Nederlandse Zorgautoriteit

The state of the healthcare markets in 2017

Inhoud

1

2

3

4

5

What is the healthcare situation in 2017? What are some important facts and figures? What new trends and developments can we discern? Which bottlenecks have we dealt with, and where do we see opportunities for improvement? Read more about the state of affairs in the various healthcare sectors and the challenges for the coming year in the State of Health Care 2017.

The Netherlands' health care is in good shape in 2017, but there is always room for improvement. For example, we have noticed a steady increase in healthcare expenditures year after year. We want to keep our healthcare system healthy in the future by providing care that is accessible to anyone who needs it, and that we can continue to pay for together.

As the population ages, so the number of people suffering from more than one disease or chronic illness grows apace. Elderly people are also living in their own homes longer. These developments require a new organisation of care: closer to home, as parts of networks, with various healthcare disciplines working together. Every care sector has recognised the need to collaborate more effectively and intensively with others, be they other healthcare professionals and providers, or providers and patients, health insurers, policy makers and supervisory bodies. This cooperation is needed in order to prevent long waiting lists for care, reduce the burden on emergency rooms, and offer patients the care they need, where they need it.

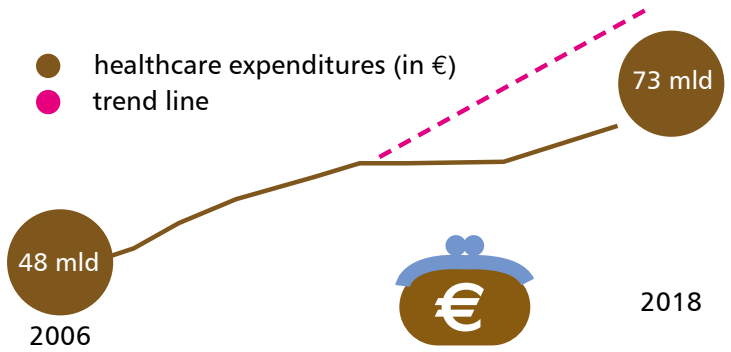
We could also do much more to prevent diseases and complications, and to intelligently apply e-health techniques. And we could do a better job of determining in advance which treatments or medications are truly effective - and which are not.

Finally, the regulations for registering and declaring care could be made more simple, more practical and more convenient, in order to ensure that the way we pay for care corresponds to actual practice.

See the Strategic Agenda of the Dutch Healthcare Authority (NZa).

1. The state of healt care in 2017

Developments in total healthcare expenditures



Source: Draft Public Health, Welfare and Sport budget, 2018

Between 2006 and 2012, healthcare expenditures increased by an average of 6.3% per year. Between 2012 and 2017, this rate of growth had been reduced to approx. 1.4% per year. However, healthcare expenditures are expected to increase by around 5.4% in 2018. This is mainly due to the favourable economic situation and extra funding for nursing home care.

First-line care

First-line care expenses per sector (amounts x € 1 million)

	2017	2018
Total first-line care	**5.637,0**	**5.802,5**
General practitioner care	2,924.2	2,999.2
Multi-disciplinary care	482.5	494.9
Health insurance dental care	753.2	764.1
Physiotherapy	512.5	548.6
Speech therapy	132.5	134.3
Occupational therapy	40.9	41.5
Obstetrics care	240.1	260.9
Post-natal care	309.5	314.5
Nutritional advice	38.8	39.4
Remedial therapy	21.8	22.4
Sensory impaired	181.0	182.8

Neighbourhood care expenses (amounts x € 1 million)

	2017	2018
Neighbourhood care	3,525.0	3,778.0
Pharmaceuticals and medical supplies	6,401.7	6,564.6

Source: VWS, data from Zorginstituut Nederland about (preliminary) financing needs Zvw and Wlz and NZa data on production agreements and preliminary realisation data. www.staatvenz.nl. The figures for 2018 are estimates in the draft budget.

The first-line care market scan conducted by the NZa in May 2017 indicated that more than 30% of the total care expenditures from the basic insurance package are paid to first-line care. Over the past few years, costs have risen dramatically: from € 8.8 billion in 2012 to € 12.7 billion in 2015. The main causes behind this increase were the introduction of basic mental health care and the transfer of neighbourhood care. The figures above show that the increase in costs is expected to continue.

See First Line Care Market Scan 2016

Comprehensive rates provide margins for bespoke service in neighbourhood care

In 2017, an estimated 86% of neighbourhood care providers were contract workers. This level of contracting is comparable to other sectors in first-line care. Almost all neighbourhood care (93%) was purchased in the form of comprehensive rates. These comprehensive rates provide margins for bespoke service in neighbourhood care These can take the form of an hourly rate, but some insurers also negotiate daily or monthly rates with care providers.

See Neighbourhood Care Contracting Monitor 2017

Specialist Medical Care

First-line care expenses per sector (amounts x € 1 million)

	2017	2018
Second-line care	**23,985.7**	**24,197.4**
Specialist Medical Care	21,659.8	21,840.9
Geriatric rehabilitation care and first-line accommodations	1,054.9	1,065.4
Availability supplement Academic care	667.8	674.6
Availability supplement capital expenses Academic care	54.4	54.5
Availability supplement other Specialist medical care	90.3	92.7
Other curative care	458.5	469.4

Source: VWS, data from Zorginstituut Nederland about (preliminary) financing needs Zvw and Wlz and NZa data on production agreements and preliminary realisation data. The figures for 2018 are estimates in the draft budget.

The expenditures for second-line care are expected to increase slightly between 2017 and 2018.

