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Introduction

Healthcare in the Netherlands

The philosophy underpinning the Dutch healthcare system is based on accessible, affordable, good quality care. The Dutch system has been shaped by a number of historical trends and developments and social conditions.

Foundation of the healthcare system
The Dutch healthcare system is governed by five basic healthcare-related acts: the Health Insurance Act (Zorgverzekeringswet), the Long-Term Care Act (Wet langdurige zorg), the Social Support Act (Wet maatschappelijke ondersteuning), the Public Health Act (Wet publieke gezondheid) and the Youth Act (Jeugdwet). In addition, there are several general laws in place (including the Competition Act (Mededingingswet)) and a number of specific healthcare acts (such as the Healthcare Quality, Complaints and Disputes Act (Wet kwaliteit, klachten en geschillen zorg)).

The five healthcare-related acts form the foundation of the healthcare system. The Health Insurance Act (which provides for hospital care) and the Long-Term Care Act (which focuses on other types of care) account for the bulk of the healthcare budget available in the Netherlands. The Long-Term Care Act is a national act governing healthcare throughout the Netherlands. In implementing the Health Insurance Act, private health insurance companies play a key role in a system based on ‘regulated competition’ and a number of specific public requirements. The central government and municipalities are jointly responsible for implementing the Public Health Act which focuses primarily on keeping people healthy. The Social Support Act and the Youth Act provide for other forms of care and support. The roughly 380 local authorities and the central government of the Netherlands are primarily responsible for enforcing these two acts.

Principles of the Dutch Healthcare System
The current Dutch healthcare system can best be explained by looking at a number of recent changes. In 2006 the new Health Insurance Act entered into force, under which all residents of the Netherlands are entitled to a comprehensive basic health insurance package. This act is implemented by private, competitive health insurers and healthcare providers. It should be noted that virtually all health insurance companies in the Netherlands are not-for-profit cooperatives that allocate any profits they make to the reserves they are required to maintain or return them in the form of lower premiums. There are a total of 23 insurers in the Netherlands which bear a risk for their operations.
The Health Insurance Act has transformed the Dutch healthcare system from a supply-driven to a demand-driven system. Private health insurance companies are improving the healthcare system in a number of ways: shorter waiting lists and less red tape in conjunction with a greater focus on effectiveness and quality, in the interest of patients and policyholders. A process of selective contracting enables health insurance companies to control the effectiveness and quality of the care provided by healthcare providers. Members of the public, in turn, also have some degree of control over this process, since they are given the opportunity every year to switch healthcare providers and can influence the policies of health insurers and health institutions. While the healthcare system is essentially a private system, the government plays a controlling role in order to protect the public interest.

The Public Health Act dates from 2007 and replaced the Public Health (Preventive Measures) Act (Wet Collectieve Preventie Volksgezondheid). It also includes regulations on infectious diseases. The Public Health Act focuses on prevention and health promotion and makes it possible to respond quickly in the event of threats and in terms of dealing with an infectious disease crisis.

**Long-term care, youth health services and social support**

The Long-Term Care Act, the Social Support Act and the Youth Act were introduced more recently, having entered into force in their present form in 2015. The Long-Term Care Act is administered by special long-term care administrators commissioned by the central government. A number of activities the Long-Term Care Act administrators deal with are the responsibility of the healthcare administration offices. Among other things they purchase the care and are responsible for implementing the personal healthcare budget.

Additionally, several other organisations are involved in its implementation, such as the Care Assessment Agency (Centrum Indicatiestelling Zorg) and the Central Administration Office (Centraal Administratie Kantoor). The local authorities are responsible for implementing the Social Support Act and the Youth Act – they provide the support, assistance or care services or are supported in this process by a healthcare provider.

