The health basket in the Netherlands

A contribution to Work Package II of the EU funded research project “HealthBASKET”: Description of benefits, entitlements, actors and decision making processes in the Dutch health care sector

E.A. Stolk, F.F.H. Rutten,
Erasmus MC, Rotterdam
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Preface

This report describes the benefits and entitlements in Dutch health care, and how these are defined. This report has been prepared by the institute for health Policy and Management of Erasmus MC in Rotterdam as part of Work Package II of the EU funded research project "HealthBASKET" (full title: Health Benefits and Service Costs in Europe, contract no. FP6 501588).

Contents

1. Organisational structure of Dutch Health care

The purpose of this report is to collect information about the individual health services that are available in Dutch health care. This first chapter describes the main characteristics of the Dutch health care system to clarify how health care benefits are defined in general. For this purpose the main policy objectives and the legal framework will be discussed. In principle we describe the current situation, i.e. we elaborate on the benefit package that exists in the spring 2005. However, the Dutch health care system is a policy area that is evolving and changing continuously. The government has planned a structural reform of the Dutch health care system in 2006. This reform will change the way in which benefits and entitlements are defined. Where this is necessary this report therefore also includes a description of the benefits and their definition after the reform.

1.1. Characteristics of Dutch health care

The Dutch health care system is social insurance based. The health care system in the Netherlands costs a year-around 44 billion euros in all. Health care financing is done through a mix of public and private health insurance. About 63% of health expenditures are paid for through public funds (OECD, 2004). Health care providers, however, are usually independent practitioners or non-profit institutions. Because of the separation between "payers" (insurers, or sickness funds) and providers, the Dutch health care system has always had some form of entitlement-setting mechanism. Consequently, a majority of health policy decisions are discussed at the level of the central government, particularly the Ministry of Health, Welfare, and Sports (Carino et al., 2005).

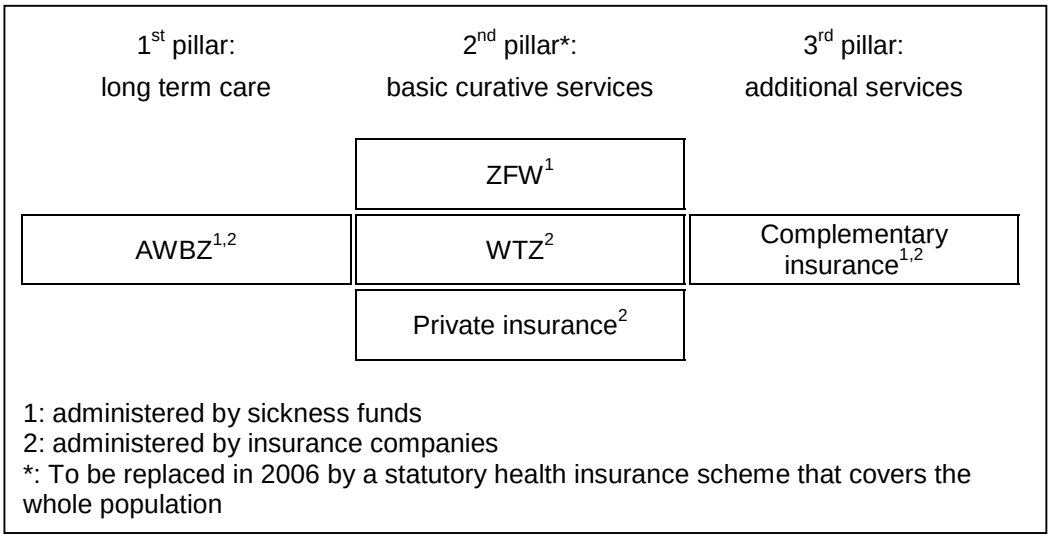
The current health insurance system broadly consists of the three compartments listed below. Every citizen pays compulsory income-related premiums for "catastrophic" long-term care covered under the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, AWBZ). The AWBZ scheme covers about 40 percent of Dutch health expenditure. Premiums are levied as part of the income tax system. Hence, they are income-dependent and not differentiated with respect to risk class or insurer. The AWBZ covers uninsurable risks such as those related to chronic illness, psychiatric hospital care, long term hospital care and nursing, and the care of the physically and mentally handicapped. For acute care, individuals are either publicly insured under the compulsory Health Insurance Act (Ziekenfondswet, ZFW) or privately insured (36% and 15% of healthcare finance

respectively). The sickness funds cover, among other things, the costs of hospital admissions, treatment by doctors, medicines, and medical appliances and aids. About 80 percent of health care expenditure is thus paid through public insurance schemes.

a) Expensive, uninsurable and long-term health care paid for under the AWBZ
b) Acute medical care paid for under the ZFW, private insurance and statutory insurance schemes for public servants
c) Other forms of health care not covered by the first two compartments

Figure 1.1 illustrates the distinction between the different compartments. The distinction between the first and the second compartment is primarily based on the duration of care, and not on the type of services. Some services can only be covered by the AWBZ or the ZFW, but many services can be covered either by the ZFW or the AWBZ depending on the circumstances. Irrespective of the type of services (e.g. hospital care, rehabilitative care), all medical services that are continued for a period longer than a year are covered by the AWBZ. When these services are provided for shorter durations they are covered by the ZFW. Furthermore all medical services that are provided to people who live in AWBZ institutions are covered by the AWBZ (e.g. dental care), while these services are covered by the ZFW for people who live in their own homes.

Figure 1.1 the three compartments of the Dutch health care system



When the new Health Insurance Act comes into force in 2006, the second compartment will be reformed. Statutory and private (voluntary) health insurance will be integrated into a single and mandatory scheme that provides coverage to the whole population. The integration of social and private insurance schemes is part of the structural reform of Dutch health care. A

central element of these reforms is the transition from a supply-led system to a demand-led system (Ministry of Health Welfare and Sports, 2004). It is the government's wish that the care system should be shaped primarily by the needs of the users (i.e. the demand side). This is to be achieved by both direct and indirect means: allowing consumers more choice and giving a more active role to insurers (as the representatives of patients' interests). The reform of the second compartment is a part of this reform as it gives all people the freedom to choose which health insurance fund they wished to join which serves to increase competition between the insurers. The integration of social and private insurance schemes implies that the coverage of the ZFW will be extended to the whole population. For that reason this report will only describe the ZFW benefit package and will not describe details about the insurance schemes that currently exist in the private sector. This means that the benefits of the different private schemes and the benefits under the Medical Insurance Access Act 1998 (Wet op de toegang tot ziektekostenverzekeringen, WTZ) will not be described. We offer a short description of these insurances in section 1.3.

The new health insurance scheme will have a private structure. Citizens will no longer be insured automatically but will be obliged to purchase a health plan themselves. The new health insurance will comprise a standard package of essential health care that should be made available to all insured. The level of the nominal insurance premium may differ between insurers, as an incentive for competition among the health insurers and for cost consciousness among the insured. Furthermore, health care insurers will not have to sign individual contracts with all providers. By abolishing this, the organization and the price of health care can be negotiated at the level of insurer and supplier. Care providers thus will compete with each other on the basis of price and quality. The insured are still free to choose their preferred provider, but the health insurer sets the level of reimbursement. However, this may not be so low as to impede the free exchange of services. In the end the goal is to build a self-regulatory system within a statutory framework, so that the level of government control for the purpose of cost containment may be reduced.

1.2. Legal framework

The Dutch constitution states that the government provides services to improve and protect public health. The AWBZ and ZFW describe in general terms the contours of the health care system that has been established to meet this constitutional requirement. These two laws describe the organisation of the Dutch health care system and delegate responsibilities to different parties. These two acts are both 'Acts of Parliament', i.e. they are legislation in formal sense. This means that they are made by the central government in cooperation with

the Staten-Generaal (Parliament, consisting of two chambers), received royal assent, and have been proclaimed. These formal laws offer a list of the functional categories of health care attention that a patient is entitled to (e.g. pharmaceutical care, hospital care, rehabilitative services). These formal laws indicate in general terms what areas of health care are covered by the insurance scheme, but they do not indicate what specific services are included in the entitlements for each area of health care. Instead the ZFW and AWBZ include a general statement that specific parts of the law may be further defined in other rules of law. Usually further specification in this sense is offered in lower types of regulations, meaning that responsibilities for defining the rules of law are delegated to the government or the minister.

Lower types of legislation, are types of legislation, which the Parliament authorises a minister, department or other body to make. Examples are governmental decrees and ministerial regulations. The lower forms of regulation specify the contents and extent of the entitlements, specify conditions, and delegate responsibilities. Two governmental decrees are associated to the ZFW and the AWBZ: the Health Insurance (Treatment and Services) Decree (Verstrekkingenbesluit ziekenfondsverzekeringen) and the Decree on Entitlement to Exceptional Medical Expenses Insurance (Besluit zorgaanspraken Bijzondere ziektekostenverzekeringen). With regard to some health care services the governmental decrees authorises the minister to further define the entitlements. The name of the associated ministerial regulations is usually not provided. Instead the Health Insurance (Treatment and Services) Decree and the Decree on Entitlement to Exceptional Medical Expenses Insurance simply indicate that ministerial regulations exist to give a further definition of the entitlements. Figure 1.2 gives an overview of the legal documents define the scope of health services in the Netherlands and are discussed in this report.

The governmental decrees and ministerial regulations contain both 'open' descriptions of the type of services that patients are entitled to as 'closed' systems. A 'closed' character means that the entitlements are further specified, either to specific services, or even to the level of specific products. An 'open' character means that only the character of medical attention is described, but not the exact services or the amount of care. The health care provider then usually decides on the provision of care using the so-called "usual care" principle. The exact entitlements then remain implicit. Some jurisprudence usually is available to decide on difficult matters. Some regulations contain both open as closed descriptions of entitlements. Implicit regulation of health care entitlements using the 'usual care' principle means that the entitlements increase with the medical possibilities. To control costs, is it common that in health care sectors with an open description of entitlements negative lists are used, that lists services that patients are not entitled to.

