves started new types of services: meals on wheels; alarm systems for the elderly living in the community; temporary admissions (for example, when a partner gets ill) after a hospital admission and as respite care for overloaded care givers; and day care. Admission to a residential or nursing home is now postponed because of the availability of home care and other services, making the average age of new residents above 80 years and increasing. In residential

homes, 40% of capacity is directed to ordinary housing for people without or with some disabilities, while 60% must be adapted to nursing home facilities, mostly for psychogeriatric patients.

During the last few years, there have been many new developments and experiments. Departments of geriatrics are developing in the general hospitals. The medical model, however, is often criticized for its concentration on diagnosis and drug treatment, for its focus on organs and for its overspecialization. But the medical model has much to offer the elderly. Departments of geriatrics try to make a multidisciplinary assessment, as the basis for integrated medical and paramedical treatment, nursing care and psychological counselling.

The Municipal Committees on Need Assessment are also broadening their scope. Until now, they covered only admissions for nursing homes and residential homes. Experiments in Amsterdam, Groningen and Utrecht are

Table 12. Nursing homes and residential homes (homes for the elderly), 1985–2001

	1985	1993	1999	2001
Nursing homes				
Beds per 1000 population	3.4	3.5	3.7	3.7
Total number of homes	328	325	334	333
Somatic	138	76	49	44
Psychogeriatric	82	65	57	47
Combined	108	184	228	242
Number of beds	49 300	53 700	57 500	59 600
Somatic	15 500	8 200	4 800	4 300
Psychogeriatric	11 700	10 700	9 100	7 800
Combined	19 300	35 000	43 500	47 500
Yearly inflow	41 500	49 400	55 300	56 300
Somatic	16 800	8 700	5 600	4 900
Psychogeriatric	5 400	5 700	5 400	4 500
Combined	19 300	35 000	44 400	46 900
Residential homes (homes for the elderly)				
Number of residents per 1000 in population of 65 years and older	63.7	67.3	49.5	46.5[a]
Total number of homes	1 575	1 485	1 366	1 340[a]
Number of beds	148 700	135 300	112 400	109 000[a]

Sources: Statistics Netherlands *(27, 28).*
Note: [a]estimate.

going to integrate this work with similar activities on the allocation of home care, house adaptation and personal support equipment, like wheelchairs. This integration creates a "one-entrance" system for medical and social services for the elderly and handicapped, enabling the introduction of a personal budget system. At this moment, personal budgets exist under strict conditions for home care only. Patients can choose from home care, a district nurse allocated by the home care organization, or someone from their informal network or from a commercial firm. In the latter case, patients receive a personal budget to pay their care provider.

The separation of living and caring is another new phenomenon in care for the elderly. The growing knowledge and skills of GPs and home care organizations, the shrinking size of medical and nursing equipment, the increase of facilities for electronic data exchange, and the better adaptability of patient homes make it possible to offer somatic and psychogeriatric nursing home care everywhere (and not only within institutions). Currently, a nursing home without walls exists in the Province of Utrecht.

Care subscription (zorgabonnement) is the last innovation, where independently living healthy elderly subscribe, for instance, to a residential home. In case of emergency, the house provides first aid and, during difficult periods, temporary admission, meals and other services. Such a subscriber system is a care guarantee, giving the subscriber a feeling of safety and postponing (again) permanent admission. Sometimes the subscription rates are incorporated in the price the elderly pay for a so-called "care house".

These innovations arise in a climate of scarcity of human and financial resources, a lack of modernized institutions and a growing share of co-payment for the cost of care. On the one hand, this climate introduces pessimism about opportunities for these innovative ideas. On the other hand, the elderly of the future are better educated than those of the past, they have a better pension and they have got used to making choices between many types of commercial goods and services. The opportunities for innovations, therefore, can be considered with optimism. A small increase in care for the elderly is expected, financed by social insurance and taxation, and a big increase in care is also expected, financed out of pocket by the elderly themselves.

Waiting lists

The issue of waiting lists for social care is a problem in the Netherlands. There are waiting lists for both mental health care in regional institutes for ambulatory mental health care and admissions to nursing homes. On several occasions, courts ruled that the regional social health insurers have a statutory obligation to purchase adequate and sufficient services. As the social insurance

schemes provide entitlements, budgetary restrictions are of secondary concern. Insufficient purchasing of services by insurance schemes may, therefore, cause purchaser's liability.

Human resources, training and practice

Human resources

Coherent data on the number of people trained and working in health care are not available internationally. The available data from different sources (Table 13) indicate that the number of physicians in the Netherlands is about 10% below the EU-15 average, that of dentists is about 30% below the EU-15 average, while the number of nurses is considerably above the EU-15 average.

Nursing education and training

Since 1997, in-service training for nurses (*Verpleegkundige*) has stopped. There are now two educational routes for nursing education – namely, secondary professional education and higher professional education. The secondary professional nursing programme can be followed after 4 years of secondary school (Middelbaar Beroepsonderwijs-Verpleegkunde, MBO-V); the higher professional nursing programme can be followed after 5 years of secondary school.

All registered nurses, regardless of their training programme, are entitled to enter specialist training courses (post-basic nurse training). Since the

Table 13. Health care personnel, 1980–2002

Persons per 1000 population	1980	1985	1990	1995	2000	2001	2002
Physicians	1.91	2.22	2.51	-	3.22	3.28	3.15
General practitioners	0.40	0.49	0.46	0.46	0.49	0.49	0.50
Dentists	-	0.49	0.50	0.47	0.47	0.47	0.47
Pharmacists	-	0.13	0.15	0.16	0.19	0.2	-
Nurses	3.62[a]	6.00	8.63	-	12.97	13.28	-
Midwives	0.06[a]	0.07	0.08	0.09	0.10	0.11	0.11
Physicians graduating	-	0.10	0.10	0.09	0.09	0.09	0.10
Nurses graduating	-	0.55	0.51	0.45	0.29	0.37	0.40

Source: WHO Regional Office for Europe health for all database.
Note: [a]Data for 1978.

introduction of the Individual Health Care Professions Act (BIG) (see below), no specialist nurse training is legally regulated. But most specialist nurse training programmes are recognized by both the nurses' and employers' associations. Specialist nurse training is aimed at obtaining additional competencies and qualifications that are not possible to obtain from clinical experience alone. The recognized specialist nurse training is all aimed at a specific category of clients (for example, intensive care nursing for adults, children, neonatal babies, and cardiac care patients).

Medical education and training

Historical note

The profession of physicians has been protected in the Netherlands since 1818. Before that time, there were no specific requirements for a medical degree. This situation changed in 1849, after the establishment of the Dutch Medical Association (Koninklijke Nederlandsche Maatschappij ter bevordering van de Geneeskunst, KNMG) and, since 1949, the Royal Dutch Medical Association was the starting point for the reorganization of medical education. Members, all university graduates, played a decisive part in passing the most important piece of legislation on the practice of the profession in public health care: the Medical Practice Act (Wet op de Uitoefening van de Geneeskunst, WUG) of 1865. The Act provided for uniform university education and improved legal protection of the profession (profession and title protection). The Act recognized only university-educated physicians (now called doctors). This legislation has remained unchanged in outline until recently.

In recent years, there has been a far-reaching revision of public health care legislation and regulation. The main revision is the Individual Health Care Professions Act (BIG), which regulates medical practice (see subsection entitled *The practice of medicine*).

Undergraduate medical education

At the moment, universities have a "numerus fixus" for medical students, which means that only a limited number of students are admitted. The greater part of available places is assigned by lot, after categorizing the applicants on the basis of their average marks: the ones with the highest average final examination marks are more likely to obtain a place.

The study of medicine is currently phased: the first phase provides education for a Master's degree, including two stages: the first year and the senior years (second to fourth year), with exams at the end of each stage. The Academic

Statute notes that the following subjects should be taken for the first year examination: introduction to the body and vital functions of the human being (in a biological and psychosocial sense) and their development; introduction to the disorders of the body and of the vital functions of the human being; introduction to public health care; and the scientific fundamentals of these subjects.

The examination covering the senior years adds subjects dealing with the recognition and influence of abnormalities and disorders of the body and vital functions of the human being, as well as public health care – including primary health care.

Graduate medical education

The second phase of the study of medicine takes 2 years (the fifth and sixth) and is concluded with the Doctor of Medicine examination. During the second phase, students are introduced to a clinical setting. The Doctor of Medicine degree qualifies a person to start practising medicine. In the Netherlands, medicine can he studied at eight different universities: Amsterdam (two universities), Groningen, Leiden, Maastricht, Nijmegen, Rotterdam and Utrecht.

Those who pass their Doctor of Medicine examination but have not (yet) taken supplementary courses are fully qualified to practise medicine, all the same. They must, however, stay within the limits of their own knowledge and competence. They may call themselves doctors and are legally qualified to prescribe medicine and provide medical certificates, such as death certificates.

Licensing and postgraduate medical education

The current legislation on the various professions in the field of health care provides no regulation for specialities in public health care. There are, however, a number of supplementary courses available after the Doctor of Medicine examination: specialist training, GP training, research and Ph.D. programmes (Assistent in Opleiding, AiO / Doctoraal, Dr. programma's) and medical officer training. The professional associations concerned have formulated their own regulations for the recognition and registration of medical specialists, medical officers and GPs. Although this is a private law arrangement, it has had a wider social impact, which is why it is seen as semi-statutory.

Depending on the specialty, medical specialist training takes 4–6 years. Currently there are 29 recognized medical specialties. Recognized instructors in recognized institutes give specialist training. Recognition and registration of medical specialists are taken care of by the following bodies: the Central College (Centraal College Medische Specialismen, CC), the Specialist

Registration Committee (Specialisten Registratie Commissie, SRC) and the Committee of Appeal (College van Beroep, CvB). The Central College has ordinary members (representatives of medical departments of universities and recognized specialists) as well as advisory members (representatives of the health ministry, the National Hospital Council (Nationale Ziekenhuis Raad, NZR) and two assistant physicians). They determine which parts of medicine are recognized as specialties and what demands are to be made of courses, instructors and institutes. Decisions on these matters are given legal force when approved by the Minister of Education and Science. The Minister may veto any decision. The Specialist Registration Committee consists of representatives of the recognized specialties, and it is responsible for registration and for carrying out the decisions of the Central College – that is, the factual recognition of certain specialists as instructors, the recognition and visitation of institutes. Specialists will be removed from the register if they have not practised their specialty on a regular basis for 5 years. Someone in training to be specialists is called Assistant Physician in Training (Assistant Geneeskundige in Opleiding, AGIO). An assistant physician is fully qualified to practise medicine within the limits of their own abilities. The assistant physician's legal position is covered by a training regulation and a model-training contract, which is linked to the assistant physician's employment contract with a hospital. The contract provides rules that help strike a balance among the assistant physician's various duties, working hours, responsibilities and conflicts, among other things.

The medical specialist is usually self-employed, with the exception of a number of categories of specialists, who are employed by teaching (university) hospitals, psychiatric clinics and rehabilitation centres. Whether self-employed or not, specialists often depend on hospitals and outpatient clinics for their work. They have a model contract with the hospital that regulates such things as the terms of admission to the hospital, personal responsibilities and administration. Staff rules are important as well, as they contain the terms for the organization, its aims and the activities of staff members. As staff members, specialists have a joint say in hospital matters.

1. **The general practitioner.** In 1973, the Royal Dutch Medical Association added a regulation to recognize and register GPs to their domestic rules, which since April 1989 has been extended to nursing home doctors. General practitioner training is provided by GP instructors, in cooperation with the universities, through the Academic General Practitioners' Institutes (Universitair Huisartengeneeskunde instituut, UHIs). The General Practitioners and Nursing Home Physicians Council (College voor Huisartsgeneeskunde, CHG) determines the demands to be met by instructors, the Academic General Practitioners' Institutes and training

courses. The General Practitioners Registration Committee (Huisarten registratie commissie, HRC) supervises the implementation of the decisions and registers recognized GPs. The General Practitioners and Nursing Home Physicians Committee of Appeals (Huisarts en Verpleeghuisarts Registratie Commissie, HVRC) hears appeals against the decisions of the General Practitioners Registration Committee.

To secure a contract with the Dutch sickness funds, registration in the GP register is compulsory; simultaneous registration in the GP register, the medical specialists register and/or medical officers registers is not allowed. As with specialists, a GP may be removed from the register if he/she has not practised as a GP on a regular basis for 5 years.

A European Commission directive from 1986 states that GP training should take at least 2 years. In the Netherlands, this period is being prolonged to 3 years. General practitioner training has a practical part and a theoretical part, and a waiting list of two and a half to four years. No lots are drawn for admission.

2. **Medical officer.** In 1930, the General Dutch Association for Social Medicine was founded. In 1956, the Royal Dutch Medical Association added regulations on recognition and registration of medical officers (practitioners of social medicine) to its domestic rules. At the same time, the Foundation for the Training in Social Medicine (Opleiding Sociale Geneeskunde, OSG) was founded in order to define the demands to be met by medical officers' training courses. Social medicine has seven branches: labour and industrial medicine (1961), juvenile health care (1962), insurance medicine (1964), general health care (1965), special forms of social medicine (1974), general social medicine (1984) and sports medicine (1986). In 1986, the new experimental branch of environmental medicine was started. All branches of social medical training take a minimum of 2 years to complete and are integrated. During this time, trainees work in the branch of their choice and have to continue uninterruptedly. Article 1071 of the Royal Dutch Medical Association domestic rules and regulations states that no simultaneous training in two separate branches is allowed, but simultaneous registration in both the medical specialist register and the medical officer register is permitted. Anyone not having practised over a period of 5 years is removed (Article 1074).
3. **AIO.** Any Doctor of Medicine can carry out a 4-year research training programme. The trainee assistant (AIO) is trained to do independent research.

The practice of medicine

The current Individual Health Care Professions Act (BIG) has had a long history. In 1967, a separate State Committee on Medical Practice was installed to deal with the question of whether it would be better to have less restricted practice. In 1973, one of the committee's proposals was to exchange the general prohibition of the practice of medicine for a prohibition of a restricted number of medical actions. Its advice forms the basis of the 1981 Individual Health Care Professions Bill. In 1986, the Bill was presented to the Second Chamber and was published as an Act on 23 December 1993.