The motivations behind the creation of these laws are opportunities to improve the quality of the care provided, promote an integrated approach, and keep healthcare available and affordable in times of an ageing population and in which many people suffer from chronic illnesses. The foundation of these domains are people’s opportunities rather than their shortcomings. Initially, people are encouraged to draw on their own network and resources for support, but support is always available for those unable to secure it themselves. Those requiring permanent supervision or 24-hour home care are entitled to care services under the Long-Term Care Act.
The healthcare system was drastically overhauled in order to facilitate the enactment of the three new acts. As a first step in this process, the General Exceptional Medical Expenses Act was repealed. This act had come to cover a wide variety of care and support services over the years, as a result of which the system of long-term care was at risk of becoming unmanageable. Some of the people making use of the provisions under this act are currently covered under the Health Insurance Act, the Social Support Act or the Youth Act. Since 2015, all long-term care has been provided under the Long-Term Care Act, which is strictly intended for the most vulnerable categories of people.

Secondly, the local authorities are responsible for administering and implementing the Social Support Act and the Youth Act. Many people who previously received care on the basis of the General Exceptional Medical Expenses Act can turn to the local government for lighter forms of care and support. The idea behind this change is that local authorities are closer to the people and are therefore able to provide effective, high-quality care. Local authorities also have plenty of options when it comes to pursuing a preventive health policy, including within other policy domains.

**The five acts in practice**

Private individuals may be affected by the five healthcare-related acts in the ways described below. For example, when someone needs to see their GP, is hospitalised, or needs nursing and care at home, this is paid out of the compulsory basic health insurance package under the Health Insurance Act. The central government and local authorities offer preventive care, for example youth healthcare for children aged between 0 and 18. Those who require permanent supervision or 24-hour home care can make use of provisions under the Long-Term Care Act after the Care Assessment Agency has carried out an assessment.

**Healthcare in the Netherlands**

- **Residents**
  - Approx. 17 million

- **Gross Domestic Product (GDP)**
  - Approx. EUR 700 billion

- **Healthcare expenditure**
  - Approx. EUR 77 billion
  - Approx. 10% of GDP

- **Total number of people employed in the healthcare field**
  - Roughly 1,2 million
The Social Support Act and the Youth Act provide for other forms of support, assistance and care. For example, those who require home assistance or a wheelchair due to a disorder can apply for this care to the local authority. The latter can then arrange for support under the Social Support Act. If there are families that require parenting support, for example, if an autistic child requires support in everyday living, or if treatment has to be provided to a young person with a psychological disorder, the local authority can provide this under the Youth Act.

These are just a few examples of the care, assistance and support services provided under the five healthcare-related acts. A general description of the five acts can be found in the next four chapters of this publication. In these sections, we review the various parties involved, the types of support, assistance and care provided under the law, the quality of the care services provided, funding, and supervision.
Health Insurance Act

Curative medicine in the Netherlands is provided for under a single Health Insurance Act, which replaced a number of separate public and private health insurance types in 2006. Roughly 60% of the total healthcare budget is allocated towards services provided under the Health Insurance Act.

Public and private
The Dutch health insurance system combines elements of public and private insurance. The central government is directly involved in implementing the Health Insurance Act and sets a number of public requirements which guarantee the social nature of the health insurance:

- private individuals are required to purchase basic health insurance and are free to choose their own insurer;
- health insurers are required to accept these private individuals under their policy, irrespective of, for example, their aged or state of health;
- the premiums for a policy offered are equal for all policyholders, regardless of their health condition, age or background;
- health insurers have a duty of care: Care insurers must provide (or have provided) and/or reimburse the care and services which the policyholder needs and which, in terms of content and scope, correspond to the statutory care entitlements;
- they must guarantee that healthcare is available in the basic package for all their policyholders;
- the contents of the insured basic health insurance package is provided for under the law.

The government is not directly involved in the implementation of the Health Insurance Act. That is something determined by healthcare providers, health insurers and policyholders. This structure ensures that healthcare providers have a great deal of freedom, while competition and market forces create the incentives for high-quality and efficient care.

Basic health insurance package
So what is included in the Dutch basic health insurance package? The central government is in charge of the contents and size of the statutory health insurance package, which is available to all residents of the Netherlands. The government is advised on these issues by the independent authority responsible for the basic health insurance package, the National Health Care Institute (Zorginstituut Nederland). The government, then, determines which types of care are included in the package and when this care should be provided.

