The Netherlands

Health Care & Long-Term Care Systems

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The Netherlands

Health care systems

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2.20. THE NETHERLANDS

General context: Expenditure, fiscal sustainability and demographic trends

General country statistics: GDP, GDP per capita; population

GDP per capita (35,996 PPS) in the Netherlands was well above the EU average (29,610 PPS) in 2015, with an overall increase since 2005 (34,415 PPS). Population stood at 17.0 million people in 2016 and has been increasing throughout the last decade. According to projections, the increase will continue, reaching 19.5 million in 2070.

Total and public expenditure on health

Total expenditure on health as a percentage of GDP (10.6% in 2015) has increased since 2005, when the share was 9.4%. This level is slightly above the EU-average (10.2% GDP in 2015). The same applies to public expenditure on health as a percentage of GDP, recorded as 8.5%, which is higher than the EU average for the same period (8.0% in 2015). Total (3,836 PPS in 2015) and public (3,097 PPS in 2015) per capita expenditure in 2015 were also above the EU average in the same year (respectively 3,305 PPS and 2,609 PPS). Looking at health care without long-term care ([274]) reverses the picture, with spending going below the EU average (5.9% vs 6.8% in 2015).

Expenditure projections and fiscal sustainability

Public expenditure on health care is projected to increase by 0.8 pps of GDP ("AWG reference scenario") ([275]), broadly in line with the projected valued of 0.9 pps for the EU. When taking into account the impact of non-demographic drivers on future spending growth ("AWG risk scenario"), the increase reaches 1.4 pps of GDP from now till 2070, slightly below the EU average of 1.6 pps. The long-term fiscal sustainability risk indicator S2, which shows the adjustment effort needed to ensure that the debt-to-GDP ratio is not on an ever-increasing path, is at 3.0% of GDP. In the long term, the Netherlands therefore appears to face medium fiscal sustainability risks. This is primarily related to the projected increase in the costs of ageing where in particular the projected increase in long-term care costs contribute 2.0% of GDP to the indicator ([276]).

Health status

Whereas life expectancy for women in 2015 was in line with the average with 83.2 years (83.3 for the EU in the same year), men live longer in the Netherlands than in the EU as a whole: 79.9 vs 77.9 in 2015. Notably, healthy life years have decreased for Dutch women, from 63.5 years in 2005, to 57.2 in 2015, which brings the Netherlands under the EU average. However this has methodological reasons ([277]). For men the picture is slightly better. Years spent in good health are still less than in 2005 (65.4), but are with 61.1 closer to the EU average of 61.6 in 2015 ([278]).

Data show an increase in the proportion of the population which is obese (from 10.7% in 2005 to 12.8% in 2015). There has been a steady reduction of the proportion of the population that is a regular smoker, going from 25.3% in 2005 to 19% in 2015, under the EU average (20.9). Alcohol consumption is decreasing too and was in 2015 with 8 litres under the EU average (10.2 litre).

System characteristics

System financing

The healthcare system in the Netherlands is insurance based. In 2015, 80.7% of total health expenditure funding was generated from public sources.

Revenue collection mechanism

Health insurance organisations operating under the health insurance act, have the obligation to accept

([274]) To derive this number, the aggregate HC.3 is subtracted from total health spending.

([275]) The 2018 Ageing Report: https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070_en.

([276]) European Commission, Fiscal Sustainability Report (2018) https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

([277]) The definition of Healthy Life Years used in the European Survey on Income and Living Conditions is different than that of Statistics Netherlands (CBS). CBS and the OECD instead show that the percentage of women older than 65 who feel healthy or very healthy is very stable in the Netherlands.

([278]) Data on life expectancy and healthy life years is from the Eurostat database.

every citizen requesting a basic health insurance. In addition, risk selection is forbidden, i.e. the insurer is not allowed to request different premiums from different clients applying for the same policy and they are obliged to accept all enrolees for all policies. As the cost profiles of the individual insured differ, a system has been set up to compensate insurers for those cost differences (risk equalisation scheme), to create a level playing field for all insurers.

The funding of statutory health insurance comes from different sources. Through their employer, citizens pay a tax-based insurance contribution, based on their income. This contribution is distributed to the different health insurers on the basis of the above described risk equalisation and counts for roughly 50% of the total revenue of the health insurers). The distribution is based on the risk profile of the population in each health insurance organisation. Indicators such as age, sex, medication use, healthcare use and socio-economic status of the insured play a role in the risk equalisation scheme. A good functioning risk equalisation scheme is vital, to prevent insurers to select citizens with a specific risk profile. The Dutch risk equalisation scheme has both ex ante and ex post risk equalisation mechanism, although ex-post measures are being cancelled. That means that insurers will run a bigger risk, but a lack of ex-post measures forms an incentive for insurers to purchase healthcare more effectively. In addition, health insurance organisations collect a nominal premium from each person insured. The level of this premium differs between health insurance organisations depending on the policy of the organisation, their internal organisation, their reserves etc. Further, as of 2016, every insured person over age 18 must pay an annual deductible of €385 ($465) for health care costs, including costs of hospital admission and prescription drugs but excluding some services, such as GP visits. An additional source of funding that insurers receive is a state contribution for the insured under the age of 18 (10% of total revenue). Altogether, nominal premium, deductible and 18- contribution account for the remaining 50%.

Insurers collect insurance premiums and the risk-equalisation scheme between insurers applies to all funds for the basic benefit package. The content of the basic benefits package is decided on by the Ministry of Health. Private and public authorities publish comparative standardised information on premiums, benefits, performance in claim processing and patient satisfaction. The annual switching rate of the insured between funds (the insured can decide before the beginning of each calendar year whether they want to switch health care insurer) is between 6% and 7% ([279]). As a general issue characterising patients choosing between alternative providers, information asymmetries, technical complexity and uncertainty as to future needs make switching between funds more difficult. In addition, four insurers account for about 90% of the market. Whether this concentration in the insurance market reduces the expected benefits of competition between insurers is unclear. It may also increase the bargaining power of insurers over care providers and pharmaceutical companies which may lead to cost-savings.

Public and total expenditure on health administration and health insurance as a percentage of GDP were broadly in line with the EU average in 2015, though slightly above (0.33% vs. 0.26% for the EU for public and 0.41 vs. 0.38% for the EU for total) which is probably due to the fact that the system is based on multiple insurers. The higher than average can be explained by the efforts to supervise costs, prices, quality, contractual terms and market developments in the health market as well as ensuring risk-equalisation and prevent risk-selection, which are necessary in the context of competition in health insurance ([280]).

The current healthcare system is open-ended, although the Cabinet uses annual budget projections for public spending. However, if faced with overspending, the Ministry in charge has the possibility to resort to a macro budgetary cap tool, which is de facto equivalent to a clawback/payback mechanism, whereby the excess spending needs to be returned by providers. The most influential decisions are taken at the start of the cabinet; in the (max. 4) years the cabinet is in power, adjustments are made to the path set out at the start. Note, though, that for some treatments the government still defines budgets and for other health care provision the government decides on

([279]) http://www.vektis.nl/downloads/Publicaties/2016/Zorgthermometer%20nr17/#5/z.

([280]) A system based on "regulated" competition inherently needs more regulatory capacity.

the remuneration methods for providers or sets prices for treatments. For the major part individual insurers negotiate prices with health care providers. Insurers also can negotiate about resource allocation / financing between sectors of care (primary care services, specialists outpatient care, hospitals current spending) and for private hospitals to decide on infrastructure and equipment. Almost all hospitals in the Netherlands are private, but not for profit. Since the healthcare system is open-ended, total health expenditure may exceed the budget-projections ([281]). However, in the recent years expected growth of health expenditure turned out to be lower instead, but according to the Netherlands Bureau for Economic Policy Analysis (CPB) latest projections, health care expenditure is expected to increase over the period 2018-2021([282]). Possible ways to finance the expected increase of health expenditure are increasing employer taxes and health insurance premiums, or increasing cost-sharing mechanisms or removing increased interventions from the basic benefit package.

