Health insurance in the Netherlands
Table of contents

Foreword 5

Introduction 7

1 Health Insurance Act 13
  1.1 Background 14
  1.2 Nature of health insurance 18
  1.3 Persons under obligation to take out health insurance 18
  1.4 Management and administration 20
  1.5 Health insurance agreements and the duty of care 21
  1.6 Care abroad 24
  1.7 Entitlements to care 25
  1.8 Government grants 29
  1.9 Funding 29
  1.10 Risk adjustment 34
  1.11 Management and supervision 41
  1.12 Disputes 44

2 Health Care Allowance Act 47
  2.1 Background 48
  2.2 Purpose of the Act 48
  2.3 Persons with legal entitlements 49
  2.4 Health care allowance entitlement 49
  2.5 Implementation 51
  2.6 Scope and model calculations of the health care allowance 52
  2.7 Guidance and supervision 54
  2.8 Disputes (objections and appeals) 55

3 Exceptional Medical Expenses Act 57
  3.1 Background 58
  3.2 Nature of the insurance scheme 58
  3.3 Insured persons 58
  3.4 Management, administration and contracts between insurers and care providers 59
  3.5 Registration and validation of health care entitlements 60
  3.6 Care under the AWBZ abroad 61
  3.7 Care entitlements under the AWBZ 62
  3.8 Government grants 64
3.9  Funding 64
3.10 Management and supervision 65
3.11 Disputes 65
3.12 Developments in the AWBZ 66

4  International aspects 69
4.1  Background 70
4.2  Guiding principles of international coordination 70
4.3  Obtaining care abroad 71
4.4  Legal proceedings at the European Court of Justice 73
4.5  Treaty countries 74

5  Related legislation 77
5.1  Health Care (Market Regulations) Act 78
5.2  Social Support Act 79
5.3  Chronically Ill and Disabled Persons (Allowances) Act 82
5.4  Personal excess compensation 85
5.5  Consumer Rights in Health Care Act 86

List of abbreviations 88

Acts of Parliament 90
Foreword

The Ministry of Health, Welfare and Sport (VWS) receives questions from the Netherlands and other countries about the insurance of medical expenses in the Netherlands. This booklet entitled “Health Insurance in the Netherlands” goes some way to meeting this information requirement. The text is geared primarily to those with some knowledge of health insurance.

This booklet contains information on the system of health insurance since 1 January 2006 when the Health Insurance Act (Zorgverzekeringswet (Zvw)) came into operation. It also deals with other laws related to health insurance. Certain matters covered in the booklet are the subject of proposed new legislation that Parliament was still discussing at the time of publication.

This booklet is also available in Dutch, French and German. The booklet text can be downloaded from www.rijksoverheid.nl/zorgverzekering

The Hague, March 2011
Introduction

General
While the countries of Europe take a wide range of approaches to organising, structuring, managing and financing health care, these systems share a number of common principles:
• Universal access to care and insurance.
• Solidarity in the distribution of costs.
• Good standard of care.

While considerable similarities exist in policy issues, there are also significant differences in the way countries seek solutions. Each national system was created in its own particular way, with policy influenced by cultural, historic and instrumental factors.

Developments in the Dutch health care system
The Dutch government is committed to maintaining a health care system that provides access to essential medical care of good quality. For many decades, the Netherlands had a fragmented system of health insurance for normal medical care. Until 1 January 2006, a system of compulsory health insurance covered a large section of the Dutch population. Others had to take out private health insurance in which some risk groups were able to obtain a policy offering legally defined, standard coverage. Certain groups of civil servants were covered by special compulsory private health insurance.
This fragmentation ended on 1 January 2006 with the introduction of a single statutory insurance regime that covers all residents of the Netherlands, called the Health Insurance Act (Zvw). The new insurance regime was designed to contribute to the fullest extent possible to the provision of effective, high-quality health care. The new system retains and where possible strengthens some established rights, like the scope for private initiative, a relatively strong private law basis with accompanying financial responsibilities for health insurers and good accessibility.
Features of the health care system
The Dutch health care system has three important features:

1. The health insurance system comprises three compartments:
   - The first compartment: major medical risks (care) provided for in the Exceptional Medical Expenses Act (AWBZ);
   - The second compartment: basic medical care with a view to cure and pursuant to the Zvw;
   - The third compartment: forms of care deemed less essential, covered by supplementary private insurance.
2. The care offered is predominantly of a private nature.
3. The health insurance system comprises a national social insurance (i.e. AWBZ) built on public law, insurance built on private law that incorporates robust guarantees under public law (i.e. Zvw) and supplementary private insurance.

The insurance compartments
The health care systems of other countries in Europe typically distinguish between cover for sickness and maternity on the one hand and industrial accidents and occupational diseases on the other. The medical care insurance required for industrial accidents and occupational diseases is embedded in the Netherlands in insurance schemes that cover the entire population. The Netherlands decided in 1967 to abolish separate insurances for industrial accidents and occupational diseases in order to increase system feasibility and reduce administrative costs. In practice it often proved difficult to determine whether the reason for requiring medical care was work-related or stemmed from the private setting. Disputes regarding this question imposed a heavy burden on both the organisation responsible for implementing care laws and the judiciary.

The first compartment
The AWBZ was introduced in 1968 to insure all residents of the Netherlands against major medical risks. In many cases, this entails chronic disorders which are unaffordable on an individual basis, including home care (with the exception of domestic care), nursing home care, care for the disabled, and long-term mental health care.
The AWBZ is a national insurance in which all residents of the Netherlands are obliged to participate. In addition, since 1 January 2007, domestic care (part of home care) has been arranged via the Social Support Act (Wet maatschappelijke ondersteuning (Wmo)). The Wmo aims to enable everyone to participate in society for as long as possible.

The second compartment
The Zvw consists of legally defined, basic health insurance package of all essential care. An obligation to take out health insurance applies, as does an acceptance obligation and a uniform premium per insurer. The acceptance obligation means no one is excluded based on the state of his or her health or an inability to pay.
The third compartment
The third compartment consists of the voluntary supplementary insurance over and above the Zvw. The cover offered varies per insurer, as does the premium and any personal excess. No acceptance obligation applies to the supplementary insurance.

<table>
<thead>
<tr>
<th>1st compartment</th>
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<tbody>
<tr>
<td>AWBZ</td>
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<tr>
<td>Obligatory national insurance for long-term and unaffordable care</td>
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<tr>
<th>2nd compartment</th>
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<tr>
<td>Zvw</td>
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<tr>
<td>Obligatory basic insurance for essential curative care</td>
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<table>
<thead>
<tr>
<th>3rd compartment</th>
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<tbody>
<tr>
<td>Supplementary insurance</td>
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<td>Voluntary insurance, range of cover</td>
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</tbody>
</table>

Predominantly private nature of care
A characteristic feature of the Dutch health care system is that private companies offer most of the care. Like many other Western European countries, the Netherlands has a long tradition of help and care provided by local and regional voluntary organisations. Some of these organisations have their roots in the Middle Ages. The vast majority of hospitals and care institutions are privately owned. They provide care as independent enterprises and not, as in other European countries, as public sector organisations. Most care institutions continue to provide services on a non-profit basis, whereas individual care providers usually operate with a view to making a profit.

Hybrid insurance under public and private laws
The Zvw is implemented by private companies operating with a view to making a profit. However, Dutch lawmakers have imposed several conditions to safeguard the social nature of the insurance. This has resulted in the Zvw becoming a combination of traditional social insurance and private insurance.
The AWBZ has been set up as traditional social insurance carried out by implementing bodies, which are care insurers that have registered to provide services under the Act. There are plans to modernise this insurance.
The AWBZ has undergone significant change in recent years. The question is how the Act can be carried out as effectively as possible in the longer term. For example, since 1 January 2008, some types of mental care (short-term mental care) have been accommodated in entitlements under the Zvw and have, consequently, been removed from the entitlements under the AWBZ. The transfer of some types of mental care will remove the financial partitions between elements of curative care and will establish greater cohesion.
In addition, the Wmo came into effect on 1 January 2007, which, among other things, transferred responsibility for domestic care previously accommodated in the entitlements under the AWBZ to local authorities.

**Overview of the care sector**

In 2008, 1.220 million worked in the care sector, some on a part-time basis. Approximately 16.5 million of the population of 16.6 million had some form of health insurance on 31 December 2009. The non-insured primarily consists of illegal aliens in the Netherlands and those who have not yet arranged insurance. The homeless are a special group. They were, in principle, covered by social insurance, but failed to register for it. Military personnel and the imprisoned receive medical care from the Ministry of Defence and the Ministry of Security and Justice, respectively. The health insurance system is implemented by around thirty care insurers. While some operate at national level, others only operate in a certain region.

In 2010, expenditure in the care sector in the Netherlands totalled approximately €60 billion\(^1\). The table below shows a breakdown of spending according to principle care sectors\(^2\).

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\(^1\) This is exclusively the supplementary private insurance and personal contributions of insured persons.

\(^2\) Source: National Budget 2011 Health, Welfare and Sport, Budget XVI, p. 188.
### Care expenditure in 2010 in millions of euros, subdivided into sectors

<table>
<thead>
<tr>
<th>Expenditure in the care sector in 2010</th>
<th>€ (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health</td>
<td>102.6</td>
</tr>
<tr>
<td>Health care</td>
<td>34,685.5</td>
</tr>
<tr>
<td>Long-term care</td>
<td>23,552.1</td>
</tr>
<tr>
<td>Social support</td>
<td>180.7</td>
</tr>
<tr>
<td>Nominal costs and contingencies</td>
<td>39.3</td>
</tr>
<tr>
<td>Social Support Act (Wet maatschappelijke ondersteuning (WMO), Municipalities Fund)</td>
<td>1,544.6</td>
</tr>
<tr>
<td>Training funds (VWS budget)</td>
<td>845.0</td>
</tr>
<tr>
<td>Chronically Ill and Disabled Persons (Allowances) Act (VWS budget)</td>
<td>520.4</td>
</tr>
<tr>
<td>Bonaire, Saint Eustatius and Saba (VWS budget)</td>
<td>1.5</td>
</tr>
<tr>
<td>Budget-financed Budgetary Framework for Care expenditure</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>61,472.1</strong></td>
</tr>
</tbody>
</table>

3 Good standard of public health, whereby people lead healthy lives and the exposure to health risks is minimised wherever possible.

4 An effective, innovative care system aimed at achieving an optimal combination of quality, accessibility and affordability for the public.

5 To ensure that people with a long-term or chronic disorder of a physical, mental or psychological nature have access to a good standard of care and that this care is provided at socially acceptable costs.

6 The entire public participates in society.

7 This item is of a technical-administrative nature. Transfers are made from the budget part of this item of wages and price adjustments to the budget’s wages and price-sensitive items. Set tasks or additional resources are assigned to this item, which have not been allocated to other items.

8 The training fund is used to finance, for instance, medical training programmes to become a GP, medical specialist or another care professional.

9 This Act enables the chronically ill and disabled to be paid an allowance for the often excessive costs they face.

10 As a means of financing health insurance on the BES islands (Bonaire, Saint Eustatius and Saba).
1.1 Background

Discussion of the system
The Health Insurance Act (Zvw) came into effect on 1 January 2006, ending a decades-long discussion about abolishing the distinction between private health insurance and compulsory insurance with health funds. In recent years, the discussion had centred on whether the new insurance system should be one under private law with public law features or one under public law with private features. The only difference in legal terms is that private insurance is established by a person and an insurer concluding an agreement with each other. Statutory insurance (i.e. insurance under public law) is established by a person meeting the conditions laid down by law, such as being an employee with an annual salary below a certain level.

Supporters of the private law approach saw the statutory approach as raising the spectre of excessive governmental regulation that would obstruct efficient insurance. Advocates of the statutory approach regarded the private variant as a threat to the solidarity required for social insurance. The discussion was dominated by concerns about the direction a new health insurance system might take. Some feared that insurance organised under public law would over time assume an increasingly statutory nature with all the perceived government involvement. Others feared that insurance organised under private law would ultimately develop into purely private insurance without the solidarity needed for social insurance.

In its second term of office, the coalition government formed by Prime Minister Jan-Peter Balkenende opted for the private approach to health insurance regulated by law, but with strong statutory safeguards. It saw this as the best way of clarifying the division of responsibilities between the government, public and medical insurers. It also considered it a responsible approach because it created social insurance with scope for entrepreneurship in the care sector while embedding the system in a robust legal framework with statutory assurances, amalgamating the social tradition of the health insurance fund and the market tradition of private insurance.

History of plans
Previous attempts at health care reform were all based on a system under public law, the most well-known of which are the Hendriks Plan (1974), Dekker Plan (1987) and Simons Plan (1992), and – ultimately – failed for a variety of reasons. The second Balkenende cabinet agreed in its coalition accord of 16 May 2003 to introduce a compulsory basic insurance for the entire population. In a letter submitted to the Lower House of Parliament on 19 December 2003 (Parliamentary Papers II 2003/04, 23619, no. 20), the Minister of VWS pointed out that health insurance funds and private insurers had converged significantly in recent years. The cabinet considered it a logical step to bring together the different types of insurances in the Netherlands into one broad-based standard insurance package for the entire population to cover the risks of medical care, medicines and medical aids to the same extent as under the health insurance fund system. Social preconditions were attached to this new basic insurance. At the same time, the cabinet aimed to promote effectiveness and freedom of choice. To this end, it declared its preference for risk-bearing insurance provided by private insurance companies.
System under private law
The decision by the second Balkenende cabinet to organise insurance under private law was not without legal complications. In fact, EU directives on non-life insurance prohibit governments from imposing statutory regulations on private insurance in respect of the person they accept, the extent of cover and the premiums payable. This prohibition exists to ensure that insurance companies in Europe compete with each other on an equal footing without one insurer being disadvantaged in relation to another because of government regulations that curtail its freedom of enterprise.

Despite this fact, the Dutch government chose to incorporate statutory safeguards to protect the social nature of health insurance precisely in the fields covered by the EU prohibition on government regulation. Anyone who applies for insurance has to be accepted, and the insurance cover and the associated terms and conditions have to be the same for everyone. An insurer is not permitted to charge the individuals it insures different premiums for the same level of cover. Dutch lawmakers justified this apparent breach of EU rules by invoking the exception clause in Non-life Insurance Directives, which stipulates that the Non-life Insurance Directives do not apply to insurance schemes that fully or partly replace social insurance. The Dutch government considered the exception applicable because the new insurance system replaced the existing health insurance funds. Moreover, the cabinet took the view that – in the final instance – it would be possible to seek recourse to the public interest as justification for departing from EU legal rules.

The deciding factor for the second Balkenende cabinet was a letter from the European Commission dated 25 November 2003. In response to questions raised by the Dutch government, the letter stated that the planned private law embodiment of the new insurance system could be deemed possible under EU law, provided that government regulations did not go beyond what was strictly necessary and did not intervene more than necessary in the insurance market. Another consideration was a trend in jurisprudence at the European Court of Justice, which seemed to indicate that the court drew a less strict dividing line than in the past between the free market on the one hand and social security organised under public law on the other. The European Court of Justice apparently saw scope for assuring the public interest through certain kinds of government interventions in the private market. Based on these facts, the cabinet developed the Act governing social insurance for medical care for the entire population, referred to as the Zvw.

\[11\] See the rulings of the European Court of Justice in the cases Commission-Belgium (C-206/98); Commission-France (C-239/98); Commission-Italy (C-59/01) and Commission-Luxemburg (C346/02).
Health Insurance Act

The Zvw makes it mandatory for everybody who resides or pays payroll tax in the Netherlands to take out health insurance. Every health insurer in the Netherlands that has stated that it will provide services under the Act has a legal obligation to accept everyone who applies for insurance. The Zvw defines insurance cover according to types of care. The care insurer may decide which qualified person or institution will provide the insured care.

The care insurer may also decide whether to provide the insured care to insured persons (i.e. in-kind insurance) or via reimbursement of the costs they incur for care (i.e. reimbursement insurance). In the latter case, the insurer has an obligation to help insured persons find available care if they request such assistance. Insurers are also free to offer some types of care in-kind and other through reimbursement.

A care insurer must offer a health insurance option without personal excess. In addition, the insurer may offer a number of legally defined tranches of voluntary personal excess in exchange for a discount on the premium. The public may choose any insurance option offered by the insurer and is free to change options and insurer from year to year.

