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Palliative care is not yet a well-defined product within the Dutch healthcare insurance system

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ABSTRACT

In the Netherlands, the quality and availability of palliative care has improved markedly within the last decade. However, many open questions remain concerning the position of palliative care as an insurable product on the Dutch healthcare market. Therefore, we analysed the policies of all private Dutch healthcare insurance companies as well as the public insurance policy for extraordinary medical costs. We studied how and which parts of palliative care were reimbursed in 2007. We observed a huge variability in costs and reimbursement regulations reflecting a rapid turnover of products for palliative care due to various new developments on this specific field of medical care. We conclude that a better definition of the product 'palliative care' is necessary for patients, health care providers and insurance companies.

1. Introduction

According to the definition of the World Health Organization (WHO), palliative care is an approach that aims to improve the quality of life of patients and their families with incurable diseases. Main therapeutic goals are prevention and relief of suffering by early identification, assessment and treatment of pain and other impairments such as physical, psychosocial and spiritual problems [1]. Palliative care in the Netherlands has made major improvements within the last decade. The Dutch government has paid specific attention to the position of palliative care within the Dutch healthcare system [2–7]. Important milestones were the introduction of regional networks for palliative care and specialized consultation teams as well as the regulation of the financing of care delivered by inpatient hospices [3].

Parallel with these rapid developments the costs for palliative care increased. However, up to now the exact costs are unknown, because of the huge variability on the daily growing field of in-hospital and ambulant palliative care. However, knowing the exact amount of costs of palliative care is of increasing importance for patients, healthcare providers and insurance companies, as these three parties are interrelated to each other in a triangle-structure [8]. The interrelationship will influence the development of palliative care and all further decisions on palliative care by the government.

2. Dutch healthcare insurance system

The Dutch healthcare insurance system can be divided in a private and a public part. Regarding the private part the *Health Insurance Act* (Zorgverzekeringswet) was intro-

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Table 1
Private healthcare insurance companies and labels in the Netherlands.

Achmea Groene Land, Meppel	IZA Zorgverzekeraar, Nieuwegein
Achmea PWZ, Amsterdam	IZZ, Nijmegen
Achmea Zilveren Kruis, Noordwijk	Lancyr, Tilburg
Aegon, Houten	Menzis, Zwolle
Agis, Amersfoort	Nationale Nederlanden, Houten
AnderZorg, Groningen	OHRA, Arnhem
Avero, Zeist	ONVZ, Houten
Azivo, Den Haag	OZF Achmea, Hengelo
Confior, Rotterdam	OZ, Breda
CZ, Tilburg	PNO Ziektekosten, Hilversum
De Amersfoortse, Amersfoort	Pro Life, Amersfoort
De Friesland, Leeuwarden	Salland, Deventer Stichting IZA
De Goudse, Gouda	Ziektekostenverzekeringen (SIZ), Delft
Delta Lloyd, Den Haag	Stad Holland, Schiedam
Dia Vitaal, Den Haag	Trias, Gorinchem
DSW Zorgverzekeringen, Schiedam	UMC Zorgverzekeringen, Nieuwegein
DVZ Zorgverzekeringen, Noordwijk	Univé, Alkmaar
FBTO, Leeuwarden	VGZ Zorgverzekeraar, Nijmegen
Fortis ASR, Utrecht	Zorg en Zekerheid, Leiden
Interpolis, Tilburg	

duced in 2006. This Act is compulsory to everyone who lives and/or pays tax in the Netherlands. The *Health Insurance Act* represents a major reform of the Dutch healthcare system [9–12]. It includes a standard package of essential healthcare tested against the criteria of demonstrable efficacy, cost effectiveness and the need of collective financing. Medical care which is reimbursed includes care provided by general practitioners, obstetricians, medical specialists and clinical psychologists, admission to and treatment as well as nursing in hospitals, ambulance, transport by taxi or public transport, drugs, medical aids, e.g. hearing aids and incontinence-related products, maternity care, dental care up to the age of 22 years and paramedical care, e.g. physiotherapy or dietary advice.

