The Dutch Health System, 2014

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What is the overall role of government?

National government has an overall responsibility for priority setting and may, when necessary, introduce legislation to set these strategic priorities. As such, government safeguards the process from a distance by monitoring access, quality, and costs. Government finances social health insurance for the basic benefit package and the compulsory social health insurance scheme for long-term care. Prevention and social support are not part of social health insurance but financed through general taxation.
The 2006 reforms introduced a prominent role for health insurers. Under the Health Insurance Act (Zorgverzekeringswet), statutory coverage is provided by private insurers and regulated under public law. Health insurers are given the task of increasing health system efficiency through prudent purchasing of health services on behalf of their enrollees.

Who is covered?

Since 2006, all residents (and nonresidents who pay Dutch income tax) are mandated to purchase statutory health insurance from private insurers. People who conscientiously object to insurance and active members of the armed forces (who are covered by the Ministry of Defense) are exempt. Insurers are required to accept all applicants, and enrollees have the right to change insurer each year. In 2013, 30,000 persons (<0.2% of the Dutch population) were uninsured. In June 2014, 325,000 (2%) defaulted on or failed to pay their premium for at least six months. Defaulters remain covered for statutory benefits, but insurers have the right to discontinue voluntary benefits. The number of people defaulting on payment increased slightly for several years, leading up to 325,000 in 2014. Health insurers report defaulters to the National Health Care Institute (Zorginstituut Nederland), which automatically deducts a premium from income equal to 130 percent of the standard premium. Once the defaulter has paid off debt to the insurer, the premium returns to the standard amount. Asylum-seekers are covered by government and several mechanisms are in place to reimburse healthcare costs of illegal immigrants unable to pay. Permanent residents (>3 months) are obliged to purchase private insurance coverage. Visitors are required to purchase insurance for the time of the visit if not covered through their home country
In addition to statutory coverage, most of the population (85%) purchases a mixture of complementary and supplementary voluntary insurance.

What is covered?

Services: Government defines the statutory benefits package based on advice from the National Health Care Institute . Health insurers are legally required to provide a standard benefits package covering: medical care, including care provided by general practitioners, hospitals, specialists, and midwives; dental care through age 18 (coverage after age 18 is confined to specialist dental care and dentures); medical aids and devices; prescription drugs; maternity care; ambulance and patient transport services; paramedical care (limited physical/remedial therapy, speech therapy, occupational therapy, and dietary advice); basic ambulatory mental health care for mild to moderate mental disorders, including maximally five sessions with a primary care psychologist); and specialized outpatient and inpatient

mental care for complicated and severe mental disorders. If the latter takes more than 365 days - from 2015 onwards three years- the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, see further on) takes over and care is considered long-term care.

Some treatments are only partially covered or are excluded, e.g.: since 2012 physiotherapy is not covered, except treatments for some people with specific chronic conditions from the 21st treatment and pelvic physiotherapy for urinary incontinence until the ninth treatment; some elective procedures are excluded (e.g., cosmetic plastic surgery without a medical indication); dental care above age 18; optometry; only the first three attempts are included for in vitro fertilization; sleep medication and antacids were excluded in 2012 for most patients; walkers and other simple mobility aids are no longer covered; and a limited number of effective health improvement programs (e.g., smoking cessation) are covered, and weight management advice is limited to three hours per year.

Long-term disability protection is organized separately from health insurance. People residing legally in the Netherlands and nonresidents who pay Dutch payroll tax are compulsorily insured for long-term care under the Exceptional Medical Expenses Act.

Cost-sharing: Every insured person over age 18 must pay an annual deductible of EUR360 (USD436) (as of 2014) for healthcare costs, including costs of hospital admission and prescription drugs but excluding some services, such as GP visits).[i,] Apart from the overall deductible, patients are required to share some of the costs of for selected services such as medical transportation via co-payments, coinsurance or direct payments for services that are subsidized to a certain limit. A reimbursement limit is set for drugs in groups of equivalent drugs. Excess costs above this limit are not reimbursed. Providers are not allowed to balance-bill patients, ie they are not allowed to charge above the fee schedule. Patients with an in-kind insurance policy may be required to share the costs of care from a provider that is not contracted by the insurance company. Out-of pocket expenses represented 11.9% of health care spending in 2011 (author's calculation).

