Nederlandse Zorgautoriteit
[Dutch Healthcare Authority]

Reference
BR/CU-2119

POLICY RULE BR/CU-2119

Policy Rule on 2014 applications for the Cure service provision contribution

Under Article 57(1), introductory words and (e), of the *Wet marktordening gezondheidszorg* [WMG – Healthcare Market Regulation Act], the *Nederlandse Zorgautoriteit* [NZa – Dutch Care Authority] establishes policy rules with regard to exercising the power to establish service provision contributions.

Under Article 59, opening words and (e), of the WMG, the Minister of Health, Welfare and Sport issued a designation to the NZa for the present policy rule under Article 7 WMG in a letter of 12 December 2012 (reference MC-U-3147126).

Title 4.2 of the *Algemene Wet Bestuursrecht* [General Administrative Law Act] ('Subsidies') and the Commission Decision of 20 December 2011 (C(2011)9380) apply to the service provision contribution.

1. Scope

This policy rule applies to having care available as referred to in Article 2 of the *Besluit beschikbaarheidbijdrage WMG* [Healthcare Market Regulation Act Service provision Contribution Decree] in conjunction with part B, sections 3, 5 and 6 to 9 of the annex. These forms of care are referred to in Article 4.1 of this policy rule.

2. Aim of the policy rule

It is not possible and/or desirable, for a number of healthcare services supplied by healthcare providers, to allocate them directly to healthcare products for individual consumers. This involves specific functions or characteristics of healthcare provision, such as availability, specific expertise or specific facilities. The aim of this policy rule relates to bearing the cost of these healthcare services.

3. Definitions

The following definitions apply in this policy rule:

3.1 *Annex*
means the annex to Article 2 of the Decree.

31.2 *Service provision contribution*
means a contribution as referred to in Article 56a of the Healthcare Market Regulation Act.

3.3 *Decree*
means the *Besluit beschikbaarheidbijdrage WMG* [Healthcare Market Regulation Act Service provision Contribution Decree] of 24 August 2012, published in *Staatsblad* [Bulletin of Acts and Decrees] 2012 no 396.

3.4 *DBC volume for burns care*
DBC (diagnosis treatment combination) volume in this policy rule means the specialist burns care DBCs carried out in the year concerned and the IC add-ons carried out with them.

3.4 *Minister*
means the Minister for Health, Welfare end Sport.

3.6 *OTO*
means Education, Training and Practice during disasters and crises as laid down on 16 October 2008 in the OTO covenant.

3.7 *A&E consultation*
means an A&E consultation having code 190015 (Policy Rule BR/CU-2104 Performance and Tariffs for Specialist Medical Care).

3.8 *WMG*
means the *Wet marktordening gezondheidszorg* [WMG – Healthcare Market Regulation Act].

4. General

4.1 Designated forms of care
A number of forms of care have been designated by the Minister by decree for which the NZa can establish an service provision contribution. The NZa has established the present policy under this decree in respect of granting the service provision contribution on application by healthcare providers for 2014.

The following forms of care may qualify for an service provision contribution:

Article 5	Specialist Burns Care
Article 6	Trauma Care by Mobile Medical Teams
Article 7	Accident and Emergency Department
Article 8	Acute Obstetrics
Article 9	Post Mortem Organ Removal
Article 10	Trauma Care Education, Training and Practice

4.2 Application for an service provision contribution
A healthcare provider which supplies a form of care referred to under Article 4.1 of this policy rule may submit an application to the NZa in order to be eligible for an service provision contribution.
Under Article 56a(2)(a) of the WMG the NZa applies on application Article 56a(1) and (7) of the WMG.
The Cure Directorate of the NZa keeps healthcare providers aware of the details which the submission must satisfy as there is a changing pathway concerning the process for service provision contributions on application.

4.3 Granting of service provision contributions
If an application referred to in Article 4.2 of this policy rule satisfies the requirements laid down, the NZa will entrust the healthcare provider with a service of general economic interest or service of general interest under Article 56a(7) of the WMG. Thereupon, the NZa can grant an service provision contribution.

4.4 Declaration of service provision contribution
The healthcare provider can charge the amount of the service provision contribution to the *College van Zorgverzekeringen* [CVZ: Dutch Healthcare Insurance Board] at the expense of the *Zorgverzekeringsfonds* [Healthcare Insurance Fund].

4.5 Establishment of the service provision contribution
After the end of the year for which the service provision contribution has been granted, the provider must submit an application for determination of this contribution to the NZa by 1 June.

Justification forms and control protocols are available on the website for application for determination of the 2014 service provision contributions for
- specialist burns care and
- trauma care by mobile medical teams.

These justification forms and control protocols are publicised in good time on the Nza's website.

The application for determination must be accompanied by an accountant's declaration.

The NZa will issue a decision within eight weeks of receipt of the fully completed application form by means of which the service provision contribution is definitively determined.

2014 application for service provision contribution
The NZa makes a form available for justification of the service provision contribution by providers.

4.6 Price indexing
The amounts in this policy rule are at the price level at the end of 2013. When the 2014 service provision contributions are granted, account is taken in the grant decision of the provisional indices for 2014. When the 2014 service provision contribution is determined, account is taken of the definitive indices for 2014.

5. Specialist burns care

5.1 Description of care
Specialist burns care as referred to in Part B, introductory words and (9), of the annex.

5.2 Grant criteria
Providers of the aforementioned form of care referred to in Article 5.1 of this policy rule which have submitted an application for an service provision contribution to the NZa as referred to in Article 4.1 of this policy rule for the availability of specialist burns care and comply with the conditions laid down. The application for the 2014 service provision contribution for burns care must be submitted not later than 31 December 2013.

5.3 Number of providers accepted
Under the decree, the NZa entrusts a maximum of three institutions with the availability of specialist burns care.

5.4 Level of service provision contribution
The level of the service provision contribution for the burns centres is based on the costs incurred for 2011 (based on the cost survey from 2012). These costs are indexed to 2013. These costs are reduced for the year concerned by the volume of the DBC combinations of diagnosis and treatment carried out for specialist burns care and the IC add-ons carried out for these DBCs.

