[DG COMP/ A3: ref: HT.2807 – NL Legislative texts, ID 2487 to 2491]

(Text applicable from: 25-06-2014)

Decree of 24 August 2012 on the types of healthcare that may be eligible for an availability contribution pursuant to the Healthcare (Market Regulation) Act and some modifications to the Decree on the expansion and restriction of the scope of the Healthcare (Market Regulation) Act (Decision on the Healthcare (Market Regulation) Act availability contribution)

We Beatrix, by the grace of God, Queen of the Netherlands, Princess of Orange-Nassau, etc. etc. etc.

On the recommendation of Our Minister of Health, Welfare and Sport of 7 May 2012, reference MC-U-3115170;
Having regard to Articles 2 and 56a of the Healthcare (Market Regulation) Act and Article 3 of the Health, Welfare and Sport subsidies Framework Act;
Having heard the Divisional recommendation of the Council of State (recommendation of 28 June 2012, number W13.12.0155/III);
In view of the further report by Our Minister of Health, Welfare and Sport of 20 August 2012, reference MC-U-3122338;

Have approved and decreed the following:

Article 1

In this decree the terms below shall be defined as follows:

a. *Our Minister:* the Minister of Health, Welfare and Sport;
b. *act:* Healthcare (Market Regulation) Act;
c. *healthcare authority:* Dutch Healthcare Authority referred to in Article 3 of the act;
d. *availability contribution:* contribution referred to in Article 56a of the act.

Article 2

The healthcare authority shall be permitted to award to a healthcare provider an availability contribution for the provision of types of healthcare described in the annex to this decree.

Article 3

The healthcare authority shall be permitted to award the availability contribution in the form of:

a. compensation for services of general economic interest as referred to in Article 2(1)(b) and (c) of European Commission Decision No 2012/21/EU of 20 December 2011 on the application of Article 106(2) of the TFEU to state aid in the form of compensation for the public service granted to particular undertakings entrusted with the provision of services of general economic interest (OJEU 2012, L 7);
b. compensation for non-economic services of general interest as referred to in Protocol No 26 to the Treaty on the Functioning of the European Union;
c. de minimis aid as referred to in Commission Regulation (EC) No 1998/2006 of 15 December 2006 on the application of Articles 87 and 88 of the Treaty to de minimis aid (OJEU L 379);
d. de minimis aid granted to undertakings performing services of general economic interest as referred to in Commission Regulation (EU) No 360/2012 of 25 April 2012 on the application of Articles 107 and 108 of the Treaty on the Functioning of the European Union (OJEU L 114);
e. individual aid as referred to in Commission Regulation (EC) No 800/2008 of 6 August 2008,

under which specific categories of aid other than ad-hoc aid can be declared to be compatible with the common market pursuant to Articles 87 and 88 of the Treaty (OJEU L 214), or

f. aid other than referred to in parts a to e inclusive.

Article 4

1. The healthcare authority takes a decision to grant an availability contribution for types of healthcare as set out in part A of the annex to this decree, but only once Our Minister has issued a declaration of no objection in this regard.

2. Our Minister shall only be permitted to refrain from giving a declaration of no objection on the grounds of breach of law or general interest.

Article 5

1. Our Minister shall be permitted to designate a healthcare provider that is entrusted to provide a type of care indicated here, as set out in part A of the annex to this decree, under conditions, regulations or restrictions to be laid down by our Minister in this regard.

2. The healthcare authority shall be permitted to designate a healthcare provider that is entrusted to provide a type of care indicated here, as set out in part B of the annex to this decree, under conditions, regulations or restrictions to be laid down by the healthcare authority in this regard.

Article 6

[Amends the Decree on the expansion and restriction of the scope of the Healthcare (Market Regulation) Act.]7 [Deleted as at 14-05-2014]

Article 8

The articles in this decree shall enter into force on a date to be stipulated by Royal Decree; this date may differ for the different articles and parts thereof.

Article 9

This decree is cited as: Decree on the Healthcare (Market Regulation) Act availability contribution.

