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Introduction

The Dutch Healthcare System

The philosophy underpinning the Dutch healthcare system is based on several more or less universal principles: access to care for all, solidarity through medical insurance (which is compulsory for all and available to all) and high-quality healthcare services. Inevitably, the Dutch system has also 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 four basic healthcare-related acts: the Health Insurance Act (*Zorgverzekeringswet*), the Long-Term Care Act (*Wet langdurige zorg*), the Social Support Act (*Wet maatschappelijke ondersteuning*) 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 (e.g. the Care Institutions (Quality) Act).

The four healthcare-related acts form the foundation of the Dutch 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 Social Support Act and the Youth Act provide for other forms of care and support. The roughly 400 municipalities in 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 24 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.

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 at the behest of the central government. Additionally, several other organisations are involved in its implementation, such as the Centraal Indicatiestelling Zorg (Care Assessment Agency) and the Centraal AdministratieKantoor (Central Administration Office). 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 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 recently 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. A portion of the people taking advantage 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 is 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 were previously covered under 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.

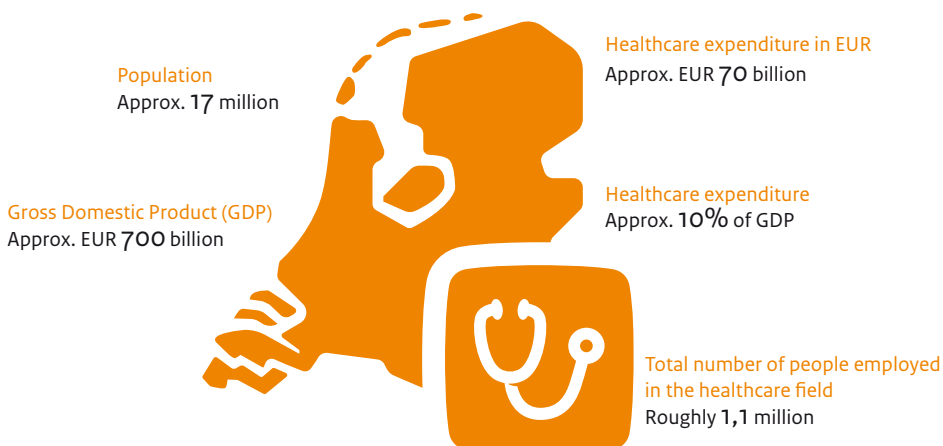
The four acts in practice

Private individuals may be affected by the four healthcare-related acts in the ways described below. For example, when someone needs to see their general practitioner (GP) or is hospitalised, this is paid out of the compulsory basic health insurance package under the Health Insurance Act. Those who require permanent supervision or 24-hour home care can take advantage of provisions under the Long-Term Care Act.

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, or if an autistic child requires support in everyday living, the local authority can provide this under the Youth Act.

These are just several examples of the health and support services provided under the four healthcare-related acts. The four acts are roughly outlined in the next four chapters of this publication. In these sections, we review the various parties involved, the types of care and support provided under the law, the quality of the care services provided, funding, and supervision.

Healthcare in the Netherlands





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 their health condition;
- 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: 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 central government is not directly involved in the actual implementation of the Health Insurance Act: the procedures involved are determined by healthcare providers, health insurers and insured parties. This structure ensures that healthcare providers have a great deal of freedom, while competition and market forces create the incentives required to work efficiently and at a high quality level.

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 Zorginstituut Nederland (National Health Care Institute). 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 and medical 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 is available to all their policyholders.

