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LEGAL AND ECONOMIC ASPECTS OF HEALTHCARE SYSTEMS IN THE NETHERLANDS AND LUXEMBOURG

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1. INTRODUCTION

Healthcare systems in the Netherlands and Luxembourg belong to the twelve most effective health systems in Europe. The other ones operate in Austria, Belgium, Denmark, Finland, France, Germany, Norway, Sweden, Switzerland and the United Kingdom. Scores being received by different criteria prove those countries' positions. Among the criteria, there are: patient rights and information (patient organizations involved in decision-making, the right to a second medical opinion, access to own medical record, registry of *bona fide* doctors, web or twenty-four-hour and seven-day telephone health consultant information, a possibility of seeking cross-border care, the catalogue of providers with quality ranking, e-accessible patient records, online booking of appointments and e-prescriptions, accessibility (family doctor same-day access, direct access to a specialist, major elective surgery in less than ninety days, cancer therapy in less than twenty-one days, CT scan in less than seven days, waiting time for paediatric psychiatry), outcomes (thirty-day case fatality for AMI, thirty-day case fatality for stroke, infant deaths, cancer survival, deaths before sixty-five years of age, MRSA infections, abortion rates, suicide rates, diabetes patients with HbA1c higher than seven), range and reach of services provided (equity of healthcare systems, cataract operations per one hundred thousand people sixty-five and more years old, kidney transplants per million population, dental care including in public healthcare, informal payments to doctors, long-term care for the elderly, percentage of dialysis done outside of a clinic, caesarean sections),

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prevention (infant eight-disease vaccination, blood pressure, smoking prevention, alcohol, physical activity, HPV vaccination, traffic deaths) and pharmaceuticals (Rx subsidy, novel cancer drugs deployment rate, access to new drugs, arthritis drugs, statin use, antibiotics per capita).[1]

The criteria include also access, health status, resilience, innovation, quality and other ones, where "Access is the extent to which medicines, treatments, diagnostics or other technologies can be accessed by the people who need them. Health Status evaluates the population's actual health status and outcomes. Resilience considers the ability of a health system to meet the population's needs in the future and the resources which ensure adaptability to innovation. Innovation assesses investments in developing new transformative medicines, treatments or technologies by both the responsible authorities and the private sector. Quality measures the strength of healthcare delivery, taking into consideration the methods of implementation of healthcare solutions."[2]

According to international comparisons, the healthcare system in the Netherlands is more effective than that in Luxembourg.[3] The outcomes of both systems distinguish the first one. The Netherlands, for example, has low antibiotic use, the small number of avoidable hospitalisations and low avoidable mortality.[4] Measuring by results, nearly year by year the Netherlands finds itself at the first position in the group of countries with the most effective healthcare systems in Europe, while Luxemburg is usually in the middle of the ranking.

2. LEGAL REGULATION OF HEALTHCARE IN THE NETHERLANDS

The most complex regulations of healthcare system in the Netherlands were introduced on 1 January 2006 by the Health Insurance Act (*Zorgverzekeringswet*).[5] According to the Act, the whole structure of the system and its regulatory mechanisms have been changed. The government resigned from substantial amount of its controlling role and its responsibilities were passed on to insurers, providers and patients. New agencies of a watchdog nature were established with their tasks to prevent improper healthcare market effects of the reform. The transfer of responsibilities to the municipalities resulted in diversified care arrangements. Self-regulation, always present in the Dutch healthcare system, increased. Professional organizations strengthened their involvement in periodic improvement and quality increase of the system.

The regulated market system does not mean central planning. Although institutions are licensed by the government, they make plans and investments

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[1] A. Bjornberg, A. Yung Phang, *Euro Health Consumer Index 2018*, The Health Consumer Powerhouse, 2019.

[2] *The Sustainability Index 2018*, Future Proofing Healthcare, 2018, https://futureproofing healthcare.com/sustainability-index (accessed on 17/06/2019).

[3] *Ibid.*

[4] M. Kroneman et al., *Health Systems in Transition. Netherlands Health System Review 2016*, European Observatory on Health Systems and Policies Vol. 18, No. 2, 2016.