Safety net: GP care and children's health care are exempt from cost-sharing. The government also pays for children's coverage up to the age of 18 and provides subsidies (known as "health care allowances") to cover community-rated premiums for low-income families (annual income of less than EUR28,482 [USD34,405] for singles and less than EUR 37,145 [USD44,956] for households); approximately 5 million people receive the allowance. Since 2013, the health care allowances are subject to asset testing. The actual allowance is on a sliding scale ranging from EUR 2 (USD2.5) to EUR72 (USD87) per month, depending on income.[i,]

How is the health system financed?

Publicly financed care

The statutory health insurance system under the Health Insurance Act is financed through a nationally defined, income-related contribution, a government grant for insured below age 18 and through community-rated premiums set by each insurer (everyone with the same insurer pays the same premium, regardless of age or health status). In 2014, the average annual community-rated premium for adults is EUR1,100 (USD1,331).[i,] The income-related contribution is set at 7.75 percent of of annual taxable income up to EUR51,414 (USD62,224) (as of 2014).[i,] Employers must reimburse employees for this contribution, and employees pay tax on the reimbursement. For those without an employer who do not receive unemployment

benefits, such as the self-employed, the income-related contribution is 5.4 percent. Contributions are collected centrally and distributed among insurers in accordance with a risk-adjusted capitation formula that considers age, gender, labor force status, region, and health risk (based on past drug and hospital utilization).

Insurers or payers are supposed to engage in strategic purchasing, and contracted providers are supposed to provide their enrollees selectively with the best value, with regard to both quality and cost. The insurance market is dominated by the four largest insurer conglomerates, which account for 95 percent of all enrollees. Among these four, only one operates for-profit, the others non-profit. In 2011, total health care spending accounted for 12.1 percent of GDP (OECD, 2014).

A large part of long-term care is financed through the Exceptional Medical Expenses Act, a statutory social insurance scheme for those whose chronic conditions require continuous care and have considerable financial consequences (Schäfer, et al., 2010). It is a largely contribution-based scheme and operates nationally. The remainder is financed through the Social Support Act, financed from general taxation.

Supplementary / complementary private insurance

Voluntary insurance covers benefits such as dental care, alternative medicine, physiotherapy, spectacles and lenses, contraceptives, and full-cost coverage of copayments for medicines (excess costs above the limit for equivalent drugs). Insurance premiums and products are not regulated: insurers are allowed to screen applicants based on risk factors. Insurers can offer both statutory and voluntary benefits. Voluntary health insurance may cover additional benefits not covered in the compulsory scheme. People with voluntary health insurance do not receive faster access to any type of care, nor do they have increased choice of specialist or hospital. Many people purchase complementary coverage because they (often wrongly) believe they are at risk of incurring high health care costs. In 2010, voluntary insurance accounted for 7.8 percent of total health spending.

How are health care services organized and financed?

Primary care: In 2013, there were over 40.000 registered doctors, including 12.195 primary care doctors and over 20.000 specialists. The general practitioner (GP) is the central figure in primary care; other primary care providers include dentists, midwives, and physiotherapists. Hospital and specialist care (except emergency care) are accessible only upon GP referral; only 4 percent of appointments with a GP result in a referral to secondary care. All citizens are registered with a GP of their choice, usually in their own neighborhood. On average, patients contact their GP five times per year; a full-time GP has a practice list of approximately 1900 patients.

Patients can switch GP without formal restriction. In 2013, there were 8,865 practicing GPs: 36.4 percent worked in group practices of three to seven, 37.9 percent worked in two-person practices, and 25.7 percent worked solo. Most GPs are independent entrepreneurs or work in a partnership (self-employed); only a small number (11%) are employed in a practice owned by another GP.

