Current developments in the Dutch healthcare market 2018

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Introduction

This report aims to provide an overview of the Dutch healthcare market.

It starts with a short description of the regulations that are important and subsequently gives a summary of the important parties involved.

The main part of this report discusses how the financing of the healthcare market is organised and the current changes and developments that are taking place. Among others, the role of health insurance companies and the effect this has on the purchasing process are described.

We do not pretend this is an exhaustive description of the current situation. However, we believe this could be a base for obtaining the most relevant information needed for parties that wish to orientate themselves on the Dutch healthcare market. More specific information is highly dependent on the situation.

The new government was installed in October 2017. The Ministry of Public Health, Welfare and Sports now has two ministers, Hugo de Jonge and Bruno Bruins, and one secretary of state, Paul Blokhuis. Already, a number of changes have been announced.

For example, a new agreement has been settled between minister Bruno Bruins and most parties in medical-specialist care. In order to maintain or even improve the quality of care, agreements have been made about moving towards the right care at the right place by the right health care professional for the right price. Furthermore, agreements have been made about reducing regulatory pressure.

Also a new subsidy scheme has been announced for 2019, which should allow promising care to be available more quickly for patients.

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1. Overview regulations Dutch healthcare

The Dutch healthcare system can be characterized as a compulsory, social system with private execution. It is roughly based on three regulations each of which cover a segment of healthcare: the Health Insurance Act for cure, the Long-term care Act for care and the Social Support Act for well-being and social support. In addition, citizens can opt for voluntary supplementary insurance for types of care that are not (fully) covered by other regulations.

1.1 Health Insurance Act (Zorgverzekeringswet/Zvw)

Since the Dutch Health Reform in 2006, The Netherlands has had a system of universal health coverage. In 2017 the total covered costs under the Health Insurance Act were around € 46,5 billion, in 2018 it is expected to be around € 51,8 billion.

Basic package Health Insurance Act

- Medical care, including from General Practitioners (GPs), hospitals, medical specialists and obstetricians
- Time spent in hospital
- Dental care (for under18s; only specialist dental care and dentures for those aged 18 and above)
- Medical devices
- Medication
- Maternity care
- Patient transport (ambulance and seated transport)
- Paramedical care (limited physiotherapy/remedial therapy, speech therapy, occupational therapy, dietary advice)

The Dutch system of compulsory health insurance is combined with competition among private health insurance providers. Insurance companies are required to accept each applicant, regardless of pre-existing conditions. Dutch residents are free to choose their own insurance company and are allowed to change their insurance company from year to year.

People have the possibility to take out an insurance through a so-called collective, for example from work or a sports association. This collective offers a discount on the premium. In 2018, 66.6% of the residents has a collective insurance.

The average costs for the standard insurance package for each Dutch resident is around €1,378 per year in 2018. The lowest price is € 1,126, the highest € 1,506This is called the nominal part. Next to this, residents pay an income-based contribution. This contribution amounts to 6.9 % over a maximum of €54,614 in 2018. This contribution is paid from one´s income or benefit.
In addition to this premium, residents pay an excess, which for 2018 remains €385. This means that the first €385 of the healthcare costs is to be borne by the residents. The costs for visits to the GP is not part of the excess. The excess is not applicable to children.

The insurance will only cover the costs exceeding this amount. Besides this compulsory excess, the insured can opt for a voluntary excess, to get discount on the premium. A reason to choose for this option is often that the insured assume that their healthcare expenses won't exceed the €385 of the compulsory excess. It is interesting to see that the amount of people choosing for the maximum excess of €500 has doubled in the last five years. Almost 75% of the insured choosing a voluntary access choose the maximum excess in 2018. This development is related to the rising premiums and the rising of the compulsory excess and also to the fact that due to the financial crisis for some people incomes have decreased. Apart from that people have become more aware of responsibility they can take for their own health expenses. There is an age factor in this: the group that chose a voluntary higher excess is younger than the group that didn´t chose the higher excess.

The amount of the nominal part of the contribution varies between health insurers. Theoretically, this element of competition between the insurers should encourage them to anticipate the wishes of the insured and thus improve the quality and the affordability of healthcare. However, since the number of health insurers that continues to operate on the health insurance market is small due to mergers, competition is limited. In 2018, the insured can choose between 55 different health care packages, provided by 24 insurance companies.

In 2018, the number of people switching from one insurance company to another was 6,2%. In 2017 this was 6,2%

For insured persons who are not or insufficiently able to cover the cost of the premium, a compensation has been created: the income-related allowance.

Dutch residents who live abroad can have their healthcare costs reimbursed if they still have the right to a pension or benefit from The Netherlands.

In-kind versus restitution

Health insurance companies offer three different types of policies; in-kind, restitution, a combination of these two. In 2017, over 50% of all insured had an in-kind policy, more than 33% chose a restitution policy and the rest chose a combination of the two. With an in-kind policy, clients get a 100 % reimbursement for treatments of contracted healthcare providers. When a client visits another healthcare provider, without a contract, there may only be a reimbursement of, for example, 80 %. In case of a restitution policy, clients are free to choose their own healthcare provider. The price difference between these policy types (price range ± €80 - € 100 a month for basic insurance) is small: about €5,- a month more for a restitution policy. However, this is going to change because health insurance companies will need to be stricter in selecting contracted providers.

1.2 Supplementary insurance

Every Dutch resident has the option to choose supplementary insurance for types of treatments and care that are not or not fully covered under the Health Insurance Act or the Long-term Care Act. Insurance companies have no obligation to accept every person for supplementary insurance. Besides, they also determine the level of the premiums and the scale of the covered services. Currently, 84.5% of all Dutch residents have some form of supplementary insurance. This percentage is significantly lower than in 2006, when 93% of the people were covered by supplementary insurance, and also lower than in 2012, when 88% of the Dutch residents had a supplementary insurance.

Reasons to choose supplementary insurance include better coverage of treatments and care that is not fully covered under the basic insurance package. This is for example the case for physiotherapy and dental care. Furthermore, people may opt for supplementary insurance for the coverage of alternative therapies.

Due to the fact that the basic insured package has been retrenched slightly in recent years, the importance of an additional insurance has grown, for those who expect healthcare expenses for treatment that used to be reimbursed, but is now cut out of the basic package.

Basically, the supplementary insurance is a private insurance which can be compared with a damage insurance.

1.3 Long-term care Act (Wet Langdurige zorg/Wlz)

The Long-term care Act went into effect on January 1st 2015 and replaced the last remaining elements of the former Exceptional Medical Expenses Act (AWBZ). Only the most serious long term care is being reimbursed from the Wlz. This act aims at guaranteeing quality of life for the elderly and handicapped that need a lot of care.
This act is part of a coherent system of new and renewed acts such as the Social Support Act, the Youth Act and the Health Insurance Act.

The financing of the Long-term care Act is the same as the financing of the former AWBZ. This statutory type of insurance is covering all Dutch residents. They pay an income-based contribution (9.65 % over a maximum of €33.715 in 2018), which is paid as part of the yearly taxes.

Execution of the Long-term care Act is primarily in the hands of health insurers. These nationwide private insurers – formally - implement the Wlz for citizens who have taken out insurance with them pursuant to the Health Insurance Act.

However, given the strong regional character of care under the Wlz, actual implementation is managed by a so-called regional health office (zorgkantoor). In practice this means that the largest health insurer within a region acts as health office and the contract it closes with health care providers is applicable for all the insured inhabitants of The Netherlands. This is only important for the health care providers. Care is always arranged through one's own insurance company.

The health agencies will be encouraged to put in maximum effort to purchase sufficient, effective and quality care.

1.4 Social Support Act (Wet Maatschappelijke ondersteuning/Wmo)

Since 2007 municipalities have been responsible for the provision of all kinds of social support for their inhabitants. Municipalities now have the opportunity to develop a cohesive policy on social support, living and welfare along with other related matters. The Wmo puts an end to various rules and regulations for the physically impaired and the elderly. It encompasses the Disabled Services Act (WVG), the Social Welfare Act and elements of the former Exceptional Medical Expenses Act (AWBZ). The Ministry of Health, Welfare and Sport defines the framework within which each municipality can draw up its own policy, based on the composition and requirements of its inhabitants.

Which type of support is the most suitable depends on the local and individual situation. To determine what the best solution is for the problems patients are faced with, a so-called 'kitchen table conversation' is used. This illustrates the fact that the patient has a say in this matter.

The Wmo is funded from local taxes and local authorities are largely free to spend these funds as they think best. This means that the provisions from the Wmo can vary enormously between different municipalities. This can be due to the limited choice in care providers in some municipalities or the standard of quality of care required by the municipalities.

1.5 Healthcare Market Regulation Act (Wmg)

One of the ideas behind the Dutch healthcare system is that a private system, rather than a Centrally-controlled healthcare system, is able to reduce the cost of care and to improve quality. The instrument to reach this goal is the use of market forces. Both the aforementioned competition between health insurers and the competition between the providers of care, have a price-depressing effect, and lead to better quality and a stronger position for the patient. As far as cure and care are concerned, the system can be described as a private system with social elements, or a social system with private execution. The social character implies that the interests of the patient/consumer are guaranteed. Therefore, the government has implemented a number of (legal) measures aimed at monitoring the public interests of accessibility, affordability and quality. The main legislation is the Healthcare Market Regulation Act (Wmg).

The Wmg became operative on 1 October 2006 and aims to contribute to the further introduction of market forces in healthcare and supervision of that market. The Healthcare Market Regulation Act offers the government the possibility to give, where possible and useful, more freedom of action to healthcare providers, patients and health insurers. This should, however, be based on the interests of patients.

