

ADMINISTRATIVE AGREEMENT ON THE FUTURE OF MENTAL HEALTH CARE 2013-2014

Executive summary

Mental health care makes a vital contribution to ensuring that the Netherlands is a healthy, robust and safe society. It is important that good, effective and varied care services are available to treat people with a mental disorder. One of the key principles is that care should be organised around the patient rather than the other way round. People with mental disorders need to be assured of society's acceptance of their illness and be able to participate in society as full and equal citizens. When dealing with the often complex care required by patients, the aim is to adopt an approach based on outpatient support. Interventions to prevent the onset or aggravation of symptoms will be carried out where possible. The focus will be on prevention, self-management and the patient's capacity for recovery. Throughout the mental healthcare system, good relationships and cooperation with physical health care and non-medical professionals are essential to an integrated approach to recovery.

Representatives of healthcare providers and professional organisations (the professional association of the mental health and addiction sector (GGZ Nederland)), the platform for mental health institutions (Meer GGZ), the National Association of Primary Care Psychologists (LVE), the Dutch Association of Psychologists (NIP), the Dutch Association of Independent Psychologists & Psychotherapists (NVVP), the Dutch Psychiatric Association (NVvP) and the National Association of Organised Primary Care (LVG)), healthcare insurers (the professional association Zorgverzekeraars Nederland), organisations representing clients and their families (LPGGZ, the umbrella organisation for mental health care), and the government (Ministry of Health, Welfare and Sport) are jointly responsible for ensuring a varied provision of good-quality, effective care for people with a mental disorder. Two vital preconditions are a uniform definition of quality and a system for comparing care outcomes in terms of price and quality. A coordinated approach can ensure that high-quality yet affordable care is still possible in the future.

Specific points agreed

This agreement sets out the substantive points on which the parties have reached consensus for 2013 and 2014.

- Client organisations, healthcare insurers and healthcare providers will set up a destigmatisation programme.

- Payment for mental healthcare support for GP practices will be made more flexible to enable GPs to better organise and monitor care for people with psychological problems. If a GP is unable to help a particular patient within his practice, the patient will be referred to primary mental health care (for patients with mild or moderate problems) or secondary care (for patients with more complex conditions). Patients diagnosed as not having any form of mental disorder will be referred to other sources of support, such as social workers.
- Healthcare insurers and providers plan to cut the current total bed capacity sharply: by 2020 the number of beds will be reduced by a third compared to the number available in 2008, with outpatient care being stepped up to replace institutional care. They will negotiate local agreements on the feasibility, details and speed of this shift towards outpatient care, as situations vary from one place to another, and will sign contracts on bed reduction in 2013. The parties have also agreed to talk about policy on outpatient care with other stakeholder groups in 2012 and will do all they can to encourage these organisations to enable this process.
- Patient organisations will dedicate themselves to the development of a personally-controlled electronic health record system, which will give patients access to information from medical records.
- The parties emphasise that performance levels must be transparent, and have therefore agreed that quality needs to be defined uniformly and that outcomes must be comparable. Routine Outcome Monitoring (ROM) is part of this. Healthcare providers at all levels, apart from general practice and mental healthcare support for GP practices, will undertake to provide information about the appropriateness, effectiveness and safety of care provided, together with feedback on patients' experiences. ROM will be used systematically to measure patient satisfaction and experiences.
- The parties believe that physical and mental health care should be treated equally in terms of information provision. They have agreed to further develop the episode-based payment system to factor in care intensity. This information will be provided in anonymised form in 2013, with details on individual cases available from 2014. This will be subject to the prevailing regulations on privacy, and assumes no change in the administrative burden and equal access to information for healthcare providers and healthcare insurers.

- Mental healthcare professional organisations and patient bodies are working with GGZ Nederland – the umbrella organisation representing the majority of mental healthcare provision in the Netherlands – and other stakeholders to establish an ambitious programme for the quality-driven development of treatment guidelines and related instruments such as care pathways, care standards, ROM questionnaires and quality indicators.
- Healthcare providers will strive to further reduce recourse to coercive measures.
- Financing
 - (1) Payment for mental healthcare support for GP practices will be made more flexible in 2013. This will give GPs more flexibility in organising care for people with mental health complaints. The Dutch Healthcare Authority (NZA) will be asked to give its opinion on whether a payment system for the GP support package can be fully in place by 2014, so that other healthcare providers can also start offering their services to GPs.
 - (2) In 2014 a uniform payment system will be introduced for primary mental health care, based on a small number of care intensity packages (around three), corresponding to the patient's needs.
 - (3) Episode-based payment will be fully introduced for all secondary mental healthcare providers in 2013, based on existing diagnosis-treatment combinations. The parties will also work on further improving the episode-based system.
 - (4) An episode-based payment system that takes account of both care intensity and care outcomes will eventually be introduced for secondary mental health care.
- Healthcare insurers will align their healthcare procurement with the annual government budget for curative mental health care, and will make agreements with care providers on rates and ceilings on reimbursement (price and volume agreements). These agreements may be revised if contracted amounts are unexpectedly too high.
- A macro management instrument (MBI) will be introduced to help care providers control expenditure. It can be used as a last resort if budgets are exceeded in spite of previous agreements. The feasibility of a differentiated MBI (distinguishing care providers who stay within budget from providers who do not) will shortly be explored. If it turns out that there are practical or legal obstacles to a differentiated MBI, or if it would not be entirely effective in controlling costs, then a generic budget cut will be introduced, whereby healthcare providers that unexpectedly overshoot their budget will see their funding reduced on a pro rata basis according to their market share.