GP remuneration includes capitation (37.3% of income) and fee-for-service payment (33% of income). Many GPs employ nurses and primary care psychologists on salary, and the

reimbursement for the nurse is received by the GP, so any productivity gains that result from substituting a nurse for a doctor accrue to the GP. At present, the role of district nurses is being strengthened, as their activities will be financed under the Health Insurance Act via spending arrangements similar to those in the curative sector. To incentivize care coordination, there are bundled payments for some chronic diseases (diabetes, cardiovascular risk management, and COPD), and efforts are under way to implement them for heart failure and depression. There are ongoing experiments with pay-for-performance and population management to improve quality in primary and hospital care.

In 2015, a new funding model that consists three segments will be introduced to all GPs. Segment 1 funds the core of primary care, and consists of a capitation fee per registered patient, a consultation fee for GPs, including phone consultation, and provision for ambulatory mental health care at the GP practice. The Dutch Health Care Authority (Nederlandse Zorgautoriteit) determines national provider fees for this segment. Segment 2 consists of funding for programmatic multidisciplinary care for diabetes, cardiovascular risk management, asthma and chronic obstructive pulmonary disease. GPs have to negotiate prices and volumes with insurers for this segment. Segment 3 provides GPs and insurers the opportunity to negotiate additional contracts – including prices and volumes - for pay-for-performance and innovation. The Dutch Health Care Authority expects that segment 1 will represent 75% of spending, segment 2 15% and segment 3 10%.

Outpatient specialist care: Almost all specialists are hospital-based and are either in group practice (40-45%, paid under fee-for-service) or on salary (most but not all in university clinics). Specialist fees (as part of Diagnosis Treatment Combinations) are set nationally but from 2015 on will be freely negotiable as a part of hospital payment. During the last decade, the proportion working on salary has increased considerably. There is a nascent trend of working outside hospitals—for example, in growing numbers of ambulatory surgery centers—but this shift is marginal, and most ambulatory surgery centers remain tied to hospitals. Ambulatory surgery center specialists are paid fee-for-service and the fee schedule is negotiated with insurers. Patients are free to choose their provider (following referral), but insurers may vary restrictions (cost-sharing) on choice within their policies (Schäfer, et al., 2010). In 2016, a third insurance type (merely a variant of the restitution policy) will be introduced that aims to control health care costs via providing more opportunity for selective contracting. In the so called 'budget policy', choice of specialist is restricted to contracted specialists - reimbursement for not-contracted care will be 0%.

Administrative mechanisms for paying Primary Care Doctors and Specialists: The annual deductible (see section on cost-sharing) is paid to the insurer. Insured have the possibility to pay for the deductible before or after health care use and may choose to pay at once or in installments.

After-hours care: After-hours primary care is organized at the municipal level in general practitioner (GP) "posts"—centralized services typically run by a nearby hospital that provide primary care between 5pm and 8am. Specially trained assistants answer the phone and perform triage. GPs decide whether or not patients need to be referred to the hospital. The GP post sends the information regarding a patient's visit to his or her GP. Doctors are compensated via hourly rates for after-hours care and are required to provide at least 50 hours

after-hours care annually for continuation of registration as general practitioner.There is no national medical telephone line.

Emergency care is provided by GPs, emergency departments, and trauma centers and is covered under statutory insurance. Depending on urgency, patients or their representatives can contact their GP or a GP post (for after-hours care), call an ambulance, or access hospital emergency department (Schäfer, et al., 2010). The great majority of hospitals have emergency departments, and all have a GP post.

Hospitals: In 2013, there were 131 hospitals and 106 outpatient specialty clinics spread among 86 organizations, including eight university medical centres. Practically all organizations were private and nonprofit. In 2010, there were also more than 170 independent private and nonprofit treatment centers whose services were limited to same-day admissions for non-acute, elective care (e.g., eye clinics, orthopedic surgery centers) covered by statutory insurance.In 2011, there were 83 private clinics specialized in care outside the benefit package and an unknown number of self-employed specialists with an own private practice.