Figure 1.2 Laws, decrees and ministerial regulations that define the entitlements to health care in the Netherlands

Laws	Associated decrees & ministerial regulations *
Health insurance act	Health Insurance (Treatment and services) decree • Regulations on medical specialist care in the Health insurance act • Regulation dental care health insurance • Regulation governing the provision of paramedical assistance • 1996 Health Insurance Fund (Provision of Pharmaceuticals) Regulation • Regulation medical devices 1996
Medical Insurance Access Act, 1998	Private Medical Insurance (Reimbursements) Implementation Decree
Exceptional Medical Expenses Act	Decree on entitlement to exceptional medical expenses • Regulations on entitlement to AWBZ care • Regulation subsidies AWBZ and ZFW
Disability (Reintegration) Act	
Public Prevention Act	Decree on public prevention
Act on Services for the Disabled	
Social Support Act	
Working hours act	
Working conditions act	

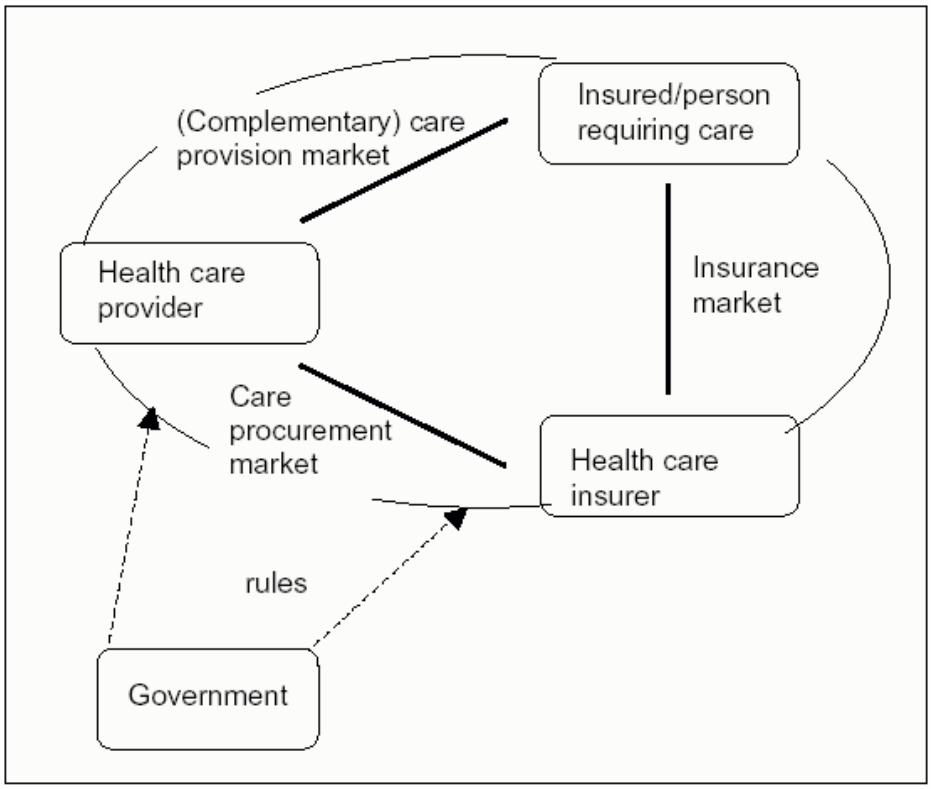
* The Dutch titles of these laws and their abbreviations are provided with the references

The usual care principle implies that the medical profession steers the achievement of optimal care. Consequently, many decisions about availability of services are taken at the meso level. As a group of physicians, the medical staff negotiates with the hospital management about investments in new equipment and material. At the group level, fees are negotiated with insurance companies, and once an agreement has been reached, the remuneration of a particular service is the same for all the members of the group (Polder et al., 2000). Although definitions are the same for all payers, and the hospitals are obliged to

offer appropriate care, the provision of care to individual patients may differ between hospitals. Especially at the edges of healthcare these differences may become apparent (e.g. uptake of new technologies, hospital rules with regard to the use of expensive medications).

The patient is free to choose the provider that will provide the medical attention covered by the ZFW or AWBZ. To be able to reclaim the cost of providing such care through the AWBZ scheme, an institution needs to be approved by the CVZ and to have a contract with the health care insurer. Insurers are currently still obliged to sign contracts for the people they insure with all accredited institutions. However, a client may be given permission to obtain health care from an individual or institution in or outside the Netherlands with whom or with which it has no contract. An insured person may also be reimbursed for the cost of obtaining care abroad insofar as provision of the care cannot reasonably be postponed until after return to the Netherlands. The entitlement covers reimbursement of the costs charged, up to the statutory maximum amount applicable in the country where the health care is provided. If no such maximum is applied in the relevant country, the amount payable is maximised at the figure, which normally applies in the claimant's country of residence or the country where he/she is staying. Any patient contributions that may be payable under the ZFW or AWBZ will be deducted from the reimbursement. Figure 1.3 summarizes the relations between the different parties in the Dutch health care system.

Figure 1.3 Relations in the Dutch health care market (modified from: SER, 2001)



1.3. Entitlements under the ZFW and their validation

The ZFW provides access to general practitioner care, paramedical care, obstetric care, maternity care, pharmaceutical care, medical devices, dental care, specialist medical care (as a hospital in-patient or otherwise), audiological assistance, nonclinical haemodialysis, genetic testing, chronic intermittent ventilation, rehabilitative care, thrombosis prevention and medically necessary transportation. Responsibility for running the ZFW scheme is delegated to health insurance funds accredited by the Dutch Healthcare Insurance Board (CVZ). The nature of the care available to those covered by the ZFW is defined in the Act itself and in more detail in the Health Insurance (Treatment and Services) Decree and the associated ministerial regulations. These lower type of regulations may be used to 1) identify services that people are entitled to which are not mentioned in the ZFW, 2) describe what services are (to what extent) comprised in or excluded from the benefit package, 3) specify the conditions upon which care is made available. These conditions differ from one field of care to another and include prescription by a doctor, quantitative maximums for prescribed medicines and prior approval by a health insurance fund. In some cases – maternity care, pharmaceutical care, medical devices and transportation – care is made available on the condition that the insured contributes to its cost.

The ZFW insurance is compulsory, but not for all residents: only for the people specified in the legislation. In the current situation, only those people with incomes below the maximum wage level are compulsorily insured under the Social Health Insurance Act ("Ziekenfondswet", ZFW). People with a higher income (32,600 euros or more in 2004) still have a choice: they can take out health insurance or they can decide to go through life uninsured. The criteria spelled out in the legislation apply, irrespective of an individual's nationality. It is not important as far as the national health insurance scheme is concerned whether someone has Dutch nationality. However, to be entitled to cover, non-Dutch people must be lawfully resident in the Netherlands. Vice versa, residence in the Netherlands is normally a precondition for anyone wishing to obtain treatment through the scheme. This condition does not apply, however, to someone living in another EU member state or in another country that is a signatory to the Treaty on the European Economic Area (Ministry of Health Welfare and Sports, 2004).

About 30 percent of the population are privately insured. The coverage of private insurances is specified in the Private Medical Insurance (Reimbursements) Implementation Decree (Uitvoeringsbesluit vergoedingen particulier verzekerden). The benefit package is roughly the same as the ZFW benefit package. Unlike national health insurance, which is provided by the state, private health insurance is based upon a civil contract, over which the government has no direct control. Private insurers apply their own acceptance criteria and the people who

take out the insurance pay a nominal premium, which is not income-related. People who don't qualify for national health insurance but cannot satisfy a private insurer's acceptance criteria (because, for example, they represent a high risk) have access to a "standard insurance package". This entitlement is specified in the Medical Insurance Access Act 1998 (Wet op de toegang tot ziektekostenverzekeringen 1998). The WTZ 1998 further regulates that privately insured people have to pay apportionment contributions (WTZ contribution). Similarly the Overrepresentation of Elderly Health Insurance Beneficiaries (Joint Financing) Act (MOOZ) requires the private insured to pay the MOOZ contribution. Both measures intend to compensate health insurers for financial losses of insuring high-risk patients. The "standard insurance package" is largely the same as the ZFW benefit package and will therefore not be discussed separately in this report. By default also the WTZ covers the health benefits as the ZFW but for a different group of people.

1.4. Entitlements under the AWBZ and their validation

Under the AWBZ, the insured are entitled to preventive services (antenatal care, tests in connection with congenital metabolic dysfunctions), and to care to accommodate with long-term medical treatment, nursing or personal or home care. The AWBZ-scheme was intended to provide for the considerable financial consequences of serious long-term illnesses or disorders, in particular the cost of caring for disabled people with severe congenital physical or mental disorders and psychiatric patients requiring long-term nursing and care. The risk of incurring such costs is actually not particularly great, but virtually nobody would be able to cover such costs, hence the term "exceptional medical expenses" (Ministry of Health Welfare and Sports, 2004).

Generally speaking, entitlements apply to all residents in The Netherlands. Insurance under the AWBZ is statutory: everyone who meets the criteria spelled out in the legislation (residents in the Netherlands or employed in the Netherlands) is automatically insured and consequently obliged to pay the statutory contribution (Ministry of Health Welfare and Sports, 2004). In the context of these basic rules, it does not matter whether a person is a Dutch national or not. A rule was introduced on 1 January 1992, under which someone from abroad who settles in the Netherlands and thus comes within the scope of the AWBZ is not actually entitled to certain types of in-patient health care covered by the scheme for a period of up to twelve months from the time that he or she takes up residence. This rule applies if the care in question was already indicated when the person took up residence in the Netherlands or if his/her medical condition at that time was such that it would have been clear that the care would be needed within six months. The waiting period applies in relation to expensive forms

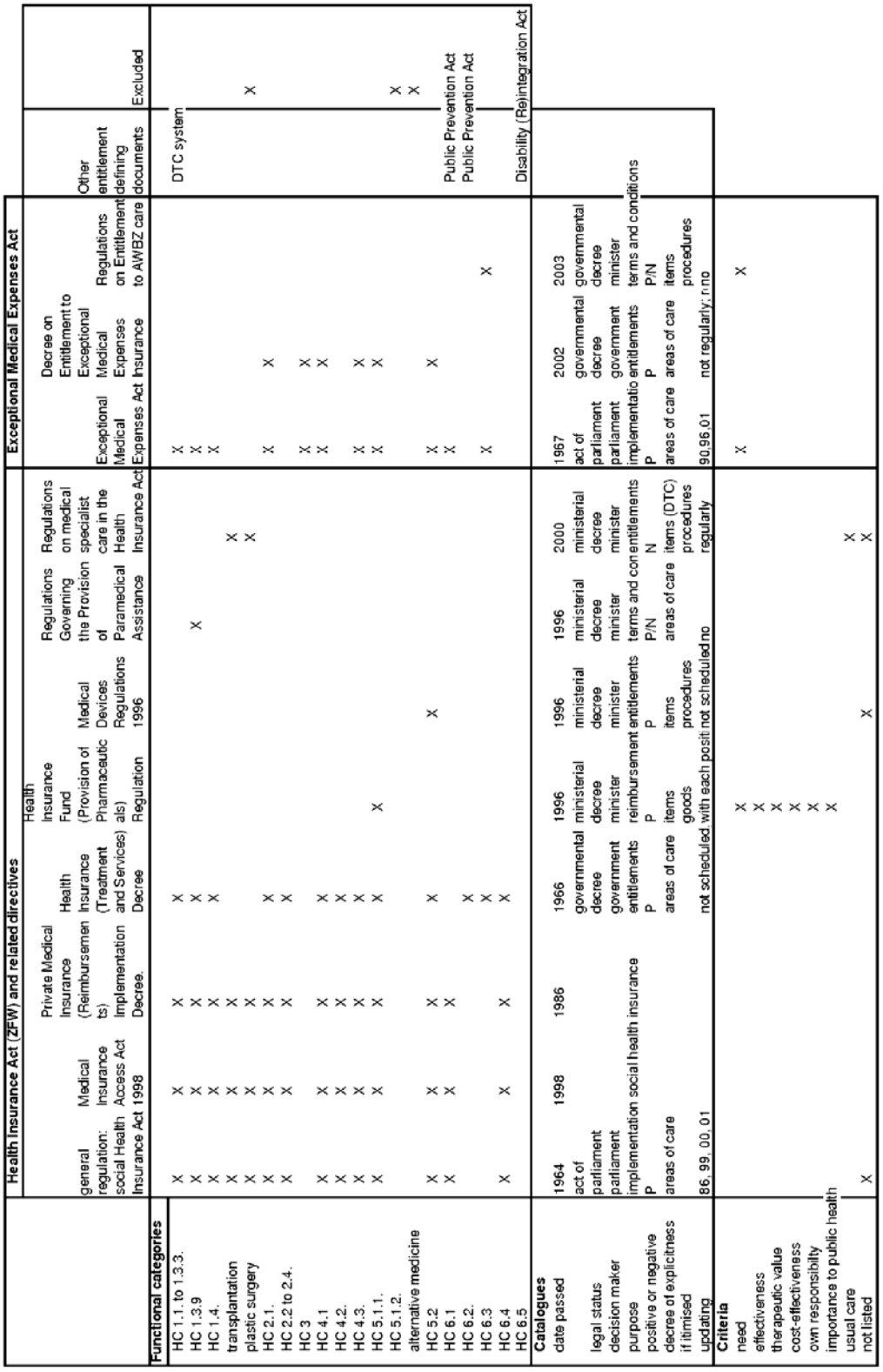
of care, such as nursing-home care. A person to whom this rule applies is not necessarily unable to obtain care, but he or she cannot claim for the cost of such care through the AWBZ scheme. Furthermore, special regulations apply to Dutch people living abroad, who do not automatically qualify for AWBZ care. Under certain circumstances, however, Dutch people living abroad may be eligibility for voluntary AWBZ insurance as is specified in the Voluntary AWBZ Insurance Act.