- In 2013 a transitional model will be introduced for funded bodies to reduce transition risks.
- Providers record care intensity data for individual patients. These data will be made available in anonymised form to other agencies (the Healthcare Insurance Board and research organisations appointed by the Ministry of Health, Welfare and Sport) to examine differences in risk and work out an equation for cost-sharing.
- Healthcare insurers and providers will endeavour to complete the contracting process by 1 January so that output volume agreements and output can be properly monitored. The possibility of quarterly reporting on work in hand will also be examined.
- In line with a report published on 6 April 2012 into types of mental health care covered by medical insurance, the Healthcare Insurance Board will present proposals in autumn 2012 on a stricter delineation of curative mental health care in the Healthcare Insurance Act (ZVW).
- The parties will draw up long-term action plans in 2012 on a large number of issues. These include reducing bureaucracy, a specific regime for people with severe psychiatric disorders, responsible use of e-mental health services, making the labour market more flexible and further develop highly specialised mental health care provision on the basis of research carried out by the Health Council of the Netherlands and the Institute for Medical Technology Assessment (IMTA).
- The parties agree to conduct a technical review into the advantages, disadvantages, obstacles, budgetary impact and problem areas associated with the possible transfer of mental health care currently covered by the Exceptional Medical Expenses Act (AWBZ) to the Healthcare Insurance Act.
- The parties would like to see an end to the division between physical and mental health care and will be drawing up an action plan to achieve this.
- The parties agree that the annual rise in costs should be limited to 2.5%, excluding annual wage increases and price adjustments, in 2013 and 2014.

ADMINISTRATIVE AGREEMENT ON THE FUTURE OF MENTAL HEALTH CARE

Introduction

Mental health care¹ makes a vital contribution to ensuring that the Netherlands is a healthy, robust and safe society. It is important that good, effective and varied care services are available to identify, diagnose, treat and/or stabilise people with a mental disorder. What this means in essence is that appropriate care must be provided at the right point, by the right practitioner, in an effective manner and as part of a coordinated programme. One of the key principles is that care should be organised around the patient² rather than the other way round.

Representatives of healthcare providers and professional organisations (the professional association of the mental health and addiction sector (GGZ Nederland), the platform for mental health institutions (Meer GGZ), the National Association of Primary Care Psychologists (LVE), the Dutch Association of Psychologists (NIP), the Dutch Association of Independent Psychologists & Psychotherapists (NVVP), the Dutch Psychiatric Association (NVvP) and the National Association of Organised Primary Care (LVG)), healthcare insurers (the professional association Zorgverzekeraars Nederland), organisations representing clients and their families (LPGGZ, the umbrella organisation for mental health care) and the government (Ministry of Health, Welfare and Sport) are jointly responsible for ensuring a varied provision of good-quality, effective care for people with a mental disorder. A coordinated approach can ensure that high-quality yet affordable care is still possible in the future. This agenda is essential for the future. The sharp rise in demand over the past few years, and the associated overshoot of budgets, led the government to take difficult and far-reaching measures in 2012. The parties intend to agree this agenda with the aim of managing the future costs of mental health care. They hope that this will avert unilateral government action.

A shared vision of the future

The purpose of the mental healthcare sector³ is to cure or stabilise people with a mental disorder, offering care where necessary but no more than is needed. This means coherent,

¹ Mental health care includes psychological, psychiatric and addiction care.

² All references to patients include their families.

³ Curative mental health care has come under the Healthcare Insurance Act since 2008. This Act covers outpatient medical mental health care and the first year of inpatient medical mental health care. The Exceptional Medical Expenses Act covers non-medical mental health care and inpatient medical mental health care after the first year. Local authorities are responsible for public-sector mental health care and for providing social support and helping patients find work under legislation such as the Social Support Act (WMO) and the Work and Social Assistance Act (WWB). Finally,

fast and effective provision of care by all professionals involved – the GP, company doctor, primary or secondary mental health services (including disease-specific programmes). The key premise is that the care must be appropriate, i.e. mental healthcare providers should always offer suitable and effective care, and should regularly review the patient’s needs rather than simply continuing to provide the care that was considered appropriate when the need first arose. Patients, their families and their social network play an important role in this. Where possible, interventions are carried out to prevent the onset or aggravation of symptoms. That is why prevention, defined as 'recognising potential problems at an early stage' or 'recognising recurring problems', is a key aim for the entire mental health care chain. This also means boosting the patient’s capacity to manage his/her own condition and recover. Recovery-oriented care, rehabilitation/reintegration and after-care are all part of the care programme. Throughout the mental healthcare sector, good relationships, cooperation, coordination of care and consultation with practitioners of physical medicine and non-medical professionals are essential to an integrated approach to recovery, allowing the patient to return to work and participate in the community as soon as possible.

E-mental health, ICT tools and domotics can be useful aids here, with benefits in terms of productivity and patient-centredness. Of course, all care must be provided safely and to a professional standard. Patients must also be given clear, transparent information so that they have sufficient freedom of choice.



Huisartsenzorg	GP care
Ondersteuning GGZ	Mental healthcare support
E-health	E-health
POH	GP practice support service
Consultatie	Consultation
SPV	Mental health nurse

forensic care is provided for patients who have been found guilty of a criminal offence. The Minister of Security and Justice has been responsible for this provision for the past few years.

Generalistische Basis GGZ	Primary mental health care
Gespecialiseerde GGZ	Secondary mental health care
Top zorg	Disease-specific care programmes

GP care

GP care is a robust system through which patients with mental health complaints can be properly identified, treated or, where necessary, referred to primary or secondary mental health care.