Hospitals budgets are determined through negotiations between insurers and hospitals over price and volume (2008). The great majority of payment takes place through the case-based Diagnosis Treatment Combinations system (a Diagnosis-Related Group-like system) and rates of approximately 70 percent of hospital services are freely negotiable: each hospital negotiates with each insurer to set the rates. The remaining 30 percent are set nationally. In 2012, the Diagnosis Treatment Combinations system was fundamentally reformed and the number of Diagnosis Treatment Combinations was reduced from 30,000 to 4,400. Diagnosis Treatment Combinations cover both outpatient and inpatient as well as specialist costs, thereby strengthening the integration of specialist care in the hospital organization.

Mental health care: Mental healthcare is provided in primary and secondary care. Primary care providers of mental healthcare include general practitioners, psychologists, and psychotherapists. When more specialized care is required, the general practitioner refers the patient to a psychologist, an independent psychotherapist, or a specialized mental healthcare institution.
In 2011, around 865,000 people were treated in specialized mental health care organizations. Around 92 percent of them received ambulatory treatment and 8 percent received inpatient care. About 35.000 receive long-term (i.e. for more than 365 days) mental health care annually. Preventive mental health care is provided by municipalities and governed by the Social Support Act.

Further integration of general practice and mental health center services was agreed to by the Ministry of Health, insurers, and providers in 2012. For several years, policy aimed to substitute inpatient mental health care for outpatient care.

Long-term care:
Long-term care, financed by the Exceptional Medical Expenses Act and Social Support Act, accounts for 44 percent of government's total health care budget. It is provided in institutions (residential care) and in communities (home care) mainly to elderly persons, patients with psychiatric disorders and persons with learning, sensory or disability conditions. The Exceptional Medical Expenses Act covers most expenditures, such as the costs of personal

and nursing care, counseling, medical treatment and accommodation. Cost-sharing for long-term care depends on the number of people within the household, annual income, indication, and assets (and length of stay). In 2011, co-payments covered 7.2% of total spending.

Health insurers are formally responsible for implementing the Exceptional Medical Expenses Act, but delegated this task to regional care offices (Zorgkantoren). The Center for Needs Assessment (Centrum Indicatiestelling Zorg) is commissioned by government to carry out eligibility assessments, which is dependent on a patient's situation, needs and the ability of informal caregivers to help. Patients, their relatives, or their healthcare providers can file a request with the Centre for Needs Assessment, which then sends its decision to a care office (Zorgkantoor).

Municipalities are responsible for services including household services, medical aids, home adjustments, services for informal carers, preventive mental health care, transport facilities and assistance via the Social Support Act (Wet Maatschappelijke Ondersteuning). Municipalities are funded through the Municipality Fund, provided by national government, and local taxes. They have a great deal of freedom in organizing services - including needs assessments. As a result, there are variations and to some extent inequalities in access to care.

Home care is provided by private, not-for profit providers including home care organizations, residential homes, and nursing homes. In 2009, there were 479 nursing homes, 1,131 residential homes, and 290 combined institutions. Most palliative care is integrated into the health system and is delivered by general practitioners, home care providers, nursing homes, specialists, and voluntary workers. Healthcare providers, palliative units, and hospices participate in regional networks in order to promote integration and coordination of care. The number of hospices and palliative units is growing: in 2013 there were 123 hospices, 143 nursing or residential homes, and 15 hospitals with special departments for symptom control and stabilization. Still, less than 5 percent of the population currently dies in a hospice.