A care insurer can offer group insurance participants a discount on the premium and is obliged to indicate in its model agreement whether the group discount applies and – if one or more personal excess options are available – to which it applies. Care insurers are not permitted to base its decision to grant the discount on characteristics of the group or its participants. This could be the case, for example, when only employees can belong to a group.

All insured persons aged 18 and older pay a nominal premium directly to their care insurers and an income-related contribution, which the employer (or state benefits implementing body) deducts from the employee’s wages (or state benefit). The insurer decides the amount of the nominal premium. An obligatory personal excess has applied to the Zvw since 1 January 2008 to replace the no-claim refund scheme, which was a feature of the Zvw during the 2006-2008 period. Under the no-claim refund scheme, care insurers refunded part of the nominal premium paid by those who use little or no care.

Just like the no-claim scheme, the obligatory personal excess only applies to insured persons aged 18 and over. GP care, maternity care, obstetric care and dental care for insured persons under the age of 18 are not subject to the personal excess obligation.

This personal excess does, however, apply to all other forms of care included in the basic health insurance package (i.e. not to forms covered by supplementary insurance). Financial compensation is paid to those who incur care expenses due, for example, to chronic illness or disability and are expected to pay the maximum personal excess structurally over time. This ensures that they do not pay more in terms of obligatory personal excess than an average insured person who receives no compensation. In certain cases, the care insurer is free to decide whether all or part of the costs associated with care will go towards the obligatory personal excess.
The Dutch Tax and Customs Administration (Belastingdienst) levies the income-related contribution. The income-related contributions are deposited in the Health Insurance Fund along with a government contribution equal to the missed nominal premiums of insured persons under the age of 18.

One of the purposes of this fund is to pay insurers amounts related to the degree of risk of those they insure. This is referred to as risk adjustment.

Health Care Allowance Act

The Health Care Allowance Act (Wet op de zorgtoeslag (WZT)) took effect at the same time as the Zvw. Under the WZT, people receive an allowance if the nominal premium is deemed excessive relative to their income. The Dutch Tax and Customs Administration pays out the allowances. The income of a person’s partner is taken into consideration when determining whether somebody qualifies for an allowance.

Abolition of the Zfw, Wtz 1998, MOOZ, civil servant schemes and private insurance

The Social Health Insurance Act (Ziekenfondswet (Zfw)), Medical Insurance (Access) Act 1998 (Wet op de toegang tot ziektekostenverzekeringen 1998 (Wtz 1998)) and Overrepresentation of Elderly Health Insurance Act Beneficiaries (Joint Financing) Act (Wet medefinanciering oververtegenwoordiging oudere ziekenfondsverzekerden (MOOZ)) were revoked on 1 January 2006. As a result, insurance involving health insurance funds and insurance under the Wtz no longer exist.

Private health insurance and public law schemes for health care insurance for civil servants have been discontinued insofar as the insurance cover is comparable to that of the Zvw or of foreign insurance that applies under EU Regulation no. 883/04 of the European Parliament and the Council of 29 April 2004 concerning the coordination of the social security systems (hereinafter referred to as: the Regulation), the European Economic Area (EEA) agreement, the agreement between the European Community and its Member States on the one hand and the Swiss Confederation on the other regarding the free movement of people, or bilateral social security treaties with other countries that include reciprocal arrangements for providing medical care.
1.2 Nature of health insurance

Obligation to take out health insurance
Under the Zvw, all residents of the Netherlands and non-residents who pay payroll tax in the Netherlands are under obligation to take out health insurance with a care insurer. The insurance is not established automatically simply by meeting the criteria, as is the case with insurance cover under the AWBZ because a person must choose an insurer and conclude an insurance agreement. For their part, the care insurers are obligated to accept everyone who applies for insurance.

Legal status under private law
Health insurance is organised under private law. The insurance is established by concluding an insurance agreement. In principle, the government is not involved in the insurance, which is in any event prohibited by EU rules. The Zvw only lays down rules for matters requiring government intervention in proportion to the public interest. This includes imposing an acceptance obligation on insurers, the obligation for them to offer the same insurance option for the same premium, and a statutory definition of the insurance cover. Against these obligations the insurers receive financial adjustment for the services they are required to provide (refer further to Section 1.10). The care insurers are subject to the same rules applicable to the entire insurance market. Consequently, they are considered ‘normal’ private companies permitted to make a profit and subject to the competition laws applicable to enterprises.

Social health insurance
As outlined in the background subsection of this section, the Zvw provides for social health insurance for the entire population, resulting in the direct applicability of the Regulation, the European Economic Area (EEA) agreement, the agreement between the European Community and its Member States on the one hand and the Swiss Confederation on the other regarding the free movement of people, or bilateral social security treaties with other countries that include reciprocal arrangements for providing medical care.

1.3 Persons under obligation to take out health insurance

General rule for obligation to take out health insurance
Those who are compulsorily insured under the AWBZ are under obligation to take out health insurance and include legal residents of the Netherlands or residents of another country who work in the Netherlands and pay payroll tax (see Section 3.3). Many take out their own health insurance, but it is also possible to do it on behalf of someone who is under obligation to take out insurance. For example, a person can take out insurance for his/her partner or children, and an employer can do the same for its personnel. The arrangement
of those who cannot or may not personally conclude an insurance agreement (e.g. minors) must be made by a legal representative, guardian, family member or authorised agent.

**Exemptions from the obligation to take out insurance**

There are two exceptions to the general rule that people compulsorily covered by the AWBZ are obliged to take out insurance under the Zvw.

- **Military personnel**
  First and foremost, this means armed forces on active service. While they are insured under the AWBZ, they do not have to take out insurance under the Zvw. They receive care from the military medical services. This cover applies outside working hours, as well as during deployment in the Netherlands and abroad. The guiding principle is for the Ministry of Defence to provide care on a scale that ensures optimum services under all circumstances to safeguard the health and deployment of members of the armed forces. As this could not be accommodated in the Zvw, military personnel are under no obligation to take out insurance under the Zvw.

- **Conscientious objectors**
  A second exception to the obligation to take out health insurance has been made for conscientious objectors. Those who object to insurance on principle pay no premiums under the AWBZ, nor are they under obligation to take out insurance under the Zvw. However, they do owe the income-related contribution in the form of a substitute tax. This extra tax paid by conscientious objectors is placed on a separate account held with the Health Insurance Board (College voor zorgverzekeringen (CVZ)). A conscientious objector may use the balance to pay for care in a manner in keeping with the cover of the health insurance.

**Suspension of insurance of detainees**

The basic insurance of prison/custodial institution detainees and of those on remand is suspended. Detainees must notify their care insurers of this. The insurance policy will continue to exist, but cannot be used during the period of detention.

As detainees pay no nominal basic insurance premium while detained, they also receive no health care allowance. The Ministry of Security and Justice pays the costs incurred by detainees who require medical care while held at a custodial institution. Any supplementary health insurance will continue to exist during the period of detention. Consequently, detainees have to continue paying the premium unless they ask their care insurer to suspend the supplementary health insurance at the same time as the basic health insurance.
1.4 Management and administration

Private health insurers carry out the provisions of the Zvw. The term ‘care insurers’ is used because the government wants them to act as effective, customer-driven organisers of care for the people they insure. A key objective of social insurance under the Zvw is to enable members of the public to receive the care they need. The care insurers play an important role in fulfilling that objective, which is not limited to paying the costs of the care provided. Above all, they must ensure that the insured are actually able to obtain the care for which they are insured. This duty of care entails the provision of the insured care a person needs (i.e. in-kind insurance) or via the reimbursement of the costs they incur for obtaining the care and, if requested, the undertaking of activities to procure such care or services (i.e. reimbursement insurance). Care insurers are required to establish an accounting system that satisfies the regulations for providing financial adjustment (see also Section 1.10).

A basic principle of social insurance is that the insured can influence the policy of the organisation implementing the insurance. This principle has been embodied in various international treaties ratified by the Netherlands, which set standards for the form and content of social insurance. A care insurer’s articles of association must ensure that the insured possess a reasonable degree of influence over the company’s policy. This approach is in line with the ‘corporate governance’ concept favoured by the Dutch government.

Conditions for implementing the Zvw

Before they are permitted to provide health insurance products, health insurers have to fulfil the following conditions:

- Licence from the Dutch Central Bank
  Health insurers in the Netherlands are not obliged to provide services under the Zvw and are free to choose whether they want to carry out the Zvw’s provisions. Health insurers opting to do so have to hold a licence for the performance of non-life insurance services for the appropriate sectors (i.e. the accidents including industrial accidents and occupational diseases licence and the health licence).
  These licences are issued by the Dutch Central Bank (De Nederlandsche Bank (DNB)) or by a sister regulator of DNB in another EU Member State.

- Registering with the Netherlands Health Care Authority
  Health insurers also have to be registered with the Netherlands Health Care Authority (NZa) to facilitate supervision of the services they provide under the Zvw and to qualify for payments from the adjustment fund.
• Area of activity
A care insurer must provide services and offer health insurance throughout the Netherlands unless it insures fewer than 850,000 people. In that case, the care insurer may confine its area of activity to one or more Dutch provinces in their entirety. The law does not permit care insurers to operate in only part of a province. These conditions are imposed to promote competition between large care insurers, while offering new market entrants the opportunity to establish a footing in a limited area of activity.

1.5 Health insurance agreements and the duty of care
Health insurance must be taken out with a care insurer within four months of establishment of the insurance obligation in order to comply with the law. People are free to conclude an agreement with any care insurer operating in their province of residence. When choosing a care insurer, people will want to take several matters into account, including the form of insurance offered (in-kind or reimbursement), the available tranches of voluntary deductible offered by the care insurer and the associated nominal premiums, and the services available from the insurer. Those under obligation to take out insurance can use initiatives like the website www.kiesBeter.nl, which provides an overview of all care insurers, their terms and conditions, and their range of options.

Supplementary insurance
The insured person can take out supplementary insurance, which is unrelated to health insurance. The government is not permitted to impose any rules on this private insurance other than those in place as part of the DNB’s general supervisory activities of the insurance industry. Supplementary insurance is not subject to an acceptance obligation, nor to compulsory deductible. Moreover, private health insurers determine the scale of the supplementary cover they offer and the level of the premiums.

Ban on cancelling supplementary insurance when changing insurers
A health care insurer is not permitted to cancel the supplementary insurance of someone who has taken out health insurance with another health care insurer.

Penalties for taking out health insurance late
If a person fails to meet the obligation to have insurance or to meet it on time, the individual care insurers will impose a fine on behalf of the CVZ if the person subsequently applies for health insurance. The insured then has to pay a penalty equal to 130% of the nominal premium for the health insurance, payable over the number of months during which the person in question was incorrectly uninsured (subject to a maximum of five years). The costs of care used during the uninsured period are for his or her own account. No penalty will be imposed if a person is not to blame for failing to take out health insurance or if
circumstances justify not doing so. This is the case, for example, if someone suffers from a psychiatric disorder. The amount of the fine can be reduced if it can be demonstrated that it is excessive relative to the exceptional circumstances. During the period of non-insurance, a person obviously has no entitlement to reimbursement of costs incurred for care or to the health care allowance (see Section 2 for more details). However, those under obligation to have insurance will always owe the income-related contribution over salary or equivalent income components, even if no insurance was taken out.

**Acceptance obligation**

Care insurers must accept everyone who is under obligation to take out insurance and respect their choice of insurance. The care insurer is not permitted to differentiate the premium according to personal characteristics, such as age, gender or medical situation. In exchange for meeting this acceptance obligation, insurers receive compensation from the adjustment scheme in order to make up any financial disadvantage incurred (see Section 1.10).

**Term**

An insurance agreement has a term of one calendar year. While the health insurance agreement can be renewed tacitly, the insured is free to choose a different care insurer or different model agreements after one year. He or she must inform the care insurer in good time that the health insurance agreement will not be renewed. Changing care insurers before the end of a calendar year is only permitted if an insurer raises its premiums during the year.

**Policy**

The care insurer is required to issue a care policy every year to every insured person as proof of the existence of the health insurance agreement. The policy sets out the content of the health insurance (in terms of rights and obligations) agreed with the insured.

**Obligation to provide information**

A person who takes out health insurance has a legal obligation to inform the care insurer immediately of all facts and circumstances that may result in termination of the insurance, including, for example, discontinuation of the obligation to have insurance due to a move abroad or an area outside the care insurer’s area of activity. The Zvw stipulates that the insurance will end in circumstances like these. The care insurer also has an obligation to provide information to the people it insures. This applies, for instance, if a change to the insurer’s area of activity means that certain insured persons no longer live in the care insurer’s area of activity.
Duty of care
Making sure that people can obtain the care they need is a key objective of the Zvw. The care insurers play an important role in fulfilling that objective. Their role is not confined to payment of costs. They must also make sure that people are actually able to obtain insured care. This is referred to as the ‘duty of care’.

An insured person is entitled to care in accordance with the following models:

• In kind model
  The care insurer provides the insured care needed by the insured through its own care providers or through contracted care providers. The care provider receives payment directly from the care insurer.
  The insured persons are free to choose from any of the contracted doctors or institutions. If – despite their decision to opt for a policy with contracted care – insured persons want to receive care from a non-contracted care provider, the care insurer will decide the level of cost reimbursement. This offers the care insurer the option of charging on the contracting costs already incurred to the insured person. However, the insurer is not permitted to set the level of reimbursement so low that it in effect makes it impossible to obtain non-contracted care.

• Reimbursement model
  Under the reimbursement model, a person receives care from a care provider with whom the care insurer has no contractual relationship. The insured person pays for the care provided and is reimbursed the costs from the care insurer. The care insurer is not permitted to set a reimbursement maximum, but it is under no obligation to reimburse more than is reasonable according to prevailing market standards in Netherlands. Insured persons are free to choose their care provider. In the reimbursement model, the care insurer must respond to requests for care mediation, which can vary from making a simple telephone call to meeting with a care provider to ensure the insured person receives care.

• Combination of the in-kind and the reimbursement models
  Variations on the models outlined above are possible and include a combination of the in-kind and the reimbursement models whereby the care insurer provides some of the insured types of care through its own or contracted care providers and others under the reimbursement model.

By offering these models, a care insurer is able to tailor its services to the needs and preferences of the people it insures.
1.6 Care abroad

The Zvw provides worldwide cover. No matter where they are in the world, insured persons enjoy the exact same insurance coverage as in the Netherlands (i.e. the Dutch health insurance package under the Dutch terms, conditions and rates).

The rights of an insured person who obtains care under his/her health insurance agreement depend on the type of policy. The rights for the different types of policy are:

• In kind policy
  In principle, those insured under an in-kind policy are required to use care providers contracted by their care insurer in the Netherlands and abroad. As a result, care may be obtained abroad under an in-kind policy, provided the insurer has contracted care providers in the country in question.
  Nevertheless, the law allows those insured under an in-kind policy to go to a non-contracted care provider in the Netherlands or abroad. The consequence of such a decision is that the insured will not be entitled to full reimbursement of the costs incurred for the care received. The insurer is permitted to set the amount of the reimbursement. However, the reimbursement must not be set so low that it would in effect make it impossible to obtain medical care. Before receiving care from a non-contracted care provider in a foreign country, insured persons should verify whether the care is included in the insurance cover of the Zvw.

• Reimbursement policy
  Those insured under a reimbursement policy can use any care provider abroad. It makes no difference whether the care provider is established in an EU/EEA Member State or a treaty country. In such cases, those insured under a reimbursement policy will be entitled to reimbursement of the costs of care obtained. However, this does not necessarily mean that the person will in all instances be reimbursed the full amount of the costs of care incurred. Under the Zww the care insurer is under no obligation to reimburse more than the prevailing market rates payable for comparable care in the Netherlands. When obtaining care in a foreign country, an insured person should check whether the care is included in the insurance cover under the Zvw.