We order and command that this Decree together with the relevant explanatory memorandum shall be published in the Bulletin of Acts and Decrees.

The Hague, 24 August 2012

Beatrix

The Minister of Health, Welfare and Sport,
E. I. Schippers

Pronounced on the thirteenth of September 2012

The Minister of Security and Justice,
I. W. Opstelten

Annex to Articles 2 and 4 of the Decree on the Healthcare (Market Regulation) Act availability contribution

Part A

Types of care in respect of which, pursuant to Article 4(1) of the Decree on the Healthcare (Market Regulation) Act availability contribution, Our Minister must issue a declaration of no objection before the Dutch Healthcare Authority is able to award an availability contribution:

1. *Care which is subject to the obligation to report,* i.e. care in respect of which the use of horizontal aid measures by the European Commission is not exempted, on the grounds of its jurisdiction derived from Council Regulation No 994/98 (OJEC L 142/1), from advance notification by the Member State to the Commission. This relates to the application of Articles 107 and 108 of the Treaty on the Functioning of the European Union (TFEU) (ex Articles 87 and 88 of the EC Treaty).
2. *Care to be provided by a safety net provider* where the healthcare insurer is no longer able to fulfil its duty of care for reasons of *force majeure*, i.e. a healthcare provider that is founded or co-founded by Our Minister to ensure the continuity of the following types of care:
   a. *Ambulance care:* care aimed at providing assistance to a sick or injured person for this illness or injury and transporting them by ambulance, or providing assistance by way of a paramedic with a specially equipped vehicle that is recognisable as such. In this case, at least 97 per cent of the population has to be able to be reached within a response time of 15 minutes and in at least 95 per cent of urgent calls an ambulance has to be on the scene within 15 minutes of the call being received by the central ambulance service;
   b. *A&E care:* care involving identifying, stabilising and resuscitating all acute medical patients. A&E care involves treating urgent symptoms and referring patients to more highly specialised practitioners. This is subject to the condition that closure of the A&E department will result in an increase in the number of inhabitants in the Netherlands that are unable to reach an A&E department by ambulance within 45 minutes and that this department has at least one A&E doctor and one A&E nurse 24 hours a day;
   c. *acute obstetrics:* emergency obstetric care. This is subject to the condition that closure of the department for acute obstetrics will result in an increase in the number of inhabitants in the Netherlands that are able to reach a department for acute obstetrics by ambulance within 45 minutes and that can receive specialist medical treatment from a gynaecologist or authorised obstetrics professional within 30 minutes[1)] of an emergency situation being identified;
   d. *crisis centre for mental healthcare:* care involving the initial diagnosis, referral and accommodation of patients suffering from an acute psychiatric episode. This is subject to the condition that arrangements are put in place on a regional basis with regard to which healthcare providers will provide mental healthcare in emergency situations;
   e. *healthcare as set out in or pursuant to the Exceptional Medical Expenses Act.*
3. *Healthcare as referred to in the preamble and under 1 and 2, in respect of which a financial solution needs to be found immediately* in the form of an availability contribution to allow this care to be provided pending a decision on the basis of the following procedures:
   a. the procedure set out in Article 34 of the Government Accounts Act 2001 to establish a safety net provider, as referred to in the preamble and under 2;
   b. the procedure set out in Article 56a of the Act to include a type of care in the annex to this decree;
   c. the designation procedure referred to in Article 59 of the preamble and under j, in conjunction with Article 7 of the Act.

Part B

Types of care in respect of which the Dutch Healthcare Authority is able to grant an availability contribution without a declaration of no objection from Our Minister pursuant to Article 4(1) of the Decree on the Healthcare (Market Regulation) Act availability contribution:

1. *Education.* In order to provide care as set out in or pursuant to the Healthcare Insurance Act or the Exceptional Medical Expenses Act, further (medical) education is required. This relates to further education to become a (medical) specialist (by specialism), a GP or a geriatric specialist, a specialist nurse and courses for auxiliary staff.
   a. Further education to train as a (medical) specialist includes:
      1. the 27 recognised medical specialisms, i.e.: anaesthesiology, cardiology, cardio-thoracic surgery, dermatology and venereology, surgery, internal medicine, ear, nose and throat medicine, paediatrics, clinical genetics, clinical geriatrics, lung diseases and tuberculosis, gastric, intestinal and liver diseases, medical microbiology,