Revision of the existing Health Professions Legislation was needed due to the following:

- The Medical Practice Act (WUG) was obsolete: it was broken time and again without any possible (and perhaps not even desirable) countermeasures. A citizen's choice of treatment of, or diagnostic method for, their disease should be the central issue in the Dutch society. Strict application of the Medical Practice Act restricted this freedom of choice to the extent that different legislation was called for; harmonization of the aforementioned legislation was desirable.
- The qualifications of nurses and other (para)medical staff to carry out medical actions needed legislation in order to abolish the infamous *"verlengde arm"* (nurses' medical actions based on doctors' implied or explicit authorization).
- Over the years, a number of medical specializations had come into existence and legal recognition was desirable.
- Medical disciplinary jurisdiction stood in need of adaptation to developments in society with regard to a better position of the plaintiff, more up-to-date formulation of the disciplinary norms, sessions with a more open nature, and adaptation of the composition of the disciplinary councils.

The 1993 Individual Health Care Professions Act (BIG) allows anyone, Dutch or non-Dutch, to practise in the field of individual health care, with the exception of the stipulated restrictions and the use of a protected professional or academic title. There are two ways for a non-Dutch graduate to be granted the right to use a protected professional or academic title. First, there is a general rule that has a Ministerial Order decide which foreign diplomas show a level of education equal to the Dutch level. Holders of such diplomas are entitled to register or to use a certain academic title. The health minister may validate diplomas, depending on the nationality of the person concerned. In accordance with EU guidelines, diplomas of doctors, dentists, pharmacists, midwives and

nurses from Member States of the EU will be recognized and validated in any case.

The second way for a non-Dutch graduate to be granted the right to use a protected professional or academic title is for the holder of a foreign diploma who is not subject to the general rule or whose nationality is not mentioned in the general rule to request recognition from the Minister of Health, Welfare and Sport. The health minister may issue a certificate of need, which indicates that there is no objection to either registration as far as the applicant's competence is concerned or to their using an academic title. Such a certificate may be issued conditionally, which may refer either to the duration of registration or to restriction in professional practice. A committee, formed with this aim, will advise the health minister on the matter of registration of diplomas (the general rule) and the issuing of certificates (the individual rule). A request for registration or for using an academic title by a foreign graduate will be denied if the person is no longer – either temporarily or permanently, fully or restrictedly – qualified to practise abroad, resulting from a judicial, disciplinary or administrative measure.

In the Individual Health Care Professions Act (BIG), the prohibition of the practice of medicine by people other than medical doctors has been replaced by a system of "reserved actions" (medical acts that may only be performed by medical doctors or other groups of designated persons). This list of reserved actions is supposed to describe the most hazardous actions that need to be performed by competent people. As changes in medicine happen quickly, Article 37 makes it possible to expand or change the list of reserved actions by implementing new regulations. The actions mentioned in Article 36 are: surgical treatment, obstetric assistance, endoscopy, catheterization, injections, punctures, anaesthesia, the use of ionizing radiation, the employment of elective cardioversion, applying defibrillation, the employment of electroconvulsive therapy, the use of a lithotripter for medical purposes, and actions with human reproductive cells and embryos.

Doctors are the only medical professionals qualified to perform all mentioned "reserved actions", as far as they may reasonably assume themselves to be competent. Besides doctors, dentists and midwives are qualified to perform a (certain) number of reserved actions, again as far as they may be deemed competent.

The Individual Health Care Professions Act (BIG) provides legal recognition and protection of eligible specialist titles, which means that the health minister must approve regulations of the professional organizations. Only recognized specialists will be entitled to use the specialist title in question. Legal recognition of a professional organization's regulation of specialties may be withdrawn if the

regulation does not meet the requirements or is not properly implemented. The government itself may then institute a regulation, as it may in those cases where there is no professional organization or when the professional organization does not do so of its own accord. The professions' regulation of specialties deals with those that have a register (Article 3), i.e. doctors, dentists, nurses and others.

Medical activities

What is striking in the new Act is that the reserved actions do not include much of what the Medical Practice Act used to include, such as diagnosing a disease. The idea was to clear the legal road for what had become practice and no longer needed to be prevented by legal action, such as calling in the advice and aid of so-called alternative healers. Only when there was a potential danger to public health was legal action taken. For instance, action was not taken against magnetizers and acupuncturists although, according to the Medical Practice Act, they practised medicine without proper qualifications. Giving advice to stimulate the cure of a disease, even if it was not preceded by an examination of the patient, was considered practising medicine under the Medical Practice Act, whereas under the Individual Health Care Professions Act (BIG) this is no longer the case.

Besides the qualification of doctors, dentists, and midwives to carry out reserved actions, the Individual Health Care Professions Act (BIG) offers other professionals, such as nurses, the possibility to do so, with their qualifications derived from those of the aforementioned professionals.

An implementing regulation may also create an independent qualification for professionals to whom the system of registration and protection of professional title applies (Articles 18–33) and/or for professionals to whom the system of protection of academic titles applies (Article 34). A special ruling has been devised for people carrying out orders virtually independently: they are allowed to carry out the functions of reserved actions independently by implementing regulation. This means that the actions may be carried out without supervision or possible intervention of the person giving the order. The obligation to be given an order remains, however. If reserved actions are carried out by a professional unqualified to do so according to Articles 35–39 of the Act, or if they have been carried out by a professional but without due cause, they are liable to legal action under Article 97 of the Act.

Apart from the system of reserved actions under the Individual Health Care Professions Act (BIG), in which doctors are qualified to carry out all reserved actions mentioned to the extent of their qualifications and competence, a number of other acts (such as the Termination of Pregnancy Act (Wet Afbreking Zwangerschap, WAZ), Contagious Diseases Act (Infectieziektenwet),

Blood Supply Act (Wet inzake Bloedvoorziening) and Ambulance Act (Wet Ambulancevervoer)) state that doctors have specific qualifications and responsibilities.

Sanctions

Complete prohibition of the practice of medicine has been replaced by a system of reserved actions; this, however, does not offer adequate protection against incompetent actions of health care professionals. A system of registration and title protection, as formulated by the Individual Health Care Professions Act (BIG), assures patients that they can receive health care from professionals who comply with legal educational standards when (legitimately) using a title.

The Individual Health Care Professions Act (BIG) mentions two kinds of title protection. Articles 3–33 of the Act describe those professions to which a system of registration and professional title protection applies. The use of a title is only legitimate when registration with the register in question has taken place. Registration will only take place if legal educational standards for that particular profession have been complied with. The institution of these registers is regulated by the Act. There is also a system of educational title protection. Article 34 of the Act states that an implementing regulation may regulate the education for a profession as designated, and it describes the area of competence of the profession in question. Completion of the education gives title protection.

The penalty clauses of the Act (Articles 96–103) are in line with the penalty clauses of the Penal Code. Article 96 of the Act is the so-called "damage-clause". The causing of damage or a considerable risk of damage to a third party during the course of action in the area of individual health care is punishable by 6 months of detention or a "third-category" fine. The perpetrator can also be denied the right to practise the profession concerned. Article 97 of the Act regulates the punishment of the unqualified performance of reserved actions. The punishment possible here is a maximum of 3 months imprisonment and/or a "second-category" fine.

Pharmaceuticals

The pharmaceutical policy of the Dutch government is based on the principle of safe and affordable pharmaceutical care for all. This policy is implemented by the Dutch Ministry of Health, Welfare and Sport and can be roughly divided into three sections. The first policy objective takes quality, preparation, distribution and supply of pharmaceuticals as its primary focus. The second

policy objective is to control the costs of pharmaceuticals. The third policy objective is geared towards encouraging responsible use among patients and stimulating a judicious and cost-conscious approach to the prescription and supply of pharmaceuticals.

Quality policy

Both the quality of pharmaceuticals and the way in which they are used are of great importance to public health. For this reason, access to the market is controlled by law, and the processing of pharmaceutical products – from preparation to supply – is subject to legally established quality standards. Many requirements and regulations have their origins in European legal frameworks. Since the founding of the EU, the Member States have harmonized much of their national legislation with regard to medicinal products.

In order to protect public health, new pharmaceuticals may only appear on the market once they have been positively assessed for quality and safety by the government.

Legal safeguards have been drawn up in order to ensure that pharmaceuticals are prepared, stored, transported and treated in the correct manner. Due to the possible risks associated with the use of pharmaceuticals, their supply to patients is also regulated by law. The supply of prescription-only pharmaceuticals is restricted to the pharmacist or the dispensing GP. The latter can be found in areas where there is no pharmacy in the immediate vicinity. So-called over-the-counter (OTC) pharmaceuticals used for self-medication, such as aspirin, can be supplied without a prescription by both pharmacists and chemists. Compared with other Europeans, the Dutch use less OTC self-care pharmaceuticals to treat minor complaints *(29).*

The Health Care Inspectorate (IGZ) is the institution charged with ensuring that these regulations are adhered to by all parties concerned.

Access to the market

In accordance with the Provision of Pharmaceuticals Act of 1958 (Wet op de Geneesmiddelenvoorziening, WGV), pharmaceuticals may only be brought onto the market in the Netherlands once the Medicines Evaluation Board (CBG) has registered a positive assessment of their quality, safety and effectiveness. In effect, registration gives the manufacturer a licence to trade the product concerned. Since 1995, two types of trading licence have existed within the EU. The European Commission trading licence allows access to markets throughout all Member States, while the trading licence issued by

a national registration authority is only valid in the territory of the Member State concerned. From 1 January 1998, a firm that has obtained a trading licence for a certain pharmaceutical in one Member State will have the right to request other Member States to recognize the validity of the licence granted by the first Member State. According to this process of "mutual recognition", the safeguarding of public health will be the only grounds on which Member States may object to the recognition of a trading licence issued by another Member State. The final decision of the European Commission is binding for all Member States. In spite of this national and European quality assessment, unexpected side effects or undesirable interactions with other pharmaceuticals cannot be ruled out entirely. Sometimes such cases only come to light in the course of wider clinical application. To deal with such eventualities, there is both a national and European monitoring system that registers and evaluates such phenomena. All manufacturers and wholesalers are required to have an action plan for the rapid and efficient removal from the market of ineffective or harmful pharmaceuticals.

Cost control

Pharmaceutical expenditure has risen in recent years (see Table 7). This can be explained partly by the increase in the number of prescriptions. Designed to curb the volume of prescribed pharmaceuticals (already in the early 1980s), patient co-payment measures were introduced, such as a fixed amount per prescription for the compulsory insured (1983). When co-payments started, the total number of prescriptions decreased substantially. The number of items, however, and prescription size (pharmaceuticals per prescription) increased inversely. Consequently, any cost-containing benefits from co-payments were offset by this increase in volume *(30).* The government challenged these consequences by limiting the number of drugs per prescription to a maximum. Furthermore, pharmacists were then allowed to dispense cheaper prescriptions with the same effect. Differences in price between the substituted brand-name product for a cheaper product could be (partly) retained by the pharmacist.

Another, more important cause of rising costs, however, is the introduction and distribution of new expensive pharmaceuticals. In order to ensure that pharmaceutical care remains accessible to all, the government has taken steps to keep the cost of pharmaceuticals under control. In accordance with this objective, the health minister decides whether a new pharmaceutical is to be allowed into the basic package covered by the sickness funds. By the same token, the health minister also has the authority to remove out-of-date and/or obsolete pharmaceuticals from the package. In addition, the government employs a reimbursement system for pharmaceuticals, which is included in

the public sickness fund insurance package and which sets maximum prices under the Pharmaceutical Pricing Act (*Wet Geneesmiddelen Prijzen*, WGP), (introduced in mid-1996). Moreover, the government also stimulates market forces and competitive pricing in order to keep prices as low as possible. Policy is also geared towards helping GPs prescribe pharmaceuticals judiciously and towards encouraging pharmacists and GPs to supply patients with the cheapest appropriate pharmaceutical available.

Admission to the sickness funds' health care package

Once a pharmaceutical has been allowed on the market, the government still has to decide whether to include it in the health care package. This determines the reimbursement available for a given pharmaceutical and, therefore, regulates its availability to patients. Not all registered pharmaceuticals automatically qualify for reimbursement. Some pharmaceuticals qualify for partial reimbursement only, while other pharmaceuticals must be subject to further investigation before a decision can be made. The determining factors in this process are whether the product has a better therapeutic effect and does not exceed the cost of a comparable pharmaceutical already in the package. Furthermore, there must be a clear description of the conditions and patient categories for which the new pharmaceutical is intended. Innovative pharmaceuticals are generally expensive and careful deliberation as to the admission of new pharmaceuticals can do little to bring down the considerable costs usually associated with their introduction. In recognition of this, the government is working towards gradual growth in the pharmaceutical budget in four different ways. First, the government will reserve extra financial resources for this purpose in the coming years, within the parameters set for growth in the publicly financed health sector. Second, savings made in other sectors will be diverted for use in the pharmaceutical budget. Third, room will also be created within the pharmaceutical budget by such processes as streamlining the existing package. Finally, more efficient prescription and supply of pharmaceuticals is being encouraged, with the aim of helping more patients within the same budget.

Streamlining the package

In 1996, pharmaceuticals in the sickness funds' health care package were screened on the basis of need and effectiveness, in order to achieve an affordable, high quality package. This process of evaluation resulted in the removal of a large number of pharmaceuticals as of 1 April 1996.

Regulating pharmaceutical reimbursement

The 1996 Sickness Fund (Provision of Pharmaceuticals) Regulation, based on the Exceptional Medical Expenses (Treatment and Services) Decree, regulates the entitlement of those insured under public health insurance to pharmaceuticals dispensed outside a hospital. These entitlements are laid down in an exclusive list of pharmaceuticals qualifying for reimbursement. Generally speaking, the same list applies to those who are privately insured. Pharmaceuticals dispensed within the hospital form part of the entitlement to hospital care and are covered by the hospital budget.

The Medications Reimbursement System determines the level of reimbursement for pharmaceuticals in the sickness funds' health care package, whether they are prescription-only pharmaceuticals or pharmaceuticals for self-medication use (OTC). Within the Medications Reimbursement System, which was introduced by the Pharmaceutical Pricing Act (WGP), the level of reimbursement is based on the average price of pharmaceuticals that have a comparable effect, are mutually replaceable and can therefore be regarded as a group ("reference price" system). If the price of the pharmaceutical is higher than the group average, the additional costs must be paid by the consumer. In practice, there are usually enough alternatives available to allow for the selection of a fully reimbursable pharmaceutical. Since 1 July 1993, the admission of new pharmaceuticals to the package has generally been restricted to those that can be included in a group of mutually replaceable pharmaceuticals. New pharmaceuticals that do not fit into an existing group are only admitted (and reimbursed in full) if they treat a condition that cannot be treated using existing pharmaceuticals or if use of the new pharmaceutical is less expensive than a pharmaceutical already included in the package.