The expenditures for expensive medications (so-called 'add-on medications') will continue to increase greatly. We recognise several causes for the increased costs. New medications are increasingly expensive, for example. Costs increase the most for the first few years after a new medication is released to the market, because the medication can be prescribed for more indications, and is therefore used to treat more patients, while the price remains the same.

The largest share of expenditures are for medications to treat cancer. In 2015, this was at least € 727.1 million Euros, an increase of 15.4% over 2014. One remarkable increase was due to the large increase in medications to treat eye diseases. Expenditures for these medications increased by 65% in 2015, to at least 36.5 million Euros.

See also the interactive graphs about expensive pharmaceuticals.

Based on the available information, patients seem to be getting the medication they need, including expensive drugs.
However, there is room for improvement if hospitals and health insurers can make agreements immediately upon the introduction of a new drug. We also advise health insurers to clearly state at which hospitals they purchase specific treatments with expensive medications in a timely manner.

See the Specialist medical care medications expenses monitor.

Waiting lists for specialist medical care polyclinic visits

Last year, the normal waiting time to visit a polyclinic for eight specialist care disciplines was four weeks. This includes the figures up to December 2016.

Specialist medical care - longest waiting times for polyclinic treatment, in weeks

Specialism	2015	2016
Allergology	6.1	6.6
Ophthalmology	5.1	6.5
Gastric, intestinal and liver diseases	5.6	6.2
Rheumatology	4.3	5.0
Rehabilitative medicine	4.5	4.9
Pain relief/anaesthesiology	4.7	4.5
Neurosurgery	4.1	4.1
Neurology	3.5	4.0

Source: Mediquest

For more information about the underlying figures, see the interactive graph.
Or read the Specialist Medical Care Market Scan 2016.

In 2017, the NZa initiated a number of activities to address these waiting periods. Read more about them in the Challenges for 2018.

Palliative care in the right place at the right time

Palliative care is tailored to the individual patient, and realising it has increased the complexity of funding. Over the past few years, several measures have been implemented to facilitate bespoke care and

collaboration between care professionals. After meeting with experts, care providers and health insurers, we have observed seven areas of improvement to develop funding for palliative care.
These include: simplifying the funding, improving regional cooperation, and setting quantifiable quality standards for palliative care. We have also amended certain regulations in order to reduce the administrative burden and to create space for bespoke treatment for the patient.

Read also the informational chart on cooperation and affordability of bespoke palliative care.

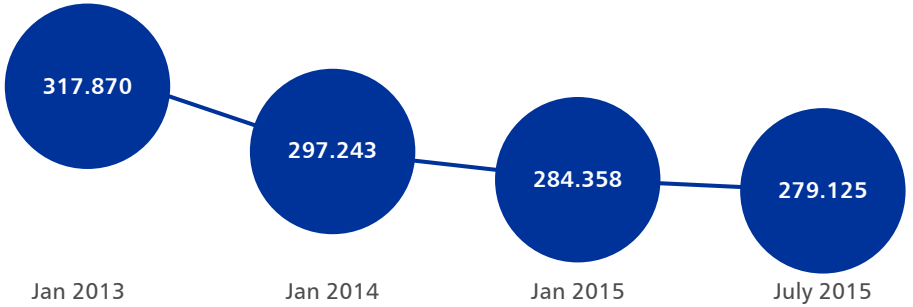
Long-term care

Long-term care expenses (amounts x € 1 million)

	2017	2018
Care in kind within contracting terms	17.255,7	18.107,2
Personal budgets	1.998,0	2.156,2
Outside terms of contracts *	1.192,0	1.548,4

Source: VWS, data from Zorginstituut Nederland about (preliminary) financing needs Zvw and Wlz and NZa data on production agreements and preliminary realisation data.
* Correction of capital costs and management costs. Also supra-budgetary compensation, dentistry Wlz, institutions for specialist medical care Wlz, other curative care Wlz, ADL, extramural treatments, healthcare infrastructure, first-line admissions, innovation and availability supplement for training Wlz.

Total number of patients in long-term care



Source: CIZ

Long-term care cost study

In 2017, the NZa has asked all providers of long-term care to participate in a cost study. With this study, we hope to gain insight into the care that providers supply to clients with a Wlz indication, or a claim to a first-line accommodations, and what this care costs. With the introduction of the care intensity packagesin 2009, the NZa calculated rates for all performance indicators. The rates were then indexed annually. Much has changed since then: care provision has been added, long-term care was transferred from the Exceptional Medical Expenses Act to the Long-Term Care Act in 2015, and more attention is being paid to (paying for) the desired level of quality. The study provides a better understanding of the current costs for long-term care. We will analyse the results of the cost study and discuss the results with care provider branch organisations and health insurers. The goal is to set new rates in the Long-Term Care Act starting in 2019.

Mental health care

Mental healthcare expenses (amounts x € 1 billion)

	2016	2017	2018
Medical mental health care (Zvw)[1]	3.6	4.0	4.0
Intramural long-term mental health care (Wlz)[2]	0.5	0.6	0.6
Juvenile mental health care (Wmo)[3] GP/poh-ggz	1.0	1.0	1.0
Assisted living (Wmo)[4]	1.4	1.5	1.6
State of the draft budget 2018	**6.6**	**7.1**	**7.2**

Source: Draft Public Health, Welfare and Sport budget

[1] Zvw mental health care, including POH care (Source POH care: 2016, Zorgprisma/ Vektis. From 2017, estimate based on 2016)

[2] This policy information for 2018 is based on claim data.

