



Quality in and Equality of Access to Healthcare Services

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Country Report for The Netherlands *March 2008*

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Addendums

Acronyms and abbreviations

ANBO	<i>Algemene Nederlandse Ouderenbond</i> National Association for Older People
AWBZ	<i>Algemene Wet Bijzondere Ziektekosten</i> Exceptional Medical Expenses Act
A&E	Accident and Emergency
BOPZ	<i>Bijzondere opnemingen in psychiatrische ziekenhuizen</i> Compulsory Admissions Psychiatric Hospitals
CBS	<i>Centraal Bureau voor de Statistiek</i> Statistics Netherlands
CBZ	<i>College Bouw Ziekenhuisvoorzieningen</i> Netherlands Board for Healthcare Institutions
CHD	Coronary Heart Disease
CIZ	<i>Centrum Indicatiestelling Zorg</i> Centre of Care Assessment
COA	<i>Centraal Orgaan Opvang Asielzoekers</i> Central Agency for the Reception of Asylum Seekers
COPD	Chronic Obstructive Pulmonary Disease
CVZ	<i>College voor Zorgverzekeringen</i> Health Care Insurance Board
DBC	<i>Diagnose Behandelcombinatie</i> Diagnostic Treatment Combinations
EHMA	European Health Management Association
EU	European Union
GGD	<i>Gemeentelijke gezondheidsdienst</i> Municipal Health Service
GP	General Practitioner
GGZ	<i>Geestelijke Gezondheidszorg</i> Mental health service
HIV	Human Immunodeficiency Virus
IGZ	<i>Inspectie Gezondheidszorg</i> Health Care Inspectorate

IND	<i>Immigratie en Naturalisatiedienst</i> Immigration and Naturalisation Service
LHV	<i>Landelijke Huisartsenvereniging</i> National Association of General Practitioners
KNMG	<i>Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst</i> Royal Dutch Medical Association
MOA	<i>Medische Opvang Asielzoekers</i> Community Health Services for Asylum Seekers
NAP	National Action Plan
NEMESIS	Netherlands Mental Health Survey and Incidence Study
NHG	<i>Nederlands Huisartsen genootschap</i> Dutch College of General Practitioners
NIVEL	<i>Nederlands instituut voor onderzoek van de gezondheidszorg</i> Netherlands institute for health services research
NPCF	<i>Nationale Patiënten Consumenten Federatie</i> Federation of Patients and Consumer Organisations in the Netherlands
NSR	National Strategy Report
NVK	<i>Nederlandse Vereniging voor Kindergeneeskunde</i> Dutch Association of Paediatricians
NZa	<i>Nederlandse Zorgautoriteit,</i> Dutch Healthcare Authority.
OECD	Organisation for Economic Co-operation and Development
PSTD	Posttraumatic stress disorder
RIVM	<i>Rijksinstituut voor Volksgezondheid en Milieu</i> National Institute for Public Health and the Environment
RVZ	<i>Raad voor de Volksgezondheid & Zorg</i> National Council for Public Health and Health Care
SCP	<i>Sociaal Cultureel Planbureau</i> Social and Cultural Planning Office
STD	Sexually Transmitted Disease
SVB	<i>Sociale Verzekeringsbank</i>
TB	Tuberculosis
VTV	<i>Volksgezondheid Toekomstverkenningen</i> Public Health Forecasting

VWS	<i>Volksgezondheid, Welzijn en Sport</i> Health, Welfare and Sports
WCPV	<i>Wet Collectieve Preventie Volksgezondheid</i> Collective Preventive Public Health Act
WMCZ	<i>Wet Medezeggenschap Cliënten Zorginstellingen</i> Participation (Clients of Care Institutions) Act
WGBO	<i>Wet op de Geneeskundige Behandelingsovereenkomst</i> Law on Contracts for Medical Treatment
WHO	World Health Organisation
WMO	<i>Wet Maatschappelijke Ondersteuning</i> Social Support Act
ZonMw	<i>Nederlandse organisatie voor gezondheidsonderzoek en zorginnovatie</i> National Health and Healthcare Research Fund
Zvw	<i>Zorgverzekeringswet</i> Health Insurance Act

Translation other terms:

<i>Algemene Rekenkamer</i>	Netherlands Court of Audit
<i>Belastingdienst</i>	Inland Revenue
<i>Bijzondere Bijstand</i>	Special social assistance
<i>Fonds Psychische Gezondheid</i>	National Mental Health Fund
<i>Gebruikelijke zorg</i>	Customary care
<i>Gezondheidsraad</i>	Health Advisory Council
<i>GGZ Nederland</i>	Dutch Mental Healthcare Association
<i>Huisartsenpost</i>	GP emergency station
<i>Koppelingswet</i>	Benefit Entitlement Residence Status Act
<i>Kwaliteitswet</i>	Law on Quality
<i>Sneller Beter</i>	Better Quicker
<i>Wet op de Beroepen in de Individuele Gezondheidszorg</i>	Law on Professions in Individual Health Care
<i>Wet Bijzondere Opnemingen in Psychiatrische Ziekenhuizen</i>	Psychiatric Hospitals (Compulsory Admissions) Act
<i>Wet Klachtrecht Cliënten Zorgsector</i>	Law on Clients' Right of Complaint
<i>Zorgbalans</i>	Dutch Health Care Performance Report
<i>Zorg voor Beter</i>	Making it Better
<i>Zorgtoeslag</i>	Health Care Allowance

Preface and acknowledgements

This report was compiled as one of eight country reports within the framework of a study funded by the European Commission through DG Employment, Social Affairs and Equal Opportunities (tender VT/2006/016: Quality and equality of access to healthcare services). The European study was led by the European Health Management Association (Philip Berman and Jeni Bremner) under the scientific direction of Dr. Manfred Huber of the European Centre for Social Welfare Policy and Research in Vienna.

The European Commission considers access to good quality healthcare services to be a prerequisite for the social integration of individuals and acknowledges that improving access to care contributes to mobilising the potential of the EU's workforce. Access for all to adequate health and long-term care, and the tackling of inequities in access are a priority objective for the streamlined EU Open Method of Coordination for social protection and social inclusion.

The objective of the study was to inform this process, and assist the development of more coherent and integrated policies in relation to access to health care as part of the further development of Member States' social inclusion strategies. The aim was to identify and analyse barriers to health care services access which are faced by vulnerable groups in society, and especially by those most exposed to social exclusion. The study looked at barriers emerging at health service supply side as well as service demand side. It also examined to which extent the organisation of healthcare systems may ease or reinforce such barriers. Another important element of the study was the review of various policy initiatives taken by the Member States to realise the objective of access for all, taking account of differences in the way healthcare systems are organised and the varying institutional contexts. The European Commission was particularly keen to be informed of policy measures to ensure access to health care to the most disadvantaged groups. Finally, the study was to help the Commission to determine the extent to which increased access to and quality of

health care services can contribute to combating poverty and social exclusion, and to increasing social inclusion.

The eight countries involved in the HealthQuest study were England, Finland, Germany, Greece, the Netherlands, Poland, Romania, and Spain. Country reports were based on existing material, including grey literature, policy reports, and interviews with stakeholders. All country reports were drafted along the lines of the same template.

The study built on earlier EHMA work on social exclusion and health access (Busse et al, 2006; Tamsma and Berman, 2004), the results of which informed the choice of barriers under consideration. In addition, specific health service access challenges faced by specific population groups, i.e. migrants, asylum seekers, and illegal immigrants; older people with functional limitations; and people with mental disorders were analysed. These groups were chosen in consultation with the European Commission.

Given the aims and objective of the overall study, this report is written with the EU's social inclusion agenda in mind. It should not be perceived as an assessment of the performance of the Dutch health care system or the health services provided in the Netherlands. Instead, it is a modest attempt to acquire more in-depth understanding of the dynamics between health care access, poverty, and social exclusion in a country that has made a recent transition to a more market-oriented health care system.

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1 Introduction

1. 1 Country profile

1.1.1 The Dutch health care system: current situation after major reforms

The Dutch health care system has been subject to major reforms that impact on all elements of the system. The reforms focus on coverage, finance and entitlements rather than on restructuring of provision. Reforms of long-term care started in 2003 and are still ongoing, while the major health care sector reforms took place in 2006. In 2007, a new compartment was created when purchasing of social support services was shifted from the long-term care compartment to the local authorities.

The reforms aim to forge a more efficient system in terms of costs as well as quality. Market forces are the key driver in achieving this, with service providers, health insurers –or local authority commissioners- and patients as main players in that market. Client-centeredness is another key issue underpinning the reforms. As health service clients, patients are to make informed choices on a transparent market. Meanwhile, that same patient is expected to develop more cost-awareness and accept more individual responsibility for his or her own situation and health. In spite of the emphasis on client choice, the health insurers ultimately are the main negotiator on the market.

Reform of acute health care coverage

Centrepiece of the reforms is the replacement of the two-tiered system of social and private (voluntary) health insurance covering curative health care services. As of January 2006, both elements have been integrated and replaced under the Health Insurance Act (*Zorgverzekeringswet, Zvw*) by one single mandatory private scheme providing coverage of a standard service basket. The Ministry of Health describes the new system as one based on private health insurance with

social conditions¹. It sets the content of the standard package (see chapter 2) and has put in place a range of other measures to secure access. As of 2007, the health insurance market is supervised by a new independent legal administrative body, the Netherlands Care Authority (*Nederlandse Zorgautoriteit, NZa*).

Private health insurance companies have to accept everyone who applies for coverage of the basic package and are to charge all clients the same premium for that package, irrespective of age, income or health status. Insurers are to compete for clients and are allowed to make profits. They can also offer a range of complementary packages, this time under no obligation to accept applicants. They are to negotiate good quality, yet affordable care packages for their clients with the health care providers.

All Dutch residents are obliged to take out health insurance, thereby entering into an arrangement with health insurers under private law. They pay a nominal premium. Children under the age of 18 do not have to pay a nominal premium. Client choice is reflected in the system changes in many ways: clients have free choice of insurer, may opt for complementary coverage and/or for a personal excess, and need to choose between a benefit-in kind policy or a reimbursement policy. Last but not least, clients can also decide to join a collective arrangement: in which case the collective will negotiate a total package for them and will therefore also make these decisions on the behalf of its members. Government introduced a no-claims bonus in the system to stimulate clients' costs-awareness (see 2.4 for more information)².

Reform of coverage of long-term health services

'Uninsurable' risks such as those related to chronic illness, in-patient mental health services, long-term rehabilitation and nursing care, and care for people

¹ See also <http://www.minvws.nl/en/themes/health-insurance-system/default.asp>

² For a brief description of the new system see http://www.minvws.nl/images/boekje-zorgstelsel--engels_tcm20-107938.pdf.

with disabilities are universally covered via the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten, AWBZ*). The AWBZ was –and still is- unique in its kind in Europe (Wörz and Foubister, 2006).

Recent modernisation of the AWBZ introduced function-specific entitlements aimed at supporting market development, client orientation and client choice. Modernisation also aimed to narrow the scope of coverage: costs of care and housing were split -and housing costs were to be borne by the client-, and coverage of treatment-oriented provisions was shifted to the Zvw. When the Social Support Act (*Wet Maatschappelijke Ondersteuning, WMO*, see below) came into force in 2007, coverage of social support, services for alcohol and drug addicts, public mental health care and prevention, domiciliary care, and support for informal carers was shifted to local authorities. Reforms in 2007 also saw financing of forensic psychiatry being shifted to the Ministry of Justice. In 2008, treatment-oriented mental health care services will be shifted to the Zvw. Consequently, the AWBZ now only covers long-term care and high-cost treatment services. Premiums are income-related and levied as part of the income tax system.

New compartment for locally driven social support

The Social Support Act (*WMO*) came into force in January 2007. It introduces a new scheme for all Dutch citizens covering care and support in cases of protracted illness, invalidity or geriatric diseases. It incorporates elements of the Exceptional Medical Expenses Act -see above- as well as legal frameworks on disability services and social welfare. Essential element in the change is a shift of responsibility to local authorities, aiming to support participation of all citizens to all facets of the society through the development of an integrated and cohesive local policy on social support, living and welfare³. Along with

³ See also <http://www.minvws.nl/en/themes/social-support-act/default.asp>

responsibilities, the budget for home help services has also been transferred to local authorities.

Implications for integrated care

Newly defined system compartments create new interfaces and hence may result in new interface problems. Initial signs indicate that these may be most imminent for people with long-term care and support needs, including older people and people with mental disorders.

Implications for policy

Against the backdrop of the recent health system changes, the role of government is changing. Its key role is now to safeguard public interest as regards the health care market, in particular as regards access, quality and financial sustainability. Government has taken a step back and this is reflected in the type of government policies. Government can be expected to take less proactive steps that could be interpreted as 'interfering' with the roles and responsibilities of key players on the health care market.

1.1.2 Additional comments: government change

In February 2007, a new government came into power in The Netherlands. It will not undo the health system reforms of the previous government, but further market-oriented shifts –for instance with regard to the *AWBZ*- are expected to be implemented at a much slower rate, if at all.

In their initial communication to parliament, health ministers Klink and Busschemaker acknowledged the needs of an increasingly vocal, assertive and demanding Dutch patient population. They also stressed government will be vigilant the needs of very vulnerable patient groups, such as sub-populations of older and disabled people and/or people with psychiatric disorders are also met. Quality of health and long-term care, and patient rights and empowerment are among the five key issues the new government intends to focus on. Government will continue to stress the importance of citizen's individual responsibility for their own health (Ministry of Health, Welfare and Sports, 2007a).

Changes have also been suggested in the scope of the standard health insurance basket (see further 2.3.1): oral contraceptives will be included, as will annual dental check-ups for adults⁴. The no-claims bonus will be replaced by another measure aiming to increase cost-awareness. Thus, a € 150 excess will be introduced in 2008 (see also 2.4)⁵⁶.

1.2 Promoting social inclusion through policy action at the system level

1.2.1 Salient socio-economic information

Overall poverty risk in the Netherlands (11%) is one of the lowest in the EU-25, where the average risk is 16%. Poverty risk is particularly low for the Dutch population above 65 years (5%, against 19% for EU). There is a strong ethnic dimension in poverty risk: ethnic minorities account for 23.4% of the total number of minimum-income households. Single parents (especially women) are over-represented in the number of minimum-income households. These households also face the highest inactivity trap. The overall unemployment trap also remains high: 83% in 2005 (European Commission, 2007).

Life expectancy at birth (76.9 for males and 81.4 for females in 2004) is above the EU average (75.1 and 81.2 for males and females in 2003). The Netherlands is one of the Member States with the lowest old-age dependency ratio (65+ population as a share of 15-64) and is projected to remain at a relatively low level in 2050 (European Commission, 2007).

⁴ <http://www.minvws.nl/dossiers/veranderingen-in-de-zorg-2006/nieuwsberichten/tandarts-terug-in-basispakket.asp>

⁵ http://www.minvws.nl/images/z-2805508b_tcm19-154216.pdf

⁶ <http://www.minvws.nl/en/nieuwsberichten/meva/2007/cabinet-approves-compulsory-health-insurance-excess.asp>

Unemployment is low compared to the EU average in 2005 (4.7% against an EU-average of 8.7%). Within the Dutch population, the gap in employment rate between non-EU nationals and EU nationals is 13.9%. This is above the EU-average of 8.1%. This gap is also visible in national data on employment rates (46.9% for ethnic minorities compared to 65.6% for the remaining population, 2005)

Socio-economic status is related to health status and to health care utilisation. People from lower socioeconomic strata in the Netherlands use more health care services. This is partly due to the fact that they suffer from more illnesses. Social life circumstances, extra costs incurred for health care services or other constraints or inconveniences reducing access to health services also play a role, however (Droomers and Westert, 2005).

Social exclusion in the Netherlands is primarily related to poor health and only in second instance to low income. There is also a strong correlation with mental well-being; more so than with paid employment (Jehoel-Gijsbers, 2004).

1.2.2 The Netherlands' NAP 2003 -2005

The Netherlands' NAP 2003-2005 (Government of the Netherlands, 2003) focused strongly on employment and social participation issues, and paid scant attention to health care. The plan did identify ethnic minorities, older people and –to a lesser extent- one-parent families and single households as being at specific risk for poverty and social exclusion, but it did not address their specific needs in terms of health and health care access (Tamsma and Berman, 2004).

One of the NAP targets was to improve the health situation of people with a low socio-economic status by extending their life expectancy by three years, from 53 in 2000 to 56 in 2020. This was partly to be achieved by improving the accessibility and effectiveness of health care for this specific group, but no mention was made as to how this was to be achieved. The plan also included objectives for the reduction of waiting lists for mental health services and care for the disabled, but again without providing clarity about the way in which this was to be achieved.

In their updated NAP Social Inclusion 2003-2005, the Netherlands did report three measures aimed at improving access to health care. One of these made reference to the reduction of mental health care waiting lists from 75,100 people waiting in 2003 to 66,300 in 2004. Two policy measures were related to the compensation of health care cost via tax reimbursement and social assistance schemes (see further 2.4).

1.2.3 National Strategy Report 2006 – 2008

The National Strategy Report 2006-2008 (Government of the Netherlands, 2006) provided an opportunity to address the interaction between the various policy areas involved in the EU social protection agenda. This includes options for mutual beneficial measures as regards the modernisation of health and long-term care on the one hand, and social inclusion on the other.

In contrast to the NAP 2003-2005, the report does acknowledge the contribution of good-quality accessible health care to the economy. Health care can help to ensure people live longer and healthier lives, and consequently to maintain a healthy workforce and make work pay for social protection.

At more individual level the relevance of health is emphasised in the section on poverty and participation. Government perceives health as one of four major factors enhancing citizens' chances of emerging from poverty through work, the other three factors being education, command of the Dutch language, and benefit dependency.

This contribution of health and health services to social inclusion and prosperity is not translated in concrete measures to improve access to and responsiveness of health care services for people living in poverty and/or at risk of social exclusion. The one exception to this is formed by the financial compensation measures for health care costs that have been put in place (see 1.1).

Employment and active participation are key to many Dutch policy targets and so is the ability of citizens to take individual responsibility for their own situation. It is noted that the 2006 Health Insurance Act creates incentives not only for the

efficient use of care, but also for the acceptance of personal responsibility. Those who are unable to perform paid work are 'encouraged toaccept personal responsibility either by acquiring the competences that will allow them to perform paid work in the future or by performing some other useful service for society, for instance by providing informal care' (National Strategy Report, 2006, p.2).

The report does not focus on measures that support vulnerable groups who may have difficulty taking individual responsibility on the now liberalised *health care purchasing* market⁷. This is in contrast with measures that are included in the national action plan aimed at improving skills of people at risk of poverty so they can assume their individual responsibility on the *labour* market.

Referring to RIVM's 2006 national health report (Den Hollander et al, 2006), the National Strategy Report (NSR) acknowledges the healthy life expectation of lower income populations is still an issue of concern. In contrast to the 2003-2005 National Action Plan, this has not led to the formulation of any specific targets. Instead, the 2006-2008 report states work on this issue is sufficiently incorporated in mainstream policies.

Improving the health of lower income groups is to also a responsibility of local government and indeed the 31 largest cities of the Netherlands have pledged to take concrete measures to this effect. The NSR refers to a concrete example of the role local authorities can play here through collaboration of two services delivered under their responsibility: preventative school health and income support. When school nurses identify specific health needs of children but poverty stands in the way of their parents addressing those needs, the parents can be referred to the local authorities' income support department. There, they will be encouraged to apply for special social assistance (*Bijzondere Bijstand*, see also 2.4.7) that may help them to meet the costs.

⁷ It does, however, refer to the legal obligation of health care insurers to accept all citizens applying for the standard basic health policy package, and to the health care allowance for lower-income groups.

2 Major barriers of access

2.1 Introduction

Within the Dutch health system, Dutch residents have a right to receive long-term care –based on the *AWBZ*- and a duty to take out health insurance –under the *Zvw*- . Their contract with the health insurer then forms the basis for their access to health care services.

As highlighted in chapter 1, safeguarding public interest and values within the context of the health care market is a key role for government. This calls for thorough and consistent monitoring, particularly as regards access, quality and financial sustainability. A key instrument in this process is the Dutch Health Care Performance Report, focusing on quality, access and costs and published bi-annually by the National Institute of Public Health and the Environment (see also 2.9).

The first assessment (Westert and Verkleij, 2006) was intentionally carried out prior to the major market-oriented systems reforms. It presented a broad picture based on 125 indicators. The main outcomes with particular relevance to the interface of access, quality and social inclusion can be summarised as follows:

- In general, the Dutch health care system is accessible;
- Co-payments, as a percentage of the total health care expenditure, are low compared with other OECD countries (OECD, 2005);
- Levels of vaccination and of participation in screening programmes are high;
- Waiting lists and waiting times have decreased considerably. Waiting is not problematic for 80% those waiting for elective hospital care;
- Regional differences in geographical access to essential health care services are small.

- One-third of the people with mental problems actually contact mental health care services for help;
- While mental health care offers effective prevention programmes, their uptake is limited;
- Access to care differs little across population groups. This also holds for groups with a low level of education and for immigrant groups. However, under-utilisation of care persists in some subgroups and for some health care services;
- Between 1997 and 2003, people with a chronic illness spent an additional 500 euro per year on illness-related costs;

The report also warns to remain vigilant in ensuring access to care in disadvantaged areas and for marginal groups (notably uninsured, illegal immigrants and the homeless) because of the volume and the nature of the health problems presented and their relation with other problems such as lack of insurance cover. Financial access to health care for the chronically ill is identified as a continuing issue for concern: people with multiple physical and functional limitations are considered particularly vulnerable, as they often have to negotiate high health care cost yet have to rely on lower income.

2.2 Population coverage for health care under public programmes

2.2.1 Main system of coverage: standard service basket

The 2006 Health Insurance Act (*Zorgverzekeringswet, Zvw*) has done away with the previous two-tiered system and created one single mandatory scheme. This provides coverage of a standard service basket (see 2.3) through private insurance. All Dutch residents thus are legally obliged to take out health insurance on a privatised health insurance market: a 'resident' beings someone who is registered as such with a local authority. The obligation also applies to

non-residents paying income tax in the Netherlands (predominantly cross-border workers)⁸.

Exemptions, but otherwise covered

Specific arrangements exist for the following groups for which exemptions apply:

- Seafarers, who are insured via the AVZV (this applied to an estimated 3800 people);
- Individuals insured under responsibility of the state, in particular:
 - o military personnel, and
 - o asylum seekers

Foreign citizens who have applied for either temporary or permanent asylum status are covered for health care costs via the Ministry of Justice pending the asylum decision process⁹. Coverage through this *Ziektekostenregeling Azielzoekers* is similar to the *Zvw* standard health care basket (see 2.3). Preventative services are contracted in through the Community Health Service for Asylum Seekers (*MOA*). See chapter 3 for more information on the situation of asylum seekers.

People who have applied for temporary or permanent *residence* are not covered via this arrangement. They can take out travel insurance or private health insurance. For people with formal refugee status, regulations for Dutch residents apply.

⁸ For people entitled to Dutch social security and/or pensions living in other EU/EEA countries special conditions apply. Their entitlements are mainly related to service provision in their home country. Analysis of cross-border provisions is beyond the scope of this report.

⁹ Source: www.denieuwezorgverzekering.nl

Exclusions

Illegal immigrants are excluded from entitlements to any social protection, including the coverage of health care costs. Their situation is further discussed in Chapter 3.

POLICY EXAMPLE:

SAFEGUARDING POPULATION COVERAGE WITHIN A PRIVATE MARKET SYSTEM

Because population coverage is arranged through private insurance, it could be argued that the Netherlands does not have a public programme anymore. Government has, however, put several social safeguards in place. It sets the content of the standard service basket (see 3.2) and has taken measures to ensure access, quality and solidarity.