1) In life-threatening situations where the pregnant woman has to be transferred from her home to the hospital, no guarantee can be given that treatment will be started within 30 minutes of a potentially life-threatening situation being identified, due to the journey time to the hospital.

neurosurgery, neurology, nuclear medicine, obstetrics and gynaecology, opthalmics, orthopaedics, pathology, plastic surgery, psychiatrics, radiology, radiotherapy, rheumatology, rehabilitation and urology;
2. technical care specialisms, i.e.: clinical chemistry, clinical physics, hospital pharmacy;
3. dental specialisms, i.e.: orthodontics, oral surgery;
4. doctor for the mentally handicapped, A&E doctor, health psychologist, clinical psychologist, psychotherapist, specialist mental health nurse.

b. In the case of further training as a GP or a geriatric specialist, this involves studying to become a GP and studying to become a geriatric specialist.
c. In the case of further education to train as a specialised nurse and auxiliary staff, this involves studying to become:
1. IC nurse, IC neonatal nurse, IC paediatric nurse, paediatric nurse, dialysis nurse, oncology nurse, A&E nurse and obstetrics nurse, hospital hygienist and plaster cast specialist;
2. operating assistant, nurse anaesthetist, radiodiagnostic laboratory assistant, radiotherapeutic laboratory assistant and clinical perfusionist.

2. *Academic care*. This involves top referral care and innovative care, and the development of new forms of diagnosis and treatment. Top referral care is highly specialised patient care associated with specific diagnostics and treatment where all referral options have been exhausted. Top referral care requires an infrastructure within which several disciplines cooperate at the highest level of expertise for the benefit of patient care and which is linked to fundamentally patient-oriented research. Innovation and development involves devising, trying out, systematically testing and distributing new treatments and forms of diagnostic testing. These relate exclusively to forms of innovation and development based on fundamental scientific research. In order to provide top referral and innovative care and to develop new forms of diagnostic testing and treatment, compensation may be required for capital expenses associated with the academic position. These capital expenses cannot be covered by normal rates.
3. *Post mortem organ removal in donors*. This involves specialised surgical activities from the first incision as far as the preparation of the organs and tissues for transportation. These activities are performed by specialist teams that are available 24 hours a day and ensure that bona fide organs are removed;
4. *Care provided by the emergency hospital*. This relates to provision for a war situation or where there is a threat of war, crises with large numbers of victims, accidents abroad involving repatriation, disasters and attacks which exceed the regular capacity and situations in which the Dutch government provides assistance with the medical treatment of foreign victims of accidents abroad. These are all special circumstances which require emergency assistance. The emergency hospital is part of the UMC Utrecht. The emergency hospital receives some funding from the Ministry of Defence budget. Up until 2012, the hospital was also funded as part of the UMCU's job-based budget. As of 2012, this has been replaced by an availability contribution. Agreements have been made with the UMCU regarding the immediate availability of staff for the emergency hospital. This is borne in mind when arranging the schedules of the staff involved;
5. *Trauma care involving coordination, education, training courses and exercises.* This relates to the availability of trauma care in institutions providing specialist medical care. It also involves the development of the knowledge function in order to provide care in the event of disasters, the coordination of the trauma (chain) care and education, training courses and exercises to prepare for disasters. These activities are essential for the provision of proper trauma care;
6. *Trauma care provided by mobile medical teams.* This relates to care provided by mobile medical teams, consisting of a medical specialist (usually an anaesthesiologist or a surgeon/trauma specialist) and a specialist nurse who is able to perform reserved procedures at the scene of an accident as referred to in the Act relating to professional practice in individual healthcare; ambulance staff are not authorised to perform these. This involves:
a. four helicopters with specialist medical teams on standby 24 hours a day that must be able to depart for the scene of an accident within two minutes
b. two vehicles with specialist medical teams available 24 hours a day;
7. *A&E department.* This involves care consisting of the identification, stabilisation and resuscitation of all acute medical patients. The A&E department treats urgent conditions and refers patients to more highly specialised practitioners. This is subject to the condition that the closure of the A&E department will result in an increase in the number of inhabitants in the