The basic health insurance package has a comprehensive structure and includes the bulk of essential medical care, medications and medical aids which are consistent with the state of the art of medical science and practice. Some physiotherapy and dental care services are covered under the package. The basic health insurance package includes the following types of care:
• medical care provided by GPs, medical specialists (consultant physicians) and obstetricians;
• district nursing;
• hospitalisation;
• mental health services, including hospital care (mental health-related) up to a maximum of three years;
• medications;
• dental care up to age 18;
• services provided by various types of therapists, including physical therapists, remedial therapists, speech therapists and occupational therapists;
• nutritional/dietary care;
• medical aids;
• ambulance support/sedentary medical transport;
• physiotherapy for people with chronic illnesses.

Within the open, specified package set by the government, health insurers have freedom to organise, within the parameters set, who provides the care and where it is to be provided. They do this through careful negotiation and selective contracting based on the large amount of (anonymised) data to which they have access regarding issues such as quality, effectiveness and customer experiences. Health insurers have a duty of care: they must guarantee that the services included in the basic insurance package are available to all their policyholders.

In addition to the care of the compulsory insurance package, policyholders also have the option of choosing for supplementary insurance for care which is not reimbursed by the basic health insurance. This includes, for example, dental care, alternative medicine/homoeopathy, glasses and contact lenses, and more generous cover for physiotherapy. Approximately 85% of Dutch people opt for a supplementary insurance policy. The supplementary insurance is fully private in nature, i.e. with no rules set by the government.
Quality
Private individuals, health insurers and healthcare providers are the main parties under the Health Insurance Act. All three have a key role to play in driving the quality of the healthcare provided and the quality of the insurance. First of all, there are the consumers themselves: they have the option to switch healthcare providers and choose a better (or less expensive) health insurer every year. In this sense, they can ‘vote with their feet’ by switching to a provider they perceive to be more beneficial. This dynamic ensures that the health insurers have to compete for consumers via their purchasing and services. Policyholders can also affect the policy pursued by insurers, for example via the member and policyholder councils, customer panels or online communities. If they are dissatisfied with the implementation of the Health Insurance Act or with the care services received, there are several independent organisations they can contact.

Secondly, there are the health insurers: they check the quality and effectiveness of the care when they purchase it. If the care is substandard, they may decide not to conclude a contract. They do this using the large quantities of information they have at their disposal. Furthermore, insurers ensure that the statements sent by health insurers are accurate and that the healthcare services specified have actually been provided and that this process has been efficient. Health insurers also have a duty of care, which includes providing assistance if necessary in finding a healthcare provider.

Finally, there is the role of the healthcare providers: they determine how the care is to be provided. What is eventually decided in the doctor’s surgery or consultation room? Health insurers have set a number of quality guidelines for this purpose.

Securing healthcare
Dutch citizens are entitled to a basic package of insured care. The question is how do you obtain that care? Excluding emergency care, the process under the Health Insurance Act is conducted as described below. The General Practitioner (GP) refers the patient to a medical specialist and acts as a ‘gatekeeper’ in making these referrals. If it turns out a referral is necessary, the doctor making the referral and the patient together determine the need for care and the necessity of treatment. The next step is for the insured person to select a service from the available supply of health services, with the health insurer providing advice and support in some cases. The healthcare provider selected by the patient discusses treatment options with the patient and provides the care required.
Funding of healthcare under the Health Insurance Act

Under the Health Insurance Act, all insured persons together contribute to the total costs of all care. There are two major financial flows: all insured persons aged 18 and over pay a ‘nominal’ premium to their health insurer. These premiums average around EUR 1,300 a year. In addition, all individuals aged 18 and over also pay a mandatory policy excess of EUR 385, one of the objectives of which is to increase cost awareness among the general public. Several forms of healthcare (including general practitioner care and maternity care) are excluded under this policy. For children and young people up to age 18, the government pays the costs of the insurance from public funds.

A co-payment (possibly) applies, in addition to the excess, for some care from the basic health insurance package. This includes items such as the transport of sick people, hearing aids, specific medications and orthopaedic shoes. Individuals may also choose to voluntarily increase their excess by a maximum of EUR 500, which causes the nominal premium to decrease. Finally, many lower-income people are entitled to a health insurance allowance, which is provided by the Tax and Customs Administration (i.e. the Dutch tax authorities). This health care allowance offers compensation for a large portion of the income and the policy excess. People on a minimum wage with average healthcare costs now pay, on balance, less for the care then under the old system.

