European Commission

Health system performance assessment – Integrated Care Assessment (20157303 HSPA)

Health system fiche | Netherlands

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Netherlands

Population size (thousands): 16,940 (State of Health in the EU, Netherlands, 2017)[1]

Population density: 502.9 inhabitants / km^2 (Eurostat, 2015)[2]

Life expectancy: 81.6 years (State of Health in the EU, Netherlands, 2017)

Fertility rate: 1.7 births / woman (State of Health in the EU, Netherlands, 2017)

Mortality rate: 8.9 deaths / 1,000 people (Central Intelligence Agency, 2017)[3]

Total health expenditure: 10.7% (State of Health in the EU, Netherlands, 2017)

Health financing: government schemes (4.8%), compulsory contributory health insurance schemes and compulsory medical saving accounts (75.8%), voluntary health insurance schemes (5.9%), financing schemes of non-profit institutions serving households (0.3%), enterprise financing schemes (0.9%), household out-of-pocket payments (12.3%) (Eurostat, 2015)[4]

Top causes of death: malignant neoplasms, circulatory diseases, and respiratory diseases (State of Health in the EU, Netherlands, 2017)

The Dutch healthcare system

The social insurance background of the healthcare system in the Netherlands fits in a Bismarckian tradition, with dominant roles for not-for-profit sickness funds and independent providers and a modest role for the government. A major healthcare reform in 2006 (European Commission, 2017i) resulted in the implementation of a unified compulsory insurance scheme, which changed the roles of actors across the healthcare system, e.g. multiple private health insurers now have to compete for insured persons, and social support was delegated to municipalities (European Commission, 2017i). In the Netherlands, the tradition of private provision of services, self-regulation and financing via a system of social health insurance resulted in a healthcare sector that is dominated by several mutually dependent actors with different backgrounds. Since the 2006 Health Insurance Reform (European Commission, 2017i), through which three markets (i.e. delivery, purchasing, and insurance of care) have become the core of the healthcare system, the role of the government has become less dominant. However, the government still plays an important role in health policy development and implementation, while advisory bodies and research institutes play an intermediate role (European Commission, 2017i).

In terms of funding allocation, the Ministry of Health decides upon the national budget for healthcare. The Ministry also decides on the budget for both municipality-based de-centralised healthcare and home nursing care (European Commission, 2017i). The municipality budget is paid into the municipality fund – the budget of this fund is allocated to the municipalities, based on certain indicators, such as number of citizens, the physical size of the municipality, and the number of people entitled to social security. In the Netherlands, public health services are primarily the responsibility of municipalities and include services such as prevention, screening and vaccination (European Observatory, 2016). Currently, attention is being paid to integrated care for chronic diseases and care for people with multi-morbidities, and the shift of care to lower levels of specialisation – from hospital care to GP care to practice nurse to self-care (European Observatory, 2016).

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[1] https://ec.europa.eu/health/sites/health/files/state/docs/chp_nl_english.pdf

[2] Population data, Eurostat http://ec.europa.eu/eurostat/tgm/table.do?tab=table&init=1&language=en&pcode=tps00003&plugin=1

[3] https://www.cia.gov/library/publications/the-world-factbook/fields/2066.html

[4] http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_sha11_hf&lang=en

Integrated care policies

In the Netherlands, the introduction of an integrated payment system in 2010 has been perceived as the cornerstone of a policy stimulating the development of a well-functioning integrated chronic care system (Tsiachristas et al., 2011). With the introduction of the Health Insurance Act of 2006, health insurers are required to offer a standard package of basic healthcare insurance to every applicant, regardless of pre-existing condition, and it is also mandatory for every citizen to have at least a basic benefit package. This framework was developed with a view to stimulating the integration of chronic care; however, according to Tsiachristas et al., 2011, integration of care ended up being dependent on whether or not a patient had voluntary supplementary insurance. Among other barriers to the implementation of care, the integrated payment model introduced by the Dutch Ministry of Health includes a reimbursement system offering an 'all-inclusive' payment for people with chronic conditions to multidisciplinary teams providing care for these patients. Under this payment system, chronic care is coordinated by groups of providers in the Netherlands.

