Det nederländska hälso- och sjukvårdssystemet (på svenska)

Källa: http://international.commonwealthfund.org/countries/netherlands/

I Nederländerna har den nationella regeringen det övergripande ansvaret för att fastställa prioriteringar inom hälso- och sjukvården, lagstifta och kontrollera tillgänglighet, kvalitet och kostnader. Regeringen finansierar också delvis socialförsäkringen och det obligatoriska social-försäkringssystemet för långtidsvård.

Prevention och socialt stöd ingår inte i socialförsäkring utan finansieras genom generell beskattning.

Kommuner och sjukförsäkringsbolag är ansvariga för större delen av öppenvården och vård av personer under 18 år, utifrån ett provisionsbaserat system (med stort lokalt självbestämmande).

År 2015 utgjorde hälso- och sjukvårdskostnaderna 10,8 procent av BNP, varav 77% finansierades med offentliga medel. Den obligatoriska sjukvårdsförsäkringen köps från privata försäkringsbolag. Dessa har ett vinstutdelningsförbud. Alla med samma försäkringsgivare betalar samma premie, oavsett ålder eller hälsotillstånd. Bidragen samlas in centralt och utfärdas till de olika försäkringsbolagen baserat på ett system som beaktar ålder, kön, hälsorisker etc.

Sjukförsäkringsbolag är enligt lag skyldiga att tillhandahålla ett standardpaket som bland annat omfattar allmänläkare, sjukhusvård och specialistvård, tandvård upp till 18 år, receptbelagda läkemedel, fysioterapi, sjuksköterskevård i hemmet och vissa delar av den psykiatriska vården. Sedan 2015 delas ansvaret för hemsjukvård mellan den nationella regeringen, kommunerna och försäkringsbolagen. Förebyggande åtgärder omfattas inte av socialförsäkring utan faller under kommunernas ansvar.

Förutom den lagstadgade försäkringen tecknar större delen av befolkningen (84%) kompletterande frivilliga försäkringar som täcker tandvård, alternativmedicin, glasögon och linser, preventivmedel och hela kostnaden för läkemedel. Personer med frivillig försäkring får inte snabbare tillgång till någon typ av vård, och de har heller inte ett ökat utbud av specialister eller sjukhus. Under 2014 utgjorde frivillig försäkring 7,9 procent av de totala hälso- och sjukvårdsutgifterna.

The Dutch Health Care System **(in english)**

Source: http://international.commonwealthfund.org/countries/netherlands/

In the Netherlands, the national government has overall responsibility for setting health care priorities, introducing legislative changes when necessary, and monitoring access, quality, and costs. It also partly finances social health insurance (a comprehensive system with universal coverage) for the basic benefit package (through subsidies from general taxation and reallocation of payroll levies among insurers via a risk adjustment system) and the compulsory social health insurance system for long-term care.
Prevention and social support are not part of social health insurance but are financed through general taxation.
Municipalities and health insurers are responsible for most outpatient long-term services and all youth care under a provision-based approach (with a high level of freedom at the local level).

Public funding
In 2015, the Netherlands spent 10.8 percent of GDP on health care, and 77 percent (2014 estimate) of curative health care services were publicly financed. All residents (and nonresidents who pay Dutch income tax) are mandated to purchase statutory health insurance from private insurers. Statutory health insurance is financed under the Health Insurance Act, through a nationally defined, income-related contribution, a government grant for the insured below age 18, and community-rated premiums set by each insurer (everyone with the same insurer pays the same premium, regardless of age or health status). Contributions are collected centrally and issued among insurers in accordance with a risk-adjusted capitation formula that considers age, gender, labor force status, region, and health risk (based mostly on past drug and hospital utilization).
The insurance market is dominated by the four largest insurance conglomerates, which account for 90 percent of all enrollees. Currently, there is a ban on the distribution of profits to shareholders. Health insurers are legally required to provide a standard benefits package including, among other things, care provided by;

- general practitioners (GPs)
- hospitals
- specialists
- dental care through age 18
- prescription drugs
- physiotherapy through age 18
- home nursing care
- basic ambulatory mental health care for mild-to-moderate mental disorders
- specialized outpatient and inpatient mental care for complicated and severe mental disorders

As of 2015, home care is a shared responsibility of the national government, municipalities (day care, household services), and insurers (nursing care at home) and is financed through the Health Insurance Act. Hospice care is financed through the Long-Term Care Act. Prevention is not covered by social health insurance but falls under the responsibility of municipalities.

Private funding
In addition to statutory coverage, most of the population (84%) purchases a mixture of complementary voluntary insurance covering benefits such as dental care, alternative medicine, physiotherapy, eyeglasses and lenses, contraceptives, and the full cost of copayments for medicines. People with voluntary coverage do not receive faster access to any type of care, nor do they have increased choice of specialists or hospitals. In 2014, voluntary insurance accounted for 7.9 percent of total health spending.