Netherlands that are unable to reach an A&E department by ambulance within 45 minutes and that this department has at least one A&E doctor and one A&E nurse available 24 hours a day;

8. *Acute obstetrics.* Emergency obstetric care. It is a condition here that closure of the department for acute obstetrics will increase the number of inhabitants in the Netherlands that can reach a department for acute obstetrics by ambulance within 45 minutes and that can receive specialist medical treatment from a gynaecologist or authorised obstetrics professional within 30 minutes of an emergency situation being identified;
9. *Specialist burns treatment.* This involves treatment in a specially equipped medical centre of burns patients with 2nd to 5th degree burns and critically ill burns patients with 1st degree burns (Recommendation on the establishing of the care availability contribution, Dutch Healthcare Authority, February 2012, page 24). The care is provided by multidisciplinary teams, which each consist of (burns) surgeons, anaesthesiologists/intensive care staff, nurses, rehabilitation experts, psycho-social support and dieticians. Special structural provisions are also required, such as a specially equipped operating theatre, compressed air in nursing departments, isolation chambers, heat canopies and climate control to 28°C;
10. *Specialist psycho-trauma care for specific target groups.* This is third-line psycho-trauma care for war victims, refugees and asylum seekers. This is subject to the condition that the care is provided by a healthcare provider that also holds the national knowledge, research and training position for curative mental healthcare provided to patients who have been traumatised as a result of (systematic) violence or abuse, the particular target groups being war victims, veterans, refugees, asylum seekers and police officers;
11. *Care provided to Jewish war victims.* This involves specific care for Jewish war victims to help them to come to terms with the consequences of the Second World War. This is subject to the condition that the care is provided by a healthcare provider that is specially equipped to provide care to this target group;
12. *Care provided during the transition between funding systems*. In order to ensure that healthcare providers are able to provide care during the transition from one form of funding to another in accordance with an instruction as referred to in Article 59 in conjunction with Article 7 of the Act;
13. *Care provided during the capital expenses transitional scheme.* Changes to the funding of hospitals, for example, is a complex and in-depth operation and also affects the payment of capital expenses. Payment for capital expenses of the financed fixed assets (intangible, tangible and financial fixed assets), based on authorisations granted on the basis of the Care Institutions (Accreditation) Act is ultimately no longer based on a risk-free system of subsequent calculation of the actual costs. The government has therefore provided an extensive transitional scheme. This includes the guarantee scheme for capital expenses. From 2011 to 2016 inclusive, the capital expenses are guaranteed in the budget in decreasing percentages. During this period, hospitals must be deemed able to implement the necessary changes in order to be sufficiently prepared for the final financing arrangements. A transitional scheme for capital expenses can also apply to other establishments, such as for specialist hospitals and establishments for curative mental health care;
14. *Care in respect of which institutions for specialist medical care received an availability contribution for small-scale A&E departments in 2011.* Since 1 January 2012, a number of hospitals have received an A&E department availability contribution. The establishments that received the availability contribution in 2012 received this contribution in accordance with the Interim Decree on the Healthcare (Market Regulation) Act availability contribution which applied in 2012. This interim decree stipulated that only institutions that received an A&E addition in 2011 under the job-based budget were eligible for an A&E availability contribution in 2012. The transitional scheme for the institutions that received an availability contribution in 2012 has been extended once again for 2013 for reasons of due care. This means that these institutions are given the opportunity to adapt their organisation to the new situation and, where necessary, to organise the (acute) care differently;
15. *Care in respect of which an availability contribution has been granted to a healthcare provider for three or more consecutive years and where the criteria for the granting of this contribution are no longer met.* Where healthcare providers have been granted an availability contribution for three or more consecutive years, a phasing-out scheme can be implemented for a maximum of three years in accordance with the provisions in Article 4:51 of the General Administrative Law Act. A phasing-out scheme of this kind gives them the opportunity to adapt their organisation to the new situation and, where necessary, to organise the care differently.