This extent of care is offered by all private healthcare insurance companies in their basic insurance policies. The companies compete with each other on the price of the policy. Every person living and/or working in the Netherlands is obliged by law to buy this basic insurance from one of these insurance companies. In 2007 thirty-nine companies (or labels) offered a policy for a basic insurance (see Table 1). The price consists of a fixed premium (2007: average € 1135,-/year) as well as an income-dependent premium (2007: 6.5% from a maximum of € 31059,-). It is up to the Healthcare Insurance Board ('College voor Zorgverzekeringen') as an independent institution to ensure that the health care system works. Insured persons have the opportunity to pay for a supplementary insurance or to pay themselves for the care not included in the standard package. Supplementary insurances are not obligatory.

Regarding the public part of the Dutch health insurance system the *Exceptional Medical Expenses Act* ('Algemene Wet Bijzondere Ziektekosten') was introduced in 1967 to cover long-term care including large and uninsurable financial risks for individuals. The *Exceptional Medical Expenses Act* provides patients who are in need of chronic and continuous care, such as care for disabled patients with congenital physical or mental disorders.

The entitlements that exist under the *Exceptional Medical Expenses Act* have been defined for different categories of care with considerable possibilities to arrange individual care. These categories include personal care, nursing, supporting guidance, activating guidance, treatment and accommodation.

To be eligible for care under the *Exceptional Medical Expenses Act* a judgement given by an independent committee is needed. The *Exceptional Medical Expenses Act* is financed by income-dependent premiums of all employees as well as by governmental contributions and personal contributions of the care recipients. These contributions are deposited in a General Fund for *Exceptional Medical Expenses* [13]. Fig. 1 depicts a scheme of the Dutch healthcare insurance system.

3. Aim of the study

Palliative care represents a rapidly growing sector. Within the near future increasing competition between insurance companies will take place. In this context we studied how and which part of palliative care was reimbursed in 2007.

4. Methods

From the website *www.kiesbeter.nl* all private Dutch healthcare insurance companies and their labels were identified. Thereafter, all thirty-nine companies were asked for a hard copy of their policies for the basic insurance as well as the supplementary insurance packages offered in 2007. All companies responded and sent the request material. The policies were screened on the keywords 'hospice (care)', 'palliative care', 'terminal care', 'home care' and 'supportive care'. The content of the *Exceptional Medical Expenses Act* was obtained from the website of the 'Health Care Insurance Board' (www.cvz.nl) and screened for eligibility of care needed by terminally ill patients.

5. Results

On the private sector the *Healthcare Insurance Act* describes the eligibility for care in general terms. In none of the 'basic insurance' policies offered by the private healthcare insurance companies, specific terms on palliative care were included. However, insurance of costs for medical care, admission to and treatment as well as nursing in a hospital, ambulance, drugs, medical aids and paramedical care, as described in the *Healthcare Insurance Act* are also applied to palliative care. Supplementary insurance packages are offered by all healthcare insurance companies and are tapered to the specific needs of particular customers. In the policies for supplementary insurances from twenty-nine out of the thirty-nine insurance companies (74%) one or more of the keywords were found. Three groups of reimbursement could be distinguished:

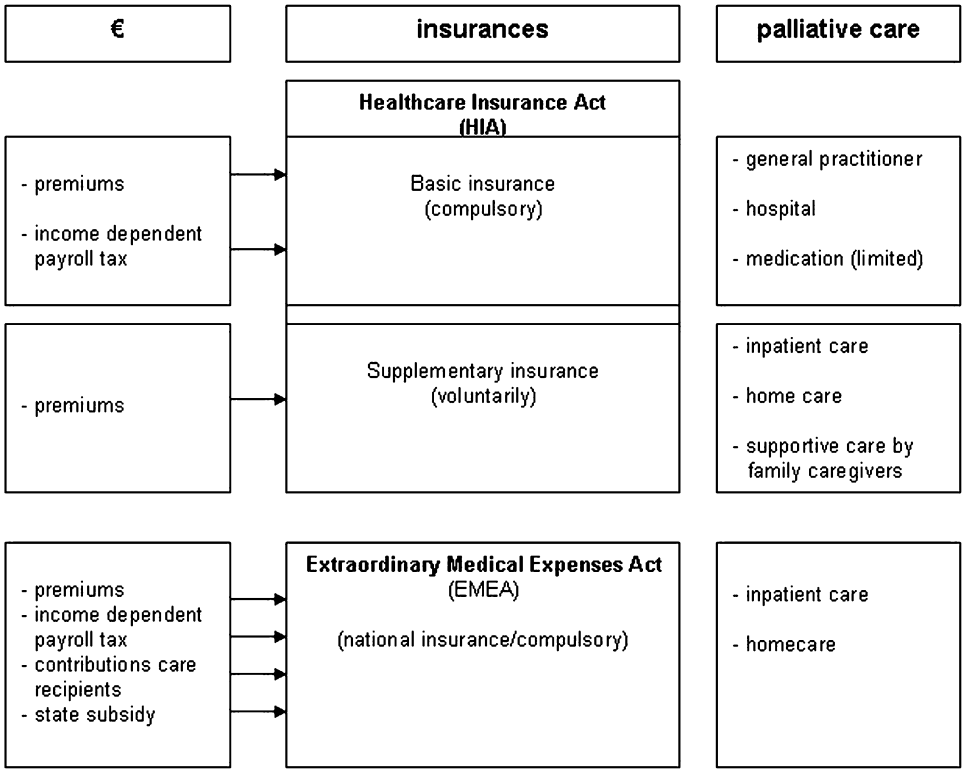

Fig. 1. Schematic presentation of the Dutch healthcare insurance system and reimbursement of palliative care.

(1) Reimbursement of care delivered by a residential hospice or palliative care unit in a nursing home ('inpatient care'). Only one insurance company (Pro Life) uses the term 'palliative care'. All others use 'hospice' or 'hospice care'.
(2) Reimbursement of home care. Eight insurance companies offer home care in general. Two offer additional availability of volunteers (Agis, Pro Life). Two offer only reimbursement of home help (Nationale Nederlanden, ONVZ). One offers reimbursement of fluid nutrition for terminally ill patients (OZ). One specifies terminal care at home (PNO) and one offers terminal care at home during the night (Salland).
(3) Reimbursement of supporting care for family caregivers. All seventeen insurance companies offer supportive care for family caregivers in general, not specified for terminally ill patients. The kind of palliative care reimbursed by the twenty-nine private insurance companies is presented in Table 2. Specification of the (range of) reimbursements of inpatient care, home care and supporting care for family caregivers is presented in respectively Tables 3, 4 and 5.

The eligibility of care under the *Exceptional Medical Expenses Act* is described in general functions. Care can only be provided when an indication for type and amount of care is given by an independent committee. The judgement about terminal care has to be completed within 2 days. There are three ways to receive palliative terminal care under the *Exceptional Medical Expenses Act*, care at home (amount and type of care functions are indicated), inpatient care in a hospice (for patients with a life expectancy of 3 months or less) and inpatient care in a palliative care unit in a nursing home. Inpatient care in a hospice is covered as home care. Indication for admission to a unit palliative care in a nursing home are only given to terminal ill patients from outside the nursing home. Nursing homes receive an extra amount of € 94,- a day on top of the regular nursing home coverage when care provided on a unit palliative care [14].

6. Discussion

Although much attention has been paid in the last decade to the development of palliative care in the Netherlands, the Dutch healthcare insurance system, divided into the public *Healthcare Insurance Act* and the private *Exceptional Medical Expenses Act*, makes it difficult to healthcare insurance companies to reimburse comprehensive palliative care.