Administrative organisation: levels of government, levels and types of social security settings involved, Ministries involved, other institutions

As mentioned above, all health insurers are obliged to accept all applicants and to charge each individual applicant the same nominal premium for the same policy ([283]). For groups, the premium may differ. Applicants are free to choose an insurer. A Health Insurance Income Support scheme provides means-tested subsidies to help those below a certain income threshold (about 60% of the households receive such a subsidy) to pay for their insurance premiums ([284]).

Coverage (population)

Since 2006, a mandatory universal health insurance scheme operated by private health insurance funds (for profit and not-for-profit) provides 100% population coverage, through contracts with providers.

Treatment options, covered health services

The basic (but comprehensive) benefits package is fixed by law. Health insurers set a nominal community-rated insurance premium corresponding to that package.

Role of private insurance and out of pocket co-payments

In 2015, private health expenditure was about 19.3% of total health expenditure, slightly below the EU average for the same year (21.6%). Out-of-pocket expenditure ([285]) was 12.3% of total health expenditure in 2015. Out-of-pocket payments apply to certain services but are limited. Eyeglasses, contact lenses and certain dental prostheses, for example, are not covered by the basic benefits package. In 2008, the government introduced an annual mandatory deductible of €150 for insured people 18 and over (which has since been increased to €385 in 2017) ([286]). GP services ([287]) are exempted from the mandatory deductible, as a means to encourage primary care services vis-à-vis specialist consultations and hospital care (indeed, to be able to go to a specialist, one needs a referral from the GP). In addition, this exemption is intended not create a financial barrier for individuals to access this type of primary care, thereby supporting the role of the GP as gatekeeper in the Dutch healthcare system. Some services have recently been excluded from the basic package of care, while others have been

([281]) According to the OECD, The Netherlands scores 2 out of 6 in the OECD scoreboard due to the not very stringent budget controls.

([282]) In these projections, health care expenditure is rising as a percentage of GDP as the projection is based on the long-term trend excluding policy measures and on demographic developments.

([283]) The voluntary deductible can then influence the price paid for a specific policy, even though the benefits package is the same.

([284]) The law on the health insurance income support scheme states that no household should pay more on their health care premiums paid to insurers than a fixed percentage of their income. Any costs for health insurance premiums above this percentage are compensated through the health care allowance. In 2013 approximately 60% received an allowance.

([285]) Note that the €150 mandatory deductible is not included in the 5.7% out-of-pocket-payments. In 2010 the total amount of OOP caused by the mandatory deductible is nearly €1.5 billion. The actual amount of OOP is therefore higher than the 5.7% reported here.

([286]) By law, the deductible is periodically adjusted in line with an index for health expenditures. Households are compensated for the growth of the deductible with a tax subsidy mentioned above.

([287]) Other services such as maternal care, district nursing and healthcare for children up to the age of 18 are also exempted.

added ([288]). About 84% of the population buy supplementary private insurance, thought this figure seems to be declining over time ([289]). It is possible to reinsure the mandatory deductible.

Types of providers, referral systems and patient choice

Provision is mostly private but publicly regulated. Primary care is provided by independent general practitioners (GPs), often working in private group practices ([290]). Outpatient specialist care is provided in outpatient hospital departments. Almost all hospitals are non-profits while university hospitals are public. Providers have to establish contracts with health insurers.

The number of practising physicians per 100 000 inhabitants (347 in 2015) is in line with the EU average (344), showing a gradual increase since 2005 (271). The number of GPs per 100 000 inhabitants (82 in 2015) is slightly above the EU average (78 in 2015), with a consistent increase over the past decade (66 in 2005). The number of nurses per 100 000 inhabitants (1,047 in 2015) is well above the EU average (833 in 2015) though recording a slight decline compared with 2013 (1,210). This fits with authorities' objective, in recent years, to increase the supply of staff. The numbers above suggest that the skill mix is improving in the direction of a more primary care oriented provision (which the authorities wish to continue to pursue). Staff supply is regulated: there are quotas for medical students and for publicly financed training for medical specialties, although there is no regulation in terms of physician location. Perhaps as a result there is some concentration of medical staff in some regions/areas and staff shortages in others.

Authorities have made strong efforts to use primary care vis-à-vis specialist and hospital care. Residents have to register with a GP and there is a compulsory referral system from primary care to specialist doctors i.e. GPs act like gatekeepers to specialist and hospital care. In addition, GP services are free. Free choice of GP is allowed but given the number of GPs and their capacity constraints, choice may be limited in some areas. Free choice of a specialist or hospital is also allowed ([291]). Moreover, authorities have planned to introduce preconditions for and stimulate the usage of ICT and e- health solutions to allow for electronic exchange of medical data (e.g. e-prescribing or e-appointments and e-health records), to support and render the referral system and care coordination more effective, reduce medical errors and increase cost-efficiency.

The number of acute care beds per 100 000 inhabitants (518 in 2015, latest available year) has decreased over time (from 690 in 2005), though remaining above the EU average until 2015 (407 and 402 for the EU in 2013 and 2015 respectively). Hospitals have autonomy to recruit medical staff and other health professionals and their remuneration level, although a pay scale is set at national level in a collective labour agreement by employers and trade unions.

Pricing, purchasing and contracting of healthcare services and remuneration mechanisms

GPs are paid a mix of a capitation (€58 per patient minimum, with increments for age and deprivation index) and a consultation fee (€9) ([292]). Specialists are paid either a salary or a fee for service or a mix of the two. GPs are eligible to receive bonuses regarding their activity or performance; these bonuses may relate to all kinds of agreements between the insurer and the GP, e.g. the prescription of generics.

Hospitals are paid on the basis of DBC's, the descriptions of which are set by the Dutch Healthcare Authority (NZa), and the prices are negotiated by the hospital and the insurer. A small part (30%) is fixed and set by NZa, whereas 70% is set through negotiations between insurers and

([288]) Some of those removed include examples such as special chairs, allergen-free mattress covers, medication for erectile malfunction, whereas methadone treatment and treatment of dyslexia for children have been added to those included.

([289]) https://www.nza.nl/1048076/1048181/Marktscan_Zorgverzekeringsmarkt_2015.pdf, page 51.

([290]) There are also a not insignificant number of salaried GPs.

([291]) Indeed, according to the OECD, the level of choice of provider in The Netherlands has a score of about 3 out of 6, while gatekeeping scores 6 out of 6.

([292]) Note that there are also salaried GPs, most of them working for another GP.

hospitals. Hospital and mental healthcare fees are based on Diagnosis Treatment Combinations ([293]).

When looking at hospital activity, inpatient discharges, based on available figures (2012 latest) are lower than the EU average (11 in 2012 vs. 16 in 2013, and 16 in 2015 for the EU) but day case discharges, on the contrary, are significantly higher, i.e. more than double, than the EU average (16,201 in 2012 vs. 7,143 in 2013 in the EU and 7,635 in 2015). The proportion of surgical procedures conducted as day cases (60% in 2012, latest available figure) appears to be considerably higher than the EU average (30.9% in 2013 and 32.3% in 2015). Hospital average length of stay seems to be below the EU average (7.6 days in 2015), thought he latest reported value is considerably outdated (6.6 in 2006 to be compared with the EU average of 8.0 in 2009). All these figures point to a high hospital throughput and high hospital efficiency ([294]).