(Text applicable from: 25-06-2014)

Instruction by the Minister of Health, Welfare and Sport of 12 December 2012, MC-U-3147126, in accordance with Article 7 of the Healthcare (Market Regulation) Act, relating to the availability contribution for curative somatic care

The Minister of Health, Welfare and Sport;

Having regard to Article 7 of the Healthcare (Market Regulation) Act;
Having written to both houses of the States General on 25 May 2012 (Parliamentary documents 2011/12, 32 393, No 16) as referred to in Article 8 of the Healthcare (Market Regulation) Act;
Having regard to the report of 29 June 2012 of a written consultation with the House of Representatives of the States General (Parliamentary documents II 2011/2012, 32 393, No 21);

Resolves:

Article 1. Definitions

In this instruction the terms below shall be defined as follows:

a. *minister:* Minister of Health, Welfare and Sport;
b. *act:* Healthcare (Market Regulation) Act;
c. *healthcare authority:* Dutch Healthcare Authority referred to in Article 3 of the Act;
d. *Decree:* Decree on the Healthcare (Market Regulation) Act availability contribution;
e. *annex:* Annex to Articles 2 and 4 of the Decree;
f. *service of general interest:* service of general interest as referred to in Protocol No 26 to the Treaty on the Functioning of the European Union;
g. *service of general economic interest:* service of general economic interest as referred to in Article 2(1), parts b and c, of Commission Decision No 2012/21/EU of 20 December 2011 on the application of Article 106(2) of the TFEU on state aid in the form of compensation for public services, granted to specific undertakings entrusted with the provision of services of general economic interest (OJEU 2012, L 7);
h. *agreement:* agreement for the year 2013 and subsequent years between the State of the Netherlands, represented by the Minister and the Minister of Defence, and the University Medical Centre Utrecht on the emergency hospital provision.

Article 2. Scope

This instruction applies to specialist medical care as referred to in Part B of the preamble and under points 3 to 9, 12 and 13 in the annex.

Article 3. Assignment

The healthcare authority lays down regulations or policy rules in order to implement this instruction.

Article 4. Post mortem organ removal in donors

1. The healthcare authority grants an availability contribution and implements this contribution for care as referred to in part B, preamble and under point 3, of the annex.

2. With regard to the healthcare providers that are entrusted with a service of general interest for this care, the healthcare authority has to use the situation in 2012 as a basis .

Article 5. Care provided by the emergency hospital

1. The healthcare authority grants an availability contribution and implements this contribution for care as referred to in part B, preamble and under point 4, of the annex.

2. The healthcare authority bases the amount of the availability contribution on the share of the financial contribution by the State of the Netherlands that is awarded to the minister in the agreement.

Article 6. Trauma care where this involves coordination, training courses and exercises

1. The healthcare authority provides an availability contribution and implements this contribution for care as referred to in part B, preamble and under point 5, of the annex.

2. With regard to the healthcare providers that are entrusted with a service of general interest in respect of this care, the healthcare authority has to use the situation in 2012 as a basis.

3. The healthcare authority has to use the situation in 2012 as a basis to determine the amount of the availability contribution.

Article 7. Trauma care provided by mobile medical teams

The healthcare authority provides an availability contribution and implements this contribution for care as referred to in part B, preamble and under point 6, of the annex.

Article 8. A&E care

1. The healthcare authority provides an availability contribution that is intended for care as referred to in part B, preamble and under point 7, of the annex.

2. For the healthcare providers that received an availability contribution for this care in 2012 and that will continue to receive this contribution in 2013, the healthcare authority bases this contribution on the level of the availability contribution in 2012.

3. For healthcare providers that did not receive an availability contribution for this care in 2012, the healthcare authority shall only provide an availability contribution on the condition that this contribution will not result in a deterioration in availability compared with the current situation nationally, with the so-called 45-minute availability standard being complied with as referred to in part B, preamble and under point 7, of the annex.