Part of the official text of this Act is the following:

“It is prohibited for a care provider to charge a fee:

a. that does not correspond to the rate, determined for the performance in question (pursuant to article 50, paragraph 1, subsection b);

b. that is not within the tariff space, determined for the performance in question (pursuant to article 50, paragraph 1, subsection c);

c. for a performance, for which no performance description has been established (pursuant to Article 50, paragraph 1, subsection d);

d. for a performance for which a different performance description is used than that laid down in article 50 (paragraph 1, subsection d);

e. other than in the manner determined in accordance with this Act.”

The Dutch Healthcare Authority (NZa,) is the governing body of the Wmg. It ensures that all parties comply with the rules and ensures the functioning of the market. The Act contains the duties and powers of the NZa. In all its actions, it must be governed by the interest of the patients/consumers.

With the interest of the patient as a starting point, the objectives of the act are:

● Where possible and desirable, market forces must be initiated and maintained.

● Where desired, the government may regulate rates and performances. This can be done through, for example, a maximum tariff, a fixed tariff or a free tariff.

● Care providers and health insurers provide patients with appropriate information, allowing them to decide which provider to go to, which health insurer offers the best healthcare insurance policy and which policy is the most suitable.

● There is coherence in the regulation and supervision of the healthcare markets.

For each of these objectives the Wmg has different, far-reaching instruments, designed to bring these objectives closer.

Some of the instruments already existed before the reform of the Healthcare system and with the introduction of market forces a few more were created, such as tariff regulation and creating performance descriptions. With the Wmg several new, specific instruments were introduced aimed at stimulating the emergence of market forces:

● the jurisdiction of the NZa to impose specific obligations on healthcare providers and/or health insurers that have significant market power within a market segment. For example, the NZa has to approve of any merger that is planned.

● the jurisdiction of the NZa to impose generic obligations on all healthcare providers and/or health insurers in a market segment in order to remove general, structural barriers that impede effective competition.

In spite of the fact that market forces in healthcare are leading, the largest part of healthcare in The Netherlands continues to be subject to one or several tariffs or performance regulation. This applies to care covered under the Health Insurance Act, as well as to care that is not covered under the Health Insurance Act and for which citizens often choose supplementary insurance. In addition, the costs at macro level for the care covered under the compulsory basic package, have to remain within the, yearly established, Budgetary Framework Healthcare (BKZ).

When determining the rates of individual performances, the NZa will have to take this into account. Where the price of one segment of healthcare rises, the price of another segment must fall.

In general, it can be said that in The Netherlands it is only allowed to invoice types of healthcare for which the NZa has created a performance description. (Article 35 of the Wmg).

An example of a fully- regulated segment of healthcare is dental care, which is partly covered by the basic package and partly by supplementary insurance. Both the performance (what type of care can be charged) and the price (the maximum fee to be charged for that performance) are determined by the NZa, regardless of whether the dental care is covered by the basic package or by, voluntary, i.e. supplementary insurance. Dental care that has not been specified by the NZa cannot be charged in The Netherlands. Care that does not have a performance description is therefore – in theory – non-existent in The Netherlands. In 2012 the NZa experimented with free tariffs for dentists. Since this resulted in an increase of fees, which were only partly covered by the insurers, it led to many protests from consumers. Therefore, the government requested the minister of Health to cancel this experiment. Thus, since 2013, once again the fees and performances in dental care are determined by the NZa.

Other segments of healthcare have been given more space for market forces since the Wmg came into force and the government has pulled back where it concerns price determination in healthcare. An example is pharmaceutical care, where since 1 January 2012 the price of the care provided by pharmacists is no longer determined by the NZa but is now the result of (contract) negotiations between individual pharmacists and health insurers. The performances that are negotiated between parties, however, are still specified by the NZa and charging other performances than the ones prescribed by the NZa is not allowed, therefore.

For hospital care there is a special type of regulation, in which the performances are described in so-called DOTs (the Dutch equivalent of DRG's). The price of these DOT's is partly determined by the NZa and partly the result of negotiations between healthcare providers (mostly hospitals) and health insurers. This complex arrangement is described in greater detail hereafter.

2. Organisation of healthcare in The Netherlands

In the Netherlands, providing healthcare is divided into several levels.

Zero-line healthcare: this is care that is offered by family, friends, neighbours, etc. First line healthcare (eerstelijnsgezondheidszorg) and second line healthcare (tweedelijnsgezondheidszorg) are explained below. Third line healthcare is care for which patients are admitted to a care institution. The latter will be further elaborated on in chapter 9.

2.1 First line healthcare

First line healthcare is directly accessible care. Patients have access to these healthcare providers without prior intervention. The general practitioner has a central role within the first line healthcare. He is usually the first contact patients see and he points the patient in the right healthcare direction. Other first line healthcare providers are, for example, physiotherapists, midwives, dentists.

Number of registered health care providers in first line health care

General practitioners	9418	in 5045 practices (41% solo, 40% duo and 19% group)
Dentists	8320	
Midwives	3221	
Physiotherapists	17802	
Pharmacist practices	1981	

2.2 Second line healthcare

Second line healthcare is care that can only be consulted after referral by a general practitioner. Medical specialists and hospitals are part of second line healthcare but also there is second line mental health care.

2.2.1 Hospital care

Hospital care is part of second line healthcare. In the Netherlands hospital care is provided by general hospitals, university hospitals, Independent Treatment Clinics (ZBCs) and so-called 'categorical' institutions.

General hospitals

Most of hospital treatments are provided by general or university hospitals. There are 71 general and 8 academic hospitals (120 locations, of which 24 are outpatient departments). Some of the general hospitals have a license to offer so-called ‘top-clinical’ treatments. The majority of these are more specialised and more expensive treatments (for example, heart surgery, neurosurgery, transplantations and IVF).

University medical centre

There are 8 university medical centres (UMCs) in the Netherlands. The university hospitals play an important role in the development of new treatments and technologies in the Netherlands.

ZBCs (Independent Treatment Clinics)

ZBCs offer treatments without patient days, treatments that are easy to schedule and non-urgent treatments. Treatments that can be performed during day treatments include the following: plastic surgery, cosmetic treatments, cardiology, gynaecology, dermatology, phlebology, ophthalmology, oral surgery, neurology, orthopaedics, ENT medicine and anaesthesiology.

There are about 231 ZBCs under the supervision of the Healthcare Inspectorate. ZBCs offer care for the Zvw if contracted by health insurance companies and compete with hospitals, but are not allowed to make a profit. At this moment 1% of hospital care in the Netherlands is offered by ZBCs.

'Categorical' institutions

Categorical institutions offer hospital treatment and care to specific groups of diseases and patients. For example, rehabilitation centres, dialysis centres and so on. There are 65 organisations of categorical institutions in the Netherlands:

Rehabilitation centres (20)

Asthma centres /lung rehabilitation centres (3)

Integral cancer centres (4)

Epilepsy centres (2)

Dialysis centres (3)

Audiology centres (2)

Therapeutic radiology centres (5)

Rest (8)

Appendix A contains an overview of Dutch hospitals.

3. Overview of relevant parties

3.1 Governmental institutions

In the Netherlands several governmental organisations play an important role in policymaking for the organisation and financing structure (including rules for reimbursement) of the Dutch healthcare sector.

3.1.1 Ministry of Health, Welfare and Sports (Ministry of VWS)

The Ministry of VWS (Ministerie voor Volksgezondheid, Welzijn en Sport) is responsible for the governmental policy for the Dutch healthcare sector. The Ministry has several departments:

● The Department of Curative Care is responsible for policies regarding the health financing system, health insurance, the hospital sector, pharmaceuticals and medical devices. This department has the following subdivisions: Curative Care (CZ), Drugs and Medical Technology (GMT) and Market & Consumer (MC). There is also a special office for financial arrangements concerning pharmaceuticals.

● The department of Public Health has the following subdivisions: Public Health (PG), Institute Nutrition & Prevention (VGP) and Sports (DS).

● The department of Long-Term Care has the following subdivisions: Long-Term Care (DLZ), Health Insurances (Z) and Macroeconomic Issues & Labour Market (MEVA).

● The department of Youth & Social Support has the following subdivisions: Social Support (DMO), War victims & Remembrance WWII, Youth Care (JZ) and Youth & Family.

www.rijksoverheid.nl/ministeries/vws

3.1.2 National Healthcare Institute (Zorginstituut Nederland/ZIN) (Formerly known as Institute for Health Insurance (CVZ))

The National Healthcare Institute is both an advisory and an executing organisation for healthcare reimbursement. It advises the Dutch Ministry of Health on the provisions in the basic insurance system (Zvw/Health Insurance Act) and the long-term care (Wlz/Long-term Care Act).

The National Healthcare Institute has four task areas:

- advising and clarifying about the basic insurance package: the content, what is and isn´t reimbursed care, judgement about pharmaceuticals
- systematic review of the basic insurance package
- providing information about, and continuous improvement of quality of care
- execution of the financing of the Zvw and the Wlz

ZIN plays an important role with respect to maintaining quality, accessibility and affordability of Dutch healthcare. Solidarity and affordable pricing for basic insurance are its main targets. ZIN has an independent position and also advises insurance companies, healthcare providers and patient organisations.

Periodically, ZIN publishes a report on the reimbursement of new and existing therapies and treatments (hospital sector, out-patient market and long-term care are all included). ZIN mostly consults umbrella organisations of healthcare providers and producers before publishing a report. The Institute publishes an annual report on the reimbursement of medical devices on the out-patient market in an appendix.