Some of these measures focus on maximising population coverage:

- Health insurers are legally required to accept everyone applying for coverage of the standard health service basket, irrespective of the applicant's age, gender or state of health. Thus, risk selection is not allowed.
- Health insurers must offer coverage subject to the same conditions and for the same prices to all their customers. While the insurers can set their own price for the standard -and additional- packages, every customer taking out the same policy will be charged the same insurance premium. They are therefore not allowed to charge 'high-risk customers' higher premiums.

To financially compensate health insurers for the consequences of this obligation, government has created a risk structure compensation fund. Roughly 90% of this fund is created through income-dependent contributions from citizens, the remaining part is paid out of the government budget (Ministry of Health, Welfare and Sports, 2005a).

2.2.2 Complementary health insurance coverage

Citizens can opt to take out complementary health insurance to cover services that are not included in the standard package. They can only do so with the same insurance company that also covers their standard package. In 2006, 95% of all insured Dutch residents opted to take out some form of complementary insurance, even those in good health and those expecting to take up very little health care. Choice between standard only or complementary coverage seems related to age and gender factors: older people and men are overrepresented among the 5% that opted for standard coverage only. Covering costs for physiotherapy and/or dental care were important reasons to take out complementary insurance (De Jong et al, 2006a).

The health insurer is under no obligation to accept the application for complementary cover. However, at the onset of the system changes in January 2006, the Ministry of Health and insurers agreed a one-off arrangement to accept all applicants. In spite of this, 2% of the Netherlands Health Consumer Panel reported having to fill in a health status statement (De Jong et al, 2006a).

2.2.3 Coverage of long-term care

Costs of non-curative long-term care related to chronic illness, in-patient mental health services, long-term rehabilitation and nursing care, and care for people with disabilities are covered via the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten, AWBZ*). Premiums are income-related and levied as part of the income tax system. Coverage is universal, applying to the same population as the *Zvw*: residents and non-resident workers paying income tax in the Netherlands.

2.2.4 Coverage of mental health care

The recent health system reforms are also resonating the mental health field. Previously, all mental health services were covered via the *AWBZ* and people with mental health problems did not have to think about which compartment of the system would cover what part of their needs, or worry about co-payments for treatment.

While mental health care was and will remain primarily covered through the AWBZ, coverage of public mental health care and prevention has shifted to the new WMO (NZa, 2007). Financing of forensic psychiatry is now the responsibility of the Ministry of Justice. In 2008, this will be followed by several treatment-oriented services including ambulatory psychiatric care being shifted to the Zvw.

2.2.5 Non-insurance

Contrary to the situation before 2006, people at risk of social exclusion are no longer automatically covered for health care costs. The European Commission therefore noted a non-negligible number of individuals may end up without insurance cover owing to a lack of information or an unwillingness to register with a health insurer (European Commission, 2007).

In May 2006, 1.5% of the population were indeed uninsured: approximately 241,000 Dutch residents, including 40,000 children. People without legal residence status are not included in these numbers. Among people relying on some form of social benefit, the proportion of uninsured is relatively low: 0.7%. To a lesser extent, this is also the case for people on income support (1 % of whose do not have standard insurance cover)¹⁰. It is not clear to what extent this may be due to the role of local authorities as collective health insurance purchaser (see 2.2.6).

Lack of health insurance cover is relatively more frequent among people from minority ethnic communities: more than 4% of the immigrant population are not insured, against less than 1 % of the native Dutch population. First generation migrants are four times as likely to be without insurance cover.

¹⁰ Source: CBS Press release PB07-034 on <http://www.cbs.nl/NR/rdonlyres/8D1AE59C-60A2-4998-9DB9-1089F21C21BA/0/pb07e034.pdf>

Nearly 60% of all children without insurance cover are from immigrant populations. Mostly, the parents of uninsured children are also uninsured themselves. Under the new insurance system, no premium needs to be paid for children under the age of 18. Financial constraints may therefore play a less important role here¹¹.

Any comparisons with the situation prior to the reforms are complicated by the fact that the old system -by its very nature- excluded approximately 30% of the Dutch population from social health insurance coverage. In 2004, the number of uninsured was estimated at 223,000 or 1.4% of the total population. In absolute numbers, this is similar to the situation in May 2006

The social health insurance exclusion criteria such as high income level and self-employment were, however, partly reflected in the composition of the group that included self-employed and/or free-lance workers as well as millionaires. Homeless people were also among the uninsured population, as were people who were refused on grounds of health selection criteria or neglected payments, and religious conscientious objectors (Westert and Verkleij, 2006).

2.2.6 Exclusion from health insurance coverage: consequence of persistent non-payment?

By December 2006, over 240,000 people persistently (for more than six months per year) failed to pay their health insurance premium over the 2006 financial year (Ministry of Health, Welfare and Sports, 2007b). At the onset of the health system changes, the Ministry of Health reached an agreement with health insurers on the potential sanctions that could be imposed on these 'negligent payers'. According to this agreement and as of July 2007, health insurers would be allowed to strike clients from their books who had persistently failed to meet

¹¹ Source: CBS Press release PB07-034 on <http://www.cbs.nl/NR/rdonlyres/8D1AE59C-60A2-4998-9DB9-1089F21C21BA/0/pb07e034.pdf>

their payment obligations. In the summer of 2007, Ministry and health insurers agreed the individual policies would not –yet- be cancelled¹².

Health insurers are obliged to accept previously uninsured clients and offer them coverage against regular insurance fees. They do not, however, have to re-accept applications from their former negligent clients. These clients will therefore have to turn to another health insurer, who will then have to accept them.

It is too early predict whether this will lead to a circle of negligent payers who annually migrate from one health insurer to another. Given the recent mergers on the health insurance market –and the reduction of the number of different health insurers on that market-, persistent non-payers may ultimately face exclusion.

The law also requires the insurer to impose a fine on negligent payment: 130% of outstanding premium for each month no payment was made, to a maximum of 5 years backlog payment¹³. The National Ombudsman has suggested the fine should be abolished¹⁴.

Should the non-payer in question be in acute need of health care, he or she will also have to pay the cost of the treatment episode before being allowed to re-apply –and be accepted for coverage (Ministry of Health, Welfare and Sports, 2005b). Local authorities have expressed their concern about this. Their social benefit offices estimate that approximately 10 % of their clients on income support may have considerable outstanding health insurance payments. Nationally, this would amount to approximately 35,000 people (Boorsma, 2007).

¹² <http://www.minvws.nl/dossiers/zorgverzekering/onverzekerden/>

¹³ www.bsenf.nl

¹⁴ <http://www.deombudsman.nl/site/content/Rubrieken.asp?SbRubrkID=4&ContentID=545>

The social and political debates on the position of persistent non-payers are further complicated by the fact that they may also be eligible for cost compensation measures such as the Health Care Allowance (*Zorgtoeslag*, see also 2.4) and many are indeed receiving this allowance. This puts public acceptance for this solidarity measure under pressure. The Ministry for Health is still working on the most optimal solution to avoid abuse of solidarity measures yet ensure access to health services (Ministry of Health, Welfare and Sports, 2007c).

POLICY EXAMPLE:

LOCAL GOVERNMENT FACILITATING ACCESS FOR PEOPLE ON INCOME SUPPORT THROUGH COLLECTIVE CONTRACTING

Local authorities are responsible for managing elements of the national social benefits package in the Netherlands. In 2006, an estimated 325 local authorities have entered the market on behalf of their clients on social income support and negotiated collective contracts that often included complementary coverage. Some local authorities will subtract the insurance premium from the benefit allowance, but other authorities may not do so. In the latter case the client will still need to make regular insurance payments themselves.

Approximately 80% of all people on social income support were covered through this type of collective contract. This percentage is much higher compared to other lower-income groups, including older people or people with a disability allowance (Sociale Alliantie, 2006).

For their clients, there may be many advantages to this:

- Coverage will be cheaper (as discounts tend to apply for collective contracts);
- They do not have to enter complex choice processes;
- They may have broader coverage as their collectively arrange package may also include services that would normally be part of complementary

packages;

- Depending on whether their premium is directly subtracted from their allowance, they do not have to budget in advance for premium payment, fill in forms to apply for the Health Care Allowance, cannot neglect their payment duties, and thus do not risk their right to coverage.

Collective contracting is further explained in 2.4.

2. 3 The scope of the health basket

2.3.1 Preventative services

National immunisation programmes for newborn and children up to 9 years include:

- Diphtheria, hooping cough (pertussis), tetanus, poliomyelitis;
- Haemophilus Influenzae type B;
- Mumps, measles, rubella;
- Meningococcosis C;
- Hepatitis B (for children at risk);
- Streptococcus pneumonia.

Immunisation against influenza is covered via the Zvw for people aged 65 and over, and for people at risk.

National screening programmes include:

- Pre- and postnatal screening;
- Cervical cancer: all women aged 30-60 are called in every five years;
- Breast cancer: all women aged 50-75 are called in every two years.

Health promotion and prevention services are covered and provided by local authorities via the *WCPV*.

2.3.2 Standard health basket

The content of the services covered under the basic health insurance package is set by government. GPs function as the gatekeeper to –coverage of- other medical services. As of May 2007, the standard health basket included:

1. Medical care and services by medical and nursing professionals, including GP services:
 - No claim/compulsory excess waived for GP services;
2. In-patient hospital costs;
3. Dental care up to the age of 18 (for others specialist dental care only);
4. Medical –assistance- devices, including dentures and personal budget for visually impaired:
 - Dentures: cheapest suitable device; co-payment of 90 Euro;
 - Glased only covered for seriously impaired;
 - For walking aids/wheelchairs/zimmer frames restrictions may apply.
5. Pharmaceuticals:
 - Prescription only;
 - Reference pricing, co-payment may apply above that level;
 - Over-the-counter drugs excluded;
 - Homeopathic remedies excluded.
6. Obstetric and maternity (pre-/postnatal services up to age of 6 months) care:
 - No claim/compulsory excess waived for maternity services;
 - Home-based maternity services coverage 24 - 80 hours, depending on family circumstances/need, plus co-payment of 3.50 Euro per hour;
 - Co-payment of 14 Euro per day and additional costs for residence and food, up to 100 Euro per day for elective prolonged in-patient antenatal services;

- Co-payment waived for prescribed in-patient maternity care.

7. Paramedical care:

- Physiotherapy: co-payment for initial nine sessions; under 18's: nine sessions annually per medical complaint, extension possible for another nine sessions; 18 and older: only covered for people with long-term needs;

8. Rehabilitative care:

- Fully covered for first 365 days.

9. Other:

- Emergency ambulance;
- Chronic intermittent ventilation (use of equipment in own home requires authorisation);
- First three sets of IVF treatment;
- Audiological advice for people with medically acknowledged hearing problems;
- Genetic testing incl. counseling for people at risk;
- Transportation for people confined to wheelchairs, people who need out-patient haemodialysis; and visually impaired;
- Haemodialysis.

As of 2008: primary and out-patient mental health care:

- Up to a maximum of eight sessions;
- Co-payment of 10 Euro per session.

2.3.3 Long-term care basket (AWBZ)

In 2007, the *AWBZ* basket covers the following care functions:

- Personal care, e.g.: help with taking a shower, bed baths, dressing, shaving, skincare, going to the toilet, eating and drinking.

- Nursing care, e.g.: dressing wounds, administering medication, giving injections,
- advice 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 problems exist.
- Treatment, e.g.: care in connection with an ailment, for example, rehabilitation following a stroke.
- Residence.

The *AWBZ* is based on a right to care according to need. Assessment is implemented regionally, based on objective, national criteria and coordinated and monitored at national level, by the Centre of Care Assessment (*CIZ*). The *CIZ* thus functions as the gatekeeper for this compartment of the health system.

2. 4 Cost-sharing requirements as barriers to access

2.4.1 Overall picture

The share of co-payments as a percentage of the total health care expenditure is low in the Netherlands compared to other OECD countries (OECD, 2005). In absolute terms, co-payments increased between 1998 and 2004 from € 3,575 million to € 5,128 million (Westert and Verkleij, 2006). In 2006, a total of € 4,010

was spent on healthcare via co-payments (CBS, 2006). Table 2.4 (below) shows a breakdown of that expenditure for care now provided under the Zvw. On the total *AWBZ* expenses for 2005, (23,771 million Euro) co-payments accounted for 1,788 million (CVZ, 2006).

Table 2.4 Co-payments healthcare, in million Euros, 2004

Type of service	Amount
Pharmaceuticals	1,200
Therapeutic aids/medical goods	1,175
Dental care	325
Medical specialist services and hospital care	142
GP services	142
Other	1,026
Total	4,010

(Source: CBS, Health accounts)

2.4.2 Evidence on access impact

The impact of co-payments on health care utilisation is not consistently researched in the Netherlands, which may be a consequence of the relatively small role of co-payments in the Dutch healthcare system. There is, however, evidence that uptake of home care decreased after co-payments were raised (Baanders, 2004) and uptake of physiotherapy decreased when this was excluded from the standard social health insurance package –except for specific groups of patients- in 2004 (Swinkels and Van den Ende, 2004). It is also clear that people with lower levels of education (a strong predictor of

income) use significantly less dental services (Westert and Verkleij, 2006). Both physiotherapy and dental services are sparsely covered in the current standard package. Covering costs for physiotherapy and/or dental care were important reasons to take out complementary insurance (De Jong et al, 2006a).

2.4.3 Socio-economic equity issues

Individual health care contributions may have a relatively strong bearing on people in lower income strata, either as a direct consequence of actual utilization of services or due to regular insurance premium payments. At the same time, a disproportionately high percentage of ill or disabled people are at risk of living in poverty. Figures for 2005 indicate the annual disposable income of under 65s with a disability or chronic illness was € 200 - 624 below the income of non-disabled people in similar social-demographic situations, even when the then applicable compensation measures were taken into account (Nibud, 2005). Based on research findings from Jehoel-Gijsbers (2004), the Dutch government acknowledges the mutually reinforcing relationship between (ill) health and poverty (National Strategy Report 2006-2008).

2.4.4 Health reforms: shifting cost perspective for citizens

Costs of the standard health care basket are partly covered through nominal, private contributions. As such, these private contributions could be labelled as cost-sharing payments.

For the approximately 70% of the population previously covered via social health insurance, the market reform has brought about a change in the way they pay for health care. They have to pay a monthly premium upfront, instead of having their social insurance contribution deducted from their wages or social benefit allowance. This requires a more active role and budgeting discipline: those failing to pay risk fines and jeopardise coverage.

For many, the overall costs for standard coverage have increased. This is, however, dependent on income as well as family situation: as of 2006 children up to the age of 18 do not have to pay the nominal premium. Nevertheless, costs incurred as a result of social health insurance nominal premium per

insured averaged to € 384 in 2005 (CVZ, 2006), against an average € 1070 for the standard coverage in 2006.

The year 2006 saw insurers offering coverage against prices below the level anticipated by the government in setting the height of 2006 health care allowance for lower incomes (*Zorgtoeslag*, see 2.4.5). For 2007, nominal premium rates have risen by an average 7%, complementary coverage rates by an average 10%. The Health Care Allowance has risen less sharply. Taking all costs and compensation measures into account, 2007 health care costs for people on minimum incomes is expected to rise by 2.5% for single households and 4% for couples (Bureau BS&F, 2006).

Table 6.2.2 (Annex) provides an overview of the various elements that may feature on the citizen's annual budget for health expenditure. The nominal premium for coverage of the standard health basket may vary between insurers: in 2007, this was anywhere between € 1056 – 1224¹⁵. The income-dependent premium equals 6.5% of income, payable from an income ceiling of approximately € 30,000. Employers and benefit agencies will reimburse this contribution to employees and clients. For pensioners, the contribution will be taken into account in the level of their pension. For those not in employment and not receiving unemployment benefits, the income-related contribution is 4.4%. Self-employed persons receive an assessment from the Inland Revenue (Ministry of Health, Welfare and Sports, 2005c).

2.4.5 Co-payment for mental health services

As of 2008, counselling and psychotherapy services from psychologists working within primary care settings will be subject to a 10 Euro per session co-payment. People in need of more than eight sessions will have to pay out of pocket. While GP services are exempt from the no-claims bonus arrangement, the services of primary care psychologists are not.

¹⁵ Source: www.vektis.nl in April 2007.

Information from stakeholders¹⁶ suggests that this change may impact on referral after central intake procedures. Counselling and support services delivered by social workers or community psychiatric nurses are not classified as 'treatment'. These services fall within the scope of the *AWBZ* instead of the *Zvw*, and are not subject to co-payments. To avoid a financial burden for client on low incomes, mental health professionals may be inclined to suggest referral to a social workers, even when the more specialised service of psychologist would be more fitting appropriate considering the client's need. Client themselves may also prefer the 'cheaper option'.

2.4.6 Financial barriers and incentives as market instruments

Cost-awareness, individual choice, and individual responsibility are key elements in the Dutch system. The market reforms thus have a very strong financial component, building on a complex mixture of private and public payment, optional fee discounts, and negotiable fee reductions. This could result in a varied landscape of financial access hurdles.

The no-claims bonus

The cost-awareness element of the system is strongly reflected in the design of the no-claims bonus. As a policy measure, the no-claims bonus intends to throw up a financial access barrier rather than tackle one. It does, therefore, not qualify as a good practice example in the light of this study. The measure is unique and innovative, but has also caused a lot of controversy as well as interest. This is why further details are presented in the text box below.

Early 2007, the new government announced its intention to annul the no-claims bonus. After a short life of three years it will be replaced in 2008 by another measure to stimulate cost-awareness: a compulsory excess of 150 euros a year. This excess will be collected by the health insurer. Like the no-claims bonus, the excess will not apply to children and young people under 18 years of

¹⁶ See acknowledgements

age. People with unavoidable long-term health expenses, for example due to chronic illness or disability, will be compensated financially¹⁷.

The Federation of Patients and Consumer Organisations in the Netherlands (*NPCF*) welcomes the decision to annul the no claims bonus. It has, however, expressed its concern over the government's intention to replace it with a compulsory excess. The Federation perceives a compulsory excess as an unjust measure that may undermine solidarity. It is anticipated implementation will bring about an additional financial and administrative burden, and may have negative privacy implications. As an alternative to the proposed compulsory excess, the Federation suggest to broaden opportunities for an optional excess. It also calls for an independent inquiry into the effectiveness and practicalities of out-of pocket payments¹⁸.

The joint national organisations of older people have also voiced their content about the abolition of the no-claims measure. Like the consumers organisation, they have doubts about its replacement with a compulsory excess and points to the already existing optional excess. The older people's representatives do not, however, call for broader voluntary excess options. Rather, they call for a combined arrangement acknowledging all co-payment arrangements in health and social care. Such an arrangement should be just and fair, and include cost-awareness incentives that impact equally on people (CSO, 2007).

POLICY EXAMPLE:

NO-CLAIMS BONUS AS FINANCIAL INCENTIVE FOR DELAYING ACCESS

The no claims bonus was introduced in January 2005, within the then still existing social health insurance pillar of the health system. People whose

¹⁷ http://www.minvws.nl/images/z-2805508b_tcm19-154216.pdf and <http://www.minvws.nl/en/nieuwsberichten/meva/2007/cabinet-approves-compulsory-health-insurance-excess.asp>

¹⁸ Source: <http://www.npcf.nl/?id=2788>

actual annual health care costs would stay below 255 Euro could have the remainder of that sum reimbursed at the end of the financial year.

Some services, such as GP services, are exempt from this arrangement.

The rationale for introducing this bonus was to increase cost-awareness amongst –potential- health care users, and consequently to reduce actual uptake of services and curb health care costs. The measure stirred a lot of debate. Critics argued the bonus was a threat to financial solidarity as people with chronic and/or long-term health needs would not stand a realistic chance of receiving a reimbursement. Hence, the healthy would ‘earn’ money back, de facto paying less premium compared to the unhealthy. Also, it was feared the measure could lead to delay of service uptake, particularly amongst people from lower income strata.

For 2005, approximately 50% of a total of 8.2 million social health insurance clients received an average of 90 Euro no claims bonus. Approximately 500,000 of these people received the maximum no-claim bonus of 225 Euro. The remaining people did not receive anything¹⁹.

Initial research by De Jong et al (2006b) into the intended effect of the no claims bonus as a policy measure concludes policy aimed at changing health seeking behaviour will not be effective as long as people do not perceive the measure applies to the reasonability of their own judgements.

In April 2005, most (77%) respondents from the Dutch Consumer Health Panel people anticipated the measure would not influence their own health care seeking behaviour, but expected only 17% of others would not be influenced. In retrospect, 3% of respondents reported the no claims bonus led to accessing less care in 2005, particularly GP and medical specialist services. Reported effects on GP visits are remarkable as GP services were

¹⁹ Verbond van verzekeraars, 2006 on <http://www.verzekeraars.nl/home.aspx>

²⁰ www.kiesbeter.nl, 2006.

excluded from the no claims bonus.

No conclusive evidence of actual reduction of health care utilisation could be found. While data on health care utilisation over 2005 do show some reduction in new referrals for the 'no claim' services, these are within regular outcome fluctuations.

Meanwhile, insurance companies report no signs of increased cost-awareness amongst their clients, with the exception of older people and people with chronic diseases.²⁰

Opt-in individual discounts

People who agree to cover the first € 100 - 500 of their total annual health care are offered discounts on the flat-rate premium for the basic package. The actual insurance fee will depend on the height of the personal excess.

Clients also can choose between a benefit-in-kind policy and a reimbursement policy. The former only guarantees full coverage for services provided by contracted providers, i.e. providers with whom better rates and/or better quality services are negotiated. In-kind policies are cheaper. Reimbursement policies offer clients maximum choice of provider, but are more expensive. Also, the client needs to pay the bill after which reimbursement will take place, which may make this kind of policy less attractive for people with a lower income. In 2006, 23% of all insured opted for a reimbursement policy (National Strategy Report 2006-2008).

It is too early to determine whether there are income- or ethnic-related differences between population groups as regards the choices made, or what the impact may be on health services access.

Collective discounts

Health insurers are allowed to offer up to 10% reduction of premium rates through collective contracts. To avoid cream-skimming, they are not allowed to base their offer on the characteristics of the collective or its members.

Employers are the dominant player in brokering collective contracts: 78% of all people insured through collective contracts have done so through their employer. Collective contracts can, however, be set up under any umbrella, including that of patient organisations. Indeed, 2% of collectively insured are affiliated to a patient collective. In setting priorities for collective contracting employers predominantly focus on negotiating a good price, while patient collectives prioritise quality. In comparison with employers, however, patient collectives needed to approach insurers more actively and ended up with financially less attractive deals (National Strategy Report 2006-2008).

Attractive deals available through this type of contracts proved to be a major motivating factor for people changing insurer at the onset of the new market system. In 2006, 44% of policies were arranged via collective contracts. For 2007, this has gone up to 57%²¹. This trend is expected to continue (Van Ruth et al, 2007).

At first sight collective contracting seems at odds with the interest of people at risk of social exclusion and poverty. As has been highlighted by the example of local authorities' collective contracting for people with on social benefits (see chapter 2.2), this does not need to be the case. Nevertheless, an arrangement that by its very nature depends on a degree of inclusiveness to a certain group could potentially reinforce existing access gaps for people at risk of social exclusion.

2.4.7 Policy measures to foster solidarity and tackle financial hurdles

The income dependent premium for the standard health basket (see 2.4.1) is one of several measures to achieve financial solidarity in the system. Three others are more directly targeted at people with lower incomes and/or to people with high health costs. Two of these measures are directly linked to the tax system.