• Combination of reimbursement/in-kind policy
  A care insurer can also offer a combination of both policy models. In that case, the health care policy specifies which model applies to the type of care in question.
Obtaining care under treaty arrangements

The paragraphs above describe a situation in which insured persons obtain care abroad under their health insurance in accordance with the policy model they have chosen. However, they may also obtain care in a treaty country under international social security arrangements. In EU/EEA Member States and Switzerland, any insured person who is entitled to medical care under the Regulation, the EEA agreement, the agreement between the European Community and its Member States on the one hand and the Swiss Confederation on the other can obtain an EHIC from his/her insurer, the presentation of which provides entitlement to essential care. Subject to the foreign insurer’s consent, it is also possible to obtain medical care in the EU, EEA and Switzerland. During temporary stays in other treaty countries, insured persons are entitled to obtain immediate essential medical care under certain conditions. Care obtained in another country under a treaty will be provided under the same terms and conditions applicable to residents of the country concerned. In addition, family members who live abroad of people who work in the Netherlands and those who live abroad and receive a Dutch pension (as well as their family members), but have no health insurance under a retirement pension in their country of residence, can receive medical care abroad that is chargeable to the Dutch insurance system, subject to application of an international arrangement. They will have to pay a treaty contribution to the CVZ (see Section 4).

1.7 Entitlements to care

Cover under the Zvw provides for essential care, as checked against its demonstrable effect, cost effectiveness and need for collective financing. It is necessary to check the insured cover against these criteria from time to time to determine whether certain types of care need to be removed from or indeed added to the health insurance package, with a long-term view to keeping cover affordable.

Functional entitlements

The care system in the Netherlands has been organised in a way to minimise direct government involvement in the provision of care. Within frameworks defined by law, the players in the care field have more freedom of choice, more policy and more decision-making latitude and various incentives for competition. One example is referred to as the ‘functional description’ of the care provided under the insurance cover. The functional description means the government only lays down legal requirements for what entitlements cover (i.e. the content and extent of cover) and when entitlements exist (i.e. medical indications). It is the responsibility of the care insurer to decide who provides the care and where. The insurer must include these arrangements in the care agreements it concludes with care providers. The care agreement must also state any procedural conditions, such as requirements for obtaining consent, referrals and prescriptions. The functional description gives insured persons, care insurers and care providers scope to tailor the insurance cover to fit the contours defined by law. This approach meets the wish of insured
persons, care insurers and care providers for the government to step away from regulating everything centrally. It also offers care insurers the option of offering customised care policies.

**Insurance coverage**

- **Medical care**
  
  Medical care consists of care provided by GPs, medical specialists, clinical psychologists and midwives. This does not necessarily mean that the care has to be provided by these people. Others may provide types of care that are not reserved treatments subject to registration and title protection under the Individual Health Care Professions Act (*Wet op de beroepen in de individuele gezondheidszorg*).
  
  This care includes the associated laboratory tests and nursing. It further includes advice on hereditary diseases, non-clinical haemodialysis, chronically intermittent respiratory treatment and assistance rendered by a thrombosis prevention unit. Equipment used for non-clinical haemodialysis and chronically intermittent respiratory treatment is covered by the rules applicable to medical devices.
  
  Types of care as typically offered by medical specialists may be excluded from reimbursement. Insured persons pay a personal contribution for each session of primary psychological care. It is possible to stipulate that insured persons pay a contribution up to the maximum permitted under the regulations.
  
  Until 2007, mental health care was covered under the AWBZ. Since 1 January 2008, mental health care (including primary psychological care) has been financed under the Zvw.

- **Dyslexia care**
  
  This form of care is related to serious dyslexia suffered by primary school children. Dyslexia causes problems with reading and spelling and becomes apparent at school. The Zvw only reimburses the treatment of serious cases of dyslexia in primary school children. In 2010, treatment has to start at the age of seven, eight or nine. In 2011, the treatment will have to start at the age of seven, eight, nine or ten. This system will be continued until all primary school children are eligible for dyslexia care in 2013.

- **Paramedical care**
  
  Paramedical care includes physiotherapy, remedial therapy, speech therapy, occupational therapy and dietary advice. The entitlement of insured persons aged 18 and older to physiotherapy and remedial therapy is limited to the treatment of certain chronic disorders, excluding the first nine treatments for each disorder. Insured persons younger than 18 are entitled to nine treatment sessions per year for each disorder, which entitlement may be extended by another nine treatments.
  
  Speech therapy must be provided for a medical purpose with the likelihood of recovery or improvement of speech function/capability.
  
  Occupational therapy must be provided with a view to promoting and restoring the self-care and
self-reliance of the insured person up to a maximum of ten treatment hours per year.
For dietary advice, there is an entitlement to reimbursement of up to four hours of treatment per year. The advice must be provided by dieticians and be for medical purposes concerning nutrition and eating habits.

**Oral care**
In addition to regular check-ups, young people under 18 are entitled to fluoride treatment no more than twice annually starting at the age of six and to sealing/periodontal care.
Oral care for insured persons aged 18 and over is limited to specialised surgical dentistry (oral surgery), the associated X-rays and dentures.
People with an exceptional dental disorder, physical/mental disability or special dental problems resulting from medical treatment are entitled to complete dental care (subject to special conditions).

**Pharmaceutical care**
Pharmaceutical care consists of medicines and foods provided for medical purposes. In principle, the medicines are divided into groups of medicines that are therapeutically interchangeable. The maximum reimbursement for such a group is set according to the average price of the medicines in the group. An insured person who chooses a more expensive medicine must pay the difference. There is no reimbursement limit for a medicine included in the cover, which cannot be substituted by other medicines. This system is referred to as the ‘medicines reimbursement system’.
Taking into account the orchestrating role that care insurers play, they are permitted to limit the reimbursable medicines to those they designate in each group. In order to further underscore the role of care insurers, the definition of the care explicitly states that care insurers will designate medicines (subject to conditions).

**Medical devices**
The medical devices covered by the insurance are mainly those that people use at home. The content of the cover varies from personal care items (e.g. incontinence materials and diabetes test strips) to equipment (e.g. hearing aids and orthopaedic footwear).
Insured persons are entitled to efficiently working devices appropriate to their limitations.
Under the Health Insurance Regulations (Regeling zorgverzekering), insured persons do not require the care insurer’s prior consent or guidance from a professional practitioner to obtain medical devices. The Health Insurance Regulations contain no further procedural stipulations, such as rules for the period of use of the medical device, rules for its replacement, modification or repair, or rules for the quantity of devices. Care insurers are permitted to impose further procedural conditions for obtaining medical devices in their insurance regulations. However, the intention is not for insurers to include material conditions in their regulations relating to the establishment of a usage period and the quantities of medical devices. The insurers are authorised to set procedural conditions to allow them to provide insured persons more
customised care.

The Health Insurance Regulations give care insurers the option of providing medical devices on loan or to transfer ownership to the recipient. This stipulation has not been formulated explicitly in the regulations, but is one of the effectiveness criteria a care insurer is required to consider.

The entitlement to medical devices does not cover reimbursement of energy costs like the use of electricity, batteries and chargers. However, the equipment is initially delivered ready for service, complete with any batteries that may be required. The energy costs of certain medical devices eligible for reimbursement will be explicitly stated in the Health Insurance Regulations.

• Accommodation
Accommodation-related costs associated with stays in care institutions considered necessary for the provision of medical care are limited to an entitlement of 365 days. The costs incurred after 365 days are charged to the AWBZ (see Section 3.7). Accommodation under the Zvw includes entitlement to nursing and care, but this does not necessarily have to be provided in a health care institution.

• Maternity care
This concerns care for mother and baby for up to ten days after childbirth.

• Transport of patients
This includes the transport of patients by ambulance, taxi or private car, provided this is medically indicated. The doctor treating the patient is required to issue a transport certificate. The entitlement further includes the costs of public transport in the lowest class to and from a health care institution. In certain cases, the care insurer may agree to special modes of transport like a helicopter.

An insured person is first required to pay a certain amount per 12 months for travel by public transport, taxi or private car. The costs of travel by private car are reimbursed through payment of an amount per kilometre.

The right to transport in a vehicle in which the patient is carried in the normal sitting position is confined to four situations (i.e. kidney dialysis, chemotherapy/radiotherapy, people with a visual impairment who are unable to travel unaccompanied, and wheelchair users). A maximum one-way journey of 200 kilometres applies. Travel over longer distances is permitted for patients who – with the care insurer’s prior consent – receive insured treatment from a health care institution or care provider located farther away (in the Netherlands or abroad).

The insurance includes a hardship clause under which insured persons who do not fall into any of the categories described above nevertheless receive reimbursement. This may be the case, for example, if an insured person requires transport for an extended period to receive treatment for a chronic illness or disorder.
Limitation of entitlements in the event of terrorism
The Zvw limits cover for acts of terrorism to a legally defined maximum that takes into account other types of cover like building insurance.

1.8 Government grants
As grants are awardable only for care or other services to be included in the insurance cover, the Zvw stipulates that the grants are temporary. The CVZ disburses the grants, sometimes in association with health care insurers. The grants are charged to the Health Insurance Fund. The Minister of VWS can impose a cap on each category of grants.

1.9 Funding
The financial resources to cover the costs of health insurance come from nominal premiums, income-related contributions and public funding.

Nominal premium
All insured persons aged 18 and older pay a nominal premium to the care insurer, which is unrelated to the person’s income. Care insurers are free to set their own premiums. Although the premiums for the various available models of insurance agreements may differ, they must be the same for everyone who chooses the same model. For instance, if an insurer offers health insurance under which all care is provided in-kind, everyone who takes that particular insurance model from that insurer will pay the same nominal premium. If the same insurer additionally offers health insurance under the reimbursement model, the nominal premium for that model may be different, but it must be the same for everybody who takes that model from that insurer. The only exception is the possibility under law to conclude group insurance schemes, under which an insurer may offer a premium discount not exceeding 10% of the premium payable for this health insurance option.

The nominal premium provides an incentive for providing effective care in two ways:
• First and foremost, care insurers are able to distinguish themselves from their competitors on the basis of price. The more effectively a care insurer runs its business and purchases care, the more attractive the premiums will be for insured persons.
• In addition, insured persons will become more aware of the costs of care. The intention is to encourage insured persons to adopt a critical stance towards the price and quality of the services provided.
**Income-related contribution**

In addition to the nominal premium, the Zvw is financed by levying an income-related contribution payable by people under legal obligation to take out insurance. Together with the public funding, the income-related contribution covers 50% of the total macro premium burden. The nominal premiums charged cover the remaining 50%. People under obligation to take out insurance owe the income-related contribution on income from current and past paid employment. The Dutch Tax and Customs Administration collects the contributions. Employers withhold the income-related contribution from the part of an employee’s salary that is subject to payroll tax. The state benefits implementing body does the same for those receiving benefits, remitting the contributions to the Dutch Tax and Customs Administration. Those under obligation to take out insurance, but who do not earn income subject to payroll tax, receive an assessment from the Dutch Tax and Customs Administration for their income-related contribution. The Zvw imposes an obligation on employers to reimburse the income-related contribution paid by employees under a statutory obligation to take out insurance. This obligation also applies to certain state benefits implementing bodies. This is the case when those drawing state benefits owe the income-related contribution over certain types of benefits – yet to be designated. Employees pay income tax on this reimbursement.

The employer’s contribution towards the costs is rooted in its responsibility with respect to its employees under civil law for such matters as the costs of medical care necessitated by circumstances arising from their employment. This obligation is not included in Zvw for self-employed persons and retired persons under obligation to take out insurance.

**Children’s premiums and other state disbursements**

The state makes several disbursements under the Zvw to help finance the insurance. The government provides, for instance, funding to defray the costs of the premiums for children aged up to 18. The government also has the option to pay part of the costs arising from such acts of hostility as war or terrorism. Finally, the Zvw also provides for the disbursement of public funding if a care insurer is unable to meet its financial commitments.

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12. The total macro premium burden consists of the income-related contributions, premiums/nominal premiums, personal contributions, government grant for children (under 18) and a number of smaller technical items which cannot easily be defined in the Zvw.
Health Insurance Fund

The income-related contributions and the public funding are paid into the Health Insurance Fund, which is administered by the CVZ. The most important sources of funding are:

- The income-related contributions collected by the Dutch Tax and Customs Administration from insured persons.
- Annual public funding towards the financing of insurance for people under the age of 18.
- The contributions the CVZ receives from people living abroad who are entitled to care under treaties.
- The income the Netherlands receives for foreign nationals in the Netherlands who have entitlements as part of a treaty claim that can be charged to a treaty country.

Care insurers receive payments from the Health Insurance Fund to compensate for any financial disadvantage they incur due to the obligation to accept everyone under obligation to take out insurance (see Section 1.10). The Health Insurance Fund is also used to make payments such as grants and the amounts the Netherlands pays other countries when insured persons or people who have entitlements as part of a treaty claim payable by the Netherlands.

Overview of Zvw financing
Financial consequences for insured persons

The Zvw has other financial consequences for insured persons other than the income-related contribution and nominal premium:

- **Compulsory deductible**
  First, there is a compulsory deductible for insured persons aged 18 and older. Obligatory personal excess does not apply to GP, maternity, obstetric and dental care for insured persons under 18. However, it does apply to all other forms of care in the basic health insurance package. Those who incur structural care expenses over time, for example, due to chronic illness or disability receive financial compensation. As a result, they do not pay more in terms of obligatory personal excess than an average insured person who receives no compensation. In certain cases, the care insurer is free to decide whether all or part of the costs associated with care will go towards the compulsory deductible.

- **Voluntary deductible**
  In addition to obligatory personal excess, the care insurer can offer health insurance options to those who aged 18 or older with a voluntary deductible of €100, €200, €300, €400 or €500 per calendar year. In exchange, a care insurer is required to give the insured person a discount on the premium. This simplifies comparison of the insurance options on offer.

- **Out-of-pocket payments**
  Insured persons may be required to cover part of a bill. This happens when someone takes out an in-kind policy, despite occasionally opting to exercise their legal right to obtain care from a care provider that has not been contracted by their care insurer. In some cases, insured persons must pay a care-related personal contribution for certain medicines and medical devices, as well as for seated patient transport and maternity care.
  Personal contributions payable by an insured person, as outlined in the examples described above, are not taken into account when calculating the insured person’s personal excess.

**Consequences of non-payment**

Insured persons sometimes fail to meet the obligation to pay their nominal premium. Since 2007, people are no longer able to cancel their health insurance if they have a premium payment arrears. This makes it impossible to switch insurers in an attempt to avoid their debts. If someone continues to refuse to pay their premium, the care insurer is entitled to terminate the health insurance. After all, it is an agreement under private law.

Starting on 1 September 2009, measures have been taken to reduce the number of people who do not pay on time or do not pay at all. These measures were primarily taken as any care expenses incurred by insured persons who do not pay premiums have to be born by those who do. This has a detrimental effect on the solidarity on which the social insurance system is based. Another reason is that failure to pay the premium opens the door for their care insurer to cancel the cover and for
becoming uninsured. This can lead to highly undesirable consequences if the uninsured end up needing care.

The Zvw includes the following provisions for tackling non-payment:

- When the insured person is in arrears for an amount equivalent to six months’ premium, the obligation to pay the nominal premium to the care insurer is converted into an obligation to pay the CVZ an administrative premium equal to 130% of the standard premium, as referred to in the Health Care Allowance Act (WZT).
- The CVZ imposes this levy on the defaulter and bears responsibility for its collection.
- As compensation for the – additional – loss of premium, the care insurer receives an amount from the Health Insurance Fund.

In order to increase the success of collecting the funds, the Zvw provides two collection options which private parties – unlike care insurers – do not have:

- The CVZ can instruct employers, state benefits implementing bodies and other organisations that make periodic disbursements to insured persons to withhold the administrative premium from any income and transfer it to the CVZ. This is also referred to as ‘withholding at source’.
- The CVZ can instruct the Dutch Tax and Customs Administration to transfer the health care allowance of the insured person and any partner to it.

Incidentally, the CVZ can also apply standard collection options (i.e. sending a giro payment slip and a reminder if payment is not forthcoming). If the insured person continues to fail to make payment, the CVZ can – without any judicial intervention – have a writ of execution issued and have the policyholder’s possessions seized, paying the administrative premium from the proceeds. The CVZ is responsible for deciding which collection options are used and the sequence of their application.

Consequences of being uninsured (subheading)

Since the introduction of the Zvw on 1 January 2006, everyone under obligation to take out health insurance has to conclude a health insurance agreement. Those who fail to fulfil this obligation and do not conclude a health insurance agreement will be uninsured. Failure to fulfil the obligation to take out insurance gives rise to an undesirable situation – primarily for the uninsured persons themselves. Those who feel they do not need insurance may end up facing a serious illness or accident and are usually unable to pay the costs of the required care themselves. Second, this situation is not in the interest of the social insurance system. From the perspective of the insurance system, any violation of the principle of solidarity on which the system is based is undesirable.
As a means of preventing those under obligation to take out health insurance from failing to take out health insurance, the Zvw included a sanction that made it unappealing for those under obligation to take out health insurance to avoid taking out insurance. Those who failed to arrange insurance in a timely manner owed a penalty equivalent to 130% of the premium for the period during which they were not insured (subject to a maximum of five years). It became apparent, however, that this penalty regime was not an effective way in all instances to ensure that everyone under obligation to take out health insurance actually does take out insurance.