Manufacturers of medical devices on the out-patient market, especially me-too and innovative products, drugs on the out-patient market and expensive drugs in the hospital sector are required to submit an application dossier to the Institute in order to obtain reimbursement for their product under the basic insurance system. During the application process ZIN consults expert teams. The Scientific Advisory Board on pharmaceuticals (WAR geneesmiddelen, Wetenschappelijke Advies Raad) of the Institute advises the Ministry of Health on the reimbursement of new and existing pharmaceuticals. During the application process for new treatments, medical technologies and pharmaceuticals, ZIN makes use of the principles of evidence-based medicine (EBM). It searches for scientific study results in international databases and also takes national guidelines of scientific organizations into account. After this, the Institute looks upon the following aspects: necessity, effectiveness, cost-effectiveness and practicability of the treatment or therapy. For this, the PICOT and GRADE questionnaires are used.

The ACP (Adviescommissie Pakket/ Package Advisory Committee) plays an important role in ZIN´s taking a position.

ZIN also takes the decisions of comparable institutions in other European member states into account. In the last years, it has further developed its connections with institutions, such as the German *Gemeinsame Bundesausschuss* (G-Ba) and *Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen* (IQWiG), the UK's *National Institution for Clinical Excellence* (NICE) and the French *Haute Autorité de Santé* (HAS). ZIN also studies the differences and resemblances in European application processes and the possibilities for further synchronisation.

Specific tasks of ZIN are:

1. Giving advice on the content of the basic healthcare insurance package

There are many developments in healthcare, as well as on the vision on healthcare insurance, the solidarity, the role of the government, and the role of the parties in healthcare. All this influences the basic package of insured healthcare. Therefore, the government must be able to make solid, well-constructed decisions along the line of social and scientific developments.

Those decisions of the government are often based on advice/recommendations of ZIN concerning the content and the construction of the packages of the Health Insurance Act and the Long-term Care Act. ZIN bases its advice on healthcare considerations, but financial and social considerations are taken into account as well.

Besides this advice, ZIN publishes statements, giving its opinion on certain topics. ZIN interprets parts of the Healthcare Insurance Act and the Long-term Care Act, for example following a disagreement between a healthcare insurer and a private person. Adjustments of the healthcare packages normally take place on 1 January of each year because health insurance companies have one year policies. These changes will enter into force, following publication of a relevant statement.

2. Dividing the premiums among the healthcare insurers

Healthcare providers charge insurance companies for the costs of healthcare provided. These costs are covered by the joined premiums paid by the insured population: the nominal premiums and the percentage premiums. The healthcare insurers collect the nominal premiums. Employers and benefit agencies keep the percentage premiums on the income of the insured and put the money into two different funds: the Healthcare Insurance Fund and the Fund for Exceptional Medical Expenses.

ZIN keeps records of all percentage premiums and divides them among the healthcare insurers and healthcare offices. Because the healthcare insurers are obliged to accept every resident for the Healthcare Insurance Act, they receive compensation for people belonging to certain risk groups. This is called risk equalisation (see also **3.5**).

3. Implementation of regulations for specific groups

To guarantee that Dutch citizens living abroad receive the healthcare they need and deserve, the Dutch government has come to agreements with countries within and outside the European Union about reimbursement of healthcare costs in those countries. ZIN, representing the Netherlands, attends meetings on regulations for medical care within the EU Regulations and on agreements with countries from outside the EU. They also inform the Dutch healthcare insurers about any changes in regulations or acts.

The reimbursement for care abroad will not exceed the costs that the health insurer would pay for a similar treatment in the Netherlands.

For treatments in EU countries on the basis of international agreements, the own contributions have to be paid by the patient. These costs can still be reimbursed by the health insurer, if he would have paid a higher amount for the same treatment in the Netherlands than he has to pay to the other country.

After the introduction of the Health Insurance Act in 2006, ZIN started executing several other roles. For instance, they make sure that people who are not insured because their religion forbids them to do so, are compensated up to a certain amount.

www.zorginstituutnederland.nl

3.1.3 Dutch Healthcare Authority (NZa)

The NZa (Nederlandse Zorgautoriteit) is the supervisory body for all healthcare markets in the Netherlands. The NZa evolved out of the National Health Tariffs Authority (CTG) and the Supervisory Board for Health Care Insurance (CTZ). The organisation supervises both healthcare providers and insurers, in the curative markets as well as the long-term care markets. The array of legal instruments available offers the NZa options for establishing general conditions for the healthcare markets such as performance descriptions, cost allocation principles, smart price ceilings and supervisory rules concerning, for instance, deceptive advertising. In addition, the NZa can take action in individual cases, such as in the case of a provider that has a dominant position in the market, if the competitive conditions are distorted.

The NZa also advises the Ministry of Health on the tariffs (maximum tariffs, negotiable tariffs, and so on) of healthcare providers and therapies and treatments which are covered under basic insurance (Zvw) and long-term care (Wlz).

Although the NZa is, based on the Wmg, the first and most important supervisor where it concerns regulation of healthcare, as can be concluded from the fourth objective of the act (Coherence in the regulation and supervision of the healthcare markets) it is not the only supervisory body that has to be dealt with. There is even a partial overlap between the different supervisory bodies in guarding the public interests of quality, accessibility and affordability. The Inspectorate for Healthcare (IGZ) is primarily responsible for the quality of the care and, based on the Competition Act (MW), the Authority Consumer and Market (ACM, the former Netherlands Competition Authority (NMa), is together with the NZa responsible for fair competition practices in the healthcare markets. Every supervisory body has its own responsibility and, independently of each other, can pass judgement. The NZa has only a coordinating task here.

www.nza.nl

3.1.4 Healthcare Inspectorate (IGZ)

The IGZ (Inspectie voor de Gezondheidszorg) monitors the quality of the healthcare providers. Its mission focuses on patient safety, effective care and care that is patient-orientated. The IGZ developed, among others, a set of performance indicators in cooperation with the Dutch Association of Hospitals (NVZ), the Dutch Federation of Academic Hospitals (NFU), and the Association of Specialist Doctors (OMS), which is presented to the Dutch hospitals annually. It is called: Base set of Hospital Performance Indicators. Performance indicators are measurable aspects of care which give an indication of quality, safety, efficiency and accessibility of healthcare.

The IGZ checks whether hospitals comply with the agreements under the action plan 'Prevent damage, work safely'. They check this in two different ways: a random check in 20 hospitals to check the functioning of the Safety Management System, and the 10 themes with points for improvement. These are monitored by means of Safety Indicators, the so-called Monitoring Indicators for Patient Safety. These safety indicators are published and are intended for monitoring the external responsibility of hospitals. They also give an impression of the progress at hospital level.

The IGZ uses standards defined by the organisation itself in cooperation with professionals. The Safety Management System however, has a specific standard: the NTA 8009:2007.

www.igz.nl

3.1.5 Authority Consumer and Market (ACM)

The ACM (Autoriteit Consument and Markt) monitors fair competition and takes action against parties that form cartels and fix prices, for example, as well as against parties that misuse a position of economic power. The ACM assesses mergers and takeovers in all sectors.

www.acm.nl

An example of the concurrence of the supervision on the market forces is the regulation of contracts between healthcare providers and health insurers. Although the NZa drafts guidelines with respect to the way these two parties should interact, the actual negotiations are governed by the rules of the Competition Act. The consumer interest the NZa aims to protect, does not always run parallel with the interest of the consumers within the meaning of the competition act. In recent years there have repeatedly been lawsuits and interventions of the ACM and the NZa. Point of focus is that healthcare providers, in principle, can only negotiate with health insurers individually. However, given the limited number of health insurers on one side and the large number of healthcare providers on the other, negotiations and contracting is not carried out seamlessly in all sectors of care.

3.1.6 Council for Public Health and Society (RvS)

The RvS (Raad voor Volksgezondheid en Samenleving) is the independent body that advises the government on public health and healthcare. It refers to the content of healthcare, not insurance and reimbursement. The RVZ advises on governmental healthcare policy. A wide area of policy is covered: prevention, health protection, general healthcare, care of the elderly and the disabled. The advisory report encompasses all aspects of policy, including insurance, planning, financing, and training, as well as ethical matters and rights of patients. The Council tackles subjects that are expected to appear on the political, or socio-political agenda in the near future. Examples of this include the supply of medicines, the health insurance system, and the effects of market forces, self-testing, and care for addicts.

www.raadrvs.nl

3.1.7 The Netherlands Organisation Health Research and Development (ZonMw)

ZonMw (Nederlandse organisatie voor gezondheidsonderzoek en zorginnovatie) subsidizes a substantial part of the health research in the Netherlands and encourages the implementation of results. Government, the Netherlands Organisation for Scientific Research (NWO) and other organisations commission ZonMw to find solutions for certain problems within the Dutch healthcare sector. ZonMw advises these organizations on structure and goals of the research and implementation programs. ZonMw holds regular grant application rounds for its programmes, when researchers (from fundamental to applied) and care providers can apply for grants for research and innovation projects. Expert committees advised by independent experts select the proposals and make a choice.

The organisation of ZonMw is divided into the following divisions: Science & Innovation, Prevention, Long-Term Care, Health & Community and Quality & Cost-effectiveness.

www.zonmw.nl

3.1.8 National Institute for Public Health and the Environment (RIVM)

The RIVM (Rijksinstituut voor Volksgezondheid en Milieu) is the centre of expertise in the fields of health, nutrition and environmental protection, and works mainly for the Dutch government. The RIVM is responsible for providing impartial and reliable information to members of the public and professionals working in the fields of health care, infectious diseases, medicines, the environment, and nutrition and safety. Their clients are, among others, the Dutch Ministry of Health and the European Union.

The Public Health and Health Services Division investigate health related behaviour and habits, health status and use of healthcare provisions of the Dutch population aimed at gaining better insight into more effective prevention and use of healthcare provisions. It also investigates and reacts to the public opinion on preventive health issues, such as vaccination resistance.

Every four years the RIVM publishes, jointly with other institutes the Public Health Status and Forecast, setting out trends and developments in public health in the Netherlands.