The market for pharmaceutical products

Since the 1980s, the authorities have implemented a number of policies to control expenditure on pharmaceuticals. Although pricing is free there is a maximum price ([295]) set for each product with a given active substance, strength and formulation which is based on the prices of medicines in four reference countries (BE, DE, UK and FR) the so called external reference pricing, and (since 2004) price negotiations between healthcare insurers, pharmacists and producers ([296]). Externally dispensed pharmaceutical: the authorities also apply internal reference pricing ([297]), whereby the maximum reimbursement level of a medicine is a weighted average price of the products in each cluster of products that a medicine belongs to, using 1998 prices. New products introduced after 1998 can get a premium price if the manufacturer demonstrates cost-effective added value, and the price of this new product becomes the maximum reimbursement level for all the products that followed and are added to the initial drug to form a cluster. Clusters of pharmaceuticals define "therapeutic equivalents", where pharmaceuticals are equivalent if they have comparable clinical characteristics, a more or less similar indication, route of administration, targeted age group and for which no clinically relevant differences in income apply. For externally dispensed pharmaceutical: only pharmaceuticals included in GVS are covered by basic health insurance - even though reimbursement may sometimes be obtained through complementary voluntary health insurance ([298]).

The authorities promote rational prescribing of physicians by stimulating the development of treatment guidelines, set up by medical experts, and the monitoring of prescribing behaviour. They also promote education and information campaigns on the prescription and use of medicines and regional platforms of physicians and pharmacists exist to discuss the use of medicines and improve its effective use. Some insurers have started to offer financial incentives to GPs based on efficient prescription of some drugs. Prescribing is done by active ingredient as part of medical training. A number of insurers initiated a policy of selective contracting of generic medicines; as of the 1st of July 2008, these insurers reimburse only the cheapest generic product (more precisely, those that are at the same price level as the cheapest pharmaceutical plus 5%) within a number of big-selling therapeutic classes. Producers of generics responded by substantially lowering their generic list prices. Insurers and their enrolees benefit from the system, but pharmacists may lose some revenues as a result of diminishing discounts and rebates provided by generic producers. As a result of these policies, the average prices of prescription medication have dropped considerably in the past.

Use of Health Technology Assessments and cost-benefit analysis

The National Institute for Health Research and the Health Care Insurance Board (ZiNL) conduct and

([293]) The OECD score for remuneration incentives to raise the volume of care in The Netherlands is therefore about 3.5 out of 6 as a result of the mix remuneration systems for physicians and hospitals.

([294]) Though this may be partly due to the broad coverage for long-term care.

([295]) The system was laid down in the Pricing Act of 1996.

([296]) A maximum price is only set for pharmaceuticals within the GVS. For pharmaceuticals which are used by medical specialists (usually for inpatient care), there is no maximum price.

([297]) The reference pricing system, introduced in 1993, is called the Medicine Reimbursement System (GVS).

([298]) Note that free choice is not excluded; if patients opt for a more expensive pharmaceutical in the same group, they have to pay the excess themselves, except if the physician decides that the more expensive one is clinically relevant for that particular individual case.

gather information on health technology assessment (HTA). Based on this HTA, the ZiNL advises the central government on what should be covered under the basic benefit package of care and the extent of reimbursement /cost-sharing in the system. It is used to determine the reimbursement of medicines and applied to new high-tech equipment, while prices are mainly set by the healthcare authority (NZa). The HTA helps defining clinical guidelines which are compulsory and to meet with effective monitoring of compliance. The ultimate decision on what should, and what should not be covered in the basic package is made by the central government. The central role of specialists in the absorption of treatment into the basic package should not be left unmentioned. New treatments or methods of diagnosis-setting adopted by medical specialists are more or less automatically covered in the basic package, since the basic package covers health care "according to the latest developments in science and technology". Only after ZiNL research shows that some methods or treatments are (cost-) ineffective the ZiNL may advise that type of treatment to be removed from the basic package.

E-health (e-prescription, e-medical records)

In the Netherlands, there is no national system for the exchange of data on e-prescription or e-medical records. The exchange of medical data is facilitated mainly on a regional level. Most of the medical records are updated electronically and are no longer available in paper. A survey shows that 93% of general practitioners and 66% of medical specialists update their records mainly or exclusively electronically. Furthermore, many doctors exchange patient data electronically. Nearly all (90%) of the general practitioners exchange patient data electronically with public pharmacies, emergency general practitioner services and hospitals. Almost half (46%) of medical specialists exchange patient data electronically with general practitioners. There are also systems which connect medical specialists or other healthcare providers who are active in the same chain of care (for example cancer or diabetes). Recently national policy has been introduced which states that the majority of chronically ill patients must have access to their own medical data (for example prescribed pharmacy), within the period 2014-2019. With this policy the Dutch government aims for more patient empowerment, higher quality and more effective care.

Health and health-system information and reporting mechanisms

In order to improve access and reduce the waiting time for hospital surgery, authorities have obliged hospitals and mental healthcare providers to give information to an integrated central and nationwide information system on patients on a waiting list. This information can be used by insurers and their insured to choose between hospitals. The publishing of this information is designed to encourage providers to increase activity and reduce waiting times. Data on patients' experience of care is published by the government, the insurers and NGOs. This improved information transparency has certainly contributed to reduce waiting times and lists, even though the major factor was most probably the implementation of pay-per-volume systems for most health care providers.

Comprehensive data exists, which enables information on physician and hospital activity and quality and patient care utilisation to be published. This information is used by insurers and patients to choose providers and by providers to improve their own activity. Surveys are conducted on patient's experience and satisfaction with the care provided. A general health care sector performance report is published on a regular basis using a comprehensive set of indicators.

Health promotion and disease prevention policies

The central government has set a number of relevant public health objectives, set in terms of processes and the reduction of health inequalities. The ambition is to decrease or at least stabilise the difference in life expectancy by 2030 compared to now, which, given the expected developments on social determinants of health and the international position of the Netherlands, is an ambitious goal. With regards to healthy life expectancy, the ambition is that of a significant decrease in differences by 2030. The 2015 level of public expenditure on prevention and public health services as percentage of GDP is in line with the average (0.29 vs. 0.25 for the EU in 2015). In terms of total expenditure, it is a bit more

markedly above the average (3.9% vs 3.4% for EU in 2015).

Recently legislated and/or planned policy reforms

Measures to control health care costs have been implemented by the government since 2008 for acute care. The breach of the Stability and Growth Pact criteria in 2010 reinforced the government's recognition that an effective control of public costs (including health care costs) was needed. The political drive of the current government (in office since 2012) to reduce the national debt to no more than 3% of the national budget has led to significant reductions in the health care budget. The measures that have been implemented can be grouped into four categories:

(1) shifting costs from public to private sources;

(2) shifting costs between various statutory sources (e.g. transfer of care from the exceptional medical expenses act (AWBZ) to the municipalities), mostly in combination with major cuts in the budgets;

(3) substitution of institutional care with home care and secondary care with primary care;

(4) increased focus on improving efficiency and eliminating fraud.

Initially, from 2009, the measures were mainly targeted at reducing overspending, shifting costs from public to private sources by limiting the basic package and efforts to prevent improper health care consumption. From 2011 onwards, the measures focused more on structural changes in the area of acute care, with the government seeking to reach a consensus with stakeholders to agree on further cost containment.

The future policy agenda for the Dutch health system commits itself to the promotion of high quality and sustainable care. In 2011, the first outline agreements between the Minister of Health, health care providers and insurers were concluded, which form a base for less growth of healthcare consumption and more high quality healthcare. These agreements work, because the use of agreements between parties is part of Dutch political culture, and because for providers there is always the latent threat of the government imposing measures, such as tariff cuts, when the agreed terms are not met. Also, the healthcare purchasing market provides sufficient incentives for both insurers and providers to produce healthcare of good quality at acceptable prices.