Despite the information provided on the obligation to take out insurance under the Zvw and the penalty regime, there are still uninsured persons in the Netherlands. As the Dutch government sees this as an undesirable situation, it drafted the legislative proposal ‘Detection of Uninsured Persons and Provision of Health Insurance’ (Opsporing en verzekering onverzekerden zorgverzekering). The Upper House of Parliament adopted the legislative proposal on 22 February 2011, and the new law took effect on 15 March 2011.

The new law is designed to ensure that uninsured persons are identified by means of database comparisons. They will receive a reminder letter from the CVZ pointing out their obligation to take out insurance and summoning them to comply. If they refuse to comply, they will have to pay a penalty equal to three times the standard premium (i.e. approximately €340). A second penalty will be imposed if a new database comparison shows that the party in question is still not insured three months after the first penalty was imposed. The CVZ will take out insurance on behalf of anyone who is still uninsured after two penalties have been imposed. The person in question will then pay an administrative premium for 12 months equal to 100%, which amount, where possible, will be withheld at source. Before the law went into effect, extensive public awareness activities aimed at specific target groups were implemented in order to reduce the number of uninsured persons even further.

1.10  Risk adjustment

Health care insurers run a financial risk when providing services covered by health insurance, related to the actual services rendered and the administrative costs of the insurance. Each year, the Minister of VWS sets a separate contribution for each care provider to defray the costs of the services they provide. Care insurers receive separate compensation for the costs of providing insurance to people under the age of 18 (state funding).

General

Under the Zvw, private insurers are responsible for running the health insurance system within the basic preconditions specified by the government (i.e. health care should be accessible, affordable and of a good standard. In a completely free health insurance market, where consumers have freedom of choice and there is sufficient transparency, various tools are available to insurers to enable them to optimise their activities:
• Risk selection.
• Premium definition.
• Efficient procurement of care services.
• Efficient operations.

One of the basic principles on which such a market operates is that insurers can charge premiums that reflect the risks insured persons represent for the insurer (i.e. the equivalence principle).\(^{13}\)

Acceptance obligation and ban on premium differentiation

However, the Zvw does not create a completely free health insurance market. The market is subject to certain preconditions as a means of guaranteeing accessibility to care. For example, the Zvw legally binds care insurers to accept everyone who applies for cover and does not permit insurers to charge different premiums to different groups of consumers. In effect, the law has suspended the equivalence principle. Without additional mechanisms, an insurer with a relatively unhealthy client base would be at a disadvantage compared to a rival with relatively healthy clients. The insurer with the less healthy clients would have little choice but to increase premiums. Such a situation would be inconsistent with the principle of a level playing field.

Care insurers have a legal obligation to accept everyone under obligation to take out health insurance, thereby ruling out the risk of direct risk selection. However, as all insured persons with the same policy pay the same nominal premium, there could be an inducement to make an indirect risk selection. After all, if individual premiums cannot be adjusted in line with clients’ risk profiles, a health insurer who takes on relatively high-risk clients stands to lose out financially. This could lead health insurers to try to – despite the acceptance obligation – avoid less healthy clients. A system of risk adjustment more or less mitigates the incentive to engage in this kind of indirect risk selection, which is undesirable from the perspective of system accessibility.

Risk adjustment contribution

The risk adjustment contribution minimises the cost differences for insurers resulting from the health profiles of insured persons. This contribution does not compensate for cost differences that ensue from such matters as less efficient procurement of care by care insurers, however. It will always be necessary for a care insurer to endeavour to procure good quality care at a reasonable price so as to maintain competitive health insurance premiums.

\(^{13}\) According to the equivalence principle, the premium to be paid by the policyholder is related to the risk for which cover is sought.
The risk adjustment system at work

The working of the risk adjustment system and the way in which it encourages care insurers to operate efficiently is based on a fairly simple principle. Care insurers receive some of their money for providing health insurance services from a fund established for that purpose (i.e. Health Insurance Fund). The payments are disbursed according to an apportionment key set on the basis of the characteristics of insured persons who form an indicator of the likely care costs. These correlations between the costs of care and the health profile of insured persons have been statistically validated. The risk adjustment model contains parameters that correct for health status differences related to age, gender and other objectively quantifiable client health characteristics. Further information on the risk adjustment system is presented in the section ‘Risk profile and adjustment criteria’.

Objective criteria

Objective apportionment criteria are needed in order to distribute money from the Health Insurance Fund. The funding that care insurers ultimately receive depends solely on the health risks of the people they insure. The purpose of the system of weighted adjustment criterion is to predict the costs of each individual insured person as accurately as possible. This concerns the costs resulting from the need for care to which the person is entitled under the Zvw. Moreover, the costs have to be predictable, as the weighting factors are determined on an ex-ante basis.

Categories

The core aspect is that the adjustment model differentiates between five different categories of services:
- Costs of Schedule B diagnosis treatment combinations (B-diagnosebehandelcombinaties (B-DBCs))\textsuperscript{14} (comparable with the USA DRG’s (diagnostic related groups)).
- Variable hospital nursing costs and specialist care costs.
- Fixed hospital care costs, i.e. fixed costs of accommodation.
- Mental health care costs.
- Costs of other services.

Ex-ante risk adjustment

Every care insurer that offers insurance in the Netherlands and that satisfies the requirements of the Zvw receives a standard amount each year, which reflects the health risks of insured persons in its client base. This allowance is set at such a level that the sum of the allowance and the realistic estimate of income from the insurer’s nominal premium and the funding shifts related to obligatory personal excess is equal to the forecast costs of the care provided.

\textsuperscript{14} A distinction is made between Category A and Category B diagnosis treatment combinations (DBCs). While Category A DBCs have fixed rates, the rates of Category B DBCs can be negotiated between care provider and insurer.
Risk profile and adjustment criteria

Risk adjustment is used to compensate care insurers for the insured persons’ risk profile, but what determines the risk profile? The following is a description of the characteristics of insured persons used in determining the risk adjustment to calculate the expected care expenses and the adjustment contribution. These characteristics are referred to as ‘adjustment criteria’, namely:

• Age and gender
  Care insurers are compensated for the age and gender of the insured persons. On average, older people have higher care expenses than younger people. The effect of age depends partly on the gender of the insured person. On average, women aged between 20 and 35 incur higher care expenses for obstetric and maternity care than men in the same age category.

• Nature of the income
  Care insurers are compensated for the nature of the income of those it insures. This adjustment criterion is used to take general account of socio-economic health differences between insured persons. Insured persons who receive, for example, a disability or other state benefit have higher care expenses on average than gainfully employed insured persons.

• Region
  A third adjustment criterion is region. The region-based classification involves the clustering of postcode areas based on the socio-economic, demographic and care-related characteristics of a postcode area. As regards the mental health care model, a specific mental health care region applies, based in part on the mental health care offered.

• Pharmaceutical cost groups
  Those with a serious chronic disorder like diabetes, rheumatism or epilepsy have a recurring high cost pattern. Care insurers are compensated for the high costs incurred by insured persons with a chronic disorder via the fourth adjustment characteristic (i.e. pharmaceutical cost groups), which is based on the use of medicines in the recent past. The idea behind the pharmaceutical cost groups is that insured persons with a certain chronic disorder can be identified on the basis of bills for medicines, known to be prescribed for the disorder in question. An insured person falls into a pharmaceutical cost group if, during the previous calendar year, more than a certain quantity (i.e. sufficient for approximately six months) of specifically described medicines have been prescribed. As a result, only the chronic cases are included when determining the pharmaceutical cost groups. The pharmaceutical cost groups do not identify all insured persons with chronic disorders because a number of disorders are treated more clinically than pharmacologically. What’s more, pharmaceutical cost groups are only based on the outpatient use of medicines. However, some insured persons with a chronic disorder receive medicines that are normally administered to those admitted to a care institution. The costs of such treatment and medicines do not end up as such in the care insurers’ administrative systems, but are included in the hospital rates.
• Diagnostic cost groups
The fifth adjustment criterion, diagnostic cost groups make it easier to predict the subsequent costs of many chronic disorders. Diagnostic cost groups are based primarily on the diagnosis of insured persons on discharge from hospital. Only diagnoses expected to entail high costs in the coming years are taken into account in determining the diagnostic cost groups. Non-chronic diagnoses (e.g. broken bones) are not taken into account in the diagnostic cost groups.

• Socio-economic status
In the sixth adjustment criterion, insured persons are categorised according to income, age and family size. The mental health care model adds the additional element of whether the insured person is single or not. Single people make more frequent use of mental health care.

Model calculations of the health care insurer’s adjustment contribution
Using an example of two (fictitious) insured persons, we can examine in more detail how care insurers are compensated for insured persons with unfavourable and favourable risk profiles.

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<th>VA 40-year-old woman who is unfit for work, has a minimum income, lives alone in the socio-economically disadvantaged Bijlmer district and has type IIa diabetes:</th>
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<tr>
<td>Woman aged 40-44</td>
</tr>
<tr>
<td>Nature of income unfit for work, aged 35-44</td>
</tr>
<tr>
<td>Region 1</td>
</tr>
<tr>
<td>SES 1 (low), aged 18-64</td>
</tr>
<tr>
<td>Pharmaceutical cost groups</td>
</tr>
<tr>
<td>No diagnostic cost groups</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Calculation premium ¹⁵</td>
</tr>
<tr>
<td>Adjustment contribution</td>
</tr>
</tbody>
</table>

On balance, the insurer receives €2,630 from the Health Insurance Fund for this insured person (unfavourable risk profile). ¹⁵

¹⁵ The calculation premium represents the average amount a care insurer has to charge in order to meet all costs of claims.
A 38-year-old man in salaried employment earns three times the modal wage, cohabits in Aerdenhout, who used no medicines and was not admitted to hospital last year for any chronic disorder:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount (€)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Man aged 35-39</td>
<td>1,020</td>
</tr>
<tr>
<td>Nature of income reference group, aged 35-44</td>
<td>51</td>
</tr>
<tr>
<td>Region 10</td>
<td>80</td>
</tr>
<tr>
<td>SES 3 (high), aged 18-64</td>
<td>94</td>
</tr>
<tr>
<td>No pharmaceutical cost groups</td>
<td>349</td>
</tr>
<tr>
<td>No diagnostic cost groups</td>
<td>131</td>
</tr>
<tr>
<td>Total</td>
<td>314</td>
</tr>
<tr>
<td>Calculation premium</td>
<td>983</td>
</tr>
<tr>
<td>Adjustment contribution</td>
<td>669</td>
</tr>
</tbody>
</table>

In theory, the health care insurer is a net payer for this insured person. In practice, however, it has never been the case that an insurer had such a healthy portfolio of insured persons that an adjustment contribution had to be paid into the fund.

The above model calculations do not take account of the obligatory personal excess of the insured person.

Adding up all adjustment contributions for a portfolio gives the cumulative adjustment contribution. This is positive for all insurers.

**Ex-post aspects of risk adjustment**

- **Retrospective calculation of insured persons**
  The contributions received by care insurers must be corrected retrospectively for differences between the estimated and actual number of insured persons. Health Insurance Fund disbursements are initially set in advance, based on forecast figures grouped according to the relevant characteristics of insured persons. However, it is important to avoid a situation where a care insurer who acquires a lot of additional clients (e.g. because an insurer quickly gains a reputation for arranging care quickly and handling claims efficiently) has to wait until the following year to receive the state’s contribution towards the cost of providing care for new clients. For that reason, the Zvw stipulates the retrospective recalculation of all amounts, taking account of the actual numbers of clients and their characteristics.

- **Macro-retrospective calculation**
  The care insurer contributions are also adjusted retrospectively to allow for differences between macro-cost estimates and macro-final costs. The higher the macro-costs, the higher the adjustment contribution. When macro-costs are lower, the lower the adjustment contribution. The macro-retrospective recalculation prevents care insurers from charging higher nominal
premiums to cover uncertainties in the development of macro costs. Macro-retrospective calculation relates to all types of costs.

- Ex-post compensation
  Ex-post methods and otherwise are used to overcome the shortcomings of the ex-ante standardisation. This involves subsequent changes to the distribution of funds to care insurers on the basis of final costs. The need for temporary ex-post compensation mechanisms can be attributed to uncertainties in an insurer’s claim levels due to changes in the financing of the care offered. An example of such a change is the introduction of diagnosis treatment combinations, under which hospitals and medical specialists are paid for the care they provide in a way that better reflects the underlying costs.

Compensation mechanisms
The ex-post compensation mechanisms are described below:

- High cost compensation
  High-cost compensation will help even out cost differences resulting from an unequal distribution of extremely high claims of insured persons over care insurers. The complexity of the risk adjustment system will increase if an attempt is made beforehand to identify individual bad risks and compensate for them.

- Proportional risk sharing
  Retrospective calculation is used to link the size of the financial risk to the scope care insurers have in influencing costs. The need for ex-post compensation mechanisms will decrease as better information becomes available for adjusting ex-ante standardisation to the cost patterns of all insured persons for the new-style funding of care services.

- Calculation premium
  The adjustment allowances disbursed from the Health Insurance Fund will not cover the cost of providing care to insured persons. In addition to this allowance, care insurers also charge insured persons aged over 18 a nominal premium. The risk adjustment system ensures that everyone pays the same premium (i.e. calculation premium). This represents the average amount a care insurer has to charge in order to financially meet all of its clients’ claims. After all, the object of risk adjustment is to compensate for cost differences between care insurers, resulting from the differences in insured persons’ health risks.

- Operating costs
  In addition to the costs of providing insured services, a care insurer incurs expenses for operating the insurance system. In principle, the government does not make corrections to reflect efficiency differences with the aim of establishing a level baseline position. This can be
attributed, for example, to economies of scale or the outsourcing of administrative records and the procurement of care. The operating expenses are not taken into account in the risk adjustment system. However, for insured persons under 18, insurers incur not only the costs of care, for which they receive an adjustment contribution, but also the operating expenses related to, for example, maintaining records and procuring care. A care insurer is unable to finance the operating expenses through a mark-up on premiums for people under 18. The care insurers receive a separate nominal payment from the Health Insurance Fund to rectify this.

1.11 Management and supervision

CVZ tasks
In the context of the Zvw, the CVZ has the task of overseeing the day-to-day operations of health insurance schemes. Its tasks and authorities are:

- Manage the package of cover by promoting unambiguous interpretation of the insured cover and issuing guidelines to care providers. The CVZ renders account as requested to the Minister on proposed policy concerning the nature, content and scale of the package. It also reports to the Minister as requested and on its own initiative about factual developments in the field of medicine that could necessitate changes to the package.
- Provide guidance to care providers, care insurers and members of the public about the nature, content and extent of the package.
- Promote harmonisation in the way the Zvw and the AWBZ are implemented and in the execution of policy in other areas of public health and social security.
- Manage the Health Insurance Fund, from which care insurers receive adjustment contributions, and the General Exceptional Medical Expenses Fund (Algemeen Fonds Bijzondere Ziektekosten (AFBZ)).
- Award grants and manage expenditure on subsidised care.
- Perform tasks such as acting as a collection and accounting office for the financial settlement of services rendered to insured persons in other countries, people living abroad with entitlement under treaties ratified by the Netherlands, and foreign nationals in the Netherlands with treaty rights.
- Implement the adjustment system.
- Manage the tax that conscientious objectors pay in place of insurance contributions.
- Levy and collect the administrative premium from defaulters and make a contribution to care insurers as compensation for the loss of premium.
- Implement the ‘Detection of Uninsured Persons and Provision of Health Insurance’ (currently a legislative proposal) after it takes effect.
Regulatory domains
The care system is subject to several areas of supervision with regulation addressing the conduct of care insurers in financial markets, how they implement the provisions of the Zvw, how markets develop, competition among care insurers and care providers, and the standard of care.