²¹ www.vektis.nl, 2007

POLICY EXAMPLE:

ALLEVIATING HEALTH CARE COSTS THROUGH TAX COMPENSATION AND TARGETED SOCIAL ASSISTANCE

Advance compensation payment via Inland Revenue (*Zorgtoeslag*)

The 'Health Care Allowance' (*Zorgtoeslag*) is an essential instrument to compensate lower-income strata for their increased health care costs as a result of the system reforms. Any Dutch resident 18 year or older who has taken out health insurance and whose annual income does not exceed € 25.068 (or € 40.120 for wage-earners) is entitled to this allowance. Monthly payment is made available via the tax office, and in advance as to limit recipients' risks of running into overdraft when they have to pay their insurance premium at the beginning of that same month.

In 2006, a total of €2.4 billion was made payable to low-income citizens via the Inland Revenue office. This way, more than 38% percent of eligible Dutch residents received an advance payment (*Zorgtoeslag*). On an annual basis, the compensation can vary between a minimum of € 24 to a maximum of € 1155, depending on income²².

While government highlights care is taken that people on low incomes can indeed benefit from this tax compensation, research indicates uptake of this compensation is still limited.

Tax relief for excessive costs as a result of illness or disability

Tax relief for those encountering disproportionate costs as a result of illness or disability has been a longstanding and again unique feature in the Dutch tax system. The possibility to deduct 'exceptionally high' (i.e. more than 11.5% of taxable income) health care related expenses from one's taxable income is available for all citizens, irrespective of income level. This measure is

²² Source: Statistics Netherlands on www.cbs.nl and Inland Revenue on www.belastingdienst.nl, 2007.

particularly relevant for people with disabilities or chronic disease although other costs incurred, such as for ante- and postnatal care can also be taken into account. Table 6.3.2 (annex) provides an overview of the eligible costs.

Research among people with disabilities or chronic illness shows that problems arise with the uptake of this tax relief. Over the 2005 financial year, 50% of those eligible for this relief did not apply for it. This is mainly due to misconceptions about eligibility. Others do not normally fill in tax forms –for instance because they do not receive a work-related income. Having to take the extra steps of applying for a tax return form and filling it in proves too big a hurdle for them (Pannekeet-Helsen et al, 2007).

Special social assistance (*Bijzondere Bijstand*)

People relying on a minimum income who meet unusually high costs can apply for earmarked social assistance. This measure is not specifically designed to meet healthcare costs. Decisions to grant the appeal for assistance are made by the local authority within their statutory responsibilities for social assistance. This could lead to geographical differences in access to this type of financial support (Ministry of Health, Welfare and Sports, 2007d).

2. 5 Geographical barriers of access to health services

2.5.1 Geographical coverage and negotiating distance

The Netherlands is among the countries with the highest proportion of people living within close as well as comparatively equal proximity to hospitals and GPs (Busse et al, 2006). While this may be of little surprise given its high population density, it is also a consequence of regulatory intervention. The Ministry sets a standard for maximum travelling time: 30 minutes (by car) to hospital and 15 minutes to a GP (CBZ, 2002).

Health care services and health care providers in the Randstad and other urban areas are in closer proximity to care users than elsewhere in the Netherlands. This does not necessarily need to lead to shorter travelling time as traffic

congestion is a very common phenomenon in the Netherlands, particularly in the Randstad area.

The difference in supply between regions with the highest and lowest density is small for general practitioners, physiotherapists, dentists, residential homes and nursing homes. The difference in supply between regions with the highest and lowest density is much greater for midwifery, day care places in nursing homes, and care for people with disabilities (Westert and Verkleij, 2006).

Access to hospitals

In practice, the travelling time to hospital is usually much shorter than the regulatory limit of 30 minutes: over 60% of the Dutch population is able to reach a hospital within 10 minutes (data from 2001). When the 30 minute target does get missed, this tends to happen in relatively remote areas, where a total of 0.4% of the population lives (Westert and Verkleij, 2006).

The high density of hospitals may be reduced over the coming years. Following mergers on the health insurance market it is expected hospitals will also merge. This could improve their negotiating power with insurers, and strengthen their position against competing service providers. Once amalgamated, hospitals then tend to opt for concentration of specific service provision on one locality (Deuning, 2007a).

Emergency ambulance services

Policy regulations require ambulance response time should not exceed 15 minutes. This 15-minute response target is divided into a 2 minute turn-out time and 13 minutes driving time. In 2003, 7.2% of the Dutch population lived in an area where the 13-minute norm could not be met. This was a cause for concern to the Health Care Inspectorate (IGZ, 2004a). In 2005, things have indeed improved, but 5.6% of the Dutch population (over 900,000 people) still live in an area where the 13-minute driving time target is missed. These are often relatively remote areas and/or border regions.

Accessibility to A&E and GP emergency stations (“huisartsenposten”)

There are 107 hospitals with an A&E department in the Netherlands (data as of January 2006). Over 55% of the population can reach an A&E department within a 10 minute care journey, while approximately 0.6% of the population (around 100,000 people) can not reach an A&E department within a 30 minute car drive (Deuning, 2007b).

The vast majority of GPs have entered into regional collaborative agreements in order to offer efficient and accessible out-of-hours service provision. There are approximately 130 of such GP emergency stations in the Netherlands²³. Increasingly, pharmacists are also joining the collaboration so that people do not need to negotiate onward out of hours travel to acquire the prescribed medication (IGZ, 2006a). Around 10.4 million Dutch people can reach a GP emergency station within 15 minutes, but 300,000 need to travel over 30 minutes by care to get there (Van Boven and Kostalova, 2006).

When it comes to timely answering emergency calls, there is great variety in performance between GP emergency stations. The Health Care Inspectorate has identified this as an area where improvement is urgently needed. The fact that 11.5% of calls were not answered within one minute, and 1% was answered with a delay of over 5 minutes was deemed ‘irresponsible’ (IGZ, 2005).

There are no data on actual travel times to GP emergency stations and A&E departments, or mode of transport used; nor are there any data on the - consequences of- delays that may be caused as a result of non-availability of transport. Furthermore, we do not know what role geographical factors – including lack of transport- play in the existence of any unmet need.

The geographical spread of health care facilities is pictured in maps in Annex 6.2.4.

²³ Source: www.vhned.nl

- in-patient admission and treatment:	7 weeks;
<i>Nursing/long-term care:</i>	
- nursing care:	6 weeks;
- home help:	13 weeks;
- home care	6 weeks;
<i>Mental health services:</i>	
- registration	4 weeks;
- assessment	4 weeks;
- out-patient treatment	6 weeks:
- sheltered living	6 weeks;
- in-patient treatment:	7 weeks.

Between 2002 and 2004, the number of people waiting for clinical hospital admission fell by nearly 17%.

The norms for hospital admissions are exceeded more frequently than those for out-patient treatment. In 2004, medical specialties with less than 5% of the patients waiting longer than the norm were general surgery, gastroenterology, cardiology, rheumatology and paediatrics. For orthopaedics, plastic surgery, otorhinolaryngology and ophthalmology over 50% of patients had to wait longer than the norm (Westert and Verkleij, 2006).

A closer look at those who were waiting longer than the norm without any obvious explanation (20% of all waiting) revealed this are predominantly people waiting for elective surgery such as hip replacement, knee replacement and cataract surgery (Singeling, 2004).

Patients can find information about waiting times in the hospital of their choice on the national kiesBeter website²⁵. Regional-specific information on waiting times is available on the RIVM 'Health Atlas' website²⁶.

Waiting for mental health services

For quite some time, waiting for mental health services has been a cause for concern (National Action Plan 2003). Following a reduction in the number of people waiting for mental health services between 2003 and 2004, in 2005 that number went up again –by 6%–, resulting in a total of 70.400 people waiting. This increase is mainly due to a doubling in the amount of people waiting in the initial phase, prior to assessment. In 2005, people had to wait 7 weeks for registration, 5 weeks for assessment and then another 17 weeks for treatment (Westert and Verkleij, 2006).

The reliability of mental health waiting list data is, however, questionable. Many people may still formally be on the list while in reality they are not waiting anymore. The average waiting time of those who actually receive care tells a different story: in early 2005, the waiting time was 3 - 4 weeks for each phase of the process, i.e. registration, assessment and treatment (GGZ Nederland, 2005).

Waiting list issues for older people with functional limitations are discussed in chapter 3.2.

²⁵ www.kiesbeter.nl

²⁶ http://www.rivm.nl/vtv/object_class/atl_wachttijsten.html

2. 7 Supply-side responsiveness

2.7.1 Utilization of services

Differences in care utilization due to level of education (see also annex 6.2.5) do exist in the Netherlands, particularly as regards higher uptake of GP services by people with lower education levels, but also (but not statistically significant) for physiotherapists, medical specialists, home care, hospital admissions and prescribed medicines. However, after correction for perceived health and other demographic factors, these differences become smaller. None of them are statistically significant (Westert and Verkleij, 2006).

People with lower levels of education do use significantly less dental services, counseling services and cervical cancer screening services (Westert and Verkleij, 2006). Between 2000 and 2005, around 83% of privately insured people visited the dentist annually, against approximately 75% of people with social health insurance. These differences remain fairly constant over the years (Schaub, 2007). Given that dental care for adults is not included in the standard package, these differences may also be reflected in the future uptake of dental services by those who have taken out complementary insurance for dental care, and those who have not.

Social-economic differences as regards uptake of medical specialist services have been reported in the Netherlands, indicating a pro-rich bias. Compared to most other OECD countries, however, these differences were found to be relatively small (Van Doorslaer and Masseria, 2004). Utilization differences between groups of different educational level could not be identified in the Netherlands (Van Lindert et al, 2004).

Uptake of GP services is higher among migrant populations (see also annex 6.2.6), but adjusted for demographic factors and health status, uptake is higher for the Turkish and Moroccan population only (Droomers et al, 2005). Health service utilization of non-western migrant communities is discussed in more detail in chapter 3.1.

For older people, access to out-patient mental health services seems to fall short. One in every five older (aged 65 or over) people visit their GP because of mental health needs, predominantly because of problems related to depression and/or anxiety. Only a small proportion are referred on to mental health services. Only 3% of clients of psychologists working in primary care settings are 65 or over, while 13% of the population falls within that age bracket (Pot et al, 2007).

2.7.2 Specific comments on access

GP services:

In the Netherlands, GPs function at the gatekeeper to other medical services. Costs incurred as a result of visits to the GP are not taken into account in no-claims bonus calculations (see 2.4).

Immunisation coverage:

The Netherlands' figures for immunization coverage exceed the 95% level and meet the standards provided by the World Health Organisation (WHO). In 2005, national coverage levels for all vaccines used in the Netherlands increased further: coverage for infants up to 6 months of age is largely exceeding the 97% level. Of all 9-year old children, 97.7% was fully immunised for measles (Abbink et al, 2006).

In spite of the high national immunization coverage, regional differences in coverage do exist. Almost all provinces reported over 90% immunization coverage for all vaccines used. Areas with a relatively low immunization coverage are concentrated in the Dutch 'Bible belt': area's with a large orthodox-protestant community objecting to vaccination for religious reasons (Abbink et al, 2006).

In the autumn-winter season 2005-2006, nearly 82% of all people aged 65 and over received immunisation against influenza²⁷. Costs of immunisation are covered for this group of the population: all 65-year olds are called in their GP. Response rates differ with age: highest uptake of immunisation is seen amongst people of 75 and older, lowest amongst the 65-70 year olds. Response is also significantly lower in highly urbanised areas (Roedig and Busch, 2006). Given the demographic structure of the Netherlands' largest cities, this is likely to have relatively strong impact on minority ethnic elderly and elderly from lower income groups.

Screening coverage:

All women aged between 50 and 75 biannually called in for breast cancer screening: response rates are approximately 80%. Coverage for cervical smears is 73%: uptake is lower for women with lower educational levels.

Dental services:

There are indications that overall uptake dental services is diminishing. The percentage of young people aged 0-19 visiting a dentist at least once a year decreased from 84.2% in 2000 to 81.1% in 2005. Meanwhile, that percentage showed an increase for older people (65 and over) from 40.3 to 47.7% (Schaub and Van Wieren, 2007). The reduction in service utilisation among adults is to a large extent due to limitations in standard coverage implemented in 2003 and 2004 (CVZ, 2006). Access problems are also reflected in the fact that 1.2% of the population that still has their own teeth would like to be registered with a dentist, but is not (Van der Schee et al, 2003).

²⁷ See also http://www.rivm.nl/vtv/object_map/o1708n21941.html for an overview of geographical differences.

2.7.3 Responsiveness to cultural need

Cultural sensitivity and language issues

As discussed in more detail in chapter 3.1, cultural differences and misunderstandings may stand in the way of timely access and good quality care.

Recruitment of health care staff from ethnic minority communities eases communication problems and enhances accessibility (Council of Europe, 2001). Peer-based models, whereby lay members of the community are trained and supervised to provide information, counselling and advice to people from their own community have proven to be successful. While they are often set up to improve health information and deliver culturally sensitive health promotion, they also play a role in preventative health services, in bridging gaps in acute health care settings, in mental health, and in services for drug users. Peer-based approaches have not only been implemented to improve services for black and minority ethnic communities, but also for other groups that may encounter specific barriers with regard to health services, such as women, gay men and lesbians, and older people (Voorham, 2003).

The vast majority (90%) of 130 intercultural interventions implemented in the Dutch health care sector between 1995 and 2002 were only of a temporary nature and may therefore not have a sustainable impact. Two-thirds of all interventions were concerned with measures to improve cultural sensitivity (e.g. training, leaflets). Measures concerning the actual care process (such as mediation, translation) were less common. Most (60%) interventions were aimed at professionals rather than at ethnic minority patients. Collaboration with migrant organisations was rare (Foets et al, 2004).

Policy

POLICY EXAMPLE:**LEGAL SAFEGUARDS FOR ADEQUATE COMMUNICATION**

By law, professional health professionals in The Netherlands are obliged to communicate with their patient in a language and manner that is understandable for the patient. This is laid down in the Law on Contracts for Medical Treatment (*Wet op de Geneeskundige Behandelingsovereenkomst*) and is further supported through the Law on Clients' Right of Complaint (*Wet*

Klachtrecht Cliënten Zorgsector), de Law on Quality (*Kwaliteitswet*) and the Law on Professions in Individual Health Care (*Wet op de Beroepen in de Individuele Gezondheidszorg*).

Ensuring adequate communication is therefore the responsibility of the professional. The professional can opt to rely on professional translators to facilitate this process. These translation services are held to confidentiality and impartiality, and are usually provided by telephone. In case of emergency, they can be available within minutes. Costs for translation services are borne by the ministries of Health and/or -in case the patient is an asylum seeker- Justice (IGZ/Pharos, 2005).

Together with the Health Care Inspectorate, a collaboration of national expertise centres and service provider organisations built on the legal framework described above to draft more specific guidance on the involvement of translators in health care settings. The settings addressed include acute health care, mental health care, community services, medical services for asylum seekers, home care, and general practice (IGZ/Pharos, 2005).

The Dutch government has made funding available to tackle cultural and language barriers in the mainstream and mental health care sector (see further chapter 3). As regards asylum seekers, staff members of the specific preventative health services for asylum seekers (MOA) are trained to deliver cultural sensitive services.

2. 8 Health literacy, voice and health beliefs

2.8.1 Specific challenges of the Dutch system

The restructured Dutch health care system has many features that could make it relatively susceptible to 'health literacy bias'. After all, 'patients are encouraged to make prudent choices through the introduction of a relationship

between the amount of care requested and the cost..... and by increasing the transparency of the care system' (National Strategy Report 2006-2008, p. 5).

The ideal health care consumer is able to analyse the increasingly detailed information that is becoming available about an increasingly varied market for services and insurance. That consumer is also aware of health care costs, taking this into account in deciding what service to access when, and what kind of insurance to take out.

In the course of that process, language skills and computer literacy can be of great help. The much needed market-related information is made available via various websites. The most prominent one, kiesBeter, is commissioned by the Ministry of Health, Welfare and Sports²⁸. The site is only available in Dutch. Its user population and accessibility are constantly monitored. The information based on data gathered in November and December 2006 suggests people with higher educational levels, from higher income brackets, and from urbanized areas are overrepresented among the users of its sub-sites, as are Dutch natives. At the same time, a relatively high proportion of 20-24-year olds and 70-95 year-olds find their way to the site Colijn and Van der Graaf, 2007).

What does the average Dutch resident know about the various choice features of the new system and is the level of awareness related to factors such as socio-economic status, language skills or educational level? Initial research on the effectiveness of the no-claims bonus indicates that three months after the measure came into effect, 22% of the insured were not aware of it, but that this percentage had decreased to 12 one year later.

The Dutch system does include financial solidarity safeguards. These are predominantly implemented via the tax infrastructure and require some form of pro-active behaviour. Experience with non-use of general income support measures suggests this may hinder access (see 2.4.7). Similar conclusions were drawn as regards the actual uptake of tax relief for excessive health care

²⁸ See www.kiesbeter.nl

expenses by people with disabilities or chronic illness (see also 2.4): here, limited uptake was also partly attributed to misconceptions about eligibility (Pannekeet-Helsen et al, 2007).

Research suggests finding one's way in other part of the system may also be difficult. One in five people for people with physical disabilities in need of some form of housing adaptation does not know how to set this process in motion; of all people in need of special transportation one in every three encounters similar problems. People living alone and people with lower education levels find this particularly hard (De Klerk and Schellingerhout, 2006).

The ability to engage with health insurers, apply for coverage and make regular insurance payments is a key skill in the new market system. Government has already acknowledged this may be difficult for people with mental health disorders (see also chapter 4) and local authorities are offering to take these responsibilities –partly- off the shoulders of people on income benefit. As discussed in 2.2.5, migrant populations are overrepresented among those without insurance cover. Recognising the vulnerability of the older migrant population ANBO, a large national organisation for older people, has produced a short DVD in nine different languages to inform older migrants about the need to take out insurance²⁹.

Lack of health insurance cover is relatively more frequent among people from minority ethnic communities: more than 4% of the immigrant population are not insured, against less than 1 % of the native Dutch population. First generation migrants are four times as likely to be without insurance cover.

2.8.2 Personal beliefs

A study into the determinants of uptake of cervical cancer screening found that women's beliefs concerning screening and attendance were strong predictors of uptake. In fact, these were stronger predictors than organisational aspects, such as whether the invitation to come in for a check reaches them through

²⁹ Source: <http://www.anbo.nl/article.asp?TID=2&SID=153&ArticleID=1719>

their own GP or the local health authorities, or even whether the smear is taken by their GP or a –female- practice assistant. Looking at the motives of non-responders indicated this group believed they were in less danger and that the probability to survive cancer was low. They also felt less encouraged by relatives. No differences were found between Dutch natives and women from minority ethnic descent. Type of health insurance -this study was carried out prior to the system reforms- or educational level were no significant factor (Tacken et al, 2006).

2.8.3 Cultural beliefs

Research based on interviews with patients from 38 GP practices in Rotterdam suggests that differences in patients' cultural background and language proficiency do influence quality aspects of the consultation, including patients' perceived quality of care and mutual understanding between patients and physician. The relation between quality aspects and the patient's cultural background differed for the various ethnic groups (Harmsen, 2004).

The impact of cultural values and beliefs on perception of illness and help-seeking behaviour is particularly pronounced in the case of mental ill health. When sense of reality is endangered, traditional cultural and religious interpretations of illness and health may become more dominant. Sometimes, the role of traditional healers is sought or clients may altogether reject advice of mainstream health services (Hoffer, 2005).

Chapter 3.1 includes further references to the importance of cultural beliefs and their potential role in delayed or inappropriate service access.

Practice example

The 'Bridge' programme in Rotterdam: improving communication and health beliefs targeting migrant women with psychosomatic symptoms.

In Rotterdam, migrant health educators have been active in a liaison role in primary care since 1996. They provide culturally sensitive information and

counseling in migrants' native language, support the communication between GP and patient and inform the primary care provider on culture-specific matters.

In the treatment of stress-related physical complaints, the communication between doctor and patient plays a crucial role. Symptoms and overall perceived health may continue or even deteriorate when communication is poor. Within the context of the Bridge programme, the migrant health educators helped to clarify the problem, transferred specific knowledge and advice on – dealing with- psychosomatic symptoms, and helped to ensure doctor and patient fully understood each other.

The evaluation was based on a randomized control trial: 56 patients receiving the intervention, while 48 did not. Results showed that communication had indeed improved, as had coping with symptoms. GPs gained a better insight into personal problems of patients, understood them better, and reported a more satisfactory relationship with them. Patients felt more supported and better informed by their GP, reported better understanding of their GP's messages and followed the doctors' advice more often. The migrant health educators' counselling sessions had also led to an improvement in perceived health and mental health. No effect was found with regard to improved conceptual knowledge, own effectiveness, or social support when dealing with pain symptoms (Joosten-van Zwanenburg, 2004).

2. 9 Interlinkages and overarching policy initiatives

Access for all, financial solidarity, and high quality client-centered service delivery are among the key objectives of the Dutch market-oriented health system. As has been extensively described in chapter 2, government has incorporated a variety of social safeguards to ensure *all* Dutch residents have access to basic coverage and that insurers charge the same prices to all who apply for a specific package.

As may be expected from a market system, government expects insurers and service providers to deliver good quality, cost-efficient answers to problems that arise as a result of many of the access barriers discussed in this chapter. The primary role of central policy is then to set preconditions and monitor performance.

POLICY EXAMPLE:

MONITORING HEALTH AND HEALTH CARE PERFORMANCE FOR POLICY: THE PUBLIC HEALTH FORECASTING AND HEALTH CARE PERFORMANCE REPORTS

The Netherlands has a well-established tradition when it comes to health monitoring and reporting. This is reflected in the way policy is informed about the public health and, more recently, the performance of the health care system.

Since 1997, the National Institute for Public Health and the Environment (RIVM) publishes an extensive report on the public health of the nation. These Public Health Forecasting (*Volksgezondheid Toekomstverkenningen, VTV*) Reports are published once every four years. They aim to evaluate policy and to help set new priorities if necessary.

The reports are primarily targeted at national and regional policy makers, but academic researchers, students and the informed public are also frequent users of the reports.

As parties outside central government take on an increasing role in the development and implementation of health policy, these are also targeted.

The reports build on the latest available data and knowledge, and present these in an integrated manner. Over the years, reporting has become more differentiated, particularly in terms of its dissemination instruments. In 2007, RIVM offers its public health information in a variety of formats:

- Overarching report once every four years;

- Local and national health monitors;
- Website with integrated information on health and health determinants (Health Compass);
- Website with geographical health-related information (Health Atlas);
- Health sector –specific reporting;
- Reporting on costs of illness.

Information is mainly available in Dutch only, but the overarching report (Den Hollander et al, 2006) is also available in English³⁰, as are elements of the work on costs of illness.³¹

Against the backdrop of the changing role of central policy in the health system reforms, government has decided to create a new instrument to monitor the performance of the system on a regular basis. As with the Public Health Reporting, the results were explicitly aiming to inform government, but also other key actors on the health care market.

The first Dutch Health Care Performance Report (*Zorgbalans*) was published in 2006, presenting a broad picture based on 125 indicators (Westert and Verkleij, 2006). The initial assessment was intentionally carried out before the onset of the reforms. Results are summarised in chapter 2.1.

The outcomes of the 2006 public health report point to relatively large health inequalities at regional and neighbourhood level. A relatively poor health status is often related to socio-economic factors as well as to unfavourable conditions in the living environment. The report emphasizes the important role of social

³⁰ See <http://www.rivm.nl/vtv/root/o37.html> for web version and key messages, and <http://www.rivm.nl/bibliotheek/rapporten/270061004.html> for full report.