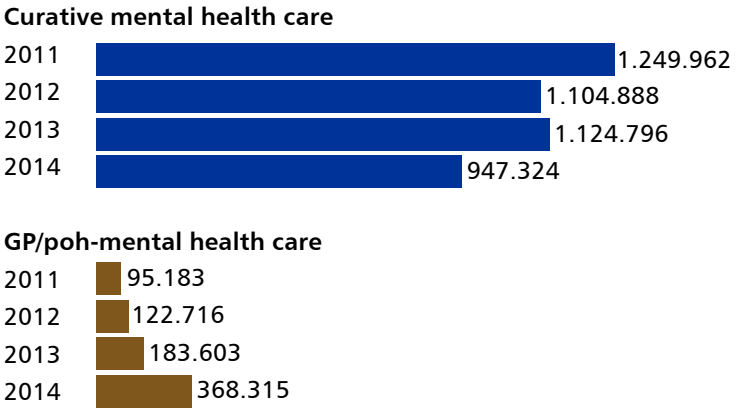
[3] Estimated available budget based on amount carried forward in 2015. This does not give an accurate picture of what municipalities actually spend on juvenile mental health care.

[4] Budgets according to September circular (2016) and May circular Wmo (2017 and later).

In 2016, we spent more than 4.1 billion Euros more for mental health care for adults (excluding assisted living). These expenditures are expected to increase to 4.7 billion Euros in 2017 and 2018.

For more information, see the interactive graphs.

Number of patients in curative mental health care



Number of patients in long-term mental health care

Source: Vektis

The number of patients is decreasing in both in long-term mental health care and curative mental health care. This decrease can be partially explained by the fact that juvenile mental health care and assisted living have both been transferred to municipalities. Remarkably, the number of patients treated by the general practitioner's mental health care practice assistant has increased greatly.

Waiting times for mental health care - longest waiting times for polyclinic treatment, in weeks	
Mental health care registration waiting times	**2016**
Institutions	
Basic mental health care	4.0
Basic/specialised mental health care	4.0
Specialised mental health care	6.0
Private practice	
Basic mental health care	3.2
Basic/specialised mental health care	5.3
Specialised mental health care	8.6

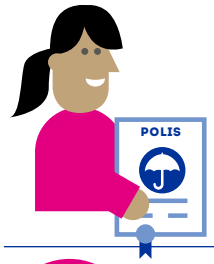
Source: Mediquest, survey September 2016

Since an appeal in April 2017, the NZa has received 94 reports from people with complaints about long waiting times in mental health care. Of them, 27 were actually on a waiting list with a mental healthcare provider. Other reports were from people who had faced long waiting times in the past, and people with complaints about their current treatment.

We contacted those whose waiting times exceeded the Treek norm, and reminded health insurers of their obligation to mediate. Usually, it was possible to find another care provider who could start treatment or assistance in time. In some cases, the waiting time to see another professional was also long.

These involved people with complex problems or with two disorders simultaneously, requiring specific expertise to treat each disorder. This corresponds to signals we have received over the past few months from physicians and patients, and the findings of our own research. Especially people with complex problems requiring specialist treatment, and who occasionally face long waiting times.

Health insurance



Health insurance 2017

€ 1.286 per jaar

Number different policies

58

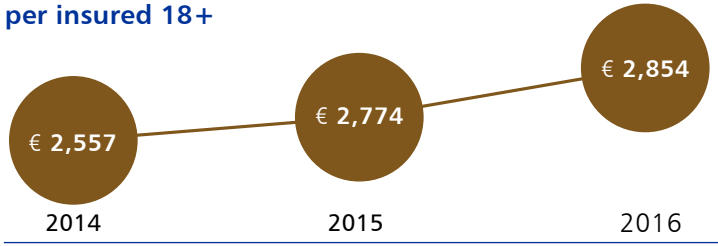
€ 2,854 Health care per insured 18++

€ 2.51 Advertising costs per insured 18+

- € 22 Financial result per insured 18+

Percentage of people changing policies: **6,8%**
Number of people changing policies: **1.17 million**
People changing policies saved a total of: **€ 61.5 million**

Development of basic insurance care expenditures per insured 18+



Source: Health insurers, basic insurance annual figures

1
2
3
4
5

Structure of the nominal premium 2017 (in €)

Public Health, Welfare and Sport standard contribution	1,326
Result on care activities	-24
Operational costs	82
Investment income	0
Withdrawals from reserves	-111
Additions to reserves	0
Profit increase	0
Other, incl. surcharges for granting group discounts	90
Total standard contribution (contribution base)	**1,363**

Source: Health insurers: uniform overview of premium structure

At this moment, there are 24 insurers offering health insurance. These health insurers are owned by nine businesses.
This year, the four largest businesses will lose a small percentage of their policy holders. The level of concentration will decrease slightly at the provincial level, but it will remain stable at the national level. Since the introduction of the Health Insurance Act, no new insurers have entered the market. This is expected to change in 2018 with the entry of IptiQ.

Health insurers contribute to solidarity in health care

In the summer of 2017, we observed that health insurers contribute to public confidence in our healthcare system. For example, health insurers accept anyone wishing to purchase a basic policy, no matter their age or health status. After additional research, we still have not observed undesirable selection for risk, even among policyholders who receive intensive mental health treatment.

See also the Summary report on the Health Insurance Act 2016

Health insurers: pay attention to difficult care requests and waiting lists

Health insurers should pay more attention to difficult care requests and waiting lists, in order to ensure that policyholders can obtain the care they need within a reasonable time frame. We also expect health insurers to provide their policyholders with accurate information at all times; over the telephone, but also via the website. The information on the website must also be easy to find.