Dutch Central Bank
As the insurers implementing the provisions of the Zvw are private companies, they are subject to the laws governing the supervision of private insurers laid down in the Insurance Supervision Act 1993 (Wet toezicht verzekeringenbedrijf). Supervision focuses primarily on whether the financial position of insurers is sufficient to cover their commitments and whether their business processes are organised in a way to assure continuity and enable them to continue to meet their commitments in the future. The Dutch Central Bank (DNB) oversees compliance with these requirements. An insurance company with its registered office in another EU Member State is subject to the supervision of the regulatory authority of that country.

Netherlands Authority for the Financial Markets
Private insurance companies are further subject to supervision to ensure they provide financial services properly. This supervision extends to care insurers, insurance agents and other distribution channels. The regulator charged with conducting this supervision, the Netherlands Authority for the Financial Markets (Autoriteit Financiële Markten (AFM)) monitors compliance with the basic requirements that those active in the financial market must satisfy to be deemed a responsible distribution channel for financial products. The primary focus is the question of whether the insurer informs insured persons properly about the insurance policy and, when selling the policies, whether the insurer informs its clients properly regarding, for instance, their options and the premiums for the various cover options. The regulator also has the authority to monitor securities transactions with a view to assuring scrupulous investment of funds by organisations like care insurers.

Netherlands Health Care Authority
The Minister of VWS is responsible for ensuring that the effectiveness of the Zvw. One of the ways to fulfil this responsibility involves informing both Houses of Parliament about how the Zvw is promoting the interests of the public. In implementing the Zvw, the primary focus is on ensuring compliance with the acceptance obligation, the ban on premium differentiation, the duty of care, and whether the insurance policy – the private law agreement between care insurer and insured person – provides the insurance cover required by law. Other relevant accountability information includes the statement about the policyholder base for the adjustment arrangements and whether the care insurer is behaving in a manner in keeping with the law with regard to group contracts. As the choice has been made for a private insurance regime that assigns greater responsibilities to insurers permitted to make a profit, it would be inappropriate for the government to supervise how effectively the health insurance system is being implemented. The government’s key objective in supervising the health insurance system and subjecting it to a judicial review of lawfulness is
ensure that the care insurer provides insured persons the services entitled under the Zvw. The designated regulator (i.e. NZa) has the following tasks and authorities:

- Report to the Minister and the CVZ on whether the Zvw and the AWBZ are being implemented in accordance with the law.
- Inform the Minister regarding the practicability, effectiveness and efficiency of proposed policy concerning the performance of its regulatory role.
- Initiate investigations of care insurers (including AWBZ insurers) at the request of the Minister or the CVZ.
- Impose rules as necessary for audits by care insurers and for the content and structure of auditor reports.

Overcoming issues impeding market forces is a key task and responsibility of the government. It must also stimulate, where necessary, the further development of the operation of market forces. The objective is to enhance the position of insured persons, remove barriers to market entry and achieve greater transparency. In a more general sense, the goal is to promote transparency in the care market in a way that enables the public to assess properly the choices they must make under the Zvw.

**Netherlands Competition Authority**

The Competition Act (*Mededingingswet*) regulates the general supervision of competition and applies to care insurers and care providers. The Netherlands Competition Authority (*Nederlandse Mededingingsautoriteit (NMa)*) has been charged with ensuring that care insurers comply with the Competition Act.

**Supervision of the quality of health care**

The Health Care Inspectorate (*Inspectie voor de Gezondheidszorg (IGZ)*) supervises the quality of public health, the provision of regulations and their compliance by care providers. The IGZ also supervises:

- The quality of professional medical activities such as the authority to perform medical procedures.
- Quality criteria, aimed at providing responsible, high-quality care, which must be provided as effectively and efficiently as possible and is geared to the patient’s needs.
1.12 Disputes

If the decision is taken to not reimburse a medicine, an insured person can ask a care insurer to reconsider. The problem may pertain to the health insurance under the Zvw or to the supplementary insurance. If the care insurer fails to respond within a reasonable period of time or address the objections raised, the insured person may take the case to court or submit the dispute to an independent disputes arbitrator.

The fact that the health insurance is a private agreement means that, in principle, a dispute must be settled in accordance with civil law. This principle is embedded in Article 112(1) of the Constitution of the Netherlands, which stipulates that the judiciary (i.e. the district/sub-district court and, on appeal, the court of appeal) must rule in disputes concerning civil and personal rights and debts. In final instance, an appeal in cassation may be lodged with the Supreme Court.

As proceedings before a court of law take considerable time and are expensive, the care insurer and the policyholder/insured person may jointly decide to refrain from approaching the civil courts and instead submit their dispute to an impartial third party. The Zvw stipulates that a care insurer must make it possible for its policyholders and insured persons to submit disputes about the performance of health insurance to an independent body. To this end, the association of Dutch care providers (Zorgverzekeraars Nederland) and the Federation of Patients and Consumer Organisations in the Netherlands (Nederlandse Patiënten Consumenten Federatie) established an independent foundation to handle complaints and disputes regarding health care insurance (Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ)).

The SKGZ consists of two parts: an ombudsman and a disputes committee. If the care insurer reaffirms its decision and the insured person does not agree, the insured person can ask the ombudsman to mediate. If the ombudsman sees no possibility for mediation or if attempts to mediate fail, the insured person can submit a complaint to the disputes committee.

Although the disputes committee’s recommendations are in principle binding on all parties, the court can assess whether the law and the policy conditions have been applied correctly. If not, the binding recommendations are no longer considered valid.

It costs money for the disputes committee to handle disputes. If the decision is in the insured person’s favour, the costs are for the insurer’s account.
Health Care Allowance Act
2.1 Background

Since the introduction of the Zvw, there has one standard premium. In addition to an income-related contribution collected by the Dutch Tax and Customs Administration, insured persons pay their care insurer a nominal premium. The care insurer sets the amount of the nominal premium, which is not based on the income of the insured person. The health care allowance was created to prevent the amount of premiums from impeding access to care.

Entitlement to the health care allowance depends on a person’s income. The health care allowance is based on an estimate of the average of the nominal premiums as a means of promoting competition between care insurers and ensure that care insurers are also assessed according to the level of their nominal premium. This is referred to as the ‘standard premium’.

Only those who have fulfilled the obligation to take out health insurance are eligible for a health care allowance.

2.2 Purpose of the Act

The Health Care Allowance Act (Wet op de Zorgtoeslag (WZT)) provides for a health insurance nominal premium allowance for those for whom the premium constitutes an excessive burden relative to their income. Under the WZT, people are entitled to financial support from the government depending on the ability to pay. Accordingly, the health care allowance is an income-based facility subject to the General Income-Linked Regulations Act (Algemene wet inkomensafhankelijke regelingen (Awir)). The terms used in the Awir (e.g. ‘allowance’, ‘partner’ or ‘means-tested income’) apply to the WZT. In determining the ability to pay, both the income of the party concerned and that of the partner are important.

Means-tested income

Pursuant to the Awir, the means-tested income is used to determine the ability of the party concerned to pay the premium. The income of the party concerned and any partner serves as the basis for this determination.

The means-tested income used to calculate the health care allowance is the aggregate income as defined by the Income Tax Act 2001 (Wet inkomstenbelasting 2001) of the year in question (i.e. the calendar year to which the health care allowance relates). The aggregate income of insured persons who file income tax returns is included on their assessment. In principle, the means-tested income is the same as the taxable income. If, for instance, an additional tax assessment is imposed after the tax assessment based on a higher aggregate income, this will lead automatically to a higher means-tested income. In order to ensure that the health care allowance properly reflects the current income of the party concerned, the income earned in the year to which the allowance relates is used as a basis.
Threshold income
Based on the view that everyone has to pay some of the costs of the care, the health care allowance factors in a threshold income, ensuring that no one is paid back nearly the entire care premium. The amount of the threshold income is set as a percentage of the statutory minimum annual wage for 23 year olds minus the employee’s share under the Unemployment Insurance Act (Werkloosheidswet) and the Sickness Benefits Act (Ziekte) plus the employer allowance for withholding the income-related contribution for the employee under obligation to take out insurance/health insurance.

Insured persons (with partner)
For the purposes of the health care allowance, households consist of only one or two people. This distinction is important for establishing the amount of the allowance. As regards determining the existence of a two-person household, Section 3 of the Awir establishes rules relating to the term ‘partner’. As an insured person and the insured person’s partner jointly have one entitlement (right), there is only one health care allowance applicant. If the insured person’s partner has no health insurance, neither the insured person nor the partner will have any entitlement to the health care allowance.

2.3 Persons with legal entitlements
The Health Care Allowance Act (WZT) applies to those under obligation to take out health insurance who have taken out health insurance under the terms of the Zvw and to those living abroad who have entitlements under treaties and have registered with the CVZ. Everyone with health insurance is entitled to a health care allowance from the first day of the calendar month following the month in which they turn 18 if the health insurance premium or contribution for people with entitlements under treaties is deemed excessive relative to their income. Any young person aged 18 or older – regardless of whether they are living in the parental home – has an independent right to a health care allowance.

2.4 Health care allowance entitlement
An insured person is entitled to a health care allowance if the standard premium exceeds the premium deemed reasonable for this insured person relative to his or her income (i.e. normative premium). The health care allowance is equal to the difference between both premiums. The Dutch Tax and Customs Administration checks whether recipients of an allowance have also actually taken out health insurance.
**Standard premium**
The standard premium is the estimated average health insurance premium. While group contracts are a factor in determining the average premium, average personal excess is taken into account. Nevertheless, it is assumed when determining the health care allowance that insured persons who are not going to incur high levels of medical expenses in the long term. In fact, these individuals are compensated for the difference between the maximum personal excess and the average personal excess.
The standard premium used to calculate the health care allowance is set each year by ministerial decree. The amount of the standard premium is the average of the nominal premiums insured persons are expected to pay for health insurance for the year in question, based on the average of the premiums/nominal premiums for health insurance estimated by the Netherlands Bureau for Economic Policy Analysis (Centraal Planbureau (CPB)) in the year prior to the year in question.

**Normative premium**
The normative premium is based on the threshold income and the means-tested income of the insured person in the year in question. The normative premium is equal to a percentage of the threshold income plus a percentage of the means-tested income (provided this exceeds the threshold income). In the case of an insured person with an insured partner, the aggregate means-tested income is used.
Any capital has no effect on the right to the allowance. The Rutte government’s coalition agreement proposes the inclusion of a capital means test in the Health Care Allowance Act (WZT). This would require an amendment of the WZT.

**Determining the right to health care allowance**
The Dutch Tax and Customs Administration determines who is entitled to a health care allowance for each individual calendar month and pays monthly advances, explaining why, for example, a change in income immediately impacts the amount of the health care allowance. It is therefore essential to inform the Dutch Tax and Customs Administration of any relevant changes. The advances are then applied immediately. This avoids any discrepancies between the advances and the definitive amount of the health care allowance (see Section 2.5).

**Health care allowance abroad**
Parties under obligation to take out health insurance abroad are eligible for the health care allowance. The same applies to people residing abroad, who are entitled to medical care chargeable to the Dutch insurance system based on international schemes – not pursuant to Dutch law. The health care allowance for these parties under obligation to take out health insurance is coordinated with the average care expenses in the country of residence.

Insured persons can retain their entitlement to the health care allowance while abroad based on various treaties (i.e. the Regulation, the European Economic Area (EEA) agreement, the agreement between the European Community and its Members States on the one hand and the Swiss
Confederation on the other regarding the free movement of people, or bilateral social security treaties between the Netherlands with other countries). As a result, everyone who lives abroad, but is subject to Dutch law, can be eligible for the health care allowance.

There are also several categories of people who are entitled to medical care chargeable to the Dutch insurance system under international agreements rather than Dutch law. This concerns family members who live in a treaty country or people who work in the Netherlands, as well as former members of the armed forces with a Dutch pension or a long-term social security benefit who would otherwise be insured under the Zvw if they lived in the Netherlands. Their family members are also eligible for the health care allowance.

2.5 Implementation

The Health Care Allowance Act (WZT) is implemented by the Dutch Tax and Customs Administration. In applying for the health care allowance, an estimate of the future income of the applicant and his or her partner is made. This will be used to determine payment of a monthly health care allowance advance, starting in December prior to the year for which the health care allowance is calculated. In general, the allowance is disbursed prior to when the nominal premium has to be paid to the care insurer. The Dutch Tax and Customs Administration can be authorised to pay the health care allowance directly to the care insurer for immediate settlement of the premium.

At the end of the year, the Dutch Tax and Customs Administration calculates the definitive amount of health care allowance, for example, based on the income tax assessment, after which any discrepancies in the amount of health care allowance discrepancies (excess or deficit) can be settled.
2.6 Scope and model calculations of the health care allowance

Around 5.6 million people receive a health care allowance, which is on average €662 per year. In 2009, the net expenditure for the health care allowance was €3.751 billion\(^{16}\).

### Model calculation

<table>
<thead>
<tr>
<th>Model calculation 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wouter is a single man who earns an annual income of €15,000.</td>
</tr>
</tbody>
</table>

**Step 1**  
Standard premium: €1,209

**Step 2**  
Applicant’s means-tested income €15,000
   
<table>
<thead>
<tr>
<th>Allowance partner’s means-tested income</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint means-tested income</td>
<td>€15,000</td>
</tr>
</tbody>
</table>

**Step 3**  
Normative premium = \(2.7\% \times €19,135 + 5\% \times (€15,000 - €19,135)\) = €516.65

**Step 4**  
- Standard premium €1,209.00
- Normative premium - €516.65
- Annual health care allowance €692.35  
   Rounding off to: €692

This is equal to €57.67 per month. This is rounded off to whole euros. The total of the monthly amounts will never exceed the annual amount.

\(^{16}\) Source: VWS budget 2010, allowance year 2008.
Model calculation 2
Henk and Til live together. His annual income is €30,000. Her annual income is €18,000.

Step 1  Standard premium: € 2,418

Step 2  Applicant’s means-tested income € 30,000
       Allowance partner’s means-tested income + € 18,000
       Joint means-tested income € 48,000

Step 3  Normative premium = 5% x €19,135 + 5% (€48,000 - €19,135) = € 2,400

Step 4  Standard premium € 2,418
       Normative premium - € 2,400
       Annual health care allowance € 18

The Dutch Tax and Customs Administration do not pay out annual amounts under €24.

Model calculation 3
Herman (member of the armed forces) and Marianne (secretary) are married. His annual income is €35,000. Her annual income is €12,000.

Step 1  Standard premium: € 2,418

Step 2  Applicant’s means-tested income € 12,000
       Allowance partner’s means-tested income + € 35,000
       Joint means-tested income € 47,000

Step 3  Normative premium = 5% x €19,135 + 5% (€47,000 - €19,135) = € 2,350

Step 4  Standard premium € 2,418
       Normative premium - € 2,350
       Annual health care allowance € 68
       x 50%
       € 34

The Dutch Tax and Customs Administration pays out annual amounts between €24 and €60 in one go.
Model calculation 4

Jan and Catharina are married and live in Poland. He receives an old age pension benefit from the Netherlands in Poland of €9,000 per year. Her annual income is €5,000.

**Step 1**  
Standard premium: \((€1,209 \times 0.0769) + €1,209 = €1,301.97\)

**Step 2**  
Applicant’s means-tested income  
€9,000  
Allowance partner’s means-tested income  
€5,000  
Joint means-tested income  
€14,000

**Step 3**  
Normative premium = 5% x €19,135 + 5% (€14,000 - €19,135) = €956.75

**Step 4**  
Not applicable (situation abroad)

**Step 5**  
Standard premium  
€1,301.97  
Normative premium  
- €956.75  
Annual health care allowance  
€345.22  
\(\times 50\%\)  
€172.61 \(\text{rounded off to €173}\)

This is equal to €14.38 per month. This is rounded off to whole euros. The total of the monthly amounts will never exceed the annual amount.

2.7 Management and supervision

In determining whether the health care allowance has been disbursed appropriately, the Dutch Tax and Customs Administration checks such issues as whether the party concerned has taken out health insurance or has registered with the CVZ as a party entitled under a treaty. The details used are those which the insurers and the CVZ are obliged to issue under the terms of the Zvw. At the end of the year in question, the Dutch Tax and Customs Administration automatically compares the details of the applicant (and any partner) with available information and then definitively sets the allowance. The information in question includes details about income, household composition and status as being insured or registered as a party entitled under the treaty.
2.8 Disputes (objections and appeals)

Objections and appeals concerning the allocation or amount of the health care allowance are laid down in the Awir. The fact that the decision on the health care allowance is taken by an administrative body means that the provisions of the General Administrative Law Act (Algemene wet bestuursrecht (Awb)) apply. Different agreements have been made regarding the time at which an objection or appeal has to be lodged.