The entitlements through the AWBZ scheme are described in the Decree on Entitlement to Exceptional Medical Expenses Insurance. This decree was recently modernized. Until April 1st 2003, the Decree on Entitlement to Exceptional Medical Expenses Insurance (Besluit zorgaanspraken Bijzondere ziektekostenverzekeringen) listed services for different target groups by type of care. Today, however, the AWBZ scheme works on the principle that people should continue living in their own homes for as long as possible, whether they receive their care at home or in an institution. For this reason, the entitlements are not defined in terms of categories of provider, but rather in functional terms. The entitlements to mental health care, care for the disabled, and nursing care are offered in terms of sector-independent descriptions. Seven functionally distinct forms of care are defined, which are listed in section 2.3. In addition the Decree on Entitlement to Exceptional Medical Expenses Insurance contains regulations about medical treatments, nursing equipment, dietary advice, long-term hospital care and long-term rehabilitative care, prenatal care, genetic counselling and vaccinations.

In the near future, more changes to the entitlements through the AWBZ are expected. In 2006 the Social Support Act (WMO) will be introduced. The WMO is the result of emphasising individual responsibility in health care, both at the insurance side as well as the provision of care side. Within this concept, the AWBZ will be stripped. Specific services will be transferred to the WMO. The AWBZ will only cover highly expensive care that is difficult to insure. The WMO introduces a new scheme for all Dutch citizens covering care and support in cases of protracted illness, invalidity or geriatric diseases. The main objective of this law is to manage the integration of people with limitations in society. The WMO covers forms of social support that stimulate persons to stay longer at home, e.g. home care activities. It also covers welfare activities, home adjustments and information and advice. The Act on Services for the Disabled (WVG), the Welfare Act and parts of the current AWBZ will be transferred under the WMO. The municipalities will be responsible for the operation of the WMO. This new law will make municipalities responsibility for home care, supporting and activating care, as well as the regulations for transport, client support and various subsidies. Municipalities will have to provide facilities in these areas, but entitlements are not defined specifically. Accordingly there will be a change in the status of these services.

1.5. Overview table

In the following chapters we will list the entitlements in the Dutch health care system. To allow for comparison across countries we used the OECD health account classification to identify health care facilities. The table below summarizes what chapters in the OECD health classification are covered by different entitlements defining documents in the Netherlands.



	Health Insurance Act (ZFW) and related directives									Exceptional Medical Expenses Act				
	general regulation: social Health Insurance Act	Medical Insurance Access Act 1998	Private Medical Insurance (Reimbursements) Implementation Decree.	Health Insurance (Treatment and Services) Decree	Health Insurance Fund (Provision of Pharmaceutic als) Regulation	Medical Devices Regulations 1996	Regulations Governing the Provision of Paramedical Assistance	Regulations on medical specialist care in the Health Insurance Act	Exceptional Medical Expenses Act	Decree on Entitlement to Exceptional Medical Expenses Insurance	Regulations on Entitlement to AWBZ care	Other entitlement defining documents	Excluded
Functional categories													
HC 1.1. to 1.3.3.	X	X	X	X					X			DTC system	
HC 1.3.9	X	X	X	X			X		X				
HC 1.4.	X	X	X	X					X				
transplantation	X	X	X					X					
plastic surgery	X	X	X					X					X
HC 2.1.	X	X	X	X					X	X			
HC 2.2 to 2.4.	X	X	X	X									
HC 3									X	X			
HC 4.1	X	X	X	X					X	X			
HC 4.2.	X	X	X	X									
HC 4.3.	X	X	X	X					X	X			
HC 5.1.1.	X	X	X	X	X				X	X			
HC 5.1.2.													X
alternative medicine													X
HC 5.2	X	X	X	X		X			X	X		Public Prevention Act	
HC 6.1	X	X	X						X			Public Prevention Act	
HC 6.2.				X									
HC 6.3				X							X		
HC 6.4	X	X	X	X					X				
HC 6.5												Disability (Reintegration Act	
Catalogues													
date passed	1964	1998	1986	1966	1996	1996	1996	2000	1967	2002	2003		
	act of			governmental	ministerial	ministerial	ministerial	ministerial	act of	governmental	governmental		
legal status	parliament			decree	decree	decree	decree	decree	parliament	decree	decree		
decision maker	parliament			government	minister	minister	minister	minister	parliament	government	minister		
purpose	implementation social health insurance			entitlements	reimbursement	entitlements	terms and con	entitlements	implementatio	entitlements	terms and conditions		
positive or negative	P			P	P	P	P/N	N	P	P	P/N		
decree of explicitness	areas of care			areas of care	items	items	areas of care	items (DTC)	areas of care	areas of care	items		
if itimised					goods	procedures		procedures			procedures		
updating	86, 99, 00, 01			not scheduled	with each positi	not scheduled	no	regularly	90,96,01	not regularly; n	no		
Criteria													
need					X				X		X		
effectiveness					X								
therapeutic value					X								
cost-effectiveness					X								
own responsibilty					X								
importance to public health					X								
usual care								X					
not listed	X					X		X					

2. Definitions of entitlements and benefit catalogues

There are two main statutory schemes that regulate patients' entitlement to health care. As noted above, the schemes partially cover the same services, depending on the duration of use. For that purpose the sectors of health care cannot be described by these schemes: instead the regulatory regimes need to be explored at a lower level.

2.1. Services of curative care

2.1.1. Curative care in hospitals (inpatient care or day cases)

The ZFW specifies a general entitlement to specialist care by hospitals. The ZFW does not distinguish entitlements to medical specialist care in terms of inpatient or outpatient services. Patients are entitled to medical, surgery and obstetric care by both modes of provision. The nature of the care available to those covered by the ZFW is defined in the Act itself and in more detail in the Health Insurance (Treatment and Services) Decree and the associated 'Regulations on medical specialist care in the Health Insurance Act'. The conditions upon which care is made available are also set out in these documents. Entitlement to hospital care may also exist under the AWBZ. The ZFW scheme pays only for the first 365 days of in-patient hospital care. If a client is hospitalised for longer, his or her subsequent care is paid for through the AWBZ scheme. If hospitalisation is no longer indicated for a client, but nursing home care is, up to a further four weeks of in-patient hospital care can be paid for through the ZFW scheme if a nursing home place is not immediately available; if more than four weeks' continued hospitalization is required, the cost is met through the AWBZ scheme.
The provided care and the amount of such care one may obtain through the scheme are limited merely by professional norms following the 'usual care' principle. Also the special area of care, haemodialysis, is therefore included, either at home or in a dialysis center (see 1.3 Services of curative home care). This entitlement is conditional upon the rule that a client is referred to the relevant specialist by a GP, by another specialist to whom a GP had referred the client, or, where obstetric care is concerned, by a midwife. Hospitalisation is only reimbursed if it is essential to the therapy. If a client is hospitalised, reimbursement is based on use of the lowest category of accommodation (third class). A ministerial regulation is used to further specify entitlements to specialist medical care, the Regulations on medical specialist care in the Health Insurance Act 2000. This regulation can be regarded an entitlements negative list. It considers two special categories of specialist medical care:

transplantation and plastic surgery. It specifies which type of transplantations are covered. Furthermore, it states that entitlement to some services (e.g. plastic surgery, prescribing of contact lenses) only exists if several conditions are met.

The Regulations on medical specialist care in the Health Insurance Act 2000 also excludes some services from funding because they are not considered usual care. For example, eyelid, ear or body sculpturing, IVF, uvoloplasty for people who snore, sterilisation or undoing sterilisation, and circumcision are not covered. These negative entitlements were added to the Regulations on medical specialist care in the Health Insurance Act 2000 on December 17, 2004 and are into force since January 2005. It should be noted that IVF is a special case: health insurers are subsidized to fund IVF treatment for the insured under the "Regeling Subsidies AWBZ and ziekenfondswet". As of January 2004, the first IVF attempt has to be paid out of pocket, but the next two attempts are reimbursed. For this purpose also some changes had to be made to the entitlements to pharmaceuticals. IVF medicines have been placed onto schedules 1A and 2 of the 1996 Health Insurance Fund (Provision of Pharmaceuticals) Regulation, to allow for conditional reimbursement (i.e. only for the 2nd and 3rd attempt). More details about the reimbursement of drugs is provided in the sections 2.5.1 and 3.1.

In the law the entitlements to medical specialist care are defined by the usual care principle. With the introduction of the DBC system – a new system for hospital financing based on Diagnosis Treatment Combinations (Diagnose behandeling combinaties, DBCs) - an effort has been made to describe all services that are provided in hospitals and to identify what services can be classified as usual care. This means that the DBC system offers a catalogue of medical care services. The taxonomy of this catalogue is described in section 3.3.

2.1.2. Out-patient care

Basic medical and diagnostic services

Medicinal and surgical care provided by general practitioners is covered under the ZFW, as specified in the Health Insurance (Treatment and Services) Decree. Such care involves mainly consultations and visits, the prescription of medicines, referral to medical specialists and minor operations. Entitlements to these services are defined implicitly: any amount of care consistent with professional norms is covered by the scheme.