³¹ http://www.rivm.nl/vtv/object_document/o5417n29501.html

and environmental health determinants in prevention. It calls for active involvement of social, educational, employment and spatial planning sectors. The report also expresses concern about increasing health risks for young people, particularly as regards unhealthy behaviour.

As highlighted in chapter 1, the Dutch National Strategy Report on Social Protection and Inclusion does refer to RIVM's 2006 health status report in concluding the healthy life expectation of lower income populations is still an issue of concern. This did not, however, result in any specific policy initiatives within the context of the national social inclusion strategy.

The Netherlands does not have an overarching policy on tackling health inequalities, also as a consequence of the increasing responsibilities of local authorities in this matter. The Netherlands Court of Audit (*Algemene Rekenkamer*) concluded in 2003 that the government had developed insufficient plans to reduce socio-economic health inequalities. In 2006, the Court of Audit asked government to clearly indicate what action it would take in this respect (as discussed in Den Hollander et al, 2006).

Within the framework of policy development for and with the 31 largest cities in the Netherlands, local authorities tackle obesity in children, and have set up programmes aiming to support healthy behaviour in deprived neighbourhoods. Given the demographic structure of the population in most of these neighbourhoods, people from minority ethnic background as well as people with lower levels of education are targeted through these programmes (Ministry of Health, Welfare and Sports, 2004a).

2. 10 Conclusion

The 2006 Dutch Health Care Performance Report concluded health care services in the Netherlands are accessible. Based on the additional analysis of access barriers discussed in this chapter, that conclusion still holds from an overall perspective. From the point of view of people at risk of social exclusion a more differentiated and sometimes less rosy picture emerges.

Before elaborating on that picture it is essential to underline it is in a way no more than a snapshot, taken at a time of health system change. Some of the policy measures discussed and practices presented in this chapter are of very recent date: it is too early to draw any conclusions as regards their impact. The second Dutch Health Care Performance Report, expected to be published in the summer of 2008, will present a first appraisal of the systems' performance after the market reforms.

In terms of population coverage, the legal measures put in place to safeguard broad coverage in the new market system access seem to have worked. Insurers do not turn down applicants for basic coverage and clients are offered packages according to the same criteria and prices, irrespective of age, gender or state of health. What can be seen, however, is a shift in the landscape of non-coverage to include more people on social income support as well as other low-income groups. In the past, these people would have been automatically covered via the social health insurance system.

The increasing role of local government as 'guardian' of their vulnerable populations is interesting in this respect. By brokering collective contracts on behalf of those populations, and by paying their insurance premium from the social benefit allowance, local authorities in a way re-establish some of the mechanisms of social health insurance, albeit this time at local level.

Co-payments are not a prominent issue in The Netherlands, but cost-awareness and individual responsibility are fundamental aspects of the new market system. Moreover, policy to ensure access for all also leans heavily on financial solidarity measures. In a genuine attempt to create solidarity within the system, the actual mechanism put in place may not be very suitable for the type of populations they are meant to serve. They require pro-active involvement, understanding of rights and rules, and some levels of health literacy. Their uptake is limited which makes the measures less effective or fit-for-purpose.

Those at risk of loosing out may also be those at risk of other aspects of exclusion. In this case, loosing out goes hand in hand with higher health care cost, as well as with additional poverty risk.

The risk of losing out on the advantages of collective contracting may also be real. Collective contracts are cheaper, and may offer more comprehensive cover. Joining a collective as such is not out of reach for people in disadvantaged positions (see also comments on the role of local authorities). An arrangement that pivots around group identity and belonging, however, may by its very nature not be constructive in tackling inequalities in access for people at risk of social exclusion.

Access problems may also have a geographical component, however unlikely this may seem in such a small and densely populated country. Again, negative determinants of health and factors that impede access and responsiveness may accumulate, this time within certain regions. Services are not evenly spread across the country. Some regions with relatively high levels of unemployment and poverty are not well served, especially as regards specialized mental health.

While waiting lists do exist in the Netherlands, they do not reach problematic levels and there are no indications of inequity in the way they are applied. There are no legal measures to impose waiting list criteria. Consultation with and commitment from health service providers on what is and what is not considered an acceptable waiting time has proven a successful –and indeed very Dutch- way of managing this organisational barrier.

Cultural responsiveness and quality issues will be discussed in more detail in chapter 3. General provisions are well-embedded in various legal measures. Culturally determined health beliefs also influence help-seeking behaviour and, more indirectly, the outcome of health care interventions.

In a broader sense, the new Dutch health system may be susceptible to a health literacy bias. It seems more suited to the needs of the assertive, well-educated and verbal health services consumer. A consumer who is able to invest time, intellectual and technological resources to find out which insurer provides the best deal and which health service provider offers the best quality.

Government has already acknowledged this may be one step too far for people with mental disorders. Nevertheless, coverage of mental health services has

been restructured along the lines of the somatic elements of the system. People with mental disorders are thus facing two new challenges: finding their way in more complex system, and meeting their responsibilities towards their health insurer.

In summary, the access problems that emerge tend to impact on the same population subgroups, where they may accumulate. Sub-populations most likely to encounter such problems include migrants and people living in long-term poverty: two groups that also overlap considerably. Older migrants and single parents seem at particular risk here. Relatively high levels of non-coverage among immigrant populations impacts very strongly on their children.

The groups that are most strongly affected by access hurdles also have lower than average health status and healthy life expectancy. Good quality accessible health care services could therefore contribute to relatively high levels of health *and* wealth gain within these populations. Their relative poor health also means they make up a relatively large 'client' group of the health care sector. From a client-centered perspective, it would seem productive and appropriate to take the needs and interests of these groups more prominently into account.

As the market develops, policy measures will focus more on setting preconditions and monitoring performance. The Netherlands has a good track record in health and system performance monitoring. This type of research has contributed to insights into health inequalities, health service utilisation, and health care access. What we do not –yet- know is the way in which access barriers interact, accumulate, and impact on health. Similarly, we do not know to what extent the recent system changes reinforce or reduce already existing inequalities in health care access. In other words: the Dutch system would benefit from a health access impact assessment.

Meanwhile, the dynamics of the market system itself are intensively researched. While it is indeed important to understand whether and how the market functions, the market is not a purpose in itself but a means to an end. The market system is to deliver good quality, accessible and financially sustainable

health care for all. To what extent it will be equally beneficial to different sub-populations of society is therefore very important to understand.

3 Improving quality of and access to health care for people at risk of poverty or social exclusion

3.1 Migrants, asylum seekers and illegal immigrants

3.1.1 Migrants

Socio-demographic information

In 2005, 19% of the Dutch population was of foreign descent, i.e. at least one of their parents was not born in the Netherlands. A small majority (54%) of these people are of non-western origin. The Netherlands' main non-western immigrant communities are Turkish, Surinamese, Moroccan, and Dutch Antillean (incl. Aruban), 50-60-% of which are first generation migrants. For more detailed demographical information, please see Annex 6.2.7.

There is a strong ethnic dimension in poverty risk in the Netherlands: ethnic minorities account for 23.4% of the total number of minimum-income households. Women from ethnic minorities are at particular risk in this respect (National Strategy Report 2006-2008). Differences do exist between non-western migrant groups. The income position of 'new' migrant groups is least favourable: in 2003, the majority of Somali, Afghan and Iraqi households and more than a third of Iranian and Chinese households had to rely on a low income. Among the other migrant groups, the situation of Moroccans is the worst: in 2003 one third of these households were living on a low income, Turkish (29%), Antillean (28%) and Surinamese (23%) households were in a slightly better position (Vrooman et al, 2006).

Overall unemployment rates for ethnic minorities amounted to 48% in 2004 (NAP 2003 Implementation Report). Dutch anti-poverty strategies pivot around employment and individual responsibility, but not so much on target groups as

such. The ability to speak Dutch is an important condition for employment and social participation (European Commission, 2007). Citizens who speak little or no Dutch have only a 3% chance of finding a job (De Graaf-Zijl et al, 2006).

This is reflected in the generation difference as regards dependency on social benefits: one third of first-generation Turks and Moroccans and a quarter of first-generation Surinamese and Antillean migrants have to rely on social benefit, compared to only one in every ten in the second generation (Gijsberts, 2004).

The financial situation of older migrants is weakened by their limited entitlement to state pension (AOW) and capacity to build up an additional pension. This is further discussed in the paragraphs on older migrants in chapter 3.2.

Health needs

Data on key health indicators show the health status of the Netherlands' four largest immigrant populations is poorer than that of Dutch natives. The same holds for overall perceived health. For all four immigrant populations, differences in health status are predominantly caused by socio-economic factors. Lifestyle factors impact differently on the health status of each of the four populations, as could be expected when comparing communities from very different origin (Den Hollander et al, 2006).

Relatively high perinatal mortality among non-western migrant populations was highlighted as a cause for concern in 2004. This difference was primarily attributed to higher mortality in the first week after birth, particularly among newborns from Surinamese and Antillean descent. For the age group of four weeks and older, mortality rates are relatively higher for Turkish and Moroccan infants. Maternal mortality risk is also higher for migrant women, accounting for 30% of all maternal deaths between 1999 and 2002. Again, differences between the four communities exist, with Surinamese and Antillean women being at highest risk (Waelput et al, 2006). Research suggests better health information and communication could reduce maternal mortality risk among migrant women (Schutte et al, 2005).

Illness prevalence patterns differ between migrants and natives, and across the four migrant populations. Higher rates for CHD can be seen for Turkish and Surinamese people. Prevalence of diabetes is higher among Turkish, Moroccan and Surinamese groups, but particularly among the Asian-Surinamese population. Breast cancer rates, though, are considerably lower among migrant women as compared to Dutch natives.

Data on mental health suggest older Moroccan and –particularly- Turkish migrants are at higher risk for depression, with Turkish women over 65 showing the highest depression rates (Van der Wurff et al, 2004). Compared with Dutch natives, schizophrenia is relatively more prevalent among Surinamese, Antillean and Moroccan migrant communities (Selten et al, 2001).

Health care utilisation

In 2000, the National Council for Public Health and Health Care (RVZ) looked at access and quality of mainstream health services for non-western migrants. They reported migrants visit their GP more often, but that GP consultation sessions with migrant patients are of shorter duration, and they receive more prescriptions. Their findings indicated that GP performance in recognising physical, mental and social problems of migrants would sometimes fall short, with inadequate referral as one of its consequences. Overall, the Council concluded Dutch health care services insufficiently accommodated for cultural differences and sensitivities, and that traditional Dutch health beliefs and values could hinder diagnosis and treatment (RVZ, 2000a).

More recent studies still indicate non-western migrants visit their GP more often than the native Dutch population. These differences are particularly marked for people over 55 (Foets et al, 2005a). Under-utilisation of services has been reported for physiotherapy, –for some migrant populations including Moroccans-, home care, residential care, and use of medication, but research outcomes are not consistent and differ across groups (Den Hollander et al, 2006). Also, some differences diminish considerably when adjusted for socio-economic status, age, and health status (Kunst et al, 2006).

Moroccans rely significantly more often on informal care provision (Foets et al, 2005a). This may be due to cultural values attached to family responsibilities, but also to formal access barriers for new immigrants. New immigrants are only eligible for care provided via the *AWBZ* after a wait of 12 months maximum (Ministry of Health, Welfare and Sports, 2007d).

Overall, differences in care utilisation are considered to be small, with a slight over-utilization of medical specialist and hospital care. However, adjusted data indicate that older (55+) Turkish and Moroccans visit medical specialists less often than their native Dutch counterparts. This could point towards unmet care demands among the first generation immigrant population (Westert and Verkleij, 2006). Differences seem to decrease for second generation migrants (Droomers et al, 2005; Lanting, 2007). The situation of older migrants is discussed in more detail in chapter 3.2.

Mental health care utilisation

Differences in service utilization between non-western migrants and native Dutch are most pronounced within out-patient mental health services: migrants use these four times more often (Kunst et al in: Den Hollander, 2006). To what extent this difference can be attributed to the higher mental health need of people from non-western descent (see above) is not yet clear. Given that need, the relative under-utilisation of in-patient mental health services is a cause for concern. A study on out-patient mental health services in Amsterdam revealed Moroccan and Turkish patients were treated for a shorter period of time than native Dutch and Surinamese patients, calling quality of care into question. Use of medication was equal in all groups (Schrier et al, 2004).

Research looking at health symptoms and help-seeking behaviour of migrants with mental health needs showed considerable inter-ethnic variety in the development of mental health symptoms, subsequent help-seeking behaviour and utilisation of services. Length of residence in The Netherlands, level of education, employment status, and degree of cultural assimilation all play a considerable role, suggesting ethnicity as such may be less important (Knipscheer, 2004).

In line with their other comments on cultural appropriate health services, the National Council for Public Health and Health Care suggested the methods and protocols used within mental health services may be too much dominated by western values and ways of thinking. Focusing on the individual rather than stressing more social and collective processes would not fit well with the non-western migrant cultures (RVZ, 2000b).

Policy

The 2006-2008 National Strategy Report does not refer to any policy initiatives that specifically aim to improve the health of migrant populations or their access to health care services. The current absence of such policies does not mean they never existed. Rather, it is reflective of the viewpoint and priorities of the 2002-2007 government.

Over the previous two decades national and local policies supported the development of a range of 'culturally sensitive' methods, instruments and activities, predominantly within health promotion settings. This included information campaigns in migrant groups' native languages, peer education programmes, and the introduction of migrant health educators with health promotion and primary care settings (see also 2.7.3 and 2.8).

In 2000, the National Council for Public Health and Health Care concluded access to good quality responsive health care for migrant communities was a persistent and urgent problem in The Netherlands. According to the Council, both the health sector and government were insufficiently aware of the problem and effective and consequent policy measures had been lacking until then³².

The Council called for government action that would lead to structural improvement of quality and access of mainstream health care for migrants. This would also require cultural awareness and expertise to become much more widespread among mainstream health care professionals.

³² Source: http://www.rvz.net/cgi-bin/adv.pl?advi_rellID=26&chap_rellID=3&last=1

In response to this, the then Minister of Health set up a project group to work out a strategy to achieve this. Among other things, this led to a four-year action plan for intercultural mental health, to be supervised by *GGZ Nederland*, the Dutch Mental Healthcare Association (Ingleby, 2006). To help improve quality and access of mainstream mental health services, the Ministry of Health, Welfare and Sports made funding available to set up a national expertise centre, Mikado (see below), with financing guaranteed until 2007.

The next government also acknowledged migrant groups encountered specific problems accessing health care services. Government released a total of € 600,000 Euro over the years 2004-2007 to encourage better and more culturally sensitive health service provision to non-western migrants. The Minister of Health did not, however, feel the government had a structural role to play here. Rather, in his view it was up to the key players on the market -professionals, providers, insurers and patients- to ensure this would happen. This led the members of the national project group on 'Interculturalisation of Health Care' to hand in their resignation³³.

As a general policy measure, the Health Care Allowance (*Zorgtoeslag*, see 2.4) is designed to financially compensate low-income groups for the increased costs of the new health insurance system. In spite of the relatively high poverty levels among non-western immigrants, they are underrepresented among those applying for the allowance. In 2006, one in every ten people receiving an allowance was of non-western origin, which is less than could be expected. Those that did receive an allowance were granted an average of € 530, compared with € 480 for native Dutch applicants³⁴. This suggests migrants would benefit from more information and help in applying for the allowance.

³³ Source: http://www.rvz.net/cgi-bin/adv.pl?adv_rellID=26&chap_rellID=3&last=1

³⁴ Source: CBS/ Inland revenue, March 2007.

POLICY EXAMPLE:

BUILDING THE KNOWLEDGE BASE FOR CULTURALLY SENSITIVE SERVICES:

THE MIKADO NATIONAL EXPERTISE CENTRE

Mikado's establishment in 2002 was policy-driven (see 3.1.1). It was set up as a national expertise centre aiming to support culturally appropriate mental health services within mainstream settings by means of transfer of knowledge, promotion of expertise and initiating research. Over the next four years it gathered and disseminated knowledge via conferences, master classes, publications and their website. This includes a series of Good Practice booklets. Mikado's target group include health care professionals and managers, as well as students, researchers and policy makers.

In 2007, Mikado broadened its focus and is now offering its expertise to all health sectors³⁵. The reasons for this were twofold. Firstly, the centre increasingly received requests for information and expert advice from outside the mental health sector and was keen to meet this demand. Secondly, Minister of Health Hoogervorst decided the centre's government funding would not be continued as a direct consequence of a more market-oriented system. Instead, Mikado was to offer its services on that market and to seek commissioning from insurers, professionals or patient organisations³⁶.

3.1.2 Asylum seekers

Population and arrangements for living

In the Netherlands, responsibility for dealing with a request for asylum lies with the Immigration and Naturalisation Service (IND). Approximately 85% of the

³⁵ <http://www.mikadonet.nl/pagina.php?id=english>

³⁶ Personal communication, 2007.

asylum seekers receive a negative decision from the IND, while 15% receive a positive decision. The decision and appeal process may take years.

While waiting for the outcome of that process asylum seekers are housed in special centres across the country. The Central Agency for the Reception of Asylum Seekers (COA) is responsible for the accommodation of asylum seekers and prepares them for their life after the IND decision. To this effect, COA accommodates asylum seekers at centres focussing on orientation and integration, or on repatriation³⁷. Both the IND and the COA operate under the responsibility of the Ministry of Justice.

As of December 2005, 28,730 asylum seekers were living in Asylum Seekers' Centres, among them 284 unaccompanied minors. Main countries of origin were Iraq, Afghanistan, Azerbaijan, countries within the Former Yugoslav Republic (FYR) territory, and Iran. In 2005, 5,394 new asylum seekers arrived in COA centres: their main countries of origin being Iraq, Somalia and Burundi. Over 17,000 people left the centres that year: 5,318 of them with 'unknown destination', thus acquiring an illegal status.

Poor mental health, including posttraumatic stress disorder (PSTD) and memory loss, may hinder the asylum procedure: the immigration authorities demand people's personal stories are credible and consistent in order to consider their request for asylum (Laban et al, 2004).

Health needs

Average standardised mortality rates of asylum seekers are similar to the Dutch population, but these figures conceal considerable health needs of subgroups. For the age groups 5-19 and 20-29, mortality rate among male asylum seekers is twice as high as their Dutch counterparts, but for men aged 40-64 mortality rates for male asylum seekers are twice as low. Infant mortality is twice as high compared to Dutch infants. This is primarily due to congenital abnormalities.

³⁷ Source: www.coa.nl

The most frequent cause of death for men is external (including accidents, drowning and suicide). Here, the mortality rate for men is twice as high compared to Dutch men, but no differences were found for women. Asylum seekers are five times more likely to die of an infectious disease, HIV/Aids being the most frequently occurring cause of death (GGD Nederland, 2006a).

The long wait for the asylum decision and the threat of repatriation, in conjunction with posttraumatic stress disorder increases the risk of suicide. Data over the years 2002-2003 indicate suicide and attempted suicide rates among asylum seekers –including those waiting for repatriation- were twice as high as the average Dutch population. This often concerns people who would perceive their personal situation as one without any future perspective. Further research suggests that the asylum procedure played a key role in 35% of the suicide cases, along with mental health disorders, domestic circumstances and relocation to another asylum centre³⁸.

Afghan, Iranian and Somalian asylum seekers report far worse health status than Dutch and resident refugee populations. Approximately half of all asylum seeker respondents suffer from more than one chronic condition.

Prevalence of mental health problems is high. Depression/anxiety is reported by 68%, post-traumatic stress disorder (PTSD) by 28%. Prominent physical health problems include muscoskeletal complaints (24%) and digestive problems (18%). Chronic dental problems are very common (reported by over 50% of asylum seekers). Chronic conditions, PTSD and depression/anxiety are relatively more common among women.

Reported health problems may vary according to country of origin and so does the uptake of services (see below). Differences are especially marked as regards mental health problems.

A closer look at the mental health needs of Iraqi asylum seekers showed that mental health may deteriorate with length of the stay –and wait- in an asylum

³⁸ Source: http://www.mikado-ggz.nl/artikel.php?artikel_id=793

seekers centre. Compared to Iraqi's who had been in the Netherlands for six months or less, prevalence of mental disorders among those who had been in the country for longer than two years was twice as high. This was not the case for PTSD. The researchers suggested this may be caused by acute stress factors linked to the living conditions of asylum seekers, including inability to work, frequent relocation, and lack of independence. Culturally sensitive training aimed at improving coping skills and understanding of the interaction between physical and mental health symptoms could improve health (Laban et al, 2004).

Health: coverage and service provision

Pending the IND decision process, foreign citizens who have applied for either temporary or permanent asylum status are covered for health and long-term care costs via a mandatory arrangement between the COA and one large health insurer, VGZ³⁹. Coverage is similar to the Zvw standard health care basket and the AWBZ basket. Dental care for people over 18 is, however, restricted to acute treatment or pain relief that can be dealt with in one session. VGZ purchases health and long-term care services with mainstream service providers. Asylum seekers are not free to choose their own physician. GPs receive a higher (factor 1.75) fee for asylum seeker patients. Standard, GPs schedule twice the normal session time for asylum seekers who are consulting them.

The COA contracts preventative health services from the local 'municipal health service' (GGD). GGDs provide preventative health services based on local authorities' statutory responsibility in this area. On behalf of all GGDs, their national association has set up regional partnerships to this effect: MOA, the Community Health Services for Asylum Seekers (GGD Nederland, 2006b).

³⁹ See: www.denieuwezorgverzekering.nl

Practice example

'Healthy asylum seekers centre' pilot project

The feasibility of implementing WHO's 'Health for All' approach in an asylum seekers centre as a 'community setting' was piloted between 2001 and 2003. Aiming to promote health and well-being, key elements of the approach are target group participation, intersectoral co-operation, political commitment and evidence-based policy-making.

Asylum seeker's participation was sought from the start. A residents group was set up to inform residents about the project and to initiate activities at the centre. In the initial phase, residents' needs and views were mapped. Factors they identified as having an impact on their health included were a hygienic and safe living environment; improved privacy; shorter asylum procedures; and meaningful ways to spend their time.

Through the project, a range of activities based on participation and intersectoral working was implemented. These included the creation of a facility for women-only meetings; a music event; a course for volunteer baby and child minders; and football matches as a step-up to STD/AIDS education by peer educators.

Evaluation of the initial results suggests the approach can be implemented in an asylum seekers centre. The more formal elements of community involvement, such as a steering group with community representative were found to be more difficult than anticipated, however⁴⁰.

⁴⁰ Source: http://www.ggd.nl/ggdnl/uploaddb/downl_object.asp?atoom=34286&VolgNr=275

SPOTLIGHT ON POLICY: SPECIFIC COMMUNITY HEALTH SERVICES FOR ASYLUM SEEKERS (MOA)

Every asylum seekers' centre has a MOA health service department staffed with practice nurses and general practitioners (GGD Nederland, 2005). Key responsibilities include⁴¹:

- provision of preventative health services such as health promotion and education, health and immunisation for programmes for 4-19 year-olds, and infectious disease control;
- referral to health care, mental health services and long-term care covered by VGZ, i.e. gate keeping;
- co-ordination of service provision within the mainstream Dutch health care system, including transfer of medical records in case of relocation to another asylum seekers centre or granted residency;
- Socio-medical advice on request. This also includes advice to the Ministry of Justice on medical needs in case asylum is rejected and the person is to be repatriated;
- crisis intervention.