In principle, anyone who does not agree with a decision by the Dutch Tax and Customs Administration regarding the allocation or amount of the health care allowance can submit an objection. The Dutch Tax and Customs Administration decides on the notice of objection and an appeal against this decision can be lodged with the court.
Exceptional Medical Expenses Act
3.1 Background

In 1962, Minister Veldkamp put forward a plan for an insurance scheme to cover the entire population against major medical risks. This scheme in question involved an insurance to cover the high financial costs associated with serious, long-term illness or disorders. Minister Veldkamp was particularly concerned about the costs of severe congenital physical or mental problems and the costs incurred by psychiatric patients who require long-term nursing and care. Although the risk of developing such disorders is not that great, but nearly no one can pay the costs when they do. This motivated the use of the term 'exceptional medical expenses'.

The AWBZ became law on 14 December 1967 (Bulletin of Acts, Orders and Decrees 1967, 617) and came into effect in stages starting on 1 January 1968.

3.2 Nature of the insurance scheme

The AWBZ is an insurance scheme that applies by operation of law. In short, anyone who meets the criteria laid down in the law is insured, regardless of the intention or desire to use the entitlements offered under law. All insured persons are obliged to pay the legally defined premium. Conscientious objectors can be exempted from the obligations under the terms of the AWBZ. Instead of premium, conscientious objectors are required to pay extra income tax or wage tax.

3.3 Insured persons

As a national insurance, the AWBZ insures the following people:

- Residents of the Netherlands or those who live in the Netherlands. While this generally means Dutch territory, it can – depending on circumstances – sometimes refer to a different place. Case law shows that actual residence outside the national borders of the Netherlands can – in certain circumstances – also be deemed equivalent to living in the Netherlands. The residency criterion applied in this case is that the person in question is in the middle of his or her socio-economic life. This can be demonstrated, for example, by the existence of socio-economic ties.
- Non-residents who are employed in the Netherlands and, consequently, subject to Dutch wage tax – primarily cross-border workers and expatriates.

According to the main rule mentioned above, it is not important whether the person in question is a Dutch national. However, foreign nationals must legally reside in the Netherlands to qualify for cover under the AWBZ.

There are a number of exceptions to the main rule. This results in both an increase in the number of insured persons (i.e. residents who are uninsured) and a decrease (non-residents who are insured). These exceptions are laid down in the decree regulating access to national insurance.
schemes (*Besluit uitbreiding en beperking kring verzekerden volksverzekeringen 1999*).
The AWBZ insurance scheme is not derived from the parents’ insurance. The circumstances of
children are used to determine their place of residence. Unlike other national insurance schemes,
the AWBZ imposes no age limits regarding the obligation to take out insurance.
Key considerations for the application of the AWBZ include the provisions of the Regulation, the
European Economic Area (EEA) agreement, the agreement between the European Community and
its Member States on the one hand and the Swiss Confederation on the other regarding the free
movement of people, or bilateral social security treaties with other countries that include
reciprocal arrangements for providing medical care (see Section 4).

### 3.4 Management, administration and contracts
between insurers and care providers

Although care insurers implement the AWBZ for their insured persons, they have, however,
delegated the tasks associated with the procurement of care under the AWBZ and the organisation
of regional meetings to care offices as part of a three-year mandate. The Minister will decide on an
extension at the end of this mandate period. The care offices execute the tasks in each region for
the agencies implementing the AWBZ, including care insurers that have registered with the NZa
with a view to implementing the AWBZ. Furthermore, the care offices, which receive data from the
AWBZ implementing bodies, also maintain records on monthly settlements and advance payments
for each institution.
The financial administration tasks are carried out by the Central Administration Office (*Centraal
Administratiekantoor* (CAK)), which pays advances and makes payments to AWBZ institutions at the
request of care offices and also bears responsibility for calculating and collecting AWBZ personal
contributions from insured persons. For implementing the AWBZ, the care offices and the CAK
receive a management costs budget established by the CVZ.

**Contracts between insurers and care providers**
The AWBZ implementing bodies have a duty of care in that they have an obligation to ensure that
insured persons can obtain the health care to which they are entitled. To this end, they or the care
offices they engage enter into contracts with health care professionals and institutions which lay
down agreements on rates, scope of care and other conditions.
3.5 Registration and validation of health care entitlements

The AWBZ imposes registration with one of the AWBZ care insurers as a condition for the entitlement to care. Care insurers registered with the NZa with a view to implementing the provisions of the AWBZ represents the people it insures as an implementing body under the AWBZ. Consequently, everyone who takes out health insurance likewise has insurance cover under the AWBZ. Those insured under the AWBZ who, for whatever reason, do not have health insurance (e.g. military personnel) can register with a care insurer for cover under the AWBZ alone. This also applies to those insured under the AWBZ who live abroad. Registration is for one calendar year and is renewed each time for one calendar year, unless written notification to not renew is received in good time. A maximum period of notice of two months applies. Insured persons who end their health insurance to take out cover with a different care insurer have their registration for entitlements under the AWBZ transferred to the new insurer.

Validation of health care entitlements; waiting times
Anyone who comes from abroad to settle in the Netherlands and consequently becomes eligible for entitlements under the AWBZ are subject to a waiting time equal to one month for every year that a person was uninsured up to a maximum of twelve months. The waiting time applies to inpatient care deemed ‘indicated’ at the start of the insurance or care that will be required in the foreseeable future. Incidentally, this does not mean that these individuals will be unable to obtain care, but no claim for the associated costs can be made under the AWBZ.

Indications
In order to be eligible for care under the AWBZ, it is necessary to establish whether the care is really required and, if so, what type of care and how much is required. This ‘indication’ is carried out by the Care Indication Determination Centre (Centrum indicatiestelling zorg (CIZ)). Children aged up to 18 with psychiatric/psychological problems can have their indication determination conducted at a Youth Care Agency (Bureau Jeugdzorg (BJZ)). The CIZ or BJZ are independent organisations which conduct care needs assessments independently, objectively and thoroughly. Insured persons can opt for care in-kind, a personal care budget, or a combination of the two.

Care in-kind
Care in-kind entails the provision of indicated care directly to the insured person by a care provider contracted by a care office (e.g. home care organisation). This care provider arranges the care and handles the associated administration in consultation with the insured person. It is not compulsory to receive all of the care from the same provider. The insured person can obtain some of the care in-kind from one provider and another part (also in-kind) from another provider.
Personal care budget

Insured persons can opt for a cash amount rather than care in-kind. This is referred to as the personal care budget (persoonsgebonden budget (pgb)). In principle, anyone who requires care under the AWBZ for more than three months will be eligible for a pgb (i.e. receive a budget to procure care on their own) for certain functions, such as nursing, personal care and supportive guidance. Pgb’s are not available for the functions ‘treatment’ and ‘accommodation’ as these are always provided in-kind, with the exception of short-term accommodation which is subject to a reimbursement maximum of two days a week as part of the pgb. The pgb can be paid monthly, quarterly, semi-annually or annually. The disbursement, however, amounts to 75% of the costs of care in-kind due to cost-cutting measures to reduce overhead costs.

The pgb offers considerable freedom. People are free to choose their health professional and determine when they want to receive the care. Many pgb recipients like having a specific care provider that they selected themselves. Although this is often someone they know, such as a neighbour or friend, people are free to go to official care providers.

The pgb also comes with certain obligations, including the procurement of care of a responsible standard and regularly rendering account of the financial aspects to the care office.

The care office is bound by a grant cap, which means that it has a fixed amount available to spend on a pgb. This amount is made available via the CVZ. Once the maximum amount is reached, the care office cannot allocate any additional pgb. The insured person is then placed on a waiting list, and the care office assesses whether the insured person is eligible for care in-kind.

Care providers

Institutions primarily provide care under the AWBZ. Before it can provide AWBZ care, an institution has to be approved and has to have concluded a contract with an AWBZ implementing body. According to the Health Care Institutions (Accreditation) Act (Wet toelating zorginstellingen (WTZi)), care institutions that want to provide care under the terms of the AWBZ need permission from the Minister of VWS. During the application process, an assessment is carried out to determine whether certain conditions are being met. The care office has to approve accommodation under the AWBZ.

3.6 Care under the AWBZ abroad

Under the terms of the AWBZ, insured persons are in principle required to obtain care from care providers contracted by the AWBZ implementing body, which is free to contract care providers in the Netherlands and abroad. This enables insured persons to obtain care abroad insofar as the implementing body has contracted care in the country in question. However, the AWBZ also enables insured persons to approach a non-contracted care provider in the Netherlands or abroad. In some cases, the prior consent of the AWBZ implementing body is required.

People can also obtain care abroad under international social security agreements (see Section 4).
3.7 Care entitlements under the AWBZ

To be eligible for care under the AWBZ, insured persons have to have a certain disorder, limitation or disability, meeting what is referred to as an indication principle. Outlined in the AWBZ, these six indication principles are:

- Somatic (physical) illness, disorder or disability.
- Psycho-geriatric disorder or disability.
- Psychiatric disorder or disability.
- Mental disability.
- Physical disability.
- Sensory disability.

The AWBZ and subsequent regulations determine the entitlements to care under the AWBZ. Procedural rules have been laid down for such matters as invoking certain entitlements to care or obtaining the prior consent of the implementing body. Insured persons can obtain care under the AWBZ after the CIZ has determined that the care is indicated.

**Personal contribution**

For most types of care under the AWBZ, those aged over 18 have to make a personal contribution, the amount of which depends on such aspects as taxable income and living situation (i.e. living at home or in an institution). Other relevant factors are whether insured persons are younger or older than 65 and whether they are married or cohabit. The personal contribution is deducted directly from the pgb (if applicable). Insured persons who pay a personal contribution towards care in-kind will either receive a bill or the amount of the contribution is set off against any state government support. The personal contribution is laid down in the Health Care (Personal Contribution) Decree (Bijdragebesluit zorg) and the associated Health Care (Personal Contribution) Regulation (Bijdrageregeling zorg).

**Function-based entitlements**

Entitlements under the AWBZ are defined in terms of functions. The focus is no longer on the available supply of care offered, but on the needs of the insured persons. This leads the way to the provision of customised care. The need to shift away from a supply-side to a demand-side approach can be attributed to a changing society in which people increasingly voice their preferences and requirements and want to organise their lives in the manner they see fit. The guiding principle of the AWBZ is also to ensure that people live at home for as long as possible, enabling them to receive care both at home and in an institution.
Functions
The broad definitions of the five functions offers considerable freedom in arranging the indicated care in consultation with a care provider. The functions are:

- **Personal care** (e.g. providing assistance with showering, bed baths, dressing, shaving, skin care, going to the toilet, eating and drinking).
- **Nursing** (e.g. dressing wounds, administering medication and injections, showing patients how to administer injections).
- **Supportive guidance** (e.g. helping others to organise the day and manage one’s life better or learn look after one’s household, both individually and as part of daytime activities).
- **Treatment** (e.g. specific treatment by a geriatric specialist, a doctor for the developmentally disabled or a behavioural scientist).
- **Accommodation**: Some are unable to continue living independently (e.g. when they require sheltered housing or continual supervision in connection with serious absent-mindedness). Inpatient care may also be necessary when the care needs are too great to address in the home environment.

Inpatient care may also be necessary when the care needs are too great to address in the home environment.

Care is provided in the form of ‘products’. For example, once a year has passed, home care, admission to a care home, nursing home, institution for the developmentally or physically disabled and those who need psychiatric help are all products offered under the AWBZ. A product consists of a single function or a combination of functions. See the example below.

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**Mr B. is confronting various limitations due to advanced dementia and is unable to continue living at home independently as he requires care and nursing. His indication touches on four functions, namely care, nursing, treatment and accommodation. This combination of functions is supplied in the form of a ‘care intensity package’. Various kinds of care intensity packages are available depending on the scope of the care needed and the sector (nursing and care, care for the disabled and long-term mental health care).**

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In addition to care functions, there is also an entitlement to, for example, patient transport, nursing supplies, care and support related to sign language, inpatient care after one year, rehabilitation care, prenatal care, research into certain congenital metabolic disorders, and vaccinations included as part of a vaccination programme.
3.8 Government grants

After the Zvw became law on 1 January 2006, the AWBZ provided for the grants chargeable to the General Exceptional Medical Expenses Fund (Algemeen Fonds Bijzondere Ziektekosten (AFBZ)). As is the case under the Zvw, the number of purposes for which the government can provide grants is limited. In principle, grants are only issued for care or other services expected to be included in the package of insurable care, which is why the Zvw also stipulates that the grants are temporary in nature.

In contrast to the Zvw, the AWBZ provides for two purposes for the grant: the pgb and pregnancy termination at abortion clinics. Pregnancy terminations are not financed using premium revenues, but from tax revenues that the government allocates as a government grant to the AFBZ. The Minister of VWS is authorised to impose a cap on each grant category, and the CVZ can impose additional rules (e.g. the impact in terms of the grant-based approach of rules stipulated in the ministerial regulation). The Minister has to approve these additional rules and can only withhold approval if the rules are counterproductive to a written or unwritten public health right or interest.

3.9 Funding

The AWBZ insurance scheme is funded using premiums, government grants and the personal contribution of insured persons. The premium for insurance under the AWBZ and the premiums for other national insurance schemes are collected via the income and payroll tax system. Each year, the government sets the AWBZ premium as a percentage of taxable income, applied to the first and second income/payroll tax brackets. The premium percentage for the AWBZ in 2011 is 12.15%. The premium for employees is withheld by the employer and transferred to the Dutch Tax and Customs Administration. Non-employees who are liable to pay tax and social insurance contributions pay the AWBZ premium via a tax assessment. Insured persons under the age of 15 and insured persons older than 15 who received no independently taxable income pay no premium. After turning 18, insured persons pay a personal contribution to obtain care under the AWBZ. This personal contribution is related to income level.

The Dutch Tax and Customs Administration transfers the collected premiums to the CVZ, which pays the money into the AFBZ. The CVZ manages and administers the AFBZ. The personal contributions collected from insured persons by implementing bodies are also transferred to the fund. Every year, the government also disburses a grant to the AFBZ for the AWBZ’s implementation. This government grant is adjusted annually.
3.10 Management and supervision

CVZ tasks
In the context of the AWBZ, the CVZ has the following tasks:
• Promote the lawful and effective implementation of the AWBZ by care insurers and care offices and the option of setting policy implementation rules.
• Inform care providers, care insurers and the public about the nature, content and scope of care entitlements.
• Render account to the Minister on request about proposed policy regarding the nature, content and scope of care entitlements.
• Report to the Minister on request and otherwise regarding actual developments which may give cause to change the nature, content and scope of care entitlements.
• Award temporary grants.
• Report to the Minister on request or otherwise regarding the required scope of funds availability from the AFBZ and the AWBZ premium.

Tasks of the NZa
The NZa is charged with overseeing the lawful and effective implementation of the AWBZ (see Sections 1.11 and 5.1).

3.11 Disputes

Complaints
Insured persons who disagree with how they have been treated by an AWBZ implementing body must first lodge their complaint with the implementing body in question. Under the terms of the General Administrative Law Act (Awb), this body is obliged to handle the complaint properly. If the insured person is not satisfied with the response, a complaint can then be submitted to the National Ombudsman, which addresses complaints by applying a standard of proper conduct. The National Ombudsman not only assesses whether the implementing body has acted contrary to rules of conduct laid down by law, but also whether its actions satisfy the requirements of reasonableness, equal treatment, motivation and care.
The insured person also has the option to submit complaints relating to AWBZ implementing bodies to the CVZ. It can respond by, for example, issuing guidelines to AWBZ implementing bodies. If several complaints about the same issue are received, the CVZ may decide to inform the Minister. This may lead to subsequent policy changes, legislative amendments or changes to regulations.
Objections and appeals
An insured person has the right to lodge an objection with the AWBZ implementing body or – in the event of a care indication determination – the CIZ against decisions relating to the implementation of the AWBZ. The body implementing the provisions of the AWBZ must then reconsider the matter and rule on the notice of objection. If the notice of objection relates to a decision on entitlement to care under the AWBZ or a corresponding payment, the implementing body is obliged – if it does not respond to the insured person’s objection in its entirety – to ask the CVZ for a recommendation on the notice of objection prior to taking a decision. This obligation does not apply to objection procedures relating to personal contributions, the level of which does not depend on a medical assessment. The insured person can appeal against the decision regarding the notice of objection by submitting it to the court’s administrative law sector.