[5] *Ibid.*

decisions by themselves. The only area strictly controlled by the government is the number of persons working in the healthcare. It decides on the income of medical students and the volume of training of other medical specialists based on forecasts and plans. Municipalities with their public health departments supervise the health of their inhabitants at local level.[6]

In 2014 Public Health Status and Forecasts Act (*Volksgezondheid Toekomost Verkenning*, VTV) added four most important general challenges for the healthcare system in the Netherlands:

– keeping people healthy as long as possible and bring people who are ill to good health;
– supporting handicapped and vulnerable people and strengthening their social links;
– stimulating autonomy and freedom of decisions;
– maintaining affordable healthcare.

The government usually formulates in its health budget priorities for shorter time frames. In 2016 it expressed the following aims to be achieved:

– such modifications in the health sector which will be visible for the people (including responsive services and better information to enable citizens to make choices);
– such amendment in pharmaceutical policy which will restrain costs and improve quality, especially for new expensive drugs;
– better quality of service to patients in nursing homes (more day care, better prepared employees);
– stimulation of health insurers to provide a better offer for chronically ill and vulnerable people;
– less bureaucracy in the healthcare institutions and fewer regulations;
– reducing antibiotic resistance in the Netherlands and in whole Europe (by the national plan for the years 2015-2019 and by activities in the European Union);
– incentives for bigger information and research work on dementia (by the national plan for dementia);
– stimulation of electronic applications with reference to healthcare.[7]

The actual activity of the Dutch Ministry of Health, Welfare and Sport is limited to the following items:

– setting public health targets;
– preparing the country health budget;
– accepting the content of the basic health insurance package;
– deciding on the level of prices for services which are not freely negotiable;
– facilitating the healthcare market for its participants (for example with information);
– general supervision of the healthcare markets.[8]

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[6] *Polska i Holandia – Zdrowe relacje. Ocena możliwości poprawy działania systemów ochrony zdrowia dzięki wzajemnej wymianie doświadczeń*, Netherlands-Polish Chamber of Commerce, 2017.

[7] M. Kroneman et al., *Health Systems in Transition…*, 2016.

[8] *Ibid*.

The Netherlands instead has a group of institutions which support and advice on healthcare policies and self-control the system in various dimensions. Some of them play an advisory role, other supervise the system and still others self-regulate it. The most important institution called the Health Council (*Gezondheidsraad*) has substantial influence on the evolution of health policy. It advises the Minister of Health, Welfare and Sport. Following its recommendations in 2013, the government, for example, introduced a national cancer screening programme. Among other authoritative advice in 2015 the Health Council formulated also its recommendations on healthy food.

The other main institutions in the Dutch healthcare system are the Council for Public Health and Society (RVS) and the Dutch Healthcare Authority (NZa). The first one advises the Minister on the societal aspects of healthcare and the other (among other functions) supervises the compliance of activities of insurers with the Health Insurance Act (ZVW) and the Healthcare Market Regulation Act (Wmg). It is worth mentioning also the substantial role of the Dutch National Healthcare Institute (*Zorginstituut Nederland*) and its part: the Quality Institute for Care (*Kwaliteitsininstituut voor de Zorg*). They conduct research and advise the Ministry of Health, Welfare and Sport on possible medical innovations and guard the quality, accessibility and affordability of the whole healthcare system.

In the Netherlands also various more specialised institutions operate advising, supervising and self-regulating the system. Among them there are the Capacity Body (*Capaciteitsorgaan*) which advises the Minster on workforce planning, the Medicines Evaluation Board (CBG), the National Institute for Public Health and the Environment (RIVM), the Healthcare Inspectorate (IGZ), the Netherlands Pharmacovigilance Centre Lareb (*Bijwerkingencentrum Lareb*), the Royal Dutch Medical Association (KNMG), the Federation of Medical Specialists (FMS), the Nurses and Carers Netherlands (V&VN), the Regional Vaccination Administration Bodies (*Entadministraties*) and the Regional Support Structures (*Regionale Ondersteuningsstructuren*, ROS). The main actors of the Dutch healthcare system and their roles in it are shown in Table 1.