GPs are supported by a team that can include mental healthcare advisers, mental health nurses or social workers. They can also consult other medical professionals such as psychiatrists, psychotherapists, GPs specialising in mental health care, clinical psychologists or primary care psychologists. This support, which is always provided in conjunction with GP care (in the GP's practice), also includes the use of e-health applications, programmes focused on enhancing autonomy, self-management and support for informal carers.

All these services help GPs make the best possible choices regarding treatment, consultation or referral on or back to primary or secondary mental health care. Support services, which work closely with GPs and providers of primary or secondary mental health care, play an important role in the community care of patients with a stable, chronic mental disorder.

Primary mental health care

This form of mental health care can only be accessed via a GP or other healthcare professional such as a paediatrician or company doctor.⁴ Primary care treatment is only started if the condition diagnosed is listed in the American Diagnostic and Statistical Manual of Mental Disorders (DSM) and is accompanied by moderate to low impairment of functioning. The problems experienced are usually mild to moderate and not complex; patients have a good social network and a high chance of recovery. Primary care is also appropriate for patients with a severe but stable mental condition requiring long-term monitoring but not specialised treatment. Primary care is also responsible for good after-care, support and prevention of relapse in people who have already undergone treatment for a mental disorder. By developing and strengthening primary mental health care, it will be possible to transfer a considerable proportion (at least 20%) of patients currently in secondary care programmes to primary care. This may be better for patients and will usually

⁴ Insurers cover this in their policies.

also be cheaper and more effective. As a result, secondary mental health care will be able to focus on patients with severe psychiatric disorders.

Secondary mental health care

Secondary mental health care⁵ involves complex forms of treatment requiring a high degree of specialist knowledge. The target group is made up of patients with a DSM disorder who are at risk of seriously reduced quality of life. An important function of secondary mental health care is diagnostics, which falls under the responsibility of a clinical psychologist, psychotherapist or psychiatrist. The main aim of treatment provided in this setting is the recovery or rehabilitation of the patient, but relapse prevention (e.g. the preventing of crises in patients with severe psychiatric conditions), self-management and e-health are also increasingly important. Wherever possible, the patients are treated in an outpatient care programme, allowing bed numbers to be cut and care to be transferred to a community setting. Patients are admitted to hospital only where this cannot be avoided. Involuntary admission is the last resort. When a patient is found to be in a stable situation and not, or no longer, in need of secondary mental health care, he is transferred to the care of his GP or other primary mental healthcare provider, in accordance with his situation and care needs.

Specific points agreed

The parties have reached consensus on various specific points, below, for 2013 and 2014, which substantiate their joint vision of the future.

- i. The parties consider it important that people with mental disorders, even those with severe conditions, are assured of society's acceptance of their illness and are treated as equal citizens. This promotes their participation in society and on the labour market, and restores their citizenship. Client organisations, healthcare insurers and healthcare providers will set up a destigmatisation programme to this end. The Ministry of Health, Welfare and Sport will co-finance a number of projects aimed at improving labour participation and increasing outpatient provision,⁶ concentrating on getting people back to work and preventing or limiting sickness absence.
- ii. The parties consider it important for mental health care to be patient-centred, for people to know to whom they can turn in the event of mental health complaints, and for care to be

⁵ This includes tertiary and quaternary mental health care for patients who, because of the severity, complexity and/or rarity of their condition, have had (or are expected to have) poor outcomes from regular secondary mental health care. It is a very specialised form of care focused on a specific target group in combination with patient-based research, care innovation and dissemination of knowledge.

⁶ See financial section.

coordinated and tailored to the individual. Healthcare insurers and providers will organise a robust system based on GP care, where patients with both mental and physical conditions are properly identified and given the treatment and support they need. Patients whose complaints are not connected with a mental disorder will be referred to other sources of help, such as a social worker. Patients whose complaints exceed the capacity of a GP will be referred to primary or secondary mental health care. Healthcare insurers will contract primary mental healthcare providers for treating straightforward, mild to moderate conditions. Secondary mental health care is available for severe, complex problems. The aim of this multi-stage approach is to provide appropriate, effective care. Patients' passage through the stages must be smooth and swift, landing them with the right care provider as quickly as possible. Care should be coordinated and given only where necessary, and patient autonomy and self-management and, if necessary, ability to refer back must be promoted.

- iii. People with a mental disorder want to play the fullest possible part in society.⁷ Accessible and adequate outpatient care programmes focused on recovery should enable people who are currently institutionalised to move towards social independence. Healthcare insurers and providers plan to cut the current total bed capacity by one third by 2020, compared to the number of beds in 2008. Outpatient care will be stepped up to replace institutional care. They will negotiate local agreements on the feasibility, content and speed of this shift towards outpatient care, as situations vary from one place to another. Agreements at national level will support this process, as well as benchmarking actual capacity used. The parties plan to have completed the groundwork on this transition (speed, numbers, conditions and transition costs) by the end of 2012, and will then make a careful well-founded decision on how this problem can best be tackled in the light of their findings. Healthcare insurers and providers will also agree on bed reductions in 2013. Contract data will show by May 2013 whether the shift towards outpatient care has begun, and what needs to be done to further encourage or facilitate this process. The parties recognise that, if the move towards outpatient care is to succeed, they must work with local authorities and other civil society organisations such as housing associations, the Employee Insurance Agency (UWV), the police and courts, schools, reintegration agencies, organisations offering help with debt problems, as well as GPs and home care agencies. They have agreed to do all they can to encourage civil society organisations to support the transition towards outpatient psychiatric care and will discuss a joint approach with the Association of Netherlands Municipalities (VNG) in 2012. These discussions will focus on aspects such as participation,

⁷ *Toekomstverkenning GGZ*, 2010 report by the Netherlands Institute of Mental Health and Addiction (Trimbos Instituut) exploring the future of mental health care.

prevention and a joint procurement policy to be followed by healthcare insurers and local authorities. Healthcare insurers will coordinate the purchase of care with local authorities, in consultation with patient organisations representing the target groups for whose care and support they are jointly responsible.