Institution	**Staff**	**Equipment**	**Max. contribution**
Martini Hospital	EUR 5 011 475	EUR 2 498 423	EUR 7 509 898
Maasstad Hospital	EUR 5 712 406	EUR 2 847 865	EUR 8 560 271
RKZ Hospital	EUR 5 896 268	EUR 2 939 527	EUR 8 835 795

DBCs for specialist burns

14C653	979004002	Day / diagnostic (serious) / Outp > 2 / Routine examination > 2 | Specialist burns care	Day treatment / diagnostic examination / More than two outpatient clinic visits involving specialist burns care
14C654	979004003	Oper 1-4 / therapeutically slight 1-4 | Specialist burns care	One to four operations or treatments involving specialist burns care

14C655	979004004	Oper > 4 / therapeutically slight > 4 | Specialist burns care	More than four operations or treatments involving specialist burns care
14C656	979004005	Clin 1-5 | without operation | Specialist burns care	Maximum of 5 days of hospitalisation involving specialist burns care
14C657	979004006	Clin 1-5 | with operation | Specialist burns care	Maximum of 5 days of hospitalisation (with operation) involving specialist burns care
14C658	979004008	Slight ambulatory | Specialist burns care	Consultation in the outpatient department involving specialist burns care
14C659	979004009	Clin 6-15 | without operation | Specialist burns care	6 to a maximum of 15 days of hospitalisation involving specialist burns care
14C660	979004010	Clin 6-15 | with operation | Specialist burns care	6 to a maximum of 15 days of hospitalisation (with operation) involving specialist burns care
14C661	979004011	Clin 29-56 | Specialist burns care	29 to a maximum of 56 days of hospitalisation involving specialist burns care
14C662	979004012	Clin 16-28 | without operation | Specialist burns care	16 to a maximum of 28 days of hospitalisation involving specialist burns care
14C663	979004013	Clin 16-28 | with operation | Specialist burns care	16 to a maximum of 28 days of hospitalisation (with operation) involving specialist burns care
14C664	979004014	Clin 57-90 | Specialist burns care	57 to a maximum of 90 days of hospitalisation involving specialist burns care
14C665	979004016	Clin > 90 | Specialist burns care	more than 90 days of hospitalisation involving specialist burns care

Intensive Care add-ons

190125	IC treatment day group 1. A calendar day on which at any given moment there has been medical treatment of a patient in IC.
190126	IC ADMISSION SUPPLEMENT GROUP 1. IS RECORDED ON THE FIRST IC TREATMENT DAY.
190127	IC artificial respiration supplement group 1.
190128	IC dialysis supplement group 1. Record in addition to IC treatment day (190125), if on an IC treatment day at any given moment there is kidney dialysis under the final responsibility of a medical specialist.
190129	IC CONSULTATION. CONSULTATION BETWEEN COLLEAGUES OUTSIDE THE IC, URGENT AND NON-URGENT.
190130	Inter-clinic IC transport (< 2 hour). Transport of an IC patient between hospitals physically accompanied by medical specialist.
190131	Inter-clinic IC transport (>= 2 hour). Transport of an IC patient between hospitals accompanied by medical specialist.
190132	Micu transport < 2 hour.
190133	Micu transport >= 2 hour.
190134	IC treatment day group 2. A calendar day on which at any given moment there has been medical treatment of a patient in IC.
190135	IC ADMISSION SUPPLEMENT GROUP 2. IS RECORDED ON THE FIRST IC TREATMENT DAY.
190136	IC ARTIFICIAL RESPIRATION SUPPLEMENT GROUP 2

190137	IC dialysis supplement group 2. Record in addition to IC treatment day (190134), if in an IC treatment day at any given moment there is kidney dialysis under final responsibility of a medical specialist.
190141	IC treatment day for group 3. A calendar day on which at any given moment there has been medical treatment of a patient in IC.
190142	IC ADMISSION SUPPLEMENT GROUP 3. IS REGISTERED ON THE FIRST IC TREATMENT DAY.
190143	IC ARTIFICIAL RESPIRATION SUPPLEMENT GROUP 3
190144	IC dialysis supplement group 3. Record in addition to IC treatment day (190141), if on an IC treatment day at any given moment there is kidney dialysis under the final responsibility of a medical specialist.
190150	Neonatal IC.
190151	Paediatric IC.

The service provision contribution is established as a maximum amount at the beginning of the year and after the end of the year the volume of the DBC combinations of diagnosis and treatment for specialist burns is deducted from it. If the DBC volume is higher than the maximum amount, the institution receives no service provision contribution for specialist burns care. The specialist burns DBCs and IC add-ons have a maximum tariff. The NZa will reduce this maximum tariff, regardless of the tariff that has in reality been agreed and/or declared between the healthcare provider and the healthcare insurer.

Fee supplement
With regard to the fee supplement to the service provision contribution for specialist burns care, the level will be established at the level of the fee supplement during 2013.

The calculation of the fee ceiling and the fee supplement will be carried out as follows:
- Where the DOT production/IC add-ons fee volume achieved with regard to specialist burns care is higher than the established fee ceiling, the difference must then be repaid, in accordance with the Management Model Policy Rule for the fees of freely established medical specialists. Since the fee ceiling is equal to the fee supplement, there is also no fee supplement remaining;
- Where the DOT production/IC add-ons fee volume achieved with regard to specialist burns care is lower than the established fee ceiling, the difference is then deducted from the fee supplement to the service provision contribution which is to be paid out.

On application by the institution, the fee component of the service provision contribution will also be advanced in accordance with the system described in Part 13 of this policy rule.

6. Care provided by mobile medical teams using a helicopter

6.1 Description of care
Trauma care by mobile medical teams (helicopter) as referred to in Part B, introductory words and (6), of the annex.

6.2 Grant criteria
Providers of the form of care referred to in Article 6.1 of this policy rule which have submitted an application for service provision contribution to the NZa as referred to in Article 4.2 of this policy rule for the availability of mobile medical teams with a helicopter and comply with the conditions laid down. The application for the 2014 service provision contribution for a mobile medical team with a helicopter must be submitted not later than 31 January 2014.

6.3 Number of providers which can receive a contribution.
Under the decree the NZa will entrust a maximum of four institutions with the availability of a mobile medical team and helicopter.

6.4 Level of service provision contribution
The level of the service provision contribution is based on the following headings:

Leasing costs
The leasing costs for the helicopter with a pilot on the basis of actual costs of the lease contract and the flights made in the year concerned.

Staff deployment
Costs of staff deployment on the basis of the standard that a deployment of 24 hours/7 days per week requires 5.5 medical specialist FTEs and 6 FTEs for the prescribed 25.5 hour nurse's shifts for each 24-hour period.