There is also an income-dependent contribution, which is paid by the employer. At the macro level, this involves an amount comparable to the annual premium. The income-dependent contribution ends up in the Health Insurance Fund along with the central government contribution for children and adolescents under the age of 18.

This means that health insurers are paid both through the nominal premiums and from resources in the Health Insurance Fund. This is done through risk adjustment. Health insurers receive what is known as an ‘risk adjusted contribution’ from the health insurance fund. Depending on the health of its customers/policyholders, an insurer receives a higher or lower contribution from the health insurance fund. The reason for this is related to the public requirements defined (as specified above). Without risk adjustment these requirements would make a level playing field impossible, since insurers’ positions would be more advantageous or less advantageous depending on the level of risk involved. At the same time this risk adjustment is also designed to prevent health insurers from selecting patients based on this level of risk.
Residents of the Netherlands can choose between different types of policies if they purchase the basic health insurance package: a contracted care policy (in kind policy) and a non-contracted care policy (restitution policy) and combinations of the two. In the case of contracted care insurance the insured party is entitled to care and he can choose from healthcare providers that have a contract with the health insurer. The health insurer reimburses the healthcare costs directly to the healthcare provider. If the insured party opts for a non-contracted healthcare provider, he will pay some of the healthcare costs himself. In the case of a non-contracted care policy the insured party is entitled to reimbursement of healthcare costs. It is then unimportant whether healthcare providers are or are not contracted. Around three-quarters of insured people in the Netherlands have some form of a contracted care policy.

There are also situations where the health insurer does not cover the expenses incurred: this is the case for medical expenses not covered under the basic health insurance package (i.e. aspirin or specific forms of cosmetic surgery) and for which no supplementary insurance has been purchased (e.g. root canal treatment carried out by dentists).

**Supervision**

There are several parties which have a number of formal responsibilities in supervising the healthcare services covered under the Health Insurance Act. The central government is responsible for the overall healthcare system and determines the quality requirements healthcare services must satisfy. There are various government agencies responsible for the supervision of these quality requirements:

- the Dutch Healthcare Authority makes rules so that good quality and affordable care is available to everyone. It also regulates healthcare providers and health insurers;
- the Netherlands Authority for Consumers and Markets, which supervises competition in healthcare in the interest of patients and insured parties;
- the Health and Youth Care Inspectorate, which oversees and enforces the quality and safety of healthcare.
Long-Term Care Act

People in the Netherlands who require permanent or 24-hour home care can make use of provisions under the Long-Term Care Act. This healthcare-related act entered into force on 1st January 2015, replacing the General Exceptional Medical Expenses Act.

Solidarity
The Long-Term Care Act applies to a smaller group of people than its predecessor, the General Exceptional Medical Expenses Act: this includes the most vulnerable groups in our society, such as elderly people in the advanced stages of dementia, people with serious physical or intellectual disabilities, and people with long-term psychiatric disorders. The Care Assessment Agency gives special-needs assessments to these people based on a national, standardised format. Clients who have received a special-needs assessment can receive care either at home or in a care home or similar provision. The Long-Term Care Act administrators implement the Long-Term Care Act for their policyholders. Healthcare administration offices, which have been designated by the Minister of Health, Welfare and Sport per region, are responsible for the actual implementation. These offices have a number of public tasks, including the purchasing of care, service to clients and keeping records. They also implement the personal healthcare budget. The Long-Term Care Act is a compulsory health insurance policy based on solidarity: anyone who pays income tax in the Netherlands pays premiums under this act.

Quality
Clients and their representatives, the central government, the Care Assessment Agency, the National Health Care Institute, the Dutch Healthcare Authority, the Health and Youth Care Inspectorate, the Long-Term Care Act administrators/the healthcare administration offices, healthcare providers and the professional associations are most important parties to the Long-Term Care Act. Together they determine the quality of the care and how it is reimbursed. They also take joint initiatives to improve the quality of the care. If clients are not satisfied with the care provided, they have the option to switch to another contracted healthcare provider, provided this provider can accommodate them. Individuals who manage their own healthcare needs through what is known as a ‘personal healthcare budget’ can also select their preferred provider and the quality required when purchasing care services.
They also have the option to submit a complaint to healthcare providers, the healthcare administration offices and the Health and Youth Care Inspectorate. The healthcare administration offices can set quality requirements when purchasing care under the Long-Term Care Act. They also check whether the statements of the healthcare providers match the specified care.