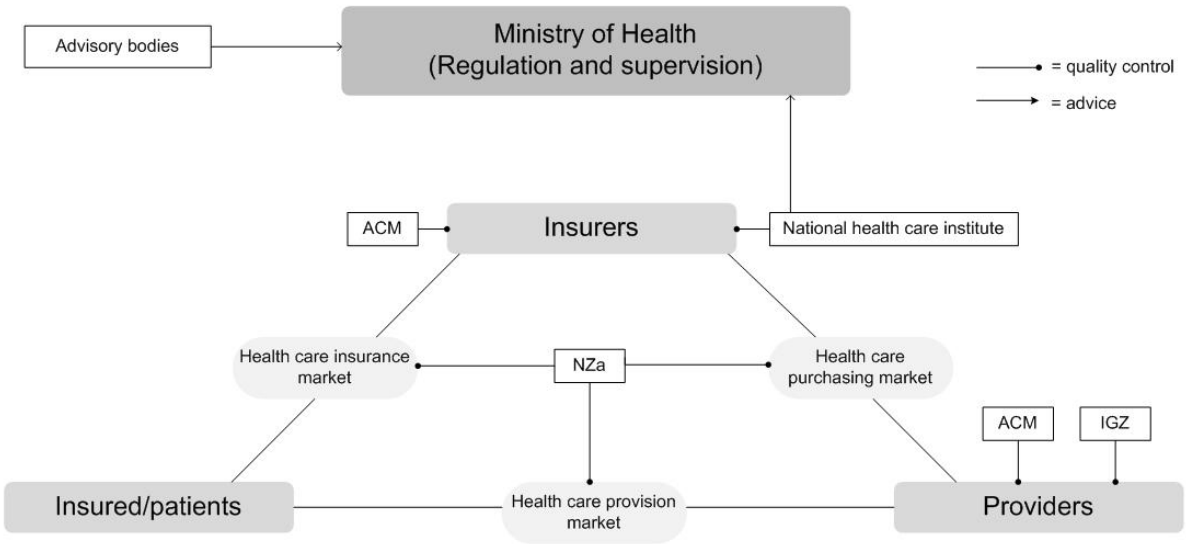
For both the Social Support Act and Exceptional Medical Expenses Act personal budgets for patients to buy and organize their own care are possible, and are set at 66% of rates paid for in-kind services. Centres for Needs Assessments and municipalities carry out assessments for personal budgets just like for in-kind care.
Patients receiving long-term care at home may apply for an allowance of EUR200 (USD242) per year (*mantelzorgcompliment*) for their caregiver.[1] In 2015, this allowance will cease to exist under the current conditions but will fall to the responsibility of the municipalities. Municipalities will have a great deal of freedom in how to support caregivers.

What are the key entities for health system governance?

The 2006 reform dramatically changed the governance structure, especially with regards to the Ministry of Health whose role changed from direct steering to safeguarding the process from a distance. The Minister of Health is responsible for the preconditions towards access, quality and costs of the health system, has an overall responsibility for priority setting and may, when necessary, introduce legislation to set these strategic priorities. A number of arm's-length agencies are responsible for setting operational priorities. At the national level, the Health Council advises government on evidence-based medicine, healthcare, public health, and environmental protection; the newly established National Health Care Institute (formerly known as the Health Care Insurance Board) integrates knowledge of various institutes involved and has the power to inform change. The Institute advises government on

the components of the statutory benefits package and has various tasks at the themes quality of care, professions and training, and the insurance system (risk-adjustment).The Medicines Evaluation Board oversees efficacy, safety, and quality of medicines. Health technology assessments (HTAs, including cost-effectiveness analysis) are carried out by the Health Council and the Health Care Institute, but decisions about the benefit package rest with the Minister (advice is not binding). The Dutch Health Care Authority has primary responsibility for ensuring that the health insurance market, the healthcare purchasing market, and the healthcare delivery market function appropriately (e.g., they set prices for 30 percent of Diagnosis Treatment Combinations), while the Dutch Competition Authority (Autoriteit Consument en Markt) enforces anti-trust laws among both insurers and providers. Diagnosis Treatment Combination Maintenance (DBC-Onderhoud) is an independent organization responsible for the design, construction, and maintenance of the Diagnosis Treatment Combinations system. In the near future, DBC-Onderhoud will be integrated with the Health Care Authority. Self-regulation of Dutch medical doctors is also an important aspect of the Dutch system(Smith et al., 2012).

The patient movement consists of a wide range of organizations, both for specific diseases or umbrella organizations. These organizations offer support for patients, provide information and increasingly look after patients' interest via participating in quality of care projects.(Peeters, Delnoij, & Friele, 2014) The Dutch patient umbrella organization (Nederlandse Patiënten Consumenten Federatie) conducts a range of activities to promote transparency. A range of other parties are involved in informing the public, including medical doctors with their Dutch Choosing Wisely campaign.



