REPORT ON THE SOCIAL SECURITY CONVENTIONS 102, 128 AND 130

For the period from 1 June 2013 to 1 June 2016, made by the Government of the Netherlands, in accordance with article 22 of the Constitution of the International Labour Organisation, on the measures taken to give effect to the provisions of the

SOCIAL SECURITY (MINIMUMSTANDARDS) CONVENTION No. 102
INVALIDITY, OLD-AGE AND SURVIVORS' BENEFITS CONVENTION, 1967 (No. 128)
MEDICAL CARE AND SICKNESS BENEFITS CONVENTION NO. 130

Ratification of Convention 102 was registered on 11 October 1962.
Ratification of Convention 128 was registered on 27 October 1969.
Ratification of Convention 130 was registered 17 January 2006.

Changes to Dutch social security legislation regarding Conventions 102,128 and 130

A. Changes to rules under the General Old Age Pensions Act (Algemene Ouderdomswet — AOW)

I Changes to AOW pension beginning date

With effect from 1 April 2012, the date from which the AOW [statutory state retirement] pension is paid has changed.
Prior to 1 April 2012, the beginning date for the AOW pension was the first day of the month in which a person reached the age of 65. As from 1 April 2012, the AOW pension is paid from the date on which a person reaches the age of 65 (i.e. his/her birthday). This is a cost-saving measure by the government. It applies to anyone reaching the age of 65 on or after 1 April 2012.

II Gradual increase in AOW pension age, from 65 to 66 in 2019 and 67 in 2023

On 1 January 2013, the AOW pension age was increased by one month. Over the next few years, the pension age will further gradually increases as table below. From 2022, pension age will be linked to life expectancy.

Increase in AOW pension age						
2013 1 month 65 + 1 month	**2014** 1 month 65 + 2 months	**2015** 1 month 65 + 3 months	**2016** 3 months 65 + 6 months	**2017** 3 months 65 + 9 months	**2018** 3 months 66 years	**2019** 4 months 66 years + 4 months
2020 4 months 66 + 8 months	**2021** 4 months 67 years	**2022** linked to life expectancy				

In raising the AOW pension age, account was taken of the transitional problems that the increase could cause for those with little time to prepare and little opportunity to make up for the loss of income. In order to ease the transition for those concerned, the following transitional measures have been adopted.

- The increase is being introduced gradually. These gradual arrangements apply to all.
- The date up to which those in receipt of an AOW pension may qualify for the AOW supplementary allowance for their partner has been extended to 1 April 2015, in order to prevent those born in November or December 1949 from losing their entitlement to the supplementary allowance for partners because of the rise in the AOW pension age. The supplement may revive if it's solely terminated as a result of accidental increase of income of the spouse.
- The person who faces a temporary drop in income due to the increase in the AOW pension age can be eligible for a bridging benefit (OBR). This can be the case if a VUT early retirement benefit or similar pension or benefit stops, decreases or is replaced by an old-age pension before the AOW pension starts. The bridging benefit is not a loan. It is a benefit at a minimum level and other income can diminish this benefit.
- The payment of statutory social security benefits (incapacity benefit, unemployment benefit and survivors' pensions) and statutory social welfare benefits (social assistance, IOAW [income support for older and partially incapacitated unemployed workers], IOAZ [income support for older and partially incapacitated self-employed persons], IOW [income support for older unemployed workers]) will be extended, provided that the relevant conditions are met, up to a person's AOW pension age.
- Those whose income threatens to fall below the social minimum as a result of the increase in the AOW pension age may claim (special) social assistance.

III Cut in AOW supplementary allowance for partners

Those in receipt of an AOW pension may qualify for an AOW supplementary allowance if their partner is under 65 and has little or no income. The supplementary allowance may not exceed 50% of the Dutch statutory net minimum wage.

Under rules in force since 1 August 2011, the supplementary allowance for partners is cut by 10% if the total income of the recipient of an AOW pension and his/her partner, including the AOW pension, is more than € 2 667,44 per month (2016).

IV Simplification of rules for people living apart together

The amount of the AOW-pension depends on the living situation; a single pensioner receives an amount of 70% of the net minimum wage, whereas a pensioner who is living together receives 50% of the net minimum wage. A person is considered to be living together if one is running a joint household. This means that two individuals share the same residence in the same building, share the costs of living and care for each other.
Concerning people who live apart together ("LAT")- relationship it was sometimes difficult to judge whether in fact a shared household existed and whether the two individuals were actually living together.
In order to clarify those rules, the so-called "two homes rule" has been introduced. In case both partners have their own place of living, they are considered to be living on their own, if the following conditions have been met:

*)Both partners are not married;
*)Both partners dispose of their own home (this may be rented or owner-occupied);
*)Both partners are registered on their own address;
*)Each partner pays for all the costs and expenses for their own home
*)Each partner may freely dispose of his or her own home.