Article 9. Acute obstetrics

1. The healthcare authority provides an availability contribution that is intended for care as referred to in part B, preamble and under point 8, of the annex.

2. The healthcare authority shall only grant the availability contribution on the condition that this contribution will not result in a deterioration in availability compared with the current situation nationally, with the so-called 45-minute availability standard being met as referred to in part B, preamble and under point 8, of the annex.

Article 10. Specialist burns care

The healthcare authority provides an availability contribution that is intended for care as referred to in part B, preamble and under point 9, of the annex.

Article 11. Care provided during the transition to the funding system for curative somatic care

The healthcare authority provides an availability contribution and implements this contribution for care as referred to in part B, preamble and under point 12, of the annex for general, academic and specialist institutions for specialist medical care where the transitional scheme contains an instruction for that purpose as referred to in Article 7 of the act.

Article 12. Care provided during the transitional scheme for capital expenses

The healthcare authority grants an availability contribution that is intended for care as referred to in part B, preamble and under point 13, of the annex for general, academic and specialist institutions for specialist medical care where the transitional scheme contains an instruction for that purpose as referred to in Article 7 of the act.

This instruction will be published in the Government Gazette, with full details being provided.

The Minister for Health, Welfare and Sport,
E.I. Schippers.

(Text applicable from: 25-06-2014)

Instruction by the Minister of Health, Welfare and Sport of 19 November 2013, 168229-112943-MC, in accordance with Article 7 of the Healthcare (Market Regulation) Act on the subject of the extension of the availability contribution and the special Mental Healthcare Association transitional model

The Minister of Health, Welfare and Sport,

Having regard to Article 7 of the Healthcare (Market Regulation) Act,
Having written to both houses of the States General on 27 September 2013 (Parliamentary documents II 2012/13, 25 424 No 231) as referred to in Article 8 of the Healthcare (Market Regulation) Act,

Resolves:

Article 1. Extension of the transitional model

The Dutch Healthcare Authority makes provision to extend the transitional regime regarding curative mental healthcare provision for specialist institutions, as referred to in the instruction of 11 July 2012 on a performance-based pricing system for medical mental healthcare (Government Gazette 2012, 15569), until 31 December 2014, with the amount paid out in 2014 being determined on the basis of the amount paid out in 2013, plus indexation.

Article 2. Extension of the availability contribution

The Dutch Healthcare Authority will ensure that the availability contribution is awarded, mutatis mutandis, in 2014 for specialist psycho-trauma care for specific target groups and care for Jewish war victims, as referred to in the instruction of 11 July 2012 on the introduction of a performance-based pricing system for medical mental healthcare. The level of the availability contribution will be equal to the 2013 contribution, plus indexation.

This instruction will be published in the Government Gazette.

The Minister of Health, Welfare and Sport,
E.I. Schippers

(Text applicable from: 25-06-2014)

Instruction by the Minister of Health, Welfare and Sport of 11 December 2012, MC-U-3146776, in accordance with Article 7 of the Healthcare (Market Regulation) Act, on the subject of the availability contribution for academic care

The Minister of Health, Welfare and Sport;

Having regard to Article 7 of the Healthcare (Market Regulation) Act;
Having written to both houses of the States General on 25 May 2012 (Parliamentary documents II 2011/12, 32 393, No 16) as referred to in Article 8 of the Healthcare (Market Regulation) Act on the use of the availability contribution instrument for curative somatic care, including academic care;
Having regard to the report of 29 June 2012 of a written consultation procedure with the House of Representatives of the States General (Parliamentary documents II 2011/2012, 32 393, No 21); and
Having written to both houses of the States General on 24 October 2012 as referred to in Article 8 of the Healthcare (Market Regulation) Act, on the use of the availability contribution instrument to fund capital expenses for academic care (Parliamentary documents II 2012/13, 32 393, No 25);
Having regard to the input of the Standing Committee of Health, Welfare and Sport for the report of a written consultation on the letter dated 24 October 2012;