Steering the appropriate use of pharmaceuticals

After a pharmaceutical has been allowed on the market and in the sickness funds' health care package, the next task is to encourage individual care providers (GPs and pharmacists) to administer these pharmaceuticals responsibly and appropriately. In addition, patients should be encouraged to make responsible and safe use of pharmaceuticals through patient information. Judicious prescription and efficient supply of pharmaceuticals is stimulated in a number of ways, such as supporting the development of guidelines and standards for medications that contain clearly defined indications for being prescribed. In addition to these measures, parameters have been set for improving levels of expertise, as well as for peer evaluation and advice. Steps to encourage efficiency have also been taken through contractual agreements on the use of formularies

and through the prescription of pharmaceuticals by active ingredient, as opposed to brand name.

Another important aspect of this process is the independent information on pharmaceuticals that is distributed among GPs and pharmacists in a number of publications, such as the *Bulletin of pharmaceuticals* and the *Pharmaco-therapeutic guidelines*. With government support, the national organizations of GPs and pharmacists have created a national network of 650 local groups that participate in the Pharmaco-Therapeutic Consultation in order to achieve better pharmaceutical care and to establish collective agreements on this subject. It is vital that patients receive adequate information, to enable them to use pharmaceuticals safely and responsibly and to prevent and reduce their unnecessary use. This is the joint responsibility of manufacturers, GPs and pharmacists. Information on correct dosage, contraindications and side effects should be displayed on the packaging and on the legally required patient information leaflet, in language that is easy to understand. Patient and consumer organizations, GPs, pharmacists and the government work together to coordinate the flow of information from various sources, in order to improve the standards of patient information. Support is also given to other programmes in which intensive information campaigns on the responsible use of pharmaceuticals are directed at various target groups, such as the elderly and specific patient groups. Last but not least, the government subsidizes support for the Pharmaceutical Information Line. Some 40 000 consumers per year call this line to ask questions about pharmaceuticals to a qualified pharmacist. This free telephone helpline would appear to satisfy the need for reliable and objective information, which the anonymous callers would not have been able to obtain through other channels *(29).*

Health care technology assessment

In the Netherlands, health technology assessment (HTA) has become increasingly visible during the last 15 years. Simultaneously, the legislature has attempted to regulate new technologies in health care.

Regulation of high technology

Regulation of technology was initiated in the 1960s and 1970s, when the expansion of health technology and care resulted in a steady increase in health care costs. The Dutch government saw the prolific construction of new

hospitals and care institutions as one of the main contributors to rising costs. The Hospital Provision Act (WZV) was introduced in 1971 and has become the national government's major planning tool. The law gives the government the power to regulate all construction of hospitals and care institutions. The main goal is to enable the health minister to regulate and coordinate the creation of inpatient facilities and outpatient services throughout the country, to ensure the population's maximum access to medical care.

The provincial health authorities were made responsible for implementing this plan. Article 18 of the Hospital Provision Act (WZV) relates specifically to the planning of supraregional, high-technology medical facilities. The law requires hospital authorities that want to provide these services to seek direct approval from the health minister. When the Minister decides that a specific technology or medical service should be regulated through Article 18, a planning document containing general planning guidelines (such as estimates of the need for that service, quality criteria to be met by hospitals and other pertinent points) is published. The Minister asks the Health Council (GR) to report on the technology's scientific state of the art, safety and efficacy aspects, cost–effectiveness, and appropriate use. Article 18 generally deals with expensive, technically sophisticated, non-experimental services that will be located in only a few facilities, for which the need can be expressed quantitatively.

Originally, Article 18 regulation was mainly used to control the diffusion of technologies by limiting the number of facilities (for example, computer tomography (CT) scanners, linear accelerators, and dialysis machines) and the number of procedures, with a focus on cost containment *(31)*. The government, however, gradually began to use this tool as a planning instrument, to ensure proper geographical distribution, to promote concentration of facilities, and to enhance expertise and quality, with an emphasis on cost–effectiveness and appropriate use. Emphasis in the Article 18 programme shifted from merely controlling the purchase of equipment to regulating the use of specialized services as a whole – for example, genetic screening and counselling, neonatal intensive care, and in vitro fertilization (IVF). Since 1984, with the introduction of the global budget system for hospitals, the government no longer attempts to regulate the volume of procedures, since this has become part of the negotiations between hospitals and insurers over the annual budget *(31)*.

Another change is that Article 18 regulation has become more flexible. Unlike before, when there was a 4-year application period for every technology, new technologies are considered on a case-by-case basis, and regulation is lifted altogether when the technology (CT scanners, for example) begins to be considered a standard procedure no longer restricted to selected institutions.

Article 18 originally applied to community hospitals, since university hospitals then fell under the authority of the Ministry of Education and Science. But beginning in 1985, the Ministry of Health and the Ministry of Education and Science began to cooperate to assure smooth functioning of the Article 18 programme. In 1990 the Scientific Education Act (Wet op het Wetenschappelijk Onderwijs, WWO) and the Hospital Provision Act (WZV) brought the academic hospitals under the authority of the health minister (as far as health care was concerned).

The coordination between Article 18 and payment decisions has also become more effective. Since Article 18 approval implies money, reimbursement decisions tend to follow such approval. For a number of technologies, specific budget parameters have been calculated for use in budget negotiations (for example, for bone marrow transplantations). Recently, Article 18 has been coupled with evaluation activities under the Investigative Medicine Programme (Ontwikkelingsgeneeskunde). The aim here is to ensure that new technologies under assessment are not widely diffused throughout the health care system before results are known and interpreted.

While the research fund bears the costs of the evaluative research, Article 18 is used to deny other hospitals the use of the new technology. Such cases are decided formally by the health minister after advice from such bodies as the Health Care Insurance Board (CVZ) and the Health Council.

In general, Article 18 works well. It has prevented oversupply and stimulates effective use of technologies. Hospitals that ignore the regulations are subject to sanctions and will not be reimbursed by the sickness funds. The procedure is, however, bureaucratic and time-consuming. Only a minority of the thousands of technologies offered by the health care system are controlled under the programme (approximately 3% of total health care costs and approximately 9% of all hospital costs). In recent years, the health minister has concentrated on a more flexible and effective approach to control health technology. This effort resulted in the new Special Medical Procedures Act (WBMV), introduced in 1998. The focus of the law is on quality of care and appropriate use, rather than on cost containment. Quality is increasingly seen in terms of health care outcomes. The main purpose of quality assurance is to promote health care with the maximum benefit and minimum risk to patients at an affordable cost to the system. Producing evidence of quality has been identified as an important task for health technology assessment. Specifically, where technologies that are shown to be beneficial for one indication are used for inappropriate or unproven indications, technology assessment might be the instrument to improve the benefits and cost–effectiveness of clinical practice *(31).*

Health technology assessment

Traditionally, the Health Council is responsible for the decisions about adoption and diffusion of new technology. This influential body decides which technologies are to be reimbursed through public insurance programmes. Most of the evaluations are based on research by medical school faculty and university hospitals, often with assistance from research institutions. The formal process of technology assessment includes several stages:

- identify technologies in need of assessment
- collect needed data to conduct the evaluation
- synthesize relevant clinical outcomes and cost data
- disseminate findings to decision makers
- take needed action.

Each of these steps requires assurance that findings are scientifically and financially valid. The emphasis in the past has been on conducting clinical trials – in particular, determining appropriateness and efficacy of new pharmaceuticals, medical and surgical procedures, and vaccines and blood products. Later on, the ethical, legal and social aspects of new medical technologies were also included in the evaluation. The Ministry of Health and the Ministry of Education and Science, as well as the Health Care Insurance Board (CVZ), finance these studies by a newly created fund, the National Fund for Investigative Medicine (Fonds Ontwikkelingsgeneeskunde). A specially established committee of experts in medicine, health economics, medical ethics, health law and health administration was given responsibility for selecting research proposals from hospitals and medical faculties for funding. Since the 1990s, such systematic evaluations of new medical technologies are used as an important tool to assist policy-making, including priority setting in health care, in a more rational manner.

Although the National Fund for Investigative Medicine proved to be a driving force behind many new HTA initiatives in the Netherlands, this programme was not without problems. Among other things, there was criticism that, although the programme was open to proposals to evaluate existing technologies, most proposals, in fact, concerned new medical technologies. This situation probably reflected the academic interest in the efficacy of new technologies. Another shortcoming was that few research proposals included an examination of the social, ethical and legal implications of technologies. This can be taken as a sign that most research has no direct link with health care policy and decision-making *(31).*

An important concern about the fund's programme was that it was not based on explicit priority setting. The submission, selection, and funding of

research proposals had no direct link to the identification of areas in health care that were considered problematic or underdeveloped. As a result, many of the selected projects could not be considered high priority in terms of policy, and many important health problems were grossly underinterpreted. Also, most proposals concerned hospital-based care and somatic disease, and limited attention was given to effective implementation. The committee concluded that the cause of this shortcoming was the bottom-up procedure developed at the start of the fund's programme and the emphasis on rigorous scientific standards (randomized controlled trials) and academic scientific relevance *(31).*

To remedy this undesirable situation, the fund's steering committee considered alternative methods for selecting projects. After some discussion, the idea of a top-down approach evolved. With this approach, high-priority subjects would be identified by the steering committee and investigators would be invited to submit proposals for those subjects.

In 1993, the top-down procedure began. After examination and discussion of existing priority lists, three priority projects were selected: the treatment of urinary incontinence, the treatment of psychogeriatric problems, and diagnostic testing. The availability of funds for these projects was announced in medical journals. Subsequently, selected proposals were funded. So far, two top-down projects have been implemented and four more are being prepared. It is too early to judge the effectiveness of the top-down programme; it has become clear, however, that this approach is very time-consuming and needs thorough preparation, in comparison to the bottom-up procedure. Some positive aspects are that the top-down programme can be linked directly to priorities in health care and social insurance and that vital questions of effectiveness and quality of care are better addressed *(31).*

Financial resource allocation

Third-party budget setting and resource allocation

As with many other regulatory issues, budget setting and resource allocation differ among compartments, and within the second compartment they differ between the statutory part governed by the Sickness Fund Act (ZFW) and the part controlled by private health insurance.

Within the first compartment, the implementing bodies (sickness funds and private insurers) were fully compensated retrospectively for their expenditures, until 1997, by the Central Fund –that is, expenditure was done jointly, and no budgets were set prospectively for third-party payers. Since 1998, the administration has been entrusted to a single regional payer, usually the largest sickness fund in each of the 32 areas (31 until 2001).

Under private health insurance in the second compartment, each health insurer has to cover expenditure out of its premium income (with the exception for those insured under the Health Insurance Access Act; see subsection on *Finance and coverage of private health insurance*).

As a result, (partial) budgeting applies only to the Sickness Fund Act (ZFW) portion of health care financing.

Budgeting of sickness funds for benefit payments

Since 1991, sickness funds have taken a financial risk in implementing the Sickness Fund Act, (ZFW) and the allocations have been budgeted to cover the costs of benefits and payments provided under the Act. Before 1991, all contributions of employers and employees were collected in a central fund, which was administered by the Sickness Fund Council. Sickness funds received

full compensation for their subscribers' medical expenses from the Central Fund.

One of the aims of the budgeting system since 1991 has been to make it in the best interest of the sickness funds to purchase and organize care for their insured as flexibly and effectively as possible. The sickness funds negotiate with care providers to determine the quantity, quality and – to a certain extent – the price of the services provided. Budgeting has been introduced to increase the financial self-reliance of the funds. A second important reason for introducing budgeting was to facilitate market competition among sickness funds.

In short, budgeting works as follows: each insured pays an income-dependent contribution (see section on *Health care finance and expenditure*). These contributions are collected in the Central Fund, maintained by the Health Care Insurance Board (CVZ). Out of the Central Fund, each sickness fund receives a budget (B), by means of risk-related capitation payments. The funds pay the providers and thus accumulate expenditure (E). The difference between the allocated budget – after three retrospective corrective measures called *equalization*, *recalculation* and *high-risk pool* (see below) – and the expenditures (E) has to be covered by the flat-rate contributions that each fund has to determine for itself. If the difference (E-B) is large, a fund must set a high flat-rate contribution; if the difference (E-B) is small, a fund can set a lower flat-rate contribution. These differences in flat-rate contributions are assumed to reflect differences in efficiency – that is, a small difference points to great efficiency, and a large difference points to less efficiency. Of course, this assumption may be questioned, as it depends on the validity of the model on which the risk-related capitation payments are based.

The starting point for budgeting is the annual decision by the Minister of Health, Welfare and Sport on the so-called Sickness Fund Act (ZFW) macro-benefits budget for the coming year. The Minister establishes rules on how the Health Care Insurance Board (CVZ) must distribute the predetermined macro-benefits budget among the sickness funds. The Board determines the distribution procedure on the basis of these rules. This decision is subject to approval by the health minister. Once approval has been obtained, the Board informs each sickness fund as to the size of its budget for the coming year. The Board distributes the allocated budgets (paid out of the Central Fund) to the sickness funds, in accordance with a fixed advance payment scheme.

Initially, the prospective allocations were largely based on historical costs. Age and gender were then the first risk-adjusters. In 1996, the system was improved by adding new risk-adjusters (region of residence and disability status) to the formula. At the same time, the percentage to which the sickness funds were really at risk for expenditure increased. In 2001, the "region factor"

was revised to better account for socioeconomic interregional differences and interregional differences in supply of health care facilities (number of hospitals/nursing homes in region, for example). Moreover, a new indicator was added to the model: Pharmaceutical Cost Groups, based on the consumption of pharmaceuticals in the past. This indicator is intended to bring morbidity into the allocation model – in particular, for chronic disease.

Budgeting only applies to those costs that sickness funds are assumed to influence. Total expenditures, therefore, were initially split into two parts. The first part included expenditures the funds cannot control; these are the fixed costs that come from capital expenditures used by hospitals to prevent the sickness funds from getting financially trapped between their own budgeting under the Sickness Fund Act (ZFW) and the budgeting of care institutions (see section on *Payment of hospitals*; the so-called double budgeting problem). The second part includes the costs the funds are assumed to control by effective purchasing (such as pharmaceutical drugs, GP care and specialist care). This was why the so-called division model was introduced into budgeting under the Sickness Fund Act (ZFW) in 1996. The model was refined in 1998 and now contains the following:

- fixed costs of hospital care
- variable costs of hospital care and specialized care
- other benefits (including GP care, medicines, aids, paramedic care and dental care).