The advantage for these persons is that they receive a higher pension, namely 70% instead of 50% of the net minimum wage. The regulation entered into force on February 1, 2014.

V Change in policy conditions voluntary old-age state pension

As per March 24, 2014 he terms of the voluntary old-age pension for people that have come to live or work for the first time in the Netherlands and buy pension rights retroactively are adjusted.

VI AOW top-up

With effect from 1 January 2015 the KOB top-up is discontinued and replaced by the new AOW top-up. The AOW top-up is an extra amount on top of the AOW pension. The amount of the top-up depends on the number of years a person has built up rights to an AOW pension. For each year of insurance under the AOW scheme, a person builds up rights to 2% of the full AOW pension. One can build up AOW pension rights for a maximum of 50 years (=100%). As from 1 January 2016, the maximum AOW top-up is € 25.48 gross per month.

B. Changes in the area of enforcement and fraud

I The new Social Affairs and Employment (Stricter Enforcement and Sanctions) Act (Wet aanscherping handhaving en sanctiebeleid SZW-wetgeving)

With effect from 1 January 2013, anyone fraudulently receiving a benefit must pay back not only the overpaid sum in its entirety, but also a fine equal to the overpaid sum. Due to a court ruling in 2014 the fine must be proportional en tailored to the individual circumstances. The law is therefore adjusted.

- Measures in cases of repeated fraud

Anyone committing fraud for the second time in five years can receive a fine amounting to 150% of the sum unduly received. The fine in the case of a repeat offence will be deducted from the benefit until it has been repaid in full, over a period of not more than five years. There is an exception for ('safety net') social assistance, where the fine for a repeat offence will be deducted for a period of not more than three months (and is not required to be deducted in full).

- Transitional provisions

Due to court ruling in 2014 the transitional arrangements are adjusted to international law. The law is therefore adjusted:

- contraventions and criminal offences committed before 1 January 2013 come under the old rules;
- contraventions committed before 1 January 2013 but continuing after 31 January 2013 come under the new rules at that time in force.

II New Act on home visits in cases where fraud is not suspected (Wet huisbezoeken bij geen vermoeden van fraude)

The organisation paying a benefit may ask a person to cooperate with a home visit regardless of whether or not fraud is suspected. Up to 1 January 2013, refusal to allow a home visit led to an application being rejected or benefits being stopped only if the benefits organisation had reasonable grounds for suspecting fraud. As from 1 January 2013, refusal to allow a home visit also has consequences for the payment of benefits in cases where — although fraud is not suspected — there is uncertainty about the circumstances in which a person is living, if the person concerned fails to supply other evidence of his/her circumstances. It is impossible in such cases for the benefits organisation to establish whether a person is legally entitled to

receive benefits. This will lead to benefits being cut or not paid at all. The circumstances in which persons are living means both their housing situation (whether they are actually living at the address given; whether they are living in separate accommodation) and their household situation (single or married/joint household). As from 1 January 2015 the household situation also comprises the number of co-occupants in the same house that can share housing costs.

C. Act limiting sick leave and incapacity entitlement for those covered by 'safety net' provisions (Wet beperking ziekteverzuim en arbeidsongeschiktheid vangnetters) Date of entry into force: 1 January 2013 (except for measures 2 and 4)

If workers employed on a permanent basis become ill, their employer is required to continue paying their wages. Benefits under the Sickness Benefits Act (Ziektewet —ZW) may be claimed by workers:

1. who do not (or no longer) have an employer and who become ill, such as those receiving unemployment benefits, temporary agency workers and workers whose employment contract runs out during their illness;
2. who have an employer, but have a high risk of becoming ill (those covered by a no-risk policy, organ donors and pregnant women).

These groups are covered by the Sickness Benefits Act 'safety net' provisions. Sickness benefits are payable for a maximum period of 104 weeks.

Measures for those covered by 'safety net' provisions

1. The conditions for entitlement to sickness benefit after the first year of illness have been made stricter, through an amendment to the relevant Sickness Benefits Act criterion. The Act lays down that the existing criterion of 'his/her work' (the work performed most recently) is replaced by the criterion applied under the legislation on incapacity for work (the Work and Income according to Labour Capacity Act — Wet werk en inkomen naar arbeidsvermogen (WIA)), namely the ability to carry out 'generally accepted work'.
2. The proposal for an introduction of an employment record requirement in the Sickness Benefit Act has been withdrawn however, social partners have started pilots where they try to re-integrate the workers receiving sickness benefit back in work.
3. Stricter obligations are being placed on sickness benefit recipients to re-integrate into the employment market and look for work, in line with the obligations under the legislation on incapacity for work, with the aim of enabling them to return to work more quickly.