- The salary costs for a medical specialist are based on BR/CU 2031 from 2011 with pay index 2012 (= EUR 195 686 per annum).
- The salary costs for a specialist nurse are based on the 2011-2013 collective labour agreement for university medical centres scale 9, step 8 (salary as at 1.8.2012) (= EUR 3 605 per month) plus unsocial hours bonus (47 % after 20.00 and on Saturdays after 12.00, 72 % Sundays and public holidays) plus holiday bonus of 8 % and end of year payment of 8.3 %.

Helicopter platform, capital expenditure, hire and foreign deployment
The costs of the helicopter platform are partly on the basis of standardisation. If an institution has stationed the helicopter on the roof, there are on the one hand capital costs which are standardised at 8.7 % of the staff costs and there are on the other hand costs for the 24/7 availability of a landing officer. The salary costs of a landing officer are based on the 2011-2013 collective labour agreement for university medical centres scale 5, step 5 (salary as at 1.8.2012) (= EUR 2 141 per month), plus unsocial hours bonus (47 % after 20.00 and on Saturdays after 12.00, 72 % Sundays and public holidays) plus holiday bonus of 8 % and end of year payment of 8.3 %. If the helicopter is not stationed on the roof of the institution, it may be that hire charges have to be paid. If that is the case, these are fully included in the service provision contribution. For institutions which have the helicopter stationed elsewhere, no reimbursement of capital costs is included in the service provision contribution and, as with the other institutions which have a landing facility, the costs for this are deemed to be covered by regular production.
The indemnification for the mobile medical team vehicle is made officially via the Policy Rule on the Cure service provision contribution. Income from foreign deployment is deducted from the service provision contribution.

Other direct costs
The following standard amounts will be used for the other costs which have a direct relationship with the function:

- costs of service clothing EUR 21 000
- training costs EUR 35 000
- patient-related costs EUR 50 000
- accommodation costs EUR 5 000.

The level of these standard amounts is based on a breakdown supplied by the institutions concerned. Best practice is used by the NZa here. The training costs heading includes an amount of EUR 30 000 earmarked for training to become a Helicopter Crew Member (HCM). The assumption is 1 HCM training course every two years per MMT.

Overhead costs
5 % uplift on the staff costs for the overheads of the institution, including management, support departments, office and administration.

7. Emergency healthcare

7.1 Description of care
Emergency healthcare as referred to in Part B, introductory words and (7), of the annex.

7.2 Grant criteria
Providers of the form of care referred to in Article 7.1 of this policy rule which have made an application for service provision contribution to the NZa as referred to in Article 4.2 of this policy rule for the availability of emergency healthcare and comply with the following grant criteria. An initial application for a contribution for this function may be made during the year. After any, an application for grant must be made by 1 December of year t-1. The application for determination must be made by 1 June of year t+1.

Under the designation, the NZa can only award an service provision contribution for emergency healthcare if the following conditions have been complied with:

(1) there is an (imminent) closure of an A&E department;
(2) the healthcare insurer can no longer comply with the duty of care it has and it cannot be blamed for this due to force majeure;
(3) the 45-minute standard is at risk;
(4) no other solutions are possible.

7.3 Level of service provision contribution
Costs of staff
In order to ensure 24/7 availability, the NZa assumes 5.5 A&E doctor FTEs and 5.5 A&E nurse FTEs. The salary costs of the A&E doctor are specified as being EUR 190 067 based on Article 62 of Policy Rule 2087 on a Transitional Payment Structure for Medical Specialist Care (BR/CU-2087). The salary costs of the A&E nurse are based on step 5 of function group 55 from the collective labour agreement on hospitals. The NZa takes account of an uplift percentage for employer's costs of 30 %.

Costs of equipment
The NZa assumes an equipment/staff ratio of 30 % / 70 %.

Costs of capital
The uplift for capital expenditure is 8.7 %.

Establishment of the income
The service provision contribution aims only to cover any shortcoming. Income that an accident and emergency department generates will thus be deducted. The determination of the income will be made for each individual case on the basis of the A&E consultations carried out and a standard income per A&E consultation of EUR 90.

The service provision contribution is determined as a maximum amount at the beginning of the year and after the end of the year the A&E consultations carried out are then deducted from it. If the volume of A&E consultations is higher than the maximum contribution, the institution receives no service provision contribution.

8. Acute obstetrics

8.1 Description of care
Acute obstetrics as referred to in Part B, introductory words and (8), of the annex.

8.2 Grant criteria
Providers of the form of care referred to in Article 6.1 of this policy rule which have submitted an application for service provision contribution to the NZa as referred to in Article 4.2 of this policy rule for the availability of acute obstetrics and comply with the following grant criteria. An initial application for a contribution for this function can be made during the year. After any, a grant application must be submitted by 1 December of year t-1. The application for determination must be submitted by 1 June of year t+1.

Under the designation, the NZa can only award an service provision contribution for acute obstetrics if the following conditions have been complied with:

(1) there is a an (imminent) closure of the obstetrics function,
(2) the healthcare insurer can no longer comply with the duty of care it has and it cannot be blamed for this due to force majeure,
(3) the 45-minute standard is at risk,
(4) no other solutions are possible.

8.3 Level of service provision contribution
Staff Costs
In order to ensure 24/7 availability the NZa assumes 5.5 gynaecologist FTEs or 5.5 obstetric professional FTEs. If the gynaecologist and the obstetric professional alternate in shifts, the ratio is determined on the basis of the actual deployment. The number of FTEs will be a maximum of 5.5. The salary costs of the gynaecologist are determined at EUR 190 067.00 based on Article 62 of Policy Rule 2087 on the transitional cost structure of medical specialist care (BR/CU-2087). The salary costs of the obstetric professionals are based on step 5 of function group 55 from the collective labour agreement for hospitals. The NZa takes account of a percentage uplift for the employer's costs of 30 %.

Equipment Costs
An equipment-staff ratio of 30 % / 70 % is assumed.

Capital Costs
The uplift for capital expenditure is 8.7 %.

Establishment of the income
The service provision contribution is established as a maximum amount at the beginning of the year. This is reduced by an estimate of the obstetrics income to be achieved in that year. After the end of the year the service provision contribution is determined on the basis of obstetrics income actually achieved that year. The NZa has established a percentage per product of the extent to which the product concerned can be attributed to the activities of the available gynaecologist/obstetric professional.