Out-patient dental care

Only people up to the age of eighteen are entitled to dental care under the ZFW. A regulation made by the minister specifies the entitlements (Regulation dental care health insurance/

Regeling tandheelkundige hulp ziekenfondsverzekering). The dental care includes 14 types of services, among which periodic checkups, fluoride application treatment up to twice a year from the age of six, sealing and periodontal care. Since 1 January 2004, adults are no longer entitled to dental care under the ZFW. However, an adult can still obtain a full set of dentures through the scheme, because a set of dentures counts as a medical device. Furthermore, full dental care is available under special circumstances to clients who have special dental conditions or physical or mental disabilities, as well as to those who have special dental problems brought about by medical treatment.

Specialised health care

A general statement is included in the ZFW that patients are entitled to medical, surgical and obstetric services specialist services other than the ones that are delivered in the hospital (inpatient, or outpatient). This statement implicitly includes medical specialists services like allergology, chiropody, dietics, and optometrics, which are often provided outside the hospital. These services are reimbursed if patients have a referral from their general practitioner. There is no list of specific interventions that patients are entitled to within these medical fields. The Health Insurance (Treatment and Services) Decree merely states that any amount of care consistent with professional norms is covered. The general rule applies that only the first year of treatment is covered by the ZFW: it treatment takes longer the AWBZ covers expenses.

The ZFW and the associated Health Insurance (Treatment and Services) Decree also cover paramedical care. Paramedical care consists of physiotherapy, Mensendieck or Cesar remedial therapy, speech therapy and ergotherapy. From 1 January 2004, after the first nine sessions per indication, clients over the age of eighteen are entitled to physiotherapy or to Mensendieck or Cesar remedial therapy only for the treatment of chronic conditions that are defined in the Regulations Governing the Provision of Paramedical Assistance (Regeling paramedische hulp ziekenfondsverzekering, 1995). The first nine sessions are excluded from reimbursement. Clients under the age of eighteen are entitled to nine sessions per indication per calendar year, although a further nine sessions is sometimes available. Speech therapy is covered by the scheme, subject to the prior consent of one's health insurance fund. However, the scheme will not pay for such therapy for the treatment of dyslexia. Clients are entitled to up to ten hours of ergotherapy per calendar year.

Mental health care and psychotherapy

An exception to the way in which medical specialist services are regulated is mental health care, which is currently covered under the AWBZ. Also the first year of treatment is covered by the AWBZ and not by the ZFW, as is the case for other medical specialist services. The

reason is that psychotherapy is often a long and intensive treatment. Ambulatory psychotherapy is often reimbursed (maximal 25 sessions, 50 in the case of personality disorders). Referral by general practitioner or psychiatrists is required. A co-payment of about 15 euro is required for each session. Patients' entitlements to mental health care through the AWBZ include treatment (therapy sessions and medication), supportive guidance, and accommodation. Special regulations apply to mental health care in children and to treatment of addictions. Copayments apply.

The current situation in in the mental health care sector is widely perceived as unsatisfactory. In the current situation people with mental health problems may contact their GP, but many people seem to have reservations toward this possibility: less than a third of patients with mental problems actually seeks help (Ministry of Health Welfare and Sports, 1998). The GP then may or may not refer them to a psychiatrists or psychotherapist. Short- or long-term stay at a mental health care institution is also possible, i.e. at the psychiatry department of a hospital, at a psychiatric hospital, or at a institution for protective living. However, there are waiting lists for admission to mental health care institutions. The current referral system does not seem to adequately direct people to the mental health care facilities that meet their needs. The government wants to make mental health care more accessible, attune it to clients' needs and improve its quality, effectiveness and efficiency. It is therefore planning to reform and restructure the mental health care service. The objective is to make mental health care a part of the basic benefit package under the new Health Insurance Act and to move from a supply-driven to a demand-driven system. Many policy efforts already reflect this intention. For example, also in the mental healthcare sectors Diagnosis Treatment Combinations are being defined, as a step towards reform of the financing of mental health care services (see for more information on DBCs in general section 3.3). If this planned transition of mental healthcare from the AWBZ to the ZFW becomes effectuated, providers in this sector will have to contract with insurers and prices of services will be negotiated between these two parties like providers of other medical specialist services.

2.1.3. Services of curative home care

Several services of curative care may be provided at home. First, people covered are entitled to kidney dialysis at home or in a dialysis centre through the ZFW. If the dialysis takes place at home, the costs of training of the person carrying out the dialysis or providing assistance during the procedure are also covered by the insurance. The costs of inspecting and maintaining the equipment and the costs of the necessary chemicals and liquids are also reimbursable. In principle, a ZFW client is also entitled to the reimbursement of extra costs,

such as modifications to the home and special sanitary fittings and heating. Second, the ZFW regulates the use of treatment for chronic intermittent ventilation. People covered by the ZFW are entitled to treatment at a ventilation centre. A centre may lend the patient the equipment for use at home or in a location where several people can use the equipment. Specialist and pharmaceutical health care provided by or on the advice of the ventilation centre is also included. Authorization by the health insurance fund is required for the provision of this type of care.

2.2. Services of rehabilitative care

Patients in the Netherlands are entitled to rehabilitative care services. Rehabilitative care consists of examination, treatment and counselling of a specialist medical, paramedical, behavioural or rehabilitation-related nature. Such care may be accompanied by general care, nursing or full-time or part-time accommodation. The entitlements are regulated under the ZFW when duration is shorter than 365 days, and entitlements are regulated under the Exceptional Medical Expenses Act if the duration is longer than 365 days. A condition for the entitlement to short term rehabilitative services is that the health insurer is notified in advance and that the provider has motivated the request thoroughly. The entitlements under ZFW in principle last for a maximum of two months, as is described in the Health Insurance (Treatment and Services) Decree. When it becomes clear that the patient will need for a longer period, permission is needed from the health insurer to continue care. The insured remains entitled to rehabilitative care services, until a decision is reached about the application. Long-term rehabilitative care under the AWBZ is available only if a so-called Regional Indication Bodies (RIO) has established that this kind of care is most appropriate for the needs of clients. Regulations are the same for different types of rehabilitative care (inpatient rehabilitation; day cases of rehabilitative care; ambulatory rehabilitation; rehabilitative home care). Patients are only entitled to rehabilitative inpatient care when compared to day cases of rehabilitative care and ambulatory rehabilitation better results are expected.

2.3. Services of long-term nursing care

Entitlement to services of long-term nursing care are specified in the AWBZ and regulated by the decree on Entitlement to Exceptional Medical Expenses Insurance and the associated Regulations on Entitlement to AWBZ Care. Regulations apply to different of services of long-term nursing care, i.e. inpatient long-term care (nursing care), day cases of nursing care, and

ambulatory long-term care services (home care). Irrespective of the environment in which care is provided (at home or at an institution), through the AWBZ patients are entitled to:

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

Before a person is considered to qualify for AWBZ care, it is necessary to establish whether care is really required and, if it is, what type of care and how much care is needed. This information forms what is known as an indication. Indications are made by Regional Indication Bodies (RIOs). AWBZ care is available only if a RIO has decided that the insured person is in need of a particular type of care. A RIO is an independent organisation responsible for determining in an independent, objective and thorough manner what care is required. Note that a RIO does not hold responsibility for paying for or providing the services. Once an indication has been made, the client knows what he or she is entitled to. The client then has the choice of receiving his/her entitlement as care in kind from the provider of his choice, or in the form of a personal care budget; a combination of the two is also possible (Ministry of Health Welfare and Sports, 2004). Entitlement to reimbursement exists only insofar as no entitlement to care exists under any other insurance scheme.

A special area of in-patient long-term care is hospice care, palliative end-of-life care. This type of care is not explicitly listed as an entitlement. However, palliative services are sometimes offered in nursing homes, hospice centers, or volunteers. Health insurers who are responsible for the execution of the AWBZ may subsidize activities of these parties under the Regulation Subsidies AWBZ and ZFW, which in paragraph 2.7.10 regulates subsidies for the coordination of informal care and the development of palliative care networks (in Dutch: 'Coördinatiekosten Vrijwilligers thuiszorg en mantelzorgondersteuning' (CVTM)). The budget

available for these palliative care activities is determined on a regional scale, on the basis of the number of elderly people (65 years of age or older) living in that region compared to other regions. This budget may be used to subsidize activities of volunteers and so-called 'palliative care networks'. Nursing homes who offer palliative care may get an additional pay of 90€ per day, per patient. To qualify for this bonus, nursing homes must also belong to a palliative care network and have a palliative care unit. With respect to hospice and palliative care it should be noted that the transition to a demand driven system where a patient's entitlements are described in functional terms makes it possible for hospices and other palliative care centres to offer (part of) their services under the AWBZ. The patient after all is free to choose the institution (or volunteer if a personal budget is used) that will provide the care.

2.4. Ancillary services to health care

2.4.1 Laboratory test

The entitlement to other medical laboratory services is implicitly arranged. The entitlement exists as a consequence of the general statement that a patient is entitled to any form of diagnostic or curative treatment by a general practitioner or medical specialists that is consistent with professional norms. Consequentially, reimbursement is available for individual laboratory tests through the ZFW, when the general practitioner prescribes it. This category of care involves regular blood sampling, laboratory testing to determine blood coagulation times and advice from a thrombosis unit to the doctor in charge regarding the medicinal control of coagulation. The general practitioner fills out a test form that indicates what should be tested. A patient takes this form to a medical laboratory to undergo the test. The test results are sent to the general practitioner who discusses them with the patient.
The only laboratory tests explicitly mentioned are tests related to thrombosis prevention. The Health Insurance (Treatment and Services) Decree states that thrombosis prevention is also covered by the ZFW. This category of care involves regular blood sampling, laboratory testing to determine blood coagulation times and advice from a thrombosis unit to the doctor in charge regarding the medicinal control of coagulation. This entitlement under the ZFW exists in so far as no entitlements exist under health insurance arrangements. For people who get accommodation under the AWBZ all other medical services are also covered by the AWBZ, including thrombosis prevention. Contracts between health insurers and hospitals cover entitlement to tests related to thrombosis that are clearly related to hospital treatment.

2.4.2. Diagnostic imaging

Entitlement to diagnostic imaging is implicit in the entitlement to hospital care. All services that meet the legal requirements stipulated in the 'Besluit in-vitro diagnostica' (2001) might be offered. Some diagnostic services, however, are classified as 'exceptional medical services', and may therefore only be offered by hospitals that are licensed by the minister of health (i.e. megavolt- and brachytherapy).

2.4.3. Patient transport

Under certain circumstances, a ZFW-client with a medical condition may be entitled to transportation. Where an entitlement exists, the scheme reimburses the costs of medically indicated transportation by ambulance, taxi or private car. The doctor handling the case is accordingly required to confirm the indication. People covered by the ZFW are also entitled to the cost of the lowest class of public transport to and from a health care institution. In certain cases, a health insurance fund may give permission for special transport, for example by helicopter. A co-payment is charged for the use of transportation services; the minister decides the amount. Qualifying clients are required to pay the first part of any expenses incurred in a given twelve-month period in connection with travel by public transport, taxi or private car. Expenses payable in respect of travel by private car are based on an allowance per kilometre.