**Care under the Long-Term Care Act**

The serious and intensive care to which residents of the Netherlands are entitled under the Long-Term Care Act are described based on a number of broadly defined forms of care. This ensures considerable freedom to organise the care specified in conjunction with the healthcare provider. The most common types of care are:

- a stay in a care facility: long-term stay, or being placed in a nursing home or designated, sheltered accommodation for people with mental disabilities;
- personal care: assistance with washing, dressing, using the toilet, and eating and drinking;
- care that increases self-reliance: assistance in structuring the day, gaining greater control over one’s life, and learning to perform household duties;
- nursing care: medical assistance, e.g. tending to wounds or administering injections;
- treatment under the Long-Term Care Act: a medical, paramedical or behavioural treatment which helps with the recovery or improvement of a specific condition;
- transport to and from day programmes and day treatment: for people whose medical condition prevents them from travelling to the day programme or day treatment independently.

The exact details of what the Long-Term Care Act care package contains are stated in the Long-Term Care Act.

**Access to healthcare**

People who require the most serious and intensive care can contact the Care Assessment Agency. The Care Assessment Agency determines the type of care someone needs. This is referred to as the ‘needs assessment’. The next step is for the Care Assessment Agency to notify the independently operating healthcare administration office, of which there are a total of 31 across the Netherlands.

The healthcare administration office manages long-term care based on the special-needs assessment provided by the Care Assessment Agency and discusses the situation with the client (i.e. the person requiring medical care), who can then state their preference for specific healthcare providers. Has the client opted for a stay in a nursing home or assisted living facility, or do they wish to continue living at home, provided this is safe and cost-efficient? Another consideration is how people are to receive the care. This may be done on a contracted basis, i.e. where the care is provided which the healthcare administration office has purchased from specific healthcare providers. Alternatively, it can also be done through a personal healthcare budget, whereby people purchase and organise their own healthcare.
The client and the healthcare provider subsequently draft a healthcare plan (for contracted care) or a budget plan (for personal care), while the healthcare administration office informs the healthcare provider that the care can be provided. The healthcare provider then provides the care as agreed in the healthcare plan or budget plan.

**Funding healthcare under the Long-Term Care Act**

The Long-Term Care Act is a statutory social insurance for which people pay an income-dependent premium through their payroll tax. The amount of the premium is based on a fixed percentage (9.65%) of the income tax, on a maximum amount of EUR 33,589. In addition, adults who wish to make use of healthcare services under the Long-Term Care Act pay a co-payment which is also income-dependent. In this case it matters whether the client lives at home or in a care facility, is younger or older than 65, and is single, married or has a domestic partner.

All contributions are deposited into the Long-Term Care Fund, which is managed by the National Health Care Institute. The central government tops up the fund using public funds if these funds are too low. Various forms of financing are used, depending on whether the client has opted for contracted care or a personal healthcare budget:

- for the contracted healthcare costs, a portion of the fund is transferred to the Central Administration Office (CAK). The latter subsequently pays the healthcare providers at the behest of the healthcare administration offices;
- for payment through the personal healthcare budget, a portion of the fund is transferred to the Social Insurance Bank (Sociale Verzekeringsbank/SVB), which manages the personal budgets for holders of such budgets. Those responsible for organising healthcare based on a personal healthcare budget are entitled to special drawing rights from the Social Insurance Bank: the invoices from the healthcare providers (up to a maximum amount) are sent to the Social Insurance Bank, which pays these invoices.