Apart of the principal legal acts mentioned at the beginning of this part of the article, the health system in the Netherlands is regulated by a bunch of other acts referring to different aspects of healthcare. It is worth mentioning the Long-term Care Act (Wlz), the Healthcare Institutions Admission Act (*Wet Toelating Zorginstellinen*, WTZi), the Act on the Supervision of Insurance Companies (*Wet Toezicht Verzekeringsbedrijf*), the Screening Act (*Wet op het Bevolkingsonderzoek*, WBO), the Quality of Health Facilities Act (*Kwaliteitswet Zorginstellingen*, KZi), the Individual Healthcare Professions Act (*Wet Beroepen in de Individuele Gezondheidszorg*, BIG), the Medical Treatment Agreement Act (*Wet Geneeskundige Behandelovereenkomst*, WGBO), the Act on Quality, Complaints and Disputes in Care (*Wet Kwaliteit, Klachten en Geschillen Zorg*, Wkkgz), the Medical Research Involving Human Subjects Act (*Wet Medisch-Wetenschappelijk Onderzoek*, Wmo), the Organ Donation Act (*Wet Orgaandonatie*, WOD), the Personal Data Protection Act (*Wet Boscherming Persoonsgegevens*, Wbp) and the Dutch Standards (*Nederlandse Normen*, NEN).[9]

[9] M. Kroneman et al., *Health Systems in Transition…*, 2016.

Table 1. Main actors of the Dutch healthcare system and their roles

Category	Actor	Tasks
Government	Central government	Setting public health targets Setting the national healthcare budget Deciding the content of the basic health insurance package Setting tariffs for services that are not subject to free negotiation Deciding capacity in long-term care institutions Facilitating actors in the healthcare market (for example with information) General supervision of the healthcare markets
	Municipality	Supervising the health of local populations Setting local public health targets Setting the budget for social support and domestic care (under the Wmo) Purchasing Wmo care (including counselling, day care, respite care, domestic care and youth mental care)
Advisory	Health Council	Advising the Minister on preventive care and other health issues (scientific)
	Council for Public Health and Society (RVS)	Advising the Minister on the health policy agenda (societal)
	National Healthcare Institute (ZiNL)	Advising the Minister on the content of the basic benefit package Advising on the content of the medicine reimbursement system (GVS) Advising the Minister on the budget for long-term care (Wlz) (also supervision; see below)
	Capacity Body (*Capaciteitsorgaan*)	Advising the Minister on workforce planning for all specialised postgraduate training programmes
	Medicines Evaluation Board (CBG)	Evaluating the safety, efficacy and quality of pharmaceuticals
	Healthcare Inspectorate (IGZ)	Advising the Minister (also supervision; see below)
	Dutch Healthcare Authority (NZa)	Advising the Minister on the definition of negotiable care products and prices of non-negotiable care (also supervision; see below)

Table 1 – continued

Category	Actor	Tasks
Supervision	Dutch Health-care Authority (NZa)	Overseeing and monitoring healthcare markets Promoting transparency among actors
	Healthcare Inspectorate (IGZ)	Inspecting safety and quality of individual and institutional providers Investigating complaints and accidents Supervising quality of care provided under the Health Insurance Act (Zvw) and Long-term Care Act (Wlz)
	National Healthcare Institute (ZinNL)	Supervising the quality, access and affordability of healthcare Regulating defaulters and uninsured people Administering the Health Insurance Fund, including risk adjustment Assessing pharmaceuticals before inclusion in the benefit package
Self-regulation (professional and other)	Royal Dutch Medical Association (KNMG)	Postgraduate medical education Accreditation of medical specialists (including GPs) Promoting professional quality
	Dutch College of GPs (NHG)	Developing clinical guidelines for GPs
	Federation of Medical Specialists (FMS)	Development of guidelines for medical specialists
	Nurses and Carers Netherlands (V&VN)	Keeping a voluntary quality register where nurses and care professionals can file their continuing education and monitor their performance Professional committee for objection and appeal
	Regional Support Structures (ROS)	Funded by the Ministry via capitation payments by health insurers Advising and supporting primary care organizations and professionals towards more integrated care arrangements

Source: M. Kroneman, W. Boerma, M. van den Berg, P. Groenewegen, J. de Jong, E. van Ginneken, *Health Systems in Transition. Netherlands Health System Review 2016*, European Observatory on Health Systems and Policies Vol. 18, No. 2, 2016

The social security systems in the European Union are generally left to the competence of member states. However, the EU can give recommendations to them. For instance, the Netherlands was advised to modernise its long-term care.