Financial incentives for employers

4. Changes to financing rules under the Sickness Benefits Act and the Return to Work (Partially Disabled) Regulation (Regeling Werkhervatting Gedeeltelijk Arbeidsgeschikten — WGA) create more financial incentives for large employers. More of the sickness and incapacity costs for temporary agency staff and workers with temporary employment contracts will be passed on to the last employer, with sickness and incapacity benefit costs for atypical workers being passed on directly to large employers via differences in contributions.

For technical implementation reasons, the proposed date of entry into force of this section on differences in contributions is 1 January 2014.

Speeding up the return to work of those covered by 'safety net' provisions

5. The opportunity has been created for the implementing body for employee insurance schemes (UWV) to conclude agreements with employers and sectors aimed at getting sickness benefit recipients back into work.

6. The maximum period for trial placements is being extended to six months.

D. Health Insurance Act (Zorgverzekeringswet (Zvw))

1. *Indexation of the compulsory deductible*
For 2015, the yearly indexation of the compulsory deductible led to a raise of €15. The compulsory deductible is set at €385 in 2016.

Types of health care which are exempt from the compulsory deductible:
- General practitioner care
- Obstetric care
- Maternity care
- Care related to certain chronic illnesses (Diabetes type 2, COPD, CVR)
- District nursing services
- Care and travel costs related to organ donation
- All types of health care delivered to children under the age of 18

2. *Reform of the Compulsory deductible compensation scheme (Compensatieregeling Eigen Risico (CER)) and of the Compensation for the chronically ill Act (Wet tegemoetkoming chronisch zieken en gehandicapten (Wtcg))*
As of 1 January 1st 2014 both the CER and the Wtcg have been repealed. The provisions of these acts have been transferred to the Social Support Act (Wet maatschappelijke ondersteuning (Wmo 2015)). With this transition the administration has been transferred from the national government to the local governments at municipality level.

The reason for this change is that often people whom the schemes were not intended for received the benefit, where other groups who really needed the benefit did not receive it, as a result of the criteria under the CER en Wtcg-schemes. For example, it turned out that in practice often chronically ill people who had structural additional expenditures did not receive the benefits. At the same time incidentally ill people received the benefits. Due to their proximity to the individuals, local governments are in a better position to assess who is eligible for the benefit in question and who is not. This way the benefits reach the right people.

3. *Changes in the basket of care*
Several types of benefits in kind have been transferred to the Health Insurance Act as a result of the repeal of the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten (AWBZ)). See paragraph B for more information on the long-term care reform:
- Care related to sensory disabilities.
- District nursing services.[1]
- Personal care budget for district nursing services.

[1] These services were transferred to the Health Insurance Act to centralise all district nursing services under one Act. The measure is aimed at allowing individuals to stay at home for as long as possible.

- The second and third year of treatment-focussed intramural mental health care.
- Dyslexia care has been removed from the basket of care of the Health Insurance Act.[2]

Long-term care reform and the repeal of the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten (AWBZ)).

The Netherlands has introduced a number of major reforms in the long-term care system to ensure that care continues to be accessible to all, of good quality and affordable. The AWBZ has been repealed as of January 1st 2015. Entitlements under the AWBZ have been transferred to the 2015 Social Support Act (Wet maatschappelijke ondersteuning 2015 (Wmo 2015)), the Youth Act (Jeugdwet) or to the Health Insurance Act (Zorgverzekeringswet (Zvw)). A new piece of legislation has been created to cover the remainder: the Long-term Care Act (Wet langdurige zorg (Wlz)).

These policy reforms were necessary because of three closely related reasons.

First of all, when the AWBZ came into force in 1968 as a residence-based social insurance scheme, it was meant to only cover exceptional, uninsurable health care costs. Over the years however, all different types of health care (costs) have been added to the insurance under the AWBZ that do not fulfil these requirements.

The Wlz, Zvw, Wmo 2015 and Jeugdwet together aim to provide a coherent legal framework within which health care and social support can be delivered according to the desires, capabilities and needs of individual people.

Secondly, under the AWBZ long-term care has become highly institutionalised; increasingly more individuals were living in residential facilities with comprehensive care. A development that had driven the AWBZ away from what it was initially intended for (exceptional, uninsurable health care costs).

The new system aims to change this. The intention is to keep people in their own homes longer, responding to their personal situation and determining what they can still do themselves or with help from their social network, whenever necessary with support from the municipality or care provided under a care insurance scheme.

Finally, since its entry into force in 1968, the amount of people receiving care under the AWBZ has grown substantially and with that, the budget that is required to fund the AWBZ. In 1968 the amount of people receiving care under the AWBZ was projected at 0,6% of the total population. In 2012 the amount of people entitled to care under the AWBZ had risen to 5% of the total population.