3.12 Developments in the AWBZ
The mounting costs of the AWBZ insurance scheme have been a key point of debate in recent years. Reforming the AWBZ with a view to increasing its financial sustainability has been under consideration for some time now. The options include transferring certain parts to the Zvw or the Wmo. The debate is likely to continue for some time. Calls for health care reform have increased in the face of the current financial and economic situation.
International aspects
4.1 Background

A country’s social security system is usually only made available to those who live or work within its borders. People who work in a country other than their country of residence may be insured twice or perhaps not at all. This restricts the free movement of workers. In order to avoid this situation, Regulation (EC) no. 883/2004 of the European Parliament and the Council of 29 April 2004 concerning the coordination of social security systems (hereinafter referred to as: the Regulation) applies at EU level. The Regulation ensures that people who are or were insured in one country, retain their social security cover when relocating to a different EU Member State to work or live. The Regulation also offers the option of obtaining medical care when people of one Member State go on holiday in another Member State or travel to another Member State to obtain medical care.

The EEA agreement includes comparable regulations between the EU Member States on the one hand and Liechtenstein, Norway and Iceland on the other. A similar regulation has also been incorporated into the agreement between the European Community and its Member States on the one hand and the Swiss Confederation on the other regarding the free movement of people. In addition, bilateral social security treaties, which are generally less exhaustive, have been concluded with other countries which include regulations for the provision of medical care.

4.2 Guiding principles of international coordination

All international coordination regulations for social security laws are based on the following guiding principles:

- **Equal treatment**
  As regards the application of national security social security law, the subjects of treaty states who visit other treat states enjoy the same rights and obligations as residents of the treaty state they are visiting.

- **Applicable law**
  All international coordination regulations specify the law that applies those who live or reside outside their home country. The idea is to prevent someone from being insured twice (and, consequently, from having to pay premiums twice) or from being uninsured (and, consequently, paying no premium at all). The main rule is that employees and the self-employed are subject to the law of the country in which they work. There are exceptions to this rule, primarily involving employees on secondment, workers active in the international transport sector, and those employed by diplomatic posts. Pensioners are often only covered by the laws of their country of residence.
• Insured periods and waiting times
Entitlements to some social security provisions only apply after someone has been insured for a certain period. This applies to some extent to the AWBZ. Waiting times are more common in other countries. When someone who was insured in country A takes out insurance in country B, this person will begin – as it were – a new insurance history in country B. In order to prevent the insured person from losing insurance periods accrued in country A, these are taken into account when calculating waiting times in country B.

4.3 Obtaining care abroad

Four different situations involving different administrative procedures may occur under the international regulations in place:

• Obtaining care abroad by insured persons residing in the Netherlands
For essential medical care, insured persons who are abroad and who can produce a European Health Insurance Card (Europese ziekteverzekeringskaart (EHIC)) or a treaty form are entitled to medical care according to the legal regulations of the country they are in. This even applies to types of care to which they are not necessarily entitled under the Dutch health insurance package. The costs of the care provided are payable via the Dutch insurance system. The insured person has to pay any personal contributions if these are provided for in the legislation of the country in which the care is obtained. The EHIC or the treaty form is issued by the care insurer with which the insured person has taken out health insurance. Those who travel to another country to obtain care must first obtain an EU/treaty form from their care insurer. In certain cases, the care insurer may refuse to issue a form if the type of care in question is also available in the Netherlands. In this case, care can be obtained abroad through the direct application of the care policy (see Section 1.6) in addition to obtaining care under an international regulation.

• Dutch pensioners residing abroad and their family members, and the family members of people working in the Netherlands
As those who reside abroad and draw only a Dutch pension and their family members and the family members who live abroad of people who work in the Netherlands do not have AWBZ insurance, they are under no obligation to be insured under the Zvw and are referred to as being entitled to care under treaties. Under the terms of the international regulations in their country of residence, these individuals are entitled to medical care financed via the Dutch insurance system. For each party entitled to care, the Netherlands usually pays their country of residence a fixed amount to cover all of the medical costs of the people concerned. In return for this entitlement to medical care, they have to pay a contribution for the entitlement to care under a treaty. They are eligible for a health care allowance subject to the same conditions as insured persons in the Netherlands and have to register with the CVZ, which issues both a form to register with the insurance body of their country of residence and the EHIC, along with proof of
insurance to obtain care. The CVZ also issues the EHIC or grants consent required to obtain care abroad (i.e. the insured person’s country of residence). The people concerned are entitled to the care provided for in the legal regulations of their country of residence, including types of care to which they are not necessarily entitled under the Dutch health insurance package. The insured persons bear responsibility for the payment of any personal contribution provided for in the laws of their country of residence. International regulations also enables them to obtain care in the Netherlands or abroad in a country that is party to the international agreement. Consent of the insurance body of their country of residence is usually required, as the costs of that care are generally charged to the insurance system of that country. Since 1 May 2010, In addition to the entitlement to care in the country of residence, retirees have also had entitlements under treaties, and their family members are entitled under the new regulation to obtain care in the Netherlands without the involvement of the insurance body in their country of residence. The family members of cross-border workers have enjoyed this right since 2006, are entitled to care under the Dutch health insurance package, and are required to pay any personal contributions and the Dutch obligatory personal excess.

• Foreign insured persons residing temporarily in the Netherlands
Foreign insured persons who reside temporarily in the Netherlands are entitled to care during their stay, even if it involves care that they are not necessarily entitled under the health insurance package of the insurance system of the country under which they are insured. They have to pay any personal contributions due under Dutch law and the Dutch obligatory personal excess and can obtain care on presentation of an EHIC or a treaty form, issued by their own foreign insurance body. If foreign insured persons come to the Netherlands with a view to obtaining care, it can be obtained on presentation of a treaty form. In effect, this form serves as proof of the consent of the foreign body to obtain this care in the Netherlands.

• Foreign pensioners residing in the Netherlands and family members of people working abroad
Residents of the Netherlands who draw a foreign pension and do not have a Dutch pension and the family members, partner and children under the age of 18 who live in the Netherlands of people working abroad are entitled to care under the Dutch regulations, even if they require a type of care not covered by entitlements in the country that pays their pension or their country of residence. The costs of the care provided are payable by the insurance system of the country in question. The insured person has to pay any personal contributions stipulated by Dutch law and the Dutch obligatory personal excess. The parties concerned must register with a care insurer designated by the Minister of VWS using a form issued by the insurance body in the country that pays their pension or where they work. The Dutch care insurer will issue Dutch proof of insurance after registration. Care can be obtained abroad in the manner outlined under category 1. Many international regulations also give these individuals the option of obtaining care in the country that pays their pension or where they work or in another country that is party to the international regulation. Consent from the insurance body in their country of residence is usually required, as the costs of that care are generally payable via the insurance system of their country of residence.
4.4 Legal proceedings at the European Court of Justice

Disputes about care provision in an EU/EEA Member State may be placed before the national court of law with jurisdiction when it is believed that the generally binding provisions of the Treaty on the functioning of the European Union (EU-Werkingsverdrag) or the regulations based on this treaty have been violated. In the event of a dispute regarding the clarification of these European regulations, the national court is authorised and – in the highest instance even obliged – to ask the European Court of Justice to issue what is known as a preliminary ruling (i.e. request for a judgement by the Court regarding the interpretation of an EU treaty regulation. The preliminary ruling by the Court of Justice is binding on national legal systems.

The European Court of Justice is also responsible for what are referred to as ‘infraction proceedings’, which the European Commission (EC) can institute if the latter believes that Member States are failing to apply European regulations properly. The proceedings start with a formal request submitted to the Member State in question to conform voluntarily to the requirements of the treaty or the regulations in question. If the Member State refuses to address the violation, the EC drafts a well-substantiated recommendation and invites the Member State to take any essential measures – potentially specified – to rectify the violation within the deadline it sets. If the Member State fails to comply with the recommendation by the deadline, the EC can initiate an appeal to the European Court of Justice.
4.5 Treaty countries

Insured persons and people with entitlements under treaties are entitled to medical care in the following countries in accordance with international coordination regulations applicable in that country:

- EU Member States: Belgium, Cyprus (the Greek part), Germany, Denmark, Estonia, Finland, France, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Austria, Poland, Portugal, Slovenia, Slovakia, Spain, the Czech Republic, the United Kingdom and Sweden.
- EEA Member States: Liechtenstein, Norway and Iceland.
- In addition: Australia (only in the event of temporary residency), Turkey, Morocco, Tunisia, Cape Verde, Croatia and Switzerland.

The old social security treaty between the Netherlands and the former Yugoslavia still applies in the states of Macedonia, Serbia-Montenegro (Federal Republic of Yugoslavia) and Bosnia-Herzegovina, provided this has not been replaced by individual treaty arrangements between these states and the Netherlands. Treaty negotiations have been completed with Macedonia and the Federal Republic of Yugoslavia, the approvals procedure for the implementation of those treaties has been initiated.
Related legislation
5.1 Health Care (Market Regulations) Act

The Health Care (Market Regulations) Act (Wet marktordening gezondheidszorg (WMG)) regulates various issues, including the establishment of the NZa. It also defines the tasks, authorities and instruments of the NZa, as well as the relationship between the NZa and the Minister and other regulators and supervisory authorities17.

Organisation of the NZa

The NZa is an independent administrative body and a legal entity under public law. Funded from the budget of the Ministry of VWS, the NZa has a maximum of three members. Interest groups have no special legal position as regards the preparation of the authority’s decisions. The NZa has established advisory committees in which they are represented. The staff are public servants employed by the NZa.

Tasks of the Netherlands Care Authority

The NZa’s tasks are to:

• Regulate the care provision, health insurance and care procurement markets (i.e. creating, monitoring and regulating markets, including rates and performance). The NZa sets health care rates insofar as not excluded from regulations (i.e. free or exempted rates). The Minister sets the type of rate: free, minimum, maximum or bandwidth rates.
• Oversee the lawful implementation of the Zvw by care insurers, also with respect to the duty of care, acceptance obligation, and the ban on premium differentiation.
• Oversee the lawful and effective implementation of the AWBZ by care insurers, care offices and the CAK.
• Impose specific obligations on parties with significant market power to stimulate the care procurement market.
• Establish general rules for care providers and health insurers in connection with market transparency for consumers. The NZa is authorised to publish information on transparency if care providers or insurers consistently fail to meet standards.

The NZa also accommodates the care fraud hotline, which addresses facts and circumstances that may not be in keeping with the WMG. Everyone can contact this hotline to report, for instance, bills from care providers that do not reflect the rates set by the NZa. The NZa coordinates follow-up with the Fiscal Intelligence and Investigation Service (Fiscale inlichtingen- en opsporingsdienst), the Economic Investigation Service (Economische controledienst), and the Public Prosecutor (Openbaar Ministerie).

Relationship between the Minister of VWS and the Netherlands Care Authority

The Minister of VWS determines the main features of policy and takes politically relevant decisions, while the NZa implements and enforces the law. The Minister decides, for example,

17 The Health Care (Market Regulations) Act came into effect on 1 October 2006.
which market segments will be subject to free pricing. If necessary, the NZa then imposes obligations on a party with significant market power. The Minister also determines, for example, the form of price regulation in market segments where it is felt rates should be regulated. The NZa develops and applies these price regulation decisions.

The Minister appoints the member of the NZa board, approves its budget, work programme, annual accounts and management regulations, and sets its budget. The Minister can furthermore advise the NZa on approaches and working methods applied in achieving its tasks and on the content of policy rules and general regulations. The Minister can also submit generally applicable decisions by the NZa to the Crown for annulment and take action if the NZa neglects its duties.

Relationship between the Netherlands Care Authority and other regulators

Among its duties, the NZa must exchange information with the NMa, DNB, AFM, the Board for the Restructuring of Care Institutions (College sanering zorginstellingen (CSZ)) and the IGZ as a means of coordinating and executing their tasks. They also draw up cooperation protocols. The NMa monitors competition in general, the DNB the prudential supervision of health insurers with a view to financial soundness, and the AFM the conduct of care insurers in so far as this does not mean any care-specific supervision of conduct, which is the responsibility of the NZa. The CSZ responds to issues relating to the continuity of care. The IGZ monitors the standard of care.

5.2 Social Support Act

The Social Support Act (Wmo) became law on 1 January 2007. Pursuant to this Act, municipal authorities are responsible for policy relating to social support for their residents and its implementation. As a participation act, the guiding principle of the Wmo is ‘participation’. The Wmo policy of municipal authorities has to promote participation in society, including those who for whatever reason whatsoever are termed vulnerable. The local authority is responsible for social support, which can link up well with the recipients’ needs and their immediate living environment. Social support policy can be integrated with other local policy areas, such as welfare and public housing.

The Wmo represents a merger of, for example, the Welfare Act 1994 (Welzijnswet 1994), the Services for the Disabled Act (Wet voorziening gehandicapten (Wvg)), as well as the domestic care provided under the AWBZ.

Nature of the Act

Municipal authorities have a considerable degree of policy freedom in implementing the Wmo. The Minister of VWS is responsible for the system of the Act, not for the way in which individual municipal authorities interpret the policy. The Wmo is based on the concept of self-reliant citizens who bear personal responsibility for participating in society. If they encounter any problems, it is the task of the municipal authority to provide support.
The municipal council drafts a plan for a maximum of four years, which outlines the direction of the decisions to be taken regarding social support. Municipal authorities are also obliged to adopt a Wmo bye-law which records the purport of individual provisions and the conditions under which these are to be made available.

**Areas of scope and obligation to compensate**
Under the Wmo, social support encompasses nine areas of scope for the provision of support to:

- Promote social cohesion and quality of life in villages, districts and neighbourhoods.
- Provide preventative support and guidance to young people having a hard time growing up and to parents encountering child-rearing problems.
- Provide information, advice and support.
- Support voluntary carers and volunteers.
- Encourage participation in society and the independent functioning of people with a disability, chronic psychological problem or a psychosocial problem.
- Make arrangements for people with a disability, chronic psychological problem or a psychosocial problem to ensure they can live independently or participate in society.
- Support community shelters, advice and support centres for domestic violence.
- Support public mental health care (OGGZ).
- Support ambulatory care for addicts.

Municipal authorities work out the specifics of each area of scope, enabling them to interpret the Wmo in a manner befitting the local situation.

**Obligation to compensate**
As part of the municipal authorities’ have an obligation to compensate. In short, they are obliged to assist residents with a limited degree of self-sufficiency and ability to participate in society to run a household, move about inside and outside of the home, move around locally using a vehicle and meet others. Municipal authorities also have to take account of personal characteristics, needs and their capacity to take measures independently. The Court assesses whether the municipal authorities interpret this obligation to compensate in a satisfactory manner.

The municipal authority can fulfil its obligation to compensate in a number of different ways, including a formal individual provision, for example, a wheelchair or adaptation in the home, making it possible to manage the household and move around the home. The obligation to compensate can also be fulfilled by means of group facilities (e.g. group transport, care for addicts, local assistance, women’s shelters or the organisation or informal support (neighbourhood support, volunteer work).

Consequently, the obligation to compensate imposes a responsibility on the municipal authority to provide a sufficient range of facilities. For individual facilities, people can choose between care in-kind or a PGB. Those who opt for the latter receive money to be used to identify, select and pay
for the required provisions. The PGB expenditure has to be comparable and sufficient.

Wherever possible, the municipal authority has to have third parties provide the social support. Most group and individual facilities are not provided by the municipal authority itself, but by a private party. For example, housekeeping assistance is provided by private parties, such as home care institutions.

Public participation
In connection with the policy freedom given to municipal authorities regarding nine areas of scope, account for the policy pursued is rendered horizontally. In other words, the municipal authorities are not held accountable to the State (i.e. vertically), but to the local council and the public.

With a view to ensuring the smooth operation of this process, it is essential that the public is involved in drawing up policy. Most municipal authorities now work with a local Wmo council, which includes representatives of various interest groups involved in the Wmo. This council advises the municipal authority and is involved in the early stages of general decision-making. Other forms of public participation are also possible. Municipal authorities are free to make all necessary arrangements as they see fit.