A summary of this is given below.

care_product_code	care_product_medical_description	total costs profile	costs profile | AC_strict	percentage_strict
150101002	Oper due to extra-uterine pregnancy | Pregn/delivery/childbed miscarriage	EUR 2 300.61	EUR 982.74	42.7 %
150101003	Diagnostic (heavy) / therapeutically slight | Pregn/delivery/childbed miscarriage	EUR 457.28	EUR 47.29	10.3 %
150101004	Clin short | Pregn/delivery/childbed miscarriage	EUR 993.91	EUR 2.23	0.2 %
150101006	(Abortion) curettage | Pregn/delivery/childbed miscarriage	EUR 1 051.66	EUR 416.36	39.6 %
150101007	Day / Outp >2 / routine examination >2 | Pregn/delivery/childbed miscarriage	EUR 394.68	EUR -	0.0 %
150101008	Clin (very) long | Pregn/delivery/childbed miscarriage	EUR 12 762.73	EUR 2.83	0.0 %
150101009	Clin medium | Pregn/delivery/childbed miscarriage	EUR 3 987.28	EUR 6.06	0.2 %
150101011	Slightly ambulatory | Pregn/delivery/childbed miscarriage	EUR 129.56	EUR -	0.0 %
159899004	Partus with complex OT fluxus treatment | Pregn/delivery/childbed delivery/compl	EUR 8 697.99	EUR 1 794.88	20.6 %
159899007	Caesarean section | Pregn/delivery/childbed delivery/compl	EUR 2 747.70	EUR 863.22	31.4 %
159899008	Post partum complications | day/ Clin cumulatively short | Pregn/delivery/childbed delivery/compl	EUR 881.54	EUR 2.47	0.3 %
159899010	Partus with (manual) placenta removal / oper cervical tear | Pregn/delivery/childbed delivery/compl	EUR 2 530.27	EUR 1 044.05	41.3 %
159899012	Post partum complications | day / Clin cumulatively medium | Pregn/delivery/childbed delivery/compl	EUR 2 744.24	EUR 4.91	0.2 %
159899013	Post partum complications | complex OT fluxus treatment | Pregn/delivery/childbed delivery/compl	EUR 8 900.35	EUR 1 002.91	11.3 %
159899014	Follow-up care spontaneous partus / multiple birth | Pregn/delivery/childbed delivery/compl	EUR 1 804.80	EUR 573.80	31.8 %
159899016	Post partum complications | (manual) placenta removal / oper cervical tear | Pregn/delivery/childbed delivery/compl	EUR 1 522.86	EUR 511.24	33.6 %
159899017	Vaginal assisted delivery | Pregn/delivery/childbed delivery/compl	EUR 1 508.13	EUR 466.12	30.9 %
159899019	Follow-up care spontaneous partus | Pregn/delivery/childbed delivery/compl	EUR 1 390.89	EUR 541.62	38.9 %

If the DBC volume attributed to this function is higher than the contribution, the institution receives no service provision contribution. Since this is a free tariff, the NZa bases the tariff on the national average tariff for the products concerned.

9. Post mortem organ removal

9.1 Description of care
Post mortem organ removal involving donors as referred to in Part B, introductory words and (3), of the annex.

9.2 Grant criteria
Providers of the form of care referred to in Article 9.1 of this policy rule which have submitted an application for service provision contribution to the NZa as referred to in Article 4.2 of this policy rule for the availability of post mortem organ removal and comply with the following grant criteria.

Providers of form of care designated in the administrative order which are also designated as a donor removal team by the minister under Article 8 of the Wmbv.

An initial application for a contribution for this function can be made during the year. After any allocation, a grant application must be submitted by 1 December of year t-1. The application for determination must be submitted by 1 June of year t+1.

9.3 Level of service provision contribution

The service provision contribution for post mortem organ removal is compensation for the university medical centres concerned in respect of the removal surgeons in the designated donor removal teams. The level of the service provision contribution is obtained from:

Staff deployment

Number of FTEs per team

Calculation of required number of FTEs for 1 FTE	
Basic FTE	1
Holiday 24 days amounting to 9 %	0.09
Compensation leave 36 hours	0.2
Absence (5 %)	0.05
Total	1.34
For a team of 2 FTEs	2.68

Staff costs

Basic gross salary (source *1)	EUR 9 865
Basis for supplements *2	EUR 9 505
Supplements * 3	EUR 3 802
Pay (salary + supplements)	EUR 13 667
Holiday pay (8 % of pay)	EUR 1 093
End of year payment (8.3 % of basic gross salary)	EUR 819
Total per month	EUR 15 579
Uplift for employer's costs of 30 %	EUR 4 674
Per annum	EUR 243 035

*1 The salary of a doctor is dependent on experience and amounts to 9865 (level 2012) for a university medical specialist (UMS scale, increment 8) in the event of full-time employment (1 FTE)
*2 Supplements cover increment 7
*3 Supplement for 24-hour shifts (20 %) + supplement for aggravating circumstances (20 %)

Equipment costs
An equipment/staff ratio of 30 % / 70 % is assumed.

Capital costs
The uplift for capital expenditure is 8.7 %.

10. Trauma care education, training and education

10.1 Description of care
Trauma care with regard to Education, Training and Practice for disasters as referred to in Part B, introductory words and (5), of the annex.

10.2 Grant criteria
Providers of the form of care referred to in Article 10.1 of this policy rule which have submitted an application for service provision contribution to the NZa as referred to in Article 4.2 of this policy rule for the availability of trauma care with regard to Education, Training and Practice and comply with the grant criteria.

10.3 Level of service provision contribution

The NZa bases the level of grant on the provider's application. The provider may submit the application for the 2014 subsidy year up to 15 April 2014. The level of the service provision contribution is a maximum of EUR 1 037 036.00 for a general hospital and a maximum of EUR 1 047 703.00 for an academic hospital. The NZa bases these amounts on the Covenant on OTO Resources which has been concluded between the Ministry of Health, Welfare and Sport and the Trauma Centres. The aforementioned amounts are at the price level at the end of 2013.
A budget is supplied by the applicant in the application for the OTO activities which the provider expects to carry out in the year concerned. This budget is at project and activities level.

OTO resources can be used by the provider in accordance with the Covenant on the following activities:

1) preparation, facilitation and organisation of activities concerning education, training and practice in the healthcare sector;
2) activities directed at the preparation of all types of scenarios in accordance with the *Leidraad Maatramp* [Disaster Measures Guideline];
3) for healthcare processes namely somatic medical assistance, preventive public healthcare and the provision of psychosocial assistance in accidents and disasters as part of facilitating, setting up and organising education, training and practice;
4) for financing the national support structure.