Resolves:

Article 1. Definitions

In this instruction the terms below shall be defined as follows:

a. *minister:* Minister of health, Welfare and Sport;
b. *act:* Healthcare (Market Regulation) Act;
c. *healthcare authority:* Dutch Healthcare Authority, as mentioned in Article 3 of the act;
d. *recommendation:* recommendation made by the healthcare authority to the minister on 20 July 2012 on the subject of capital expenses incurred by university medical centres, reference TURS/djon/TSZ/9039;
e. *Decree:* Decree on the Healthcare (Market Regulation) Act availability contribution;
f. *annex:* annex to Articles 2 and 4 of the Decree;
g. *academic care:* care as referred to in part B, preamble and under point 2, of the annex;
h. *service of general interest:* service of general interest as referred to in Protocol No 26 to the Treaty on the Functioning of the European Union;
i. *PBA funds:* funds provided in the context of the regulations for the Planning system for the Building Volume of Academic hospitals;
j. *agreement:* agreement on the Decentralisation of the Accommodation for Academic Hospitals;
k. *exceptional capital expenses:* expenses arising from the finalisation of decrees by the minister in relation to capital expenses incurred by providers of academic care, taken during the course of the Subsidy scheme for academic positions and the preceding period in which academic positions were financed using the fund created by healthcare insurers in 2005, in which a fixed contribution was paid by healthcare insurers on a voluntary basis for each insured party for the benefit of academic positions.

Article 2. Scope

This instruction applies to academic care.

Article 3. Assignment

The healthcare authority shall lay down regulations or policy rules in order to implement this instruction in a timely manner before 1 January 2013.

Article 4. Academic care

1. The healthcare authority shall provide an availability contribution, this contribution being intended to provide compensation for the provision of a service of general interest for academic care.

2. In order to establish the amount of the availability contribution and with regard to healthcare providers entrusted with the service of general interest, the healthcare authority has to base its calculation on the situation in 2012, provided that when awarding the availability contribution it takes into account the deduction of €10 million for academic care, as included in the commentary to the budget laid down by the Ministry of Health, Welfare and Sport for 2012.

Article 5. Capital expenses associated with academic care

1. The healthcare authority provides an availability contribution and implements this contribution for capital expenses associated with academic care on the basis of the proposal contained in the recommendation, provided that it establishes the availability contribution in its official capacity, uses a normative approach, takes account of the PBA funds and limits the option to set aside for the purpose for which an availability contribution for capital expenses is granted to a maximum period of four years.

2. The healthcare authority must use the situation in 2012 as a basis for those healthcare providers that are eligible for an availability contribution for capital expenses.

3. As regards the amount of the availability contribution, the healthcare authority must use as a basis the proportion of the capital expenses for academic care that is allocated to the minister in the agreement, also taking into account the deduction of €10 million for academic care, as included in the commentary to the budget laid down by the Ministry of Health, Welfare and Sport for 2012.

Article 6. Exceptional capital expenses of academic care providers

1. The healthcare authority provides an availability contribution and implements this contribution to cover exceptional capital expenses.

2. When it comes to academic care providers that may be eligible for an availability contribution as referred to in paragraph 1, the healthcare authority must use the minister's decisions on exceptional capital expenses as a basis.

This instruction will be published in the Government Gazette, with full details being provided.

The Minister of Health, Welfare and Sport,
E.I. Schippers.

(Text applicable from: 25-06-2014)

Instruction of the Minister of Health, Welfare and Sport of 21 December 2011, No MC-3098541, in accordance with Article 7 of the Healthcare (Market Regulation) Act, on the 2012 availability contribution

The Minister of Health, Welfare and Sport,

Having regard to Articles 7 and 59 of the Healthcare (Market Regulation) Act;
Having written to both houses of the States General on 22 November 2011 (Parliamentary documents II 2010/11, 32 620, No 33) as referred to in Article 8 of the Healthcare (Market Regulation) Act on the proposals relating to the use of the availability contribution instrument in the introduction of a performance-based pricing system for specialist medical care;
Having regard to the brief notes of the Senate of the States General of 6 December 2011, reference 43547/WB;
Having regard to the general consultation with the House of Representatives of the States General on 21 December 2011;

