Policy framework for emergency centres in large-scale new-build locations

Introduction
Primary healthcare is characterised by generalist healthcare and low-threshold access. This care in the community is directed at man in his environment and is of an ambulatory nature. Integrated primary care involves multidisciplinary primary care, which is supplied jointly by several healthcare providers with different disciplinary backgrounds.

The usual way in which integrated primary care is provided is that various healthcare professionals cooperate in an already existing residential area. Integrated primary care centres (hereinafter referred to as health centres) are mostly started up in existing neighbourhoods for an intended population upwards of approximately 8 000 registrations. This order of scale is generally sufficient to set up a broadly integrated healthcare offering. Setting up health centres in large-scale new-build locations involves specific start-up problems. Thus, healthcare insurers are reluctant to invest because it is unclear whether a sufficient number of insured persons will come and live in the area. The inflow of residents, and thus registered patients, is often affected by delays as a result of hold-ups in the supply of houses. In addition, when the start-up phase of the centre is being financed, banks often provide insufficient credit or provide credit at high interest rates. There are, then, various problems in setting up integrated primary care in large-scale new-build locations. Health centres cannot get off the ground as a result of these specific market problems.

Because of this market failure and the public interest involved, developing and offering integrated primary care during the construction of large-scale new-build locations on previously unbuilt land is designated up to 2013 as a service of general economic interest (SGEI) within the meaning of the Decision of the Commission of the European Communities of 28 November 2005 (2005/842/EC). Health centres, as undertakings, will be responsible under an agreement for implementing this service. As compensation, they will receive an institution subsidy under the *Kaderregeling VWS-subsidies* [Health, Welfare and Sport Subsidies Framework Regulation] during the start-up phase of the construction of the health centre. This compensation takes account of the actual costs and income so that overcompensation is prevented. The subsidy policy for integrated emergency centres in large-scale new-build locations is set out in this temporary policy framework.

The following issues are dealt with in turn:
1. new-build locations
2. integrated primary care centres
3. subsidy conditions
4. obligations.

1. New-build locations
This subsidy policy is directed at large-scale new-build locations on previously unbuilt land. Well-known large-scale new-build locations also used to be called VINEX areas. VINEX areas were designated as development areas for towns by the then Minister for Housing, Spatial Planning and the Environment in 1993. They involved housing production between 1995 and 2005 under the *Vierde Nota Ruimtelijke Ordening Extra* [Fourth Note on Extra Spatial Planning]. Housing production after 2005 is by definition not VINEX housing. In order to have a better understanding of the areas where problems arise during the start-up of large primary care cooperation associations, we refer below to ‘large-scale new-build locations on previously unbuilt land’.

Criteria which a large-scale new-build location must satisfy are the following:
- It is ‘previously unbuilt’ land. There must be no question of redevelopment of housing. Previously unbuilt land generally means former agricultural land (including possible small-scale house building such as farmhouses) and/or former industrial complexes and/or land which becomes available as a result of reclamation.
- The intended number of residents in the new residential area after completion of the respective plans is a minimum of 8 000. The application must provide a more detailed

description of the area including recent building plans and postcodes for the area. The new build locations must be specified in the application for the subsidy, among other things by providing the postcodes.

2. Integrated primary care centres

This subsidy policy is moreover directed at integrated primary care centres or health centres.

Health centres may in broad terms be organised in two different ways. In the most simple form, a health centre consists of a single legal person which operates the centre and employs the (medical) staff to provide the primary healthcare. In this case the relevant legal person is eligible for subsidy. The essence of the other way of organising health centres is that there is one legal person which operates the centre and other (legal) persons provide the primary healthcare in the centre. The healthcare providers pay for the use of the centre. The legal person operating the health centre is also eligible for subsidy in this case.

The legal person, i.e. the undertaking, which operates a health centre is referred to here as the operator.

3. Subsidy conditions

The operator of a health centre in a large-scale new-build location may be responsible for a service of general economic interest. This means that the operator has the task of providing and further developing integrated primary healthcare during the construction of that new-build location. A start-up subsidy may be provided to the operator for this under the Health, Welfare and Sport Subsidies Framework Regulation.