These objectives, moderate growth and improved quality of care, need to be anchored into the Dutch healthcare system. The following policy objectives will be aimed for in doing so: Primary healthcare (PHC). The Dutch healthcare system is widely known for its well-functioning PHC system. The aim is to further improve coordination between general practitioners, pharmacies, district nurses, and paramedics. Especially the district nurse will become more important; as from 2015 it will be reimbursed by the insurer (without usage will be subject to own risk), with a central role for care in districts. A central role of PHC will also make it possible for healthcare to become more patient-oriented, as more care can be provided at or near a patient's home.

Regarding innovation, this is regarded as an important feature of the system, which should remain available to patients to safeguard high quality care. New and innovative healthcare services will therefore be adopted into the basic package, under strict conditions of proven therapeutic effect and cost-efficiency. In addition, innovation has the potential to empower patients and to increase self-reliance, as well as unburden healthcare providers. Both aspects, again, make it possible for healthcare to become more patient-oriented.

On transparency, insurers need to know what the outcome of healthcare provision is, as a means of purchasing care based on quality. This also means that they are not obliged to remunerate inefficient healthcare. For the system to work efficiently, it is therefore important that everyone takes up responsibility to solely provide sensible and cost-conscious healthcare. Care provision receipts therefore need to become more understandable for patients and quality of healthcare provision will become more widely available by ZiNL ([299]). This

([299]) Regarding patient information, ZiNL has set up a website support informed patient choice: kiesbeter.nl; furthermore it is also among the responsibilities of the insurer to make quality of care available to their enrollees, in a transparent and comparable manner.

will empower patients, and it also provides a base for insurers to select care providers, mainly through selective contracting of healthcare by the insurer. The effect aimed for is that non-sensible use of care will be cut back, while it can also improve safety and, again, patient-oriented healthcare.

Challenges

The analysis above shows that a wide range of reforms have been implemented over the years, to a large extent successfully (e.g. the policies to control pharmaceutical expenditure; to strengthen primary care; to reduce hospital use; to improve data collection and monitoring; and, to improve life-styles), and which The Netherlands should continue to pursue. The challenges for the Dutch health care system are as follows:

- To continue increasing the efficiency of health care spending in order to adequately respond to the increasing health care expenditure over the coming decades, which is a risk to the medium-term sustainability of public finances.

- To continue to enhance and better distribute primary health care services and basic specialist services to ensure equity of access and the effectiveness and efficiency of health care delivery; To ensure an effective referral systems from primary to specialist and hospital care and improving care coordination between types of care, notably by ensuring that users register with their GP and by exploring the development of electronic patient records in the future.

- To find a balance between possible economies of scale and consumer choice between providers and insurers. Possible economies of scale exist in health care provision and insurance; and the challenge is to balance these economies of scale with the need for sufficient user choice between providers/insurers, so that providers/insurers will also in the long-run optimise the mix between quality and costs.

- To ensure that the gains expected to be achieved through competition between insurers as well as providers outweigh the administrative costs associated with the need to monitor and regulate many different dimensions of the health care market.

- To continue to improve accountability and governance of the system and identify possible cost-savings in the health sector administration. To further the existing efforts, such as financial incentives for GPs in smaller areas, to ensure that resource allocation, including that of medical staff, between regions is not detrimental to poorer regions.

- To continue to improve data collection and monitoring of inputs, processes, outputs and outcomes so that regular performance assessment can be conducted and use to continuously improve access, quality and sustainability of care and serve as a tool of patient empowerment.

- To further the efforts to support public health priorities and enhance health promotion and disease prevention activities, i.e. promoting healthy life styles and disease screening given the recent pattern of risk factors (smoking, alcohol) and the pattern of both infectious and non-infectious diseases.

Table 2.20.1: **Statistical Annex – The Netherlands**

General context												EU- latest national data			
GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
GDP, in billion Euro, current prices	546	579	613	639	618	632	643	645	653	663	683	12,451	13,213	13,559	14,447
GDP per capita PPS (thousands)	34.4	35.6	37.2	36.7	33.8	34.1	34.7	34.8	34.7	34.7	36.0	26.8	28.1	28.0	29.6
Real GDP growth (% year-on-year) per capita	1.9	3.4	3.5	1.3	-4.3	0.9	1.2	-1.4	-0.5	1.0	1.8	-4.7	1.5	0.1	2.0
Real total health expenditure growth (% year-on-year) per capita	:	0.9	4.2	4.3	3.1	2.7	2.1	2.1	0.7	-0.3	-1.1	3.7	0.2	0.2	4.1

Expenditure on health*	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Total as % of GDP	9.4	9.2	9.3	9.5	10.3	10.4	10.5	10.9	11.0	10.9	10.6	10.2	10.1	10.1	10.2
Total current as % of GDP	9.4	9.2	9.2	9.5	10.2	10.4	10.5	10.9	10.9	10.9	10.6	9.3	9.4	9.9	9.9
Total capital investment as % of GDP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.9	0.6	0.2	0.3
Total per capita PPS	2,825	2,922	3,109	3,325	3,443	3,562	3,643	3,770	3,848	3,847	3,836	2,745	2,895	2,975	3,305
Public total as % of GDP	6.7	7.6	7.7	7.8	8.5	8.6	8.7	9.0	8.9	8.8	8.5	8.0	7.8	7.8	8.0
Public current as % of GDP	6.7	7.6	7.7	7.8	8.4	8.6	8.7	8.9	8.8	8.8	8.5	7.7	7.6	7.6	7.8
Public total per capita PPS	2,004	2,416	2,581	2,718	2,838	2,945	2,996	3,093	3,086	3,096	3,097	2,153	2,263	2,324	2,609
Public capital investment as % of GDP	0.01	0.02	0.01	0.02	0.02	0.04	0.01	0.01	0.01	0.01	0.01	0.2	0.2	0.2	0.2
Public as % total expenditure on health	70.9	82.7	83.0	81.7	82.5	82.7	82.2	82.0	80.2	80.5	80.7	78.1	77.5	79.4	78.4
Public expenditure on health in % of total government expenditure	16.5	16.0	16.1	16.6	16.1	16.1	17.1	17.0	17.2	17.0	16.9	14.8	14.8	15.2	15.0
Proportion of the population covered by public or primary private health insurance	97.9	98.5	98.6	98.8	98.8	98.8	99.9	99.8	99.8	99.8	99.9	99.6	99.1	98.9	98.0
Out-of-pocket expenditure on health as % of total current expenditure on health	7.8	9.2	8.7	10.7	5.8	5.8	5.9	10.4	11.7	12.2	12.3	14.6	14.9	15.9	15.9

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Population, current (millions)	16.3	16.3	16.4	16.4	16.5	16.6	16.7	16.7	16.8	16.8	16.9	502.1	503.0	505.2	508.5
Life expectancy at birth for females	81.7	82.0	82.5	82.5	82.9	83.0	83.1	83.0	83.2	83.5	83.2	82.6	83.1	83.3	83.3
Life expectancy at birth for males	77.2	77.7	78.1	78.4	78.7	78.9	79.4	79.3	79.5	80.0	79.9	76.6	77.3	77.7	77.9
Healthy life years at birth females	63.5	63.5	64.3	59.9	60.1	60.2	59.0	58.9	57.5	59.0	57.2	62.0	62.1	61.5	63.3
Healthy life years at birth males	65.4	65.2	66.1	62.5	61.7	61.3	64.0	63.5	61.4	63.3	61.1	61.3	61.7	61.4	62.6
Amenable mortality rates per 100 000 inhabitants*	60	57	55	52	50	49	100	99	95	88	91	64	138	131	127
Infant mortality rate per 1 000 live births	4.9	4.4	4.1	3.8	3.8	3.8	3.6	3.7	3.8	3.6	3.3	4.2	3.9	3.7	3.6