The European Union created also the "Together for Health" health strategy which complies with its general Europe 2020 strategy. It stresses that healthy citizens constitute a fundamental condition for sustainable economic growth and prosperity as a whole. The EU authorities maintain that spending additional money for healthcare may increase economic growth. "Health in all policies" is the main motto of the European Union health strategy.

The same principle has been a long distance priority of the World Health Organization. It recommends Whole Government System. According to it, the ministries of health in all member countries and elsewhere should inspire other ministries to promote health goodness and equity.

This is a part of healthcare stewardship activities formulated in 2008 in the Tallinn Charter aiming to strengthen health systems of different countries.[10]

3. ORGANIZATION AND ECONOMICS OF HEALTHCARE IN THE NETHERLANDS

In the last decades of the 20th century, the Netherlands had a non-effective and cost-consuming healthcare system which did not satisfy the country's citizens.

The governments decided to analyse deeply the problem and to solve it. The beginning of systematic research started with W. Dekker Commission which listed the greatest disadvantages of the existing healthcare system. Among them there were too strong interference of the state in the number of the cures paid by the government and their prices which brought lower efficiency, the separate financing of different healthcare sectors which brought difficulties in proper use of flexible treatment and lack of choice of the insurer by the patient (and similar cases). Having identified these weaknesses, the Health Insurance Act was introduced on 1 January 2006.[11] From that time, the Dutch healthcare has been ever better financed.

Now the Netherlands treats healthcare as investment. It maintains that citizens who are in good health produce more goods and higher income improves quality of their life and prosperity of the nation as a whole.[12] Such approach to the health issue (being in line with the EU recommendations) makes the country's health spending as a share of GDP among the highest in the European Union. It amounted to 10.5% in 2016[13] and, according to the other sources, reached even 13.3% in 2017 and was highest in the EU.[14] Consequently (what has been mentioned at the beginning of this article), for some time the Dutch healthcare system has been the most effective in the EU nearly every year.

All inhabitants of the Netherlands are entitled to the integrated complex package of basic treatment and cures, which is paid for and delivered by public or private insurers and suppliers. There is full competition among insurers and suppliers. Each

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10 *Ibid.*

11 *Polska i Holandia – Zdrowe relacje…*

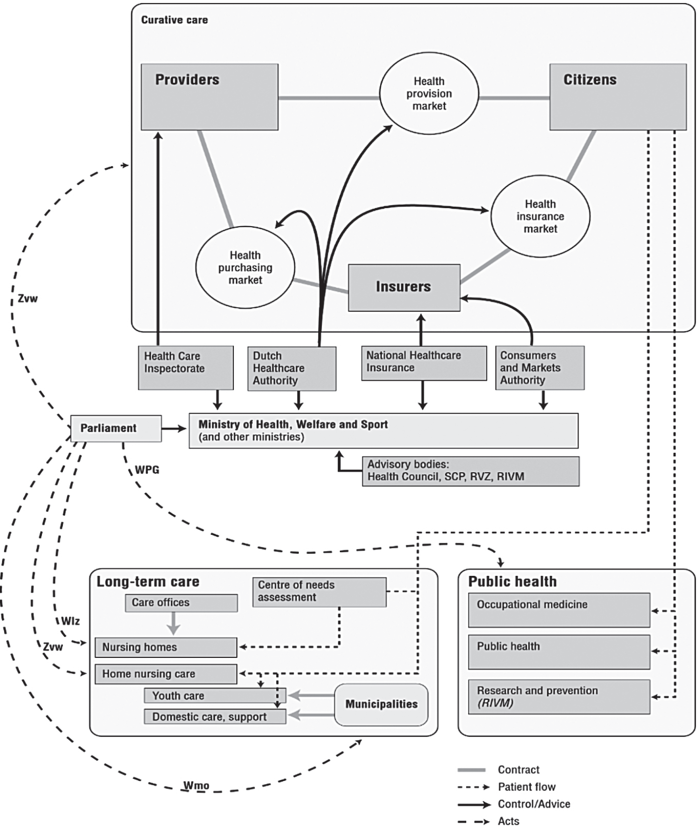
12 *Ibid.*

13 *OECD Health Statistics 2017 (2018)*, WHO Global Health Expenditure Database.