The Nutrition, Medicines and Consumer Safety Division advises the Dutch Food and Consumer Products Safety Authority on the safety of foods and consumer products; advises the Medicines Evaluation Board on the acceptance of new pharmaceuticals; and advises the Ministry of Health, Welfare and Sport on food safety and healthy nutrition.

www.rivm.nl

3.2 Professional associations of medical professions

Health professionals are frequently consulted by governmental organisations during the policy-making and decision-making processes. Organisations such as ZonMw, the Institute and NZa all make use of the expertise of ‘clinical experts’ and ‘medical advisors’ when allocating grants for new scientific research and during the application processes for new DBC codes and when deciding on the reimbursement of new therapies. Also, the consensus statement (i.e. the medical consensus that is agreed upon as the evidence-based, state-of-science knowledge in a certain area of healthcare) of a scientific association is an integral part of the application dossier for a new DBC code.

The major Dutch associations of medical professions are listed in Appendix B.

3.3 Associations of healthcare institutions

A selection of umbrella organisations for healthcare institutions is included in Appendix C.

3.4 Patient organisations

In The Netherlands, as in other countries, patients are represented in many different patient organisations. Many of these organisations work together in an umbrella organisation, the Federation of Patients and Consumer Organisations in The Netherlands (Patiëntenfederatie Nederland) The Patient federation aims to strengthen the position of patients and consumers of healthcare. It promotes their common interests by working with government, policymakers in national, regional and local institutions, professional organisations and providers of healthcare (home care, hospitals) and health insurance companies.

www.patientenfederatie.nl

Another party that is active in healthcare consumer issues is the consumers association (consumentenbond). For example, at the moment they take action to have the hospital and healthcare tariffs made public.

www.consumentenbond.nl

3.5 Health insurance companies

In the healthcare system, there is, for cure as well as for care, a central role for the health insurance companies. They can be seen as the spindle in the healthcare segment.

Health insurers are private health insurance companies that are, for that purpose, admitted to the Dutch market by The Dutch Central Bank.

Part of the health insurers come from the former Health Funds (ziekenfondsen) and another part was only active on the market for private, voluntary health insurances before 2006. Traditionally, each region of the Netherlands had its own local health insurance companies. Which insurance company healthcare providers have to deal with still largely depends on the region.

In the old system, around 63% of the Dutch citizens were insured through a health fund. In 1942 there were around 204 funds. Due to regional mergers and cooperations this number decreased to around 30 in 2006.

Since the new system came into force there have been a large number of mergers between the different health insurers, which has resulted in only a limited number still being active on the Dutch market. Currently, there are four major health insurance companies in the Netherlands, all with diverse labels. The competition between the different health insurers is, therefore, also limited. This puts a lot of power into the hands of the health insurers.

This does not apply to the implementation of the Long-term Care Act. In fact, the health insurance companies are the implementing bodies for the government.

In terms of the health insurances, the health insurance companies are risk-bearing (i.e. they can gain a profit from these insurances but they can also suffer a loss in the event of high healthcare expenditures for a patient).

To prevent this risk-bearing from causing health insurers to perform risk-selection among the insured, health insurers are compensated for the risk-differences between insured. This is called the high costs equalisation (Hoge Kosten Verevening HKV).

In many ways the health insurers have been commissioned to actively control the costs of healthcare and to improve the quality. This role of the health insurers is best illustrated in their acting as purchaser of care. In that capacity, the health insurers negotiate with healthcare providers about the price, the quality and the accessibility of the care that is to be provided. Moreover, it depends on the market forces whether and for which price a healthcare provider can provide care to the insured of this specific health insurer. For part of this care it is also determined that it cannot be provided without a contract with a health insurer. The centre of gravity of market forces lies, therefore, in the contracting between individual providers of care and the health insurer.

Since health insurance companies are considered to be commercial parties, they can set their own conditions for the purchasing process. Jurisprudence has shown that the Procurement Act 2012 is not applicable to health insurance companies.

An example of the fact that health insurers have started to fulfil their purchasing role more seriously is, among others, the so-called preference policy in pharmacy. In this policy the health insurer, rather than the pharmacist, decides which medicine must be supplied by a contracted pharmacist.

Starting point here is the medicine for which the health insurer has been able to negotiate the lowest price (except in case of a medical emergency to supply a specific brand of medicine). More about the preference policy can be found in chapter 7.

The purchasing role of the health insurers is expected to become increasingly stronger in the coming years.

Appendix D contains an overview of the health insurance companies currently active in the Netherlands.

4. Financing and reimbursement of healthcare

4.1 Budgetary Framework Healthcare (BKZ)

At the beginning of each governmental period the level and the growth of the healthcare expenditure for the whole period is established, the so-called Budgetary Framework Healthcare. This BKZ is therefore an important part of the negotiations for the government formation. In practice, however, the BKZ is adjusted each year.
The BKZ includes all healthcare expenditures that are financed with public funds (mostly premiums). In other words: all healthcare expenditures that are part of the Wlz and all care that falls within the basic package of the Zvw. Besides that, the BKZ also includes the municipal expenditures in the context of the Wmo.
In fact, the BKZ is nothing more than an estimation of the costs, based on historical data and expected and desired growth. It turns out that each year the budget is exceeded (since 2002 there has only been an undershoot once, in 2007)
Politically however, the importance of the BKZ is significant: it indicates the limits of the collectively financed expenditures. Exceeding the BKZ in a specific sector of healthcare is often reason for measures related to the level of the tariffs in that sector, the size of the insured package or whether or not more market forces should be introduced in the sector.
An example of such a measure is the Macro Management Tool (MBI), which was created for hospital care. The MBI is applied when costs of the BKZ in hospitals are exceeded. This is a discount hospitals are jointly liable to pay into a central fund. The NZa allocates the amount of the excess to an individual hospital in proportion to the share of its annual turnover in the total turnover of all hospitals.
The BKZ only establishes the macro framework for the expenditures in a specific sector of healthcare, which means, among other things, that within that sector there is room for large differences between providers of

healthcare and the costs involved in that care. However, measures like the MKI can still lead to interventions at a micro level.

4.2 Financing system of healthcare providers in the out-patient context

Since 2005 the prices of several groups of healthcare providers (general practitioners, physiotherapists, psychologists, pharmacists) in the Dutch outpatient context have gradually been released. Releasing prices must ensure that healthcare providers invest more in quality, develop new products and become more enterprising. It stimulates providers to differentiate in order to win the favour of consumers and health insurance companies. The NZa therefore examines per profession whether the consumer is better off when prices are free.
For some professions, for example pharmacy, physiotherapists and outpatient psychology, the prices are completely free and are usually determined in negotiation with health insurance companies. For other professions such as general practitioners, speech therapists, dentists and midwives, there is a maximum tariff. The NZa determines this tariff.

4.2.1 Financing of General Practitioners

Since 2015 the care from general practitioners is divided into three segments:

Segment 1: covers the basic GP care where the GP is the first point of contact for patients. This is the largest part of GP care.

Segment 2: covers the multidisciplinary chronic chain care for diabetes, COPD, cardiovascular risk management and asthma. The tariffs for this segment are negotiable between health insurers and healthcare providers.

Segment 3: aims at performance related pay and modernisation and innovation (M & I) of care. It offers health insurers and healthcare providers room to agree on rewarding outcomes within the basic GP care and multidisciplinary care. The tariffs for this segment are also negotiable between health insurers and healthcare providers.

As of January 1st, 2018, there will be a new system for the financing of Organization and Infrastructure for GP´s, based on 4 quadrants for districts and regions, both mono- and multidisciplinary management.

5. Hospital financing system

In 2016 the total costs for hospital treatments amounted to € 27 billion.

Since 2005 a lot of changes to the hospital financing system have been implemented. The ultimate goal of the government is a system where hospitals are financed on basis of actually delivered production and quality of this production. Health insurance companies have a key role in this healthcare system. It is increasingly expected by the government that they negotiate with hospitals about prices and quality. However, this doesn´t seem to be the case yet.

History of the hospital financing system

Until 2005 the Netherlands had a budget financing system for all hospital treatments.

The total budget of an individual hospital was 100 % based on so-called budget parameters, such as budget parameters for the number of outpatients' clinic visits, hospital days and certain expensive medicines and technologies. Each year the regional responsible insurance company discussed the budget for the next year based on the historical production of budget parameters. Hospitals had a lot of freedom in in using their budgets.

With the introduction of DBC codes (Dutch equivalent DRGs) in 2005 the first case-based payments were introduced in the Dutch hospital sector. From 2005 onwards about 30,000 DBC codes were developed. Each type of physician used its own codes (codes had been developed by the relevant scientific organisations of hospital physicians), based on diagnosis and treatment. The 30,000 developed DBC codes were divided into the so-called A segment and B segment. Treatments that belonged to the A segment were in fact reimbursed in the same way as before 2005, which meant a fixed yearly budget for these treatments mainly based on historical production.

For treatments that belonged to the B segment, case-based payments were introduced, which meant extra production per declaration for hospitals. From 2005 until 2012 the B-segment grew from 10 to 70 % and fixed hospital budgets gradually declined.

In 2012 a new hospital financing system was put in place in which almost only case-based payments were being processed. Within the new system the old available budgets of the A segment gradually ceased to exist. Also the old 30,000 DBC codes were replaced by 4,600 so-called 'care product' codes.

5.1 Current hospital financing system

Performances within the reimbursable medical-specialist care and the tariffs are determined by the NZa. A distinction is made between DBC care products and other care products.

DBC care products

- All care is divided into care activities. For the application of care activities the existing rules for registration (registratieregels) are applied.
- Differentiation between care product codes is based on the chapters and sub chapters within the ICD-10.
- A care product consists of the whole of care activities provided by a care provider concerning the care demand of the patient.

- Each DBC care product has a code, which determines what the maximum tariff is that may be charged.