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data			
Composition of total current expenditure as % of GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	2.7	2.0	1.9	1.8	2.0	2.0	2.0	2.0	2.1	2.1	2.2	2.7	2.6	2.7	2.7
Day cases curative and rehabilitative care	0.3	0.2	0.2	0.3	0.4	0.4	0.4	0.5	0.5	0.4	0.5	0.2	0.2	0.3	0.3
Out-patient curative and rehabilitative care	1.8	2.2	2.2	2.4	:	:	:	2.8	2.8	2.8	2.7	2.5	2.5	2.4	2.4
Pharmaceuticals and other medical non-durables	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0.9	0.9	0.8	0.8	1.2	1.2	1.5	1.4
Therapeutic appliances and other medical durables	0.5	0.5	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.3	0.3	0.4	0.4
Prevention and public health services	0.4	0.4	0.4	0.4	0.5	0.5	0.4	0.4	0.4	0.4	0.4	0.3	0.2	0.3	0.3
Health administration and health insurance	0.4	0.5	0.5	0.4	0.5	0.5	0.5	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Composition of public current expenditure as % of GDP															
Inpatient curative and rehabilitative care	2.1	1.9	1.8	1.7	1.9	1.9	1.9	1.9	2.0	1.9	2.1	2.6	2.5	2.5	2.5
Day cases curative and rehabilitative care	0.2	0.2	0.2	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.5	0.1	0.2	0.3	0.3
Out-patient curative and rehabilitative care	0.8	1.6	1.6	1.8	2.0	1.9	2.0	2.0	2.1	2.1	1.9	1.8	1.8	1.7	1.8
Pharmaceuticals and other medical non-durables	0.6	0.8	0.8	0.7	0.8	0.8	0.7	0.6	0.6	0.5	0.5	0.9	0.9	1.0	1.0
Therapeutic appliances and other medical durables	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.2	0.2
Prevention and public health services	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.2	0.2	0.3
Health administration and health insurance	0.2	0.4	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3

Source: EUROSTAT, OECD and WHO.

Table 2.20.2: **Statistical Annex - continued – The Netherlands**

												EU- latest national data			
Composition of total as % of total current health expenditure	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	28.5%	21.2%	20.2%	18.7%	19.0%	19.3%	18.7%	18.5%	19.4%	19.4%	21.2%	29.1%	27.9%	27.1%	27.0%
Day cases curative and rehabilitative care	2.9%	2.6%	2.6%	3.2%	3.5%	3.9%	4.2%	4.4%	4.4%	4.0%	4.7%	1.7%	1.7%	3.0%	3.1%
Out-patient curative and rehabilitative care	19.1%	24.2%	23.8%	25.4%	:	:	:	25.6%	25.9%	26.2%	25.3%	26.8%	26.3%	23.7%	24.0%
Pharmaceuticals and other medical non-durables	10.9%	10.9%	11.0%	10.3%	10.0%	9.8%	9.5%	8.3%	7.8%	7.6%	7.8%	13.1%	12.8%	14.7%	14.6%
Therapeutic appliances and other medical durables	4.9%	4.9%	4.8%	4.9%	4.6%	4.6%	4.8%	4.7%	4.4%	4.4%	4.8%	3.6%	3.6%	4.1%	4.1%
Prevention and public health services	3.9%	4.2%	4.3%	4.1%	4.5%	4.4%	4.1%	3.9%	3.8%	4.0%	3.7%	2.8%	2.5%	3.0%	3.1%
Health administration and health insurance	4.7%	5.0%	4.9%	4.3%	4.8%	4.8%	5.0%	3.9%	3.9%	4.0%	3.9%	4.5%	4.3%	3.9%	3.8%
Composition of public as % of public current health expenditure															
Inpatient curative and rehabilitative care	31.5%	25.3%	23.7%	22.0%	21.9%	22.2%	21.7%	21.4%	22.3%	22.0%	24.4%	33.9%	33.6%	32.1%	31.9%
Day cases curative and rehabilitative care	2.3%	2.8%	2.9%	3.5%	4.0%	4.5%	4.8%	5.0%	5.0%	4.5%	5.3%	1.9%	2.0%	3.4%	3.5%
Out-patient curative and rehabilitative care	12.6%	21.2%	20.7%	22.7%	23.1%	22.5%	22.9%	22.8%	23.2%	23.4%	22.5%	22.9%	23.5%	22.2%	22.5%
Pharmaceuticals and other medical non-durables	8.8%	10.8%	11.0%	9.5%	9.0%	8.8%	8.5%	7.0%	6.2%	6.2%	6.3%	11.8%	11.9%	12.6%	12.7%
Therapeutic appliances and other medical durables	2.5%	2.8%	2.7%	2.6%	2.8%	2.8%	2.8%	2.6%	2.4%	2.4%	2.8%	1.8%	1.9%	2.0%	2.1%
Prevention and public health services	2.8%	3.4%	3.5%	3.7%	3.8%	3.8%	3.6%	3.6%	3.4%	3.7%	3.4%	2.9%	2.5%	3.2%	3.2%
Health administration and health insurance	3.4%	4.7%	4.7%	4.2%	3.9%	3.7%	3.8%	3.7%	3.7%	3.9%	3.9%	4.1%	4.0%	3.6%	3.4%

												EU- latest national data			
Expenditure drivers (technology, life style)	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
MRI units per 100 000 inhabitants	0.66	0.78	0.76	1.04	1.09	1.22	1.29	1.18	1.15	1.29	1.25	1.0	1.4	1.5	1.9
Angiography units per 100 000 inhabitants	:	:	0.7	1.0	1.0	:	:	:	:	:	:	0.9	0.9	0.9	1.0
CTS per 100 000 inhabitants	0.8	0.8	0.8	1.0	1.1	1.2	1.3	1.1	1.2	1.3	1.4	2.1	1.9	2.1	2.3
PET scanners per 100 000 inhabitants	0.1	:	0.2	0.2	0.3	0.2	0.3	0.3	0.3	0.4	0.4	0.1	0.1	0.2	0.2
Proportion of the population that is obese	10.7	11.3	11.2	11.1	11.8	11.4	11.4	12.0	11.1	12.9	12.8	15.0	15.1	15.5	15.4
Proportion of the population that is a regular smoker	25.2	25.2	23.1	23.3	22.6	20.9	20.8	18.4	18.5	19.1	19.0	23.2	22.3	21.8	20.9
Alcohol consumption litres per capita	9.7	9.8	9.5	9.6	9.2	9.3	9.0	9.3	8.7	8.0	8.0	10.4	10.3	10.1	10.2
Providers	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Practising physicians per 100 000 inhabitants	271	280	279	287	292	296	313	325	331	343	347	324	330	338	344
Practising nurses per 100 000 inhabitants	819	820	830	840	:	:	:	1190	1210	1034	1047	837	835	825	833
General practitioners per 100 000 inhabitants	66	68	68	70	72	73	73	77	79	82	82	77	78	78	78
Acute hospital beds per 100 000 inhabitants	690	617	608	559	553	546	535	528	523	524	518	416	408	407	402
Outputs	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Doctors consultations per capita	5.4	5.6	5.7	5.9	5.7	6.6	6.6	6.2	6.2	8.0	8.2	6.2	6.2	6.2	6.3
Hospital inpatient discharges per 100 inhabitants	10	10	11	11	11	12	12	11	:	:	:	17	16	16	16
Day cases discharges per 100 000 inhabitants	8,817	9,602	10,324	10,987	11,766	12,509	12,618	16,201	:	:	:	6,362	6,584	7,143	7,635
Acute care bed occupancy rates	67.0	67.0	55.9	54.5	52.7	52.8	47.5	45.6	:	:	:	77.1	76.4	76.5	76.8
Hospital average length of stay	7.2	6.6	:	:	:	:	:	:	:	:	:	8.0	7.8	7.7	7.6
Day cases as % of all hospital discharges	46.5	48.0	49.3	50.1	51.1	51.8	51.4	60.0	:	:	:	28.0	29.1	30.9	32.3