In the above division, the aforementioned semi-fixed costs of hospitals and other care institutions are split between group 1 (fixed costs of hospital care) and group 2 (variable costs of hospital care and specialized care).

Two adjustment mechanisms, which are retrospectively applied, ensure that the aforementioned intentions are met: First, the difference between the budget allocated and the actual costs for each sickness fund is determined at the end of the budget year, and any difference found in financial results is partly shared ("equalized") among the sickness funds, up to a specific percentage (the *equalization percentage*). This equalization is designed to adjust for possible inconsistencies in the distributive operation of the budget model. Through this process, there is a shift of resources from sickness funds that have received "too much" money (those with low expenditure) to those that have received "too little" (those with high expenditure).

Second, at the end of the budget year, an adjustment is made for the differences between the total amount of budgets allocated and actual expenditures; this adjustment relates to the ability of the sickness funds to influence the level of actual costs. These differences are paid out of the Central Fund, up to a

specific percentage (the *recalculation percentage*). This recalculation option was introduced to link the financial risks involved to the ability of the sickness funds to influence the level of actual costs. So long as the sickness funds have insufficient influential powers, they cannot bear the full financial risk for their budgets.

Table 14 indicates the recalculation and equalization percentages (2004). If a sickness fund runs over its allocated sub-budget for specialist services, 30% of its overspending is shared among all sickness funds. In addition, if the money allocated to all sickness funds for specialist care is insufficient, the funds retrospectively obtain 35% of the difference on top of the prospectively calculated expenditure. Equalization and recalculation percentages for the third group ("other benefits") have recently been abolished.

Table 14. Equalization and recalculation for the various components of the sickness fund budgets

Sub-budgets	Approx. share of total budget (%)	Equalization percentage	Recalculation percentage
Fixed costs of hospital care	22	0	95
Variable costs of hospital care and specialized care	36	30	35
Other benefits (GPs, pharmaceuticals, etc.)	42	0	0

The objective is to also reduce to zero over a period of a few years the equalization and recalculation percentages for variable costs of hospital care and specialized care. To meet this objective, the distributive operation of the budgetary model must first be improved, and then the instruments available to the sickness funds to influence costs must be extended and strengthened.

After the equalization and recalculation percentages have been reduced stepwise, the inter-fund variation in flat-rate contributions among sickness funds has to be substantially increased (see the section on *Finance and coverage under the Sickness Fund Act*).

On 1 January 1997, a specific type of equalization for high costs was introduced to supplement the generic equalization system described above. The specific equalization system was introduced explicitly to cope with differences in costs among sickness funds caused by the uneven distribution of insured people with high health-care costs. This high-cost equalization means that the sickness funds can reclaim 90% of the expenditure for an insured individual from a pool, provided that the expenditure exceeds the €2036 limit (since 1999, €3394) (Table 15). Only those claims that are charged to the sub-budgets

variable costs of hospital care and other benefits are relevant. The pool required for this is financed by a percentage deduction of the variable costs of hospital care and other benefit budgets.

In summary, the changes in both the formula used to determine the prospective allocations – that is, the risk-adjusters used – and the retrospective adjustment obtained by subdividing the overall budget into three components with different degrees of equalization and recalculation, as well as the high-risk pool applied on the individual level, constitute a complicated puzzle. Taken together, the various factors increased the percentage of full "risk" for the sickness funds from 3% in 1995 to about 35% in 1999 (see Table 15). In 2002, this figure further increased to about 41%, and it is estimated that the funds in 2004 are at risk for up to 53% of their expenditures.

Table 15. The changing blend of payments to sickness funds, 1992–2004

Year	% of expenditure at full risk for sickness funds	Risk-adjusters	High-risk pool
1992	0	–	–
1993–1995	3	Age, gender	–
1996	15	Age, gender, region, disability status	–
1997	27	Age, gender, region, disability status	90% of annual expenditure above €2 036
1998	29	Age, gender, region, disability status	90% of annual expenditure above €2 036
1999	35	Age, gender, region, employment/social security status	90% of annual expenditure above €3 394
2000	36	Age, gender, region, employment/social security status	90% of annual expenditure above €4 538
2001	38	Age, gender, region, employment/social security status	90% of annual expenditure above €4 538
2002	41	Age, gender, region, employment/social security status, Pharmacy-based Cost Groups	90% of annual expenditure above €7 500
2003	52	Age, gender, region, employment/social security status, Pharmacy-based Cost Groups	90% of annual expenditure above €7 500
2004	53	Age, gender, region, employment/social security status, Pharmacy-based Cost Groups, Diagnostic Cost Groups	90% of annual expenditure above €12 500

Source: Modified from van Vliet et al. *(32)* and van de Ven et al. *(33)*

Budgeting of sickness funds' administrative costs

A special budget for administrative costs (implementation costs) of the sickness funds has existed since 1984. Using the same system applied for budgeting of benefits, the Minister of Health, Welfare and Sport sets a macro-administrative costs budget each year, whereby rules are established for the distribution of the budget by the Health Care Insurance Board (CVZ). The Board decides on the distribution procedure. This decision is subject to approval by the health minister. Once approval has been obtained, the Board determines the size of the administrative costs budget for each sickness fund and informs the funds of this determination. The budget is then allocated to the funds in accordance with a fixed advance payment scheme.

No equalization and recalculation takes place on the administrative costs budget, in contrast to the benefits budget. If a sickness fund is under budget on its administrative costs, any money left over must be placed in the reserve. If a sickness fund does not have enough in its administrative costs budget, the shortfall can be covered by the flat-rate contributions it receives or through the reserve.

The size of the macro-administrative costs budget was initially established on a historical basis (with annual adjustments). In 1995, the macro-budget was reviewed on the basis of the average actual administrative costs of the most efficient sickness funds. As a result, allocation now largely takes place on the basis of standardized amounts for each insured person.

Payment of hospitals

Charges of health care services are uniform throughout the country, with the exception of the per diem price for a hospital bed. The Board for Health Care Tariffs (CTG) sets guidelines for the composition and calculations of charges and tariffs. Before 1984, the health care reimbursement system was open-ended. As part of the cost-containment policy, all hospitals and other health care institutions are now required to have an overall annual budget, which is calculated prospectively. There is, in principle, no possibility of recalculation or compensation afterward if the hospital exceeds its budget. Specialist fees are not part of this overall hospital budget.

Since 1988, there has been a function-directed budget system in the hospitals. The budget can be divided in four cost components: location costs, fixed costs, semi-fixed costs and variable costs. [NB: The terminology used here is not the same as the one used in the budgeting process of sickness funds.] *Location*

costs are concerned with infrastructure: the building and equipment, including depreciation and interest. These investments are approved by the health minister under the Hospital Provision Act (WZV). Hence, capital expenditures are part of acceptable budget cost. *Fixed costs* are costs that do not generally vary, regardless of the volume of activity. The parameter for these "availability" costs is the number of inhabitants served by the hospital in the region – a major operational parameter for the hospital. *Semi-fixed costs* are not influenced in the short term by the scope of the production of a hospital. These are capacity-based costs, including the number of beds and specialist units. Finally, v*ariable costs* relate directly to the volume of activity or the production in the hospital. Parameters for these costs include admissions, outpatient visits, nursing days, day care and day treatments. Each year, agreements are reached between the hospital and local or regional insurers, both private and the sickness funds, on the number of "production units". This part of the budget can be regarded as open-ended (even though within certain limitations).

The hospital budget is determined as follows: Number of persons in service area (x tariff) + Number of licensed hospital beds (x tariff) + Number of licensed specialist units (x tariff) + Negotiated volumes of production units, such as hospital admissions (x tariff), inpatient days (x tariff), first outpatient contacts (x tariff), day surgery (x tariff) and special treatments (such as renal dialysis, open-heart surgery, IVF and brain neurosurgery) (x tariff). Tariffs vary according to hospital size – bigger hospitals receiving a higher tariff than smaller hospitals, assuming that bigger hospitals perform more difficult medical procedures.

In addition to this, hospitals receive additional budgets, for instance for capital expenditures. Major renovations and the construction of new hospitals are covered 100% by a mark-up that is applied for 50 years – that is, payment is guaranteed for 50 years through a mark-up in the per diem rate (see below). In addition, hospitals receive a normative budget for small investments (such as repairs and maintenance). These investments do not need the formal approval of the health minister. Thus, hospitals are not at risk financially for their major capital expenditures.

The fees charged by the hospital to insurers or to patients provide hospital budget financing. There are two types of fees: ancillary "tariffs" and per diem nursing rate. Ancillary tariffs are fees that cover about 1600 treatments or diagnostic activities in the hospital. These rates are universal and close to real average costs. The second type of fee, the per diem nursing rate (or daily charge for the hospital), is derived directly from the individual hospital budget as follows. The income from ancillary medical procedures (such as lab testing, X-rays and surgical procedures), for which uniform fees ("tariffs" set by the Board for Health Care Tariffs) are applied, is deducted from the hospital budget.

The remainder is divided by the estimated number of inpatient days; the result is the daily nursing rate, which is equal for all patients and for all insurers that pay the hospital (both sickness funds and private health insurers), but it differs between hospitals. This daily charge may not be confused with the tariff per inpatient day used in the calculation of the budget (see above). While the daily charge is often more than €300, the tariff calculated is only around €40.

Before 2000, the principle was: budget = budget. That meant that when a hospital produced less inpatient days than estimated (as is usually the case), it still received the full budget through a surcharge on the nursing rate in later years (and vice versa). That principle has now been changed, however. Payment is now related to performance. Thus, if a hospital produces less inpatient days than agreed upon with the health insurers, it gets paid less, and so on. The rationale of this change is to stimulate hospital production, in order to combat waiting lists.

The change from fixed to target budget was, however, only the first step of changing the hospital payment system altogether. Hospital budgeting seems to be politically dead as the problems are multifold.

- Hospital budgets did not keep pace with the increase in demand for hospital care. Budgeting has eroded the fundamentals of insurance: you pay for it, you are insured; but the service is not available because of waiting lists.
- The tariffs for admissions, inpatient days, day surgery – used to determine the budget – are completely artificial and do not reflect true costs.
- The incentives for efficiency are weak. Stay within your budget is the strongest incentive.
- Hospital budgeting does not stimulate hospitals to inform insurers and patients about their performance. This point has become politically very important, as hospitals have received extra money to reduce waiting lists. Politicians ask hospitals what they have done with the extra money, but hospitals are reluctant to provide information. This was also the main reason why the previous principle of "budget = budget" has been replaced by the principle of performance-related payments.
- The hospital budgets insufficiently reflect differences in severely ill patients.

A new hospital payment scheme is sought in Diagnosis Treatment Combinations (Diagnose Behandelings Combinaties, DBCs). This can best be compared with a DRG (Diagnosis Related Group) system, though there are some important differences:

- While DRGs are often coded at the beginning of the treatment, DBCs are coded afterwards.

- A patient can be coded in more than one DBC.
- The coding is not done by special personnel, but is done by the medical specialist.
- The physician payment (honorarium) is included in the DBC, thus giving physicians an incentive for "upcoding".

These developments in Dutch hospital financing are more or less similar to those occurring internationally. More flexibility is being given to parties negotiating at the local level on such factors as production, number of treatments and number of specialists. Furthermore, efforts are being undertaken to integrate the fee-for-service system for specialists and the hospital budget system into a single integrated budget.

Location costs, however, will remain fixed costs, as the government still decides on new hospital construction. All of the other maintenance costs will be integrated into the location cost centre of hospital budgets set by the Board for Health Care Tariffs (CTG). The DRG-like system is supposed to be carried out through budgeting procedures used by the sickness funds. Private insurers, however, are not subject to budget procedures based on the Social Health Insurance legislation. Government policy is moving in these directions, but the system is not completed yet. The new financing of hospitals is also called output pricing, which means that patient-treatment categories are defined and priced. Hospitals have to be contracted by the sickness funds, based on these patient-treatment categories.

Nevertheless, it is intended that DBCs will be introduced in January 2005, and the system is then expected to be fully operational in 3 years.

Payment of physicians

Payments to physicians depend on their position and where they work. Physicians in their specialist training (assistant physicians (AGIO), see section on *Human resources*) are salaried employees of the hospitals. General practitioners are paid on a per-person basis for patients insured under the Sickness Fund Act (ZFW) and on a fee-for-service basis for privately insured patients.

Medical specialists, on the other hand, were traditionally reimbursed through a fee-for-service system, except university and municipal hospital physicians, who are salaried employees. Specialist fees for private patients are negotiated with the insurance companies and are usually higher. Most medical specialists practise only in the hospital setting. In recent years, there has been a tendency for medical specialists to work in private practice out the hospital.

Policy-makers in the Netherlands discovered that complete reliance on fee controls as an instrument failed to achieve effective cost containment in the area of specialist care. Specialists could respond to a cut in their fees with an increase in the volume of health services. In order to counteract such a response, an expenditure target (cap) has been introduced. The political rationale behind this target was that it allowed the fee-for-service payment system to continue as the great symbol of professional autonomy under a fixed national budget, which was the primary target of the government and health insurers.

Since 1995, medical specialists have been budgeted, both at the national level and at the level of the individual hospital. The hospital management negotiates a service volume with each specialty in the hospital, in terms of number of first polyclinic visits, hospital admissions and day care/surgery. This results in a budget for each specialty. While there is a strong historical component in the volume agreement, new elements can be introduced (for example, the hospital's policy to increase the volume of day care surgery). It is then up to the hospital management to negotiate the overall service volume with the insurers – that is, the major sickness fund plus one private insurer representing all private insurers. As these negotiations take place in the presence of a representative of the medical staff, the contracts may be considered tripartite. Ideally, the sum of internal agreements equals the overall volume agreed upon with the insurers.

As a consequence, the specialists' revenues are now part of the hospital budget. There is a budget for each specialty. Medical specialists, however, are still paid on a fee-for-service basis. If their service volume is lower than agreed, they will then receive less remuneration than anticipated. If the volume is higher, the hospital can negotiate an additional production volume with the insurer. This arrangement has only been introduced in 2001 and is based on the government's policy of reducing waiting lists. (Note that the above story only applies to specialists who are paid on a fee-for-service basis. The revenues of specialist who are salaried have always been part of the hospital budget.)