The 2015 long-term care policy reform aims to ensure future solidarity of the system and care and support for the most vulnerable people in society.

Following these three considerations a new long-term care system has been set up based on the following four principles:

1. Quality of life: the starting point of the new system is to focus on people's capabilities rather than disabilities.
2. Taking care of each other: when one needs support, one's own personal network and financial capabilities come first in providing support.
3. For those who do not have the (financial) capabilities to support themselves, care and social support is always provided.
4. Those who need care, assistance and supervision permanently, are entitled to care under the Wlz.

[2] Dyslexia care has been transferred to the Youth Act (Jeugdwet). The reason for this transfer is that dyslexia care is often provided by (youth) mental care providers who are reimbursed through the Youth Act. Coupling these types of care under one Act minimises the administrative burden.

In light of the principles above, the different types of care and social support previously part of the AWBZ have been reassessed. Depending on the (target) group the types of care and social support have been transferred to one of the four acts (Wmo 2015, Zvw, Jeugdwet, Wlz). This results in the following.

Changes as of January 1st 2015

The set up of the new long-term care system has led to several changes as of January 1st 2015. As mentioned above, the AWBZ has been repealed. Entitlements that used to be part of the AWBZ have been transferred to one of the following four acts, depending on the nature of the entitlement. For a visualisation of the changes and transfers, see Appendix 1.

- The Long-term Care Act (Wlz).
  Like the AWBZ, the Wlz is part of the social security system and all residents in the Netherlands are automatically insured, as are non-residents who work in the Netherlands. The insurance is financed through contributions. The new Act covers all forms of care for people with serious, long-term care needs who require intensive care or supervision at close hand 24 hours a day, such as vulnerable old people and people with severe disabilities. These might include elderly people with advanced dementia or people with a serious physical or mental impairment. The Act governs care in both institutions and at home. Benefits may be in kind, on the basis of a personal budget, or be made up of a combination of the two. Care is granted on the basis of a care needs assessment.

  To ensure a smooth transition, the starting point for the Wlz is that nobody is forced to leave a care institution he or she already lives in.

- The Social Support Act (Wmo 2015).
  The primary objective[3] of the Wmo 2015 is to enable individuals to live independently for as long as possible in their own homes and to participate in society. The Wmo 2015 differs from the Wlz in that the responsibilities for the execution and policy making of this act lie with the municipalities. Furthermore, the WMO 2015 is no social insurance but part of the welfare legislation in the Netherlands. Examples of support that fall under the Wmo 2015 are support for participation, support for independent living, support in cleaning the house and support for informal care.
  Furthermore, in the Wmo 2015 the right to this type of care, under certain conditions, is laid down, but the municipalities have a discretionary competence in choosing *how* they execute this act. It is not stipulated in advance what kind of provisions someone can apply for. The aim is to allow municipalities to 'tailor' the way care and support are provided for.

  Moreover, in assessing whether someone should receive tailored care or support, the municipalities will review the overall situation of the individual. They will assess whether and to what extent an individual's own social network or existing, commonly accessible, provisions can suffice in enabling the individual to live independently and participate in society. These circumstances are being considered by the municipality before a decision is being made. Clients can appeal the decisions if they disagree.

  In order to ensure a smooth transition period, the act contains a transitional arrangement: people who received care under the AWBZ which has been transferred to the Wmo 2015,

[3] The Social Support Act 2015 also contains provisions concerning domestic violence, shelter for the homeless, etc.

have a right to receive the same care they previously received until December 31st 2015.

- The Youth Act (Jeugdwet).
  All care because of a mental disorder, mental health care, parenting support and social support provided to children under the age of 18 have been decentralised under the Jeugdwet. Extension of the care provided under the Jeugdwet is possible up until the age of 23 if there is no other act that regulates the type of care provided.

  Most entitlements to care for disabled children and young people previously part of the AWBZ have been transferred to the Jeugdwet. Moreover, entitlements to and provisions for youth related care under the Zvw (see *changes in the basket of care* above) and the old Wmo (social support and care provided by the municipalities) have been transferred to the Jeugdwet. Care that is covered by the Wlz or the Zvw, is not part of the Jeugdwet.

  The execution of the Jeugdwet lies with the municipalities. The objective of the Jeugdwet is comparable to that of the Wmo 2015: children should be enabled to grow up in a healthy and safe way towards independency, self-reliance and participation in society; all dependent on their age and level of development.

- The Health Insurance Act (Zvw)
  See *changes to the basket of care* above for the relevant transfers.