- The actual fee is negotiated by care provider and health insurance company

Other care products
Apart from the DBC care products there are other care products. These are divided into four categories with sub categories.

- supplementary care products, such as add-ons
- first line diagnostics
- paramedic treatment and examination
- other performances

Medical specialist fee

The fee for the medical specialist was, until 2015, an earmarked portion per care product. As of 2015 there are integral tariffs for care products. This means that the hospital management has to negotiate with the medical specialists in their hospital about their fee. This fee is settled through the hospital and no longer with the specialist.

Specialised Medical Performances Act (WBMV):

The Ministry of Health, Welfare and Sports grants licences that allow the hospitals in the Netherlands to perform special medical performances, characterised by a special and expensive infrastructure.
The WBMV gives the government the opportunity to organise the introduction and diffusion of these operations. This way, the Act can help to optimise the quality and efficiency of these operations and to increase their use. All of this needs to be in accordance with current medical, ethical and social views. Because of the licences required to perform these medical operations, there is no place for negotiable tariffs.
In the long term it can be investigated whether parts of the WBMV can be transferred to the negotiable tariffs. The Minister of Health has developed plans to develop a guideline in order to make the in-and outflow of expensive medical performances more objective. The Healthcare Institute will advise on the execution of this guideline as an objective party. Apart from that, the guideline will describe that new licenses for the WBMV will be for a limited time only, with a maximum of four years. Also, the guideline will have to guarantee that from time to time there will be a so-called ‘horizon scan’ that will investigate which very expensive medical healthcare performances in the near future (1–5 years) will possibly have a great impact on the expenses of (hospital) care. This should provide insight in which provisions are effectively involved, within what timeframe the introduction can be expected in The Netherlands, which costs will be involved and what application and demand there will be in The Netherlands. Based on this it can be determined whether these provisions should be taken into the WBMV.

Intensive Care:

The IC has got a stable product structure: these products are defined by means of the 'add-ons'. However, because the IC care needs to meet the demands of the IGZ, the products of the IC cannot be included in the negotiable tariffs.

5.2 Reimbursement of pharmaceuticals

Pharmaceuticals are part of the care product. Hospitals have to negotiate with the pharmaceutical companies about purchasing costs.

' Add-ons '

Expensive pharmaceuticals are financed through the so-called 'add-ons'. Add-ons are separate care products, expressed in terms of care activities that are declared in combination with a care product. This way, these high expenditures (which are only needed for a relatively small number of patients) will not influence the mean price of individual care products. Therefore, it prevents the adverse consequence of the differences in costs between the care products.

5.3 Application procedure for hospital reimbursement of new medical devices or technologies

When a new device or technology replaces and resembles an existing product or technology it is up to the hospital to use this product or technology under the existing care codes.

When the device or technology is different from the existing, an appropriate performance prescription or code should be obtained.

The NZa and the Healthcare Institute each play a role during the decision-making process regarding the reimbursement of a new care product.

For obtaining a new performance description there are several possibilities:

1. By submitting a change request. The procedure has roughly the following outline:

- submission of the request at NZa. NZa maps the outlines of the request. In addition, political and technical aspects play a role. This phase lasts six to eight weeks and ends in a reasoned go or no-go.
- advice by NZa. In this phase NZa looks further into the details of the request. This results ends in the “change request advice”. A positive advice also contains the functional specifications for admission into the system.
- the Board of Directors of the NZa subsequently decides about all detailed change requests and informs about these decisions (second go or no-go). This decision still holds reservations regarding the technical implementation of the request.

After the decision of the Board of Directors NZa elaborates on the change request in a product description. After this technical elaboration the NZa comes to a final decision about the total package extradition.

Ultimately the Healthcare Institute is asked to pass judgement about whether or not the performance should be part of the basic insurance package.

2. By using the possibilities, created for healthcare innovation. More about these in Chapter 8 Innovation in healthcare.

4. By submitting a request at NZa to get a so-called DOT-registration code (also called innovation DOT). Based on a completed Quick Scan this procedure starts at NZa. The Medical Scientific Advisory Board (MWAR) assesses the request on the basis of a number of criteria, the KEEPS test: quality, economical aspects, ethical aspects, patients’ preferences and system consequences.

If there would be uncertainty whether the innovation is covered by the basic package of the health insurance a request will be directed at the Institute for a ruling. The currently known execution time of such a request is at least 14 weeks.

The application dossier for a new code has to be submitted to NZa by the relevant scientific organisation of medical doctors, a care provider or a health insurance company.

5.4 Hospital purchasing processes in health technology

Based on available data it is estimated that hospitals in The Netherlands spent about € 3.2 billion on health technology. This concerns both investments in medical equipment (11%) and expenditures on consumables such as disposables (51%), implants and prostheses (25%) and instruments and equipment (14%). These expenditures form about 13% of the total amount spent by hospitals.

In the last years there has been optimization in the purchasing process. Not only is looked at the purchase price, but also at the Total Costs of Ownership (TCO). This means that exploitation costs, such as future costs of maintenance and the purchase of disposables that are needed to use the technology, are also taken into consideration.

Apart from that, hospitals look at the potential benefits from an investment. Also they look into new financing constructions in order to keep the costs low, such as lease, equipment on loan, pay-per-view and financing through scientific or partnership constructions.

The purchase process has been professionalised: more people are involved and the process is more conscious. More attention is paid to life cycle costs (purchase and use) and the potential benefits. Value-based procurement will become more and more important.

This developments must continue in the years to come: cost-effective health technology can play an important role in this. Also cooperation between different parties, such as distributors, health insurance companies, medical specialists and hospitals, is required in order to make optimal use of the chances offered by health technologiy.

6. Reimbursement of medical devices on the outpatient market

The reimbursement of medical devices on the outpatient market is arranged by the Medical Devices Act. Most of the products on the list of the Medical Devices Act are being described according to the bodily malfunction they compensate for. The descriptions are based on the ICF (the International Classification of Functioning, Disability and Health, a reference classification of the WHO).

Devices related to health

In terms of the ICF, devices related to health intervene on the level of impairment with the aim of:

- fully or partially removing the impairment
- preventing or slowing aggravation of the impairment
- reduction of physical symptoms as a result of an impairment
- replacement of a complete or partial absence of a body part or body function.

In short, these are devices related to impairments that are often worn on or attached to the body. The devices in this category are often used for treatment or related to treatment. The devices in this category are covered by the Zvw. Therefore, the health insurers are responsible for reimbursement of these medical devices.

The list below shows which devices are reimbursed.

1a. Prostheses for shoulder, arm, hand, leg and feet (art. 2.8)

1b. External medical devices for the respiratory system (art. 2.9)

1c. Medical devices for hearing (art 2.10)

1d. External medical devices used for urination and defecation [bowel movement] (art. 2.11)

1e. External medical devices for physical movement (orthoses and orthopaedic shoes) (art. 2.12)

1f. External medical devices that have a visual function (art. 2.13)

1g. Medical devices related to disorders in the level of consciousness (art. 2.)

1i. Medical devices for contraception (art. 2.16)

1j. Medical devices related to bedridden care and nursing (art. 2.17)

1k. Medical devices used for disorders in the skin function (art.2.18)

1l. Injection needles (art. 2.19)

1m. External medical devices as long-term compensation for functional failure of the blood vessels during the transportation of blood, or for a functional failure of the lymphatic vessels during the transportation of lymph.

1n. External medical devices related to disorders in the hematologic system

1o. Medical devices used for control and regulation of disorders in blood sugar level

1p. Portable, external infusion pumps (art. 2.22)

1r. Medical devices for the administration of food (art. 2.24)

1s. External medical devices related to and for compensation of limited speech

1t. Medical indicated devices for communication, information supply and signalising (art. 2.26)

1y. External electro stimulators against chronic pain

1hh. Medical devices for dialysis at home (art. 2.36)

For each type of medical device there are further regulations, specified in supplementary articles of the Medical Devices Act (the table above lists the relevant article numbers). These regulations specify, among others:

- whether prior permission by health insurance companies is necessary
- whether there are additional payments for patients
- who is the owner of a medical device provided (patient/health insurance company)
- who is responsible for maintenance and cleaning of a certain medical device (regular maintenance is mostly the responsibility of the patient, reparation and/or replacement are mostly the responsibility of the health insurance company)
- who is responsible for the disposables
- how often medical devices and/or disposables can be provided
- whether there are certain medical devices that are excluded from reimbursement

It is only possible to get a medical device reimbursed through the Medical Devices Act, if it is listed for long-term use. Medical devices which are used in an out-patient context, but are intended for short-term treatment, cannot be reimbursed under this Act. Some devices may be reimbursable as part of (short-term) hospital treatment.

Each year the Institute advises the Dutch Ministry of Health if there are (categories of) medical devices that should be excluded or included from the Medical Devices Act. These recommendations are published on the website of the Institute. For this, the Institute consults relevant stakeholders, such as patient organisations, umbrella organisations of producers, medical doctors and health insurance companies. Individual manufacturers are not consulted, although exceptions are possible.

The total costs for medical devices on the out-patient market amounted to approximately € 1.44 in 2016.

The Top-5 categories of medical devices in spending amount is as follows:

1. Incontinence devices
2. Stoma materials
3. Other care products
4. Medical indicated shoes
5. Hearing aids

6.1 Role of health insurance companies

Besides the regulations in the national Medical Devices Act, each insurance company has an additional guideline for the provision and reimbursement of medical devices (Reglement Hulpmiddelen). Health insurance companies, for example, can have their own guidelines on how often a medical device must be

replaced or if a device may be repaired first. Another issue is whether patients must have permission from the health insurance company. Also, insurance companies may have guidelines on the maximum tariff for reimbursement. This way, they can influence patients to select the most cost-effective, available option.