6.1. Little transparency of costs

The lack of a well-defined product 'palliative care' makes it difficult to get information about amount of care and costs. In addition, amount of care and costs during the last phase of life are often higher than average costs. General practitioners have to do more visits at home, use consultation teams for problems they cannot solve and prescribe more and expensive drugs to treat multiple symptoms.

Table 2
Reimbursement of kinds of palliative care in supplementary insurance packages.

Type of palliative care			n	Insurance company/label
inpatient care			3	IZA Zorgverzekeraar, Stichting IZA Ziektekostenverzekeringen,UMC Zorgverzekeringen
	home care		3	Nationale Nederlanden, ONVZ, OZ
		supportive care for family caregivers	5	DSW Zorgverzekeringen, Achmea Groene Land, Achmea PWZ, Achmea Zilveren Kruis, Interpolis
inpatient care	home care		6	Delta Lloyd, Dia Vitaal, Lancyr, OHRA, PNO Ziektekosten, Salland
	home care	supportive care for family caregivers	2	Avero, Stad Holland
inpatient care		supportive care for family caregivers	7	Azivo, Confior, De Goudse, DVZ Zorgverzekeringen, Menzis, Trias, Zorg en Zekerheid
inpatient care	home care	supportive care for family caregivers	3	Agis, Pro Life, Univé
Palliative care not specifically mentioned			10	Aegon, Anderzorg, CZ, De Amersfoortse, De Friesland, FBTO, Fortis ASR, IZZ, OZF Achmea, VGZ Zorgverzekeraar
		total	39	

6.2. Basic package of private policies

Concerning the content, the policies of the private insurance companies do not differ very much. This is not in accordance with the intention of the government. The intention was to stimulate insurance companies to compete on content and price. Disease management programes should be more visible in the private policies.

6.3. Differences in supplementary packages of the private policies

It was expected that there would be more variety in what insurance companies offer in their supplementary packages. However, we found no common point of view in offering terminal care in a supplementary package. It is doubtful if the population is interested in terminal care

Table 3
Reimbursement of inpatient care in supplementary insurance packages.

Insurance company	Height of reimbursement	Conditions
Agis	€ 34,-/day	Maximum of 13 weeks
AZIVO	€ 20,-/day	
Confior	€ 35,-/day	Maximum of € 1050,-
De Goudse	100% of the own contribution	
Delta Lloyd	€ 500,- — 100% of own contribution[a]	
Dia Vitaal	€ 500,- — 100% of own contribution[a]	
DVZ	Maximum of € 114,-/day	Maximum of 2 months
IZA	€ 130,-/day	
Menzis	€ 35,-/day	Maximum of € 1050,-
Lancyr	€ 500,- — 100% of own contribution[a]	
OHRA	€ 500,- — 100% of own contribution[a]	
PNO	100%	Personal contribution as care recipient (EMEA[b]) is not reimbursed
Pro Life	€ 34,-/day	Maximum of 13 weeks
Salland	€ 35,-/day	Maximum of 15 days
Trias	100%	
SIZ	Maximum of € 129,-/day	
Univé	€ 25,-/day — 100% of own contribution[a]	Maximum of 3 months
UMC zorgverzekering	Maximum of € 130,-/day	
Zorg en Zekerheid	€ 35,-/day	Maximum of € 1050,-

[a] Depends on type of supplementary insurance package.
[b] EMEA: *Exceptional Medical Expenses Act*.

Table 4
Reimbursement of home care in supplementary insurance packages.

Insurance company	Height of reimbursement	Conditions
AGIS	€ 0,- to € 775,-/year[a]	–
	Max. € 115,-/year	Home care by volunteers
Avero	0–100%	Replacing or shortening hospital admission
Delta Lloyd	€ 500,- — 100%[a]	
Dia Vitaal	€ 500,- — 100%[a]	
Lancyr	€ 500,- — 100%[a]	
Nationale Nederlanden	Max. € 205,-	Max. 14 days
ONVZ	Max. € 205,-	Max. 14 days
OHRA	€ 500,- — 100%[a]	
OZ	€ 7,-/day	Fluid nutrition during terminal homecare
PNO	100%	Terminal care
Pro-	€ 0,- to € 775,-/year[a]	–
Life	Max. € 115,-/year[a]	Home care by volunteers
Salland	100%	Terminal homecare at night, max. 1 month
Stad Holland	€ 165,-/day — 100%[a]	Max. 14 days/year
Univé	€ 500,-/year	In combination with temporarily stand-in for home caregivers