Where a patient travels from abroad, only the cost of travelling from the border or the airport is reimbursable. However, if a patient receives treatment abroad with the prior permission of and at the expense of a health insurance fund, the cost of the whole journey is reimbursable. People insured by a health insurance fund who live outside the Netherlands and return to their home abroad from the Netherlands only receive reimbursement for transport to the normal border crossing or the airport. However, if the patient is a frontier worker who works in the Netherlands and lives abroad, the entire journey to his or her home abroad is charged to the health insurance fund.

In addition, the AWBZ entitles some patients to transportation. This applies to patients who are entitled to receive supportive or activating guidance in an institution, may get their transportation costs reimbursed, insofar as this is medically necessary.

2.5. Medical goods dispensed to out-patients

2.5.1 Pharmaceuticals and other medical non-durables

Prescribed medicines

The compulsory Health Insurance Act (Ziekenfondswet, ZFW) regulates entitlements to pharmaceuticals and other medical non-durables on the national level. Pharmaceutical care includes the provision of medicines, dietary products for medicinal use and bandages. Not all registered medicines automatically qualify for reimbursement. The 1996 Health Insurance Fund (Provision of Pharmaceuticals) Regulation, based on the Health Insurance (Treatment and Services) Decree, regulates the entitlement of people covered by the public health insurance scheme to medicines that are dispensed outside of a hospital. Section 3.1 of this report describes the Regulation in detail. Only medicines that appear on a positive list (schedules 1A and 1B of the Regulation) are reimbursed. The definitions are uniform to all payers. Sometimes, however, limits are set to reimbursement (e.g. reimbursement is restricted to particular groups of patients, or only a particular medical specialist may prescribe it). The medicines for which this is the case are listed at Schedule 2 of the regulation. The minister of Health decides about inclusion of drugs in the benefit package. The Pharmaceutical Care committee (CFH) of the Health Care Insurance Board CVZ advises the minister. Health care insurers generally use the same list for people with private insurance.

Medicines dispensed in hospitals are part of the entitlement to hospital care. They used to be financed out of the hospital budget, whereby the insurer separately reimbursed an additional percentage (about 75%) of some expensive hospital drugs. As of 2005 they are financed as part of DBCs. The financing of hospital drugs is perceived as problematic as it leads to large variation in the availability of certain expensive drugs across hospitals and to referral of 'expensive' patients to specialised centres. A satisfactory strategy to minimize the problems of expensive drugs in the newly developed DBC structure is not yet available, because the current DBC structure does not always distinguish between patients who receive expensive medication or other cheaper drugs for the same condition.

Over-the-counter medicines

The 1996 Health Insurance Fund (Provision of Pharmaceuticals) Regulation that describes entitlements to pharmaceutical products indicates that OTC-drugs and homeopathic treatments are not classified as pharmaceutical care. People are therefore not entitled to reimbursement of OTC-drugs and homeopathic drugs. The reimbursement status of OTC-

drugs has changed frequently in the recent past. Until medio 1999 all OTC-drugs on prescription were reimbursed for everyone. In 1999 the reimbursement status of OTC-drugs changed: only people who needed to use OTC-drugs chronically (> 3 months) got their prescriptions reimbursed. As of January 2004, this exception was withdrawn, and OTC-drugs were for everybody excluded from the basic benefit package. Most over-the-counter (OTC-) drugs are still not included in the Dutch benefit package. As of January 2005, an exception is made for 5 groups of OTC drugs used by chronic patients (6 months or longer), namely:

- Laxatives
- Calcium tablets;
- Anti-allergics;
- Anti-diarrhoea drugs;
- Anti-emetics

2.5.2 Therapeutic appliances

There are different laws regulating patients' entitlement to medical devices. There are separate laws for people living at home and those who live in institutions. The laws also distinct different types of use: e.g. work related, living related, or health related. Devices that are designed for surgical implantation like stents or artificial hips are implicitly covered by the hospital budget.

The Services for the Disabled Act (Wet voorzieningen gehandicapten, WVG, 1996) states that municipalities are responsible for adaptation to houses or household appliances that patients may need to be able to elevate or reduce limitations of handicapped persons in the normal use of their homes (e.g. stair lifts), transport facilities, and wheelchairs. Often municipalities have contracts with selected providers for the provision of appliances.

The AWBZ covers medical devices for people who live in nursing homes or other AWBZ institutions, e.g. institutions housing people with mental disabilities, or institutions for revalidation. The institution decides whether a patient can own the device or gets it on loan.

Other medical devices are covered by the ZFW. This primarily concerns items that a patient may use at home. The cheapest suitable device is made available in all cases. The items in the package range from personal care materials (such as incontinence products and diabetes test strips) to appliances (for example hearing aids and orthopaedic footwear). All medical devices that are covered by the ZFW are explicitly listed in the Regulation medical devices 1996. Regular devices like glasses, orthopaedic appliances, and hearing aids are covered, as well as other medico-technical services (e.g. a stoma, mamma prosthesis, or

crutches). Sometimes the regulation specifies to what indication entitlements are limited. Co-payments may apply. The health insurer decides whether a patient can own the device or gets it on loan. The availability of medical devices under the ZFW used to be heavily regulated, but has been simplified recently. Since 1 January 2002, a client has not been obliged to seek the prior permission of his/her health insurance fund or instructions from a treatment provider in order to obtain a medical device. A number of the other procedural provisions of the Medical Devices Regulations 1996 have been dropped, such as the rules on the length of time for which a device may be used, rules on the replacement, modification or repair of devices and rules on device volumes.

Products that are contributing to occupational safety and health of employees are covered by the Disability (Re)integration Act (Wet op de (re)integratie arbeidsgehandicapten, WREA, 1998). The minister of Social Affairs and Employment is responsible for the Wet REA, not the minister of health. Examples of the type of services that are covered are: ergonomic devices to prevent repetitive strain injuries, transport facilities for the purpose of getting to work, Assistive Listening Devices for deaf people, and so forth. Cheap devices (less than 1.85 times the minimum daily income) are excluded. Also general devices are excluded (e.g. adapted bicycles).

2.6. Prevention and public health services

2.6.1 Maternal and child health; family planning

Obstetric and maternity care is covered by the ZFW. Obstetric care may be provided by midwives or general practitioners and consists of routine visits whereby blood and urine samples are analyzed, and weight and growth of the uterus are monitored. The maternity care is available at home or in an institution. Home care provided by a maternity assistant from a maternity care centre who looks after mother and child and takes care of domestic chores at the home of the insured. This care continues for twenty-four hours to eighty hours, spread over a maximum of ten days. The recipient pays a contribution per hour of home care or per day of in-patient care in an institution. Where in-patient care is provided in an institution, the recipient also pays any costs in excess of a certain daily amount.

Since 1 January 2003 municipalities are responsible for child health care (from 0 to 19 years of age) by virtue of the Public Prevention Act (Wet Collectieve Preventie Volksgezondheid, WCPV). Following maternity care, people can make use of a system for care and counseling that falls under the responsibility of municipalities. People do not have to pay for these services; municipalities are responsible for regulation and finance of these general services

of child health care. For children of 0 to 4 years care and counseling is offered by so-called counseling centers. These counseling centers monitor the development of each child and observe trends in the development of child health and the presence or absence of health risk. They offer referrals to specialists (e.g. speech therapy) if abnormalities or health risks are detected. They are the primary coordinator of all activities related to child health. For older children (4 to 19 years of age) child development is monitored at schools (see below).
Contraceptives are reimbursed by the ZFW, but reimbursement is limited to specific groups of people:

- Insured who are younger than 21 years of age
- Insured for whom levonorgestrel-releasing intrauterine system (IUS) is prescribed as progestogenic adjuvant therapy to prevent endometrial hyperplasia as a consequence of estrogen use by peri- and postmenopausal women or to treat menorraghia (excessive menstruation) if patients become anemic which is judged to be the case when hemoglobin levels are lower than reference levels that are used clinical guidelines.

2.6.2. School health

Dutch preventive adolescent health care is delivered by teams of school-physicians/nurses, health educators and epidemiologists of Municipal Health Services ('GGD-s') in cooperation with schools. 'JGZ'-interventions are individual- as well as community-oriented. All children from 4 to 19 years of aged are entitled to these services. For children who do not go to school after the exit of compulsory education at age 16, these services are coordinated by a regional "Meld- en Coördinatiecentrum".

2.6.3 Prevention of communable diseases

Vaccination protects both children and adults from infectious diseases. In 1957, a national immunization program was introduced, for which the Minister of Health, Welfare and Sport is responsible. This programme is financed through the AWBZ. The minister of health decides which vaccines the government vaccination programme covers. Art. 6 of the "Regeling zorgaanspraken AWBZ" describes what vaccines are covered and at what age vaccination is carried out. Children receive their vaccinations according to a schedule. In principle, people can be vaccinated against any disease against which the body reacts by producing antibodies.

- DKTP-Hib' vaccine: This inoculation combines the vaccines against a total of five dangerous infectious diseases: diphtheria, pertussis, tetanus, polio and Haemophilus influenzae B, carries out at The vaccination is carried out at age 2, 3, 4 and 11 months. Revaccination with the DKTP vaccine occurs at the age of 4 years and with the DTP vaccine at the age of 9 years.
- Measles, Mumps, and Rubella vaccine (MMR): Vaccination is carried out at 14 months. Revaccination occurs at the age of 9 years.
- Hepatitis B-vaccine is provided at the age of 2 months, 4 months and 11 months if one of the parents comes from a country where there still exists a large hepatitis B disease burden (listed in an annex of the regulation), or if the mother of the child is HbsAg-positive.

These vaccination services are supplied by the Municipal Health Services, for which the municipal authorities are responsible. The National Institute of Public Health and the Environment (RIVM) provides information on the prevalence of infectious diseases, and the Health Inspectorate monitors developments in this field. The RIVM also advises the minister on the newly developed vaccines that may be added to the immunization programme. For example, the RIVM is preparing an advice regarding the varicella vaccine that can be added to the MMR vaccine. Most infectious diseases are under control in the Netherlands. Although eight of the ten most prevalent diseases are infectious, they are not usually fatal.

People are in general not entitled to vaccines that are not included in the government vaccination program. The ZFW covers several vaccines, but limits are set to the entitlements; the ZFW only covers vaccines for defined 'at-risk' groups.

2.6.4 Prevention of non-communable diseases

The AWBZ covers prenatal screening for congenital anomalies. All pregnant women are offered a blood test after 12 weeks. Tests to investigate if the developing baby has Down syndrome or spina bifida are also only free for women who are at least 36 years of age or women with a family history of congenital anomalies. The AWBZ also covers postnatal tests for phenylketonuria, congenital hypothyroidism, and adrenogenital syndrome (PKU/CHT/AGS). National screening programs exists for breast cancer and cervical cancer. Adoption of a colorectal screening program is considered.