With regard to the variety of integrated care payment schemes in Europe, such as PFC (pay-for-coordination), PFP (pay-for-performance) and bundled payments, Tsiachristas et al. (2013) reported that the Netherlands (together with Austria, France, England and Germany) have implemented payment schemes that are designed to promote the integration of chronic care. The implemented payment schemes target different stakeholders in different countries depending on the structure of each individual health system.

Implementation of integrated care in the Netherlands: national-level initiatives

- *Buurtzorg Model,*[5] a home care organisation with small nursing and personal care teams, which has introduced an in-built attempt to contact and integrate with other local, formal and informal care providers;
- *INCA Model,*[6] which aims at providing integrated care for patients with multi-morbidity;
- *JOGG – Jongeren op Gezond Gewicht (i.e. Young People at Healthy Weight),*[7] which looks to encourage young people (0–19 years of age) in a city, town or neighbourhood to eat healthy food, do physical exercise and adopt healthy lifestyles;
- *Dutch Obesity Interventions in Teenagers (DOiT),*[8] which aims at preventing obesity amongst pre-vocational school children by improving energy-balance-related behaviours (EBBs).

Assessment of the maturity of the health system

[5] A detailed description of this integrated care model is available at http://www.buurtzorgnederland.com/

[6] A detailed description of this integrated care model is available at http://www.icare4eu.org/pdf/INCA_Case_report.pdf

[7] A detailed description of this integrated care intervention is available at http://platform.chrodis.eu/clearinghouse?id=801

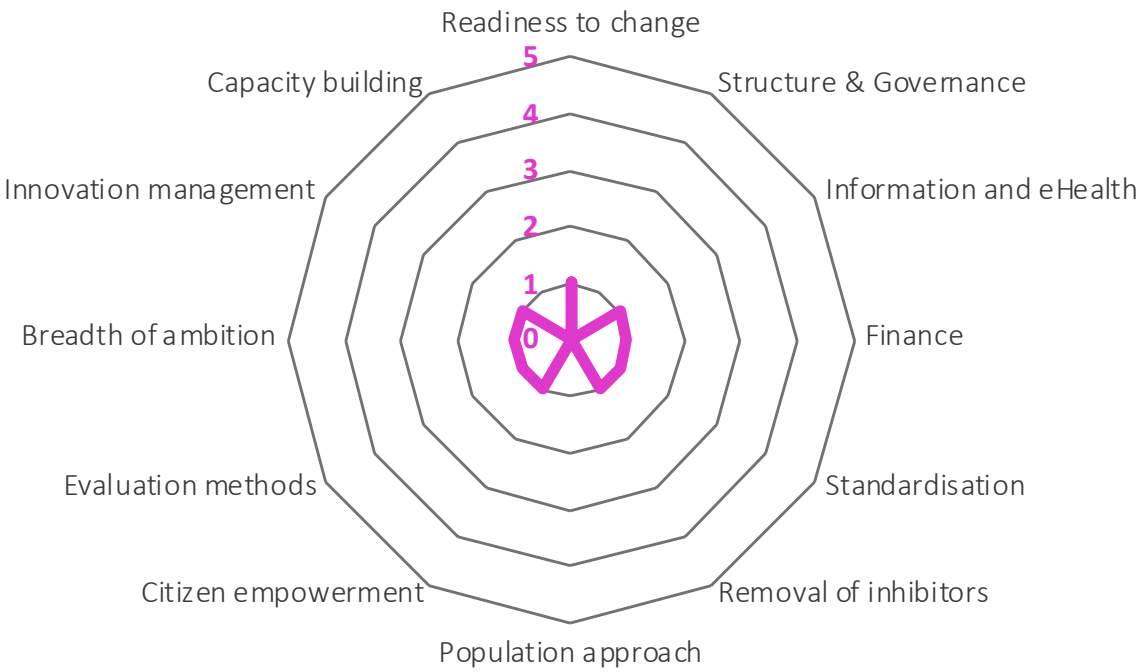
[8] A detailed description of this integrated care intervention is available at Dutch Obesity Interventions in Teenagers (DOiT)

