Better off without the AWBZ?

Summary

Is the patient better off without the AWBZ?

The AWBZ (*Algemene Wet Bijzondere Ziektekosten*, the General Act on Exceptional Medical Expenses) was introduced fifty years ago for people with congenital or chronic conditions. The AWBZ paid for care that was uninsurable otherwise and improved their quality of life. Now that everyone can take out health insurance and the municipalities are obliged to help everyone to participate in society (WMO - *Wet maatschappelijke ondersteuning*, the Social Support Act), the continued existence of the AWBZ is no longer so obvious. Moreover, the AWBZ is an expensive regulation for which it is difficult to keep the costs in check.

The future of the AWBZ is therefore open to discussion. The RVZ (*Raad voor de Volksgezondheid en Zorg*, Council for Public Health and Health Care) and other bodies have recommended discontinuing the AWBZ and placing the care functions under the health insurance system and the social support functions of the WMO. There are also other options, though, which the SER (*Sociaal Economische Raad*, Socio-Economic Advisory Council) is going to make a statement about in 2008. The RVZ has been asked by the secretary of state for VWS (the Ministry of Health, Welfare and Sport) to update its previous AWBZ advice "People with disabilities in the Netherlands (2005)" from the client's point of view. What do chronic patients need? How can a change to the financing contribute to improved care arrangements? In other words, where are the opportunities? Also: what risks are patients running and how could these be handled?

The RVZ has selected four medical conditions and examined these jointly with the patients' organizations involved. These are Down's syndrome, stroke, dementia and schizophrenia. Down's syndrome is a congenital condition. Stroke, dementia

and schizophrenia are examples of chronic conditions that can affect healthy people during the course of their lives. These conditions represent not only the "traditional" AWBZ clients, but also chronic patients from the health insurance system.

A carefully-phrased answer

Large groups of patients, particularly where care for the elderly and mental healthcare are involved, may be better off in the new situation. The benefits for the patients only arise, however, if insurers and municipalities can provide the impetus towards better-organized provision of services.

For other groups, particularly those with disabilities, the end result is probably poorer or neutral at best.

The possible benefits for patients with chronic conditions are that:

- avoidable restrictions are avoided more effectively
- the quality of treatment and revalidation is improved
- support and supervision at home is improved
- more possibilities for social participation appear because people are encouraged to stay outside the care institutions.

The risks are that:

- continuity and (legal) assurance of the transition of health care and the WMO are less well guaranteed
- health insurance and the WMO will have been insufficiently modified to suit the needs of chronic-phase patients.

Therefore this recommendation

1 Adjust health insurance and the WMO
   - Incorporate a number of elements from the AWBZ into health insurance:
     - the care-oriented aspects of the supporting and reactivating supervisory function
     - treatment of pedagogic, psychological and behavioural science aspects
     - 'co-treatment' of the client system and/or the social/family carers

- individual personal budgets for claims that are transferred from the AWBZ to the *Zorgverzekeringswet* (Health Insurance Act)
- independent determination of indications for long-term stays.

– Extend the WMO to cover aspects of the personal care, supporting and reactivating supervision, residential (modified accommodation) and transport functions that are oriented towards social participation.
– Specify the compensation obligation in the WMO and make it possible to indicate for each target group what is required to allow people to cope independently and participate in society.

2 Improve the organization of the care
– Assign a sufficiently high priority to the development of the care chain for chronic illnesses and develop a suitable policy and costing structure for this.
– Arrange for solid case management within the health insurance system. Give it a clear label, for example as part of the treatment or reactivation supervision function. Pay case management fees separately, either as part of a diagnosis/treatment combination or some other payment arrangement.
– Take the initiative and develop policy to set up a properly functional first line for supervising chronic patients and their social/family carers.

3 Aim to discontinue the AWBZ in the longer term
– We recommend a short transitional period of no more than four years, in which the health insurance system and the WMO are modified (recommendation 1) and policy is developed for a more effective organization of healthcare (recommendation 2)
– A staged transition, in the following sequence:
  - patients whose conditions are based on somatic or psycho-geriatric problems
  - patients with psychiatric problems
  - patients with physical, mental or sensory handicaps.

4 Do not make *a priori* exceptions for patients for whom more intensive health care is indicated.

It is possible and desirable that this group should also be covered by the health insurance system. It is then in the insurers' interests that alternatives in society are also sought out for this group. For the relatively small group for which this is not possible, proper implementation can be guaranteed by a combination of independent determination of the indications, assiduous application of the instruments for evening out the care provided and monitoring of healthcare purchasing by the NZa (Dutch Healthcare Authority). Should it not prove possible to build in these guarantees, the alternative for this group (which is in principle clearly definable) would be for a national arrangement to be provided.