14 https://*www*.statista.com/statistics/576000/total-health-expenditure-as-share-of-gdp-in-the-netherlands/.

citizen signs an insurance agreement with a freely chosen insurance entity, pays part of the subscription (ca. Euro 1,200) and another part of it is paid by the employer and the government. More than 90% of population have additional insurance. Figure 1 shows the organizational overview of the Dutch healthcare system.

Figure 1. Organizational overview of the Dutch healthcare system



Source: M. Kroneman, W. Boerma, M. van den Berg, P. Groenewegen, J. de Jong, E. van Ginneken, *Health Systems in Transition. Netherlands Health System Review 2016*, European Observatory on Health Systems and Policies Vol. 18, No. 2, 2016

4. LEGAL REGULATION OF HEALTHCARE IN LUXEMBOURG

The values and principles of the healthcare system in Luxembourg are contained in the Article Eleven of the Constitution of the Grand Duchy of Luxembourg issued in 1868 and in the Code of Health and the Code of Social Security. The most complex present regulations were in preparation since the middle of the last decade and introduced in 2008. The single national health fund called the National Health Insu-

rance (*Caisse Nationale de Santé*, CNS), merged nine healthcare funds. Its aim was to increase sustainable financing and transparency of the Luxembourg healthcare system and to cope with problems of non-residents, ageing society and increasing costs of services and treatment provided abroad. It was said that it should allocate better the resources and rationalise the purchases of medical services.

According to the next regulation, the Health Reform Law, introduced in 2010 with the aim of continued improvement of the quality and efficiency, the standardised accounting system for hospital services and new electronic health infrastructure were launched. It resulted in establishing of the National Agency for Shared Information in Health which adopted in 2015 the Shared Health Record (*Dossier de Soins Partagé*, DSP). According to it, patients and authorised suppliers of health services receive automatically the information on patients' health condition and treatment history.

Earlier, in 2011, the European Union introduced the Directive which allows patients to calculate different potential treatment options and costs in the country and abroad. Following this Directive, Luxembourg adopted in 2014 the law which guarantees patients access to all available information about their health status, examinations, diagnosis, treatment options and plans to help them make as informed decisions as possible. The institution of Health Mediator which helps in all this was also introduced. Both reforms have led to the personalised medicine which constitutes one of the most current topics.[15]

The most important institutions in the Luxembourg health system are the Ministry of Health and the Ministry of Social Security. The ministries cooperate, take decisions jointly and share responsibility for organization, legislation and financing of the healthcare system. The Ministry of Health (its Health Directorate) is responsible for planning health service provision in the whole country, conducting health studies, preparing surveys, advising public institutions on health issues and supervising health authorities in the country, public health suppliers and non-hospital sector. Another important institutions of the Luxembourg health system are the Luxembourg Institute for Health (LIH), National Health Laboratory (*Laboratoire national de santé*, LNS), the Social Security Medical Review (*Conrôle médical de la sécurité sociale*, CMSS), the Medical-Surgical Mutual Fund (*Caisse médico-chirurgicale mutualiste*, CMCM), the Nomenclature Commission (*Commission de nomenclature*, CN) and the Association of Medical and Dental Doctors (*Association des médecins et médecins-dentistes*, AMMD).[16]

5. ORGANIZATION AND ECONOMICS OF HEALTHCARE IN LUXEMBOURG

Luxembourg has the second highest per capita health spending with purchasing power parity (PPP) among European countries belonging to the World Health Organization. It keeps staying on such a high position for many years and amounted to