By 1 June after the end of the subsidy year concerned, the provider must submit an application for determination of the service provision contribution. Under the subsidy requirements a determination cannot be higher than allocated in the initial award decision. It is possible to justify activities and projects other than those stated in the initial application at the time of the determination and allow them to be eligible for reimbursement. It is a condition for this that these activities and projects comply with the requirements set out above and in the Covenant.

11. Conditions, provisions and restrictions

The NZa will include the conditions, provisions and restrictions in this article in the order on the service provision contribution.

11.1 The service provision contribution is exclusively spent on the activities and associated costs of the form of healthcare for which it has been allocated.

11.2 The healthcare provider is responsible for well-organised and appropriate administration which provides a correct, full and current picture of the activities for which the service provision contribution has been allocated.

11.3 The healthcare provider keeps sound supporting documents for all expenditure relating to activities for which the service provision contribution has been allocated and for all income which may be eligible for the determination of the service provision contribution.

11.4 The healthcare provider must inform the NZa and the CVZ promptly of facts or circumstances that may reasonably be of importance for the amendment or repeal of the grant or for the determination of the service provision contribution.

11.5 The service provision contribution may be determined at a lower level if:
a. the activities for which the service provision contribution has been granted have not or have not fully taken place;
b. the healthcare provider has not complied with the obligations associated with the service provision contribution;
c. the healthcare provider has supplied incorrect or incomplete information and the provision of correct or full information would have resulted in a different decision on the grant application;

or
d. the granting of the service provision contribution was otherwise incorrect and the healthcare provider knew or should have known this.

12. Advances

Except in special circumstances, the NZa makes advance payment of the service provision contribution. The service provision contribution advances are paid in twelve equal instalments.

13. Advance for specialist burns care

13.1 Ahead of the final determination of the service provision contribution for specialist burns care as referred to in Article 4.5, a healthcare provider may, in the application form, ask the NZa to grant an advance with regard to the burns care service provision contribution or to amend an advance already made.

13.2 The request must comprise as a minimum:
the estimated scale of the DBC specialist burns production and IC add-ons for the year to which the advance relates, taking into account the provisions laid down in this policy rule.

13.3 If a request is not made at the same time as the application for an service provision contribution, a request for an advance may also be made during the year concerned. A request must be received by the NZa not later than 1 October 2014.

13.4 The request will be granted if, in the opinion of the NZa, it can reasonably be assumed that there will be a situation in which the burns care service provision contribution will be higher than the anticipated specialist burns DBC volume. Requests for amendment of an advance already made will be rejected if the institution concerned has already made two previous requests for amendment.

13.5 The advance (on an annual basis) is a maximum of 50 % of the service provision contribution for specialist burns care included in the award decision and also cannot be higher than the balance for the specialist burns care service provision contribution as stated by the institution less the stated volume of specialist burns DBCs. The advance is paid out by the CVZ in monthly instalments. If the requested advance subsequently appears to be higher than the service provision contribution laid down in the award decision, a standard rate of interest is calculated on the difference.

13.6 In addition, interest rate benefits enjoyed owing to the receipt of too great an advance will be charged for. ‘Too great’ means: the difference between the advance received and the burns care service provision contribution ultimately allocated in the determination order or, if no service provision contribution is allocated in the determination order, the total advance. This interest rate benefit is established on a standard basis at 4 % per annum and is calculated per month, from the month in which the first payment was made until the time of determination of the final service provision contribution.

13.7 The interest rate benefits calculated under the previous paragraph are deducted from the service provision contribution which is finally determined.

13.8 If an advance has been received and there is a higher specialist burns care DBC volume than the specialist burns care service provision contribution allocated in the award decision, the advance that has been paid, increased by the interest rate benefit calculated under this article, must be transferred by the institution to the *Zorgverzekeringsfonds* [Healthcare Insurance Fund] according to a method to be announced by the NZa.

14. Procedure for CVZ payment

The healthcare provider may approach the *College van Zorgverzekeringen* [CVZ: Dutch Healthcare Insurance Board] for payment of the service provision contribution. The following procedure must be followed:

14.1 The CVZ form 'Statement of bank account number' should be completed (this form may be downloaded from the websites of both the NZa and the CVZ). The healthcare provider must state the bank account number, the name and the bank which should be used by the CVZ on the form.

14.2 The form should be signed by an officer authorised to act as a representative within the healthcare provider's organisation. This authorised representative must be registered with the Chamber of Commerce.

14.3 For verification, the healthcare provider must send a copy of a recent extract from the Chamber of Commerce with the form to the CVZ.

14.4 The healthcare provider must state the accompanying order number on the form. This number may be found at the top left of the order.

14.5 A copy of the service provision contribution order must also be sent.

15. Entry into force and citation

This policy rule will enter force with effect from the day after the date of publication of the *Staatscourant* [Dutch Government Gazette] in which the communication referred to in Article 20(2), Part b, of the Healthcare Market Regulation Act is placed and will have retrospective effect to 1 January 2014.

This policy rule may be referred to as: 'Policy Rule on applications for the Cure service provision contribution'.

The policy rule 'Policy Rule on applications for the Cure service provision contribution' with reference BR/CU-2118 will be withdrawn at the same time as the entry into force of this policy rule.

Explanatory memorandum relating to the policy rule

Amendment compared with the previous version
This policy rule replaces Policy Rule BR/CU-2118. The difference from the previous version is that Article 9 concerning the post mortem organ removal healthcare function and Article 10 concerning the OTO healthcare function have been developed. In addition, the opportunity has been taken to make a few minor amendments to the text and a clarify a few points in the explanatory memorandum.

General points concerning service provision contributions
It is not possible and/or desirable, for a number of healthcare services of healthcare providers, to assign them directly to healthcare products for individual consumers. They involve specific functions or characteristics of the care provision, such as availability, specific expertise or specific facilities. These forms of care are designed by the minister in a decree.