See also the Health Insurance Market Scan 2017

2. New forms of funding

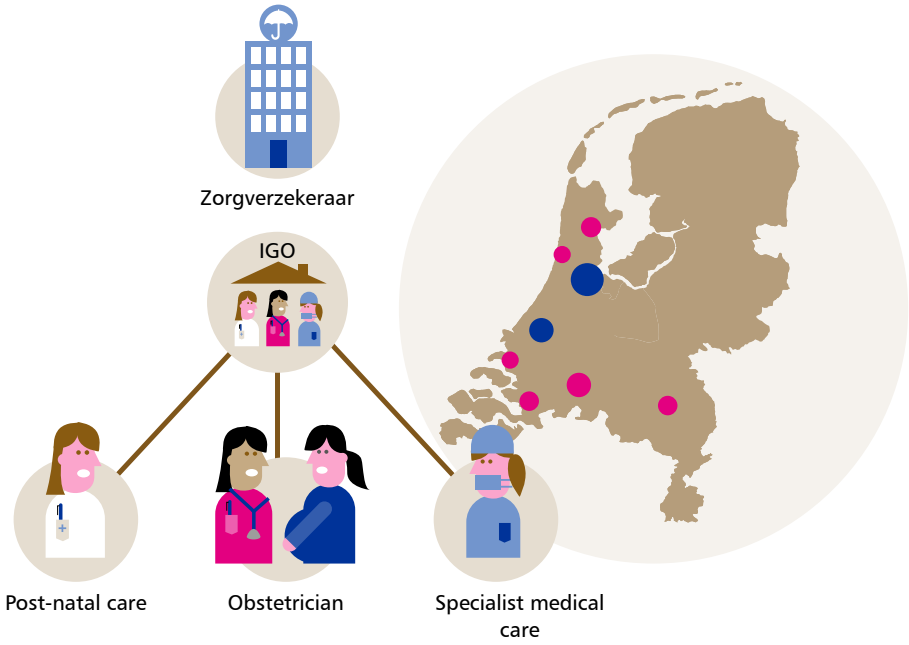
Many sectors desperately need a new way to finance health care, in order to reward quality, organise care more conveniently for the patient, do more about prevention and e-health, and to reduce the administrative burden. It is not enough to simply use past expenditures as the basis for current funding. To that end, we are working together with care professionals, health insurers, experts and patient representatives to find new forms of funding.

Eight regions choose for more cooperation in obstetrics care

Comprehensive obstetrics care is a far-reaching, voluntary collaboration between care providers assisting pregnant women. The collaboration and the exchange of information and knowledge results in enhanced safety and higher quality care during and after pregnancy. The pregnant woman's dossier is centralised, ensuring that no information is lost. The documents, information and knowledge are no longer held by a single party, but are made available for all of the stakeholders. This offers more safety for the mother and her unborn child.

See also the Comprehensive obstetrics care video

The organisation and contract agreements for comprehensive obstetrics care 2017



Source: Perined. The size of the circle corresponds to the number of pregnancies in the region in 2015.

In 2017, eight regions switched to a form of comprehensive funding for obstetrics care. The goal of comprehensive funding is to facilitate improved cooperation between the various care providers, in order to improve the quality of care for the mother and child. Comprehensive funding is voluntary, and complements funding for individual disciplines of first-line obstetrics care, second-line care and post-natal care. The NZa will monitor the effects of this collaboration in 2017 and 2018.

Working on new forms of funding for mental health care: balance between payment and treatment

One of our goals is to examine all aspects of patient care, which naturally includes how it is funded. As a result, we will examine the similarities between patients based on their need for care. We would like to move away from using past expenditures to determine future rates. Instead, we would like to learn from best practices and work to create a funding system that corresponds to the reality of care. In the field of mental health care, this means that we will no longer provide funding based on a diagnosis, but rather consider the need for care when registering and claiming treatments.

See the presentation about pilot projects for the new system of funding mental health care here.

For more information about the care clusters we would like to use to fund mental health care, see this animation about care clusters.

Towards improved funding for neighbourhood care

Together with the neighbourhood care providers, the NZa is looking for ways to organise neighbourhood care around the client. Instead of organising care around the various care domains, we aim to organise it around the client's needs. Funding that care should naturally meet those needs as well.

See the video about neighbourhood care

Growing Old Together: comprehensive care programme for the elderly living at home