In addition to the above genetic counselling is covered by the ZFW. The available care consists of testing for genetic abnormalities using genetic testing (by means of ultra sound tests, or analyses of the family tree, DNA, chromosomes, and certain metabolites), genetic

counselling and related psychosocial support in a suitably licensed institution. If a genetic issue involving a ZFW client affects people other than the client, genetic counselling may be made available through the ZFW to these other people as well. A referral by the general practitioner or specialist is required.

2.6.5 Occupational health

The Working Hours Act (1996) and the Working Conditions Act (arbeidsomstandighedenwet, or short arbowet, 1998) are the main pieces of employment protection legislation in the Netherlands with regard to health and safety. The term working conditions signifies the entire range of public-law rules directed at protecting employees against influences connected with their work that endanger their health, safety and well-being. The Working Hours Act deals with the permissible total length of working life and daily and weekly working hours and rest periods, and also contained several specific provisions on the protection of young workers and women. Before 1996 this was regulated in the Labour act. The Working Conditions Act was introduced in 1980. The Working Conditions Act has a broad objective, i.e. the promotion of humane working conditions (quality of work). Given this breadth of scope, the Act takes the form of a framework law, with many of its Articles requiring more detailed implementing regulations to be enacted to give them practical meaning.

Under the Working Conditions Act, all employers are required to include in their company policy measures to avoid or reduce absenteeism and to monitor employees who are ill, and since 1 March 1996 they have been given an incentive to do so by the change from public to private provision for sick pay (see sickness benefit). Since 1 March 1996, following the enactment of a change to the Civil Code (Articles 1638c and 1638ca), employers are liable under private law to continue paying such employees at least 70 per cent of their normal pay (topped up where necessary to the level of the minimum wage) for up to 52 weeks. After this period of entitlement to a year's sick pay, the pre-existing public disability benefit provisions (AAW/WAO) come into effect. Responsibility for the enforcement of health and safety law lies with the officials of the Labour Inspectorate, now incorporated into the I-SZW .

3. Description of itemized benefit catalogues

In the Dutch health care system several catalogues that list a benefit package appear. These catalogues differ in the kind of

3.1. Medicine Catalogue

The Health Insurance Fund (Provision of Pharmaceuticals) Regulation, in Dutch Regeling Farmaceutische Hulp 1996 (RFH 1996), is a catalogue of all medicines that are covered by the ZFW. The RFH 96 is regularly updated, namely with each new medicine that gets covered. A pharmaceutical company applies for reimbursement of a pharmaceutical through administration of an application form of Farmatec (Farmacie en Geneeskundige Technologie), which is a unit of the Central Information Unit on Health Care Professions (Centraal Informatiepunt Beroepen Gezondheidszorg, or CIBG) that belongs to the ministry of health. With this request, all information that is necessary to come to a decision is provided. The minister of health decides within 90 days of the initial application. If the presented data are insufficient to reach a decision, the company gets the opportunity to provide additional data and the deadline for the decision will be suspended. It also happens regularly that (groups of medicines) are withdrawn from the regulation. There is no formal procedure that describes when and how the minister may cease funding of medicines. Since July 1993, however, several withdrawals were executed. For example, in 1993 alternative and homeopathic medicines were excluded, in 1994 and 1999 most OTC-drugs were withdrawn, and the reimbursement of contraceptives was limited to specific patient groups in 2004.

2.6.2 Provision of Pharmaceuticals Regulation and the Medicine Reimbursement System

For medicines that are included in the benefit package the RFH 96 executes a reimbursement policy that was launched in 1991, referred to as the Medicine Reimbursement System (GVS). For this purpose, the RFH consists of three schedules with medicines covered by the CVZ, schedule 1A, 1B and 2. Schedule 1A contains medicines with a reimbursement limit; schedule 1B contains a list of medicines without a reimbursement limit. The cost of the medicine is then reimbursed in full. Sometimes entitlement conditions apply. If that is the case a medicine is also listed on Schedule 2. Because decisions about reimbursement are taken monthly, the schedules 1A, 1B and 2 RFH are also updated on a monthly basis. Since the schedules have a legal status, all additions to the schedules 1A, 1B and 2 are published in the Staatscourant. Moreover, the current version of the three

schedules is available through the (Dutch) website: http://wetten.overheid.nl. On this website people can fill in the title of the law (h.l. Regeling Farmaceutische Hulp) to get the complete text of the law, which in this case also includes a comprehensive list of all products included in the different schedules is available for schedules 1B and 2. A list of all medicines included in schedule 1A is not published here, probably because of its size. To inform patients and professionals about the reimbursement status of different medicines, a website has been launched that can be consulted to find out the cost of a medicine, if it is covered, what part of the costs counts in the computation of no-claim, what part of the costs is a co-payment, and what medicines are available for replacement that are fully reimbursed (see <http://www.medicijnkosten.nl/>).

The structure of the GVS (schedule 1A) is that clusters are formed when a drug can be clustered with at least one other drug. The number of clusters is consequentially huge: over 400 clusters have been defined. In 2003 the total number was 436; it is likely that this number has increased since 2003 because medicines listed on schedule 1B may have come out of patent since (Pharmo, 2004). The GVS system is based on the ATC/DDD classification system, which is the Anatomical Therapeutic chemical Classification system with the addition of a measure of the assumed average maintenance dose per day for a drug used for its main indication in adults (Defined Daily Doses). In the ATC system drugs are classified into groups at 5 different levels.

1. The anatomical group (there are 14 main groups, identified by one alpha character)
2. Therapeutic main group (two numeric characters)
3. Therapeutic/pharmacological subgroup (one alpha character)
4. Chemical/therapeutic/pharmacological subgroup (one alpha character)
5. Subgroup for chemical substance (two numeric characters)

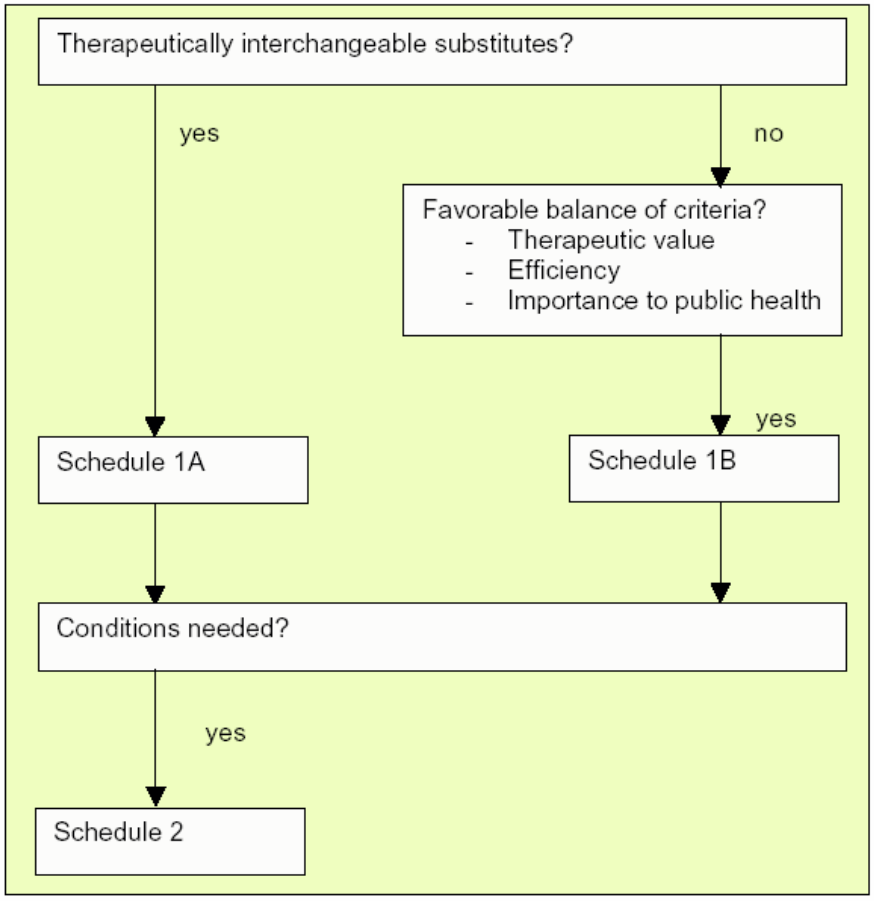
The clusters are usually identified by their ATC code at the level of therapeutic group or subgroup. For example, the GVS, schedule 1A categorizes antipsychotic drugs in 4 clusters in: there are two groups of oral antipsychotic drugs (cluster 1*N05AD*AO contains conventional oral antipsychotic drugs, cluster 4*N05AH*AO the atypical oral antipsychotic drugs), and two types of parenteral antipsychotic drugs (conventional antipsychotic drugs in cluster 2*N05AD*AP and conventional Long-acting depot antipsychotic drugs in cluster 1*N05AD*APD). In these cluster names the part derived from the ATC code is printed in italics.

2.6.3 Reimbursement decisions

Figure 3.1 illustrates the procedure for reimbursement decisions in the RFH. The Pharmaceutical Care Committee (Commissie Farmaceutische Hulp, CFH) of the Health Care

Insurance Board (College voor Zorgverzekeringen, CVZ) advises the minister on the inclusion of new medicines in the public health care package. In evaluating a new medicine they look first to see whether there are other medicines that are substitutes for the medicine concerned. Medicines that have a similar area of application and a comparable method of administration, with no clinically relevant differences in their properties and intended for the same agree group together make up a group (known as a 'cluster') in schedule 1A. If this is not the case so that only intake through schedule 1B is possible, the evidence about the

Figure 3.1 Reimbursement decisions RFH



(cost)-effectiveness of the medicine is evaluated. Next an advice to the minister is prepared. The decision of the minister not necessarily follows the advise of the CFH, because the minister uses a broader definition of importance to public health. Also budget impact and severity of the disease are considered. There is an accelerated evaluation procedure for medicines that are regarded as a breakthrough in the treatment of a disease.

A difference between schedule 1a and 1b is that intake of new medicines through schedule 1A will not increase pharmaceutical spending, while this is the case of medicines are placed onto schedule 1B. This is because medicines that are placed onto schedule 1A are considered me-too drugs and are clustered with their competitors. A reimbursement limit is

determined for each cluster by Farmatec. This is the maximum amount that will be reimbursed. If the price of a medicine is higher than the limit, the patient has to pay the difference. This system of clusters of interchangeable medicines with a reimbursement limit for each cluster is known as the Medicines Reimbursement System (Geneesmiddelen vergoeding systeem, GVS). The system has been structured in such a way that in theory there is at least one medicine in each cluster that is fully reimbursable. Since drugs manufacturers often tailor their prices to the reimbursement limits, it is seldom that a patient has to pay towards a medicine.