The conditions of budgetary constraint provoke deep conflicts in the negotiating process for fees. The representative organizations of medical specialists have increasingly seen themselves forced to employ defensive strategies. These strategies, however, have not protected them from the medical profession's loss of financial autonomy *(34)*.

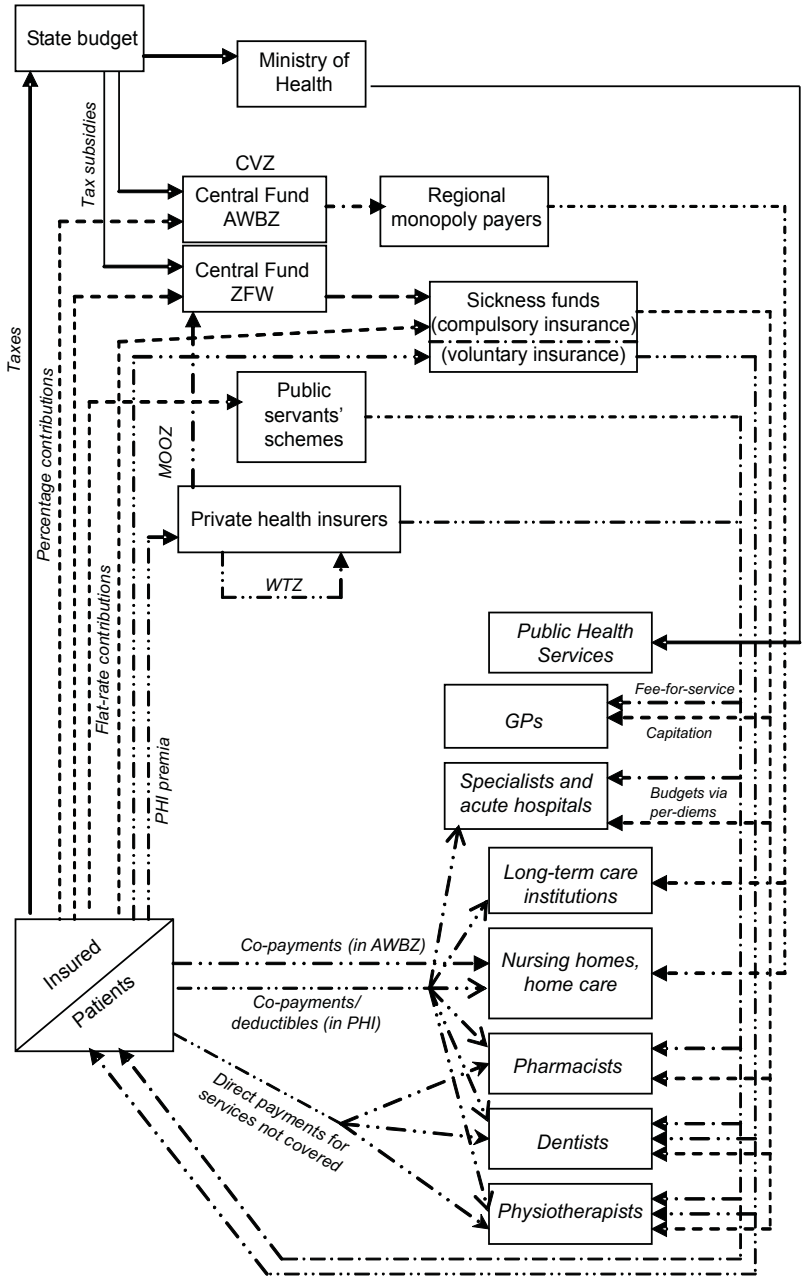
Another characteristic of the Dutch system is the total lack of a well-developed monitoring system for implementing expenditure targets. As a result, an overrun of the expenditure target in one year must be compensated by a temporary cut in the fees for the following year(s). These *ex post* cuts always give rise to deep conflicts between the government and the specialist organizations. The Netherlands does not have an equivalent of the *Kassenärztliche Vereinigungen*

in Germany, which monitor expenses for specialist care over the year and are made responsible for necessary adjustments of the fees, in order to preclude an overrun of the expenditure target (a situation that has been modified since 2001, as explained above).

In game theory, in the prisoner's dilemma, the more specialists do, the less they receive for each service. The introduction of an expenditure target, therefore, only brought temporary peace in the relationships among specialists, the government and the health insurers, which did not last long. Since the mid-1990s, there has been a shift from national negotiations on medical specialists' income to local contracts. In these strong bottom-up processes, which originally started as experiments, the medical staff negotiated the abolition of the fee-for-service payment in exchange for a fair lump-sum payment, which has to be renewed each year *(9).* An additional component is a harmonization to reduce differences in income between specialties. These "local initiatives", heavily subsidized by the government, started in almost all general hospitals. As participation was higher than expected, and as participants were exempted from budget cuts as a compensation for earlier cost overruns, the experiments resulted in higher expenses than expected. Similar projects have focused on increasing quality of medical care *(35).*

Fig. 13 provides a simplified financing flow chart for the Netherlands.

Fig. 13. Financing flow chart



Notes: AWBZ is the Exceptional Medical Expenses Act; ZFW is the Sickness Fund Act; WTZ is the Health Insurance Access Act; CVZ is the Health Care Insurance Board; PHI is private health insurance; VHI is voluntary health insurance; and MOOZ is the Act on the Joint Funding of Elderly Sickness Fund Beneficiaries.

Health care reforms

Process and content of reforms

Health insurance in the Netherlands has oscillated between efforts to unite the different coexisting systems into one and retaining the existing systems, and the future is still unclear. A summary of the main changes that have occurred is shown in Fig. 14, which visualizes how the reforms relate to the three compartments and the changes that have taken place among the three compartments.

Dekker Committee

The Dekker Committee, which was set up by the government in 1986 to consider the structure and funding of health care, published its report on 26 March 1987. The report, entitled *Willingness to change (36)*, included recommendations aimed at controlling the growth of health care in terms of volume, reforming the health insurance system and introducing deregulation.

The government's response to the Dekker Committee report was set out in a policy document entitled *Change assured (13)*, which indicated, among other things, the kind of health insurance system it envisaged. There would be one system providing so-called basic cover for everyone and accounting for around 85% of health care costs and the associated services. The idea was to remove the divisions between cover under the Sickness Fund Act (ZFW), private insurance and the insurance schemes for public servants. In their place, there would be a national health insurance scheme (offering a relatively wide range of benefits) in which every resident in the country would be required to participate. People would be able to take out supplementary private insurance for care that was not included in this basic package. The premium for this basic package would be

related mostly to income – that is, a percentage premium – with only a small flat-rate component. These changes were to be phased in as of 1 January 1989, with the gradual disappearance of the distinction between the sickness funds on the one hand and private insurance and the insurance schemes for public servants on the other.

First phase amendments

The following changes were made. On 1 January 1989, ambulatory psychiatric services and the provision of aids and appliances were brought within the scope of the Exceptional Medical Expenses Act (AWBZ), having previously been covered under the Sickness Fund Act (ZFW), private schemes and the insurance schemes for public servants. The contributions/premiums payable for sickness fund/private insurance were therefore reduced, while contributions under the Exceptional Medical Expenses Act (AWBZ) increased.

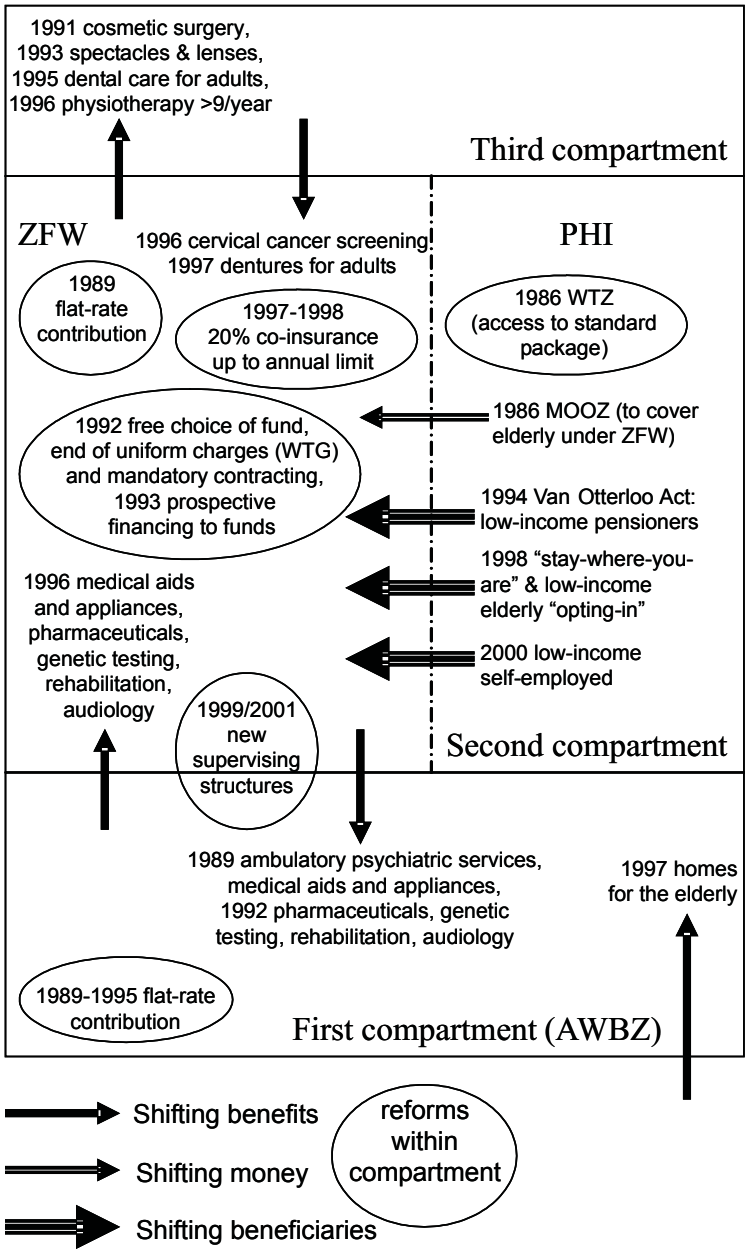
Also in January 1989, a flat-rate component was introduced in the contributions payable under both the Sickness Fund Act (ZFW) and the insurance schemes for public servants, accompanied by a reduction in the income-related component. The government set the flat-rate contribution for 1989 at €71 per person per year for the insured and their partner. The rate for children was €35 per year for the first and second child (subsequent children were insured free of charge). [NB: The flat-rate contribution for children insured as dependants under the Sickness Fund Act was abolished on 1 January 1995.]

Since 1 January 1991, the sickness funds have been free to set the amount of flat-rate contributions themselves. The reason they have been vested with this authority is that, with the introduction of the Health Insurance System First Phase Amendments Act (Wet stelselwijziging ziektekostenverzekering eerste fase), it has become possible to budget payments from the Central Fund to the sickness funds to cover the cost of benefits in kind and in cash. The sickness funds began to bear genuine risk as they had to cover costs from these budgeted funds and from the flat-rate contributions received. The amount of the flat-rate contribution, therefore, depends partly on the financial results of the funds, which it is hoped will be an incentive for them to work more efficiently and cost-effectively.

Second phase amendments

After the change of government in 1989, the Dekker plan was slightly modified and became known as the Simons Plan, named after the then Deputy Minister of Health.

Fig. 14. Health care reforms since 1986 and their relationship to the three compartments of the health care system



Notes: AWBZ is the Exceptional Medical Expenses Act; ZFW is the Sickness Fund Act; WTZ is the Health Insurance Access Act; CVZ is the Health Care Insurance Board; MOOZ is the Act on the Joint Funding of Elderly Sickness Fund Beneficiaries; WTG is the Health Care Tariffs Act; PHI is private health insurance.

The introduction of the Health Insurance System Second Phase Amendments Act, on 1 January 1992 changed the Exceptional Medical Expenses Act (AWBZ) benefits and contributions and also abolished the sickness funds' obligation to conclude contracts with health care providers. It was the second step on the road to a single system of health insurance for the whole population.

1. Changes in the Exceptional Medical Expenses Act (AWBZ) benefits and contributions

With the introduction of the Health Insurance System Second Phase Amendments Act on 1 January 1992, cover for pharmaceuticals, genetic testing, rehabilitation and the services of an audiology centre was transferred from the sickness fund insurance scheme and from the private medical insurance and the health insurance schemes for public servants and brought under the scope of the Exceptional Medical Expenses Act (AWBZ).

This required a further adjustment of the contributions/premiums payable for the various forms of insurance. The percentage contribution for cover under the Exceptional Medical Expenses Act (AWBZ) rose by 1.5%, and a flat-rate contribution was introduced. The percentage contribution under the Sickness Fund Act (ZFW) and the health insurance schemes for public servants decreased. The maximum premium for the Health Insurance Access Act package for the various age groups was reduced accordingly. Most private insurers also reduced the premiums. The flat-rate contributions were intended to cover parts of the expenditure for the services moved to the AWBZ scheme. The implementing bodies bore some of the risk of these forms of care, which they had to pay for from the budgeted payments provided by the AWBZ Fund and the flat-rate contributions paid by insured persons to their insurer. The 1995 budgets allocated to the AWBZ implementing bodies were based on the objective criteria of age and sex only, whereas the budgets allocated to the sickness funds, as well as being based on age and sex, included a regional and disability component.

It also became possible for people insured under the Exceptional Medical Expenses Act (AWBZ) to include an "excess" condition in their cover that would pay for all costs up to an agreed ceiling, in return for a reduction in their flat-rate contribution. Cover under the Act can be in the form of either benefits in kind or reimbursement of the costs incurred.

[NB: From 1996, prescription drugs, medical devices and rehabilitation were re-transferred from the Exceptional Medical Expenses Act (AWBZ) to the second compartment of normal health care services, followed in 1998 by hospital-related home health services. At the same time, the flat rates for the AWBZ were abolished. With the (re-)transfer of the budgeted services

to the second compartment, the AWBZ again became a complete system of full retrospective cost-coverage.]

2. **New regulations for contracting and the freedom for sickness funds to operate in the whole country**

   Since 1 January 1992, sickness funds have been able to expand their field of operation to cover the entire country. They now all operate in every municipality in the Netherlands, thereby giving people a choice of insurer. Thus, the obligation for every sickness fund to set a contract with every care provider who so wished one (provided there were no pressing reasons for not doing so) was likewise abolished. In theory, this was true for the Exceptional Medical Expenses Act (AWBZ) implementing bodies as well, but only for the services that came into the AWBZ in 1992. It never worked, however, as the AWBZ implementing bodies did not have the tools to work it out.