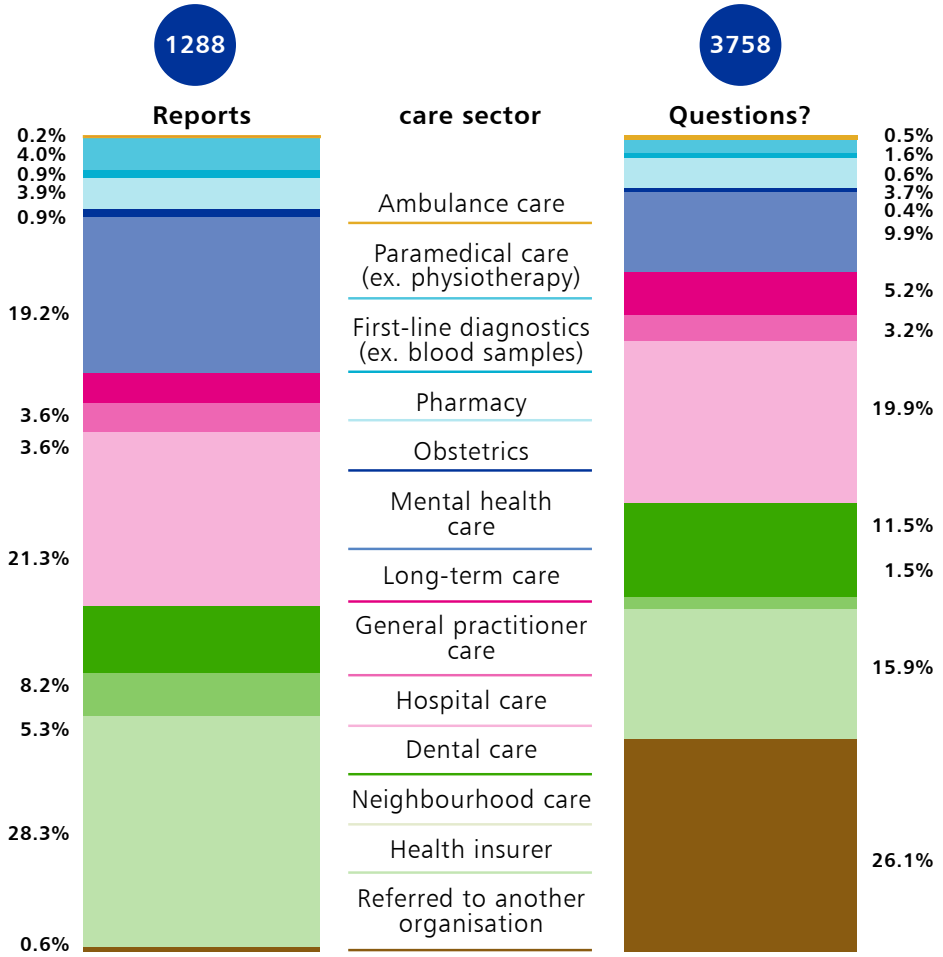
Growing Old Together offers a comprehensive care programme for elderly people (75+) living at home, consisting of services provided by an integrated care- and welfare network. This care programme is administered by an Elderly Care Team, under the leadership of a general practitioner. The team also consists of a geriatric specialist and two case managers: a neighbourhood care provider and a geriatric consultant.
This team will organise and coordinate coherent, proactive and multi-disciplinary care and assistance to elderly people living at home, in accordance with the stepped care method. This method is organised around the person's quality of life and need for care, rather than their illness. The goal is to help elderly people continue living at home for as long as possible and feasible.

See the video about supporting independent living

3. Your reports and questions in 2017

What were your reports and questions over the past year?

Quarters 1-3, 2017



Your reports

Paying more for the dentist

Over the past quarter, we have received several reports about high dental bills. For example, patients paid around € 20 for a supplemental medical history (C22), even though they had filled in a routine questionnaire, which is free. Patients were also charged six times the rate for cleaning (M03). This is absolutely not permitted. Patients are charged for each 5 minute period that their teeth are being cleaned, and not for the dentist's administration costs. The NZa has asked the dentists to bring their invoices into compliance with the applicable regulations.

Quality statute on mental healthcare provider website

Over the past few months, many mental healthcare providers have published their quality statutes. As of 1 January 2017, providers are required to post such a statute on their website.
We have reminded providers for whom we were aware that they had such a statute, but had not yet posted it, to please do so. They have since posted their statutes on their website. The quality statute describes the entire care process for current and potential clients, from the moment they enter the door to the last follow-up care. It also describes the mental healthcare provider's responsibilities, duties and competencies. As a result, clients know how their mental healthcare provider has organised the care, and the quality of care is made transparent and quantifiable.

Billing for no-shows

Last year, a citizen on Twitter expressed his dissatisfaction with a health insurer regarding the billing rate for a so-called 'no show'. He received the bill because he had not cancelled an appointment with his physician in time.
His health insurer informed him that the NZa had set the rate for no-show billing. This is not the case; health providers may set the rate for no-shows themselves, subject to the provision that the rate is clearly posted on their price list and website. We have informed the insurer of his mistake in informing the client.

Medication delivery service

One person submitting a report needed medication in a hurry. Unfortunately, the local pharmacy was closed between 00:00 and 08:00, so his doctor referred him to the regional emergency pharmacy. The person therefore got in his car and drove to pick up the medication at his own expense. What the doctor had not told the patient was that the regional emergency pharmacy also has a delivery service, paid for by the health insurer. The NZa referred the report to the health insurer, which then informed the pharmacist and the doctor.

Yoga, meditation and massages in mental health care

A mental health institution includes activities such as yoga, meditation and massages as part of a mental health treatment. Some patients have raised questions about the quality and expense of this care, and reported their concerns to the NZa. The NZa discussed the issue with the institution, and exchanged e-mails on the topic. The mental health institution then edited one of our e-mails to make it seem as if the NZa was of the opinion that the institution had not violated any rules.
The NZa therefore reported the incident to the police. If you have asked for an explanation of the costs for mental health treatment,

but have not received an answer, please report the situation to the NZa. If you are unsatisfied with the quality of treatment, please contact the Landelijk Meldpunt Zorg (National Health Care Helpdesk).

No compensation for rehabilitation care

The NZa has received questions from citizens about health insurers denying compensation for rehabilitation care. In some cases the insurers did not compensate the expenses, and the citizens do not understand the reason behind that decision. The NZa has therefore asked the insurer to explain its justification. If you do not agree with an answer provided by your health insurer, please contact the Stichting Klachten en Geschillen Zorgverzekeringen (Health Insurance Complaints and Conflicts Foundation - SKGZ). They will deal with your complaint about your health insurer.