Intake of new pharmaceutical entities through schedule 1B does increase pharmaceutical expenditure, which explains why the intake procedure for schedule 1B is more restrictive. Schedule 1B has been closed from 1993 to 1999. Only drugs that offered the first pharmacological treatment option for a previously intractable condition were exempted in this period. In this period the system has been restructured. Since 1999 new drugs that are higher priced than existing substitutes may be reimbursed if efficiency and effectiveness requirements are met. The pharmaceutical company provides evidence on therapeutic value, effectiveness and the importance of the medicine to public health. A committee for pharmaceutical care (the CFH) within the Dutch Healthcare Insurance Board (CVZ) evaluates the available evidence and sets out its recommendations in an assessment report that is published on the Internet (<www.cvz.nl>). If the minister, having considered the CFH-report, decides that the medicine will be included in the package, it is put into schedule 1B. From 2005 onwards a pharmaco-economic study and budget impact analysis is formally required for new drugs with a premium price (during 2002-2004 the submission of a pharmaco-economic study was encouraged). Such study should be carried out and submitted by the manufacturer. In 1999 the Healthcare Insurance Board has issued guidelines for the pharmaco-economic part of such submission. These guidelines are currently evaluated and revised were necessary.

3.2. Catalogue of therapeutical appliances

The ZFW entitles patients to the use of medical devices. The Medical Devices Regulations 1996 specifies what devices are eligible for funding under what circumstances. This specification of circumstances is relevant because entitlements to devices may exist under the ZFW, the AWBZ or occupational laws, depending on the circumstances of use. The medical devices available under the ZFW are primarily items that a patient may use at home. In this case a general practitioner or other authorised physicians prescribes such a medical device. The items in the package range from personal care materials (such as incontinence

products and diabetes test strips) to appliances (for example hearing aids and orthopaedic footwear). However, to allow health insurers to enter into contracts with different providers, the catalogue only lists the type of devices that are made available, not individual products. Thirty-two different categories of devices are identified; for each category is explained what type of devices are included or excluded and under what conditions. Table 8.1 lists these different categories (source: art 2, Regulation medical devices 1996).

Health insurance funds are allowed to apply their own rules regulating the availability of medical devices, however, they are not expected to limit the length of time that such items are made available or to set volume limits. The process of deregulating medical device provision is underpinned by the principle that a client is always entitled to a suitable device. Because the rules explicitly state that this entitlement always exists, health insurance funds are obliged to make appropriate arrangements for the provision of spare or replacement devices. The withdrawal of the old centrally defined conditions was intended to enable funds to adopt a more customized approach to the provision of care. As such, most health insurers have established contracts for its insured population to receive devices with several providers. The decision about provider generally remains with the patient as he or she selects the device and determines his or her own need for services, but patients may have financial incentives to select providers within the network. The choice of provider depends on the type of device, the patient's preferences, or the preferences of the health insurer.

Since this catalogue lists types of devices and not the individual products of different providers, there is no periodic updating scheduled in the law. If new products enter the market for ZFW reimbursed devices, the manufacturer will usually make sure that the product fits into one of the reimbursed categories. On an ad hoc basis, however, changes can be made. The latest changes were on 1-1-2002 and 1-1-2003. The minister of VWS is responsible for these updates.

Table 8.1 Categories of medical devices that are covered by the ZFW

	Type of device
a	Prosthesis for shoulder, arm, hand, leg or foot
b	Breast prosthesis
c	Facial prosthesis
d	Ocular prosthesis
e	Ortheses for back (medical corsets), arm, leg, foot, head, and neck
f	Glasses, contact lenses, bandage lenses, special optical devices
g	Hearing devices
h	Incontinence products
i	Devices for contraception
j	Simple mobility devices (e.g. crutches, walking frames, rollators, white sticks for the blind)
k	Wigs and toupees
l	Hypodermic needle and syringe
m	External devices, to be used in long term compensation of functional decline of vascular channels in transporting blood or of lymph vessels in transporting lymph
n	Devices for diabetes care
o	Positive expiratory pressure devices
p	Portable flow regulator
q	Therapeutic shoes other than orthopaedic footwear
r	Feeding devices
s	Anti-allergy bed covers
t	Reading and writing technology for people with special needs, such as the visually handicapped, blind, and dyslexic
u	Lower or upper jaw prosthesis
v	Oxygen delivery devices
w	Lung vibrator
x	Inhaler
y	Computer monitor magnifying glasses
z	External electro stimulation device for pain management
aa	Continuous positive airway pressure (CPAP) device
bb	Computer equipment for speech recognition (Solo)
cc	Tactile devices for reading
dd	Replacement hearing technology (Bone Conduction)
ee	Non-motorized mobility aids (chair walker, bike walker)
Ff	Adapted furniture

3.3. Catalogue of medical specialist care

In the area of medical specialist care the law only describes an open system of the benefits included; a negative list is added to exclude certain services from funding. Recently however a new system has been introduced for hospital finance: hospital financing will be on the basis of a (negotiated) price per Diagnosis Treatment Combination (Diagnose behandeling

combinatie, DBC) from 2005 onwards. On January 1st 2003 the Ministry of Health, Welfare and Sport in the Netherlands introduced the DBC-system as an alternative to existing methods of reimbursement of hospital services. The overall aim of the system is to shift emphasis from a supply regulated system to one following demand, placing patient needs at the centre of stage. When fully implemented, cost prices and standard time respectively are then linked to this care profile and health insurers will be paying hospitals and medical specialists on the basis of DBCs. To apply this DBC system all hospital activities have to be mapped into one or more DBCs. The DBC system therefore can be interpreted as a catalogue that describes a large part of the Dutch benefit package.

A DBC is defined as the whole set of activities and interventions of the hospital and medical specialist resulting from the first consultation and diagnosis of the medical specialist in the hospital. This definition implies that the DBC describes both the diagnosis of patient and the provided treatment. The definition of treatment covers the whole path of a patient, including consultations, examinations and diagnostic procedures, treatment and evaluation of treatment (Oostenbrink, 2004). The procedure is that from the moment a patient sees a specialist in hospital from referral by a general practitioner, the specialist will set up a DBC for the patient. The DBC records every step in the patient's treatment, starting with the first consultation or examination and finishing with all final activities. This will constitute the complete care path of that patient. The care profile includes all hospital activities and the time effort of the physician. For example, a patient who has been consulting his GP several times with a sore throat may be referred to the otolaryngologist. At his first contact with this specialist, the latter will open up a DBC for this patient and not close it until the patient has been discharged. It also will be closed when the patient is referred to another specialist (in this case that specialist will open a new DBC) or when the patient dies.

The operationalisation of the DBC model requires the registration of all actions and activities and their mapping in the DBCs. Expert opinion was used to define DBCs en estimate duration of each procedure, on which basis the price is determined. An independent institution (DBC Zorg) validated estimated of time consumption of each the DBCs, by confronting time estimates with the actual time available in hospitals. Forty so called frontrunner hospitals made an enormous effort in piloting the resulting DBC system to ensure a complete and adequate registration of DBCs for each medical specialty and to calculate cost prices for all the relevant care activities. Now, nearly 3 years after the project was started, the project organization has a unique database with more than 1.5 million patient specific care episodes. On the basis of these care episodes the scientific associations of each Medical Specialty Society compiled a classification list of DBCs. The end result in 2003 was a summary of the care profiles in about 22.000 DBCs. This list has been extended in following years: in January 2005 already 105726 DBCs have been registered and priced.

The National Health Tariffs Authority (CTG/ZAio) keeps a central registry of all official DBC codes and sets a maximum price for each as long as competition on the prices is not introduced, i.e. the maximum price that hospitals may charge to a health insurer for the provision of that DBC.

The responsibility for maintenance of the DBC system has been delegated to a foundation (DBC-maintenance) that acts on behalf of the different private parties: hospitals, other health care institutions, medical specialist groups, health insurers and patients. This foundation is responsible for the further development of the DBC system, its management and maintenance (e.g. updating, consistency), and communication. The hospitals and health insurers are negotiating on the price. The government will remain responsible for decisions about inclusion of DBCs in the basic benefit package.

Table 8.2 Overview of the DBC-system at January 2005

		Number of DBCs				
AGB	Specialisme	List A[1]	List B[1]	Red list[2]	Orange list[2]	Product groups[1]
1	Ophthalmology	1789	3	18	14	15
2	Otorhinolaryngology	692	6		35	14
3	Surgery	3671	18	28	505	53
4	Plastic surgery	13712	63	205	544	33
5	Orthopaedics	3058	14	12	4	43
6	Urology	37717	950	116	174	38
7	Gynaecology	536	22	6	34	34
8	Neurosurgery	1253	27	15	13	29
10	Dermatology	396	10	32	33	11
13	Internal medicine	3335	19		612	49
16	Paediatrics	3492	10	9	12	61
18	Gastroenterology	10946	190		342	21
20	Cardiology	353			44	39
22	Respiratory medicine	1054	14	55	371	43
24	Rheumatology	2042	12	951	96	17
26	Allergology	599				8
28	Thorax surgery	1034		10	50	27
29	Psychiatry	648				3
30	Neurology	2739	18	44	61	43
35	Geriatrics	918				16
61	Radiotherapy	468			195	14
62	Radiology	13216			472	8
89	Anesthesiology	582		10	38	19
90	Clinical genetics	100				3
	Total	104350	1376	1511	3649	641

1 Published at the website of the National Health Tariffs Authority (CTG/ZAio): <http://www.ctg-zaio.nl/index.php>
2 Published at the website of the DBC-maintenance organisation, http://www.DBConderhoud.nl/_downloads/20050406_lijst_rode_DBCs.csv and http://www.DBConderhoud.nl/_downloads/20050418_lijst_oranje_DBCs.csv.

Table 8.2 lists the number of DBCs per medical specialty. This summary shows how many different DBCs are defined within a medical specialty distinguishing between list A (prices fixed until further notice) and list B (negotiated prices), how many are not covered by compulsory insurance: the "red" list. Also an "orange" list exists with DBCs for which reimbursement is conditional, e.g. DBCs that are only reimbursed for a specific diagnosis. Finally, the table shows how many product groups have been defined to cluster DBCs into homogenous price groups.

The total number of DBCs is huge. For example, over 10.000 DBCs have been defined in each of the specialties urology, radiology, plastic surgery, and gastroenterology. Clearly it is impossible for the hospitals to compute costs for all DBCs and then negotiate about the level of reimbursement with health insurers. Two strategies are implemented to reduce the impact of the transition to the DBC-system. First, negotiation on prices for DBCs is introduced step by step. At the moment (April 2005) the price is fixed for all DBCs in list A. Prices for the DBCs included in list B are subject to negotiation between hospitals and health insurers. These DBCs cover 10% of total hospital expenses and concern non-acute treatments. Negotiations of the prices for (parts of) the DBCs in the A segment is not due until sufficient experience is gained with the variable pricing in the B segment. Second, it has been recognized that a small part (about 20%) of the DBC determines a large part of the volume of resource use and the costs (about 80%). For that reason health insurers and hospitals can limit their negotiations to a subset of all DBCs. For that purpose the DBCs were categorized into 3 to 61 product groups per profession. The groups are formed such that they are homogeneous in terms of care profile and costs.

To facilitate the exchange of DBC information between different users, each DBC has received a code. The coding structure is universal across all medical specialties. The code describes 4 'axes' of information that are used in the definition of a DBC, which are listed below. For each of the axes in a DBC-code specification is possible at several levels: the components may simply be listed, or alternatively the components may be categorized into main groups or subgroups to group codes that belong together. The professionals in a medical specialty decide on the depth of information included in the DBC codes. Not all specialties use the same depth of information in their description of services, because they differ in the number of services that are provided or in the way in which the services are described.