For access to mainstream health services the MOA practice nurse is always the first port of call. The practice nurse then decides whether referral to mainstream services –including a GP- via the GGD is necessary: in 35% of patient contacts this is indeed what happens. It is not clear whether this role of the practice nurse leads to more efficient use of GP services, but it is sometimes perceived as an extra hurdle by asylum seekers (Gerritsen et al, 2005). On the other hand, the MOA practice nurse is trained to provide culturally sensitive services and to understand the often complex needs of asylum seekers, helps to bridge the gap with mainstream providers, and co-

⁴¹ GGD Nederland. Community Health Services for Asylum Seekers in the Netherlands. Utrecht, 2005.

ordinates services when necessary. The rationale behind the system may be apparent to native Dutch people, but confusing to people from non-western cultures.

MOA services are only available during office hours: the COA purchases out-of-hour services via the health insurer as part of the mainstream care package. Given the specific health needs of asylum seekers (vulnerability to injuries and accidents, mental health), this could lead to delay and confusion.

The Health Care Inspectorate reviewed the MOA services in 2002 and again in 2006, concluding they were accessible and of sufficient quality. Nevertheless, the COA has announced it will terminate the contract with the MOA in 2009. This is partly motivated by the political point of view that health care for asylum seekers should be a mainstream responsibility in its entirety⁴².

Data from a pilot evaluation study (Van Wieringen, 2002) show some levels of client dissatisfaction as regards opening hours –limited opening times-; the usefulness of information provided, the level of perceived understanding for their personal situation, and the outcome of consultation sessions.

Health service utilisation

In spite of their sometimes very considerable and urgent health needs, asylum seekers' overall utilisation of health care services –including GP services- is comparable to Dutch residents (Van Oort et al, 2003). The very high prevalence of mental health problems is not reflected in a high utilisation of mental health services. Only 14% of people with mental health needs are referred to mainstream mental health services (Gerritsen et al, 2005).

⁴² Source: www.coa.nl

Language and cultural barriers:

Cultural factors may impact on the uptake of services. When compared to other groups of asylum seekers, people from Somalia report less contact with a GP, less use of mental health services and of medication (Gerritsen et al, 2005). This may be related to the cultural preference to look ahead and not reminiscence in bad things that have happened in the past⁴³.

MOA nursing staff receive special training to help them understand the various cultural and historical backgrounds of their clients. To bridge language barriers, MOA staff relies on professional translators that offer their services by phone. Medical specialists, however, are reported to be reluctant to use these services. The Health Care Inspectorate has expressed its concern about this (IGZ, 2006b).

Organisational barriers: discontinuity of care as a consequence of relocation.

The Dutch immigration laws have become stricter over the last years. This has led to a reduction of new applications and of the absolute number of asylum seekers. Consequently, the number of asylum seekers centres more than halved between early 2004 (137) and late 2005 (64). Asylum seekers living in a centre that is closed down are then faced with relocation to another centre which may be in a different part of the country. Ties with local health service providers and other services –including education- are cut and have to be rebuilt somewhere else.

Confidential exchange of medical records between MOA staff at different locations can be guaranteed relatively easy: clients are informed in advance and asked permission as a standard element in the intake procedure. However, the exchange of records between mainstream service providers also requires the client to give explicit permission, as every Dutch citizen would. The MOA does have a role in coordinating and enabling this process, but can only do so when informed of the client's relocation. The Health Care Inspectorate has

⁴³ Personal communication: Nysingh, ten Broeke, Metz and colleagues.

identified this as a problem and has advised the IND and COA to inform the MOA more timely when clients are relocated (IGZ, 2006b).

Practice example

MOA guidelines and methodology for multi-agency collaboration

The MOA services are playing a key role in education and training of mainstream health service providers. This includes the development of guidelines for multi-agency collaboration to improve quality of services. There are seven such guidelines, each focusing on a health problem that calls for involvement of a range of professional services: maternity care; termination of pregnancy; domestic violence; child abuse; hunger strike; psychological crises; and suicide attempts (Verhave et al, 2005).

The high suicide rates among asylum seekers again show the importance of this kind of expert advice and support for mainstream health professionals. The guidelines highlight risk factors, explain how to recognise signals, and provide a protocol on how to act⁴⁴.

To accommodate for local differences in health service provision and networks, MOA also designed a methodology for developing local collaborative agreements (Schouten, 2006).

Practice example

Specialist mental health services for asylum seekers in home and sheltered accommodation settings

The high prevalence of mental disorders among asylum seekers and the complexity of these disorders have led to the development of two specialist mental health services:

1. Intensive treatment in home care settings (in '*PIT units*')

⁴⁴ Source: http://www.mikado-ggz.nl/artikel.php?artikel_id=793

This type of service is offered to people living in asylum seekers centres who suffer from long-term mental health problems that are so serious that they prevent them from maintaining basic life and social skills, but do not endanger either themselves or the other residents. These patients live independently in a specialist unit on the centre's compound where they receive a range of tailored services that are co-ordinated by specialist professionals from a mainstream mental health provider. Main objectives of these services are to stabilise and improve the patients' physical and mental health condition, and to improve quality of life wherever possible and to guide the patient towards a situation where he or she may be able to live within a more 'normal' environment, either within or outside the asylum seekers centre where it is anticipated he or she may still need treatment. The service was set up in 2000. In 2007, PIT services are concentrated in two asylum seeker centres, Leusden and Schalkhaar (Ten Broeke, undated).

2. High-level support in sheltered living accommodation

This type of service is delivered during a shorter -3 to 9 months- period of time. It focuses on asylum seekers whose behaviour causes problems to others and who are expected to benefit from intensive treatment in a quiet environment with little tension. The objective is to stabilise the patient and enable him or her to take up regular living routines within the asylum seekers centre⁴⁵.

⁴⁵ Personal communication: Nysingh, ten Broeke, Metz and colleagues.

POLICY EXAMPLE:

BUILDING THE KNOWLEDGE BASE FOR CULTURALLY SENSITIVE SERVICES:

PHAROS, NATIONAL KNOWLEDGE CENTRE FOR REFUGEES AND HEALTH

Pharos is a national knowledge centre specialised in the field of health care for refugees, asylum seekers, undocumented migrants and other migrants. It was set up in 1993 and is mainly funded by government. In the first phase of its existence, Pharos provided treatment for refugees and asylum seekers, but also supported professionals in the health care field working with this group. It also played a key role in international networking in the nineties, and was designated a WHO Collaborating Centre for Mental Health and Refugees in 1995. In 2001, Pharos' treatment services were shifted elsewhere. The organisation's main mission now is to support professionals and organisations that want to improve the provision of (health) care and services to refugees and migrants. To that end, Pharos develops practically applicable knowledge and methodologies, and offers information, training and advice. The organisation also developed prevention and health education projects, books, an information and advice line, an information and documentation centre and a magazine (Phaxx)⁴⁶.

3.1.3 Illegal immigrants: 'sans papiers' or 'undocumented migrants'

Population

Estimates of the number of people who are living –and sometimes working- in The Netherlands without any legal status range between 75,000 and 185,000⁴⁷.

⁴⁶ See: <http://www.pharos.nl/supernavigatie/english>

⁴⁷ Source: Pharos and Lampion, 2007.

This is a very diverse group of people. Among them are rejected asylum seekers; foreign workers without a work permit; victims of human trafficking; travellers and tourists who have overstayed the duration validity of their visa; and partners and family members of people whose residence permit is linked to a resident but have lost their legal ties with that person (for instance as a result of divorce). Approximately 25,000- 50,000 illegal immigrants are women. Most illegal immigrants live in the four major cities in the Netherlands.

Health needs and barriers

Specific health needs of asylum seekers and immigrants with a legal status are also reflected in the health needs of illegal immigrants. In addition, they may have health problems as a consequence of their status and situation. Stress-related mental health problems and depression are more common, as are psychosomatic complaints such as high blood pressure, digestive problems, headaches and back pains. Depending on their living conditions, they may also be at higher risk for infectious diseases –including TB- and malnutrition (Van den Muijsenbergh, 2004).

Preliminary findings from a study into the health of female ‘sans papiers’ reveals most of these women are living in vulnerable situations and under poor conditions. Nearly 50% of them perceive their overall health as bad, against 5% of the native Dutch women. Mental health needs are high. Approximately one third of the women in the study report incontinence problems, 44% report having been subject to sexual violence and 52% have had at least one abortion⁴⁸.

Each year, 500-1200 babies are born out of illegal immigrant mothers. Sometimes these newborns are registered with local authorities. This option is open to anyone and there is no need to leave a registered address. Registration improves the child’s access to local preventative health services and 0-4 children’s services.

⁴⁸ Source <http://www.lampion.info/Symposiumverslag.pdf>

Access to services may be severely hindered by fear of being 'discovered' and sent back to the country of origin. People delay accessing services and/or break the ties with their service provider, leading to discontinuity of services and medication. While some access options exist for acute health needs, this is not the case for treatment of chronic conditions. Consequently, access to treatment of conditions such as arthritis, diabetes or HIV infection is a particular problem (Stam, 2004).

In cases where illegal immigrants do turn to a professional health service provider for treatment, they may find that not all of them are willing to provide care. A small number of health professionals, on the other hand, may have a disproportionately large number of illegal patients (Van Oort et al, 2001). Care providers in need of additional information or support when helping illegal immigrants and other clients 'sans papiers' can turn to a special national expertise centre: Lampion⁴⁹.

Rights to services

While illegality in itself is not an offence, the individual has no rights. Illegal immigrants are excluded from access to public services, with the exception of legal aid, education (for children between 5 and 16), medically necessary health care (see below) and preventative health services in the interest of public health protection.

Preventative public health and health promotion services are a responsibility of local authorities under the Collective Preventive Public Health Act (*WCPV*). This Act does not make a distinction between legal and illegal service receivers. Consequently, illegal immigrants can appeal to the local 'municipal health service' (GGD) for preventative health service for infants aged 0-4 and for immunisation of their children, or for STD and TB services.

⁴⁹ See: www.lampion.info

Policy

Since 1998, entitlement to social protection –including social health insurance– is linked to legal residence status via the *Koppelingswet*, which was incorporated in the 2000 Immigration Law (Aliens Act). Taking out health insurance, though, is a private arrangement and theoretically, illegal immigrants could do so. However, all but one health insurance company require their clients to show a residence permit as a precondition for coverage.

In accordance with international human rights the *Koppelingswet* does acknowledge the ‘minimal duty to care’ for those residing in the Netherlands without a legal status. To that effect, the law includes an exemption to safeguard ‘emergency and medically necessary health care’. This concept is further defined as care provided in ‘a situation that does not allow for withholding or delay of medical care without jeopardising the life or health care of the person involved and/or seriously endangering public health in the Netherlands’. What exactly should be considered as ‘medically necessary’ is left to the discretion of the health care provider and more particularly of the medical professional. It does include maternity services.

To cover the costs that primary health care providers may have to make to provide medically necessary care a special fund (*Koppelingsfonds*) was created. Resourced by the Ministry of Health, administration and reimbursement is handled via a charity foundation⁵⁰. Hospitals, emergency services, and residential rehabilitation centres are to book these costs under a special budget post. The Ministry of Health has stressed that both sectors (primary care and acute) need to ensure they do all they can to reclaim the treatment costs on the individual concerned (Ministry of Health, Welfare and Sports, 2006a), similar to the situation as regards uninsured people (see 2.2.6).

This arrangement still stands in the new health care system, but as of January 2006 hospitals have a legal obligation to ask all their patients for formal

⁵⁰ See <http://www.stichtingkoppeling.nl>

identification. Their financial leeway has also been tightened under the new negotiations with the health insurers. As a result, the hospital management may put pressure on the medical professional working within their hospital to restrict or even refuse service provision to illegal immigrants. The medical professional is then caught between their professional obligation to meet the need of their patients on the one hand and the financial requirements of the hospital management on the other.

This had led to a need for more explicit clarity about the basket of services that could be considered 'medically necessary', and the conditions under which they could and should be provided. The Royal Dutch Medical Association (KNMG) has set up a commission to provide professional guidance on this matter.

The Dutch Association of Paediatricians (NVK) has already developed a 'code of behaviour' for treatment of children from illegal parents. This code reaffirms the importance of providing medical care and support at all times, regardless of the legal status of the child. It also confirms the professional responsibility for continuity of care. Consequently, the professional will object against involuntary relocation –including repatriation to the country of origin- if this can have adverse effects for the child's health⁵¹.

3. 2 Older people with functional limitations

3.2.1 Socio-demographic information

In 2006, 2.2 million Dutch people were aged 65 or over, which is 14% of the Dutch population. This percentage is relatively low compared to many other EU-countries (CBS, 2006). The majority of older people are women and this is even more so in the eldest age groups: of all 75-84 year-olds 61% are women, for the over 85s this is even 73% (De Boer, 2006). Not only do women live longer than older men, they also live longer in relatively poorer physical and mental health.

⁵¹ www.nvk.pedinet.nl/pdfs/gedragscode_kinderarts_illegaal.pdf

As noted in chapter 1, overall poverty risk is low for the Dutch population above 65 years (5% in 2004). Low income levels are underrepresented in the age group of 65 and this older population has to face less material deprivation when compared to the younger people. However, poverty is relatively more prevalent among older women.

While the death of a partner generally leads to a reduction in the disposable income of the surviving partner, the reduction is relatively larger for widowed women who will generally have to rely on their husbands' retirement pension. That pension is then converted into a lower surviving dependant's pension (De Boer, 2006).

The population aged 75 and over seems to be more at risk of social deprivation (SPC, 2006). For all older aged groups, social participation is most likely to be impaired among people with mental health needs, including cognitive impairments as a result of dementia (Hoeymans et al, 2005). An estimated 730,000 of the people over 65 are living with functional limitations⁵².

For 2004, an estimated 800,000 people between 50-74 years old could be qualified as having low literacy levels. Although computer ownership has increased rapidly among older people, many are still not able to use a computer and have difficulty accessing information provided via internet. Approximately 16% of people over 75 living independently have difficulty filling in forms and paying bills via bank accounts (De Boer, 2006).

Health needs

Coronary health disease, stroke, COPD, lung cancer and diabetes are the most prominent health problems encountered by Dutch 65-75 year-olds. An estimated 8% of people aged 65 and over suffer from dementia (Gezondheidsraad, 2002). For one in every five older persons with dementia, their condition has reached severe levels. Co-morbidity is thus a common

⁵² Based on estimates on www.movisie.nl

phenomenon among the elderly: almost a quarter of 65-74 year-olds and a third of the over-75s suffer from more than one chronic disorder⁵³.

In 2003, almost half of all older persons (in this case 55 and over) with severe physical disabilities received some form of home care (including nursing care at home), while a quarter received informal help (De Boer, 2006). Research into the situation of patients in residential and nursing homes in the Netherlands (97% of which were 65 and over), indicates approximately 75% of all residents are female. The average age of people in residential and nursing care is 84, but over 50% of all residents are 85 or older.

3.2.2 Waiting

As of January 2005, approximately 52,000 people were waiting for some form of nursing care, to be delivered either at home (31%) or in a residential setting (69%). While this number includes all age groups, 80% are 75 or older, and around 50% is between 80 and 90 years old.

In October 2003, waiting times averaged between 4 – 13 months, which exceeds the agreed norms considerable. Waiting times vary considerably between regions (Kostalova, 2006).

While waiting, 65% rely on substitutive care, usually home care (Van Gameren, 2005). Those who have to wait in hospital face costs if they have to wait longer than four weeks after their need for residential care is confirmed. From that moment on, they will have to pay the regular co-payment *AWBZ* fee set for the first six months of residential care. Depending on income, this fee can amount to a maximum of € 696 per month.

3.2.3 Overall access and responsiveness issues

Research findings suggest older people's access to medical care in the Netherlands leaves much to be desired (Kool et al, 2005; Heymans et al, 2003). Factors that play a role here are:

⁵³ Source: CBS/SCP.

- shortages of medical, nursing and support staff in residential settings and nursing homes;
- lack of collaboration and co-ordination across professionals and sectors, resulting in discontinuity of care and problems with medication;
- Limited understanding of co-morbidity resulting in a narrow focus on one specific illness and serial treatment;

On an annual basis, one in five independently functioning people over 65 is given at least one prescription that may actually be harmful to their health. The building of new knowledge is hindered by the fact that older people are often not included in medical or pharmaceutical research (IGZ, 2004b; Gezondheidsraad, 2005). Meanwhile, the prolonged and multi-use of medication is common among older people. Two-thirds of people aged over 65 take at least one form of medication daily, 30% of the population of 74 years and older takes more than four different medicines each day (Raijmakers et al, 2005).

Both the Health Care Inspectorate in 2004 and the Health Advisory Council in 2005 warned that quality of medical treatment and care to older people was far from optimal. They also called for improvement of the understanding within in the health and care sector of geriatric and co-morbidity issues.

Results from a focus group interview suggest proximity and more flexible availability are important issues for them when it comes to access of GP services. Suggestions for improvement included more options for longer consultation sessions; daily opportunities to consult the GP over the phone; walk-in consultation options; a brief consultation option on Friday to reduce anxiety as regards the weekend; more opportunities for home visits; shorter distances between GP surgery and the pharmacy; and a less prominent role for the GPs assisting staff as regards the process of making an appointment.

Proximity to pharmacy and dentist, less fragmentation and more continuity of home care, and more personal time with the home care provider were mentioned as important improvements for other primary and community

services, as were a stronger focus on preventative health and regular health checks (Brouwer et al, 2006).

3.2.4 Specific remarks on mental health

As age advances, mental disorders become more common. Almost one in every five 75-85 year-old suffers from a depressive disorder. Of all 55-85 year-olds, 10% of 55-85 year-olds suffered from anxiety (especially generalised anxiety), 15% from depressive disorders (in particular minor depression), and a further 10% from cognitive disorders. Women suffer from depression or anxiety significantly more often than men (data from 1993; De Boer, 2006).

Access to ambulant mental health services, however, seems to fall short for older people. One in every five older (aged 65 or over) people visit their GP because of mental health needs, predominantly because of problems related to depression and/or anxiety. Only a small proportion is referred on to mental health services. Only 3% of clients of psychologists working in primary care settings are 65 or over, while 13% of the population falls within that age bracket (Pot et al, 2007).

Older persons living independently make less use of mental health care provisions than younger adults: 5.3% of 35-54 year-olds had used mental health care services in the 12 months preceding the survey, compared with only 2.4% of 55-64 year-olds and 1.7% of the over-65s (De Boer, 2006).

Factors identified as playing a role in under-treatment of depression and other mental disorders among older people include:

- the mental health needs of problems of older people are not recognised as such, for instance because their complaints may not meet the standard diagnostic criteria;
- all attention is focused on other –physical- problems;
- a feeling of depression is often considered to be a normal aspect of growing old and of persistent medical problems

Recognition of mental health needs may not necessarily result in treatment as professionals may believe little can be done to alleviate the depression, or may be worried about the negative effects of anti-depressants (Penninx, 2002). Also, older people with depression may be prescribed the wrong medication, particularly benzodiazepines (as cited in De Boer, 2006).

3.2.5 Older migrants

As highlighted in chapter 3.1, the financial situation of migrants is relatively poor. This is particularly true for older migrants due to their limited entitlement to state pension (AOW) and capacity to build up an additional pension. 53% of all minority ethnic pensioners is living in poverty, compared to 14% of their native Dutch counterparts (Merens and Van der Vliet, 2006).

AOW entitlements are linked to length of stay in the Netherlands between the ages of 15 and 65. Maximum state pension is only available to those who have lived in the country for a period of 50 years. For each 'absent' year, 2% is subtracted from the pension. Consequently, 99.9 % of Turkish and Moroccan men, 90% of Surinamese men and 78% of Antillean men do not receive full AOW pension, compared to 5 % of native Dutch men. The figures are even worse for women (SVB, 2006).

Consistent employment is an important prerequisite to build up additional pension rights. The opportunity to do so is subject to length of employment. People who have migrated to the Netherlands at a later stage in their life are likely to encounter problems in this respect. The high unemployment levels among non-western migrants suggest participation in employment-related pension funds may be out of reach for many.

Again, the situation for women is even less favourable: they have often joined their husbands later in life, and many of them have never been in paid employment. Many migrant women are younger than their husbands and therefore likely to face widowhood in old age (Schellingerhout, 2004).

Information on the health needs, services utilisation and access barriers of older migrants is available, but based on interviews with relatively young (55 and

over) population of Turks, Moroccans, Surinamese and Antilleans. From this piece of work (Schellingerhout, 2004) the following picture emerges:

Overall, the perceived health of Turkish, Moroccan and Surinamese older persons is worse than that of the other elderly groups. On average, men enjoy better health than women, and health problems increasing with age. Education level is an important health determinant. The percentage of persons with severe physical limitations and reported chronic disorders is highest among older Turks, when compared to Moroccans and Surinamese and for all these three groups it is higher than the native Dutch population. Antillean and Moroccan older people report slightly less limitations and disorders than the native population. Due to the interplay of health determinants, older persons with several chronic disorders often have physical limitations, poorer mental well-being and poorer perceived health.

The utilisation of health care services is higher than the native Dutch population, but mainly determined by perceived health and reported chronic disorders. Adjusted for these factors the take up of provisions is equal or even lower than Dutch natives. In some respects, utilisation of medical services may be culturally determined. Older persons with a lower degree of social and cultural integration use more prescription medicines, visit the GP more often and visit the dentist less frequently than older persons who are more socio-culturally integrated.

Turkish and Moroccan older people are satisfied with their GP, but less so when compared to older people from the other three migrant communities. Not being able to arrange appointments at short notice, and a difficulty understanding their GP are mentioned as key problems. Many Turkish and Moroccan (61% respectively 53%) need language assistance when visiting their doctor. This is, however, seldom provided by professionals but almost always by the partner or children instead. The need for language assistance is especially marked among older Turkish and Moroccan women.

Older migrants do not use of home care services as much as their indigenous peers, even when differences in physical limitations and other health indicators are taken into account. Surinamese older persons are the exception to this rule: they use home care services as often as the native Dutch population. Over 45%

of Turkish older persons with severe limitations receive no help whatsoever, either formal or informal.

Low utilisation of home care is caused predominantly by a stronger reliance on informal care. Older migrants prefer help provided by children and family, and informal care is often more readily available (larger families, children living nearby). However, older migrants may also encounter difficulties accessing home care services. They may expect language problems, encounter problems applying for the services, consider it too expensive, or may not even be aware these services exist. Lack of knowledge about the service is especially prominent among older Turkish people.

3.2.6 Impact of health system reforms

The recent health system reforms have created a new compartment (the Social Support Act, see also 1.1.1). This could lead to new problems at all interfaces of the new and/or modernised compartments. For older people with functional limitations, some of these may have relatively large impact:

- Under the Social Support Act (*WMO*), local authorities have become responsible for purchasing home help services previously covered under the *AWBZ*. Local authorities put these services out to tender. Consequently, many clients lost contact with their long-term professional carers.
- Under the *WMO*, the provision of mobility aids has also become a local authority responsibility. Clients can also opt to receive a personal budget in order to buy their own appliance, thereby increasing opportunities for choice.
- A one-stop-shop approach for all services provided via the *WMO*. This could impact positively on access as application procedures may become less complicated.
- People who are eligible to receive care in a residential setting – and would therefore have the costs of their domestic services covered – but have chosen

to stay at home to receive their health care there can also have these cost covered⁵⁴.