No beds at a care institution

On 26 March, a Nieuwsuur broadcast dealt with people waiting for long-term care. At least 125 clients appealed to MEE NL, because they were forced to wait for admission to an institution for disability care. This broadcast was concurrent with a study by the NZa, so the organisation reminded healthcare bureaus of their obligation to offer suitable care to clients waiting for long-term care. The NZa expects healthcare bureaus to take immediate action until all of the clients have received the help they need. All of the healthcare bureaus are required to work on plans for improvement and to implement structural corrective measures. If you are having difficulty finding an opening at an institution, or if you would like to know what your rights are in this aspect, the healthcare office can help you. Read more about this issue in our factsheet.

High bill for rehabilitation care

After the Zembla broadcast about rehabilitation care on 1 March, the NZa called on citizens to report suspected cases of misuse of healthcare funds in specialist medical rehabilitation care. The NZa received a number of reports, which are currently under investigation. The new regulations for 2018 will address as many of the reported problems as possible. We are also working closely with Zorgverzekeraars Nederland, the Association of Rehabilitation Physicians and Rehabilitations Netherlands to create a new funding structure, in which we aim to reduce several of the undesirable effects.

Dialysis transport to and from the hospital

Over the past quarter, kidney patients from the Netherlands Kidney Patient Association (NVN) have complained about their taxi to and from the hospital. The health insurer is responsible for organising this transportation, so the NZa has asked the insurer for an explanation. The insurer is currently in negotiations with the hospital and taxi company in order to come to an agreement.

Long waiting times for mental health care

This quarter, the NZa has received 94 reports from people with complaints about long waiting times in mental health care. After an analysis of the complaints, we found that 27 citizens had been waiting too long for mental health care. The NZa has contacted them and explained that their health insurer is able and obliged to help them. The health insurer then helped the citizens find another care provider that was able to offer care immediately or within a shorter time frame. Where that was not possible, the health insurer provided temporary care while the patient was on the waiting list. Since then, mental healthcare providers and insurers have made

agreements to address the long waiting lists.
The NZa is closely monitoring whether the parties will abide by these agreements. Read more in our press release.

Your questions to our hotline in 2017

I am looking for the terms and conditions of my health insurance policy. I cannot find them on my insurer's website. How can I see my policy conditions?
Your health insurer is obliged to post the terms and conditions of your policy on their website, so that they are easy to find. If your insurer has not done so, please contact the NZa at tel.: 088 - 770 8 770. You can also ask your health insurer to send you a copy of the terms and conditions via the post or e-mail.

I was only in the hospital for 10 minutes, but I received a huge bill. Is that right?
Yes, in some cases, you might receive an expensive bill for a very short stay in the hospital. If you would like to learn why, watch our animated video From X-ray to bill. It explains how our healthcare system pays for hospital care.

My health insurer won't pay my bill. Are they allowed to do that?
It can happen, but your health insurer must explain clearly why it will not pay the bill. If your insurer does not provide an explanation, please submit a complaint to the health insurer or report the issue to the NZa.

I have to wait too long for a treatment in the hospital. What can I do about it?
If you are confronted with a long wait for treatment, you can contact your health insurer and they can help you find a hospital that may have an opening sooner. You can find more information about waiting lists here.

Can the NZa tell me how much my treatment will cost?
Your health insurer can do that better than we can! They can provide you with information about the financial consequences for your deductible, for example, or if there is no contract with a provider. The insurer must provide an amount, or a reasonable estimate if it does not know the exact amount. Read more about this issue in Article 16 of our regulation 'Provision of health insurance information to consumers'.

My dentist bill includes work that was not performed. Can you check if it is correct?
The NZa cannot confirm whether a bill is accurate or not. However, if you suspect that an item has been claimed incorrectly, you may of course submit a report.
If you have questions about your bill, the best option is to ask your dentist. He or she may only bill for activities that have actually been conducted. The factsheet 'The bill from the dentist and oral hygienist' contains more information on this topic.

Is my treatment covered by my basic insurance policy?
This is a question that your health insurer is best equipped to answer. Your insurer knows the exact amount of coverage you are entitled to, but perhaps it is useful to know that the government decides what is included in the basic insurance package. The national government website has more information about what is included in the basic health insurance package.

I want to submit a complaint about the quality of care I have received from my provider. Can I submit it to the NZa?
f you are not satisfied with the care you have received, the best thing to do is to submit a complaint to your care provider first. The Landelijk Meldpunt Zorg (National Health Care Helpdesk), a unit of the Health Care Inspectorate (IGJ), can advise you further. If the complaint requires an investigation by the IGJ, then the Landelijk Meldpunt Zorg will submit it to the Inspectorate for evaluation.

I've just returned from a trip abroad, and went to an ophthalmologist in the Netherlands for a check-up. Then I received a bill that I have to pay myself. Is that allowed?
Yes, sometimes you might receive a bill for treatment that is covered by your policy, and unfortunately it's not so easy to explain why. We have therefore provided a visual explanation based on a fictional example. Click here for the visual explanation.

4. Opportunities and challenges in 2018

As a healthcare regulator and supervisory body, the Dutch Healthcare Authority (NZa) foresees several important challenges over the next few years - for care providers, health insurers, the legislator and itself as a supervisory body. The goal is to keep basic care covered by the basic insurance coverage affordable and accessible for everyone who needs it. NZa employees tell about the concrete challenges that they will be working on in the near future, together with patient and branch organisations, health insurers and care providers.