- Type of DBC: generic to all specialties, e.g. regular first consult, follow-up visit, emergency services, consulting other colleagues.
- Nature of demand: specific to a medical specialty, e.g. within internal medicine a classification of the nature of complaints

- The diagnosis: specific to each specialty
- Type of treatment: e.g. inpatient, outpatient, surgery

Following the instructions of table 8.3, each medical specialty maps at least information on the axes regarding the 'type of DBC' and 'diagnosis' in the DBC code; the profession decides if also 'type of care' and 'treatment' are included in the codes. If information on type of care and treatment is omitted in the DBC list of a medical specialty, the digits allocated to that particular bit of information are filled with zeros. To deal with these differences between medical specialties, the maximum number of digits used in any medical specialty defines the number of digits allocated for a particular axis. If for other specialties a component of a DBC code is shorter than the allocated space, this part is filled up from the left with zeros until all positions are filled. Accordingly, each DBC can be uniquely represented by a label code that describes the medical specialty, the so-called ABG-code (listed in the table 8.2), and the code that describes the components of care per axes. These DBC codes are therefore the main vehicle in information exchange between different parties. On their bill patients find information on the DBCs they have consumed. Hospitals record what DBCs have been provided and charged to a health insurer.

Table 8.3: composition of DBC codes

Medical specialty	Type of DBC	Nature of demand	Diagnosis	Type of treatment	Letter indication*
ABG-code	DBC generic codes	Specialty specific codes	Specialty specific codes	Specialty specific codes	0, no 1, yes
2 digits	2 digits	2 digits	4 digits	3 digits	1 digit
Obligatory	Obligatory	Conditional	Obligatory	Conditional	Obligatory

*indication that in the DBC list of that specialty the code for the diagnosis is alphanumeric. This is the case in three areas of medical specialist care: allergology, gynaecology, and rehabilitation, which based their definitions of the diagnosis on the ICD-10. The algorithm a=01, b=02, z=26 is used to convert alphanumeric chapter codes that are used in the ICD-10 into digits.

The tariff of a DBC or product group is based on the hospital's costs and the medical specialist's workload. For this purpose the cost-price of the hospital for a certain DBC(s) is computed as well as the standard time required for this DBC(s) multiplied by the (still to be determined) hourly rate (the remuneration). CTG/ZAio publishes the fixed prices for the DBCs included in list A, and maximum prices for the honorarium component of the DBCs included in list B. When sufficient experience is gained by hospitals and health insurers with the application of the DBC system in their declaration and reimbursement policies, variation in price forming will be extended. In the final stage all prices of DBCs are the outcome of

negotiations between health care suppliers and health insurance companies. The DBC system differs significantly from the familiar Diagnosis Related Group (DRG)-system, as it is not merely a classification of patients according to some medical or economic indicator; the Dutch system covers also the activities that are performed to meet the demand of the patient. Both systems are case mix management systems, but in the DRG system, patients are classified afterwards on the basis of their main diagnosis at discharge from hospital, whereas in the DBC system, the initial need of the patient for care is the starting point of the registration. It is expected that this results in greater transparency between quality of care and the costs of care, which is essential in the transition towards a more demand-driven system where cost-containment through competition is the policy objective.

4. Discussion

How strictly defined is the benefit package?

In the Netherlands decisions about the medical services offered to a patient are often left to the physician (and/or health insurer), the professional norms of whom determine whether a service can be classified as usual care for a certain condition. This 'usual care' criterion is not very restrictive. It gives way to an expansion of the entitlements with growing medical and technical opportunities. Negative lists are in some functional categories used to exclude certain services (e.g. red and orange lists of DBCs). Irrespective of this regulatory device, however, policy remains quite liberal. The extent to which new or old technologies (therapy, diagnostic services and medicines) are provided to the patient in the context of a DBC is still left to the providers in the hospital.

For a long time only medical services (e.g. plastic surgery) for conditions that are not considered to belong to the domain of health care, were explicitly excluded. In recent years more heroic exclusions were carried through, e.g. limits to physiotherapy and psychotherapy for a lack of demonstrated effectiveness. Strong restrictive legislation actually only exists in the pharmaceutical sector where an itemised positive list exists of individual products that is frequently updated. For several other functional categories also positive lists exists, but these are only itemised to procedures and are not frequently updated: e.g. medical devices, and vaccines. All in all the Dutch system has not restricted medical consumption much.

As indicated previously the pharmaceutical sector is one of the few examples where there is a positive list of medicines that are reimbursed on the basis of ZFW. Here it is interesting to observe that the reimbursement of extramural drugs (prescription through the city pharmacist) is centrally regulated, while for the use of drugs in the hospital a liberal policy exists. Finance of these drugs comes from the hospital budget (and from DBCs in the future) and only the insurer separately reimburses some expensive hospital drugs. Insurer and hospital at the local level negotiate on the percentage of reimbursement (from 0-75%). This liberal policy leads to large variation in the availability of certain expensive drugs across hospitals and to referral of 'expensive' patients to specialised centres. This is not a situation that may continue much longer.

The role of practice guidelines

An important further way to influence service provision is through practice guidelines (compare NICE in the UK). Many disciplinary and interdisciplinary practice guidelines for both primary and secondary care exist, some of which are also based on economic evidence. In

the Netherlands, a government program to support the development of practice guidelines ran in 1998-2002 producing some 31 consensus guidelines for medical practice addressing 23 disorders across 7 ICD disease groups. The guidelines in this program were all evidence-based, the evidence including information on the cost-effectiveness of alternative treatment strategies. One example is the guideline for the use of cholesterol lowering drugs in primary and secondary prevention with strict rules for the prescription of statins according to the patient's personal risk profile. In the development of practice guidelines similar criteria are preferably used as in restricting access to the benefit package for, for instance, new medicines.

The influence of case law

Further delineation of the package is through jurisprudence. The committee for disputes on health services of the Health Insurance Board (CvZ) provides the opportunity for appeal and publishes the verdicts. Most of the cases concern medical appliances.

Structural reform

The Dutch situation differs from most of the European systems in the sense that a large part of the health care sector is financed through private insurance. The benefit package of the private insurance more or less follows that of the ZFW with some exceptions for specific insurance policies. This is going to change fundamentally with the introduction of the new Health Insurance Act in January 2006, which forms the final phase of the Dekker plan. The proposal to implement regulated competition in the markets for insurance and health care of the Dekker committee in 1987 has been of guidance to successive governments during the last 18 years. The principle characteristics of the plan were:

- Compulsory basic insurance
- Deposition of income related premiums into a central fund
- Allocation of risk adjusted capitation payments to insurers
- Comprehensive uniform benefit package described in functional terms
- Limited provider plans allowed
- Open enrolment

Now 18 years down the road we see a sophisticated formula for risk adjusted capitation payments to Sick Funds (to prevent cream skimming), a flat rate premium that has been introduced in 1989 (in 2005 the range of premiums was €239 - €455 per year), yearly open enrollment since 1992 and full risk sharing among Sickness Funds regarding their health

care expenditure. Since 1998 there is a new anti-trust law and anti-trust agency, which has recently become quite active in the health care sector. In 2007 compulsory basic insurance will be introduced as private insurance system under European law with a number of important public conditions (compare the characteristics described above). Some doubt that these conditions comply with the requirements of necessity and proportionality as formulated in art. 54 of the 3rd European liability insurance guideline.

Although the new system is regarded as private from the perspective of European Law the benefit package will be described in detail and securely delimitated. As has been mentioned above the package will be described in DBCs, which are or are not reimbursed. Currently it is being discussed how the definition of DBCs can be further detailed to include specific statements on which technologies to use in the treatment of patients. For instance, it may be that in the future it is specified in a DBC which hospital drugs should be available for treatment. The price of the DBC should then include the costs of those hospital drugs. Currently a so-called 'maintenance organisation for DBCs' is set up to assume the task of (re)defining DBCs and to tackle problems as discussed above. But the division of responsibilities for the definition of the basket in the new system over the various advisory and administrative bodies in the Dutch system is not yet clear. Also unclear is the basis for deciding on the benefit package and the extent to which the process will be 'evidence based'.

The reforms aim to reduce government control in the health care sector and to provide incentives to patients and insurers to become cost conscious. Health care should no longer be supply regulated but should follow the preferences of consumers. In that context it follows that entitlements are formulated in functional form rather than as specific facilities or services. This was already the trend in formulating entitlements of the AWBZ but will be true for all sectors with exception of those discussed above (hospital treatment and pharmaceuticals). It is still to be seen whether the local actors in the market will assume a role in further defining the basket or whether the government will as much as possible centralize decisions through a process or institute resembling the situation in the UK (NICE) or Germany.

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Legal documents: Abbreviations and translations*

English title	Dutch title (abbreviation)	Year
Health insurance act	Ziekenfondswet (ZFW)	1964
Health Insurance (Treatment and services) decree	Verstrekkingenbesluit ziekenfondsverzekering	1966
• Regulations on medical specialist care in the Health insurance act	Regeling medisch specialistische zorg Ziekenfondswet	2000
• Regulation dental care health insurance	Regeling tandheelkundige hulp ziekenfondsverzekering	1995
• Regulation governing the provision of paramedical assistance	Regeling paramedische hulp ziekenfondsverzekering	1995
• 1996 Health Insurance Fund (Provision of Pharmaceuticals) Regulation	Regeling farmaceutische Hulp (RFH)	1996
• Regulation medical devices 1996	Regeling hulpmiddelen	1996
Medical Insurance Access Act, 1998	Wet op de toegang tot ziektekostenverzekeringen (WTZ)	1998
Private Medical Insurance (Reimbursements) Implementation Decree	Uitvoeringsbesluit vergoedingen particulier verzekerden	1986
Exceptional Medical Expenses Act	Algemene Wet Bijzondere Ziektekosten (AWBZ)	1967
Decree on entitlement to exceptional medical expenses	Besluit zorgaanspraken AWBZ	2002
• Regulations on entitlement to AWBZ care	Regeling zorgaanspraken AWBZ	2003
• Regulation subsidies AWBZ and ZFW	Regeling subsidies AWBZ en ziekenfondswet	2000
Disability (Reintegration) Act	Wet op de (re)ïntegratie arbeidsgehandicapten (WREA)	1998
Public Prevention Act	Wet Collectieve Preventie Volksgezondheid (WCPV)	1992
Decree on public prevention	Besluit collectieve preventie volksgezondheid	1992
Act on Services for the Disabled	Wet voorzieningen gehandicapten (WVG)	1993
Social Support Act	Wet maatschappelijke ondersteuning (WMO)	2006
Working hours act	Arbeidstijdenwet	1996
Working conditions act	Arbeidsomstandigheden wet (Arbo-wet)	1998

* Dutch laws are full-text available on the internet: see http://wetten.overheid.nl. By default the law is presented that is valid on the date that the website is consulted, but older laws are also available.