Van Otterloo Act

Having come this far, the planned reforms were then brought to a halt by the question of whether the future health insurance system should receive more public funding or less. Some categories of insured people with private medical insurance premiums that were disproportionately high in relation to their income were having serious financial difficulties. Parliament finally voted unanimously in favour of the bill tabled by the then Member of Parliament G.J.P. Van Otterloo; the bill amended the Sickness Fund Act (ZFW) to help elderly pensioners with no supplementary pension or a very small supplementary pension in addition to their state pension. The changes made by the Van Otterloo Act mean that, since 1 July 1994, pensioners have been covered under the ZFW, provided that the total amount of their state pension plus any income from work and/or their supplementary pension does not exceed €14 004 gross a year in the case of single people (1995 figures). In return, the "stay where you are" principle was abolished (see below). Interest on savings, annuities, dividends, single-premium insurance policies and the like are disregarded for this purpose. For married or cohabiting couples, who both receive a state old age pension, this ceiling applies to each of them. If the income of one of the partners exceeds this amount, neither of them is eligible for cover under the ZFW. The same ceiling, however, applies to pensioners with a partner who does not receive a state elderly pension; any supplement they receive on top of their basic pension is disregarded. Their partner's income, therefore, does not affect their entitlement. An old age pensioner who is covered by one of the health insurance schemes for public servants, either in their own right or as a member of someone else's household, will continue to be insured under that scheme.

This Act eliminated a number of problems in the sickness fund insurance scheme, while creating some new ones. One improvement was that people over the age of 65 years on low incomes became eligible for cover under the Sickness Fund Act (ZFW); on the other hand, however, elderly people who had been covered under this Act throughout their working lives now had to be privately insured in retirement because their pensioner's income was over the eligibility threshold.

Restructuring of the Sickness Fund Act

The Kok government that came into power in 1994, which had the aim of eliminating the various problems in the existing health insurance system, introduced a series of measures intended to lead to a restructuring of the sickness fund insurance scheme. For instance, sickness funds were legally obligated to have an annual open enrolment period at the beginning of the year; by the end of 1995, eligible people had a choice of sickness funds. From 1996 on, several benefits were re-transferred from the Exceptional Medical Expenses Act (AWBZ) to the sickness fund scheme, and the flat-rate contribution to the AWBZ was abolished (see above).

On 1 January 1997, the ceiling for cover under the Sickness Fund Act (ZFW) for people entitled to a state pension was increased sharply to €15 973. The result was that more elderly people became eligible for cover under the Act. There was another substantial increase on 1 July 1997 to €17 330. In addition, there was an amendment of the ZFW that came into force on 1 August 1997; under this new amendment, new students could no longer be jointly insured free of charge under their parents' sickness fund. Since that date, students have had to arrange for private insurance, and the Student Finance Act provides for a grant to cover the cost of this. Those who had already begun their studies and who were insured as dependants could remain so for the remainder of their studies.

At the same time, the government introduced a system of limited user charges for sickness fund enrollees, to give them an incentive to use health services more prudently. The introduction of cost sharing for physician and hospital charges was a very controversial issue (although for long-term care and in the private health insurance market, user charges are quite common). In 1997, a system of very complicated user-charges for GP visits and hospital admissions was introduced. Due to its complexity, however, this co-payment scheme was abolished in 1999.

The Act on the Restructuring of the Sickness Fund Act (Wet Herstructurering Ziekenfondswet) of 24 December 1997 *(Bulletin of acts and decrees, 777)* was the third and final step in the restructuring process. It came into force

on 1 January 1998. With this amendment, the "stay where you are" idea was reintroduced in the sickness fund insurance scheme as an insurance principle for people aged 65 years and over, as was the case before the introduction of the Van Otterloo Act. This meant that those covered under the Sickness Fund Act (ZFW) could continue to be insured under the Act after reaching the age of 65 years. Those with private insurance who turn 65 could opt to join a sickness fund, provided their income does not exceed a certain ceiling. People under the age of 65 years with private insurance who should be eligible for cover under the Sickness Fund Act (since they are in receipt of social security benefits), but who would prefer to remain privately insured, were also given the option of exemption from the sickness fund insurance scheme under certain conditions. Pensioners who had to switch from private insurance to a sickness fund as a result of the Van Otterloo Act were given a once-only opportunity to return to the private sector. It is expected that mainly retired public servants who are eligible for the Public Servants' Medical Expenses scheme will take advantage of this.

Finally, since January 2000, self-employed people up to the age of 65 years who were insured under the Incapacity Insurance (Self-employed Persons) Act (Wet arbeidsongeschiktheidsverzekering zelfstandigen, WAZ) and whose gross income is less than a certain maximum became eligible for Sickness Fund Act (ZFW) insurance.

Changes in the supervisory provisions

The acts of 27 March 1999 (amending the Sickness Fund Act, Health Care Tariffs Act and Hospital Provision Act; *Bulletin of acts and decrees* 1999, 185) and of 5 July 2000 (amending the Act of 27 March 1999) have amended the role, composition and procedures of the administrative bodies governed by the Sickness Fund Act (ZFW), the Exceptional Medical Expenses Act (AWBZ) and the Health Insurance Access Act (WTZ). The advisory and implementation structure of government policy in the aforementioned areas is used to encompass a complex array of responsibilities, positions and interests; although in a formal sense it was a government matter, the matter was actually positioned between the government and grassroots movements. The government considers it important, against a backdrop of the desired separation of tasks, to differentiate between and redefine the various responsibilities, positions and interests. This differentiation process led to each of the parties participating in the decision-making process on the basis of clearly predefined responsibilities. The aim here is to fulfil ministerial responsibilities through management on the one hand and supervision on the other.

Within the Health Care Insurance Board (CVZ), more independence has been given to the Supervisory Board for Health Care Insurance (CTZ), by conferring on it an explicit legal basis – whereby the members of the Supervisory Board are appointed by the health minister.

The government also planned to give further autonomy to supervisory activities. The creation of autonomous supervision means that two independent organizations have been set up in parallel. The Health Care Insurance Board (CVZ) will provide management "upstream", and the Supervisory Board for Health Care Insurance (CTZ) will provide supervision "downstream". The desire to make supervision autonomous springs from a desire for impartial supervision. Another important factor is the need to gain more control over the implementing organization of the Sickness Fund Act (ZFW) and the Exceptional Medical Expenses Act (AWBZ), where developments in the insurance sector, such as concentration and the formation of groups, also have a part to play.

The Health Care Insurance Board (CVZ) maintains a coordinating task, covering activities aimed at encouraging effective coordination in the implementation of social health insurance and also between this and the implementation of other social security legislation. This also means that the Board must respond to signals that it receives from the grassroots level (including insured parties) and that the Board can also communicate guidelines (based on these signals) on the interpretation and implementation of the Sickness Fund Act (ZFW) and the Exceptional Medical Expenses Act (AWBZ) to the relevant executive body or to all executive bodies.

Summary of reforms

Table 16 contains a chronological list of crucial pieces of legislation, policy papers and advisory reports in the development of Dutch health care, from 1941 to 2003.

Reform implementation

Although implementation of the reforms is far behind schedule, radical changes in legislation have still been realized within a relatively short period of time. An example of this is the abolition of the contract obligation for sickness funds. During the last decades of this century, there was a long conflict between sickness funds and physicians about whether or not sickness funds should have the option to selectively contract with physicians. Ultimately, the physicians

Table 16. Chronology of main events in Dutch health policies, 1941–2003

1941	Sickness Fund Decree (*Ziekenfondsenbesluit*)
1964	Sickness Fund Act (*Ziekenfondswet*, ZFW)
1968	Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*, AWBZ)
1971	Hospital Provision Act (*Wet Ziekenhuisvoorzieningen,* WZV)
1974	Policy paper *Structuring health care* (*Structuurnota Gezondheidzorg*)
1980	Health Care Tariffs Act (*Wet Tarieven Gezondheidszorg*, WTG)
1986	Health Insurance Access Act (*Wet op de Toegang tot Ziektekostenverzekeringen*, WTZ) Executive Regulation on the Privately Insured (*Uitvoeringsbesluit Vergoedingen Particulier Verzekerden)* Act on the Joint Funding of Elderly Sickness Fund Beneficiaries (*Wet houdende Medefinanciering Oververtegenwoordiging Oudere Ziekenfondsverzekerden*, MOOZ)
1987	Dekker Committee report: *Willingness to change* (*Bereidheid tot Veranderen*)
1988	Government paper on health care reforms: *Change assured* (*Verandering Verzekerd*)
1989	First Phase Amendments Act (flat-rate premium in sickness fund insurance and Exceptional Medical Expenses Act; shift of ambulatory psychiatric care and other services to Exceptional Medical Expenses Act) End of municipal planning of general practitioners Collective Prevention Public Health Act (*Wet Collectieve Preventie Volksgezondheid*)
1991	Health Insurance System Second Phase Amendments Act (further expansion of the Exceptional Medical Expenses Act; deregulation planning and tariff legislation) Maximum Tariff Act: end of mandatory contracting of self-employed health professionals by sickness funds Dunning Committee report: *Choices in health care* (*Kiezen en Delen*) Health Council report: *Medicine at a crossroad* (*Medisch Handelen op een Tweesprong*) Introduction of reference price system for pharmaceuticals Quality of Health Facilities Act (*Kwaliteitswet Zorginstellingen*)
1992	Government paper: *Modernizing health care* (*Modernisering gezondheidszorg*)
1993	Parliamentary Commission advisory bodies report: *Advice curtailed* (*Raad op Maat*); Bruins Slot Committee report (on the budgeting of sickness funds); Individual Health Care Professions Act (*Wet op de Beroepen in de Individuele Gezondheidszorg*, BIG)
1994	Biesheuvel Committee report: *Better care by sharing care* (*Gedeelde zorg: Betere zorg*) Willems Committee report (on decision-making in health care) Welschen Committee report (on the future funding of care for the elderly Governing manifesto 1994 (*Regeerakkoord 1994*) of new coalition government Van Otterloo Act (extending access to the Sickness Fund Act scheme for low income elderly) Health policy paper: Health and wellbeing (*Gezond en Wel)* Health Care Complaints Act (*Wet Klachtrecht clienten zorgsector*)
1995	Medical Treatment Agreement Act (*Wet Geneeskundige Behandelingsovereenkomst*, WGBO) Pharmaceuticals Pricing Act (*Wet Prijzen Geneesmiddelen*)

1996	Blood Supply Act (*Wet inzake Bloedvoorziening*) Public Health Status and Forecast report (*Volksgezondheid Toekomst Verkenningen*, VTV) State of Health Care report (*Staat van de gezondheidszorg*, STG) Client Representation Act (*Wet Medezeggenschap Clienten Zorginstelling*) Directive on Sickness Fund Insurance Provisions (*Verstrekkingenbesluit Ziekenfondsverzekering*)
1997	Funding of retirement homes under the Exceptional Medical Expenses Act (AWBZ) Koopmans Committee report (on pharmaceutical policies) Restructuring Sickness Fund Act
1998	Hoekstra Committee report (on the efficiency of ambulatory mental care) Lemstra Committee report (on the variation of public health provided by local authorities) Governing manifesto, 1998 (*Regeerakkoord 1998*)
1999	Policy paper on mental health care (*Brief sectorvisie GGZ*) Policy paper *Public health policy* (*Strategische notitie public health beleid)* Policy paper *Welfare policies 1999* (*Welzijnsnota 1999)* Report *Europe and health care* by the Council for Public Health and Health Care *(Raad voor de Volksgezondheid en Zorg,* RVZ) Act on 27 March 1999, amending the Sickness Fund Act, Health Care Tariffs Act, and Hospital Provision Act (*Wijziging Ziekenfondswet, de Wet tarieven Gezondheidszorg en de Wet Ziekenhuis Voorzieningen*)
2000	Report *Dividing the roles* (De rollen verdeeld) by the Council for Public Health and Health Care *(Raad voor de Volksgezondheid en Zorg,* RVZ) Report *Towards a sound system of medical insurance* by the Social and Economic Council *(Sociaal Economische Raad, SER*) Report on *Health care without borders – the Dutch health care system in international-legal perspective* (*Grenze(n)loze zorg. Het Nederlandse zorgstelsel in internationaal-rechtelijk perspectief*) by the Ministry of Health, Welfare and Sport Act on 5 July 2000 amending the Act on 27 March 1999 (*Wet tot wijziging van de artikele 19 en 77 van de Ziekenfondswet, artikel 62 van de Algemene Wet Bijzondere Ziektekosten en artikel 51 van de Wet Financiering Volksverzekeringen*) Act on 13 December 2000 amending the Sickness Fund Act and establishing the Supervisory Board for Health Care Insurance (*Wet op de Instelling van een onafhankelijk College van Toezicht op de Zorgverzekeringen,* CTZ)
2001	Report *The basic package: contents and borders'* By the Health Care Insurance Board (*College voor zorgverzekeringen, CVZ*) Government report *A question of demand* (*Vraag aan bod*)
2002	Governing Manifesto 2002: Strategic Agreement 2002 (*Regeerakkoord 2002*) Report *A healthy judgement? Health and Health Care in the Netherlands in international perspective* by the RIVM Report *Gezondheidszorg en Europa, een kwestie van kiezen* by by the Council for Public Health and Health Care *(Raad voor de Volksgezondheid en Zorg,* RVZ)
2003	Governing Manifesto 2003: Outline Agreement 2003 (*Regeerakkoord 2003*) Report *Exploding Health expenditures (Exploderende Zorguitgaven)* by the Council for Public Health and Health Care *(Raad voor de Volksgezondheid en Zorg,* RVZ)

Source: Based on and updated from *Handboek Structuur en Financiering Gezondheidszorg (37)*

won this conflict, and from 1941 (until 1991) sickness funds had the legal obligation to enter into a uniform contract with each physician established in their working area. Though creating the opportunity for selective contracting is not the same thing as putting it into practice, it certainly is a fundamental change from a historical perspective *(38).*

Those who are familiar with the history of Dutch health care policy probably have foreseen that the government's timetable was far too optimistic. On the other hand, if government had announced a more realistic timetable – 20 years, for example – probably nothing would have changed until now. As discussed before, the credible threat of competition has generated an enormous change in conduct in all parties involved.