What is being done to ensure quality of care?

The Dutch Health Care Performance Report 2010 provided indisputable evidence that the quality and price of Dutch health services vary substantially among providers, and that more needs to be done to address the variation in quality (Westert, et al., 2010).

At the system-level, quality is ensured through legislation governing professional performance, quality in healthcare institutions, patient rights, and health technologies. The Dutch Health Care Inspectorate (Inspectie Gezondheidszorg) is responsible for monitoring quality and safety. Most quality assurance is carried out by providers, sometimes in close cooperation with patient and consumer organizations and insurers. Disease management for

chronically ill has been a prominent theme for years. In the last years, many parties have been working on quality registries. Mechanisms to ensure quality of care provided by individual professionals include reregistration/revalidation of specialists based on compulsory continuous medical education; regular on-site peer assessments by professional bodies; and profession-owned clinical guidelines, indicators, and peer review. The main methods used to ensure quality in institutions include accreditation and certification; compulsory and voluntary performance assessment based on indicators; and national quality improvement programs based on the breakthrough method *sneller beter* ("faster, better"). Patient experiences are also systematically assessed and, since 2007, a national center has been working with validated measurement instruments in an approach comparable to that of the Consumer Assessment of Healthcare Providers and Systems in the United States. The center also generates publicly available information for consumer choice on waiting lists, patient satisfaction, and a few quality indicators. The Dutch Patient organization launched a website for public reporting of quality of care and provider performance.

The Ministry of Health recently issued a directive to parliament stating that, from 2014, a central body (the National Health Care Institute) needs to be established to further accelerate the process of quality improvement and to encourage evidence-based practice**.** In 2013, the Ministry of Health and a number of national representative organizations signed a covenant that effectively sets a ceiling for the annual growth rate of spending to be accomplished by improvements in quality and efficiency. Most notably, the covenant included fewer referrals to hospitals, further concentration of top-clinical care, more stringent compliance to guidelines and a critical use of resources – appropriate care. In October 2013, a range of representative organizations launched a Dutch version of the Choosing Wisely campaign. The campaign is aimed at stimulating 'wise choices' and to support medical specialists and their patients in shared decisions about appropriate use of care.

Delivery system integration and care coordination

A bundled-payment approach to integrated chronic care is used nationwide for diabetes, Chronic Obstructive Pulmonary Disease, and vascular risk management. Under this system, insurers pay a single fee to a principal contracting entity—the "care group"—to cover a full range of chronic disease services for a fixed period. The care group is a legal entity formed by multiple healthcare providers, often exclusively general practitioners, which assumes clinical and financial responsibility for all assigned patients in the care program and either delivers services itself or subcontracts with other providers. The bundled-payment approach supersedes traditional healthcare purchasing for the condition and divides the market into two segments—one in which health insurers contract care from care groups, the other in which care groups contract services from individual providers. The price for the bundle is freely negotiated by insurers and care groups, and fees for the subcontracted providers are similarly freely negotiated by the care group and the providers (Struijs, 2011). An initial evaluation of the new payments system indicated that it improved the organization and coordination of care, but no improvement of health outcomes were reported (de Bakker, 2012). At present, the role of district nurses is being strengthened, aiming to reach vulnerable populations and provide a better alignment of care.

What is being done to reduce disparities?

Smoking is still a leading cause of death, followed by obesity. For many determinants, lower socioeconomic groups do worse on all fronts. However, the current government does not have

a specific policy to overcome health disparities, as the cornerstone of present policy is an emphasis on people's personal responsibility for healthy lifestyles. In 2013, government decided to include diet advice and smoking cessation programs in the statutory benefits package.

What is the status of electronic health records?

Authorities are working to establish a central health information technology network to enable information exchange across providers. All Dutch patients have a unique identification number (Burger service nummer). Virtually all general practitioners have a degree of electronic information capacity—for example, they use an electronic health record, and can order prescriptions and receive lab results electronically. At present, all hospitals have an electronic health record.