Subsidy may be obtained for practice costs, these being the costs of staff, accommodation and computerisation insofar as these costs are acceptable in comparison with the costs of similar health centres. Furthermore, it is permitted to make a provision for illness and incapacity for work up to a maximum of 7.56 % of the amount of pay. Of course, subsidy is only provided for costs which are not or cannot be reimbursed by others. The subsidy is a minimum of EUR 125 000 a year and a maximum of EUR 300 000 per health centre. The subsidy is solely provided in the first five calendar years after the start of the healthcare offering in the health centre and for as long as 8 000 residents are not yet expected in the relevant subsidy year within that period. This applies even if the health centre changes operator, for example as a consequence of a merger.

In order to be eligible for subsidy, the following criteria must be complied with:

- The health centre must be open to all the residents of the new-build location and the operator must have made a plausible case that a minimum of 8 000 patients is a realistic estimate of the number of patients to be obtained.
- There must be a multidisciplinary healthcare offering. The healthcare offering consists of a minimum of three disciplines, with in any event general medical practitioner care and at least two other primary care disciplines.
- There must be an integrated healthcare offering. With regard to cooperation, coherent healthcare interventions are agreed upon and coordinated between the disciplines concerned. Where the different disciplines are not provided by the operator’s staff, there is a cooperation agreement based on a joint vision of integrated primary care laying down the way in which cooperation takes place.
- There must be a healthcare provision plan.
- The continuity of the health centre must be guaranteed. Not later than five years after the start, the health centre can be operated without subsidy. If it does not provide the care itself, the operator has concluded agreements with healthcare providers guaranteeing continuity.
- There must be written agreements concerning integrated primary healthcare with the preferred healthcare insurer. These agreements must show that there is support for the cooperative association from the preferred healthcare insurer and that a future contract is intended, on the

basis of the NZa Dutch Care Authority's policy rule on Integrated Primary Healthcare Products ensuring the continuity of the health centre.

If the construction of homes in the large-scale new-build area runs up against delays such that the number of residents is insufficient to operate the health centre without subsidy after five years, the subsidy period may be extended by a maximum of two years. In all cases the maximum subsidy over the entire subsidy period is EUR 1 500 000.

The method of granting the start-up subsidy is governed by the Health, Welfare and Sport Subsidies Framework Regulation. Amongst other things, reference should be made to the provisions relating to the application and the justification. It must be seen from the application that the criteria described in this policy framework are complied with in order to be eligible for subsidy. To that end a multi-annual budget is necessary showing that the health centre can be operated without subsidy after the years of subsidy. When the multi-annual budget is drawn up, the costs as they apply at that time are used as a basis. It is also important to present an estimate with a solid basis for the development of the population in the new-build area. The agreements referred to above should also be sent with the application.

4. Obligations

The subsidy also entails the obligation to conclude an implementation agreement between the health centre and the Ministry of Health, Welfare and Sport. Under this agreement the operator is responsible for the service of general economic interest, namely the provision and further development of **integrated primary care** during the construction of the relevant new-build area.

If the legal person, in addition to carrying out the service of general economic interest, carries out other activities, there should be separate accounts, so that the assets and liabilities of the various activities are separate and it is clear which of them relate to the implementation of the service of general economic interest.

Otherwise the usual obligations under the Health, Welfare and Sport Subsidies Framework apply. Thus, there is an examination of what the actual costs and income are when the subsidy is determined. Subsidy funds which are not spent after carrying out the eligible activities are added to a so-called equalisation reserve. The equalisation reserve amounts to not more than 10 % of the subsidy granted. If the equalisation reserve amounts to more than 10 %, this will be recovered. As long as a subsidy is being granted, the equalisation reserve can be used in the following year if the subsidy falls short. Thus, there is no overcompensation.

5. Conclusion

This policy framework is the follow-up to the subsidy policy in respect of health centres included in the letter to the Dutch Lower House of Parliament of 5 September 2011 (*Kamerstukken* [Proceedings of the Dutch Parliament] 2010-2011, 29 247, no 150). That subsidy policy related to the years 2011, 2012 and 2013. The present policy framework applies to the year 2014. In 2014 it is being examined whether and, if so, how the present financing from 2014 can take place, and this is also in the light of changes in payment for general practitioner healthcare. Health centres must therefore take account of the fact that with effect from 2015 no more subsidies will be issued.

Applications for subsidy grants for 2014 may be submitted not later than 1 December 2013 by derogation from the usual period of time under the Health, Welfare and Sport Subsidies Framework Regulation. A special form is used for applications for the subsidy. This form can be obtained via the website of the Ministry of Health, Welfare and Sport.