In the context of horizontal accountability, municipal authorities are also obliged to complete an annual questionnaire on performance and to investigate the degree of satisfaction among social support applicants. This information is published every year before 1 July. The municipal authority is also obliged to make these details available to third parties. The research institution designated by the Minister of VWS compiles and analyses the data, referring to it in reports comparing and contrasting the performance of various municipal authorities. The publication of this data will enable the public and civic/social organisations to compare the performance of the various municipal authorities.

Personal contribution or individual contribution
The municipal authority can opt to impose a personal contribution on those who claim use of a provision in-kind or financed using a PGB. This has to be laid down in the municipal Wmo bye-law. The amount of personal contributions is linked to legally defined maximum limits. The CAK imposes the personal contributions and collects them from the public on behalf of the municipal authorities.

When the municipal authority financially reimburses someone for a provision (e.g. adaptation to the home), the municipal authority can for payment of an individual contribution. As a result, the amount of the financial reimbursement and the personal contribution depends partly on the income of the provision recipient and of his or her partner. The individual contribution is withheld by the municipal authority. The amount of the individual contribution is linked to legally defined maximum limits.
The CAK ensures that the total amount of personal contributions and individual contribution under the Wmo and the AWBZ do not exceed the maximum.

5.3 Chronically Ill and Disabled Persons (Allowances) Act (Wet tegemoetkoming chronisch zieken en gehandicapten)

The Chronically Ill and Disabled Persons (Allowances) Act (Wtcg) became law in January 2009. The chronically ill and disabled persons often incur extra care expenses. Establishing rules for an allowance for the chronically ill and disabled, the Wtcg replaces the extraordinary expenditure scheme included in the income tax return. This scheme made it possible to deduct medical expenses from the taxable income, as a result of which people paid less tax or even received a refund. The Wtcg consists of a number of measures to compensate for the abolition of the extraordinary expenditure scheme. These measures are clarified briefly below.

General allowance

Every year, the chronically ill and disabled automatically receive a general allowance if they fulfil one or more conditions. Whether a person is eligible for a general allowance and, if so, the amount involved depend on the age and the use of care.

To be eligible for the allowance in 2009, people have to comply with one or more of the following criteria. They must have:

• Had grounds in 2009 for at least 26 weeks of care under the AWBZ in a care institution (i.e. at least one day a week at an AWBZ institution) or at home (i.e. at least one hour or a half day each week).

• Received at least 26 weeks of assistance in-kind with housekeeping in 2009 under the Wmo (housekeeping financed using a PGB was not yet eligible in 2009).

• Been admitted in 2008 for a serious chronic disorder (e.g. cancer, cystic fibrosis, pancreatic disorders, chronic bronchitis and pulmonary emphysema (COPD), asthma, cardiac conditions and renal complaints disorders, Parkinson’s or serious injuries).

• Received rehabilitation care in 2008 in or by a certified rehabilitation centre.

• Received physiotherapy or remedial therapy in 2009 due to a chronic disorder.

• Used certain medicines intensively in 2009 (entitlement to a number of medicines is contingent on whether certain medical devices have also been reimbursed).

Care insurers and the CIZ forward to the CAK the name, address, contact details, Citizen Service Number and date of birth of those fulfilling these conditions. The CAK then sets the allowance and effects payment to the entitled parties. In all cases, those in question have to be insured in the Netherlands for medical expenses under the Zvw and must have received the care in the Netherlands.
The Wtcg provides for a high and low allowance, the amount of which depends on, for example, the individual’s age, use of care and living situation (i.e. at home or in a care institution). Anyone aged 65 or older in the year to which the allowance relates receives either €150 or €350. Anyone under the age of 65 receives either €300 or €500. The allowance is exempt from income tax and does not affect the amount of the tax return deductions.

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<tr>
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<th>Younger than 65</th>
<th>Older than 65</th>
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<tr>
<td>Low allowance</td>
<td>€300</td>
<td>€150</td>
</tr>
<tr>
<td>High allowance</td>
<td>€500</td>
<td>€350</td>
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</table>

The CAK pays the allowance annually in arrears. The allowance for 2010 is paid out in the autumn of 2011. Anyone entitled to an allowance is informed automatically to that effect in the autumn of 2011. The CAK transfers the amount in question at the end of 2011 to the account of the party with the entitlement. The recipient does not have to take any action.

**Discount on the AWBZ/Wmo personal contribution**

Personal contributions for care supplied since 2009 are no longer tax deductible. The entitlement to a discount on the personal contribution for AWBZ care or the Wmo is subject to the following conditions:

- **Residential care**
  Those residing in an AWBZ institution have paid a lower personal contribution since January 2009. The discount for people aged 65 or older is 8%, while those under the age of 65 receive a 16% discount.

- **Non-residential care/Wmo**
  A 33% discount applies to people who live independently or who receive home care under the AWBZ. The same applies to a PGB.

**A new fiscal scheme for specific care expenses**

A new fiscal scheme for specific care expenses has been in place since 2009. These expenses are tax deductible insofar as no reimbursement or allowance has been provided, for example, via the health insurance/supplementary health insurance or the special assistance grant. The general allowance for the chronically ill and disabled does not count as a reimbursement for specific care expenses.

The following expenditures are still tax deductible:

- Prescribed medicines and medical assistance.
- Additional family help.
- Additional clothing and bedclothes.
- Diet prescribed by a doctor.
- Medical devices (e.g. support soles or a set of dentures).
- Patient visits and transport.
The following have no longer been tax deductible since 2009:

- Personal contributions under the AWBZ/Wmo.
- Premium for supplementary insurance.
- Funeral, cremation, childbirth and maternity care expenses.
- Expenses for eyeglass frames, eyeglass lenses, contact lenses and laser eye treatment.
- Expenses associated with old age, incapacity for work and/or chronic illness and the family medicine chest.
- Adoption expenses; the Ministry of Security and Justice has a separate, non-fiscal arrangement for these costs.

**Compensation for the elderly**

Under the extraordinary expenditures scheme, people aged over 65 could add a fixed amount to the exceptional expenditure. Instead, however, they have received since January 2009 a higher allowance on the payment under the terms of the General Old Age Pensions Act (Algemene Ouderdomswet (AOW)), i.e. the AOW allowance. The elderly person’s tax credit and the income limit have been raised for this discount. As a result, more family members are eligible for the elderly person’s tax credit. The upper income limit for the rent allowance for the elderly has also been raised.

**Compensation for those unfit for work**

Under the extraordinary expenditures scheme, people who are unfit for work were permitted to deduct a fixed amount. This has been replaced by a net annual allowance of €350. This allowance is designed for those who have an unfit for work rating of 35%, who are insured under the AWBZ and who receive invalidity benefit from the Institute for Employee Benefits Scheme (Uitvoeringsinstituut Werknemersverzekeringen (UWV)). It makes no difference whether the benefit is made possible under the terms of the Invalidity Insurance Act (Wet op de arbeidsongeschiktheidsverzekering), Work and Income (Capacity for Work) Act (Wet werk en inkomen naar arbeidsvermogen), Return to Work (Partially Disabled Persons) Scheme (Regeling Werkhervatting Gedeeltelijk Arbeidsgeschikten), Fully Disabled Persons Income Scheme (Regeling Inkomensvoorziening volledig arbeidsgeschikten), Invalidity Insurance (Young Disabled Persons) Act (Wet arbeidsongeschiktheidsvoorziening voor jonggehandicapten) or the Invalidity Insurance (Self-Employed Persons) Act (Wet arbeidsongeschiktheidsverzekering independenten).
5.4 Personal excess compensation

In certain cases, insured persons can receive an allowance to compensate for the personal excess. The CAK pays this amount automatically to those entitled.

Who is eligible for personal excess compensation?
The following are eligible for the 2010 personal excess compensation:
• People who on 1 July 2010 had resided in an AWBZ institution for at least six consecutive months. This includes nursing homes, institutions for the physically disabled, institutions for the mentally disabled, psychiatric hospitals and sheltered living institutions.
• People who received inpatient treatment for certain disorders by a medical specialist in 2007 and 2008.
• People who have a certain chronic disorder for which more than 180 standard daily dosages of specific active ingredients in medicines were supplied in 2008 and 2009. A standard daily dosage is an internationally set measure for the quantity of active ingredient in medicines which an adult uses on average per day.

List of disorders
The compensation scheme applies to those who take medicines for the following disorders:
• Disorders of the brain and spinal cord.
• Asthma and COPD.
• Cystic Fibrosis/Pancreatic disorders.
• Type I and II diabetes.
• Epilepsy.
• Glaucoma.
• Growth hormones.
• Heart conditions.
• HIV/AIDS.
• Cancer.
• Renal complaints.
• Parkinson’s.
• Psychological disorders.
• Rheumatism.
• Thyroid gland disorders.
• Transplants.
• Crohn’s disease/Colitis Ulcerosa.
5.5 Consumer Rights in Health Care Act

The Consumer Rights in Health Care Act (Wcz) entitles consumers to effective care and also gives them a say in the organisation and provision of care. To this end, they have to have a sound legal position. In 2008, with a view to achieving this, the government established the initiative ‘Seven health care consumer rights: investing in the care relationship’ (Zeven rechten voor de cliënt in de zorg: investeren in de zorgrelatie). This was established in close consultation with consumers, care providers and insurers. The government used this programme as the basis for the Wcz bill. The Wcz will only become law after approval by both Houses of Parliament.

The government’s aim with the Wcz is to strengthen and clarify the consumer’s legal position both individually and severally. The law entitles consumers to good care not only in the context of individual medical treatment, but in all relationships between consumers and care providers along the entire care chain. Consumers will soon find it easier to choose care providers that are best suited to them and their care needs. It will also simply complaints procedures.

The Wcz not only lays down consumer rights and obligations, but also the responsibilities of care providers as regards the standard of care. Inclusion of the rules governing the relationship between care provider and consumer in a single piece of legislation facilitates the more effective coordination of the rights and obligations of both parties.

Focus on the consumer

The government’s aim is for everyone to have access to good, safe, expedient and affordable care. The focus of the Dutch care system is very much on the consumer. Care providers, care insurers and policymakers have to arrange and organise the care from the consumer’s perspective. In addition to the practical significance that the Wcz has for the relationship between care provider and consumer, the bill also symbolises a shift in thought regarding the management and control of care.

The basis for good care is the relationship of trust between the consumer and the care provider. A foundation rooted in mutual trust enables the care provider to ask the client all necessary and relevant questions and discuss the options for providing care openly. Within the framework of trust, the consumer has to trust that the care is of a good standard and that the care provider respects his or her rights.

The client must also enable the care provider to provide good quality care. Consumers are expected to cooperate with treatment, nursing and care. This means that the client is responsible for providing optimal information to the care provider, sharing ideas, participating in the decision-making process relating to treatment and instructions, complying with advice and observing lifestyle guidelines. All this is intended to clarify the mutual relationship between the consumer and the care provider in the context of care practice by means of bilateral general conditions. This goal has now been achieved in the nursing, care and home care sector.
Why is a new law necessary?
The rights of consumers and the associated obligations for care providers have been laid down in various laws. This makes it possible for consumers to ascertain what their rights are. Care providers have difficulty viewing the interrelationships of their obligations. Combining the rules in existing laws to form a single new law permits the legal position of the consumer and regulations governing the functioning of care providers to be arranged together. The creation of a single piece of legislation also supports the goal of achieving greater cohesion in care, for example, between the first and the second lines and between long-term and curative care. It also achieves greater transparency for all the parties concerned, which is vital for increasing the standard of care and the influence of consumers.
# List of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AFBZ</td>
<td>General Exceptional Medical Expenses Fund (Algemeen Fonds Bijzondere Ziektekosten)</td>
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<td>AFM</td>
<td>Netherlands Authority for the Financial Markets (Autoriteit Financiële Marktten)</td>
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<tr>
<td>AOW</td>
<td>General Old Age Pensions Act (Algemene Ouderdomswet)</td>
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<tr>
<td>Awb</td>
<td>General Administrative Law Act (Algemene wet bestuursrecht)</td>
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<tr>
<td>AWBZ</td>
<td>Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten)</td>
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<tr>
<td>Awir</td>
<td>General Income-Linked Regulations Act (Algemene wet inkomensafhankelijke regelingen)</td>
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<tr>
<td>BJZ</td>
<td>Youth Care Agency (Bureau Jeugdzorg)</td>
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<tr>
<td>BSN</td>
<td>Citizen Service Number (Burgerservicenummer)</td>
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<tr>
<td>CAK</td>
<td>Central Administration Office (Centraal Administratie Kantoor)</td>
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<td>CIZ</td>
<td>Care Indication Determination Centre (Centrum indicatiestelling zorg)</td>
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<tr>
<td>CPB</td>
<td>Netherlands Bureau for Economic Policy Analysis (Centraal Planbureau)</td>
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<tr>
<td>CVZ</td>
<td>Health Insurance Board (College voor zorgverzekeringen)</td>
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<td>CSZ</td>
<td>Board for the Restructuring of Care Institutions (College sanering zorginstellingen)</td>
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<td>DBC</td>
<td>Diagnosis treatment combination (Diagnose behandelcombinatie)</td>
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<td>DKGs</td>
<td>Diagnostic cost groups (Diagnose kostengroepen)</td>
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<tr>
<td>DNB</td>
<td>Dutch Central Bank (De Nederlandsche Bank)</td>
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<tr>
<td>EEA</td>
<td>European Economic Area (Europese Economische Ruimte)</td>
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<tr>
<td>EHIC</td>
<td>European Health Insurance Card (Europese ziektekostenverzekeringekaart)</td>
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<td>EU</td>
<td>European Union (Europese Unie)</td>
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<tr>
<td>EU-Werkingsverdrag</td>
<td>Treaty on the functioning of the European Union</td>
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<tr>
<td>FKGs</td>
<td>Pharmaceutical cost groups (Farmaceutische kostengroepen)</td>
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<tr>
<td>GGZ</td>
<td>Mental health care (Geestelijke gezondheidszorg)</td>
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<tr>
<td>GVS</td>
<td>Medicines reimbursement system (Geneesmiddelenvergoedingensysteem)</td>
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<tr>
<td>IGZ</td>
<td>Health Care Inspectorate (Inspectie voor de gezondheidszorg)</td>
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<tr>
<td>MOOZ</td>
<td>Overrepresentation of Elderly Health Insurance Act Beneficiaries (Joint Financing) Act (Wet medefinancing oververtegenwoordiging oudere ziekenfondsverzekeren)</td>
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<tr>
<td>NMa</td>
<td>Netherlands Competition Authority (Nederlandse Mededingingsautoriteit)</td>
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</table>
NPCF  Federation of Patients and Consumer Organisations in the Netherlands (Nederlandse Patiënten en Consumenten Federatie)
NZa  Netherlands Care Authority (Nederlandse Zorgautoriteit)
PGB  Personal care budget (Persoonsgebonden budget)
SKGZ  Health Care Insurance Complaints and Disputes Foundation (Stichting Klachten en Geschillen Zorgverzekeringen)
de Verordening  EC Regulation no. 883/2004 of the European Parliament and the Council of 29 April 2004 concerning the coordination of social security systems
VWS  Ministry of Health, Welfare and Sport (Volksgezondheid, Welzijn en Sport)
Wcz  Consumer Rights in Health Care Act (Wet cliëntenrechten zorg)
WFD  Financial Services Act (Wet financiële dienstverlening)
WMG  Health Care (Market Regulations) Act (Wet marktordening gezondheidszorg)
Wmo  Social Support Act (Wet maatschappelijke ondersteuning)
Wtcg  Chronically Ill and Disabled Persons (Allowances) Act (Wet tegemoetkoming chronisch zieken en gehandicapten)
WTZi  Care Institutions (Accreditation) Act (Wet toelating zorginstellingen)
Wvg  Services for the Disabled Act (Wet voorzieningen gehandicapten)
WZT  Health Care Allowance Act (Wet op de zorgtoeslag)
Zvw  Health Insurance Act (Zorgverzekeringswet)

Additional information on international aspects of the Zvw and the AWBZ is included in a separate VWS booklet entitled ‘Your health insurance if you live outside the Netherlands’ (Uw ziektekostenverzekering als u in het buitenland woont). This booklet can be downloaded from www.rijksoverheid.nl/zorgverzekering
Acts of Parliament


EC Regulation no. 883/04 of the European Parliament and the Council of 29 April 2004 concerning the coordination of social security systems (OJ no. L 149 of 5.7.1971)


Bills

Consumer Rights in Health Care Act (Wet cliëntenrechten zorg) (Parliamentary Papers II 2010, 32 402)