**Supervision**

In the Netherlands, the central government is responsible for ensuring that the healthcare system functions properly. Long-term care professionals, patient advocacy groups and other relevant stakeholders can develop quality frameworks which the Health Care Institute registers in the statutory register. In addition, there are several government agencies which are responsible for supervision: the Health and Youth Care Inspectorate monitors the quality and safety of care under the Long-Term Care Act. The Dutch Healthcare Authority ensures that healthcare services are provided efficiently and in accordance with the rules. Finally, the Netherlands Authority for Consumers and Markets supervises competition in healthcare sector, in the interest of citizens who are reliant on the Long-Term Care Act.
Social Support Act

Under the Social Support Act 2015, local authorities are responsible for providing support to people with disabilities. Examples are people with physical, mental or psychological disabilities, such as people with (mild) disabilities and the elderly. The support is designed to increase people’s self-reliance and ensure that people can continue to be productive members of society and to enable them to continue living at home. Furthermore, under the Social Support Act, local authorities can provide sheltered accommodation and social support to people who have no other options or who are unable to live at home. Lastly, local authorities are also responsible, on the grounds of the Social Support Act, for the organisation of regional advice and reporting centres for domestic violence and child abuse.

Local authority approach: personalised care and inclusion

The Social Support Act is based on the principle of personalised solutions and an individual approach. The local authorities discuss the client’s request for support together with the client. It is then up to the local authority to provide the appropriate type of support and determine how this support is to be organised.

Besides individual personalised provisions, local authorities are required to provide general provisions for people in need of support. The objective of these provisions is to ensure that all people, irrespective of their disabilities, can be active members of society: this is the foundation of the inclusive society.

Support under the Social Support Act

Under the Social Support Act, local authorities support people who are unable to participate, or have difficulty participating, in society or who cannot take care of themselves or have a need for sheltered accommodation or support. This means support, for example, in the form of:

- assistance and day programmes/daytime activity;
- household support;
- support by an informal carer or volunteer;
- a place in a sheltered environment (sheltered accommodation) for people with long-term psychological disorders;
- support for men, women and children who are victims of domestic violence;
- social support, e.g. for people who are homeless;
- medical aids, such as a wheelchair;
- social-recreational transport.
In providing support under the Social Support Act, the local authorities distinguish between general provisions and personalised provisions. General provisions are intended for the community as a whole. Examples are coffee mornings at the local community centre, buses that transport the elderly to shops, the ‘meals on wheels’ service, or transport for all people aged 75 and older. Personalised provisions are designed for a single person. This might include domestic assistance and support (cleaning and organisation), support in keeping personal records, or an arrangement involving multiple types of support.

Securing support

People who require support in continuing to live at home independently or participating in society can contact the local authority. They do not have to ask for a specific provision because the local authority will investigate with the client whether and how a provision can be arranged. Alternatively, the GP or another service provider may refer patients to the local authority or the neighbourhood community team. Many local authorities have set up these types of neighbourhood teams, as an access point in the neighbourhood and to provide light forms of support.

The local authority includes in the investigation the question of what the clients themselves can contribute to self-reliance, what the network can do (voluntary carers, family and other close relatives) and whether a general provision is sufficient. The aim is to acquire a full picture of the circumstances. The local authority therefore also assesses other matters such as debts, work (or the absence thereof) and loneliness. After that the client can, if desired, submit an application for a personalised provision, on which the local authority will take a decision to award or reject the application.

That personalised provision can be provided in two ways, namely in a non-monetary form, whereby the support is made available by the local authority (that contracts a healthcare provider).
or, if the client so wishes, via a personal healthcare budget. In the latter case the client purchases the support himself. For the personalised provision the local authority can ask the client to make a co-payment. The amount of this payment is determined by the government. The amount of the contribution to a general provision is determined by the local authority itself.

**Quality**
A basic quality standard is included in the act which does not provide any detailed rules about the quality of the support offered. The support provider must ensure that the provision is of a good quality. In other words it has to be safe, effective and efficient and attuned to the client’s need and other forms of care or assistance that he receives. A care provider must also observe the professional standards of its professional group. The local authority can set additional quality-related requirements in the agreement with the provider. Supervision is a task of the local authority itself and it will appoint supervisors. A lot of local authorities cooperate with the Health and Youth Care Inspectorate.

People who need support can object to the decision taken by the local authority. They can also report complaints and malpractices about the provider and the local authorities. They can also switch to a different provider. In addition, people receive free independent client support for advice and assistance. Finally, the town council ensures that the Municipal Executive performs its duties under the Social Support Act correctly.