As discussed in chapter 1 and 2.8, the various system changes are partly motivated by the objective to increase both individual choice as well as individual responsibility. The emphasis on the responsibility of the individual and his or her family is also reflected in the new concept of 'customary care' (*gebruikelijke zorg*). This concept refers to the kind of care and support that can reasonably be assumed to be delivered by family or loved ones. This implies that those closest to the person affected – in practice a partner where present and any available children living at home – are expected to provide the necessary care. Applications for formal care can only be granted when the need for care is prolonged and there is a lack of informal resources (CIZ, 2005).

The changes require patients to take on a more pro-active role on the market. However, in 2006 older people made relatively little use of the opportunity to change their health insurer. While 20-25% of 18-64 year-olds changed, only 10% of people aged 65 and over did so (Smit and Mokveld, 2006). This cannot be due to selection factors: insurers had to accept every applicant when the system changes were introduced in 2006, including those applying for complementary packages.

The use of appliances may have played a role as these can be on loan from the insurance company and the new insurance company has to be willing to take over that contract. It is not clear whether any assumptions about possible refusal may have influenced older people in refraining from changing their contracted insurer (De Jong and Groenewegen, 2006).

The financial aspects of the change may also cause problems. For pensioners, the income-related premium for standard coverage amounts to 4.4% of their income. However, this premium is automatically withheld and therefore people reliant on more than one pension pay twice. This problem has been recognised

⁵⁴ <http://www.minvws.nl/kamerstukken/lz/2006/volledige-zorg-thuis-en-pgb.asp>

by both the government and parliament, as a result of which excess premium payment will be reimbursed⁵⁵. Nevertheless, payment does take place in advance and may cause short-term cash-flow problems for people at lower income levels.

Financial barriers may emerge when local authorities ask their citizens for an out-of-pocket contribution for home help and other services provided under the Social Support Act. Local Authorities are free to do so –and the level of the contribution may differ from one authority to another-, although some refrain from this.

In 2005, only half of all people with disabilities or chronic disease made use of the opportunity for a tax rebate due to exceptional illness expenses, while 83% would be eligible. Research suggests this is predominantly owing to wrong assumptions about –lack of- eligibility (in 54% of all cases) and not applying for a tax return form and/or filling in the form (39%). Those who did apply had more often receiving a written tax return reminder compared to those who had not. Those over 65, however, were relatively well represented among applicants (Pannekeet-Helsen et al, 2007).

3.2.7 Policy targeting service innovation and efficiency

Late 2003, the Ministry of Health, Welfare and Sports launched a programme to increase efficiency, improve quality and encourage innovation in the hospital sector. This *Sneller Beter* (Better Quicker) programme aims to foster innovation and learning from good examples. It focuses raising awareness and benchmarking; performance measurement and transparency; and improvements in hospital settings.

A similar programme was set up for the long-term care sector under the banner *Zorg voor Beter* (Making it Better).

⁵⁵ Source: www.kiesbeter.nl

POLICY EXAMPLE:

FOSTERING INOVATION IN LONG-TERM CARE:

THE ZORG VOOR BETER PROGRAMME

The *Zorg voor Beter* (Making it Better) programme encourages the long-term care sector to improve the quality of the care provided within the scope of the AWBZ, e.g. residential care, personal care, treatment and counselling. It aims to support service providers to improve quality of care, adopt a more client-centered yet result-driven approach, measure their performance, and learn from each other.

The programme facilitates identification, implementation and dissemination of good practices (National Strategy Report 2006-2008). It also supports a national programme to improve services for people with dementia. Other themes covered in included pressure sores, preventing falls, prevention of sexual abuse, nutrition, and safety of medication.

‘Making it Better’ is initiated by the Ministry of Health, Welfare and Sports and co-ordinated by the National Health and Healthcare Research Fund. The programme is implemented by Vilans and TNO Quality of Life. A total sum of 36.6 million Euro is available for the programme. Government funding will be available until the summer of 2009⁵⁶.

3. 3 Conclusions

As highlighted in chapter 2, the impact of access barriers may accumulate within certain population subgroups and the adverse effects may be mutually

⁵⁶ <http://www.zonmw.nl/nl/programmas/alle-programmas/zorg-voor-beter/>

reinforcing. The population groups most at risk of encountering access problems are similar to those at risk of poor health. There is sufficient evidence to conclude that poverty, social exclusion, poor health and health access problems go hand in hand, also in the Netherlands.

For non-western migrant communities this is certainly the case. They are overrepresented in the Dutch poverty statistics, have less a favourable health expectancy and overall health status, and may encounter a range of barriers in accessing good quality health care services. While migrants clearly do find their way to primary care services, GPs invest less time in per session with them. Given the additional challenges posed by language and communication problems, the opposite would be expected if equal quality of service is to be safeguarded.

Levels of cultural assimilation, Dutch language proficiency, and education are important factors in developing effective help seeking behaviour as regards mental health services. It is not clear to what extent these findings can be extrapolated to the broader health care sector. Nevertheless, the under utilisation of medical specialist and home care services by older first generation migrants of Turkish and Moroccan descent and their strong reliance on informal care suggest this may indeed be the case.

Added to the relatively high levels of non-insurance among migrant communities and their low uptake of the Health Care Allowance, the impact of barriers to service access accumulates along with migrant's levels of unmet need. Against the backdrop of an ageing migrant population the social and economic consequences may worsen if no measures are put in place to improve access to services for older first generation migrants. It is not so much the lack of solidarity measures as such but rather the utilisation of these measures by migrant communities that cause problems.

Insofar as access problems are susceptible to lack of financial resources, they may be worsened by the limited pension entitlements of older migrants, and particularly of older migrant women. These women are also likely to encounter

problems in communicating with health professionals, and in other areas of health literacy.

Policy makers have acknowledged the importance of good quality accessible health services for migrant populations. The development of culturally sensitive services and has been on the local and national government agendas since the late '80. This had led -among other things- to peer-based health promotion and culturally sensitive education and training. The current market reforms have, however, caused government to withdraw as an active partner in generating these kinds of activities: it is now up to the market's key players to deliver good quality services for all. Government still has a role in safeguarding equitable access and monitoring performance, though. The broad range of access problems faced by some migrant groups suggests a specific focus on their situation should be included in that monitoring process.

Health service access for asylum seekers is closely related to their status and choices made by the Ministry of Justice within the context of asylum policy. Asylum seekers are housed in specialised reception or repatriation centres. From a health access perspective, this opens up more possibilities to reach asylum seekers with health information and preventative services. Also, specialised services can be delivered more efficiently. On-site community health services (MOA) do meet the demand, even though their -lack of- out-of-hours availability may cause problems.

The decision to set up on-site community health services (MOA) originated from asylum policy, as does the recent decision to abandon this model in 2009.

On the less positive side, lengthy asylum and immigration procedures can impact negatively on asylum seekers' health. Lengthy procedures imply people have to cope with long periods of insecurity and long mandatory stays in the asylum seekers' centre. Again as a result of immigration policy, centres may be closed. Their inhabitants are uprooted, having to relocate to another centre in a different part of the country. From a health access perspective, this may throw up an extra hurdle as it may frustrate continuity of care. Also, people have to re-establish their relationship with local MOA-staff and other health service

providers. This may be particularly problematic in case of mental ill-health, where the building of trust is so important in treatment and support. Given the high prevalence of serious mental health problems among asylum seekers, this could set back effectiveness of mental health service provision.

Relocation processes also impact on the innovative specialist services set up by mental health providers, such as *PIT* projects. These are only offered by a few providers, who have a regional remit. Consequently, the first unit had to close down with the closure of the asylum seekers centre in the area. Pharos, the national expertise centre, can play a key role in supporting mainstream health care providers across the country to deliver sensitive services for asylum seekers living in their area.

Immigration law also impacts on health service access for illegal immigrants, albeit in a totally different way. The *Koppelingswet* has made it impossible for undocumented migrants to access any form of social protection, including coverage of long-term services through *AWBZ*. Theoretically this does not limit their option to take out health insurance, but in practice health insurers do not provide coverage to people who without a residence permit.

The market reforms seem to have made matters worse. Not only are hospitals now legally required to ask their patients for identification, but government is also no longer willing to cover additional costs incurred by hospitals as a result of treating illegal immigrants. These patients are not part of their client population of health insurers and services provided to them are not part of the contracting process on the health care market. Health professionals are put under pressure to be more stringent in the application of international human rights agreement as regard entitlement to emergency care. Preventative services, which are provided by the local authorities and are not funded via the private health insurance market, are not affected by the health system changes.

The social-economic position of older people in the Netherlands is relatively favourable. They form a very diverse population ranging from very active, assertive, affluent and computer literate people to frail, vulnerable people with multiple needs and low pensions. Some older people may therefore be very well

able to make the most of the opportunities of the new market system, just as they have been relatively successful in using financial solidarity measures such as tax rebates to compensate for excessive health care costs.

On the other hand, the market changes have relatively passed many older people by: only a small minority changed health insurer in 2006 and benefited from the window of opportunity to secure their additional coverage without pre-conditions. Existing contracts for appliances could have been one reason for staying with their insurer. As, from 2007, health insurers are allowed to set conditions for additional coverage, older people with known health problems may miss out on at least this aspect of market dynamics, unless they join a collective (see 2.4.6).

The increasing role of internet-based information as a key instrument for 'health care consumers' to operate on the market may impact negatively on older people's ability to take on that role.

At the other end of the health system spectrum, the new responsibilities of local authorities for purchasing and coordinating social support services could be beneficial for older people. The one-stop-shop approach close to home may make things easier and simpler for them. The fact that many local authorities have contracted in other service providers, however, has caused upset among some older people who had to part with their trusted home help. The introduction of the 'customary care' concept may throw up an additional hurdle to access long-term (*AWBZ*) care, particularly for older people without a strong social network.

Organisational access hurdles impact relatively strongly on older people. Waiting lists for home and residential care cause problems, especially for the very old. Should they have to wait for this type of care while occupying a hospital bed, this may literally cost them as they have to start paying their *AWBZ* co-payment after four weeks even if they are still in hospital.

Health systems and health service organisations also seem ill-equipped to respond to patients with more than one disease. Co-ordination and continuity of care leave much to be desired, as does adequate prescribing. While in a

general sense services seem to fall short in responding to older people's needs, this is particularly true as regards their mental health needs.

These shortcomings seem at odds with the kind of services older people themselves would want, such as personal contact, close to home, integrated service provision, good out-of-hours availability. Improvement and innovation of health and long-term services are addressed via government funded programmes such as Better Quicker and Making it Better.

4 Country information for the case study on mental health

4.1 Introduction

Based on data from 2003, Den Hollander et al (2006) concluded that mental disorders are the most prominent cause for quality of life lost for the overall Dutch population, but particularly for women. For women, anxiety and depression are the two leading diseases causing loss of quality of life. Table 6.2.8 (Annex) provides more insight into the incidence and prevalence of mental disorders, as measured in that year.

These data suggest that, in 2003, more than 500,000 people in the Netherlands suffered from either depression, anxiety disorders or schizophrenia. Lifetime prevalence of mental ill-health is much higher, however. At any one point in their life, 42.5% of men and 39.5% of women in the Netherlands will suffer from some form of mental illness (van Dorsselaer et al, 2006).

While many people may therefore be confronted with a mental illness during their lifetime, a much smaller group of people could be classified as chronically suffering from high levels of mental illness. Estimates from Michon et al (2003) suggest that at any one time, there are approximately 72,000 people with chronic mental disorders in the Netherlands, 48,000 of which receive mental health services over a prolonged period of their life. Around 7,000 of them are treated within long-term hospital settings, while 24,000 do not receive any care (Michon et al, 2003). Only ten percent are in regular employment.

Data on mental health in The Netherlands suggest people from some migrant communities may be more at risk for some forms of mental disorders. Compared to Dutch natives, schizophrenia is relatively more prevalent among Surinamese, Antillean and Moroccan migrant communities (Foets et al, 2005b). Older Moroccan and –particularly- Turkish migrants are at higher risk for depression, with Turkish women over 65 showing the highest depression rates (Van der Wurff et al, 2004; Foets et al, 2005c).

4.1.1 Legislation

In the Netherlands, people with mental disorders have the same rights to health care access as any other person. The position of *all* patients and clients is protected and supported through several laws. These include the Law on Contracts for Medical Treatment (*Wet op de Geneeskundige Behandelingsovereenkomst*), the Client's Right of Complaint (Care Sector) Act (*Wet klachtrecht cliënten zorgsector*), and the Participation (Clients of Care Institutions) Act (*Wet medezeggenschap cliënten zorginstellingen*).

These laws also apply to people with mental disorders and/or clients of mental health services, and are explained in more detail below:

- The Law on Contracts for Medical Treatment (*Wet op de Geneeskundige Behandelingsovereenkomst*, *WGBO*, 1995) lays down health professionals' responsibilities to provide good quality care. It also safeguards patient rights. Key themes addressed through this Act include:
 - The duty to provide patients with clear and understandable information about diagnosis, treatment and associated risks, so that the patient can take informed decisions about his or her health;
 - The requirement of informed consent for all medical treatment;
 - The legal position of minors;
 - Privacy and confidentiality;
- The Client's Right of Complaint (Care Sector) Act. (*Wet klachtrecht cliënten zorgsector*) deals with the possibility to appeal through official complaints committees.
- The Participation (Clients of Care Institutions) Act (*Wet medezeggenschap cliënten zorginstellingen* (*WMCZ*)). This is a mechanism to ensure the voice of clients is heard within residential and in-patient settings. Every health and social care service –including

mental health services- has to set up and support a 'client council'. These councils have the legal competence to advise service providers on matters related to health service quality.

There is one specific law that may impact negatively on the accessibility of health care services to people with mental disorders: the Psychiatric Hospitals (Compulsory Admissions) Act (*Wet bijzondere opnemingen in psychiatrische ziekenhuizen, Bopz, 1994*). This act safeguards the legal rights of persons suffering from a mental illness in the event of and during involuntary admission to a mental hospital (Ministry of Health, Welfare and Sports, 2004b). The act lays down rules for the procedure for compulsory admission, the discharge of patients and the granting of leave, the use of compulsory treatment, the use of means of restraint and restraint measures, and the restriction of the freedom of the patients during their compulsory admission. It also provides for a complaints and compensation procedure. The act may that may also apply to people with learning disabilities or people suffering from dementia.

For people admitted under this act, decisions as regards their somatic health needs are taken by their legal representative. The Act by no means restricts any rights to somatic health care, but it does the particular patient cannot make any independent decisions as regards his or her health care needs.

The Compulsory Admissions Act is evaluated every five years and discussed with parliament. Over the past few years, these evaluations have led to a broadening up of legal possibilities for compulsory treatment. The policy rationale behind this is that this would improve options for and limit duration of treatment. In 2007, a new element has been added: clients can sign a formal declaration that they agree to compulsory treatment when this is considered appropriate. The client will have to sign this when he or she is –still- fully aware and competent to make this judgement.

Unlike in some other EU countries, seclusion separation is not forbidden in the Netherlands. Annually, approximately 18,000 people with mental health

disorders are put in separation while in a mental hospital. This is only allowed in case of serious acute danger for the patient or his/her environment⁵⁷.

4.1.2 Policies

Currently, there is no overarching national mental health policy in the Netherlands, nor an overarching national policy on mental health services. Instead, issues related to prevention, care and cure of mental ill-health are incorporated into overall health promotion, health care and social support policies.

The national public health policy for 2007 – 2010 (Ministry of Health, Welfare and Sports, 2006b) thus includes a focus on the prevention of depression as one of five priority areas, along with tackling overweight, smoking, alcohol abuse and diabetes. The way this is translated into preventive programmes is discussed in more detail in par. 1.1.3 ('plans and programmes'). Other areas of mental health are not addressed within the national public health policy document.

Government policy on mental health care strives to integrate thinking about mental health services into broader health care policy frameworks. Policy pivots around two themes:

1. Improving collaboration between mental health service providers and other players in health and social care, strengthening the role of primary health care, and putting a halt to the further development of mental health services as a separate sector.

This is underpinned by an increasing awareness of the impact of co-morbidity issues among policy makers: 'somatic and mental health problems are insufficiently recognised and responded to in a way that takes their interplay into account' and 'the needs of people with mental

⁵⁷ Source http://www.ggzplaza.nl/nl/index.php?nodeID=14&action=article_detail&id=774

health disorders cannot be met by the specialist mental health sector only' (Ministry of Health, Welfare and Sports , 2003).

2. Bringing the system of mental health service finance in line with that for the acute health sector. This is based on the rationale that mental health services should be perceived as health services, and should therefore be based on the same principles and funded according to the same system. Consequently, funding of treatment-oriented services is shifted to the Zvw and only long-term care will remain covered via the AWBZ. In addition, innovative schemes set up to improve quality and effectiveness of somatic health care also become available for mental health services.

Section 1.5 will discuss in more detail how these shifting policy paradigms are translated into practice.

For the purpose of this report it is important to note that, in spite of the recognition of co-morbidity factors, policy proposals focus almost exclusively on a more adequate response to meeting *mental* health needs. The question as to how the *somatic* health needs of people with mental disorders could be met more appropriately seems to be outside policy makers' scope.

Reducing waiting lists for mental health services was a specific objective in the 2003-2005 National Action Plan on Social Inclusion (see also 1.2.2 of the Netherlands country study). The 2006-2008 National Strategy Report (NSR) concludes the initial target - a maximum of 35,750 people waiting for care services- will not be achieved, but the number of people waiting did decline by 1.5%. Supply of services did increase and seemed to keep pace with increasing demand. Hence, it was not considered necessary to include the target in the current strategy report.

4.1.3 Plans and programmes

Prevention

Access to evidence-based interventions aiming to prevent depression is a specific priority within the framework of the national public health strategy (Ministry of Health, Welfare and Sports, 2006b). The need for improved access

to prevention services is illustrated by the fact that only one percent of all estimated 359,000 Dutch residents suffering from depression indeed access preventative services. Barriers acknowledged being of influence here are poor links between mental health prevention services and primary care services; limited integration of preventative services within regional collaborative service arrangements; and fear of stigmatisation that may block people with depressive complaints from asking for help.

The national strategy document does not set any specific targets. For the implementation of the objective it refers to the 'Depression Prevention Partnership'. This is a major initiative led by the two key players at national level, the Trimbos Institute –with a national remit in mental health promotion and research- and the Dutch Mental Healthcare Association (*GGZ Nederland*).

Increasing awareness of mental health problems and developing e-health solutions such as depression prevention courses via the internet⁵⁸ are among the suggested measures to improve access to mental health prevention. In 2007, 65 preventive web-based interventions targeting young people, adults and older people could be identified (Riper et al, 2007).

Care and cure

As pointed out in 1.1.2, national innovation and quality improvement schemes have opened up to initiatives that aim to improve mental health services. There are three such programmes, each targeting one 'silo' of the health system: acute care, social and long-term care, and public health. Improving access to mainstream services for people with mental disorders does not feature specifically in any of them.

The increasing recognition of the impact of co-morbidity, however, has given way to a strand of work that could help improve the health of people with mental disorders. The 'Making it Better' (*Zorg voor Beter*) programme includes a nationwide scheme aiming to improve somatic health of people with mental

⁵⁸ See <http://www.kleurjeleven.nl/>

disorders⁵⁹. The programme targets the mental health sector and their role in assisting their clients. Improving collaboration with mainstream somatic health services is, however, a key element of the programme. It has identified several good practices, all of which are carried out under responsibility of the mental health sector (see further 1.4.6).

Efforts to improve insight into mental health problems among mainstream care providers include a nationwide programme to improve the quality of primary mental health care, implemented via the Dutch College of General Practitioners (NHG) and the National Association of General Practitioners (LHV). As with many other initiatives that aim to increase the role of primary care professionals, the prime focus is on meeting mental health needs, not on somatic needs of people with mental health disorders. An evaluative study concluded the programme's impact on GPs professional practice with regard to mental health care was limited (see further 1.5.2).

Public awareness

The National Mental Health Fund (*Fonds Psychische Gezondheid*) plays an important role in public awareness campaigns and the provision of information about mental ill-health to the broader Dutch public. The Fund's activities range from nationwide billboard and mass media campaigns to organising events around Mental Health Day and running a national telephone information line. They also have an annual budget of 600,000 Euro to fund research, innovative care initiatives, prevention and awareness, and to provide individual support⁶⁰.

The Fund's most recent national campaign focuses on young people. It tackles stereotypes and improves awareness of the prevalence of mental health problems among young people. Six young national celebrities are involved in

⁵⁹ See <http://www.zorgvoorbeter.nl/onderwerpen/over/psychische-en-somatische-problematiek/>

⁶⁰ See www.fondspsychischegezondheid.nl. Dutch only

the campaign. It is supported by a computer game, education pack for schools for further education, posters and freecards, and a website⁶¹.

4.1.4 Research

Structured research activities that could contribute to or provide insight into access to health care for people with mental disorders include:

- Research on public perceptions and attitudes toward people with mental health disorders, and the impact of negative attitudes on delay of help seeking behaviour. Funded by the National Mental Health Fund and implemented by the Trimbos Institute, this research does not include a focus on attitudes of health care professionals or on delayed access to acute services.
- The Netherlands Mental Health Survey and Incidence Study (NEMESIS). This is a nationwide cohort study into mental health based on data gathered between 1996 and 1999 from representative sample of the 18-64 year-old population. Among many other things, NEMESIS I did look into the implications of mental ill health for employment, care and quality of life (Vollebergh et al, 2003). NEMESIS II is scheduled to start in 2007 and will also include a focus on co-morbidity.
- Policy-driven research aiming to contribute to better collaboration between primary care and the mental health sector, carried out by NIVEL (Netherlands Institute for Health Services Research). This research is to support the system reforms, particularly the shift of treatment-oriented mental health services to the Zvw and the strengthened role of the primary care sector.
- Between 1997 and 2006, the National Health and Healthcare Research Fund (*ZonMw*) supported research into diversity issues. This strand of

⁶¹ <http://www.fondspychischegezondheid.nl/jongerenproject-ben-jij-gek.10.html>

research also included work on the responsiveness of mental health care for people from minority ethnic communities.

- RIVM's research into the performance of the Dutch health care sector (see chapter 1). This does include information on consumer experiences with acute health care, but not on the experiences and views of people with mental health disorders in this respect. It also concludes that information on consumer experiences with mental health services is lacking.

In summary, none of the prominent national lines of research provide specific insight in the question that is central to this case study: access to general health care services for people with mental disorders.

4.1.5 Health services

When living in the community, people with mental disorders are expected to rely on mainstream health services in order to have their somatic health needs met. For clients in sheltered living accommodation, mental health service providers may set up a formal collaborative arrangement with a local GP practice. Within mental hospitals, somatic health care is to be provided to resident clients up to at least primary care level standard. A recent development is the creation of specialist somatic nursing teams within inpatient settings (IGZ, 2004c). The focus on and quality of somatic health services within mental hospitals has increased following a Health Care Inspectorate report in 1999 (IGZ, 1999).

4.1.6 Civic society

The landscape of mental health stakeholder and patient organisations in the Netherlands is rich and varied (see Annex 6.3 for an overview). Partly as a result of the –legal- emphasis on client participation, stakeholder organisations are often also active at local or regional level.

4. 2 Methods

For this case study, a literature search of key national and international databases was carried on –combinations of- appropriate terms such as ‘access’, ‘physical health needs’, ‘health problems’, patient views’ and their Dutch equivalent. This included searches of the national research database and the database of the National Health and Healthcare Research Fund. Publications based on non-national data were disregarded as international data will be included HealthQuest synthesis report.

A wide range of websites were scanned, including those of national research and development institutes in the health sector, national stakeholder associations and professional organisation, and patient organisations. Interesting leads were followed through; the routes followed becoming too detailed to be described here. The website of the Ministry of Health was also extensively searched, as were RIVM’s own resources.