Copies of the present report have been communicated in accordance with article 23, paragraph 2, of the Constitution of the International Labour Organisation to the following representative organizations of employers and of workers:
- the National Federation of Christian Trade Unions (CNV)
- the Netherlands Trade Union Confederation (FNV)
- the Trade Union Federation for Professionals (VCP)
- the Confederation of Netherlands Industry and Employers (VNO-NCW) and MKB-Nederland

Direct Requests ILO-Conventions 102

Part VIII of the report form. Maternity benefit. Articles 49 and 52 of the Convention. ***The Committee would like the Government to substantiate these contradictory statements by reference in both cases to concrete provisions of the national legislation.***

Answer Dutch Government

The Committee notes that the Dutch government has made contradictory statements about the provisions under the Health Insurance Act. The following has been stated in the past:

- In answer to a previous observation from the Committee the Dutch government answered that "all medical care related to childbirth is covered in the basic coverage".
- In its 44th report on the European Code of Social Security (ECSS) the Dutch government stated that "maternity care is provided for mother and baby up to ten days after childbirth. There is no cost sharing for maternity care on medical indication" .

The Dutch government would like to specify these statements by referring to the relevant provisions of the Health Insurance Act. The right to maternity care is laid down in article 10 (f) of the Health Insurance Act. Further specifications are laid down in article 2.11 of the Royal Decree on health insurance and article 2.36 of the Ministerial Regulation on health insurance.

Insured persons are entitled to all medical care related to childbirth. This includes the necessary obstetric care and maternity care, for both of which there is no compulsory deductible. This means that all obstetric care, whether at home -provided by the GP or by midwives- or in a hospital, is provided without cost sharing. Additionally all medically necessary (meaning: with medical indication) hospital/ intramural maternity care is provided without cost sharing. However, in case an insured person decides to stay in a hospital/intramurally *without* a medical indication, cost sharing is involved. Co-payments to be paid by the insured person are set at Euro 16,50 per day and any amount exceeding Euro 119 per day (2016).

In the 44th report on the ECSS the Dutch government stated that maternity care is provided for mother and baby up to ten days after child birth. This specifically refers to the maternity care provided in the home environment. This type of care is aimed at empowering the mother/family, ensuring a smooth start through instruction and teaching skills and to be able to identify possible (health and/or social) risks at an early time. For this type of care there is a co-payment set at Euro 4,20 per hour (up to a maximum of 80 hours).

The Committee pointed out that the contingencies covered by part VIII include provision of *medical* care should be provided free of charge until restoring the health of the woman concerned. In conclusion the Government takes the position that legislation and practice is in conformity with part VIII of Convention 102 as co-payments are only applicable for types of care for which there is *no* medical indication and/or are aimed at ensuring a smooth transition to the new situation.

Direct Requests ILO Convention 130

Part II (Medical care) of the report form and Article 13(a) of the Convention. Domiciliary visiting. ***The Committee would like the Government to specify the provisions in these or any other relevant texts which expressly refer to domiciliary visiting by general practitioners, as required by Article 13(a) of the Convention.***

Answer Dutch Government

This answer is in line with the answer given to a direct request on domiciliary visiting in the 2015 report on the European Code of Social Security.

The entitlement to healthcare provided by general practitioners is laid down in article 10 of the Health Insurance act. The entitlement is further laid down in article 2.4 of the Royal Decree on health insurance. Domiciliary visits are included (and paid for) in this entitlement at the discretion of the general practitioner.

The Dutch healthcare authority's (NZa) most recent "market scan on general practitioner healthcare" (December 2012) gives insight into the amount of domiciliary visits per 100 patients. As can be seen in the table below the amount of domiciliary visits per 100 patients is fairly stable at around 6 visits per 100 patients.

Please note that these numbers are not percentages as some people have different types of visits with a general practitioner.

Type of visit	**2006**	**2007**	**2008**	**2009**	**2010**
At the Doctor's office	69,3	68,6	72,2	73,6	72,8
Domiciliary visits	5,7	5,6	6	6,8	6,2
Consultation via telephone	28,9	30,5	34,5	37,7	40,5

Source: http://www.nza.nl/104107/105773/475605/Marktscan_Huisartsenzorg.pdf page 16

Article 13(e). Dental care for adults. ***The Committee would like the Government to explain the reasons for leaving the essential dental care outside the basic health insurance coverage and the accessibility of the additional private dental care insurance to persons of small means protected by the Convention.***

Answer Dutch Government

In the Netherlands the entitlement to dental care is laid down in article 10 (b) of the Health Insurance Act and further laid down in article 2.7 of the Royal Decree on Health Insurance. A distinction is made in dental care provided to insured persons younger than 18 years of age and insured persons aged 18 and over.

Dental care to which insured persons younger than 18 years of age are entitled, consists of dental care of both a preventive and curative nature. Dental care for insured persons 18 and over consists of dental care of a curative nature and is focussed on specialist surgical dentistry (oral surgery), the associated X-rays and dentures. Moreover it consists of restoring developmental and contracted deficiencies to the tooth-jaw-mouth system.