Health insurance companies contract manufacturers and distributors for the delivery of medical devices and additional services to clients who have an indication and who they have given permission for a certain device. Often, there are no additional payments for patients, when they make use of a contracted provider. When patients choose their own provider and/or another brand of a medical device, they are sometimes required to pay for part of the device (this is, for example, the case for innovative nebulisers). It is not always allowed to choose one´s own provider.

According to their contract, contracted providers are often responsible for maintenance, cleaning and repairs of the devices they delivered. Also they may be responsible for the delivery of disposables and the training of nurses. Contracted providers often receive a daily tariff for the services they supply (for instance, in case of oxygen providers).

6.2 Application procedure for out-patient reimbursement of medical devices

The producer of a new product, belonging to a category specified in the Medical Devices Act, is not required to submit an application dossier to the Healthcare Institute. The company is a 'free rider' and is not required to invest in the costs for an application dossier. Reimbursement of the new product on the Dutch market will depend on the exact wording in the Medical Devices Act, the exact wording in the guidelines of individual health insurance companies, and the possibilities for negotiating with insurance companies about contracts and preferred provider.

It may be unclear if a new product belongs to an existing category in the Medical Devices Act. In that case, health insurance companies can ask the Healthcare Institute for advice.

Application dossiers for new categories of medical devices have to be submitted to the Healthcare Institute. After this, the Healthcare Institute advises the Dutch Ministry of Health on reimbursement. The decision-making process regarding the reimbursement of medical technology on the Dutch outpatient market is as follows:

● Is a comparable product already being reimbursed within the basic insurance package? (Is it included in the Medical Devices Act)

● If so, the new product is reimbursable as part of the basic package.

● If not, an application dossier should be submitted to the Healthcare Institute. This advises the Ministry of Health, and the latter makes a decision. If this is a positive decision, the product is reimbursable. If not, there may be possibilities on the free market, within the Social Support Act.

During the application process the Healthcare Institute takes the following considerations into account:

● Is it a common product? (When products can be regarded as 'common' and 'not too expensive', they may not be reimbursable. This was, for example, the case with glasses some years ago.)

● Is the product effective, have studies been carried out that provide evidence?

● Is the product cost-effective, compared to other possible therapies?

● Is the product not too expensive for Dutch society, in other words, what is the budget impact? (Some years ago the RVZ stated that the health costs of any citizen should not be exceed €80,000 a year on average.)

● Are there enough healthcare providers who can assist patients when using the product?

● Is the product being reimbursed in other European countries?

● Is the product intended for the treatment of an actual disease or rather to relieve discomfort?

Requirements application dossier

The application dossier must include information and data such as description and function of the product, patient group, distribution, efficacy and costs of the product, etc.

Devices related to well-being

Apart from the formerly mentioned devices related to health there are devices that are related to well-being. In terms of the ICF, these devices are devices that improve social participation.

They are used to decrease:

● disabilities: the difficulties a person encounters in performing activities

● participation problems: the problems a person has with participating in a social life

In short, these are devices related to impairments that are generally not worn on or attached to the body.

The devices in this category are covered by the Wmo. This means that the municipalities are responsible for the provision and reimbursement of these medical devices.

The regulations for the latter group of devices are different from those of the former. Relevance to the patient is more important than evidence-based.

The operation of the Wmo and the effect it has on the insured is monitored closely.

6.3 Medical specialist care at home (MSVT)

MSVT is care that falls under the responsibility of the medical specialist. It usually concerns complex nursing at home. Medical devices that are necessary for this are part of the reimbursement of this MSVT and therefore part of the DOT.

From 2018 on, MSVT will no longer exist.

7. Reimbursement of pharmaceuticals on the out-patient market

The expenditure for pharmaceuticals on the out-patient market was € 4.66 million in 2016.

Pharmaceuticals that are prescribed and used in an outpatient setting can be reimbursed when they are included in the Pharmaceutical Reimbursement System (GVS). The GVS is part of the claims regulation of the ZVW. An insured is entitled to reimbursement of a registered medicine when the Minister of Health has included the medicine in Appendix 1 of the Healthcare Insurance Regulation. For some pharmaceuticals specific criteria must be met before delivery; these are listed in Appendix 2 of the aforementioned Regulation. The Regulation describes how pharmaceuticals are classified in groups of interchangeable pharmaceuticals and how the compensation limits are calculated.

Pharmaceuticals are marked interchangeable when they:

- can be used for a similar indication area
- are administered via the same route of administration
- in general are intended for the same age category

Interchangeable pharmaceuticals are placed on appendix 1A of the Regulation. Pharmaceuticals that are not interchangeable are placed in appendix 1B of the Regulation.

Whether or not pharmaceuticals are reimbursed by the health insurer is determined by the preference policy they pursue. This policy is aimed at keeping the costs of the pharmaceuticals that are prescribed under control.

The preference policy is based on the Health Insurance Decree (Besluit Zorgverzekering, article 2.8) It states that the health insurer must designate the reimbursable pharmaceuticals from the GVS.

For this, there are two (extreme) possibilities: the first is for the health insurer to reimburse all pharmaceuticals admitted to the GVS by the Minister of Health. In that case there is no preference policy. The other extreme is for the health insurer to designate a group of pharmaceuticals that is as restricted as possible. The limits for the restriction drift of health insurers are set out in the aforementioned article 2.8 of the Decision Health Insurance. It stipulates that the health insurer must designate at least one pharmaceutical for each effective substance (or combination of effective substances). Pharmaceutical in this case means one performance, regardless of the strength, type of administration or distributor (label).

Between these two extremes, everything is possible. In practice, however, there are two options of applying the preference policy:

- 'Transparent'

At a certain point the health insurer announces which pharmaceuticals it wants to include in the preference policy. Distributors are given time, until a certain date, to adjust their prices in the public price lists to become more appealing to the health insurer. After that, the insurer determines which pharmaceuticals are included in the preference policy. Often, they are the cheapest but there are other important conditions as well. Usually there is a condition that the distributor must guarantee being able to provide the entire market with the relevant pharmaceutical during the time it is declared preferential.

- 'Under cover'

The health insurer invites distributors to submit an offer in a closed envelope. The public price of the pharmaceutical is not adjusted. However, afterwards the health insurer will be charged the discount price, mentioned under cover by the distributor, accounted for based on the pharmaceuticals invoiced by the pharmacist.

The eventually agreed price is not disclosed by the parties. This way, a pharmaceutical could be declared preferential in spite of the fact that it is expensive compared to the other pharmaceuticals on the list.

Medical necessity

Under the preference policy, health insurers are obliged to give space to the insured that cannot use the preferential pharmaceutical on medical grounds. That is also provided for in article 2.8, mentioned above. The health insurer must reimburse pharmaceuticals other than the declared preferential pharmaceuticals if treatment with the preferential pharmaceutical is medically unjustified for the insured.

8. Innovation in healthcare

8.1 Standard of care and daily practice

For the introduction of a new form of care in the basic insurance package, ZIN determines whether this form of care can be labelled standard of care and daily practice.

In order to decide this ZIN assesses whether the treatment leads to a clinical relevant added value for the patient, taking the favourable and unfavourable effects into account and comparing it to the standard or conventional treatment. In other words, is the assessed treatment a desirable, relevant and large enough addition and does ZIN have enough confidence that this addition will actually occur.

In order to take a stand, ZIN decides:

- What is the target group the treatment aims at?
- What treatment is the new treatment compared to?
- Which outcomes are crucial/important and are taken into account?
- Is the outcome of the comparison large enough? (In other words, is the outcome clinically relevant?)

The principles of evidence based medicine (EBM) are used. This means that apart from scientific findings, expertise and experiences from practice can be taken into account.

The assessment of EBM takes place through a fixed roadmap: searching and selecting information, assessing the information and draw a conclusion. Searching (PICOT questions) takes place on the following aspects: relevant patient population, the intervention to be assessed, the intervention that it is being compared to, the relevant outcome and the minimum follow-up period. The literature found is assessed on the basis of the methodological aspects: the importance of the results, generalizability and research design. For this GRADE methodology is joined. With the help of this method an estimate of the quality of the total collected evidence can be given. GRADE has four levels: high, medium, low and very low quality. The final step for ZIN is what conclusion will be drawn.

If a new form of care is not labelled standard of care and daily practice, there are still a few options to obtain reimbursement.

8.2 Guidelines for Innovation (Beleidsregel Innovatie)

This guideline is aimed at experimenting with short-term and small-scale innovative healthcare performances with the ultimate goal of improving value for money in healthcare. This experiment gives space to determine whether a definite performance description will be submitted.

For this experiment a care provider together with a health insurance company submits a request with the NZa. This request should be about improving care that is already covered by the basic package of the health insurance. There should also be a research proposal: a proposal including how the funding will be organized and also where the money should come from. If the NZa approves the proposal the experiment can start with the intended target group. The research period initially has a maximum of three years. However, as it turned out that this can be too short a period for a good experiment, since 1st January 2017, the experiment can be extended for a maximum of two years.
In practice, the Institute is also consulted.

8.3 Subsidy scheme for quicker availability of promising care for the patient

As of 2019, a new subsidy scheme for promising care will be introduced. This should promote that the cost-effectiveness of potentially promising care is made visible more quickly.
Through this scheme, parties involved can apply for financing of both the costs for care as the research costs during the research period.

After the research period judgement is passed by the Institute, which states whether the care concerned can be taken into the basic insurance package.

The scheme aims at new treatments, medical technology, medical devices and specific groups of pharmaceuticals.

The main chances in the procedure are, in short:

- Runtime of the preparation period is halved
- Preparation is simplified
- Application for the subsidy scheme is possible twice a year
- Decision making is simplified

9. Long-Term Care

As of January 1st 2015 the new Long-term care Act (Wlz) has been introduced. This Act has replaced the Exceptional Medical Expenses Act (AWBZ). Only the most serious, long-term care is reimbursed from the Long-term care Act. This Act is part of a coherent system of new and renewed acts such as the Social Support Act (Wmo), the Youth Act and the Health Insurance Act.