Electronic records for the most part are not nationally standardized or interoperable between domains of care, reflecting their historic development as regional initiatives. In 2011, organizations representing general practitioners, after-hours general practice cooperatives, hospitals and pharmacies set up the Union of Providers for Health Care Communication (De Vereniging van Zorgaanbieders voor Zorgcommunicatie) responsible for the exchange of data via an IT infrastructure named AORTA; data are not stored centrally. Patients must approve their participation in this exchange, and have the right to withdraw . The network stores a patient's general practice file and information about use of medications. Patients need to ask a provider for access to the medical file. In 2012, the previously mentioned four parties, organizations representing insurers and patients (Nederlandse Patiënten Consumenten Federatie), and several others signed an agreement to promote further development of the national healthcare IT infrastructure.

How are costs controlled?

Bending the cost curve was one of the most significant themes in public debate surrounding the most recent elections (2012). Most recent figures on annual expenditure from Statistics Netherlands indicate that growth has fallen significantly to1.6 percent.

The pharmaceutical sector is generally considered to have contributed significantly to the decrease in spending growth. In 2013 pharmaceutical use as well as their average prices decreased. The policy of insurers to reimburse only the lowest-price generic drugs has contributed to the decrease in average price. From 2012 onwards, reimbursement for expensive drugs has to be negotiated between hospital and insurer. There is some concern that this and other factors may reduce access to expensive drugs in the near.

The annual deductible is responsible for the main part of patient cost-sharing and more than doubled from EUR170 () in 2008 to EUR360 in 2014 (USD206 to 436).[i] There are some worries that this has increased the number of people abstaining/postponing from needed medical care.
Health technology assessment is gaining in importance and is mainly used for decisions on the benefit package and on the appropriate use of medical devices. Additionally, the Minister launched a call for suggestions in 2013 on how to reduce the scope of the benefit package or how to improve efficiency and reduce waste.

When the 2006 reforms were first introduced, government aimed allow market forces to operate. The main approach to controlling costs system rests on regulating competition between insurers and improving efficiency of care through the use of performance indicators. In addition, provider payment reforms, including a shift from a budget-oriented reimbursement system to a performance- and outcome-driven approach, have been implemented; costs are increasingly expected to be controlled by the new Diagnosis Treatment Combinations system, in which hospitals must compete for prices of specific services; and various local and national programs aim to improve healthcare logistics.

In 2013, an agreement was signed between the Ministry of Health, all healthcare providers, and insurers that sets a voluntary ceiling for the annual growth of hospital and mental care volume. When macro-costs exceed this limit, government has the ability to control spending via generic budget cuts. However, this agreement included an extra 1 percent spending growth allowance for primary care practices in 2014 and 1.5 percent in 2015–2017, provided that they demonstrate that services are a substitute for hospital care.

What major innovations and reforms have been introduced?

Growing dissatisfaction with the dual system of public and private coverage eventually led to the 2006 reform and the introduction of the Health Insurance Act. The underlying logic of managed competition is that consumers who have the right to exercise choice induce competition among insurers, and insurers will therefore push healthcare providers to increase the quality and efficiency of their services (Westert et al., 2009). The last years, steps have been taken to further stimulate competition among insurers and providers. For example, in 2011, the ex-post risk adjustment to limit insurer's financial risk were abolished. In addition, under very strict conditions, hospitals are allowed to operate for-profit.

Long-term care is undergoing fundamental reform. All extramural care that is currently covered by the Exceptional Medical Expenses Act will be transferred to the Social Support Act and the Health Insurance Act. The second and third year of inpatient mental healthcare will shift to the Health Insurance Act, sheltered living to the Social Support Act. As a result, the former Exceptional Medical Expenses Act will transform to a far smaller provision for people requiring intramural long term care (Wet Langdurige Zorg). As of January 2015 municipalities will be responsible for all social support and assistance in the adjusted Social Support Act, while all nursing and care activities fall under the Health Insurance Act.

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[i] All figures in USD were converted from EUR at a rate of about 0.83 EUR per USD, the purchasing power parity conversion rate for GDP in 2013 reported by OECD (2014) for the Netherlands.