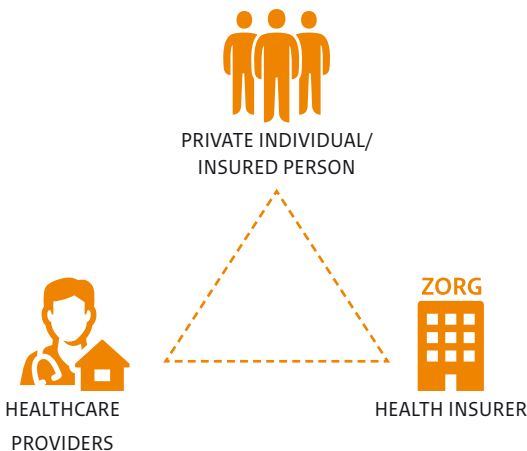
In addition to the compulsory basic insurance package, health insurers provide supplemental insurance for additional care, of which roughly 90% of the Dutch population take advantage. This includes, for example, a special dental insurance policy, alternative medicine/homeopathy, eyeglasses and contacts, and more generous cover for physiotherapy, maternity care and medications. Private individuals can determine themselves whether they wish to make use of supplemental insurance policies, and, if so, if they wish to use the same insurer that provides their basic health insurance package. The supplemental 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 nine health insurance groups operating in the Dutch market must compete for consumers. In addition, people can also exercise control over health insurers’ policies through various representative bodies. 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 quality of the care is inadequate, they can decide not to sign a contract based on the large amount of information to which they have access. Since the healthcare budget is fixed, health insurers are encouraged to maintain efficient purchasing policies. 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

All residents of the Netherlands are entitled to a basic health insurance package, but what do they need to do to obtain this 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: on the one hand, all insured persons aged 18 and over pay a ‘nominal’ premium to their health insurer. These premiums average around EUR 1,200 a year. In addition, all individuals aged 18 and over also pay a mandatory policy excess of EUR 385 (amount for 2016), 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.

On the other hand, there is 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.

For some types of care under the basic insurance package, individuals are required to pay a co-payment on top of the policy excess. 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 can be used to cover a substantial portion of the premium, along with the policy excess. People with the lowest incomes pay less, on average, than they did under the former system.

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 a “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 and a non-contracted care policy. Under a contracted policy, insurers provide full cover only for the health providers with which they have signed a contract; in all other cases, policyholders pay a portion themselves. Under a non-contracted care policy, people can choose their own health insurance provider, while this insurer covers all medical expenses incurred. Around three-quarters of insured people in the Netherlands have some form of 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 supplemental 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, which ensures that the Health Insurance Act is implemented in accordance with the rules and regulations, as well as acting as the market regulator in healthcare markets;
- the Netherlands Authority for Consumers and Markets, which supervises competition in healthcare in the interest of patients and insured parties;
- the Dutch Healthcare 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 take advantage 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 Centrum Indicatiestelling Zorg (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 facility. The Long-Term Care Act is administered by special long-term care administrators at the behest of the central government. These administrators have transferred the actual implementation to healthcare administration offices; these are offices designated in each region which are closely affiliated to a health insurance company. They organise the way the healthcare services are provided. 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 Dutch Healthcare Authority, the healthcare administration offices and the healthcare providers are the main parties to the Long-Term Care Act; together, they determine the quality of the act and the healthcare services covered, as well as implementing initiatives to improve the quality of the care provided. If clients are not satisfied with the care provided, they have the option to switch to another contracted healthcare provider. 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 Healthcare Inspectorate. The healthcare administration offices can set quality requirements when purchasing care under the Long-Term Care Act. In addition, they also check that the statements sent by the health insurance companies match the care specified and the production agreements made.

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 functions. This ensures considerable freedom to organise the care specified in conjunction with the healthcare provider. The most common functions are:

- 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 central government decides what types of care eventually end up in the healthcare package under the Long-Term Care Act, and is advised in this process by the National Health Care Institute.

Access to healthcare

People who require the most serious and intensive care can contact the Care Assessment Agency which determines the type of care someone needs. This is referred to as the 'diagnosis'. 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/sheltered accommodation, or do they prefer to continue living at home, provided this is responsible? 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 subsequently 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 take advantage of healthcare services under the Long-Term Care Act pay a personal contribution 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 Healthcare 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. The central government determines the quality requirements which the providers under the Long-Term Care Act must satisfy. In addition, there are several government agencies which are responsible for supervision. The Authority for Consumers and Markets oversees competition in the healthcare sector, so that private individuals dependent on the Long-Term Care Act can benefit as a result. The Dutch Healthcare Authority ensures that healthcare services are provided efficiently and in accordance with the rules. Finally, the Dutch Healthcare Inspectorate oversees and enforces the quality and safety of care under the Long-Term Care Act.