During years before 2015, the number of people receiving care, financed from the AWBZ, had grown enormously and the expenses with it. Therefore, several tasks that used to fall under the Exceptional Medical Expense Act have been transferred to the Social Support Act and the Health Insurance Act. Apart from the reason of costs savings, there was another reason for the transfer. With the decentralisation the government aimed to improve the quality and the accessibility of healthcare. People should have more possibilities to take responsibility for their own lives. Also this should lead to more participation from society in the care for vulnerable citizens.

The assumptions of the vision of the government concerning long-term care and support are:

1. Most important is what abilities people (still) have instead of their disabilities. Quality of life is paramount.
2. If support is needed, first the own social network and the financial capabilities of the parties involved are looked into and help is organized nearby.
3. For those who cannot be self-reliant -even with the support of the environment - there is always participatory support and / or appropriate care
4. The most vulnerable people are entitled to appropriate care in a protective, in-patient setting in the new Long-term Care Act.

9.2 Wlz

The Wlz is aimed at vulnerable elderly and disabled people that permanently need full time care around them and/or continuous supervision. They are unable to live independently in their own home with support from their social network, municipality or with home care.

In 2014, over 800.000 people in The Netherlands used long-term medical care financed under the Exceptional Medical Expenses Act (AWBZ). In 2015, 370,000 people received long-term care from the Wlz.

The main issues of the Wlz are:

Right of care:

Children and adults who are permanently dependent on continuous supervision or 24 hour care around them have an insured right of care.

Complete care package:

Clients have an insured right of a complete care package. This package consists of stay, personal care, conduction, nursing care, treatment and individual use of mobility devices. Also transportation to and from daycare.

Care plan:

Care providers are obliged to have a conversation with every client about the care provided. The results of this conversation is established in a care plan. In the care providing the wishes, possibilities and needs of the client are most important. The social network of the client is involved in this conversation.

Form of care:

Patients who have an indication for care have the choice of receiving this entitlement as care in kind or in the form of a personal care budget ('PGB').

The choice available to the patient is dependent on his/her situation.

1. Care in kind

The care is provided by a healthcare provider, for example a home care organisation. The patient's care office has an agreement with this provider and arranges the payments. The patient is free to choose any provider. Every patient entitled to Wlz care has the right to opt for care in kind.

2. The PGB

A PGB refers to a personal budget allowing the patient to purchase the care he needs, by making arrangements with the healthcare providers. He is obliged to keep a record of the purchased care, which must be shown to the healthcare office.

The demands for these forms of care are sharpened.

Home adaptation:

If needed for the PGB or the complete package at home adaptations are reimbursed.

Care profiles

In the Wlz, the indication for long term care is expressed in a care profile. This care profile describes the nature, content and broad scope of health care. These care profiles offer room for customization.
The care profiles are organized into the following categories:

- Sector Nursing and Care
- Sector Mentally retarded
- Sector Slightly mentally retarded
- Sector Physically handicapped
- Sector Sensory disability, auditory and communicative
- Sector Sensory handicapped, visually
- Sector Mental health, group B

Indication

The Centre for Indications in Care (CIZ) assesses whether client are eligible for care from the Wlz. This results in a care profile. This describes the category of care and the way this care is given (PGB, care in kind at home or in an institution). Furthermore, it can be decided to which extent care is been given per week, whether there is an indication for day activities and whether transport is indicated in that case

9.2 Social Support Act

The Social Support Act has made the municipalities widely responsible for the support of citizens with a limited ability to participate. This should lead to people being able to live at home longer and to participate in society. This will improve their sense of well-being and prevent unnecessary medicalization and the associated cost.

The budgets involved are to be used by the municipalities. Municipalities have great freedom at organizing this customized support.

In return for the support offered the municipality expects citizens to do their best to participate, both socially and financially.

Municipalities are at the moment still busy organising the care they need for meeting their assignment. Often they have contracted parties that can offer the whole package of care and support. For these contracts the procedures for a European tender is being followed.

9.3 Health Insurance Act

Long term care that is aimed at curing or maintaining physical and mental abilities, such as nursing, is part of the Health Insurance Act. Parts of the former Exceptional Medical Expenses Act that are aimed at treatment and care were transferred to the Health Insurance Act.

This should lead to more possibilities for healthcare providers and health insurance companies to develop well organized chain care, in coherence with social support and youth care.

Since 2017 the health insurance companies are risk-bearing for outpatient nursing care and related personal care.

9.4 Youth Act

The Youth Act has taken effect in 2015 and covers all the care for the youth. The responsibility for this act lies with the municipalities. Because of the connection with the Youth Act the treatment for children with mental disabilities or psychiatric disorders is united in this Youth Act.

9.5 Financial consequences

The aforementioned changes have led to major financial transfers within long-term care and support. The total expenditure however will remain virtually the same as the expenditure in 2014.

9.6 Evaluation of the reformation of the system of Long Term Care

The transitions in the system of Long Term Care has been evaluated from 2015 until 2017. This evaluation aims at determining whether the long term care develops the way the Ministry of Health intends it to develop. The evaluation focuses on the Wmo, the Wlz, district nursing and intramural mental healthcare.

The evaluation is carried out by the Netherlands Institute for Social Research (SCP) in the following subprojects:

- Evaluation of the whole reformation of long term care
- Evaluation of Wmo and district nursing
- Evaluation of Wlz

Several sub reports will be published during the evaluation. The end report of the total evaluation will be published on the 1st of July 2018 at the latest.

APPENDIX A

Overview of hospitals in the Netherlands (per province)

Drenthe

City	Hospital	Number of beds
Assen	Wilhelmina Ziekenhuis Assen	265
Emmen	Treant Ziekenhuis Scheper	381
Hoogeveen	Treant Ziekenhuis Bethesda	272
Meppel	Isala Diaconessenhuis (MCM)	330

Flevoland

City	Hospital	Number of beds
Almere	Flevoziekenhuis	386
Emmeloord	Antonius Ziekenhuis Emmeloord	160
Lelystad	MC Zuiderzee	200

Friesland

City	Hospital	Number of beds
Drachten	Ziekenhuis Nij Smellinghe	339
Heerenveen	Ziekenhuis Tjongerschans	382
Leeuwarden	Medisch Centrum Leeuwarden	700
Sneek	Antonius Ziekenhuis	300

Gelderland

City	Hospital	Number of beds
Apeldoorn	Gelre ziekenhuizen – locatie Lukas	697
Arnhem	Rijnstate Ziekenhuis Arnhem	850
Doetinchem	Slingeland Ziekenhuis	348

Ede	Ziekenhuis Gelderse Vallei	600
Groesbeek	Universitair Longcentrum Dekkerswald	83
Harderwijk	Ziekenhuis Sint Jansdal	341
Nijmegen	Cansius-Wilhelmina Ziekenhuis	653
	Sint Maartenskliniek (hospital specialising in posture and movement)	300
	Universitair Medisch Centrum St Radboud	953
Tiel	Ziekenhuis Riverenland	373
Velp	Rijnstate Ziekenhuis Velp	16
Winterswijk	Streekziekenhuis Koningin Beatrix	314
Zevenaar	Rijnstate Ziekenhuis Zevenaar	120
Zutphen	Gelre ziekenhuien – location Het Spittaal	228

Groningen

City	**Hospital**	**Number of beds**
Delfzijl	Ommelander Ziekenhuis Delfzicht	186
Groningen	Martini Ziekenhuis	580
	Universitair Medisch Centrum Groningen (largest hospital in the Netherlands)	1339
Stadskanaal	Refaja Ziekenhuis	200
Winschoten	Ommelander Ziekenhuis Lucas	240

Limburg

City	**Hospital**	**Number of beds**
Brunssum	Zuyderland Medisch Centrum Brunssum	63
Geleen	Zuyderland Medisch Centrum Sittard-Geleen	423
Heerlen	Zuyderland Medisch Centrum Heerlen	592
Horn	Centrum voor Integrale Revalidatie Orgaanfalen (Hornerheide) (hospital specialising in asthma patients)	45
Kerkrade	Zuyderland Medisch Centrum	429

Maastricht	Academisch Ziekenhuis Maastricht	715
	(trauma centre for Limburg)	
Roermond	Laurentius Ziekenhuis	429
Venlo	VieCuri Medisch Centrum	569
Venray	VieCuri Medisch Centrum	444
Weert	Sint Jans Gasthuis	272

Noord Brabant

City	**Hospital**	**Number of beds**
Bergen op Zoom	Bravis Ziekenhuis	309
Boxtel	Jeroen Bosch Ziekenhuis	214
Breda	Amphia Ziekenhuis	837 (2 locations)
Deurne	Elkerliek Ziekenhuis Deurne	494 (2 locations)
Eindhoven	Catharinaziekenhuis	695
	Maxima Medisch Centrum	365
	Sint Annaziekenhuis	423
Etten-Leur	Amphia Ziekenhuis	837
Geldrop	Sint Annaziekenhuis	423
Helmond	Elkerliek Ziekenhuis	494 (2 locations)
’s Hertogenbosch	Jeroen Bosch Ziekenhuis	1009 (3 locations)
Oosterhout	Amphia Ziekenhuis	251
Oss	Ziekenhuis Bernhoven	237
Roosendaal	Bravis Franciscus Ziekenhuis	472
Tilburg	ETZ Elisabeth Ziekenhuis	673
	ETZ TweeSteden Ziekenhuis	430
Veghel	Ziekenhuis Bernhoven	230
Veldhoven	Maxima Medisch Centrum	471
Waalwijk	ETZ Ziekenhuis	75