Face-to-face and/or telephone contact has been made with representatives of patient organisations and stakeholder organisations in the –mental and mainstream- health sector. The topic of this case study was also raised in some of the stakeholder contacts that were established to advance other elements of the Netherlands country report, of which this case study is only a part. The sometimes very extensive insights shared could not all be integrated in this case study due to the limitations of its focus. Where appropriate, for instance in the case of access to mental health services for ethnic minority communities, it will be included elsewhere in the Netherlands country report.

4. 3 Access to general health care for people with mental disorders

4.3.1 Introduction: health status of people with mental disorders.

A broad epidemiological overview of the health status of people with mental disorders in The Netherlands is not available. There is, however, some

evidence from Dutch studies that suggest people with anxiety disorders or depression may be at higher risk of somatic ill health:

- Adults with anxiety disorders are two times more likely to suffer from a chronic somatic illness such as COPD, high blood pressure, migraine, diabetes or arthritis when compared to people without these anxiety disorders. They are also more likely to be treated for these chronic illnesses, although it is not clear whether this is in proportion to the higher prevalence of chronic illness (Neeleman et al, 2001);
- Depression increases the risk for certain somatic illnesses, including cardiovascular disease (Kamphuis, 2006; Kamphuis et al, 2006), stroke and Parkinson's disease (Ensinck et al, 2002);
- Through a disease management programme within the mental health sector, increased somatic risk factors were identified among 28% of patients with schizophrenia. This included metabolic disorders with an increased risk of COPD. Many of the somatic conditions identified via this programme had not been previously diagnosed (Planije and Smits, 2006);
- Mental disorders -and mood disorders in particular- may generate physical discomfort and pain. People with anxiety disorders are more likely to develop chronic back pain (Verdurmen et al, 2006).

Pharmacological treatment of mental disorders may have negative physical side-effects. Anti-psychotic medication, for instance, may trigger metabolism changes and lead to weight gain and diabetes (van Gool, 2006). Data on patient profiles in primary care data indicates that depression may coincide not only with other mental health problems such as sleep and anxiety disorders, but also with somatic disorders like hypertension or diabetes mellitus. Anxiety disorders are reported to coincide with neck and back pain, hypertension, eczema and fatigue (Cardol et al, 2004).

4.3.2 Co-morbidity

Co-morbidity – the coexistence of other conditions with a defined index condition (Feinstein, 1970) – has become a more prominent focus of mental health research in the Netherlands over the last few years. This is triggered partly by shifting policy paradigms (see chapter 1.5), but also by the desire for more in-depth understanding of the needs of older people.

For the purpose of this case study, co-morbidity studies that focus on mental disorder(s) as the index condition(s) would be particularly helpful. Recent Dutch research efforts on psychiatric and somatic co-morbidity, however, tend to take somatic disorders as the starting point. A recently (2007) published major review commissioned by the Ministry of Health indeed predominantly looked at (inter)national evidence on psychiatric co-morbidity of 11 somatic disorders (Van der Feltz-Cornelis et al, 2007).

The most comprehensive work on somatic and psychiatric co-morbidity within the Dutch population is based on the NEMESIS cohort study (see also introduction). A research group from this study tried to find out whether mental disorders are more prevalent among people suffering from five groups of somatic disorders: asthma and COPD; rheumatism; chronic back pain; high blood pressure; and problems of the digestive system. The results can be summarised as follows:

- For all five somatic conditions, people suffering from any of these conditions were approximately 1.5 times more likely to also have a mental disorder;
- Problems of the digestive system, chronic back pain and rheumatism are associated with various mental disorders: mood disorders, anxiety disorders and addiction;
- People suffering from high blood pressure are more likely to also suffer from anxiety disorders;

- People with asthma report more substance addiction, but contrary to international evidence no relationship with anxiety or mood disorders could be found.

Findings from another Dutch cohort study confirmed that somatic and psychiatric morbidity often go hand in hand. This may also be due to underlying factors, including personality traits. The researchers conclude clinicians and researchers should focus not only on the psychiatric disorders associated with such personality traits but also on their medical consequences (Neeleman et al, 2003).

4. 4 Barriers in access to general health care for people with mental disorders

4.4.1 Gaps in coverage

Like any other Dutch resident, people with mental health disorders are required to take out private health insurance for coverage of preventative and acute health care. As discussed chapter 2, health insurers are obliged to offer standard coverage to all applicants irrespective of –mental or physical- health status.

While there is no obligation to accept applicants for complementary cover, a one-off arrangement to accept all applicants was agreed in 2006 when the changes came into effect. It is too early to say whether insurers have turned down any new applicants in 2007 on grounds of mental health status or a history of mental ill-health.

Chapter 2 also highlighted that people with less structured lifestyles and health literacy skills may find it relatively difficult to navigate the insurance –based system. Persistent non-payers face exclusion from their insurance arrangement. For mental health patients living in residential or sheltered living settings, payments may be monitored or even arranged via their professional guardians

or their loved ones. People with mental health problems living in the community -including homeless people- may therefore be more at risk in this respect.

The Ministry of Health, Welfare and Sports has acknowledged people with mental disorders may encounter difficulties in negotiating health insurance packages and making regular payments to ensure their coverage. They have launched an information campaign targeting all people that may have problems to this effect, as well as their carers or loved ones. Government has also announced that, for people with mental health problems, failure to pay health insurance will not automatically result in a fine. Instead, their situation –and the consequences of their failure to pay- will be assessed individually⁶².

4.4.2 Scope of health and social benefit basket

People with mental disorders are entitled to the same range of health services as anyone else with the same insurance cover. People admitted under the Compulsory Admissions Act are not legally eligible to make decisions about their medical treatment: this will be done on their behalf by their formal representative.

In 2006, the Dutch court ruled that while admitted under the Compulsory Admissions Act people lose their right to regular social assistance. To be eligible for this type of social benefit, people have to be available on the job market and people in compulsory admission are not. The ruling had clear financial consequences for people in compulsory admission. It left them and their dependents without any financial safety net and in danger of not being able to meet essential financial commitments including paying rent and paying health insurance. In July 2007, government proposed a new legal arrangement via which this group of people will be entitled to receive special social assistance (*bijzondere bijstand*, see 2.4.5)⁶³.

⁶² Source: www.minvws.nl/dossiers/overheveling-ggz/vraag-en-antwoord.

⁶³ Source: http://home.szw.nl/actueel/dsp_persbericht.cfm?link_id=122742&set_id=134

4.4.3 Cost-sharing

The income situation of people with mental disorders is often relatively unfavourable and many have to rely on social security benefits for long periods of time. Financial barriers limit their opportunities to participate in society and may also negatively influence their uptake of public services (Oudenampsen and De Gruijter, 2006). This may also impact on their utilisation of certain health services or on their opportunity to take out complementary health insurance cover.

In the run-up to the 2006 health system reforms, this potential problem was also identified by many national stakeholder organisations. They pointed out that people with mental disorders are already confronted with various co-payments as a result of the mental health needs: having to pay for complementary health insurance cover may be financial step too far for them⁶⁵.

No research findings are available to indicate whether people with mental disorders are indeed underrepresented among the –very large- part of the population who have opted for additional cover, or to what extent financial hurdles may have kept them from applying for such cover.

As highlighted in chapter 2.2, people on minimum income can turn to their local authority for earmarked social assistance (*bijzondere bijstand*) if they meet unusually high healthcare costs. This arrangement is available for all Dutch residents, including people with mental disorders.

4.4.4 Geographical barriers

As mentioned in paragraph 2.5, the geographical density of primary care and hospital care facilities is very high in the Netherlands and geographical factors only form a relatively minor barrier to healthcare access. While no specific data

⁶⁴ See: http://docs.szw.nl/pdf/34/2007/34_2007_3_10891.pdf

⁶⁵ Statement Platform GGZ Utrecht/Rotterdam, 2003 on http://www.xs4all.nl/~slkf/STATEMENT_PLATFORMGGZ.doc

are available about the way people with mental disorders are affected by this type of access barriers, it may be fair to assume they are also of relatively minor importance to this group.

A factor that has not been explored, however, is to what extent people with chronic mental health problems are more likely to be reliant on public transport and may therefore also be more vulnerable to the impact of geographical barriers. For those living in sheltered housing or other residential facilities, this problem may be exacerbated as some of these are located within more rural areas which are less well served by public transport. Some mental health hospitals, however, do have in-house medical staff that can attend to the needs of their clients.

Table 6.2.4 in the annex of the Netherlands country report includes a map of mental health care services, based on data from 2004. This map shows that - compared to other health services- mental health services are more unevenly spread across the country, with the northern and south-western regions being served relatively poorly. This is particularly the case for specialised services for children and young people. Over the last decade, the landscape of mental health services has seen many mergers (see 1.5.). Consequently, specialised services are being provided at fewer locations within the catchment areas of service providers.

4.4.5 Organisational barriers

Data on the uptake of primary care by people known to be suffering from clinical depression suggest they do find their way to the GP to present their non-mental health needs. According to Cardol et al. (2004), people who are known to suffer from depression have an average of 14 contacts with their GP each year. Only 4 of these contacts are related to their depression. Figures are similar for people who are known to suffer from anxiety disorders.

Clinical guidelines may hinder recognition and appropriate treatment of co-morbidity. Only 14 of 36 guidelines for treatment of somatic illnesses addressed psychiatric co-morbidity. Only seven of these provided actual information about diagnosing a mental disorder (Van der Feltz-Cornelis et al, 2007).

Clinical guidelines for depression, schizophrenia and -to a lesser extent- anxiety disorders, however, do incorporate information on somatic co-morbidity and its consequences for diagnosis and treatment. The multidisciplinary guideline for schizophrenia calls for awareness of reduced physical well-being, somatic side-effects of psychopharmaca, increased risk of heart failure, and the importance of dental health checks (Van der Feltz-Cornelis et al, 2007).

The increasing popularity of illness-specific treatment programmes in The Netherlands is at odds with the needs of patients with multi-morbidity. This discourages tailor made service provision. It may also lead to a situation where a patient is being treated via two –or more- parallel programmes or receives serial episodes of treatment (Schellevis, 2006).

Clients of mental health services may also turn to their mental health service provider to have their physical health needs met. In 1999, the Health Care Inspectorate reviewed the response of general mental hospitals to the somatic needs of their clients, concluding this issue was receiving (too) little structural attention (IGZ, 1999). This triggered the National Association of Mental Health Service Providers to develop somatic care protocols and multidisciplinary guidelines for somatic co-morbidity (see above). These guidelines were to better equip mental health services in dealing with somatic needs of their clients.

Meanwhile, however, health sector changes had been set in motion that increased the divide between the mental and somatic health services (see further 1.5) and also saw the closure of many in-house medical facilities in mental hospitals. By 2005, only seven mental health service organisations still have their own medical services. These are primarily looking after the somatic health needs of long-term hospital patients (Planije and Smits, 2006). All other clients, therefore, have to rely on mainstream health care providers.

In 2004 the Inspectorate concluded somatic care in mental health settings was improving (IGZ, 2004c). To what extent the multidisciplinary guidelines developed by the mental health sector are also taken on board in the somatic health care sector could not be identified.

Organisations representing people with mental disorders do not have a prominent role in raising the health care sector's awareness about the somatic health needs of the people they represent⁶⁶. Within the mental health sector, however, client councils have been calling for a stronger focus on unmet physical health needs.

In Rotterdam, this resulted in a project that has been piloted with outpatient clients of a mental hospital but is foreseen to be implemented at a broader level. Mental and mainstream health service providers do collaborate through this 'Improve Medication Management and Somatic Conditions of Chronic Psychiatric Outpatients with a Multidisciplinary Intervention in Rotterdam' approach. The role of mainstream health services seems, however, still limited. Co-ordination lies with the mental health service provider (Planije and Smits, 2006).

4.4.6 Supply-side responsiveness

Data from a nationwide study on primary care showed that, per consultation session, GPs spend a more than average amount of time with patients with a depression. The average length of a consultation session with people from this patient group is 14.6 minutes, compared to the 9.7 minutes that is generally spent with patients (Cardol et al, 2004). It is not clear what this extra time is spent on, so it can not necessarily be interpreted as a positive sign of responsiveness. On the other hand, there are no indications that GPs are reluctant to set aside contact time with this group of patients.

The same national study did, however, find that GPs are less likely or even more reluctant to diagnose someone with depression when this person already suffers from a chronic somatic illness (Nuyen et al, 2005). To what extent this is reinforced by guidelines that pay relatively little attention to psychiatric co-morbidity (see 4.4.5) is not known.

⁶⁶ No literature could be found that reported any activity in this respect and from communication with Pandora –a key national advocacy group- no specific initiatives emerged.

As discussed in chapter 3.2.6 of the national report, GPs seem either hesitant or unsuccessful in referring older people with mental health needs to ambulant mental health services. While one in every five people aged 65 or over visit their GP because of mental health needs, only a small proportion is referred on to mental health services. Older people are also underrepresented in the client population of primary care psychologists (Pot et al, 2007).

Research findings that could shed light on existing negative or discriminatory attitudes towards people with mental health disorders within the mainstream health care sector could not be identified. Through their telephone help line and email contacts, the national advocacy organization for people with mental disorders Pandora does, however, receive many complaints to this effect.

Based on the experiences of the people that contact them, Pandora points to the potential negative impact of information on a current or past mental health problem in the patient's medical record. Many clients feel their physical health problems may be all too quickly attributed to psychosomatic factors and not taken seriously in their own right. Some also feel health professionals approach them in a different, more prejudicial way if their mental health history is known to them. People with mental health problems may therefore not be keen on sharing this information with physicians or other health care professionals and want control over who can access their medical records⁶⁷.

This would suggest further development of an Electronic Patient Record may not necessarily be perceived as a good thing by this patient group. This was indeed confirmed through a focus group session with mental health service clients. They felt an electronic patient record would have negative privacy implications and contribute to a life-long stigma of them as a mental health patient (Brouwer et al, 2006).

⁶⁷ Personal communication in April 2007.

Paradoxically, having a more complete picture of their patient's physical and mental health needs may be essential if health professionals are to provide good quality care.

Across the mental health sector, five initiatives were identified that focus on – preventative- screening for clients' physical health problems. One of these (in the Eindhoven region) is specifically concerned with prevention and management of diabetes among in-patient clients (Planije and Smits, 2006). They are offered an integrated package of examination and treatment by a multidisciplinary team. The services are provided within one and the same day⁶⁸.

Other initiatives include the Rotterdam 'Improve' project mentioned in 1.4.5, and three projects that focus on overall somatic screening and early diagnosis activities.

Chapter 3.1 addresses factors that may impact on access to mental health services for migrants and asylum seekers. It also presents some examples of projects that aim to improve access and increase cultural awareness of service providers. Mikado, the national expertise centre on ethnicity and health (see 3.1), is currently leading efforts to develop a 'cultural awareness annex' for multidisciplinary mental health guidelines (see 4.4.5).

4.4.7 Health literacy

People with mental disorders who also have somatic needs turn to their GP at a relatively late stage in order to present these needs. Their mental health problems stand in the way of expressing their complaints verbally. Health care providers may sometimes have difficulty distinguishing the somatic and mental aspects of the patient's needs (Planije and Smits, 2006).

⁶⁸ <http://www.zorgvoorbeter.nl/onderwerpen/over/psychische-en-somatische-problematiek/voorbeelden/polikliniek-en-skillslab-binnen-medische-dienst-ggz-eindhoven/>

Research by Knipscheer (2004) has shown that there is considerable variety across minority ethnic communities in the way they develop mental health symptoms, as well as in their subsequent health-seeking behaviour and utilisation of mental health services (see also 3.1). It is not clear to what extent this may also resonate in their help seeking behaviour as regards somatic health care.

In chapter 2.8 of the Dutch country report, remarks have been made about the potential 'health literacy bias' of the recent health system changes. Information from stakeholders does suggest that this may hold particularly true for people with mental health problems: 'Political decision makers put increasing emphasis on individual responsibility and choice, market forces, competition and autonomy. This may offer good opportunities for those who are able decision makers: for them it is easy to access the information they need and they are able to compare the performance of health service providers. Meanwhile, people with considerable disabilities in many aspects of their lives who are reliant on long-term care are in danger of becoming excluded'⁶⁹.

As already pointed out in par. 1.4.1, the Ministry of Health, Welfare and Sports has acknowledged these potential difficulties. To counteract them, they have launched an information campaign and are considering waiving fines for people with mental disorders who fail to make regular health insurance payments.

4.5 Policy initiatives and their impact on access to general health care for people with mental disorders

This subchapter will look at recent shifts in policy thinking about mental health and how that may contribute to more responsive somatic health care provision to people with mental disorders. It will also explore the impact of the overall health system changes on the mental health sector and on options for improved

⁶⁹ Platform Chronische Psychiatrie in: Ministry of Health, Welfare and Sports, 2007 (e).

access to general health care for their clients. Finally, the interlinkages with socio-economic deprivation will be examined.

4.5.1 Recent shifts in mental health policy paradigms

Over the last decade, health sector changes and financial system incentives were put in place that led smaller scale mental health providers to merge into large provider organisations. For people with mental health needs, this meant that they could call on one provider for a wide variety of services to meet different aspects of their –mental- health needs: care, cure, support and social reintegration programmes. These services were all funded out of the *AWBZ*. Clients did not need to re-negotiate access hurdles with different providers, and or co-ordination problems were limited (Ministry of Health, Welfare and Sports, 2003).

The Ministry of Health, Welfare and Sports has acknowledged this has led to more integrated and seamless service provision, and that this may be especially beneficial to people with chronic mental health problems. The Ministry also identified less desirable consequences, however. It concluded the mental health sector has become too inward looking, with insufficient collaboration and integration with the somatic health sector as well as community and social care providers. This could work out negatively for clients with less long-term needs as well as for those with multiple needs, i.e. mental, somatic and practical needs.

It was also decided that mental health services should focus on it key objective: the treatment of mental disorders and the prevention of those disorders. As such its mission (not its focus!) is similar to that of somatic health services. Consequently, it would make sense to bring mental health service finance in line with the restructured system for the acute health sector. In Dutch, this has been labelled the ‘cut’ across the mental health sector. Starting from 2008, in- and outpatient services aimed at treatment will be covered via the *Zvw*, long-term care services will be covered via the *AWBZ*, and support and social integration will be the responsibility of local authorities via the *WMO* (see chapter 1 for further information about the Dutch health system). The long-term

impact of these reforms on the mental health sector will remain to be seen, but could result in re-compartmentalisation and re-fragmentation of mental health services (Ministry of Health, Welfare and Sports, 2006c).

Treatment will be purchased and financed according to the same administrative system as was set up for the acute sector, via 'Diagnostic Treatment Combinations' (*DBC*s). Information from stakeholders suggests this encourages serial treatment. It may delay or hinder tailored service provision to people with multiple needs, including people with mental and somatic health needs. There are several hundred *DBC*s in mental health only, each related to a separate diagnosis. Although the needs of one client can be 'translated' into more than one *DBC*, one *DBC* will be put in the forefront to guide access and treatment. People with complex needs often receive a 'delayed diagnosis' which is a *DBC* in its own right. Somatic *DBC*s do not feature in the *DBC* system for treatment of mental disorders, in spite of the acknowledgement of somatic co-morbidity in clinical guidelines for mental health.

Policy guidance (Ministry of Health, Welfare and Sports, 2006d) has also stressed that:

- Mental health services are to be delivered according to the principle of 'stepped care'. This principle is already been firmly introduced in the acute health sector. It implies that patients should first be offered the most effective, cheapest and shortest form of treatment that can be expected to interfere least with their day-to-day life. Only when this intervention does not have sufficient effect will treatment be intensified;
- The role of primary mental health care, and particularly the services of psychologists working within primary care settings, is to be strengthened;
- The influx into specialised mental health services is to be reduced. This is to be achieved by strengthening the role of primary care services - social work included- in recognising mental health problems at an early stage, and in providing support and treatment to people with mental health disorders. Access to specialised mental health services will be

possible on referral only, with a prominent role for GPs as gatekeepers similar to their responsibility in guarding access to acute services.

It is likely the latter will impact on the accessibility of out-patient mental health services.

4.5.2 Collaboration between the mental and somatic health care sectors

Improving coherence and collaboration between the mental and somatic health sector has become a key policy priority. This push for collaboration has primarily been driven by the mental health policy agenda. Within that agenda it is an instrument to address the *mental* health needs of the population and to take pressure off the specialised secondary mental health services. There is much less focus on the benefits of collaboration to help improve the responsiveness of the general health care sector to the physical needs of people with mental health problems.

Policy thus triggered efforts to improve understanding of mental health issues within the mainstream health system, and particularly within the primary care sector. It has also put the issue of co-morbidity more firmly in the spotlight, but with somatic diseases as the prime index illness (Van der Feltz-Cornelis et al, 2007).

An early example of the former was a nationwide training programme to improve primary mental health care, initiated in 2001. It was led by the two main national professional bodies for GPs but implemented at regional level. Through this programme 141 different training and information interventions were made available, the regional GP associations could then choose which ones fitted their need best. Although this programme mainly focused on improving quality, increased knowledge and understanding was also expected to contribute to reducing access barriers. From the evaluation of the programme it was concluded it did not have considerable impact on the professional practices of GPs with regard to mental health care (Heideman et al, 2007).

GPs have indicated the various policy measures to strengthen the role of primary mental health services have indeed reduced their mental health-related

workload. GPs have also become more positive about the collaboration with primary care psychologists as the secondary mental health sector. However, GP referral patterns have not changed and their uptake of postgraduate training on mental health issues has been reduced. GPs thus seem to invest less in their own understanding of mental health issues and more in multidisciplinary collaboration. To what extent this may also impact on GPs' understanding of the physical health needs of their patients with mental disorders has not been addressed in this evaluation (Emmen et al, 2007).

The policy changes have also opened up other avenues for collaboration. 'Making it Better', the ongoing national programme aiming to improve quality, effectiveness and efficiency in the acute and primary health sectors broadened to include work on mental health. The 'Making it Better' initiatives aim to support innovation and the dissemination of evidence-based approaches. While integrated service provision is a key concern within this programme, they seem to predominantly target the various sectors separately. New programme themes that will be addressed within the mental health care sector include co-morbidity. One of the first efforts in this respect has been focusing on people with a substance addiction that also suffer from mental health disorders⁷⁰. Treatment of both types of disorders falls within the responsibility of the mental health sector.

4.5.3 Impact of broader health system reforms

As mentioned earlier, the health system reforms of 2006 may impact relatively strongly on people with mental disorders. They will have to take out health insurance and find their way as a health care consumer on the Dutch health care market. The skills required to make the most of the market opportunities may exceed their capabilities and are particularly ill-fitted for the majority of people with mental disorders. To have their mental health needs met, they may be faced with different assessment agencies, administrative procedures and

⁷⁰ See <http://www.trimbos.nl/default19840.html>

purchasers depending on whether they need treatment, care and/or support services.

Should they have somatic health needs, they will have to find their way to their GP or –via the GP- to secondary care. Should their mental health care provider play a role as a mediator in this process, the GP cannot keep them informed due to professional confidentiality. This may hamper continuity of care. Reversely, mental health services are to inform GPs of the patient's health status and treatment progress. With the implementation of an electronic patient record these communication problems may ease. At the same time, mental health stakeholder organisations suggest the use of electronic patient records may also have a negative impact as it may contribute to stigmatisation (see also 1.4.6).

The health system reforms may also impact on local client organisations. Under the new system, responsibility for the -financial- support of client organisations has shifted to local authorities via the *WMO*. It is not clear what impact this may have on the sustainability of these organisations. However, client organisations (through the Landelijk Platform GGZ) have expressed their concern about this: 'The organisation of client support should not be left to the liberty of local authorities. National government should provide more safeguards in this respect'⁷¹.