Preventing waiting lists through regional collaboration

In 2017, we observed that several regions and sectors faced long waiting times for treatment. Research has shown that many of these waiting lists could be avoided or reduced if care providers cooperated more, kept each other informed and referred patients to care mediation by health insurers. This requires up-to-date insight into the waiting lists for each region and sector, however. The NZa will take action to address this issue over the coming period.

Dealing with waiting times in health care

In the Netherlands, access to care is generally well organised, but the NZa takes reports of long waiting times, refusing patients and the obligation of care seriously. We have therefore conducted a variety of studies and refined the applicable regulations.
The mental healthcare sector has already reached an agreement between the parties in order to eliminate the long waits for treatment. Starting in 2018, mental healthcare providers will submit their waiting lists on a monthly basis. This obligation also relates to the sector's initiative to publish a new website in 2018, where patients can find information to help them make an informed choice for a mental healthcare provider. Other sectors should follow their example in order to address the problem of long waiting lists.

> " A good insight into the actual waiting times for treatment and effective cooperation between insurers and providers is crucial in order to solve the problems"
> **Marian Kaljouw, NZa board president, 2017**

We will monitor the information about waiting times on the websites for hospitals and treatment clinics in order to verify that they are accurate and up to date. We require providers of specialist medical care to actively (verbally) inform patients if the waiting time for polyclinic, diagnostic or other treatments are longer than the norms.

Care providers must also actively inform their patients about the possibility of requesting waiting list mediation from their health insurer. This information must be published along with the waiting time information on the website. That way, patients who would like to receive help faster can contact their health insurer or healthcare bureau to request mediation to find a care provider that can treat them sooner.

Do you have to wait too long to be admitted to a nursing home?

People faced with a long waiting list to be admitted to a nursing home can also report that fact to their healthcare bureau, which can refer them to an institution that has an opening or help them find intermediate care. We asked the healthcare bureaus which structural measures they have taken to ensure that people do not have to wait too long for long-term care. In their plans for improvement, the healthcare bureaus have indicated how they ensure that their clients receive timely and suitable care, as well as which initiatives they have taken to reduce long waiting times for health care. The NZa will discuss these plans with the healthcare bureaus, and ensure that the improvements are actually implemented.

More cooperation in acute care

At the moment, Dutch residents have sufficient access to acute care. When one emergency room is full, there is generally enough space at other hospitals or institutions in the vicinity. Although the capacity of, and demand for, acute care differs per region, in general the demand for acute care is increasing over time.

More and more elderly people living at home are visiting the emergency room and general practitioners. The cooperation between various acute care providers can and should be improved. If hospitals and general practitioners were to work together more effectively, the general practitioners would be able to take on more of the less serious emergency care. That would free up emergency rooms to provide more complex care. It is also vital that care providers have enough knowledge about elderly patients with complex problems, and to know about the options for follow-up care for elderly patients after the acute care phase.

In late September 2017, the LHV and Actiz presented a uniform referral framework for first-line hospital admissions. This will help patients to receive the right care at the right place.

For more information, read the studies published by the NZa in 2017 on Acute care and Cooperation between emergency rooms and general practitioners.

Improving emergency care for vulnerable elderly people: prevention is better than the cure

The NZa has previously recommended that care providers make better agreements based on studies of acute care for vulnerable elderly people. It is vital that this cooperation and coordination of care for vulnerable elderly people is improved where necessary. This is primarily the responsibility of care providers. If there is insufficient cooperation and coordination between care providers, then it seems natural that the health insurer should step in and take control. This has already been done successfully in certain regions. Ideally, health insurers should conduct risk analyses of future patient flows and their effects on the healthcare chain. These analyses would give health insurers insight into the potential bottlenecks, in order to prevent problems in the future.

Give healthcare bureaus more opportunities to deal with personal budget fraud

Healthcare bureaus currently do not have enough opportunities to deal with personal budget (PGB) fraud. The Dutch Healthcare Authority (NZa) has come to this conclusion as the result of a study of claims for repayment after the improper use of personal budget funds. The PGB offers people in need of long-term care the opportunity to purchase the care they need themselves. The NZa and the healthcare bureaus are of the opinion that the PGB is a good instru-

ment for providing individual care, but that the regulations should be made more resistant to fraud.

More room for e-health

E-health can help improve care for patients and make it more accessible. For example: a general practitioner can take a photo of a patient's skin condition and send it to a dermatologist for consultation. This saves the patient a separate visit to a hospital. Or consider games for speech therapy that children can practice at home.

Watch the e-health for general practitioners video

E-health offers an ever-increasing number of opportunities for health care. We look forward to new developments with enthusiasm, as long as e-health can make health care better and more affordable. The current funding system already presents care providers and health insurers with the option of making agreements pertaining to e-health.

Watch the e-health video

One example of e-health in home care is remote assistance in helping patients use of medications. A medication alarm provides the medications at the proper time, and even removes the packaging if necessary. The care provider then receives a notification if the medication has not been removed from the dispenser in time. He or she can then help the client by calling or visiting them at home. This innovation helps reduce healthcare costs and prevents the client from having to deal with too many different caregivers. It also helps elderly people be more independent, while still abiding by their therapy regime.

Watch the Technology in home care video

More attention for prevention

We feel that prevention should receive more attention in the healthcare sector. To that end, the various healthcare domains must collaborate more intensively. Providing care in the right place at the right time can prevent the situation from becoming much worse. Attention to and supervision of health risks can prevent expensive treatments.