In the case of service provision contributions a distinction is made between official service provision contributions and service provision contributions on application. This distinction has been made in order to be able to achieve a careful cost breakdown of the service provision contributions. In 2012 this was confined to the granting of service provision contributions at the level of the 2011 budget reimbursements. This is in accordance with the principle used by the Ministry of Health, Welfare and Sport to link with the old situation (as regards budgets and providers) as much as possible, both as regards the level of the contribution and as regards the recipient providers. In fact only the method of financing changed in 2012. From 2013 onwards the service provision contributions are being provided function by function with a new cost breakdown. In this policy rule on service provision contributions on application, availability functions have been laid down which are provided with a new cost breakdown, and for this reason these contributions on application have been established by the NZa. The availability functions which have not yet been broken down are officially laid down in the policy rule on Cure service provision contributions.

General process
The process of the granting and establishing of an service provision contribution by the NZa will take place as follows. The NZa will first, on application, adopt an award decision and subsequently, after receipt of the determination form, adopt a final determination order. The award decision which the healthcare provider receives at the beginning of 2014 is combined as standard for a number of functions with the granting of advances, and this is also possible on request in the case of burns under certain conditions. The level of the service provision contribution is definitively laid down by the NZa in the determination order, which in most cases is adopted after 2014. The healthcare provider has to approach the CVZ for payment of the service provision contribution laid down by the NZa.

Emergency Healthcare and Acute Obstetrics
In early 2012 the Minister of Health, Welfare and Sport made a promise to the Dutch Lower House of Parliament that an service provision contribution would also be made possible for acute obstetrics. Moreover, it is desired that, in addition to the existing hospitals with an accident and emergency department which historically receive an service provision contribution on the basis of a transitional arrangement, other hospitals with an accident and emergency department will also be eligible for this if necessary.

The service provision contribution for accident and emergency departments and acute obstetrics is, under the *Besluit beschikbaarheidbijdrage WMG* [Healthcare Market Regulation Act Service provision contribution Decree] (the decree), only intended for situations where the income from tariffs which are charged for providing this healthcare is not sufficient to have the form of healthcare available under the conditions referred to in that decree. This will mainly be the case in shrinking areas, where there may be insufficient demand and where no other offering of that form of healthcare is present. Examination of this condition has been incorporated in the method by which the level of the service provision contribution is specified under this policy rule and in the conditions referred to in Article 7.2 and Article 8.2 of this policy rule. This means that, in the assessment as to whether an

service provision contribution is allocated, the question arises as to the costs one must normally incur in order to keep the healthcare available under the conditions referred to in the decree and whether those costs are covered (or can be covered) through the income from the tariffs charged (or to be charged) for that healthcare. If the answer to this is positive, there can usually be no question of an imminent closure. Of course all the conditions referred to in Articles 7.2 and 8.2 of this policy rule must be complied with. These conditions apply cumulatively. Among other things this means that the service provision contribution is only granted if there is force majeure involving the insurer. The service provision contribution intended in this case is thus not intended to compensate for financial problems involving the healthcare provider as a consequence of causes other than those referred to above. The regular continuity policy which envisages that a safety net foundation can be set up by the Minister of Health, Welfare and Sport is intended for such other causes in order to continue the emergency healthcare or acute obstetrics. This is if insurers are not in a position to ensure this under their duty of care due to force majeure.

The minister has also expressed the intention of ending the transitional arrangement under which a number of accident and emergency departments receive a contribution on historic grounds, so that the same regime will apply to all providers.

This policy is intended to bridge the period until the minister has established her policy vision on emergency healthcare. A number of reports have been drawn up, including one by ZN, in which possibilities are outlined as to how emergency healthcare can be organised in the Netherlands. The minister will ultimately have to provide guidelines for this. This policy with regard to emergency healthcare and acute obstetrics will consequently be adjusted at that time.

The minister has created the possibility in the Healthcare Market Regulation Act Service provision contribution Decree of 24 August 2012 for the NZa to allocate an service provision contribution for emergency healthcare and acute obstetrics as of 1 January 2013. In a designation of 12 December 2012 the minister directed the NZa to draw up (policy) legislation for this taking into account the conditions included in the designation.

The policy which the NZa will be implementing for an application for an service provision contribution for emergency healthcare or acute obstetrics has been established in this policy rule

<u>Administrative order on service provision contributions</u>
Under the *Besluit beschikbaarheidbijdrage WMG* [Healthcare Market Regulation Act Service provision contribution Decree] the NZa may from 1 January 2013 award an service provision contribution for emergency healthcare and acute obstetrics. These functions are defined as follows.

Emergency healthcare
This involves healthcare, consisting of the diagnosis, stabilisation and resuscitation of all acute medical patients. Emergency healthcare involves the treatment of emergency disorders and referral to more specialist practitioners. This includes the condition that an accident and emergency department can be reached by ambulance within 45 minutes and has a minimum of one A&E doctor and one A&E nurse 7 x 24 hours.

Acute obstetrics
Obstetric care in the event of an emergency situation. This includes the condition that this care can be accessed by ambulance within 45 minutes and that the required medical specialist treatment can be started within 30 minutes after diagnosis of an emergency situation by a gynaecologist or authorised obstetric professional.[1]

[1] That means that treatment must start a maximum of 75 minutes after an ambulance call by an obstetric professional or gynaecologist.

It is an important point regarding an service provision contribution for emergency healthcare that an accident and emergency department forms an integral part of the hospital and also generates income for that hospital. This income should not be directly linked to the activities in the accident and emergency department. There are no specific A&E DBC healthcare products.

Designation by minister
The administrative order states that the NZa *may* award an service provision contribution for this function. It states who is eligible for a contribution and provides guidance on the level of the contribution.

Emergency healthcare
In the designation the minister linked the following conditions to an award:
'For healthcare providers which received no service provision contribution for this care in 2012, the healthcare authority will provide an service provision contribution exclusively on condition that there is no deterioration in accessibility compared with the present national situation, based on sensitivity to the so-called 45-minute accessibility standard[2] as referred to in Part B, introductory words and (7), of the annex.'
This passage is developed further in the explanatory memorandum to the designation.

'For these healthcare providers the healthcare authority will grant an service provision contribution for A&E healthcare exclusively on condition that there is no deterioration in accessibility compared with the present national situation. In other words: emergency healthcare at that location must be necessary to ensure that the present accessibility situation does not deteriorate.