Cost-sharing and out-of-pocket spending
As of 2016, every insured person over age 18 must pay an annual deductible of EUR385 (USD465)1 for health care costs, including costs of hospital admission and prescription drugs but excluding some services, such as GP visits. Apart from the overall deductible, patients are required to share some of the costs of selected services, such as medical transportation or medical devices, via copayments, coinsurance, or direct payments for goods or services that are reimbursed up to a limit, such as drugs in equivalent-drug groups. Patients with an in-kind insurance policy may be required to share costs of care from a provider that is not contracted by the insurance company. Out-of-pocket expenses represented 14.7 percent of health care spending in 2014 (author's calculation). Providers are not allowed to balance-bill above the fee schedule.

Safety net
GP care and children's health care are exempt from cost-sharing. Government also pays for children's coverage up to the age of 18 and provides subsidies (health care allowances), subject to asset testing and income ceilings, to cover community-rated premiums for low-income households. Approximately 4.42 million people, or about a quarter of the total population, receive allowances set on a sliding scale.

How is the delivery system organized and financed?

Primary care
The GP is the central figure in Dutch primary care. Although registration with a GP is not formally required, most citizens are registered with one they have chosen, and patients can switch GPs without formal restriction. Referrals from a GP are required for hospital and specialist care.

Care groups are legal entities (mostly GP networks) that assume clinical and financial responsibility for the chronic disease patients who are enrolled; the groups purchase services from multiple providers. To incentivize care coordination, bundled payments are provided for certain chronic diseases, such as diabetes, cardiovascular conditions, and chronic obstructive pulmonary disease (COPD).

In 2015, the government introduced a new GP funding model comprising three segments; Segment1 (75% of spending) funds core primary care services, Segment 2 (15% of spending) consists of funding for programmatic multidisciplinary care for diabetes, asthma, and COPD, as well as for cardiovascular risk management. Segment 3 (10% of spending) provides GPs and insurers with the opportunity to negotiate additional contracts—including prices and volumes—for pay-for-performance and innovation.

Outpatient specialist care
Nearly all specialists are hospital-based and either in group practice (in 2015, 54% of full-time-equivalent specialists, paid under fee-for-service) or on salary (46%, mostly in university clinics). As of 2015, specialist fees are freely negotiable as a part of hospital payment. This so-called "integral funding" dramatically changed the relationship between medical specialists and hospitals. Hospitals now have the responsibility of allocating their financial resources among their specialists. There is a nascent trend toward working outside of hospitals—for example, in growing numbers of (mostly multidisciplinary) ambulatory centers—but this shift is marginal, and most ambulatory centers remain tied to hospitals.

After-hours care
After-hours care is organized at the municipal level in GP "posts," which are centers, typically run by a nearby hospital, that provide primary care between 5 p.m. and 8 a.m. GPs must provide at least

50 hours of after-hours care annually to maintain their registration as general practitioner. The GP post sends the information regarding a patient's visit to the patient's regular GP. There is no national medical telephone hotline.

Hospital care
Hospital payment rates, through which doctors are paid, are determined through negotiations between each insurer and each hospital over price, quality, and volume. The great majority of payments take place through the case-based diagnosis treatment combination system, and the rates for approximately 70 percent of hospital services are freely negotiable; the remaining 30 percent are set nationally. The number of diagnosis treatment combinations was reduced from 30,000 to 4,400 in 2012. Diagnosis treatment combinations cover both outpatient and inpatient as well as specialist costs, strengthening the integration of specialist care within the hospital organization.

Mental health care
Mental health care is provided in basic ambulatory care settings, such as GP offices, for mild-to-moderate mental disorders. In cases of complicated and severe mental disorders, GPs will often refer patients to basic mental health care (e.g., a psychologist or an independent psychotherapist) or to a specialized mental health care institution. The delivery of preventive mental health care is the responsibility of municipalities and is governed by the Social Support Act.

Long-term care and social supports
A substantial proportion of long-term care is financed through a statutory social insurance scheme for long-term care and uninsurable medical risks and cost that cannot be reasonably borne by individuals. It operates nationally, and taxpayers pay a contribution based on taxable income. The remainder of services are financed through the Social Support Act. Cost-sharing depends on size of household, annual income, indication, assets, age, and duration of care. In 2015, copayments covered 8.7 percent of total spending in the compulsory long-term care scheme.

With funding provided through a block grant from the national government, municipalities are responsible for household services, medical aids, home modifications, services for informal caregivers, preventive mental health care, transport facilities, and other assistance, in accordance with the Social Support Act