The reason behind this distinction is that dental care of a preventive and curative nature for insured persons younger than 18 years ensures all insured persons are entitled to regular check ups during the developmental phase of the tooth-jaw-mouth system. The Government takes the position that with these entitlements during the developmental phase of the tooth-jaw-mouth system any check ups (of a preventive nature), possible fillings and extractions after the insured person's 18th birthday can be borne by the individual, who has an overall responsibility to keep his tooth-jaw-mouth system in a healthy state. Moreover, as the Committee also points out insured persons have the option of taking out supplementary health (dental) insurance or may choose to pay for treatment on the spot. Private health insurance companies offer different types of insurance policies with different types of coverage. Effectively, every health insurance company has at least one dental insurance policy accessible to all.

Article 7 (a) of the Convention requires for curative medical care to be provided and, *under prescribed conditions,* for preventive care to be provided. Therefore the Government takes the position that articles 8, 9 and 13 (e) are complied with as the legislation on dental care entitles insured persons to curative dental care needed to maintain, restore and improve dental health. Additionally, dental care provided to insured persons younger than 18 years of age (the *prescribed condition*) has a clear preventive nature aimed at ensuring the development of a healthy fully grown tooth-jaw-mouth system.

Effectiveness of medical care. ***The Committee understands from this statement that in order to determine the quality standards of medical care provided for the population the Government relies on supply and demand outcomes and would like the Government to explain the respective roles played in this process by the Dutch Quality Institute and the Health Care Inspectorate. In order to demonstrate that the Dutch health-care system has not lost its effectiveness after privatization in 2006, the Committee would like the Government to show in its next report, on the basis of the available health statistics and quality indicators for the period 2006–13, that the health status of the Dutch population has been improving***

Answer Dutch Government

This answer is in line with the answer given to a direct request on effectiveness of medical care in the 2015 report on the European Code of Social Security.
The government will first reply to the question regarding reporting on the health status of the population (part a).
Subsequently, the government would like to make use of this opportunity to explain in more detail how the quality and effectiveness of the health care is assured. In this elaboration the respective roles of the Dutch Quality Institute and the Health Care Inspectorate will also be explained (part b).

a. Reporting on the health status and effectiveness of medical care in the Netherlands

There is a statutory system in the Netherlands with regard to reporting on the health of the population. This system is laid down in de RIVM Act (Wet op het RIVM). The Minister of Health has commissioned the National Institute of Public Health and the Environment (RIVM) to periodically report on the current state of affairs and future developments in public health and health care in the Netherlands.[4] The RIVM is independent in choosing the research methods for these reports.[5] This is to ensure that research is scientifically relevant and internationally comparable.
Every four years, the RIVM publishes a report called (Gezondheids)Zorgbalans (Dutch Health care Performance Report). A second recurring report is the Volksgezondheid Toekomstverkenning (Public Health Status and Foresight Report) which provides a broad overview of the most important trends in Dutch public health with a focus on the future. The Dutch Health Care Performance Report 2014 can be downloaded from http://www.gezondheidszorgbalans.nl/English. The Key findings of the Dutch Public Health Status and Foresight Report 2014 can be downloaded from http://eengezondernederland.nl/en/English_version/Key_Findings. The Government refers the Committee to these reports. In the following section the government highlights a few relevant findings of these reports regarding the health of the population.

Relevant findings in the Dutch Health care Performance Report

With regard to the health of the Dutch population, as measured in terms of life expectancy, the Dutch Health Care Performance Report 2014 shows that the health of the population has improved since 1990, and especially in the first decade of the 21st century.[6] People live longer, and they live longer in good health. In diseases whose mortality rates are known to be influenced by health care, diagnosis-specific trends over time have shown improved health outcomes. These can be seen in overall mortality rates as well as in measures such as 30-day mortality (for cardiovascular diseases) and 5-year survival ratios (for cancer). Statistics like

[4] On the basis of Article 3(1 sub b) of the RIVM Act.
[5] On the basis of Article 5 of the RIVM Act.
[6] RIVM (2014). Dutch Health Care Performance Report, p. 267

these are evidence for the positive value of health care in improving public health. International studies of the same diagnostic groups have confirmed that contribution.
The Report highlights numerous positive developments, as well as some issues for consideration. International comparison of quality indicators by the Organisation for Economic Co-operation and Development (OECD) has shown that the Netherlands scored above average on the majority of indicators when compared to other affluent countries. Results for more specific aspects of the system were varied. On some indicators, the Netherlands ranked amongst the best-scoring countries: it had the lowest volume of primary care antibiotic prescription and a higher 48-hour surgery rate for hip fractures in comparison with many other countries. Scores on other indicators were less positive, including higher than desirable rates for mortality following strokes or acute myocardial infarctions and for perinatal mortality. Many quality indicators revealed favourable trends. For a complete picture, the Government refers to the Dutch Health care Performance Report 2014.