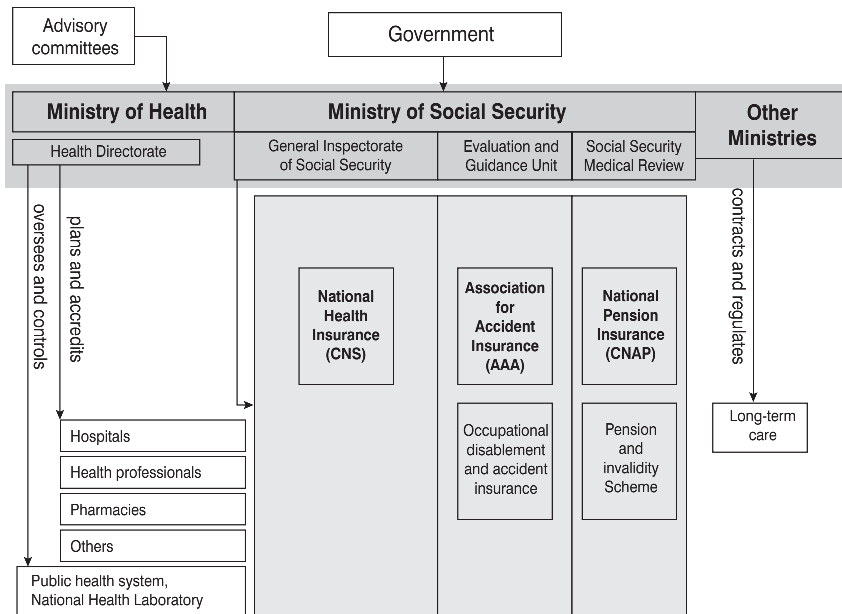
[15] F. Berthet et al., *Health Systems in Transition, HiT in Brief Luxembourg*, European Observatory on Health Systems and Policies, the Government of the Grand Duchy of Luxembourg, 2015.

[16] *Ibid*.

USD 6,475 in 2017.[17] However, compared to neighbouring countries, Luxembourg spends a significantly lower percent of its GDP on healthcare. It is because the country has the highest GDP per capita in Europe.

The main factor of so high per capita spending on healthcare is the limited number of inhabitants in Luxembourg (slightly more than half a million) and connected with it small number of specialised medical institutions. This makes citizens of this country go abroad to receive substantial part of necessary treatment, cures and services and Luxembourg insurers have to pay for it. The problem of increasing costs of services and treatment provided abroad was one of the major considerations that has led to establishing the country health fund: the National Health Insurance (CNS) in 2008 (what has been mentioned in the above section of this article).

Figure 2. Organizational overview of the Luxembourg healthcare system



Source: F. Berthet, A. Calteux, M. Wolter, L. Weber, E. van Ginneken, A. Spranger, *HiT in Brief Luxembourg, Health Systems in Transition*, European Observatory on Health Systems and Policies, the Government of the Grand Duchy of Luxembourg, 2015

The main principles of the health system in Luxembourg consist of the following:
– general access through obligatory social health insurance system (SHI) financed mainly by contributions;
– SHI consisting of three parts (healthcare, accident insurance and long-term care);

[17] *Health Spending Indicator*, OECD 2019 (accessed on 16/06/2019).

- open choice of service suppliers and direct availability of specialist treatment for patients;
- core role for self-employed physicians (authorised by the Ministry of Health and accredited at the CNS; reimbursed pursuant to price lists agreed with the CNS);
- whole country planning of hospital and pharmaceutical sectors by the Ministry of Health.[18]

The financing of the health insurance is done in 40% by the state and in 60% equally by insured persons and employers. The long-term care insurance is covered in 40% by the state, in around 1% by electricity consumers using more than 1 million kW a year and by the insured. The CNS negotiates annual budgets with hospitals (14 hospitals in Luxembourg in 2015) for operating costs and annual tariffs with professional groups, as the already mentioned Association of Medical and Dental Doctors in Luxembourg (AMMD) and with other suppliers of medical services and goods.[19] Figure 2 shows the organizational overview of the Luxembourg healthcare system.

6. CONCLUSIONS

The Netherlands and Luxembourg, two neighbouring countries, have similar but slightly different healthcare systems. In case of these two countries the most important is their size and the level of government intervention in them. The first country, with much bigger population and incomparably greater number of insurers and providers of medical services, relies mostly on home market and great competition among and between them. Additionally, the government does not interfere too much. The other country, due to the limited population, has a small number of hospitals and specialised medical centres, and has to send its citizens abroad to receive substantial amount of medical help. Moreover, it seems that Luxembourg authorities interfere in its health market more than the Dutch ones. As a result, the Dutch healthcare system with moderate expenses is considered to be the most effective (nearly in each consecutive year) in Europe and the Luxembourg one, with the considerably minor effectiveness, is the second most cost consuming (per capita) in Europe.