Reasons for "slow" progress

At least four reasons can be given for the "slow" progress of the reforms. First, there has been resistance from interest groups who have powerful lobbies. Dutch health policy is characterized by a diffuse decision-making structure without a clear-cut centre of power. Hence, the government cannot impose changes without the consent of major interest groups, such as the organizations of physicians, health insurers, employers and employees *(39).* Employers opposed the Simons Plan because they were afraid that the government would pay more attention to compulsory health insurance with a broad benefits package (which would increase total health care costs because of moral hazard) than to cost containment and improving efficiency. Because the premium is partly paid by employers, increases in health expenditures would increase their labour costs and, thereby, weaken their international market position. Insurers opposed the Simons Plan because they strongly opposed a system of risk-adjusted premium subsidies from the Central Fund and other government regulation that reduces their entrepreneurial freedom. Physicians opposed the Simons Plan because they found the description of the benefits package too general, leaving too much room for competition among providers of care *(38).*

The second reason for the slow progress of the reforms is that the implementation strategy chosen had triggered growing political opposition. From a political point of view, the two key elements of the reforms are well balanced. The compulsory health insurance is attractive for the political left wing; regulated competition is attractive for the political right wing. This political balance of the reform proposal probably explains why both a centre-right and a centre-left coalition cabinet supported the reform proposal. Because of the complexity of the reforms, however, they have to be implemented

step by step. But the step-by-step approach itself introduces a new complexity. In order to be politically acceptable, each step has to be as balanced as the whole reform proposal. According to the perception of the politicians, this was not the case. In the early 1990s and mid-1990s, the political right wing, supported by employers, strongly opposed some steps because in their opinion more emphasis was put on the implementation of compulsory health insurance than on cost containment efforts. Another political problem is that the introduction of compulsory health insurance for the whole population is likely to generate negative income-redistribution effects for relatively young and healthy middle-class people with private health insurance, because they will have to subsidize the poor and unhealthy by paying an income-related premium instead of the present, considerably low risk-related premium.

The third reason for the slow progress in reform is that there is no urgent need for quick reform. In a sense, the reorganization of the health care system is aimed at anticipating the "luxury" problems of the twenty-first century: advancing medical technology, an ageing population and an expected increase in the share of gross national product for health care. From a macroeconomic point of view, a step-by-step reform of the health care system can be afforded *(38)*.

The fourth reason for the slow progress in reform is that it is very complex technically, an aspect that has been seriously underestimated. Several problems relate to the process of implementation, such as the coordination of overlapping and sometimes inconsistent new and old regulations, the avoidance of substantial negative effects due to wealth for parts of the population, and fine-tuning with complex EU regulations. Another important problem concerns the content and the appropriate definition of the benefits that should be covered by compulsory insurance. In addition, the problem of maintaining a workable competitive health care system should be addressed, which requires the development and enforcement of an effective anti-cartel policy in health care *(40)*. Probably the most vexing problem, however, is related to the proposed role of the insurer as a third-party purchaser of health care on behalf of the consumer. The problem here is how to prevent cream skimming (or preferred risk selection) in a competitive health insurance market.

Effects

Although it is too early for a complete evaluation, the following effects of the reforms are worth mentioning *(38)*:

- As a result of only discussing a more market-oriented health care system, a huge increase in activities concerning quality improvement and quality

assurance was observed during the early 1990s. Probably the main driving force for all of these quality-improving activities was the idea that quality of care will be a major issue in a competitive health care system.

- Since the early 1990s, investments in cost-accounting systems by hospitals and other health care institutions have increased. Knowledge about the nature and real costs of the different services is necessary in a more competitive market. It prevents providers of care from selling products below costs – that is, with losses – and it enables insurers to be prudent buyers of care and to make the appropriate trade-offs between products that are substitutes for each other.
- Since the early 1990s, a total reorganization of the internal structure of sickness funds took place. Entrepreneurial, market-oriented managers replaced administration-oriented chief executives who went into (early) retirement. The service to their members was being improved, like more flexible hours and mobile offices.
- Since the early 1990s, several innovative activities have been observed. For example, sickness funds broke the price cartel of providers of some medical devices. Subsequently, prices went down by a quarter to a third. Insurers began developing mail order firms as an alternative distribution method of pharmaceuticals. Also, a wealth of electronic data interchange (EDI) projects began development, aimed at better cooperation among providers and more efficient cooperation between providers and insurers.
- In the mid-1990s, price competition started among sickness funds. The lowest flat-rate premium in 2001 is more than 40% lower than the highest.
- In the 1990s, increased price competition for supplementary health insurance started among sickness funds for group contracts with employers.
- Because employers have been bearing the financial risk of their employee's sick leave since the mid-1990s, they have a large interest in low waiting times when their employees need medical care. As a part of the group contracts with the employers, the sickness funds are now competing with each other on "waiting time reducing activities", such as contracts with private clinics.
- In the 1990s, activities of managed care, such as selective contracting (with physiotherapists, for example) and physician profiling (GPs, for example) increased.

Learning from the Dutch experience

Behind schedule due to technical and political complexity

The first lesson from the Dutch reforms is that it is very difficult to make a realistic timetable for the full realization of such radical reforms. The implementation period originally projected was 4 years. A more realistic timetable would be at least 15–20 years. Such a schedule for a politically sensitive issue as health care (financing), however, is hard to implement for a cabinet that is in office for only 4 years. On the other hand, if in 1988 a realistic schedule had been presented, it is doubtful whether all the changes that were realized in the 1990s, thanks to the pressure of a tight schedule, would have been realized.

No free health care market

A second lesson is that the Dutch proposal for market-oriented health care is not a proposal for a free health care market. A free market in health care would yield effects that in most societies are considered undesirable. In a free health care market, most low-income people and the chronically ill would not have financial access to all the care they need. It is important to realize that the Dutch government formulated a proposal for "regulated competition". Government regulation will not fade away, but its emphasis will change dramatically. Instead of direct government control on volume, prices and productive capacity, government will have to create the necessary conditions to prevent the undesired effects of a free market and to let the market achieve society's goal with respect to health care. Access to good quality care for the whole population is a major goal. The emphasis of government regulation, therefore, will be primarily on compulsory health insurance for everyone, risk adjusted premium subsidies to insurers, anti-cartel measures, quality control and disclosure of information. It is better, therefore, to describe the Dutch health care reforms as "reregulation" instead of "deregulation" *(38).*

How to prevent cream skimming?

A third lesson is that the prevention of cream skimming is a necessary condition to reap the fruits of regulated competition in health care. Cream skimming (or preferred selection) is the selection that occurs because insurers prefer profitable consumers to unprofitable consumers. In the Netherlands, sickness funds receive an age–gender–region–disability-adjusted premium subsidy per insured from the Central Fund and a community-rated flat-rate premium contribution from the consumer. Consequently, the sickness funds are confronted with financial incentives for cream skimming. Chronically ill patients (such as individuals with

diabetes, cancer, heart disease, AIDS, or a transplantation) are unprofitable and, therefore, non-preferred insured within each age–gender–region(–disability) group. Because the sickness funds make a substantial predictable loss on their high-risk members, they prefer not to insure them. For example, if a sickness fund used information on prior hospitalizations and prior costs over three preceding years, it could identify a subgroup of 4% of its members whose predicted costs are threefold their average age/gender-adjusted premium *(41)*. Another example is that 5% of individuals with the highest health care expenditures in any year can be predicted to have per person expenditures over (at least) the next 4 years that are twice their average age/gender-adjusted premium *(42)*. Because the profits and losses per sickness fund are currently shared between the Central Fund (in 2001, approximately 60% on average) and the sickness funds (40%), the incentives for cream skimming are reduced. This risk sharing, however, also reduces the sickness funds' incentives for efficiency *(38)*.

Despite the open enrolment requirement, cream skimming can take place in several ways. Insurers may skim cream both by actively selecting preferred consumers and by deterring non-preferred consumers. For example, even if the benefits package (such as hospital care and physician services) and the cost-sharing structure are fully specified by the regulator, insurers may differentiate their coverage conditions by contracting different panels of providers. An insurer may contract a selected panel of providers who work according to strict protocols, or it may contract managed care firms who apply strict utilization management techniques. Such an insurer is more attractive for the low-risk individuals than for the high-risk individuals within each age–gender–region(–disability) group and, therefore, can afford to demand a relatively low premium. Cream skimming can also be performed in the following ways *(38)*:

- by selective advertising and direct mailing;
- by contracting with providers who practice in "healthy" districts;
- by risk-sharing between the health plan and the contracted providers (such that providers have an incentive for cream skimming);
- by the design of supplementary health insurance (no coverage for mental health care,
- prescription drugs and reconstructive breast surgery);
- by a package deal of health insurance and other forms of insurance bought mostly by relatively healthy people;
- by providing the bad risks with poor services (such as reimbursement);
- by providing the insurance agent with incentives to advise relatively unhealthy people to buy health insurance from another company; or

- by a "golden handshake" for unhealthy members at "disenrolment" – that is, offering an AIDS patient a large sum of money if, during the next open enrolment period, he/she chooses another insurer.

The adverse effects of cream skimming can be as follows: problems with financial access to coverage for high-risk individuals with low income, a reduction of the quality of care, and a reduction of both allocative efficiency and efficiency in the production of care. Although there may be good reasons why cream skimming may not be much of a problem in the first years after reforms, in the long run these effects should be taken seriously. In principle, the prevention of cream skimming can take place in three ways: by a good risk-adjustment mechanism, by risk-sharing arrangements and by additional pro-competitive measurers *(42,43,44).* In order to reap the fruits of a competitive sickness fund market, the prevention of cream skimming should be given a very high priority.

The future system

It is expected that the above-mentioned restructuring will not be the last word in political circles on the new shape of the health insurance system. There is pressure from the parliament to examine the possibility of income-based insurance. In this way, people on low incomes who do not currently have a legal right to cover, such as small businessmen, would become eligible. The government has now submitted the results of three studies of the health insurance system to the Second Chamber. Two of them deal with possible solutions for eliminating current problems in the health insurance system within the existing structure of the system and for strengthening the administrative infrastructure. The other study looks at possible ways of restructuring health insurance into a limited national insurance scheme, whereby an individual's taxable income determines whether the individual is insured or not. Further decisions will most likely be made on this when the next government is formed.

In more detail, the reports on these studies dealt with restructuring the health insurance system; in particular, they were from the Council for Public Health and Health Care (RVZ) and were called *Europe and health care (45)* and *Dividing the roles (46).* The first report focused on the impact of EC law on the Dutch health care system, although this was not undisputed among Dutch health lawyers. It concluded that the mixture of public/private insurance makes the Dutch social health insurance system vulnerable to EC law. It further concluded that the standard policy provided by the Health Insurance Access Act (WTZ) and the surcharges based on the Act on the Joint Funding of Elderly Sickness Fund Beneficiaries (MOOZ) were a violation of EC law. Notably,

the conclusion on the WTZ standard policy has been criticized by the health ministry and for its legal doctrine.

In its second report, *Dividing the roles* (*De rollen verdeeld) (46)*, the Council emphasized the need for more entrepreneurship, since the notion of insurance is not in accordance with the current policy of deliberately created scarcity. Besides the increase in entrepreneurial behaviour of providers and insurers, the Council also stressed the necessity of increased responsibility of citizens. Citizens are entitled to health benefits vis-à-vis such obligations as own risk, proper use and self-care. The Council advised the governmental on its role as "market superintendent" and supervisor and, simultaneously, on increasing the role of providers, insurers and patients. This concept is based on the introduction of a basic compulsory insurance with an additional (voluntary) policy. Within compulsory insurance, the citizens would be enabled to opt for a preferred provider policy.

The third report, from the Social and Economic Council *(Sociaal Economische Raad,* SER), was called *Towards a sound system of medical insurance (47);* it focused on solidarity within the health insurance system. The SER report asserted that the present medical insurance and health care system does not cope with future changes and is, moreover, incapable of anticipating them. The SER advised introducing a system of national health care insurance for curative care that is compulsory for everyone. The system should be financed on the basis of solidarity between high-income and low-income groups and between high-risk and low-risk groups. The SER proposed retaining the Exceptional Medical Expenses Act (AWBZ), but amending it to focus on serious medical risks and long-term care. It also advised gradually replacing the present system of supply, price and budget management with a demand-driven, competitive, open market system. The Social and Economic Council opted for a system of private competitive insurers. It is questionable, however, as to whether this would comply with EC law.

Finally, a Sickness Fund Council report continued to elaborate on the discussion that started with the Dekker Committee (1989), concerning the substance of the basic package based on such criteria as "necessary care", accessibility and efficiency. The report, *The basic package: contents and borders (48)*, dealt with a future scenario for modernizing a benefit package – notably the nature and scope of future health insurance entitlements.

In July 2001, the then Dutch cabinet finalized plans to reform its health insurance system in a bid to loosen government control, while guaranteeing access for all to a basic package of care. The then Minister of Health, Welfare and Sport, Els Borst, emphasized that solidarity "between old and young, sick and healthy" lay at the heart of the new system. The plan, published as *Vraag*

aan bod (*A Question of Demand),* propsed to scrap the division between the Sickness Fund Act (ZFW) and the privately insured *(49).* In its place, everyone would be obliged to join a single general health insurance scheme comprising "all necessary medical care" – defined as care of proven effectiveness – that, in general, people cannot afford. It was suggested that within 4 years this would also include long-term nursing and home care costs for the elderly. People could opt to pay for extras by taking out additional private health insurance or else have the freedom to pay a lower premium for access to a limited range of providers.

Everyone, however, would have to make some contribution or "own payment" to the cost of care received each year. A sum of around €100 was suggested. Currently, own payments apply only to those with private insurance. Insurers would, however, be obliged to accept everyone, while people could choose to change their insurer once a year.

The health ministry argued that the new system was designed to address the increasing demands of a better informed, but increasingly elderly, population. It said that patients require not just standard care, but more individualized care, which is best provided by fewer central regulations and by a shift of management and responsibility from government to care insurers and providers. Providers would be given more freedom to work within a "market" of care in a "responsible manner". The plans were similar to the original Dekker plan (see above).

Ms Borst retired in 2002, after nearly 8 years as health minister. She saw a new system built on solidarity as her "political testament" and feared that unless an insurance system was obliged to accept everyone, developments in genetics could result in uninsurable patients in the future. But the plans, intended to be put into practice in 2 years, left many questions, especially financial ones, to be answered by the new government. The questions of how far insurance contributions will be related to income and the level of individual co-payments were already the subject of debate between the left and right wings of the then coalition. Doubts also arose whether general practice would be part of the package of necessary medical care.