- iv. The parties believe that self-management by patients with mental disorders must be improved, as this will increase patients' understanding of their condition and autonomy. In response to the policy adopted by the Federation of Patients and Consumer Organisations in the Netherlands (NPCF), patient organisations are campaigning for the development of a personally-controlled electronic health record system, which will give patients access to information from medical records. Patients will be informed at an early stage of available resources, including the emergency medical identification card, self-help and peer support, patient contact groups and client-driven initiatives. Healthcare insurers and providers will strengthen the role of peer support workers (in terms of accreditation, training and working conditions) to ensure that care is focused on recovery and the patient's perspective.
- v. The parties emphasise that performance levels must be transparent, and have therefore agreed that quality needs to be defined uniformly and that outcomes must be comparable. Routine Outcome Monitoring (ROM) is part of this. Healthcare providers at all levels, apart from general practice and mental healthcare support for GP practices, will undertake to provide information about the appropriateness, effectiveness and safety of care provided, together with feedback on patients' experiences. ROM questionnaires will be administered only to patients who can deal with them and where instruments have been defined. The main aim is to support and improve treatment and to offer the patient a way into self-management. The following agreements have been reached in this respect:
 - Primary and secondary mental healthcare providers will systematically measure patient satisfaction and experiences by means of user-friendly instruments. In order to gain a better idea of the effect of treatment, healthcare providers will provide the Dutch Mental Healthcare Benchmark Foundation (SBG) with baseline and final measurement data, derived from ROM questionnaires, so that comparative data can be compiled for healthcare insurers, patient organisations and healthcare providers. Privacy regulations, data protocols and methodological issues will be respected. The results will be disclosed

to healthcare insurers, patients and patient organisations to enable patients to make informed choices.⁸

- As no agreement has yet been reached with providers of primary mental health care, they will be exempt from supplying ROM data until 2014.
 - A research programme will get under way in 2012 on developing or identifying specific monitoring instruments for psychiatric care in university and general hospitals. The aim is to make ROM tools suitable for the specific situation of patients undergoing treatment in the psychiatry wards of university or general hospitals. This is also part of the inpatient psychiatry action plan.⁹ University medical centres will submit data to the SBG starting on 1 January 2014.
 - The parties will decide in 2015 whether the application of ROM meets their expectations in terms of improving patient care, transparency and comparison.¹⁰
- vi. The parties believe that physical and mental health care should be treated equally in terms of information provision. Good use must be made of information and data on the part of both healthcare insurers and healthcare providers. The parties are drawing up working agreements to determine what specific individual case information is vital for the procurement and billing process. This information will be provided in anonymised form by 2013.

Research and development investment is needed to produce a rational, robust data structure that offers added value for all stakeholders and will allow groups to learn from the experience of others. In the light of this, the parties have agreed to further develop the episode-based payment system to factor in care intensity. The aim of this agenda is to ensure that from 2014 onwards healthcare insurers and providers will have access to information on care costs and intensity of care needs for particular individuals, just as physical healthcare providers do.

These agreements will be subject to the current regulations on privacy, and assume no change in the administrative burden and equal access to information for healthcare providers and healthcare insurers.

⁸ The SBG has been asked whether it is possible to indicate how compliance with methodological issues (validity of content, comparability, reliability of registration and statistical differentiation) should be assessed when generating comparative information.

⁹ The Dutch Psychiatric Association (NVvP) will be responsible for the inpatient psychiatry project and its organisation. The project is expected to run for six to eight months, and is due for completion in the first quarter of 2013.

¹⁰ They would prefer all parties to be represented in the management structure, with the scientific council of the SBG responsible for upholding quality.

- vii. The parties feel that it is vital for the Netherlands to have a top-quality mental healthcare system. Multidisciplinary cooperation between professionals is essential to ensure that care is properly and effectively organised around the patient, as part of a coordinated programme implemented by the right care providers. Mental healthcare professional organisations and patient bodies are working with GGZ Nederland – the umbrella organisation representing the majority of mental healthcare provision in the Netherlands – and other relevant stakeholders to establish an ambitious programme for the quality-driven development of treatment guidelines and related instruments such as care pathways, care standards, ROM questionnaires and quality indicators. It will be carried out by the Dutch Psychiatric Association (NVvP) and the Dutch Association of Psychologists (NIP). Care pathways will be developed in close cooperation with healthcare insurers, and patient bodies will be directly involved in setting care standards. The National Healthcare Quality Standards Institute will also be consulted.
- viii. Healthcare providers will strive to further reduce recourse to coercive measures. It has been agreed that these are a last resort. Where a patient is kept in isolation, healthcare providers will ensure that he always has the opportunity for personal contact. Isolation will be as brief, humane and safe as possible. In case of prolonged isolation, internal consultation will take place after one week and external consultation after six weeks. Clear records of such measures must be kept within institutions, and will be used internally to evaluate and adjust the institution's approach. All mental healthcare facilities will record measures that restrict patient freedom throughout the institution, using the Argus data set, and will submit this information to a national database. The performance indicator Isolation and Forced Medication (core set of mental health performance indicators) is linked to the Argus records. The Netherlands' umbrella patient organisation for mental health care (LPGGZ) will receive an annual summary of Argus data broken down by identifiable organisational unit, so that they will be able to give its members reliable information on this subject.
- ix. The parties believe that children with a disorder or illness must have access to high-quality and responsible paediatric mental health care, provided in conjunction with youth care services, adult mental health care and physical health care. Any problems in aligning physical health care, paediatric mental health care and adult mental health care as a result of spending cuts must be prevented or resolved in consultation with local authorities. According to the State Secretary for Health, Welfare and Sport and the State Secretary for Security and Justice: "GPs play a key role in paediatric mental health care. Since mental problems in young people often present as physical symptoms, such as stomach ache and