**Funding support under the Social Support Act**
The tasks which the local authority has on the grounds of the Social Support Act are financed by the central government via the Municipal Fund. The central government determines how much money each local authority receives in this fund. Local authorities are free to decide how they spend the resources on implementing the act. The Municipal Executive is accountable to the town council for its expenditure. The contracted support is paid by the local authority directly to the provider with whom a contract has been concluded. For the support which citizens arrange themselves with a personal healthcare budget, the local authority transfers funds to the Social Insurance Bank. Clients with a personal healthcare budget can send the invoices they have received for their support to the Social Insurance Bank as well and have them paid; this is referred to as “drawing rights”.
The Public Health Act

Improving health and preventing illnesses requires an effort on the part of the people and the government. The central government and the 380 local authorities are working on this together. Their responsibilities and authorities are laid down in the Public Health Act. This act focuses on individual prevention, collective prevention, health promotion and the way these tasks have to be organised. It also deals with what has to be done in a crisis situation which includes a threat to public health.

Activities based on the Public Health Act

Under the Youth Act, local authorities support children, adolescents (up to age 18, which may be extended in some cases to age 23) and their parents in dealing with developmental, parenting and psychological problems and disorders. Local authorities are also responsible for implementing child protection measures and youth rehabilitation. By shifting the responsibility for these various duties to the local authority, it is easier now than in the past to provide integrated care to young people. This also encourages the local authorities to develop preventive youth and family policy.

The Public Health Act refers to the following tasks:

1. having an insight into the population’s health situation;
2. creating a plan for public health policy;
3. infectious disease control;
4. population screening;
5. creating programs for prevention and health promotion (including sexual behaviour);
6. medical environmental healthcare;
7. technical hygiene healthcare and psychosocial assistance in the event of disasters;
8. prenatal information for expecting parents;
9. youth healthcare services;
10. geriatric healthcare (e.g. preventing falls and encouraging exercise).

The first four tasks are carried out by both the central government and local authorities. The other tasks are carried out entirely by the local authorities. Local authorities have a major role to play in terms of execution because many factors that have an effect on public health, such as the living environment, can best be tackled close to the people. For youth healthcare, infectious disease control and population screening there are more specific descriptions of the activities which have to be carried out. The central government supports local authorities with the development of the necessary know-how and by arranging sufficient (professional) capacity for execution.
Ministry of Health, Welfare and Sport

Healthcare in the Netherlands
Incidents and crises
Incidents can develop into (inter)national crises particularly in the field of infectious diseases. The Public Health Act stipulates who should take the lead in the event of an (impending) infectious disease epidemic. The mayor is responsible for this task except when there is an (impending) outbreak of a so-called A-infectious disease (which poses a serious risk of public health). In that case the Minister of Health, Welfare and Sport takes control, while the chair of the safety region group (regional mayors of several local authorities) is responsible for the administrative implementation. If necessary the Ministry of Health, Welfare and Sport cooperates with the European Commission and the World Health Organization.

In all cases whereby a person has contracted an infectious disease which constitutes a danger to public health, the mayor or the chair of the safety region group can oblige a person to be kept in isolation in a hospital. Anyone who may be infected with a serious infectious disease, but who is not yet ill, can be forced into quarantine by the mayor or the safety region group. This stipulation in the Public Health Act is intended to prevent the spread of the infection and thereby protect the population.

The funding of public health
The various activities in the field of public healthcare are financed in a number of ways. The central government’s tasks are financed via the national budget. The tasks of local authorities are financed via the Municipal Fund. Whenever local authorities acquire new tasks or the costs of a task increase substantially, central government will supplement this fund with the required amount. The National Influenza Prevention Programme, the population screenings for cancer and programmes aimed at sexual health are financed on the basis of a subsidy scheme.