Relevant findings in the Public Health Status and Foresight Report
The sixth edition of the Public Health Status and Foresight report contains information on trends and prospects in public health and health care in the Netherlands. The situation is positive in many respects.
As a result of improvements in the health care system, Dutch people live increasingly longer. This has an effect on many areas of health care, in particular in the management of diabetes mellitus, pregnancy, cardiovascular disease and cancer. An estimated 40% of the total drop in mortality from coronary heart disease is accounted for by improved treatment options. A host of preventative measures formed another contributing factor in the rising life expectancy. A particularly positive effect came from anti-smoking measures, the increased use of drugs to reduce blood pressure and cholesterol levels, population screening, the elimination of trans fatty acids from foods and improved road safety. Things could be further improved by living healthier lives.
At the same time, more people have to live with long-term illnesses. One of the reasons of this development are the health care improvements; people who live longer are more likely to develop health problems. Diseases that used to be fatal at younger ages, such as diabetes and cardiovascular conditions, can now be managed in ways that allow people to grow increasingly older.

b. Further elaboration on quality assurance
First of all, the Government would like to state that the Government is highly committed to a high quality, accessible and affordable health care system. All insured persons in the Netherlands are entitled to a basket of care established by the government. Starting point is that the insured person must always receive care within a reasonable time and at a reasonable distance. Improving and further developing the quality of health care, as well as the affordability of health care is a continuous process and will continue to be a priority. The system under the Health Insurance Act offers various guarantees for the quality and effectiveness of medical care. A number of them are explained below.

The most important vehicle to *improve* the quality of care and to increase affordability is the system of contracting: health insurance companies agree on quality and price with the care providers. A contract between a health insurance company and a health care provider contains all different sorts of demands on for example the quality of care, following guidelines, providing service, waiting lists etcetera. The task of the health insurance company is to contract good quality care and good service for an affordable price on behalf of its insured

persons. If a health care provider does not meet the quality criteria a health insurance company can choose not to contract this provider.
Furthermore, the legal framework for quality assurance by health care providers is laid down in the Quality of Health Facilities Act (Kwaliteitswet zorginstellingen / KZi), the Individual Health Care Professions Act (Wet Beroepen in de Individuele Gezondheidszorg / BIG) and the Medical Treatment Agreement Act (WGBO). To guarantee the quality of health care, the Quality of Health Facilities Act requires individual health care providers to provide 'responsible' care. In order to do so, health care providers have to set up a quality-system. The health care provided must meet the needs of the individual patient and the health care has to be administered in an effective and efficient way. The Health Facilities Act requires health care providers to provide responsible care. The term 'responsible care' is not further defined by law as the Government takes the view that patients, health care providers and health insurers together know best what constitutes good health care. Moreover, the idea of what constitutes responsible care, can change over time. To allow for this type of reconsideration, some flexibility is necessary, something which cannot be achieved by fixing a definition in law.

In the Netherlands health care providers, health insurance companies and patients together set the guidelines. They do this for each type of disorder. The guidelines are registered with the Health Care Quality Programme of the Health Care Institute (Quality Institute). This Institute has a legal status. The registration process includes a screening on whether all stakeholder groups were included in the process of making the standard and whether a layman's version of the guideline is included. The register is publicly accessible. Finally, it should be noted that these guidelines, although not defined by government, do enjoy a legally binding status.
The Health Care Inspectorate (Inspectie voor de Gezondheidszorg (IGZ)) supervises the compliance to these guidelines. In its competence as the supervisory body for the inspection of the quality and safety of health care provided, the Health Care Inspectorate is the guardian of good quality health care. The Inspectorate supervises the quality of public health and ensures that health care providers are in compliance with the legal requirements and guidelines. The Inspectorate investigates complaints and irregularities in health care and takes measures if deemed necessary and appropriate. Complaints may give rise to a visit or an investigation to check whether guidelines and procedures are observed. The Inspectorate is competent to take measures in case quality standards are violated, such as ordering improvement within a certain time limit, imposing an administrative fine and/or tightening supervision. If a health care provider doesn't show enough improvement, the Inspectorate is – in the end– able to close down the practice.

As another aspect to assure the quality of medical care the Government would like to highlight the screening procedure for treatments or medicines. For a new treatment and/ or a medicine to become part of the basic package covered by the Health Insurance Act it has to go through a screening procedure. The screening procedure entails four criteria: (medical) necessity, efficacy/effectiveness, cost effectiveness and feasibility. The efficacy/effectiveness criterion screens new treatments/medicines as to whether they meet scientific and good practice standards. This ensures that only health care of high quality is part of the basic package under the Health Insurance Act. When part of the basic package, health insurance companies are expected to contract hiqh-quality, accessible and affordable health care on behalf of their insured persons.