difficulty sleeping, GPs will continue to be the first port of call for children with mental health complaints. This underscores why GPs must retain their role in paediatric mental health care. We will examine whether legal measures need to safeguard this point.” (from the progress report on the changes to the youth services system, dated 27 April 2012).

- x. An appropriate payment system will be introduced so that patient-centred care can be offered in the right way at all levels. This depends on there being a level playing field for all healthcare providers, with as much scope as possible for freedom of manoeuvre, minimal bureaucracy, a spirit of enterprise and patient choice. The payment system must also give healthcare insurers effective management tools to control quality and costs. The following measures will accordingly be taken:

(1) Payment for mental healthcare support for GP practices will be made more flexible in 2013. The special funding arrangements for GP care will be adjusted to reflect this. As a result, GPs will have more flexibility in organising care for people with mental health complaints. GP practices will be able to arrange for the right professionals to help their patients, in keeping with local circumstances. This may include, for example, offering web-based facilities or consultation with psychiatrists, psychotherapists, clinical psychologists and primary care psychologists. This will make GPs better placed to organise and monitor care for people with mental health complaints. The Dutch Healthcare Authority will be asked to examine ways of achieving this in August 2012. It will also be asked to give its opinion on whether a payment system for the GP support package can be fully in place by 2014 so that other healthcare providers can also start offering their services to GPs. This means that there will be no surcharge on GPs' capitation fees; instead this will be a package that can be offered by various healthcare providers to complement and support GP care. It should always be offered in the GP practice and support the GP. GPs will be involved in developing the package, which will include preventive measures currently covered by health insurance. The parties also emphasise the need for GPs to have access to a new uniform method of screening/identifying problems and performing triage, so that patients with mental conditions that cannot be dealt with by a GP can be referred to primary or secondary mental health care, or – if their complaints are not related to mental illness – to a social worker.

(2) The parties agree that a small number of care intensity packages, probably around three, will be defined in 2012 for primary mental health care, so that uniform payment can be introduced in 2014 for these packages, corresponding to patients' needs. This may include providing an e-health programme, for example, or using a particular healthcare provider in a consultative role. Primary mental health care providers will use suitable, and if possible

standardised, diagnostic tools to determine the intensity of care required by patients. In accordance with accepted professional guidelines, an intervention programme will be set out based on care intensity, diagnosis and other patient-specific factors. Once this choice has been made, the provider will administer the programme in line with evidence-based treatment guidelines. The NZA will be asked to advise on the most appropriate pricing structure. In spring 2013 it will receive instructions from the Minister, which will be used to draw up administrative rules on a new payment system as of 2014. It is important that primary mental healthcare outcomes can be properly compared with those of secondary mental health care, and that the data and registration systems used are appropriate for the care packages that are to be developed, and use the same terms and measures for communication purposes.

(3) Episode-based payment will be fully introduced for all secondary mental healthcare providers in 2013, based on existing diagnosis-treatment combinations. The system of funding institutions according to parameters in the Exceptional Medical Expenses Act will be abolished in 2013. At the same time, the current rates (maximum rates for non-funded providers and fixed rates for funded providers) will be replaced in 2013 by 'max-max' rates, which will take the place of the standard maximum rates. The parties will also work on further improving the episode-based system.

(4) An episode-based payment system that takes account of both care intensity and care outcomes will eventually be introduced for secondary mental health care.

- xi. Healthcare insurers will align their healthcare procurement with the annual government budget for curative mental health care.¹¹ They will contract appropriate, good-quality care, paying particular attention to price, quality and appropriate use and to reducing undesirable over- and under-treatment. To do so, insurers will need adequate and accurate information. Insurers' contracts with healthcare providers, institutions and independent healthcare professionals cover rates and the maximum volume of care to be claimed. These agreements will be drawn up in such a way that they can be revised if the contracted volume turns out to be too large (when compared against the funds available in March and September of the current year). Healthcare insurers must regard the volume control that this

¹¹ The macro budget for health care (known as the Healthcare Budgetary Framework) annually forms the basis for calculating the 'macro performance sum', which is used to work out the equalisation contribution for healthcare insurers. The difference between the two reflects inflation and the room for growth the following year (included in the sum) and mental health co-payments (not included in the sum).

approach is intended to achieve as a best efforts obligation. It does not relieve them of their statutory duty of care. They must conduct procurement in a way that ensures a level playing field for – and hence equal treatment of – all healthcare providers, irrespective of how they are funded up to the end of 2012. Equal or equivalent care services are considered and assessed according to the same standards, though of course macro cost management and the one-off transitional arrangements will remain in force. The government's plan to amend section 13 of the Healthcare Insurance Act, on reimbursement of care expenditure in policies providing for care in kind, will consider the patient's position with regard to choice of practitioner. Insurers must notify their policyholders in good time of how they will apply section 13.