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**	**Change 2016-2070, in pps. Netherlands**	**EU**
AWG reference scenario	6.2	6.4	6.6	6.7	6.8	6.9	6.9	7.0	7.0	7.0	7.0	7.0	0.8	0.9
AWG risk scenario	6.2	6.5	6.7	6.9	7.0	7.2	7.3	7.4	7.5	7.6	7.6	7.6	1.4	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**	**Change 2016-2070, in % Netherlands**	**EU**
Population projections until 2070 (millions)	17.0	17.4	17.9	18.4	18.8	19.0	19.2	19.2	19.3	19.3	19.4	19.5	15.1	2.0

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

The Netherlands

Long-term care systems

3.20. THE NETHERLANDS

General context: Expenditure, fiscal sustainability and demographic trends

The size of the population in the Netherlands in 2016 accounted for 3.4% of the total EU population, and it is projected to increase up to 19.6 million by 2070 ([546]). In 2015, it generated a GDP of roughly €683 billion or 4.7% of the GDP of the Union as a whole. With a GDP per capita of almost 36,000 PPS per capita, the Netherlands is also among the richest Member States (EU 29,610 PPS in 2015). Public expenditure on long-term care (health and social part) ([547]) was in 2016 with 3.5% of GDP, more than double the EU average of 1.6%.

Health status

Life expectancy at birth for both women and men is respectively 83.2 and 79.5 years, above the EU average for men and broadly in line for women in 2015 (83.3 and 77.9 years respectively). As for the healthy life years at birth however, these are lower than the EU-average both for women and for men, though more markedly for females, with 57.2 years vs 63.3 for the EU; for men, the 2015 value is of 61.1 vs. 62.6 years for the EU. At the same time, the percentage of the Dutch population having a long-standing illness or health problem is slightly higher than in the Union as a whole (35.3% and 34.2% respectively). The percentage of the population indicating a self-perceived severe limitation in its daily activities is also lower than the EU-average (7.3% vs. 8.1% in 2015).

Dependency trends

The amount of people living in the Netherlands depending on others to carry out activities of daily living is projected to significantly increase over the coming decades. From slightly less than 1.16 million residents living with strong limitations due to health problems in 2016, an increase of 42% is envisaged until 2070 to approximately 1.64 million. That is a steeper increase than in the EU as a whole (25% for the EU over the same period). Also as a share of the population, the dependents are expected to become a bigger group, from 6.8% to 8.4% by 2070, an increase of 24%, which is also higher than the EU-average projected increase of 21%.

Expenditure projections and fiscal sustainability

With the demographic changes in the Netherlands, the public expenditure on long term care as a percentage of GDP is projected to steadily increase by 2.5 pps, from 3.5 percent in 2016 to 6.0 percent in 2070 in the "AWG reference scenario" ([548]). In this scenario, public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The "AWG risk scenario", which captures in addition the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 4.8 pps of GDP by 2070. Overall, projected long-term care expenditure increase is expected to add to budgetary pressure. The long-term fiscal sustainability risk indicator S2, which shows the adjustment effort needed to ensure that the debt-to-GDP ratio is not on an ever-increasing path, is at 3.0% of GDP. In the long term, the Netherlands therefore appears to face medium fiscal sustainability risks. This is primarily related to the projected increase in the costs of ageing where in particular the projected increase in long-term care costs contribute 2.0% of GDP to the indicator ([549]).

System Characteristics

In the Netherlands, a system of public long-term care insurance had been in place since 1968 until recent years. Everyone who lived in the Netherlands was insured under the AWBZ (Algemene Wet Bijzondere Ziektekosten; Exceptional Medical Expenses Act). The AWBZ covered not only care for the elderly, but in principle all chronic care, especially concerning large expenses where insurance on a private market would not be feasible. This act covered at-

([546]) Based on Eurostat projections.

([547]) Long-term care benefits can be disaggregated into health related long-term care (including both nursing care and personal care services) and social long-term care (relating primarily to assistance with tasks linked with Activities with Daily Living).

([548]) The 2018 Ageing Report: https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070_en.

([549]) European Commission, Fiscal Sustainability Report (2018) https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

home care and care in institutions for the elderly, institutions for the mentally and physically handicapped and institutions for chronic psychiatric patients. Some form of income-dependent cost-sharing existed for practically all long-term care services. Moreover, in institutions a contribution had to be paid for the comprehensive package of care and board and lodging. However, in 2016, the Netherlands spent a very high share of long-term care public spending on institutional care (92.7%), which is largely above the average of 56% for the EU in the same year. This points to an inefficient use of resources, as institutional care is typically the most expensive way to provide long-term care. Looking more closely at the figures for institutional care, unit costs per recipient, measured as a share of GDP per capita, stood at 185 in 2016, which is more than double the EU average of 77.1 for the same year. This measure expresses the pressure on the budget deriving from the current provision of institutional care and suggests that there is ample scope to improve long-term care provision from a cost-efficiency perspective. Accordingly, the long-term care system has recently undergone a major reform with the aim to promote and support independent living. Indeed, the Netherlands spent in 2016 only 7.3% of the total long-term care budget is spent on home care, and, with unit costs of 8.4, home care stands well below the EU average value of 33.9 in terms of unit cost per recipient as a share of GDP per capita, which suggests that shifting resources to this mode of provision could be an efficiency enhancing measure.

The Exceptional Medical Expenses Act, close to becoming unmanageable due to the breadth of covered services, was repealed. Whereas some of those previously covered under this act are currently covered under the Health Insurance Act, the Social Support Act (Wmo) or the Youth Act, the most vulnerable categories, i.e. those requiring permanent supervision or 24-hour care nearby, are entitled to care services under the Long-Term Care Act (Wlz).

Administrative organisation

The Exceptional Medical Expenses Act (AWBZ), in place since 1968, used to cover the bulk of expenditures, and was a truly national and largely contribution-based scheme which covered for the costs of personal and nursing care, guidance, accommodation and, on certain conditions, even medical treatment. The basket of covered benefit had grown to such an extent over time that the system was close to becoming unmanageable in the previous setting. In 2007, the provision of home help for domestic activities was delegated to the municipalities as part of a broader decentralising pattern. In 2015, the Exceptional Medical Expenses Act was repealed and was replaced in its scope by other acts like the Social Support Act (Wmo), the Health Insurance Act (Zvw) and Youth Act. Under the Wmo, the local authorities are in charge of provision of care and of the needs assessment, which they formulate based on an interview with the citizen.

The Long-Term Care Act (Wlz), a compulsory health insurance policy based on solidarity, focusses a smaller group of high-need individuals. The amount of the premium is (9.65%) of the income tax, with a ceiling of 33,589 euros. In addition, there is an income-dependent co-payment for adults. This depends on whether the client lives at home or in a care facility, is younger or older than 65, and is single, married or has a domestic partner.