Social Support Act

Under the Social Support Act 2015, the responsibility of providing support to people with disabilities has been transferred to the local authorities; this includes people with physical, mental or psychological disabilities, including people with learning disabilities and the elderly. The support is designed to 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 support to people who have no other options or who are unable to live at home.

Municipal 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 have difficulty participating in society or who cannot take care of themselves or have a need for sheltered accommodation or support. This includes, for example:

- assistance and day programmes/daytime activity;
- household support;
- support by an informal carer;
- volunteers;
- 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;
- financial support for people who incur significant additional expenses on account of their chronic illness or condition.

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: this might include, for example, coffee mornings at the local community centre, buses that transport the elderly to shops, “meals on wheels” services, Or free or discounted 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 and participating in society can contact the local authority. Alternatively, the GP or another service provider may refer them 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.

After registration, a meeting is scheduled with the person requesting the care: the local authority investigates what the client is still able to do themselves, using their personal network or a general provision. The applicant is also asked about any other factors that might be at play, such as debt, social isolation and confusion. Based on this information, the local authority then makes a recommendation, which it documents in a report. The conclusion here might be that the client can organise the support themselves using their social network, can organise support with a general provision, or that a personalised provision is their best option. If a request is submitted for a personalised provision, the local authority decides whether it will grant or decline the application for support. The personalised provision can be offered in two different ways: on a contracted basis, i.e. where the support is made available by the local authority itself and where the local authority provides the support. Alternatively, if the client so wishes, they can receive a personal healthcare budget, whereby people purchase support themselves. The client may be asked to pay a personal contribution for the personal provision.

Quality

People who require support and their informal carers, the local authorities and the providers are the first parties involved in the Social Support Act and they determine to a large extent the quality of the support provided under the Social Support Act. The law provides for a basic quality standard; for all other aspects, the local authorities, providers and clients agree a number of terms. People requiring support can protest the decision made by the local authority while they also have the option to report complaints and malpractices/wrongdoings relating to the provider and the local authorities and can switch to another provider if desired. In addition, people also 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 financing method used under the Social Support Act is relatively simple: local authorities receive funds from the central government through the Municipal Fund. Local authorities are free to allocate the funds/resources under the law. 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 who provided the support. For the support arranged by individuals by means of a personal healthcare budget, the local authority transfers funds to the Social Insurance Bank, where clients with a personal healthcare budget can send the invoices they have received for their support and have them paid; this is referred to as “drawing rights” or “special drawing rights”. Finally, clients can pay a personal contribution for personalised provisions, which may be dependent on income or capital, up to a maximum of the cost price.



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 ongoing support, for example due to a severe mental disability, are not covered by the Youth Act but under the Long-Term Care Act. The type of care provided ranges from general prevention to specialised voluntary or compulsory care. In enforcing the Youth Act, the local authorities aim for children to grow up in safety and in good health, become independent and become productive members of 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 families in dealing with developmental, parenting and psychological problems and disorders. The local authorities are also responsible for implementing child protection measures and for youth rehabilitation services, and the advising on, and processing of, reports of domestic violence and child abuse. 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.

Municipal approach

Under the Youth Act, local authorities have a formal duty to provide 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 to file complaints with the provider of the youth health services and with the local authority to request a switch of providers. The local authorities receive funds from the central government under 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 refer young people to a youth services provider for contracted youth 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 (contracted or non-contracted).

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

The main parties under the Youth Act are young people with a need for support and their families, the local authorities and providers of youth services, and they are, then, the ones who largely determine the quality of the youth 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. Furthermore, 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 request the local authority to switch to another 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 Healthcare Inspectorate or the 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 Act also sets out rules for the level of expertise of local authorities to provide efficient access to youth services. The Inspectorates of the central government are 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.



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