- xii. A macro management instrument (MBI) will be introduced to help care providers control expenditure. It can be used as a last resort if budgets are exceeded in spite of previous agreements and measures. In 2013 it will apply to the budgetary framework for secondary curative mental health care. From 2014 onwards there will be a single integrated framework for all curative mental health care, excluding GP care. The parties want to have a differentiated MBI, which would give due consideration to healthcare providers that have complied with their contractual agreements. The basic principle is that providers who enter into a contract with a healthcare insurer must be able to depend on the contract being respected, without any retrospective adjustments. The next step will be to further investigate how a differentiated MBI can be constructed so that it is effective, feasible and legally robust, and what are workable criteria for 'good conduct'.¹² If it turns out that there are practical or legal obstacles to a differentiated MBI, or if it would not be entirely effective in controlling costs, then a generic budget cut will be introduced, whereby healthcare providers who unexpectedly overshoot their budget would see their funding reduced on a pro rata basis according to their market share. This means that the same reduction percentage would apply to all.
- xiii. Healthcare insurers and providers are holding national discussions on quality issues in 2012 with a view to agreeing criteria such as re-allocation and delegation of tasks and the role of the healthcare professional who is responsible for the treatment programme, partly in the light of the arm's-length structure –payment structure for treatment carried out under supervision and responsibility of the psychiatrist-. The aim must be for care always to be provided by the professional who is best equipped to do so and who is able to provide the care most effectively.

¹² One aspect of 'good conduct' is compliance with contractual agreements.

- xiv. In 2013 a transitional model will be introduced for minimising the transition risks of funded institutions. The model is designed to manage only the systemic risks¹³ of providers, not normal turnover risks.¹⁴ This is how the transition model will operate.
- By 2013 episode-based pricing will be adopted by all healthcare providers.
 - At the end of 2012, healthcare insurers will for the last time, collectively conclude output volume agreements with funded institutions for 2013. They will do this for each funded institution both in terms of the old budget parameters and in terms of episode-based pricing.
 - The 'transition sum' is the difference between the 'output agreements in terms of budget parameters' and the 'episode-based output agreements', both to be drawn up at the end of 2012. This is a sum in euros that may be either positive or negative. Once it is set at the end of 2012 it will be irrevocable.
 - At the end of 2013, accounts will be drawn up for the relevant providers on the basis of their output, where their activity is based on output agreements with healthcare insurers.
 - The transition sum multiplied by 70% will also be paid out or charged.
 - The collective procurement model will be abolished in 2014 and providers will negotiate with individual healthcare insurers on the basis of episode-based pricing.

Some highly specialised funded institutions¹⁵ have a supraregional function and/or specific knowledge function, and consequently a largely supraregional patient population. These may face particular problems in ensuring continuity of care for their patient groups during the transition to episode-based funding. This is the case if the difference in funding under the old system and under the new episode-based system exceeds 15%. In these cases and for this type of institution, the transition percentage will be 95%.

Independent cost reviews will be conducted for institutions applying this higher transition percentage. The reviews will consider objective care-based statements explaining why the

¹³ The systemic risk to which an institution is exposed is the difference between the income that a healthcare institution would have received for a particular quantity and quality of care under the old system and what it receives for the same quantity and quality of care under the new system. This means systemic risks relate only to the shifts in turnover between healthcare providers associated with technical changes to the funding system, and not to changes in turnover that are the result of variations in the volume and nature of the care provided by the institution.

¹⁴ Normal turnover risks relate to shifts in turnover that are solely the result of changes in the nature and volume of care provided by an institution.

¹⁵ This term refers to non-integrated institutions that focus exclusively on providing care for a particular patient target group outside a hospital setting.

episode-base system and current rates are not appropriate for these institutions, and may lead to changes in rates or in the episode-based product structure, or to a special facility payment. The reviews will also take account of objective information on the required intensity of care for patients. The parties will do their utmost to clarify the issue by 2013 so that the Ministry of Health, Welfare and Sport can make a final decision and introduce the necessary changes in good time. If these adjustments cannot be made in time, the transitional arrangements may be extended for these institutions by one year.

xv. The parties recognise that understanding the relationship between the intensity of care needs and costs is essential in order for effective care to be purchased. If differences in care intensity lead to differences in the cost of treatments, it will have to be investigated whether the relationship between care intensity and cost can be incorporated into the ex-ante cost sharing model. Intensity of care data will have to be ascertained on an individual basis for this purpose and will need to be made available in anonymised form to other agencies (the Healthcare Insurance Board and research organisations appointed by the Ministry of Health, Welfare and Sport) to examine differences in risk and work out an equation for cost-sharing.

xvi. Monitoring

Proper monitoring of output agreements and all healthcare providers' output over the year is vital. All parties will contribute to this. Healthcare insurers and providers will endeavour to complete the contracting process by 1 January.

All healthcare insurers will provide the following information on curative mental health care to the Dutch Healthcare Authority once a year:

- by 15 March (year n): output agreements made plus an estimate of spending on non-contracted care in year n, broken down into secondary mental health care and other curative mental health care;
- by 15 September (year n): an update on the output agreements plus an estimate of spending on non-contracted care in year n, broken down into secondary mental health care and other curative mental health care.

The Dutch Healthcare Authority will calculate the total of these sums and report it to the Ministry of Health, Welfare and Sport. If the sum exceeds the funds available, the Ministry will alert healthcare insurers and providers so that they can take action within the current year.

Healthcare insurers will submit a single joint return to the Dutch Healthcare Authority, showing claims paid out per provider over the course of a year. This information will be used for the purposes of the macro management instrument (MBI).