Health insurers and care providers can already make agreements regarding the provision of preventive care in the form of long-term contracts, facilitative first-line performance or via the Innovation policy priority. This gives them the opportunity to experiment with new forms of care or supervision for a period of three years. One example of a successful initiative is the Combined Lifestyle Intervention (GLI).

Watch the Lifestyle Intervention video

This programme consists of a combination of consultations and supervision of nutrition and eating habits, healthy exercise and behavioural changes geared towards maintaining a healthy lifestyle. It can not only prevent diseases, but can also keep an existing disease from deteriorating or complications from developing. Over the past few years, several experiments have been conducted involving this type of care and supervision. Monitoring the effect of this support is vital in order to learn the health benefits over the long term, and how much they will cost.

Better information about care, waiting times and policies

Health insurers have implemented a number of improvements over the past period. In 2017 and 2018, we will continue to monitor whether health insurers have improved the information provided to policy holders. They must also provide accurate information about comparable policies, payments and contracts to potential policy holders during the transitional period. The health insurance card introduced in 2017 is a useful tool in this effort. In it, health insurers announced that they will also publish a health insurance card for supplemental policies in 2018. This will help policy holders to make informed choices for health insurance policies that suit their own personal situations. Health insurers are also obliged to help their policy holders if they are faced with long waiting times for a specific care provider. Care providers are also responsible for informing their patients of the option of requesting care mediation.

The NZa also works to publish the costs of health care up to the highest voluntary deductible, so that citizens know what a treatment will cost in advance.

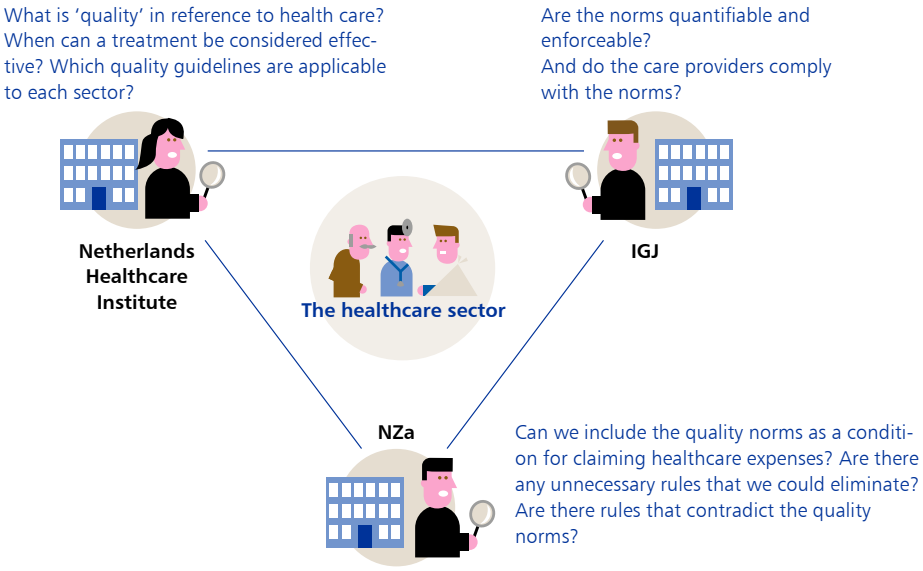
To discuss these issues and others, we regularly organise meetings with health insurers, care providers and patient organisations. Together, we look for opportunities for improvements and solutions to bottlenecks.

Greater insight into the quality of care

There is still too little insight into the quality and service offered by care providers. How effective is the treatment? Which services are offered, exactly? What does one care provider do better than another? Without these insights, health insurers would only be able to negotiate for the purchase of care based solely on price.

The NZa provides support and assistance to facilitate each sector in formulating effective quality guidelines in the near future, so that care providers can know when they are performing well and can be rewarded for 'extra service' or 'extra quality'. But this is also important for citizens, so that they can make an informed choice for a care provider based on price and quality. Quality and affordability are two sides to the same coin.

Many quality criteria are still vaguely formulated and do not offer the opportunity to determine whether a care provider meets the guidelines or not, and whether the treatment is effective or not. In order to improve that information, the NZa works together with the National Health Care Institute and the Juvenile Health Care Inspectorate based on these organisation's public duties:



Reducing administrative burdens

We do our utmost to reduce the regulatory burden in the healthcare industry. If something can be simplified, it should be. There are already many opportunities to do so in the agreements made between care providers and health insurers. In many sectors, they can already begin offering new forms of health care. They may also make agreements for the long term, or combine certain types of care and agree to a single rate. In fact, many sectors already utilise a comprehensive rate for health care. This has the effect of significantly reducing administrative burdens for care providers, health insurers and patients.

5. Questions from care providers about regulations in 2018

1 2 3 4 5

During the administrative meetings for healthcare administrators in the fall of 2017, many participants had questions about the regulations that will be applicable in 2018. Here are a list of the questions and answers.

Questions about policy rules for mental health care / forensic care in 2018

What opportunities do other professions have to register mental healthcare claims?
Watch the video

How does the new mental healthcare model help reduce administrative burdens for the treating professional?
Watch the video

What are the criteria for equitable admissions?
Watch the video

Questions about policy rules for long term care in 2018

Does the policy take transportation costs into consideration?
Watch the video

Does the policy take regional differences in prices into consideration?
Watch the video

How do the norms relate to working as part of a team?
Watch the video

Reducing administrative burdens: What's in it for us?
Watch the video

Questions about policy rules for specialist medical care in 2018

How can I register a telephone consultation that is not a replacement for a follow-up visit to the polyclinic?
Watch the video

How can I register a palliative care consultation if the patient has a parallel need for care?
Watch the video

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