4.5.4 Interlinkages with socio-economic deprivation.

Mental (ill) health and socio-economic status are interrelated. People with mental disorders are relatively often unemployed and lower educated (Michon et al, 2003). Lower levels of education, employment status and income do generate a higher risk of experiencing stressful life events. Also, people from lower socio-economic strata may be more vulnerable to such events due to less sense of self-control and self-confidence (Maas and Jansen, 2000).

⁷¹ Platform Chronische Psychiatrie in: Ministry of Health, Welfare and Sports, 2007 (e).

In the Netherlands, 25.8% of people with from lower education levels suffer from some form of mental ill-health, compared to 11.6% of the highly educated population (Reijneveld and Schene, 1998). Uptake of outpatient mental health services among people from low income strata is over 100% higher than average, and uptake of other forms of mental health services is 50-100% higher (Kunst et al, 2006). A study on care needs of people with severe mental illness revealed that prevalence of unmet mental health needs did seem to be related to socioeconomic circumstances. Unmet need was also related to the system of mental health care, particularly with little integration and continuity of care (Wiersma, 2006).

Any policy measure that impacts relatively highly on people with lower socio-economic status (see also chapter 2 of the country study) is therefore also likely to impact on people with mental disorders. The potential impact of cost-sharing for access to ambulant mental health services has already been addressed in par. 1.4.3. As of 2008, the no-claims bonus will be annulled and replaced by an annual compulsory excess of 150 euros. Government has announced that people with unavoidable long-term health expenses due to chronic illness or disability, will be compensated financially for this. It is not known whether this will also apply to people with chronic mental disorders. Also, such a financial compensation will likely to entail another administrative procedure and may therefore add to the existing complexity of the system that people with mental disorders need to negotiate.

Complementary cover of mental health treatment services can be obtained, but it is not extensive. Given the financial means of many people with mental disorders, taking out complementary cover may not be a likely option for this group of health care consumers anyway. Where local authorities have entered the health insurance market to purchase collective contracts –with more extensive cover- for their clients on social benefits, it is not clear whether mental health service organisations would be allowed to act in a similar way.

4. 6 Conclusions

Evidence suggests that people with mental disorders in the Netherlands are at relatively high risk of somatic ill health and may therefore have more physical health needs. Within the Dutch health care system, mainstream health services are responsible for meeting these needs.

Very little research has been done to identify to what extent the primary and acute health care sector is providing good quality, accessible somatic health services to people with mental disorders. The research work that has been carried out focuses mainly on mainstream sector responsiveness to population mental health needs.

Based on experience, stakeholder organisations do express concern over some aspects of mainstream health service access and responsiveness. Patients' fear of stigmatisation may trigger ambivalence towards innovations such as the electronic patient record. Meanwhile, such innovation may actually be helping professionals to respond to patients in a more holistic way, thus avoiding the risk of unmet need.

There is no indication that the mainstream health care sector is taking specific somatic needs of people with mental disorders on board. In their capacity as physical health care consumers, this patient group does not seem to be in the health sector's focus. This relative blind spot is remarkable given the recent policy-driven emphasis on co-morbidity issues and on collaboration between the mental health and acute/primary care sector. The underlying policy agenda is, however, primarily driven by objectives to address the mental health needs of the population. As such, it may be triggering a more one-sided approach to co-morbidity.

Insofar as the health system is addressing to the physical health needs of people with mental disorders, this happens primarily via the mental health sector. Acknowledging the impact of co-morbidity and responding to earlier criticisms about its own performance, the mental health sector has adopted a more pro-active stance in embracing a whole systems approach to the needs of

'their' clients. This had resulted in various initiatives, for instance as regards mental health guidelines, identifying unmet need and improving somatic disease prevention and self-management.

Innovative policies and incentives follow the demarcation lines of health system finance, while performance-focused research tends to concentrate on sectors. Against the backdrop of recent health system changes, policy makers are now approaching mental health services as a specialized form of health service that delivers either care or cure, not a separate integrated sector. This does open up mainstream innovation programmes focusing on cure or care, but these then are to improve quality and efficacy of mental health services. The one programme addressing somatic co-morbidity targets mental health services as prime actors, not somatic health care providers.

Should the mainstream health care sector not consider the specific health needs of people with mental disorders, new health reforms may impact negatively on the progress made. Future fragmentation of the mental health sector as a separate entity may lead to weaker position of this sector as advocates of comprehensive care packages for 'their' clients. It may also increase the distance between long-term mental health services -as they will be subject to 'cure' oriented policies and finance- on the one hand, and the acute health care sector and health insurers on the other hand.

Government and stakeholder groups do agree on the potential negative impact of the recent health system finance reforms on overall access and coverage. People with mental disorders are not the kind of assertive, well-informed and conscientiously paying health insurance client that new system seems more suited for. They are also relatively poor, which may keep them from taking out additional cover for such services as physiotherapy or dental care.

Much still remains unknown, however, about the actual situation as regards access to and quality of somatic health care for people with mental disorders. While there is a clear need for more explicit ownership of this agenda within the mainstream health system, the need for more research is also apparent.

Research could, for instance, help to acquire a better understanding of any specific problems that people with chronic mental disorders may encounter in their new position as consumers on the health care and insurance market; of their health needs and the way they may be exacerbated by their mental disorders; of the way the mainstream health care sector is taking these health needs on board; and of effective methods to improve their health literacy. New research could also help to understand whether and/or how access problems differ for people with chronic mental health problems as compared to people going through a single episode of mental illness.

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5. 1 Tables and maps

5.1.1 Data Summary sheet NSR

The Netherlands: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)		
				15-64			15-24	55-64		15+		
				Total	Male	Female				Total	Male	Female
2000	3.9	124.0	2000	72.9	82.1	83.5	68.7	38.2	2000	2.8	2.2	3.6
2002	0.1	125.3	2002	74.4	82.4	86.2	70.0	42.3	2002	2.8	2.5	3.1
2004	2.0	124.7	2004	73.1	80.2	86.8	65.9	45.2	2004	4.6	4.3	4.8
2006	3.0f	126.1f	2005	73.2	79.9	86.4	65.2	46.1	2005	4.7	4.4	5.1

*: Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp %GDP	Public Health Exp % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop
	Male	Female	Male	Female	Male	Female						
	1995	74.6	80.4	14.7	19.0	61.1						
2000	75.5	80.5	15.3	19.2	61.4	60.2	5.1	2000	8.3	63.1	9	75.6
2004	76.9sp	81.4sp	16.2sp	19.8sp	61.7e	58.8e	4.1	2004	9.8	61.2	7.8	

s: Eurostat estimate; p: provisional; e: estimate

*THE: Total health expenditures

**PHI: Private Health Insurance

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function. % of total benefits							Age-related projection of expenditure (€)					
Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	Old-age dependency ratio eurostat	Level in 2004 and change: 2004		
										Total social expend.	Public pensions	Health care
1995	30.6	38	28.5	9.9	4.6	6.5	12.6	2005	20.7			
2000	26.4	42.4	29.3	5.1	4.6	6.8	11.8	2010	22.2	-0.3		
2004	28.5	41.6	30.4	6.3	4.8	6	10.9	2030	36.7	3.8		
								2050	38.6	4.9		

* including administrative costs

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate					Poverty risk gap					Income inequality		
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+	Total	S80/20
Total	11b	15b	9b	10b	5b	21b	21b	22b	22b	12b	Total	4.1
Male	11b	-	9b	10b	5b	22b	-	23b	26b	11b	Male	
female	11b	-	10b	10b	6b	20b	-	20b	20b	12b	Female	

People living in jobless households				Long-term unemployment rate			Early school-leaver				
Children	% of people aged 18-59*			% of people aged 15-64			% of people aged 18-24				
Total	Total	Male	Female	Total	Male	Female	Total	Male			
1999	6.9	7.8	6.3	9.4	1999	1.2	0.9	1.5	1999	16.2	17.5
2004	7.0	8.0	6.7	9.3	2004	1.6	1.5	1.6	2004	14.0	16.1
2006	6.2	7.4	6.2	8.6	2005	1.9	1.9	1.9	2005	13.6	15.8

*: excluding students; b: break in series

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male
Relative income of 65+	0.879b	0.882b	0.879b	Aggregate replacement ratio	0.426b	0.475b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions			
Net	Gross replacement rate					Coverage rate (%)		Contribution rates	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	pensions Current estimate (2002)

5.1.2 Annual personal expenditure to cover health and long-term care costs:
insurance fees, compensations and optional reductions, in Euros (2007)

Payment	Entitled/applicable	Amount	
		-	+
Standard coverage nominal premium	Mandatory for all residents	± 1150	
Standard coverage income-related premium	30,000 threshold	4.4 – 6.5 % annual income	
Complementary coverage	Optional for all	± 200	
AWBZ coverage	Mandatory	12.5% of income to € 30,631 ceiling (2006)	
No claims bonus	All		≤ 255
In-kind fee discount	Optional for all		± 100
Personal excess	Optional for all		0 - 500
Co payments Zvw/AWBZ/WMO		variable	
Health care allowance (advance tax payment, <i>Zorgtoeslag</i>)		24 - 1155	
Tax deduction excessive costs as result of illness or disability	11,5 % annual income threshold		variable

Special social assistance for excessive costs of living			variable
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5.1.3 Tax deductible expenses exceptional health care costs

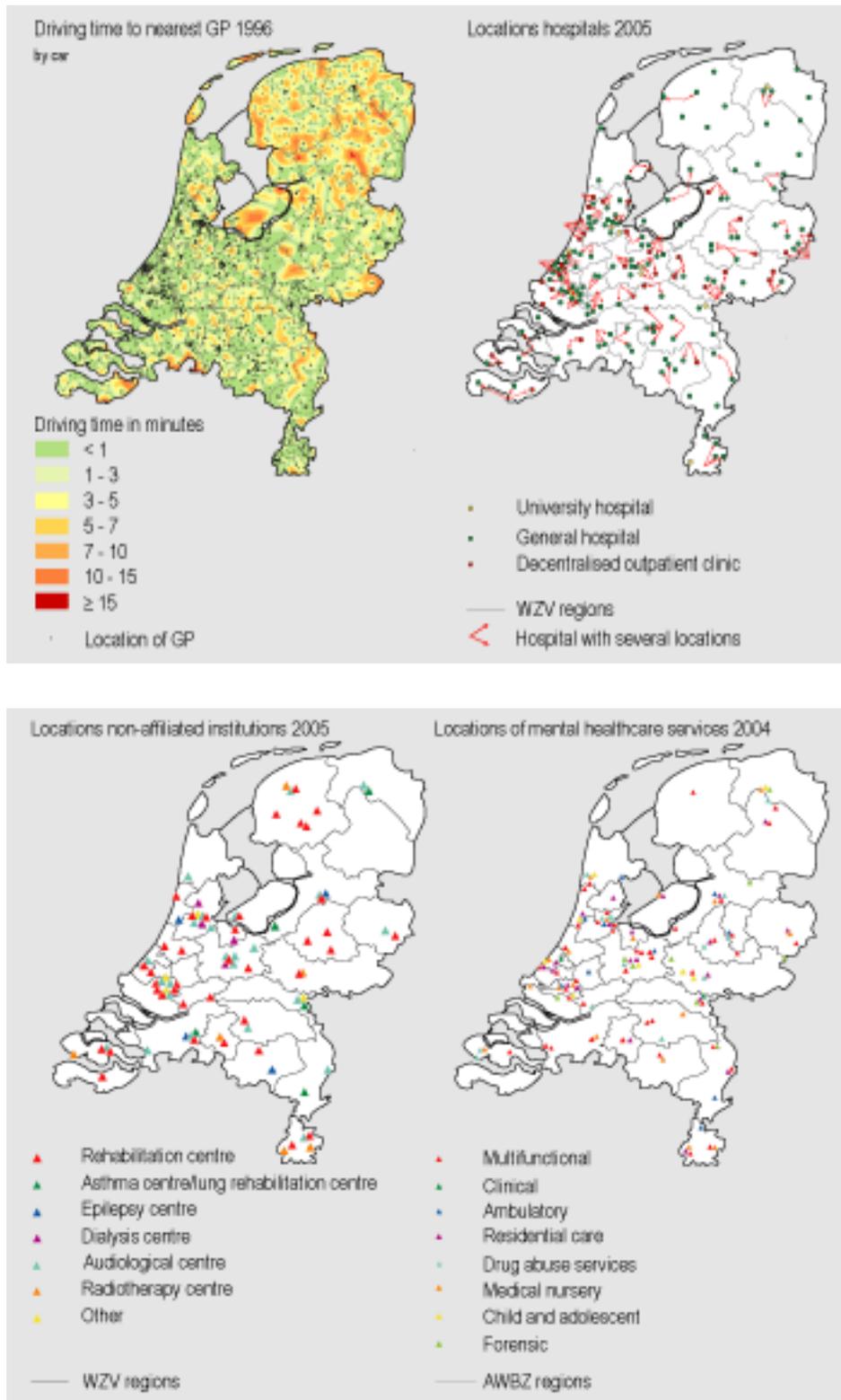
Tax deductible expenses exceptional health care costs (*Buitengewone uitgaven*) in 2006, after costs exceed threshold (11.5% of income)

Source: Inland Revenue.

Type of service	2006
Premium standard coverage	1050 per person over 18 years old in household, <i>only</i> when not eligible for 'Zorgtoeslag'
Premium complementary coverage	Deductible to maximum
Income-related premium standard coverage	Deductible to maximum
Deduction for chronically ill under 65 not eligible for illness benefit	€ 795
Basic pharmaceuticals	€ 23 per person in household
Extra clothing expenses in case of long-term (more than 1 year) illness or disability	€ 310
Prescribed diet	Real costs
Travel costs for hospital visits	For own car, € 0,19 per km
Hearing aids, walking aids and zimmer frames, orthopaedic material, glasses, prosthesis, dentures	Deductible

Maternity care: delivery costs	Deductible
Additional home care as result of illness or disability	Partly deductible
Nursing care at home or elsewhere	Partly deductible
(Homeopathic) medicines on prescription	Deductible
Costs related to services of medical professional, dentist, hospital admission to hospital, physiotherapy, acupuncture, rehabilitation, speech therapy, homeopathy, chiropractor	Deductible
Transport to hospital or to visit medical professional	Deductible
Transport costs as result of illness or disability	Deductible
Adaptations to home, car or bike as result of illness or disability (as prescribed)	Partly deductible

5.1.4 Proximity of care services by traveling time, or by number of locations of care services per region or municipality. Source: www.zorgatlas.nl (in Westert and Verkelij, 2006).



5.1.5 Care utilization by people over 25 years of age by level of education in 2001 (%). Source: Van Lindert et al, 2004.

	Level of education			OR	
	Low	Middle	High	Corrected for demographic s ^{g,h,i}	Corrected for demographics and subjective health ^{g,h,j}
General practitioner ^a	51	42	36	1.4	1.2
Physiotherapist ^b	16	16	14	1.3	1.1
Home care ^b	14	6	3	1.3	1.1
Dentist ^b	39	76	86	0.2	0.2
Medical specialist ^a	26	21	19	1.1	0.9
Admission to hospital, nursing home or rehabilitation centre ^b	11	7	6	1.2	1.0
Psychosocial care ^c	15	20	30	0,5	0.5
Regional institutes for ambulatory mental health care ^{b,k}	2	1	1	-	-
General social work ^b	2	1	1	-	-
Independent psychologist ^b	1	2	3	-	-
Alternative medicine ^b	5	7	9	0.7	0.6

Prescribed medicines ^d	23	16	13	1.3	1.0
Prescribed medicines used ^d	70	47	40	1.2	0.9
Over-the-counter medicines used ^d	33	39	39	1.0	1.1
Influenza vaccination ^c (aged 45-64)	37	30	26	-	-
Influenza vaccination ^c (aged 65-74)	83	82	82	-	-
Pap smear ^e (women aged 30-59)	75	82	85	0.5	0.6
X-rays breast ^f (women aged 18 and over)	46	38	29	0.8	0.8

^a Past 2 months; ^b Past year; ^c Ever; ^d Past 2 weeks; ^e Past 5 years; ^f Past 2 years; ^g OR >1: people with low level of education use *more* care than people with high level of education; ^h OR<1: people with low level of education use *less* care than people with high level of education; ⁱ Adjusted for gender, age, level of urbanisation, marital status, unemployed, incapacitated, housewife/househusband, insurance status and level of education; ^j Also adjusted for *subjective health*; ^k Also adjusted for GHQ score (indicator mental complaints); **Bold**: statistically significant p <0.05.

5.1.6 Differences in care utilization (not adjusted) of people aged 18 years and over by ethnicity (%), 2001–2002. Source: Droomers et al, 2005.

	Dutch	Turks	Moroccans	Surinamese	Antilleans
General practitioner (past 2 months)	41.8	52.2	46.9	53.3	48.4
Medical specialist (past year)	41.3	57.4	44.3	54.1	58.3
Physiotherapist (past year)	16.4	13.9	12.6	20.2	11.4
Hospital admission (past year)	7.3	7.6	6.8	6.4	9.2
Home care (past year)	6.3	3.9	2.3	4.8	6.7
Prescribed medicines (past 2 weeks)	47.2	38.4	35.9	52.4	41.1
Over-the-counter medicines (past 2 weeks)	37.8	31.3	31.1	37.4	38.9

Bold: significantly different from the Dutch population

5.1.7 Demographic data on non-western migrants in the Netherlands

Migrants (as of January 2005, CBS statline):

Total national population: 16,305,526

Non-native, western 1,423,675

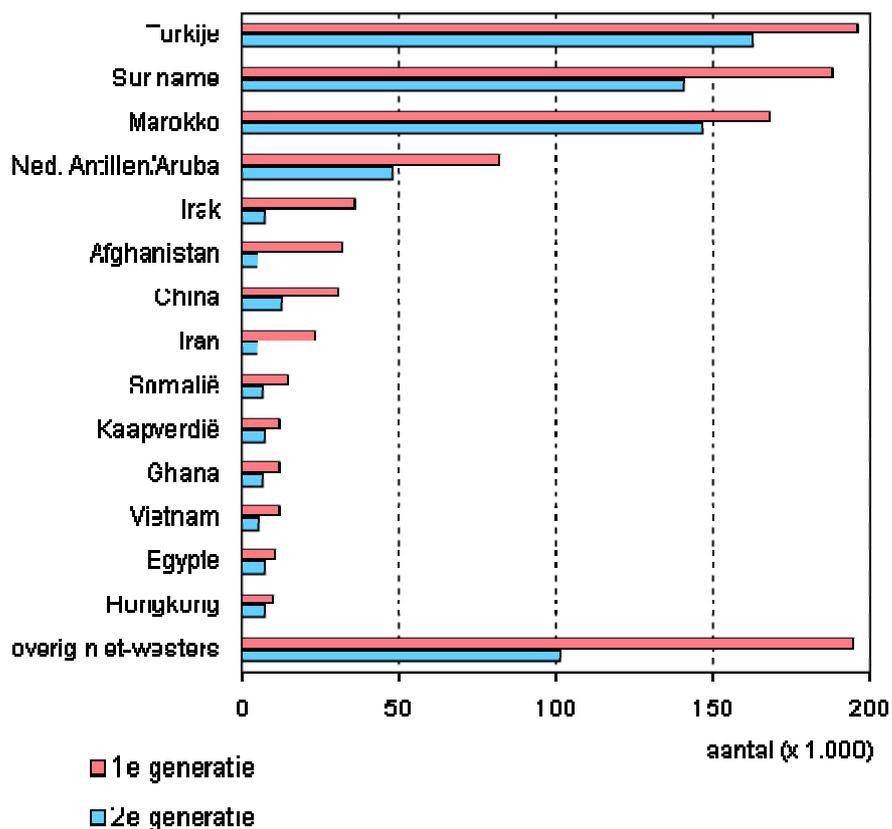
Non-native, non-western 1,699,042

<u>Non-western migrants</u>	First generation	Total
Turkish	195,678	358,846
Moroccan	168,400	315,821
Surinamese	188,367	329,430
Dutch Antillian	82,321	130,538

Figure:

Non-western immigrants, as of January 1, 2005 (Source: CBS)

Source: http://www.rivm.nl/vtv/object_document/o3198n21020.html



5.1.8 People suffering from mental disorders: incidence and prevalence in 2003

(Based on known registered cases, mortality and life years lost: absolute population numbers. Source: Den Hollander et al, 2006.)

		incidence	prevalence	mortality	Lost life years
Psychiatric disorders, total	men			1.915	14.246

	women			4.645	28.237
Dementia	men	4.500	29.500	1.909	10.996
	women	10.300	72.100	5.142	28.925
Schizophrenia	men	950	17.600	5	76
	women	900	13.500	9	106
Depression	men	38.400	116.900	4	64
	women	73.600	246.700	13	244
Anxiety disorders	men	16.600	42.200	0	0
	women	32.000	89.400	2	48

5. 2 Mental health voluntary organisations in the Netherlands

The information provided in this annex is partly based on <http://www.enusp.org/groups/n/eth.htm>. This list is not inclusive and only covers organisations that focus on the mental disorders that fall within the scope of this report.

[Angst, Dwang en Fobie stichting](#)

Supports people with depression, anxiety disorders and obsessive compulsive disorders. They also provide training and education to the general public.

[Caleidoscoop](#)

Represents the interest of people with dissociative problems and their families. Provides peer support as well as information to the general public. Also focus on awareness raising.

[Christelijke Vereniging Angsten en Fobieën](#)

Supports people with anxiety disorders, their friends and relatives. The also focus on awareness raising, providing information to the general public, and peer support.

[Cliëntenbond in de geestelijke gezondheidszorg](#)

Advocacy organisation representing the interests of (ex) users of mental health services with many local branches. Provides information and runs a telephone helpline. Also involved in political lobbying and peer support.

[Depressie Stichting](#)

Represents people and families with depression. Provides peer support. Also involved in training and education, raising awareness, dissemination of information.

[De wegwijzer](#)

Focusing on a broad range of people with mental disorders. Involved in awareness raising and dissemination of information.

[Labyrint~In Perspectief](#)

Supports family and friends of people with mental disorders. Provides information and peer support.

[Landelijke Patienten en Bewonersraden \(LPR\)](#)

National association of patient councils. Represents (ex-)users of in-patient mental health services. Also focuses on political lobbying, awareness raising, dissemination of information.

[Stichting Borderline](#)

Represents and supports people with bi-polar disorder. Focuses on lobbying, training and education, raising awareness, dissemination of information, peer support.

[Stichting Empty Memories](#)

Supports people with traumatic stress disorders. Also provides information to professionals and the general public.

[Stichting Fobievrienden](#)

Supports people with anxiety disorders, obsessive compulsive disorders, and depressive disorders. Also focuses on raising awareness and dissemination of information.

[Stichting Pandora](#)

Organisation centering around the experiences of anyone who has, has had or might develop mental health problems or disorders. Focusing on providing advice and support, advocacy and lobbying, information and education.

[Stichting Weerklank](#)

Supports people with schizophrenia. Focuses on raising awareness, dissemination of information, and peer support.

[Vereniging Anoksis](#)

Advocacy organisation for people with schizophrenia and psychosis, their friends and loved ones. Also focused on raising awareness, dissemination of information, and peer support.

[Vereniging voor Manisch-Depressieven en Betrokkenen](#)

Supports people with bi-polar disorder and their relatives. Also focuses on lobbying, training and education, raising awareness, dissemination of information, and peer support.

[Ypsilon](#)

Advocacy organisation for people with schizophrenia and their family. Also provides information.