Noord Holland

City	**Hospital**	**Number of beds**
Alkmaar	Noordwest Ziekenhuisgroep	913

Amstelveen	Ziekenhuis Amstelland	255
Amsterdam	Academisch Medisch Centrum	1002
	(affiliated with the University of Amsterdam)	
	Nederlands Kanker Instituut and	
	affiliated hospital Antonie van	
	Leeuwenhoek Ziekenhuis	
	(specialised cancer centre)	180
	BovenIJ Ziekenhuis	313
	Onze Lieve Vrouwe Gasthuis/Sint Lucas	
	Andreas Ziekenhuis	
	Slotervaartziekenhuis	310
	VU Medisch Centrum	
	(affiliated with the Free University)	733
Beverwijk	Rode Kruis Ziekenhuis (also a burn	
	injuries centre)	384
Blaricum	Tergooiziekenhuis	340
Den Helder	Noordwest Ziekenhuisgroep	310
Haarlem	Spaarne Gasthuis	900
Heemstede	Spaarne Gasthuis	15
Hilversum	Tergooiziekenhuis	490
Hoofddorp	Spaarne Gasthuis	455
Hoorn	Westfriesgasthuis	500
Purmerend	Waterlandziekenhuis	331
Zaandam	Zaans Medisch Centrum	459

Overijssel

City	**Hospital**	**Number of beds**
Almelo	ZGT Almelo	653
Deventer	Deventer Ziekenhuis	380
Enschede	Medisch Spectrum Twente	1070
Hardenberg	Röpcke-Zweers Ziekenhuis	198
Hengelo	ZGT Hengelo	392
Oldenzaal	Medisch Spectrum Twente	1070 (including Enschede)

Zwolle	Isala klinieken	1100

Utrecht

City	Hospital	Number of beds
Amersfoort	Meander Medisch Centrum	982
Baarn	Meander Medisch Centrum	982
Nieuwegein	St. Antonius Ziekenhuis	584
Utrecht	Centraal Militair Hospitaal	200
	Diakonessenhuis	402
	Sint Antonius Ziekenhuis	530
	Universitair Medisch Centrum Utrecht	1042
Soest	Meander Medisch Centrum	982
Zeist	Diakonessenhuis	138

Zeeland

City	Hospital	Number of beds
Goes	Admiraal de Ruyter Ziekenhuis	364
Oostburg	ZorgSaam Ziekenhuis Antonius	43
Terneuzen	ZorgSaam Ziekenhuis Antonius	288

Zuid Holland

City	Hospital	Number of beds
Alphen aan den Rijn	Alrijne Ziekenhuis	30
Capelle a/d IJssel	IJsselland Ziekenhuis (specialises in liver, stomach, intestine)	390
Delft	Reinier de Graaf	881
Dirksland	Van Weel-Bethesda Ziekenhuis	140
Dordrecht	Albert Schweitzer Ziekenhuis	537
Gorinchem	Beatrixziekenhuis	323
Gouda	Groene Hart Ziekenhuis	500
Den Haag	Haga Ziekenhuis	1195
	Haaglanden Medisch Centrum Bronovo	350

	Haaglanden Medisch Centrum Westeinde	527
Leiden	Alrijne Ziekenhuis	300
	Leids Universitair Medisch Centrum	882
Leiderdorp	Alrijne Ziekenhuis	470
Leidschendam	Haaglanden Medisch Centrum	
	Antoniushoeve	250
Rotterdam	Erasmus MC	1320
	Havenziekenhuis (specialises in	
	tropical diseases)	160
	Ikazia Ziekenhuis	359
	Maasstad Ziekenhuis	621
	Oogziekenhuis (specialises in eye disorders)	
	Franciscus Gasthuis	613
Schiedam	Franciscus Vlietland Ziekenhuis	300
Sliedrecht	Albert Schweitzerziekenhuis	20
Spijkenisse	Ruwaard van Putten Ziekenhuis	288
Zoetermeer	Lange Land Ziekenhuis 242	
Zwijndrecht	Albert Schweitzer Ziekenhuis	166

APPENDIX B

Professional associations of medical professions

Dutch Association for General Practitioners/Nederlands Huisartsen Genootschap (NHG)

The NHG is the research organization for General Practitioners in The Netherlands. In future, GP's will play a central role in the treatment of patients with chronical conditions. The NHG has, among others, developed several standards and clinical guidelines for heart diseases and diabetes. Apart from that the NHG has developed indicators to measure the quality of the care, provided by GP's to patients with diabetes or after a CVA.

www.nhg.org

Diabetes GP Advisory Group/Diabetes Huisartsen Advies Groep (DiHAG)

This organization represents the GP's within the Dutch Diabetes Federation/Nederlandse Diabetes Federatie (NDF), a cooperation of patients with diabetes, GP's and nurses.

www.dihag.nl

Royal Dutch Medical Association/Koninklijke Nederlandsche Maatschappij ter bevordering der Geneeskunst (KNMG)

This is the professional organization for physicians in The Netherlands. This physician's federation has eight members: seven professional organisations for physicians and the union *The Medical student* as the eighth member

www.knmg.nl

Federation of medical specialists/Federatie Medisch Specialisten

This is the professional organization of medical specialists. All Dutch scientific organizations are connected. The Federation represents about 20.000 medical specialists. The Federation is committed to the position, organization, and financing of medical specialists, both independent and employed and academically employed.

The Federation offers for example legal aid and other services to its individual members.

www.demedischspecialist.nl

National GP's Association/Landelijk Huisartsenvereniging (LHV)

The LHV is a nationwide professional organization for GP's. The main tasks of the LHV are:

- Reinforcing the strategic position of GP care.
- Material interests representation
- Joining of forces of professionals
- Improving of the quality of GP care

- Support in practice management

The LHV is connected to the Federation of Medical Specialists

www.lhv.nl

NEVI Healthcare/Zorg

NEVI is established as a professional association for purchasers. NEVI Healthcare is the section for purchasers that work in healthcare, such as hospitals, care institutions, institutions for handicapped and psychiatric institutions. The section aims at further professionalizing purchasing in healthcare.

www.nevi.nl/zorg

APPENDIX C

(Selection of) umbrella organisations of healthcare institutions

Dutch Hospital Association/Nederlandse Vereniging van Ziekenhuizen (NVZ)

The NVZ is the trade association for general hospitals and specialist institutions in the Netherlands. They represent the interests of their members where healthcare, the economy, and society are concerned.

www.nvz-ziekenhuizen.nl

Netherlands Federation of University Hospitals/Nederlandse Federatie van Universitaire Ziekenhuizen (NFU)

The Netherlands Federation of University Medical Centres represents the eight cooperating UMC´s in The Netherlands, as an advocate for and employer of 65,000 people. The NFU was founded in 2004 as a spin-off from the University Hospitals Association (Vereniging Academische Ziekenhuizen,VAZ), which was established in 1989. The objective has remained the same: to ensure that agencies that decide healthcare issues in The Netherlands take into account the special role of the academic hospitals (in the past) and the UMC´s (presently).

www.nfu.nl

Independent Clinics Netherlands/Zelfstandige Klinieken Nederland (ZKN)

Independent Clinics Netherlands (ZKN) is the branche organisation for independent clinics in The Netherlands. Both clinics for reimbursed care (ZBC's) and clinics that offer healthcare which isn't reimbursed are connected to ZKN. ZKN guarantees the quality of the connected clinics.

www.zkn.nl

Rehabilitation Netherlands/Revalidatie Nederland

Rehabilitation Netherlands is the association of rehabilitation institutions. The association represents the interest of its members that offer medical specialistic rehabilitation care. All the rehabilitation centres in The Netherlands are connected. Apart from that, three ZBC's are connected.

www.revalidatienederland.nl

Mental Healthcare Netherlands/Geestelijke gezondheidszorg Nederland

GGZ Nederland is the branch organisation for institutions in mental health care and addiction care. It stimulates and improves good mental health care and raises all the conditions that are necessary to achieve this. Over a hundred members are adjoined, varying from large, regional to smaller, specialised care providers.

APPENDIX D

Health insurance companies in The Netherlands

Health Insurers Netherlands (ZN)

ZN (Zorgverzekeraars Nederland) is the sector organisation representing the providers of healthcare insurance in the Netherlands.

www.zn.nl

The following health insurance companies offer Basic Health Insurance (and supplementary insurance) in The Netherlands:

Zilveren Kruis 5 million

- Avéro Achmea Zorgverzekeringen
- FBTO Zorgverzekeringen
- Interpolis Zorgverzekeringen
- OZF Achmea Zorgverzekeringen
- Zilveren Kruis Achmea Zorgverzekeringen
- De Friesland

CZ 3.6 million

- Delta Lloyd Zorgverzekeringen
- OHRA Ziektekostenverzekering
- OHRA Zorgverzekeringen
- OWM CZ Groep Zorgverzekeraar

DSW-Stad Holland 450,000

- Zorgverzekeraar DSW
- OWM Stad Holland Zorgverzekeraar

ASR 300,000

Menzis 2.2 million

- Menzis Zorgverzekeraar
- AnderZorg

ONVZ 450.000

Eno 151.000

Coöperatie VGZ 3.8 million

- IZA Zorgverzekeraar
- IZZ Zorgverzekeraar
- Maatschappij voor Zorgverzekering Gouda
- Univé Zorg
- Zorgverzekeraar UMC
- VGZ Zorgverzekeraar

Zorg en Zekerheid 400,000

iptiQ Life 200,000

Multizorg

Multizorg/VRZ is the joint purchasing organisation for hospital care and medical devices of insurance companies ASR, Eno, ONVZ and Zorg & Zekerheid. These insurance companies are all strong in one region, but have difficulties in contracting healthcare providers in other Dutch regions. Because of this they have combined forces to contract providers.

www.multizorg.nl