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LEGAL AND ECONOMIC ASPECTS OF HEALTHCARE SYSTEMS IN THE NETHERLANDS AND LUXEMBOURG

Summary

The article addresses issues related to legal regulations, organization and economics of healthcare systems in the Netherlands and Luxembourg. In order to provide the bird's eye view of these systems, the most important acts introducing them have been presented. Other significant regulations and principal institutions introducing, consulting and self-controlling them have been mentioned. The main economic conditions and organization of healthcare systems in the Netherlands and Luxembourg have been described. The organizational structures of both systems have also been included in the text. The whole analysis aims at delivering preliminary information on how the most effective (nearly in each consecutive year) healthcare system in Europe, the Dutch one, was established and is organized in comparison to one of the most expensive systems (per capita), the Luxembourg one, the effectiveness of which is considerably minor.

Keywords: legal aspects, economic aspects, healthcare system, the Netherlands, Luxembourg

PRAWNE I EKONOMICZNE ASPEKTY SYSTEMU OCHRONY ZDROWIA W HOLANDII I LUKSEMBURGU

Streszczenie

Artykuł porusza zagadnienia związane z regulacjami prawnymi, organizacją i uwarunkowaniami ekonomicznymi systemów ochrony zdrowia w Holandii i Luxemburgu. Aby dostarczyć widok z lotu ptaka na oba te systemy, zostały przedstawione najważniejsze akty prawne wprowadzające je. Zostały także wymienione inne odnoszące się do nich znaczące uregulowania prawne, jak również główne instytucje, tworzące, konsultujące i samokontrolujące je. Zostały ukazane podstawowe warunki ekonomiczne i organizacja obu systemów. W teście znalazły się również ich schematy organizacyjne. Artykuł ma na celu dostarczenie wstępnych informacji o tym, jak powstał i jest zorganizowany najbardziej efektywny w Europie (niemal w każdym kolejnym roku) holenderski system ochrony zdrowia w porównaniu do systemu luksemburskiego, jednego z najdroższych (na jednego mieszkańca), którego efektywność jest znacząco mniejsza.

Słowa kluczowe: prawne aspekty, ekonomiczne aspekty, system ochrony zdrowia, Holandia, Luksemburg

ASPECTOS LEGALES Y ECONÓMICOS DEL SISTEMA DE PROTECCIÓN DE SALUD EN HOLANDA Y LUXEMBURGO

Resumen

El artículo trata de cuestiones relacionadas con la regulación jurídica, organización y condiciones económicas del sistema de protección de salud en Holanda y Luxemburgo. Para tener una vista global de ambos sistemas, el articulo presenta los actos normativos principales, como

otras regulaciones importantes, instituciones principales que los crean, coadyuvan i autocontrolan. También trata de condiciones económicas básicas y organización de ambos sistemas. El texto contiene esquemas de organización. El articulo tiene por objetivo aportar información inicial sobre la constitución y organización del sistema holandés más efectivo en Europa de protección de salud (considerado así casi cada año) en comparación con el sistema luxemburgués, uno de los más caros (por un habitante), cuya efectividad es considerablemente menor.

Palabras claves: aspectos legales, aspectos económicos, sistema de protección de salud, Holanda, Luxemburgo

ПРАВОВЫЕ И ЭКОНОМИЧЕСКИЕ АСПЕКТЫ СИСТЕМЫ ЗДРАВООХРАНЕНИЯ В НИДЕРЛАНДАХ И ЛЮКСЕМБУРГЕ

Резюме

В статье обсуждаются вопросы, связанные с правовым регулированием, организацией и экономическими аспектами функционирования систем здравоохранения в Нидерландах и Люксембурге. Для получения общего представления об обеих системах здравоохранения рассмотрены важнейшие законодательные акты, лежащие в их основе. Также рассмотрены другие значимые нормы законодательства в этой области, основные составные части системы здравоохранения и институты, обеспечивающие контроль и самоконтроль за ее работой. Рассмотрены основные экономические и организационные аспекты обеих систем. В тексте содержатся также схемы организационной структуры рассматриваемых систем здравоохранения. Целью статьи является предоставление базовой информации о том, как создавалась голландская система здравоохранения, которая почти ежегодно признается самой эффективной в Европе, и как она организована. Для сравнения выбрана люксембургская система здравоохранения (одна из наиболее затратных в пересчете на одного жителя), являющаяся гораздо менее эффективной.