Resolves:

Article 1. Definitions

In this instruction the terms below shall be defined as follows:

a. *minister:* the Minister of Health, Welfare and Sport;
b. *act:* the Healthcare (Market Regulation) Act;
c. *healthcare authority:* the Dutch Healthcare Authority, as referred to in Article 3 of the act;
d. *Interim decree:* Interim decree on the Healthcare (Market Regulation) Act availability contribution (Bulletin of Acts and Decrees 2011, 589);
e. *Instruction on the transitional model:* Instruction on the transitional model for the performance-based pricing system for specialist medical care 2012 of 29 July 2011 (Government Gazette 2011, 13950);
f. *compensation for services of general economic interest:* compensation for services of general economic interest as referred to in Article 2(1)(b) of Commission Decision No 2005/842/EC of 28 November 2005 on the application of Article 86(2) of the EC Treaty on state aid in the form of compensation for public services which is awarded to particular undertakings entrusted with the management of services of general economic interest (OJEU L 312);
g. *compensation for non-economic services of general interest:* compensation for non-economic services of general interest as referred to in Protocol No 26 to the Treaty on the Functioning of the European Union.

Article 2. Scope

This instruction applies to specialist medical care as referred to in Articles 2 and 4 of the Interim decree.

Article 3. Implementation

In order to implement this instruction, the healthcare authority will, where necessary, lay down regulations and policy rules once the proposal submitted by Royal Decree on 25 May 2010 to amend the Healthcare (Market Regulation) Act and a number of other laws in connection with the supplementation with instruments for funding has been adopted and has entered into force and once the Interim decree has entered into force.

Article 4. Entrusting healthcare providers

The healthcare authority shall only entrust healthcare providers that are entitled to an offset amount as referred to in Article 7(2) of the Instruction on the transitional model with the provision of the type of care mentioned in Article 4 of the Interim decree.

Article 5. Form in which the availability contribution is granted

1. The healthcare authority awards the availability contribution for academic care, burns care, A&E care and trauma care as referred to in Article 2 of the Interim decree in the form of compensation for services of general economic interest.

2. The healthcare authority awards the availability contribution for post mortem organ retrieval in donors and care provided by the emergency hospital as referred to in Article 2 of the Interim decree in the form of compensation for non-economic services of general importance.

3. The healthcare authority awards the availability contribution for the provision of specialist medical care in the transition from job-based funding to performance-based funding as referred to in Article 4 of the Interim decree in the form of compensation for services of general economic interest.

Article 6. The amount of the availability contribution

1. The healthcare authority calculates the amount of the 2012 availability contribution for the types of care listed in Article 2 of the Interim decree, in accordance with the calculation method and parameters applicable in 2011, with the proviso that for academic care there is a reduction of €10 million compared with the amount that was available for this care in 2011.

2. The healthcare authority calculates the level of the availability contribution for care as referred to in Article 4 of the Interim decree, with application of Articles 4 to 7 inclusive of the Instruction relating to the transitional model.

Article 7. Granting method and determination of the availability contribution

1. The healthcare authority ensures that for care as referred to in Article 2 of the Interim decree, its policy regulations state that availability contributions are determined and granted ex officio. When granting the availability contribution, the healthcare authority does so by way of monthly advances.

2. The healthcare authority ensures that for care as provided for in Article 4 of the Interim decree, its policy regulations state that it implements the availability contribution ex officio in accordance with the provisions of Articles 4 to 7 inclusive of the Instruction on the transitional model. The availability contribution is awarded at the request of a healthcare provider. The healthcare authority arranges for the contribution to be paid by way of monthly advances from the time of the request, provided that the advance funding does not exceed 15 % of the job-based budget for 2011.

This instruction will be published in the Government Gazette, with full details being provided.

The Minister of Health, Welfare and Sport,
E.I. Schippers