The Healthcare Insurance Board has pointed out the need to improve the quality of claims payment data. Healthcare providers, insurers and the Ministry are therefore working together to ascertain whether information on various aspects of work in hand can be incorporated into quarterly reports along with information that is already available. This would comprise:

- o care episodes that have been concluded but not yet billed, and
- o care episodes that have not yet been concluded.

Healthcare insurers will use this information to estimate as accurately as possible the probable outstanding claims payments at the end of the year, in addition to the elements referred to above. This information will be submitted to the Ministry via the Healthcare Insurance Board within a month of the end of the quarter.

xvii. Co-payments

Co-payments for secondary curative mental health care (both treatment and accommodation) were introduced on 1 January 2012 as a corollary to a similar system for primary mental health care.

The 2013 government budget proposes partially abolishing co-payments for the treatment component of secondary mental health care ('budget agreement') to protect vulnerable groups. €55 million has been set aside to this end in 2013. The Minister of Health has introduced a bill on lower co-payments for people on a low income (up to 110% of the guaranteed minimum income).

The Minister has also promised to monitor the impact of co-payments for mental health care on vulnerable groups, and will report the initial interim results to Parliament in September, after consulting with the parties and the Ministry of Security and Justice.

The sector-specific organisations (GGZ Nederland, NVVP, NIP, LVE, NVvP and LPGGZ) are opposed to compulsory co-payment, as this would stigmatise individuals with mental disorders. Moreover patients in secondary mental health care often have severe clinical conditions. The LPGGZ is concerned that people will put off seeking treatment on financial grounds, which would have a harmful impact on both patients and society.

- xviii. Healthcare insurers and the Ministry of Health, Welfare and Sport believe that entitlement to curative mental health care needs to be more clearly defined in the Healthcare Insurance Act in order to prevent undue pressure on care provided under the Act, including from related social, health, judicial, educational and care welfare schemes. In line with a report published on 6 April 2012 into the types of mental health care covered by medical insurance, the Healthcare Insurance Board will suggest ways in which curative mental health care can be more clearly defined in the Act. Its proposals are expected in autumn 2012. These proposals will also look at restricting insured care to DSM-classified disorders.
- xix. The parties have agreed to draw up long-term action plans in 2012 covering the following issues: (a) reducing bureaucracy, (b) introducing a specific regime for people with severe psychiatric disorders (SPDs),¹⁶ (c) eliminating obstacles to and accelerating progress towards responsible use of e-mental health, (d) further developing highly specialized mental health care, partly on the basis of research carried out by the Health Council of the Netherlands and the Institute for Medical Technology Assessment (IMTA), (e) documenting existing research and examining the feasibility of promoting initiatives such as the Mental Strength Programme, (f) making the labour market more flexible so that it can respond better to future changes, (g) examining how more attention can be paid to treating work-related disorders, and (h) enhancing inpatient psychiatry.
- xx. Healthcare providers believe that transferring the remaining aspects of mental health care currently covered under the Exceptional Medical Expenses Act to the Healthcare Insurance Act would improve coordination and reduce bureaucracy. The parties agree that a technical review should be carried out into the advantages, disadvantages, obstacles, budgetary impact and problem areas, such as the effects on risk equalisation and demarcation problems. The review must provide all the elements needed for a decision to be made in good time, with the final decision being left to a future government. Until such time, local consultative bodies can decide to transfer funds from the Exceptional Medical Expenses Act to the Healthcare Insurance Act at local level. Once such a decision is made, the funds in question remain available for disbursement in the context of the Healthcare Insurance Act.
- xxi. The parties would like to see an end to the division between physical and mental health care. The aim is to recognise physical health problems in patients with mental disorders, and conversely, to spot mental problems in people being treated for physical symptoms. The parties share the view that the current division between physical and mental illness is no

¹⁶ Preparatory work for the SPD forensic group will preferably be carried out in conjunction with the Ministry of Security and Justice.

longer justified given current medical knowledge. Most patients requiring specialist medical care have multimorbidity. Patients may have multiple mental disorders, or a combination of physical and mental problems. In the latter case, identifying and offering parallel treatment of all problems is often sufficient. In more complex cases, integrated care by attending care professionals working closely together is essential. An action plan will be drawn up to eliminate the division between physical and mental health care, and to strengthen the relationship between them.

xxii. Financial section

The shared aim is to reduce the growth in mental healthcare spending, which has stood at 8% per year in nominal terms in recent years, to a significantly lower level. This is a major challenge for the parties, which can only succeed through the implementation of a whole raft of measures involving all the sectors responsible.

It has been agreed that the annual increase in spending should not exceed 2.5% over inflation in 2013 and 2014. This figure is for the total increase in spending, and all the provisions in this agreement must be accommodated within this envelope.

Assuming inflation of 2.75%, this would amount to about 5.3% in nominal terms. The base figure used to calculate the growth figure is €4.029 billion for 2012.¹⁷ This means that the following sums would be available for curative mental health care in the period 2012-2014:

Including assumptions for inflation:

2012	2013	2014¹⁸
4.029bn	4.243bn	4.469bn

¹⁷ This set of figures also includes funding available for the treatment of severe dyslexia without comorbid conditions, estimated at €34 million in 2012. The same applies to an increase in episode-based rates for treatments lasting 18,000 minutes or longer. The figures also include the funds needed to implement quality standards policy and for projects focusing on employment and expanding outpatient care, and for the destigmatisation campaign. The technical details of how funds will be made available for these purposes are still being worked out.