[a] Depends on type of supplementary insurance package.

in making a choice for an insurance company and/or supplementary package. Reimbursement of 'hospice care' and 'home care' offered by private insurance companies do not automatically mean reimbursement of all costs of care by the private insurance company. Some of these costs are already covered by the public *Exceptional Medical Expenses Act*. Only those costs are reimbursed which patients have to pay in addition to the public *Exceptional Medical Expenses Act*. Not all private insurance companies are clear enough in their policies which of these costs are reimbursed.

6.4. Exceptional Medical Expenses Act

Recently, palliative care was included within the *Exceptional Medical Expenses Act*. Long-term home care and long-term care in a nursing home were already covered by the *Exceptional Medical Expenses Act*. However, the assignment of palliative care to the *Exceptional Medical Expenses Act* can be questioned. Whether palliative care can be characterized as long-term care and whether palliative care is an 'uninsurable risk' remains doubtful. Costs of care, covered by the *Exceptional Medical Expenses Act* increase every year [15]. The government therefore investigates how to decrease the eligibility of this public insurance. One of the options could be to bring palliative care under the eligibility of the *Healthcare Insurance Act*. In 2007 the government started with the preparation to distinguish eligibility of inpatient care and home care. For inpatient care a system of defined 'care packages' (ZorgZwaartePakketten/ZZP) will be introduced in 2009. One of the packages is called '*Sheltered accommodation with intensive palliative-terminal care*'. This development can be an important step in defining a comprehensive product of palliative care.

6.5. Additional care

Psycho-social and spiritual care are specifically mentioned in the WHO definition of palliative care [1]. Both types of care are not specifically reimbursed by the private *Health Insurance Act* and supplementary insurances and are also not covered in home care and inpatient hospice care. Supportive care for relatives during the grieving process is not mentioned in the policies of the private insurances. Although the benefits from specialized palliative care are sparse [16], the hospice program which as introduced in the United States [17] and the organization palliative care

Table 5
Reimbursement of supporting care for family caregivers in supplementary insurance packages.

Insurance company	Height of reimbursement	Conditions
AGIS	15–21 days/year[a]	
Avero	€ 500,- — 100%/year[a]	
Azivo	21 days/year	
Confior	€ 125,-/day	Max. 15 days/year
De Goudse	€ 125,-/day	Max. 15 days/year
DSW	100%	Max. 14 days/year
DVZ	Max. 21 days/year	
Achmea Groene Land/PWZ/Zilveren Kruis	21 days/year	
Interpolis	21 days/year	
Menzis	€ 125,-/day	Max. 15 days/year
Pro-Life	15–21 days/year[a]	
Stad Holland	100%	Max. 14 days/year
TRIAS	€ 125,-/day	Max. 15 days/year
Univé	€ 500,- to € 1000,-/year[a]	In combination homecare
Zorg en Zekerheid	100%	Max. 6 weeks

[a] Depends on type of supplementary insurance package.

of Sweden [18,19] are interesting examples. In the Medicare insurance in the United States 'hospice' is a total care concept for patients who have a life expectancy of 6 months or less. Included is supportive care for the relatives during the grieving process for 1 year. In Sweden, where they do not have a private healthcare insurance system, specialized, multidisciplinary teams are taking care of the terminally ill patients at home from the moment they leave the hospital.

7. Conclusions

Despite the major developments that have been made in The Netherlands during the last decade, palliative care for terminal ill patients is still not a well-defined care product. We conclude that more transparency and a better definition of the product 'palliative care' is desirable for the patients, the health care providers and the insurance companies.

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