Ключевые слова: правовые аспекты, экономические аспекты, система здравоохранения, Нидерланды, Люксембург

RECHTLICHE UND WIRTSCHAFTLICHE ASPEKTE DES GESUNDHEITSSYSTEMS IN DEN NIEDERLANDEN UND LUXEMBURG

Zusammenfassung

Der Artikel befasst sich mit Fragen der gesetzlichen Vorschriften, Organisation und den wirtschaftlichen Gegebenheiten der Gesundheitssysteme in den Niederlanden und Luxemburg. Um einen Überblick über beide Systeme zu geben, werden die wichtigsten, diesen zugrunde liegenden Rechtsakte und die Durchführungsbestimmungen vorgestellt. Es werden auch die anderen, in diesem Bereich anwendbaren gesetzlichen Regelungen angeführt und die wichtigsten Institutionen benannt, von denen die Gesundheitssysteme ausarbeitet, konsultiert und selbstüberwacht werden. Dargestellt werden die wirtschaftlichen Rahmenbedingungen und die Gestaltung beider Systeme. In dem Text sind auch ihre Organisationsstrukturen dargestellt. Der Artikel soll erste Informationen darüber liefern, wie das holländische Gesundheitssystem, das (fast Jahr für Jahr) effizienteste Gesundheitssystem Europas, entstanden und organisiert ist

und einen Vergleich mit dem luxemburgischen Gesundheitswesen bieten, einem der teuersten Systeme (pro Einwohner), dessen Effizienz deutlich geringer ist.

Schlüsselwörter: rechtliche Aspekte, wirtschaftliche Aspekte, Gesundheitssystem, Niederlande, Luxemburg

ASPECTS JURIDIQUES ET ÉCONOMIQUES DU SYSTÈME DE SANTÉ AUX PAYS-BAS ET AU LUXEMBOURG

Résumé

L'article traite de questions liées à la réglementation, à l'organisation et à la situation économique des systèmes de santé aux Pays-Bas et au Luxembourg. Pour donner une vue d'ensemble des deux systèmes, les principaux actes juridiques les introduisant ont été présentés. D'autres réglementations juridiques importantes les concernant ainsi que les principales institutions qui les créent, consultent et contrôlent ont également été mentionnées. Les conditions économiques de base et l'organisation des deux systèmes ont été présentées. Le texte comprend également leurs organigrammes. Cet article vise à fournir des informations préliminaires sur la manière dont le système de santé néerlandais a été créé et organisé de la manière la plus efficace en Europe (presque chaque année suivante) par rapport au système luxembourgeois, l'un des plus coûteux (par habitant), dont l'efficacité est nettement inférieure.

Mots-clés: aspects juridiques, aspects économiques, système de santé, Pays-Bas, Luxembourg

ASPETTI GIURIDICI ED ECONOMICI DEL SISTEMA SANITARIO NEI PAESI BASSI E IN LUSSEMBURGO

Sintesi

L'articolo affronta le questioni legate alle regolamentazioni, all'organizzazione e alle condizioni economiche dei sistemi sanitari dei Paesi Bassi e del Lussemburgo. Per fornire una visione generale di entrambi i sistemi sono stati presentati i loro principali atti giuridici costitutivi. Sono state anche indicate altre significative regolamentazioni giuridiche che vi fanno riferimento, così come le principali istituzioni responsabili della loro creazione, consultazione e autocontrollo. Sono state mostrate le condizioni economiche fondamentali e le organizzazioni di entrambi i sistemi. Il testo contiene anche schemi organizzativi. L'articolo ha lo scopo di fornire informazioni preliminari su come è nato ed è organizzato il sistema sanitario dei Paesi Bassi, il più efficiente in Europa (quasi in ogni anno) confrontandolo con il sistema del Lussemburgo, uno dei più costosi pro capite, e con un'efficienza significativamente minore.

Parole chiave: aspetti giuridici, aspetti economici, sistema sanitario, Paesi Bassi, Lussemburgo

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