Under the Wlz, 31 regional care offices (zorgkantoren) are in charge to provide care purchased with public funds. The agencies are generally independent subsidiaries of the dominant health insurer in each region. Although they have a contracting budget, these agencies have no funds of their own (except for administrative costs), as care providers are directly paid from a general public fund on the basis of contracts concluded with the agencies. Hence, purchasing agencies bear no financial risk on purchasing care. All contributions collected under Wlz are deposited into the Long-Term Care Fund, which is managed by the National Healthcare Institute. The central government tops up the fund using public funds if these funds are too low. Although the care costs are paid from the Wlz fund, the care offices are charged with keeping costs within the national and regional budget and with purchasing care as efficiently as possible. In addition, the purchasing agencies can set quality standards and check services invoiced by the healthcare providers match the required standards. All long term care tariffs are regulated by the Dutch Healthcare Authority (NZa). The NZa set maximum prices,

where under bargaining between purchasing agencies and providers is allowed.

Types of care

The main recipients of long-term care include persons with learning, physical or sensory disabilities, elderly persons and persons with psychiatric disorders. The Long-Term Care Act (Wlz) covers the most vulnerable categories, i.e. those requiring permanent supervision or 24-hour care nearby, providing a broadly defined set of services including residential care. The Wmo covers a broad package of services, such as personal care, nursing and domiciliary care for individuals that need assistance but are not as severe cases. All these services (including treatment and stay in an institution) were previously delivered under AWBZ.

Most clients apply for care-in-kind, but since the mid-1990s they may also opt for a personal budget to purchase health services privately (under both Wlz and Wmo). The cost explosion of the personal budget scheme from 413 million euro in 2002 to 2.2 billion in 2010 highlights the popularity of this scheme. However, experts worry that it did not equally lower the demand for in-kind care and also tends to crowd out informal care.

In providing support under the Social Support Act, the local authorities distinguish between general provisions and personalised provisions. General provisions are designed for the community and cover a range of services from recreational activities to transportation. Personalised provisions are designed for a single person; this might include domestic assistance and support. Currently, the assistance is aimed at being able to live independently (for example, help with organising the household or with administration).

To facilitate the elderly living at home (as opposed to living in a rest home or care institution), the government encourages municipalities, social housing associations and care institutions to build homes adapted to the needs of older people. Accessible local care also plays a part in helping the elderly to be independent for as long as possible. In order to achieve this, a new focus has been placed on creating local health care networks where general practitioners, nurses and other care givers cooperate in offering custom care to patients.

Eligibility criteria

Patients' eligibility for Wlz care is assessed by an independent Care Assessment Centre (CIZ). There are no financial incentives for CIZ: its financial position is not affected by its decisions. CIZ's task is to carry out independent, objective and integral assessments. The procedure is the same for care reimbursed in cash and for in-kind care. CIZ adopts certain standards to determine different 'profiles' (packages), in which the eligibility is determined on the needs and characteristics of the client.

The centre decides if patients are eligible for Wlz care and how much care they are entitled to. Once assessed, patients can opt either to receive in-kind care (either in an institution or at home) or a cash benefit ("personal budget") that is roughly equivalent to 100% of the care related costs of in-kind care. The cash-reimbursement option is not commonly used for treatment and stay in an institution, except for some small-scale initiatives. For most of the budget, patients are obliged to be able to show that they did spend the money on care. Out of the 2016 budget of 19.9 billion, 1.3 billion is the amount attributed to the personal budget. Based on these figures, cash benefits amount to roughly 6.5% of total expenditure for Wlz ([550]).

Clients who prefer in-kind care have some say with regard to which care organisation delivers their care, however, the responsibility for organising and purchasing this care remains with the 'zorgkantoren' (regional care offices).

Under the Wmo, the local authorities are in charge of delivery and discuss the client's request for support together with the client. It is then up to the local authority to provide the appropriate type of support and determine how this support is to be organised. People can either contact the local authority or be referred by a GP. A meeting is set-up to assess the request for support, in light of

([550]) https://www.rijksoverheid.nl/onderwerpen/prinsjesdag/documenten/begrotingen/2015/09/15/xvi-volksgezondheid-welzijn-en-sport-rijksbegroting-2016, p.138.

factors such as the possibility of the individual to draw on their personal network or on a general provision. Hence the local authority decides whether to accept or reject a request of support, which, if granted, can materialise into services of a personal budget with or without a co-payment. As for the financing, the local authorities receive funds from the central government through the Municipal Fund, which they can allocate to services discretionally. They then pay providers for services or transfer funds to the Social Insurance Bank for personal healthcare budgets.

Co-payments, out of the pocket expenses and private insurance

The long-term care system is funded by social security premiums, taxes and co-payments. Since co-payments are income- and wealth-dependent, care users will not run into severe financial difficulties. But it is quite well possible that persons in institutions have to contribute so much that they just have 'a clothing allowance and pocket money' left to spend according to their own preferences. At the same time, the income-related co-payment covers only a small portion of the total costs of long-term care (10% of total for Wlz in 2015).

Role of the private sector

Institutional care providers must be non-for-profit organisations, while the home care market has been opened to for-profit companies.

Formal/informal caregiving

Since its inception in 1968, the Exceptional Medical Expenses Act has been expanded and improved. However, long-term care has also changed in its nature and extent through a whole range of supplementary regulations. This has led to an increased demand for care, rising costs and a sizeable bureaucracy. Moreover, it has led to a system that is aimed too much at the provision of care (by institutions) and too little on the patient. In some cases, the appeal for Exceptional Medical Expenses Act care has increased needlessly, without clear benefits for the patients. There is also the threat of a shortage of care workers. In 2010 there were 1.3 million employees in the care and welfare sector. According to calculations by the National Institute of Public Health and Environmental Protection (Rijksinstituut voor Volksgezondheid en Milieuhygiëne or RIVM), over the coming 15 to 20 years at least 400,000 extra care providers will be needed in the care sector alone, if the policy remains unchanged. At the same time, the working population will decline during the coming decades. To respond to this future challenge, the Netherlands has carried out projections of future needs for carers, and is implementing a reorganisation of the labour force (including financial support for institutions) in long-term care. Nonetheless, given the size of the challenge, this area deserves regular monitoring. During the last few years there have been several reports published in which the conclusion is put forward that measures were needed in order to allow the Exceptional Medical Expenses Act to take future developments into account. Besides these reports, analyses have also been compiled within the care sector itself by organisations such as ActiZ (organisation for care providers in the Netherlands) as well as a collaboration of client organisations, which show that the Exceptional Medical Expenses Act does not make sufficient use of the strengths of the people involved and those around them.

Recently legislated and/or planned policy reforms

The main objective of the recent reform of long-term care was to guarantee its fiscal sustainability in future. As such, substantial cuts were made in the system, including the delisting of day care and personal counselling under the Awbz, lifting the entrance barrier of residential care for persons with severity-package 1-3 and a substantial reduction of the state budget for municipalities to carry out the Wmo.

The reform of long-term care includes a radical revision of the institutional structure. The most important changes are: (a) decentralisation of non-residential (extramural) long-term support to municipalities under the new Wmo, (b) the abolishment of the Awbz and the simultaneous introduction of the Long-term Care Act (*Wlz: Wet Langdurige Zorg)* to cover care for the most vulnerable and (c) the transfer of personal care at home from the Awbz to the Health Insurance Act (for people who are not meeting the Wlz criteria). In addition, municipalities are attributed the

responsibility for most ([551]) of the youth care as established by the new Youth Law approved in 2014. The reform of long-term care has not only institutional and budgetary implications but also a *normative* component consisting of three main elements emphasising the importance of individual responsibility, encouraging and promoting independent whenever possible.

The first significant step was the introduction of the Wmo in 2007, a key element of which was the decentralisation of parts of long-term care from the AWBZ to municipalities, which became responsible for household cleaning. Under the arrangement municipalities must give support to people who cannot run a household on their own and participate in social life. Each municipality has discretionary power as regards need assessment, which may lead to unequal access.