Knowledge and execution
The National Institute for Public Health and the Environment and the municipal health services make an important contribution in terms of executing the tasks. The National Institute for Public Health and the Environment operates at national level together with the 25 Municipal Public Health Services and reports periodically about the state and future development of public health and performs (inter)national scientific research. It also coordinates the execution of population screenings and supports the Ministry of Health, Welfare and Sport and local authorities in terms of infectious disease control. The Municipal Public Health Services work for local authorities and perform the majority of tasks relating to public health.
Quality and Supervision

The services and quality of execution are supervised in two ways. Horizontal supervision applies to the implementation of services and the available resources. In other words the town council makes sure that the Municipal Executive, and in particular the councillor who is responsible for public health, fulfils his responsibilities properly and ensures adequate services and execution. In addition, the Health and Youth Care Inspectorate supervises the quality of the implementing organisations and the quality of the care provided by professionals.
Youth Act

The Youth Act, which was introduced in 2015, provides for the decentralisation of support, assistance and care for children and adolescents, for which local authorities are currently responsible. The Youth Act covers support, assistance and care for young people and their families coping with parenting and developmental issues, psychological problems and disorders. Young people who require long-term support, for example due to a severe mental disability, are not covered by the Youth Act but by the Long-Term Care Act. The type of care provided ranges from general prevention to specialised voluntary or compulsory care. In terms of providing youth services the local authorities aim for children to grow up in safety and in good health, become independent and participate in society based on their own abilities.

Support, assistance and care under the Youth Act
Under the Youth Act, local authorities support children, adolescents (up to age 18, which may be extended in some cases to age 23) and their parents in dealing with developmental, parenting and psychological problems and disorders. Local authorities are also responsible for implementing child protection measures and youth rehabilitation. By shifting the responsibility for these various duties to the local authority, it is easier now than in the past to provide integrated care to young people. This also encourages the local authorities to develop preventive youth and family policy.

Municipal approach
Under the Youth Act, local authorities have a formal duty to provide timely and suitable assistance and support to young people who need it. They are free to determine themselves what form this support should take and what type of youth services are provided. This gives them the option to assist people on a personalised/individual basis and organise the best possible youth services for their specific environment and young people. Children, adolescents and their parents also have the option of filing complaints with the provider of the youth health services and with the local authority with a view to requesting a different provider. Local authorities receive funds from the central government for the implementation of the Youth Act.
Securing support
Those who require youth services can report to the local authority. The latter can provide support itself through the neighbourhood team/youth team, which many local authorities set up when the Youth Act was enacted in 2015. The neighbourhood team can engage a youth services provider (‘contracted youth health services’). In some cases the GP, paediatrician or medical specialist may refer the youngster to the local authority or directly to a youth services provider. Alternatively, the local authority may also provide a personal healthcare budget, whereby the parents of children and adolescents purchase their own healthcare and involve youth services providers.

If the young person and his/her parents want a different form of youth service than they are being offered, they can address their question to the local authority. If this does not result in a solution, they can object to the decision of the local authorities and appeal the decision before the court if necessary.

Quality
Young people who require care and their family, the local authorities, and the providers of youth health services are the most important parties involved in the Youth Act. They therefore largely determine the quality of the youth health services.

Local authorities purchasing healthcare services can set quality standards and can later check whether the statements sent by the providers of youth services match the agreements made. They also ensure that the healthcare services specified have actually been provided, and that this has been done efficiently. The town council ensures that the Municipal Executive performs its duties under the Youth Act correctly.
Young people and their parents can file complaints with the provider of the youth services and can ask the local authority for a different provider. Through the client council they can also exercise control over the quality of the youth services. They and their parents can also submit a complaint to the Health and Youth Care Inspectorate.

The central government has overall responsibility for ensuring that the healthcare system functions properly. The Youth Act sets out quality requirements for youth services providers, administrators of child protection measures and youth rehabilitation and for hotlines for domestic violence and child abuse. An important regulatory provision concerns the requirement that individual practitioners providing youth health services must be licensed/board-certified and must meet the educational requirements. The central government inspectorate is responsible for monitoring compliance with the quality requirements.

**Financing youth services**
Local authorities receive funds from the central government for the implementation of the Youth Act. The local authority provides the contracted youth services directly to the provider. For the youth services organised by parents or representatives of the children and adolescents themselves with a personal healthcare budget, the local authority transfers funds to the Social Insurance Bank. Parents with a personal healthcare budget can send the invoices they received for the youth health services to the Social Insurance Bank as well. These parents with a personal healthcare budget can themselves also serve as youth services providers and use the budget to pay themselves. This may be the case, for example, if they lose income as a result of caring for their child.