The so-called 45-minute standard is used to assess the accessibility of hospitals with an accident and emergency department which complies with the present standards of the *Inspectie voor de Gezondheidszorg* [Healthcare Inspectorate]. The standard specifies that everyone must be able to be transported to an accident and emergency department within 45 minutes. The accident and emergency department of a hospital may be necessary for accessibility within 45 minutes in those situations where the closure of the accident and emergency department of that hospital has the consequence that a number of people can no longer be transported to an accident and emergency department within the standard. In brief, if only one resident would no longer be able to reach emergency healthcare within 45 minutes as a result of the closure of the accident and emergency department concerned and this cannot be resolved in some other way, the emergency healthcare provider will be eligible for an service provision contribution. No loss of accessibility will be accepted. In order to bring about this status quo healthcare insurers are encouraged to continue to comply with their duty of care. The healthcare authority can seek a connection with the policy rules on function-based budgeting, such as those which were applicable up to 2011 for the so-called emergency healthcare small scale supplement, when it determines both the level of the service provision contribution and the providers that may be eligible.'

Acute obstetrics
In the designation the minister linked the following conditions to an award of a contribution for acute obstetrics:
'The healthcare authority will provide the service provision contribution exclusively on condition that there is no deterioration in accessibility compared with the present national situation, based on sensitivity to the so-called 45-minute accessibility standard as referred to in Part B, introductory words and (8), of the annex'.
This passage is developed further in the explanatory memorandum to the designation.

'This article makes an service provision contribution possible for obstetric care in the event of an emergency situation. The following conditions apply: that this care is accessible by ambulance within

[2] Under an RIVM analysis of 19 June 2013 eight accident and emergency departments are sensitive to the 45-minute standard.

45 minutes and that the required medical specialist treatment by a gynaecologist or authorised obstetric professional can be started within 30 minutes of the diagnosis of an emergency situation. It goes without saying that it is also a condition for granting an service provision contribution that the income from tariffs which are charged for providing this healthcare is not sufficient to have this form of healthcare available under the conditions referred to above.'

Articles 7.2 and 8.2 Grant criteria

The criteria which apply to the grant are cumulative. This means that if the NZa notes that one of the conditions is not complied with, it need not examine the other criteria.

1. Closure: how specific does the threat of closure have to be?
An important starting point is that the responsibility for the sufficient availability of these two functions lies with the healthcare insurer on the basis of its duty of care. It is consequently primarily up to the healthcare insurer to assess whether the framework conditions set out by the minister are being complied with and whether the imminent closure is real. It will continue to be standard procedure to assess this (both primarily for the insurer and secondarily for the NZa).

In any event it makes sense that a healthcare provider together with the healthcare insurer will make a sufficiently reasonable case that the emergency healthcare or obstetrics facilities is to be closed.

2. Duty of care of the healthcare insurer
Regarding the question as to what the interpretation of the duty of care means for the healthcare insurer, a connection is sought with the Policy Rule on the Continuity of Crucial Care in the event of Force Majeure.[3] There is a point at which it can no longer be realistically expected that the healthcare insurer will find a solution (force majeure). Force majeure involves (as regards services which are insured on a designated care basis) a situation where the insurer can no longer comply with its duty of care with regard to the provision of healthcare. It is a serious and exceptional situation where the insurer can demonstrate that it has done everything possible to ensure the continuity of the healthcare provision concerned but, in spite of this, cannot succeed. What the duty of care precisely means is explained in more detail in the Policy Rule on the Control Framework for the Duty of Care of Healthcare Insurers (Health Insurance Act).[4] Emergency healthcare and acute obstetrics are for that matter also functions which are regarded as forms of crucial care falling under the Policy Rule on the Continuity of Crucial Care in the event of Force Majeure and the Policy Rule on the Continuity of Care Service provision contribution.[5] The latter contribution is intended for specific costs which are incurred by a safety net foundation which has been set up by the Minister of Health, Welfare and Sport in order to continue the provision of crucial care.

A connection is made in the wording of the conditions in Articles 7.2 and 8.2 with what has been stated in the Policy Rule on the Continuity of Crucial Care in the event of Force Majeure concerning the way in which compliance with the duty of care by designated care insurers is examined. Regarding the question as to whether the duty of care cannot be complied with because of force majeure, the NZa examines on the basis of that policy rule whether the care can no longer be provided within the standards applicable to accessibility (such as the 45-minute standard) and whether the insurer has done everything possible to organise the provision of this care to its insured persons, for example through buying in this care elsewhere or providing it itself. We refer to the aforementioned policy rule for further information.

3. 45-minute standard
This standard is specific and relatively simple to examine.

[3] Policy Rule TH/BR-011.
[4] Policy Rule TH/BR-009.
[5] Policy Rule AL/BR-0013.

It is primarily up to the healthcare insurer here to make use of the analysis carried out by the *Rijksinstituut voor Volksgezondheid en Milieu* [RIVM – National Institute for Public Health and the Environment]. The RIVM periodically carries out an analysis and draws up a list, for both emergency healthcare and obstetrics, of the locations which are important for the achievement of this standard.

4. Other solution possible
If a problem arises with the 45-minute standard, the insurer must examine other solutions. This requires an active attitude and role by the healthcare insurer in which the insurer where possible has to organise an alternative for the emergency healthcare or obstetrics facilities concerned through for example creating an extra ambulance stand or concluding specific agreements with the trauma helicopter service and/or surrounding general practitioner clinics. A specific proposal for an alternative requires an analysis as to whether the 45-minute standard is thereby achieved and possibly an examination by the Healthcare Inspectorate as to whether the proposal is a real alternative for the location of emergency healthcare.

Articles 7.3 and 8.3 Level of the service provision contribution

Only if a healthcare insurer has demonstrated on the basis of above criteria that it cannot comply with its duty of care as a result of force majeure can an service provision contribution be provided. The NZa must subsequently determine what the level of that contribution should be. Standardisation of both the costs and income has been chosen in order to prevent as far as possible a subjective determination of the level.

Establishment of the costs of the Accident and Emergency Department
Staff Costs
24/7 availability means that 5.5 A&E doctor FTEs and 5.5 A&E nurse FTEs are needed.
Any unsocial hours bonuses and employer's costs are also included in the salary costs.

Equipment Costs
The NZa uses an equipment/staff ratio of 30 % / 70 %.

Capital Costs
The uplift for capital expenditure is 8.7 %.

Establishment of the A&E income
As the service provision contribution only aims to compensate for any loss, it must be determined what income an accident and emergency department generates. Since no direct declarations are made by the A&E doctor, the income will be determined on a standard basis at EUR 90 per A&E consultation. The following methodology is used to determine this amount.

The part of the healthcare activities within a DBC pathway which are carried out on the day of the A&E consultation is included as income-generating activities for the accident and emergency department.