In conclusion, the Government takes the position that legislation and practice in the Netherlands complies with Article 9 of Convention 130. In this respect, the Government notes

that from Article 9 of the Code it follows that medical care is afforded to the persons protected by the Contracting Parties with an aim at maintaining, restoring or improving the health of the person protected and his ability to work and to attend to his personal needs. How this is achieved is the competence of the Contracting Party.

Part III (Sickness benefit). ***The Committee asks the Government to confirm that stricter conditions for entitlement and stricter obligations placed on recipients to return to work introduced by the abovementioned Act do not concern the granting of the sickness benefit during the first 52 weeks of incapacity.*** The Dutch government confirms that stricter conditions for entitlement and stricter obligations placed on recipients to return to work introduced by the abovementioned Act do not concern the granting of the sickness benefit during the first 52 weeks of incapacity.

Observation ILO Convention 130

Article 31 of the Convention. Participative management of the health insurance scheme.
Noting this development with ***concern,*** the Committee cannot but observe that the position of the Government perpetuates the violation by the Netherlands of its obligations under a ratified international treaty, which is this Convention

Answer Dutch Government:
In reply to the Committee's observation on the participative management of the of the health insurance scheme, the Dutch government would like to note the following. This note is in line with the answer given to a direct request on participative management in the 2015 report on the European Code of Social Security.
It is the government's vision that insured persons should have a fair degree of influence on the course of affairs of their health insurance company. This is why Article 28, paragraph 2 of the Health Insurance Act stipulates that the statute of the health insurance company guarantees a fair degree of influence of the insured on their policy. Furthermore, Article 28, paragraph 1 of the Health Insurance Act prescribes that the statute of the health insurance company include provisions for monitoring the policy of the Board and the general course of affairs of the company.

The Government is of the opinion that it complies with article 30(2) and 31 of Convention 130, both by legislation (article 28, paragraph 2 of the Health Insurance Act), and in practice (statutes and regulations of the health insurance companies): Article 31(a) of the Convention 130 stipulates that representatives of the persons protected shall participate under prescribed conditions.
In the Netherlands, within all health insurance companies, insured persons have a fair degree of influence on the course of affairs in *at least* a consultative capacity. Article 28, paragraph 1 and 2, of the Health Insurance act are therefore in conformity with Articles 30 and 31 (a) of Convention 130. The following information is of relevance:

- All health insurance companies have a Council of Insured Persons or a Council of Members, which is composed of insured persons.
- The majority of health insurance company groups are cooperative societies or guarantee societies. The highest body within these two types of societies, whose competences are laid down in the company's statute, is the Council of Members. In these companies the Council of Members has at least a consultative competence. In many cases, stipulated in the statute, the Council of Members has more competences. For example the competence to approve certain decisions of the Board, the annual accounts, the appointment or removal of members of the supervisory board, mergers or amendments to the statutes.
- Three health insurance companies do not take the legal form of a cooperative society or guarantee society. These companies have a Council of Insured Persons that does have an advisory role (*consultative capacity*).

Finally, the Government points out that according to Article 31(b) of Convention 130 participation of employers and public authorities is optional, not mandatory. It is the vision of the government that representation of the *employers and public authorities* in the governing bodies of health insurance companies does not match the way the Dutch health insurance system is organised. This is because health insurance companies insure *all* citizens, regardless of the fact whether they belong to the workforce or not.

Settlement of disputes

In addition, the Government would like to point out that there is a legal system in place for the settlement of disputes. If the decision is taken by a health insurance company not to reimburse a medicine or treatment, an insured person can ask the insurance company to *reconsider*.

If the insurance company 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 policy 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, paragraph 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 insurance company and the insured person may jointly decide to refrain from approaching the civil courts and instead submit their dispute to an impartial third party.

Article 114 of the Health Insurance Act stipulates that a health insurance company must make it possible for its policy holders and insured persons to submit disputes about the performance of health insurance to an independent body. To this end, the Minister of Health Welfare and Sports has appointed the Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ) as the competent independent foundation to handle complaints and disputes regarding health insurance. With this, the Netherlands has implemented the Directive 2013/11/EU on alternative dispute resolution for consumer disputes. The SKGZ meets European quality standards associated with this Directive.

The SKGZ consists of two parts: an ombudsman and a disputes committee. If the health insurance company 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 health insurance company has to pay the costs.

Finally the government would like to point out that the Dutch Health Care Authority (NZa) has not given any recommendations or imposed sanctions on health insurance companies for failing to include provisions regarding participative management in their statutes or to apply them in practice. There was never a reason for imposing a sanction.