¹⁸ These figures may change as a result of the effects of package measures incorporated into the 2010 coalition agreement, which relate to stringent package management, regularity under the Healthcare Insurance Act, and a low burden of disease. The same applies to any other package measures. On the other hand, however, the duty of care with regard to a particular form of care will no longer exist. The turnover of mental healthcare providers may change as a result of package measures through supplemental insurance. The figures may also change if a new government decides to take additional measures, or in the light of technical adjustments such as a transfer of funding from the Exceptional Medical Expenses Act to the Healthcare Insurance Act in connection with changes to the way in which the capital burden is dealt with.

Excluding future inflation, i.e. at 2012 prices:

2012	2013	2014
4.029bn	4.130bn	4.233bn

This puts the estimated year-on-year rise at 5.3%, including assumed inflation.¹⁹

The parties are subject to a best efforts obligation rather than an obligation to achieve particular results because these agreements cannot relieve them of their statutory duty of care. They are required to do their utmost to achieve the aim of lower macro growth. Healthcare insurers will aim to limit average growth in spending to no more than 2.5% above inflation for their contracts from 2013 onwards. Healthcare providers will help bring about such agreements, and will do all they can to continue to meet waiting time targets and to prevent or shorten waiting lists.

xxiii. Response to over- and underspending

Over- and underspending in 2011 and 2012

An overspend of €115 million is expected for 2011 on the basis of figures received from the Dutch Healthcare Authority, the Vektis healthcare information centre and the Healthcare Insurance Board in March 2012. The Minister of Health, Welfare and Sport is willing to take on €40 million of this by increasing the base figure. If it is subsequently found that the 2011 overspend is different from the expected figure of €115 million, this will not lead to a change in the base figure for 2012. It is assumed that the 2011 overspend will have little or no impact on 2012 in view of the measures introduced in the curative mental health system in 2012.

Healthcare insurers are monitoring utilisation of contracted curative mental health care (see section xvi for monitoring agreements). In this regard, they will submit a statement of contracted mental health care and an estimate of non-contracted mental health care purchased to the Dutch Healthcare Authority in September 2012. If the total sum exceeds the funding available, the Minister will accordingly alert healthcare insurers and providers so that they can take action.

If over- or underspending should unexpectedly occur again in 2013, the same approach will

¹⁹ The figure of 2.75% assumed for inflation is not binding. Actual inflation will be determined in the government's spring financial report, which will also specify whether payments will be adjusted accordingly. The amounts specified in the Ministry's budget exclude inflation. The 2013 budget is based on 2012 prices.

be taken as for over- and underspending in 2013-2014.

Over- and underspending in 2013-2014

Healthcare insurers will aim to limit average growth in spending, excluding inflation, to no more than 2.5% for their contracts in 2013 and 2014. Any excess will not normally be covered unless it can be established that additional care had to be contracted to fulfil the statutory duty of care.

The Minister will hold discussions with the parties on any overspend shown up by actual expenditure figures that may unexpectedly occur despite the monitoring agreements. In addition to either flat-rate or differentiated reductions in payments to providers, measures relating to packages and co-payments may also be considered. The nature and cause of overspending will be taken into account. The parties are jointly responsible for resolving some of the problems that may arise, to the extent that the expected expenditure trend is in line with the aims set out in this agreement.

However, if no timely²⁰ and complete agreement is reached, the Minister of Health, Welfare and Sport can, as a last resort, exercise her responsibilities by using the macro management instrument (MBI) or by unilaterally reducing rates, whilst respecting the spirit of this agreement.

Any underspend will not affect curative mental healthcare funding. Growth below the level agreed in one year allows scope for a higher growth rate the following year, provided that this would not exceed the funding available for curative mental health care.

²⁰ 'Timely' means that any measures to be put forward as an alternative to the implementation of the MBI in full, subject to the relevant rules, can be submitted to the House of Representatives and the Senate in time (before 1 June in year n+1). This means that consultations based on estimates must begin in March of year n+1, as part of the government's spring decision-making process. Implementation of the MBI relates to year n. Other measures, e.g. on insurance packages or co-payments, will often not take effect until year n+2 (it is vital to ensure that they are implemented before year n+3). In that case, the budgetary impact of the missing years n and n+1 must be taken into account in the measures.

- xxiv. The parties agree to discuss progress on the points agreed four times a year, based on an implementation agenda related to the points set out in this administrative agreement. The initiatives under this administrative agreement will be reviewed in 2014.

The Hague, 18 June 2012,

On behalf of the Netherlands' umbrella organisation for mental health care (LPGGZ),

On behalf of GGZ Nederland (professional association of the mental health and addiction sector),

Ms H.W.A. Vermolen-van Gerwen,
Vice-Chair

Ms M.A.M. Barth, Chair

On behalf of Zorgverzekeraars Nederland (professional association of health insurers),

On behalf of the Dutch Psychiatric Association (NVvP),

Mr A. Rouvoet, Chair

Mr R.J. Van der Gaag, Chair

On behalf of the Dutch Association of Psychologists (NIP),
Subject to consultation of members

On behalf of the National Association of Organised Primary Care (LVG),

Ms P.M. Altenburg, Chair

Mr L. Kliphuis, Director

On behalf of the National Association of Primary Care Psychologists (LVE),
Subject to consultation of members

On behalf of Meer GGZ (platform for mental healthcare institutions),

Mr J.P.A. Kamsma, Chair

Mr B. Bakker, Chair

On behalf of the Dutch Association of Independent
Psychologists & Psychotherapists (NVVP),
Subject to consultation of members

On behalf of the Ministry of
Health, Welfare and Sport,

Mr A.A. Van Buuren, Chair

Ms E.I. Schippers, Minister