The May 2002 elections sent a shockwave through the Dutch political landscape. A new party of right populists (LPF) was elected second biggest party, forming a right coalition with the election winning Christian democrats (CDA) and the former coalition member, the liberals (VVD). The right populist LPF provided the new Minister of Health, Eduard Bomhoff. The coalition adopted the plans laid down in the policy document *A question of Demand (49)*, but opted for a flat rate premium. It also continued the existing plans from the former cabinets for the modernisation of the AWBZ. The new government was short lived. The coalition partner LPF proved to be an unstable factor and, due

to internal struggle, the first Balkenende government resigned on 16 October, 2002.

New elections took place in January 2003. The elections showed a marginalization of the former coalition partner LPF. A new center right cabinet, Balkenende II, consisting of Christian Democrats, Liberals and Social Liberals, was installed. Continuing where the first Balkenende cabinet left off, the Outline Agreement of Balkenende II, published on 16 May 2003, returned to the issue of basic insurance. In the Outline Agreement, the government announced its intention to introduce a compulsory standard insurance policy for everyone, scheduled to come into effect 1 January, 2006. Writing to the Lower House on 19 December, 2003, the new liberal Health Minister, Hans Hoogervorst, pointed out that in recent years the sickness funds and private insurers have become much more alike. Bringing together all the different kinds of insurance currently in use to form a single basic insurance scheme seems a logical continuation of this trend. In the meanwhile, modernisation of the AWBZ, in order to cope with rising costs went according to plans, with the emergence of 'functions' instead of categories or providers in April 2003 as one of the latest achievements.

The social democrats (PVDA) as the biggest opposition party support the plans to introduce a new basic insurance scheme in 2006. Much depends on the approval of the new Health Insurance Act, of which a concept is scheduled to go to parliament in September 2004. Crucial in the discussions will be whether the new Health Insurance Act guarantees sufficient compensation for lower income groups in a flat rate scheme and whether the several powerful interest groups will settle for the new scheme. Assuming that the new reforms are a done deal may be premature given the Netherlands' experience with health care reforms in the past.

Conclusions

In many respects, the Dutch health care system is different from other European health care systems. One of the reasons is the separation of health care financing and organization into two main compartments, of which only one is an insurance system with universal coverage. This is also the oldest insurance system in the world explicitly covering many of the risks associated with the need for long-term care (even though nursing homes were added rather recently to the benefits basket).

Of the three compartments, the second compartment is separated into a compulsory health insurance segment and a rather large segment for private insurance (a separation that is otherwise, although differently, known only in Germany). This separation has very noticeable effects on the funding side of the system and its equity, as one euro income above or below the threshold determines whether a person pays an income-related contribution or a (health) risk-related premium and whether spouses and children are covered (almost) free of charge. Unsurprisingly, the Netherlands ranked only tenth within the group of EU-15 countries in the *World health report 2000 (50)* regarding "fairness in financing". This relative inequity in funding, which is not accompanied by similar inequities on the provision side, has given rise to various reform initiatives over the last 15 years, and currently an introduction of a population-wide insurance system for the second compartment has been proposed and is being debated again. The exact mechanisms of subsidies or premium rebates for low-income persons will determine the new system's impact on equity.

The almost continuous debate about the structure of the health care system is another characteristic of the Dutch health care system. As advice from expert panels, governmental plans and parliamentary decisions are widely publicized and debated, it is often difficult for outsiders to differentiate fact from fiction. Independent of the details of the often-changing reform plans, the Dutch

experience has shown that the introduction of effective market competition – while simultaneously maintaining solidarity and financial accessibility – is not simple. The necessary institutional framework to direct competition in health care in a socially desirable direction is complex and requires a long-term implementation and adaptation process.

The impact of health care reforms on access to health care (geographically and financially) is rather ambiguous. On the one hand, introducing open enrolment and dissolving the sickness funds' regional monopolies entitled the insured to find the necessary care outside the region and abroad, thereby increasing a patient's access to health care. On the other hand, mergers among large insurers and hospitals disclosed their monopolistic/oligopolistic behaviour, which decreases a patient's free choice of (individual/contracted) provider. Furthermore, sickness funds did not use the option of selective contracting, so that there was a lack of effective competition among insurers and providers.

Besides such moves to increase competitiveness, the Netherlands also used, and still use, instruments that are usually associated with national health service (NHS) countries and not with social health insurance (SHI) countries – that is, gatekeeping and budgets. While the former is one of the measures viewed by many inside and outside the country as promoting and guaranteeing a high level of quality in providing care, the latter has – while successfully curbing costs in the 1990s – led to the problem of waiting lists and waiting times, which is now tackled by additional financial resources. The problem, however, is also often rooted in insufficient capacity, especially in human resources – in which the Netherlands has underinvested.

In terms of "responsiveness", the Netherlands ranked fourth within the EU-15 countries in the *World health report 2000*, surpassed only by Luxembourg, Denmark and Germany. Similarly, the Dutch are in the top group of EU-15 countries in regard to population satisfaction with the health care system. In 1999, 73.2% of the Dutch were very satisfied or fairly satisfied – ranking sixth in the EU.

A growing area of concern should be that life expectancy, at least for women, has stagnated since the early 1990s and that the Netherlands is clearly falling behind the EU trend in this area. An evaluation of whether this is due (in part) to declining health care effectiveness should be an area of high priority.

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Glossary

Dutch name	Dutch abbreviation	English name
Algemene Maatregel van Bestuur	AMvB	Implementation Regulation
Algemeen Psychiatrische Ziekenhuis	APZ	Psychiatric Hospital
Algemene Wet Bijzondere Ziektekosten	AWBZ	Exceptional Medical Expenses Act
Auditdienst	AD	Audit Department
Bereidheid tot veranderen		Dekker Committee report: Willingness to change
Centraal Bureau voor de Statistiek	CBS	Statistics Netherlands
Centrale raad voor Beroep	CRvB	Central Appeals Tribunal
College bouw Ziekenhuisvoorzieningen	CBZ/NBHF	Netherlands Board for Hospital Facilities
College Tarieven Gezondheidszorg (voorheen: Centraal Orgaan Tarieven Gezondheidszorg, COTG)	CTG	Board for Health Care Tariffs; also known as the Health Tariffs Authority (previously: Central Council for Health Care Charges (COTG))
College ter Beoordeling van Geneesmiddelen	CBG/MEB	Medicines Evaluation Board (MEB)
College van toezicht op de zorgverze¬ke¬ringen (voorheen: Commissie toezicht uitvoeringsorganisatie, CTU)	CTZ	Supervisory Board for Health Care Insurance (previously the CTU)
College voor zorgverzekeringen (voorheen: Ziekenfondsraad)	CVZ	Health Care Insurance Board (previously: Sickness Fund Council)

Dutch name	Dutch abbreviation	English name
Directie Bestuursondersteuning	DBO	Management Support Department
Directie Financieel-Economische Zaken	FEZ	Financial and Economic Affairs Directorate
Directie Geestelijke gezondheidszorg, Verslavingszorg en Maatschappelijke opvang	GVM	Mental Health and Addiction Policy Directorate
Directie Gehandicaptenbeleid	DGB	Disabled Persons Policy Directorate
Directie Geneesmiddelen en Medische Technologie	GMT	Pharmaceutical Affairs and Medical Technology Directorate
Directie Innovatie, Beroepen en Ethiek	IBE	Innovations, Professions and Ethics Directorate
Directie Internationale Zaken	IZ	International Affairs Directorate
Directie Jeugdbeleid	DJB	Youth Policy Directorate
Directie Macro-Economische Vraagstukken en Arbeidsvoorwaardenbeleid	MEVA	Economic Affairs and Labour Market Policy Directorate
Directie Personeel & Organisatie	DP&O	Personnel and Organization Directorate
Directie Preventie en Openbare Gezondheidszorg	POG	Prevention and Public Health Directorate
Directie Sociaal Beleid	DSB	Social Policy Directorate
Directie Sport	DS	Sports Directorate
Directie Verpleging, Verzorging en Ouderen	DVVO	Nursing, Care and Older Persons Directorate
Eenheid Oorlogsgetroffenen en Herinnering WOII	OHW/VRW	Department Victims and Remembrance WW II
Directie Voeding en Gezondheidsbescherming	VGB	Food and Health Protection Directorate
Directie Voorlichting en Communicatie	DVC	Information and Communication Directorate
Directie Wetgeving en Juridische Zaken	WJZ	Legislation and Legal Affairs Directorate
Directie Zorgverzekeringen	Z	Health Care Insurance Directorate
Eerste Kamer der Staten-Generaal	EK	First Chamber or Senate
Facilitaire Dienst	FD	Facilities Department
Financieel en Personeel Beheer	FPB	Financial and Personnel Administration Service
Gemeentelijke Indicatiecommissie	GIC	Municipal Committee on Need Assessment

Dutch name	Dutch abbreviation	English name
Geneesmiddelvergoedingssysteem	GVS	Price Reference System
Gezondheidsraad	GR	Health Council
Huisarts		Family physician/general practitioner
Huisarten registratie commissie	HRC	General Practitioners Registration Committee
Inspectie voor de Gezondheidszorg	IGZ	Health Care Inspectorate
Inspectie Jeugdzorg	IJZ	Inspectorate for Youth Care
Kiezen en Delen		Dunning Committee report: Choices in health care
Koninklijke Nederlandse Maatschappij ter bevordering van de Geneeskunde	KNMG	Royal Dutch Medical Association
Kwaliteitswet Zorginstellingen	KZ	Quality of Health Facilities Act
Mededingingswet		Anti-Cartel Act
Medisch handelen op een Tweesprong		Health Council report: Medicine at a crossroad
Ministerie van Economische Zaken	MEZ	Ministry of Economic Affairs
Ministerie van Financiën	MF	Ministry of Finance
Ministerie van Sociale Zaken en Werkgelegenheid	SZW	Ministry of Social Affairs and Employment
Ministerie van Volksgezondheid, Welzijn en Sport	VWS	Ministry of Health, Welfare and Sport
Nederlandse Mededingings authoriteit	Nma	Dutch Anti-cartel Authority
Nederlandse Patiënten/ Consumenten Federatie	NP/CF	Dutch Federation of Patients and Consumers
Psychiatrische Afdeling Algemeen Ziekenhuis	PAAZ	Psychiatric Department of a General Hospital
Raad voor de Volksgezondheid en Zorg	RVZ	Council for Public Health and Health Care (previously National Council for Public Health)
Regeerakkoord		Government manifesto
Raad voor Gezondheidsonderzoek	RGO	Advisory Council on Health Research
Raad voor Maatschappelijke Ontwikkeling	RMO	Council for Social Development
Regionale Instelling voor Beschermende Woonvormen	RIBW	Sheltered housing scheme

Dutch name	Dutch abbreviation	English name
Regionaal Instituut voor Ambulante Geestelijke Gezondheidszorg	RIAGG	Regional institute for ambulatory mental health care
Rijksinstituut voor de Volksgezondheid en Milieuhygiëne	RIVM	National Institute for Public Health and the Environment
Sociaal Cultureel Planbureau	SCP	Social & Cultural Planning Office
Staatsblad	Stb	Official journal of the state, Bulletin of acts and decrees
Structuurnota Gezondheidszorg		Policy paper: Structuring health care
Tweede Kamer der Staten-Generaal	TK	Second Chamber of Parliament
Universitair Huisartengeneeskunde instituut	UHI	Academic General Practitioners' Institute
Vereniging van Nederlandse Gemeenten	VNG	Association of Dutch Municipalities
Voedsel- en Waren Autoriteit	VWA	The Food and Consumer Product Safety Authority
Volksgezondheid Toekomst Verkenningen	VTV	Public Health Status and Forecast report
Wet op de Arbeidsongeschiktheids verzekering	WAO	Disablement Benefit Act
Wet op de Beroepen in de Individuele Gezondheidszorg	BIG	Individual Health Care Professions Act
Wet op Bijzondere Medische Verrichtingen	WBMV	Special Medical Procedures Act; also known as the Exceptional Medical Procedures Act
Wet Collectieve Preventie	WCP	Public Prevention Act
Wet Financiering Volksverzekeringen	WFV	National Insurance Financing Act
Wet Geneeskundige Behandelingsovereenkomst	WGBO	Medical Treatment Agreement Act
Wet op de Geneesmiddelenvoor ziening	WGV	Provision of Pharmaceuticals Act
Wet inzake Bloedvoorziening		Blood Supply Act
Wet Klachtrecht Cliënten Zorgsector	WKCZ	Health Care Complaints Act
Wet Medefinanciering Oververtegenwoordiging Oudere Ziekenfondsverzekerden	MOOZ	Act on the Joint Funding of Elderly Sickness Fund Beneficiaries; also known as the Overrepresentation of Elderly Health Insurance Act Beneficiaries Joint Financing Act
Wet Medezeggenschap Cliënten Zorginstellingen	WMCZ	Client Representation Act

Dutch name	Dutch abbreviation	English name
Wet Prijzen Geneesmiddelen	WPG	Pharmaceutical Prices Act
Wet Tarieven Gezondheidszorg	WTG	Health Care Tariffs Act; also known as the Health Care Charges Act
Wet op de Toegang tot Ziektekostenverzekeringen	WTZ	Health Insurance Access Act; also known as the Medical Insurance Access Act
Wet op de Toegang tot Ziektekoste nverzekeringen, 1998	WTZ 1998	Health Insurance Access Act 1998
Wet Uitoefening Geneeskunde	WUG	Medical Practice Act
Wet Ziekenhuisvoorzieningen	WZV	Hospital Provision Act; also known as Hospital Facilities Act
Wetenschappelijke Raad voor het Regeringsbeleid	WRR	Scientific Council for Government Policy
Ziekenfondsbesluit		Sickness Fund Decree
Ziekenfondswet	ZFW	Sickness Fund Act
Ziektewet	ZW	Sickness Benefits Act
zorgkantoor		care office
Zorgverzekeraars Nederland	ZN	Dutch health insurance umbrella organization
Zieketekostenregeling ambtenaren	IZA	Public Servants' Health Insurance Scheme
Ziektekostenregeling provincies	IZR	Provincial Authorities' Health Insurance Scheme
Ziektekostenregeling politie	DGVP	Police Medical Service

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