The principles on the basis of which the level of the service provision contribution is specified (the costs of the accident and emergency department are on the basis of the availability of an A&E doctor) must as far as possible be the same as the principles by which the income in an A&E is estimated (on the income side only that income which the A&E doctor then generates). The system is also non-sensitive to changes in the product structure.

The starting points for the service provision contribution under the administrative order for the A&E function are as follows:
- 24/7 presence of an A&E doctor and A&E nurse
- standard staff/equipment ratio of 70/30
- uplift for capital expenditure of 8.7 %

The starting points for determining the income of the accident and emergency department are then as follows:
- The accommodation function of the hospital (e.g. days of hospitalisation) is not included, but a first aid consultation is included.
- Only activities which can be directly allocated to the action of the A&E doctor / A&E nurse in the accident and emergency department have been included in the determination of the standard income per A&E consultation. The use of a drip or the cleaning of a wound should be included here rather than further diagnostics such as for example performing an MRI scan.

The production figures from DIS 2010 and DIS 2011 are used as a basis. Regular DBC pathways which have arrived at the hospital via the accident and emergency department are identified on the basis of the occurrence of the A&E consultation (code 190015).

Up to 2008 there were about 2.3 million A&E DBCs per annum.
The number of A&E consultations in 2010 and 2011 is on the same scale and the production data used are therefore robust and representative for this purpose.

The average income per A&E consultation is determined in this way for each institution. The national average is EUR 90.04. The distribution of the institution-specific average income per A&E consultation is homogenous (combined variation value = 0.38).

Establishment of the costs of acute obstetrics
Staff Costs
24/7 gynaecologist and/or obstetric professional requires 5.5 FTEs. Any unsocial hours bonuses and employer's costs are also included in the salary costs.

Equipment Costs
The NZa uses an equipment-staff ratio of 30 % / 70 %.

Capital Costs
The uplift for capital expenditure is 8.7 %

Establishment of acute obstetrics income
Income from the obstetrics DBCs. The level per DBC is established on the basis of national average product prices (these are after all free tariffs). Only the part of the care activities within these DBC pathways which is carried out by the gynaecologist / obstetric professional is attributed as income, given as a percentage.

There is a list of the products concerned below with percentages.

care_product_code	care_product_medical_description	total costs profile	costs profile | AC_strict	percentage_strict
150101002	Oper due to extra-uterine pregnancy | Pregn/delivery/childbed miscarriage	EUR 2 300.61	EUR 982.74	42.7 %
150101003	Diagnostic (heavy) / therapeutically slight | Pregn/delivery/childbed miscarriage	EUR 457.28	EUR 47.29	10.3 %
150101004	Clin short | Pregn/delivery/childbed miscarriage	EUR 993.91	EUR 2.23	0.2 %
150101006	(Abortion) curettage | Pregn/delivery/childbed miscarriage	EUR 1 051.66	EUR 416.36	39.6 %
150101007	Day / Outp >2 / routine study >2 | Pregn/delivery/childbed miscarriage	EUR 394.68	EUR -	0.0 %
150101008	Clin (very) long | Pregn/delivery/childbed miscarriage	EUR 12 762.73	EUR 2.83	0.0 %
150101009	Clin medium | Pregn/delivery/childbed miscarriage	EUR 3 987.28	EUR 6.06	0.2 %
150101011	Slight ambulatory | Pregn/delivery/childbed miscarriage	EUR 129.56	EUR -	0.0 %

159899004	Partus with complex OT fluxus treatment | Pregn/delivery/childbed delivery/compl	EUR 8 697.99	EUR 1 794.88	20.6 %
159899007	Caesarean section | Pregn/delivery/childbed delivery/compl	EUR 2 747.70	EUR 863.22	31.4 %
159899008	Post partum complications | day/ Clin cumulatively short | Pregn/delivery/childbed delivery/compl	EUR 881.54	EUR 2.47	0.3 %
159899010	Partus with (manual) placenta removal / oper cervical tear | Pregn/delivery/childbed delivery/compl	EUR 2 530.27	EUR 1 044.05	41.3 %
159899012	Post partum complications | day / Clin cumulatively medium | Pregn/delivery/childbed delivery/compl	EUR 2 744.24	EUR 4.91	0.2 %
159899013	Post partum complications | complex OT fluxus treatment | Pregn/delivery/childbed delivery/compl	EUR 8 900.35	EUR 1 002.91	11.3 %
159899014	Follow-up care spontaneous partus / multiple birth | Pregn/delivery/childbed delivery/compl	EUR 1 804.80	EUR 573.80	31.8 %
159899016	Post partum complications | (manual) placenta removal / oper cervical tear | Pregn/delivery/childbed delivery/compl	EUR 1 522.86	EUR 511.24	33.6 %
159899017	Vaginal assisted delivery | Pregn/delivery/childbed delivery/compl	EUR 1 508.13	EUR 466.12	30.9 %
159899019	Follow-up care spontaneous partus | Pregn/delivery/childbed delivery/compl	EUR 1 390.89	EUR 541.62	38.9 %

Post mortem organ removal

The service provision contribution for post mortem organ removal is compensation for the respective UMCs in respect of the removal surgeons in the designated donor removal teams.

The respective UMCs are compensated for the loss of income as a consequence of the deployment of these removal surgeons. Instead of post mortem organ removal, the UMC would have also been able to deploy the surgeon concerned on income-generating ‘DBC production’.

Explanation of the FTE described in 9.4.
The NZa concludes that in total: 2 FTEs + (0.2 FTE * 2) + (0.09 FTE * 2) + (0.05 * 2) = 2.68 FTEs per removal team are needed in order to have the post mortem organ removal function available on an annual basis.

It is important to note that these 2.68 FTEs are provided by a team of many more removal surgeons who also perform other duties if they have no post mortem organ removal work. In one example: if there is a team of 10 surgeons who provide the post mortem organ removal services, there are 2.68 surgeons who cannot be rostered to work on regular, declarable, services because they are on post mortem organ removal duty. The service provision contribution is intended to compensate the hospital for not being able to deploy 2.68 FTEs on declarable production.

The NZa bases the distribution of the services of the post mortem organ removal care function among the different university hospitals and the accompanying service provision contribution on the information from the application.

The justification which the respective centres supply to the NZa for the establishment of the service provision contribution in year t+1 contains information that the NZa uses. The NZa uses that information amongst other things in order to establish the level of the service provision contribution and to assess the applicable policy for the post mortem organ removal service provision contribution.