Later on, *some non-residential (extramural) services in LTC* were transferred to municipalities (and insurers), and, together with a 40% cut in the budget for household cleaning, a revision of the Wmo along the following lines was adopted:

– the Wmo stresses individual and social responsibility;

– municipalities are responsible for the implementation of the Wmo;

– the municipalities deliver tailor-made services (*maatwerk*) based on a need assessment procedure *(keuken-tafelgesprek);*

– the municipalities decide on whether to assign a personal budget;

– means-testing is forbidden, but municipalities can set co-payments.

Wlz ([552]) is set up as a social health insurance scheme based on income contributions and covering the entire population, who has a right to long-term care subject to need. As for the range of benefits, the Wlz covers either services in-kind or a personal budget or a total package at home (*volledig pakket thuis*). The system of severity-adjusted packages (*zorgzwaartepakketten*) remains in place. The new Wlz has many features in common with the former Awbz. For instance, the care offices have been preserved and are in charge of contracting LTC providers, the system of regional budgets is still in place and the Nza sets maximum tariffs.

It is yet not known whether the reform of the long-term care has started to deliver results and quantifications of projected savings are not yet available. In terms of fiscal sustainability this therefore leaves the Netherlands exposed to the high long-term risks driven by the projected increase in long-term care spending mentioned above.

Challenges

The Netherlands has undergone a major reform of the long-term care system to tackle the high projected costs of its long-term care system while preserving quality. The following are acknowledged as the main challenges for the Dutch long-term care system and many are included in their policy agenda:

- **Improving the governance framework:** to ensure a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities concerning the provision of long-term care services; to share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes; to deal with cost-shifting incentives across health and care.

- **Improving financing arrangements:** to consider reviewing the extent of user cost-sharing on LTC benefits or to consider pre-funding elements, which implies setting aside some funds to pay for future obligations.

- **Support independent living:** to provide effective home care, tele-care and information

([551]) Some aspects of youth care are regulated under Zvw or Wlz.
([552]) It covers groups of people that need constant assistance due to the nature of the condition or to the risk that the condition would worsen with lack of support and supervision.

to recipients, as well as improving home and general living environment design.

- **Supporting family carers:** to further the efforts in establishing policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **Ensuring availability of formal carers:** further the efforts in determining current and future needs for qualified human resources and facilities for long-term care, with a focus on ensuring their future availability.

- **Ensuring coordination and continuity of care:** to establish better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- **Improving value for money**: to invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services; to invest in ICT as an important source of information, care management and coordination, to encourage competition across LTC providers to stimulate productivity enhancements.

- **Prevention: to promote healthy** ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

- **Improving administrative efficiency**.

Table 3.20.1: **Statistical Annex – Netherlands**

GENERAL CONTEXT

GDP and Population	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
GDP, in billion euro, current prices	546	579	613	639	618	632	643	645	653	663	683	12,451	13,213	13,559	14,447
GDP per capita, PPS	34.4	35.6	37.2	36.7	33.8	34.1	34.7	34.8	34.7	34.7	36.0	26.8	28.1	28.0	29.6
Population, in millions	16.3	16.3	16.4	16.4	16.5	16.6	16.7	16.7	16.8	16.8	16.9	502	503	505	509
Public expenditure on long-term care (health)															
As % of GDP	2.0	2.0	2.1	2.2	2.7	2.7	2.7	2.7	2.7	2.6	2.4	1.1	1.2	1.2	1.2
Per capita PPS	638.0	675.9	780.6	834.4	824.5	826.7	840.8	942.4	921.7	921.8	859.0	264.1	283.2	352.1	373.6
As % of total government expenditure	4.6	4.5	5.0	5.1	5.5	5.6	5.7	5.8	5.7	5.7	5.2	1.6	1.8	2.5	2.5
Note: Based on OECD, Eurostat - System of Health Accounts															
Health status															
Life expectancy at birth for females	81.7	82.0	82.5	82.5	82.9	83.0	83.1	83.0	83.2	83.5	83.2	82.6	83.1	83.3	83.3
Life expectancy at birth for males	77.2	77.7	78.1	78.4	78.7	78.9	79.4	79.3	79.5	80.0	79.9	76.6	77.3	77.7	77.9
Healthy life years at birth for females	63.5	63.5	64.3	59.9	60.1	60.2	59.0	58.9	57.5	59.0	57.2	62.0	62.1	61.5	63.3
Healthy life years at birth for males	65.4	65.2	66.1	62.5	61.7	61.3	64.0	63.5	61.4	63.3	61.1	61.3	61.7	61.4	62.6
People having a long-standing illness or health problem, in % of pop.	:	32.0	31.6	31.3	32.7	32.6	34.1	34.6	36.2	34.7	35.3	31.3	31.7	32.5	34.2
People having self-perceived severe limitations in daily activities (% of pop.)	:	8.2	8.0	5.8	5.4	5.5	6.2	5.8	5.7	5.5	7.3	8.3	8.3	8.7	8.1

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
Number of people receiving care in an institution, in thousands	:	:	123	196	268	340	346	353	383	389	396	3,433	3,851	4,183	4,313
Number of people receiving care at home, in thousands	:	:	499	539	580	621	632	645	544	552	561	6,442	7,444	6,700	6,905
% of pop. receiving formal LTC in-kind	:	:	3.8	4.5	5.1	5.8	5.9	6.0	5.5	5.6	5.7	2.0	2.2	2.2	2.2
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients															
Providers															
Number of informal carers, in thousands	:	:	:	3,500	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	300	300	296	303	297	289	288	260	252	240	:	:	:	:	:

Source: EUROSTAT, OECD and WHO.

Table 3.20.2: **Statistical Annex - continued – Netherlands**

PROJECTIONS

Population	**2016**	**2020**	**2030**	**2040**	**2050**	**2060**	**2070**	**MS Change 2016-2070**	**EU Change 2016-2070**
Population projection in millions	17.0	17.5	18.4	19.1	19.2	19.3	19.6	15%	2%
Dependency									
Number of dependents in millions	1.16	1.21	1.41	1.53	1.62	1.63	1.64	42%	25%
Share of dependents, in %	6.8	6.9	7.7	8.0	8.4	8.4	8.4	24%	21%
Projected public expenditure on LTC as % of GDP									
AWG reference scenario	3.5	3.7	4.4	5.3	5.8	6.0	6.0	69%	73%
AWG risk scenario	3.5	3.7	4.7	5.9	6.8	7.5	8.3	134%	170%
Coverage									
Number of people receiving care in an institution	302,600	323,061	405,482	493,287	558,504	583,530	581,921	92%	72%
Number of people receiving care at home	520,886	559,734	709,656	825,104	896,694	898,625	916,233	76%	86%
Number of people receiving cash benefits	0	0	0	0	0	0	0	:	52%
% of pop. receiving formal LTC in-kind and/or cash benefits	4.8	5.1	6.0	6.9	7.6	7.7	7.7	59%	61%
% of dependents receiving formal LTC in-kind and/or cash benefits	71.2	72.8	79.0	86.0	89.8	90.8	91.3	28%	33%
Composition of public expenditure and unit costs									
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	0%	5%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	:	-27%
Public spending on institutional care (% of tot. publ. spending LTC in-kind)	92.7	92.8	93.0	93.4	93.6	93.8	93.7	1%	0%
Public spending on home care (% of tot. publ. spending LTC in-kind)	7.3	7.2	7.0	6.6	6.4	6.2	6.3	-13%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	185.0	183.8	187.7	191.8	187.7	185.5	188.8	2%	10%
Unit costs of home care per recipient, as % of GDP per capita	8.4	8.2	8.0	8.1	8.0	8.0	8.0	-4%	1%
Unit costs of cash benefits per recipient, as % of GDP per capita	:	:	:	:	:	:	:	:	-14%

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).