Maturity Model – Netherlands	
Readiness to Change to enable more Integrated Care	
Self-assessment	1 – Compelling need is recognised, but no clear vision or strategic plan
Justification	Policy-makers, professionals and payers (also at municipal level) recognise shortcomings, inability to deliver truly integrated care and lack of communication. Also, inefficiencies and high costs incurred are recognised.
Structure & Governance	
Self-assessment	0 – Fragmented structure and governance in place
Justification	Various sectors do their best to keep delivering high-quality healthcare, and generally still accomplish this laudable goal despite barriers in organising and establishing integral health service systems. By design (healthcare market), each individual healthcare provider is expected to compete for market share by showing value for money. This results in perverse incentives when done in the absence of clear benchmarks and quality control measures.
Information & eHealth Services	
Self-assessment	1 – ICT and eHealth services to support integrated care are being piloted
Justification	No general grand design but some interesting and promising initiatives are operational. These might ultimately serve as best practice exemplars, yet the risk of non-progression due to absence of governance is very real.
Finance & Funding	
Self-assessment	1 – Funding is available but mainly for pilot projects and testing
Justification	National funding is not available. Governance is lacking, as is a national vision or plan in this respect. The notion that ultimately the optimal system will emerge through competition and survival of the fittest is predominant. Some healthcare insurance companies invest limited amounts for limited periods in pilot or research projects.
Standardisation & Simplification	
Self-assessment	1 – Discussion of the necessity of ICT to support integrated care and of any standards associated with that ICT
Justification	Rudimentary development. Attempts have been made, yet in the absence of governance the 'market' is not going to solve the issue.
Removal of Inhibitors	
Self-assessment	1 – Awareness of inhibitors but no systematic approach to their management is in place
Justification	Interviewed stakeholder is inclined to say no awareness, yet in some pilots the awareness and sense of urgency is present.
Population Approach	
Self-assessment	0 – Population health approach is not applied to the provision of integrated care services
Justification	Apart from local (sometimes quite successful) pilots no systematic general implementation.
Citizen Empowerment	
Self-assessment	1 – Citizen empowerment is recognised as an important part of integrated care provision but effective policies to support citizen empowerment are still in development
Justification	The notion and concept of citizen empowerment is recognised as relevant, and the lack of empowerment is further recognised as a barrier. However, in the absence of clear governance and leadership this will not evolve.

Evaluation Methods	
Self-assessment	1 – Evaluation of integrated care services takes place, but not as a part of a systematic approach
Justification	Most services currently deployed are part of research programmes or pilots. Thus evaluation is generally part of the process. This clearly is not part of a systematic approach.
Breadth of Ambition	
Self-assessment	1 – The citizen or their family may need to act as the integrator of service in an unpredictable way
Justification	It is the opinion of the interviewed stakeholder that if informal caregivers recognise the need for integration some may succeed and achieve some level of integration. Integration may be achieved successfully as part of local pilots, but this remains rare.
Innovation Management	
Self-assessment	1 – Innovation is encouraged but there is no overall plan
Justification	In general, an entrepreneurial spirit is supported and considered relevant by national government and subsequently delegated to knowledge institutes. However, progress in this area is currently very slow, as there is not an overall, policy-based national plan to guide this.
Capacity Building	
Self-assessment	0 – Integrated care services are not considered for capacity building
Justification	No formal systematic approaches are in place. The niche or void is recognised and a professional master's programme has even been developed.

The current situation regarding implementation of integrated care is characterised by lack of political consensus and development of national-level policies. It was also noted that, while there are numerous 'bottom-up' integrated care initiatives (e.g. pilot projects) across the Netherlands, it will remain challenging to implement integrated care effectively without an all-encompassing national-level policy. These elements were reflected in the Maturity Model Assessment, where all the assessment dimensions were rated as either 0 or 1.

Netherlands



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