European Commission

# State of Health in the EU

# Netherlands

## Country Health Profile 2017

OECD
BETTER POLICIES FOR BETTER LIVES

European Observatory on Health Systems and Policies
a partnership hosted by WHO

## The Country Health Profile series

The *State of Health in the EU* profiles provide a concise and policy-relevant overview of health and health systems in the EU Member States, emphasising the particular characteristics and challenges in each country. They are designed to support the efforts of Member States in their evidence-based policy making.

The Country Health Profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by Member States and the Health Systems and Policy Monitor network.

## Contents


1 • HIGHLIGHTS 1

2 • HEALTH IN THE NETHERLANDS 2

3 • RISK FACTORS 4

4 • THE HEALTH SYSTEM 5

5 • PERFORMANCE OF THE HEALTH SYSTEM 8

5.1 Effectiveness 8

5.2 Accessibility 10

5.3 Resilience 12

6 • KEY FINDINGS 16


## Data and information sources

The data and information in these Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated in June 2017 to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 28 Member States unless otherwise noted.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following StatLinks into your Internet browser:
http://dx.doi.org/10.1787/888933593722

## Demographic and socioeconomic context in the Netherlands, 2015

| | | The Netherlands | EU |
|---|---|---|---|
| **Demographic factors** | Population size (thousands) | 16 940 | 509 394 |
| | Share of population over age 65 (%) | 17.8 | 18.9 |
| | Fertility rate[1] | 1.7 | 1.6 |
| **Socioeconomic factors** | GDP per capita (EUR PPP[2]) | 37 000 | 28 900 |
| | Relative poverty rate[3] (%) | 5.8 | 10.8 |
| | Unemployment rate (%) | 6.9 | 9.4 |

1. Number of children born per woman aged 15–49.
2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.
3. Percentage of persons living with less than 50% of median equivalised disposable income.

**Source:** Eurostat Database.

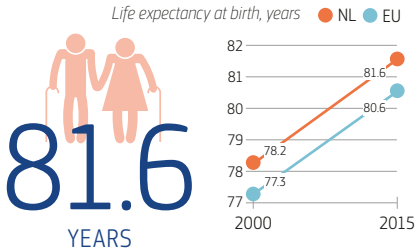

***Disclaimer:*** *The opinions expressed and arguments employed herein are solely those of the authors and do not necessarily reflect the official views of the OECD or of its member countries, or of the European Observatory on Health Systems and Policies or any of its Partners. The views expressed herein can in no way be taken to reflect the official opinion of the European Union. This document, as well as any data and map included herein, are without prejudice to the status of or sovereignty over any territory, to the delimitation of international frontiers and boundaries and to the name of any territory, city or area.*
*Additional disclaimers for WHO are visible at http://www.who.int/bulletin/disclaimer/en/*

© OECD and World Health Organization (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

# 1 Highlights

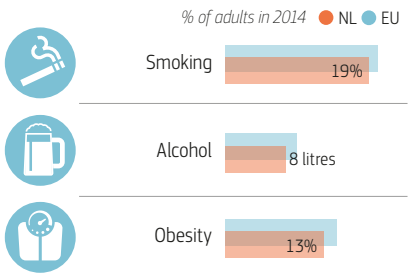
The Dutch health system is one of the most expensive in the EU. But Dutch people get something in return: they enjoy good access to a dense network of effective primary and secondary care providers and generous long-term care. Since the mid-2000s, two major reforms in insurance and long-term care have changed the face of Dutch health care and will continue to do so in the foreseeable future.

## Health status



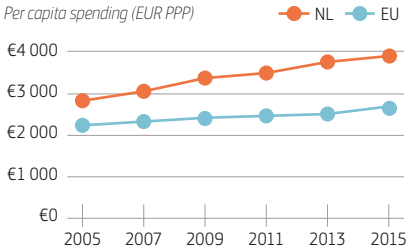

Life expectancy at birth was 81.6 years in 2015, up from 78.2 years in 2000 and above the EU average, although women are below the EU average. However, about half of the extra years of life are not spent in good health. Life expectancy gains are mainly the result of a consistent reduction of premature deaths from cardiovascular diseases. Lung cancer and dementia are now among the leading causes of death.

## Risk factors




In 2014, 19% of adults in the Netherlands smoked tobacco every day, which is below the EU average and down from 23% in 2008. Overall alcohol consumption per adult has also decreased and is below the EU average. While obesity rates remain below the EU average, obesity is on the rise: 13% of adults in the Netherlands were obese compared with only 11% in 2005, a rise of almost 20%.

## Health system

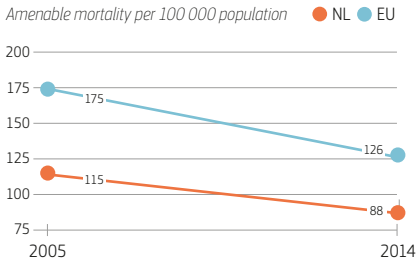



Health spending in the Netherlands is high: EUR 3 954 per head in 2015, compared to the EU average of EUR 2 797. This is 10.7% of GDP and the fourth highest in the EU (which averages 9.9%). It is also increasing (up from 9.4% in 2005) but broad sectoral agreements in 2012 have flattened the cost curve. High overall spending is mainly due to comparatively large long-term care expenditure. Over 80% of health spending is publicly funded, although the share of out-of-pocket spending has increased and become a topic for public debate.

## Health system performance

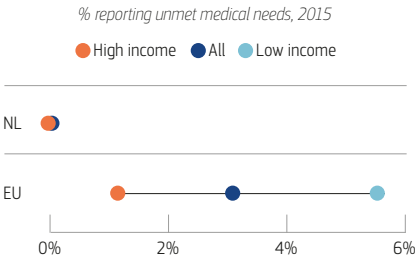
### Effectiveness

Amenable mortality in the Netherlands is very low, indicating (together with other relevant indicators) that the health care system is effective.




### Access

Access to health care in the Netherlands is good, with low numbers reporting unmet needs for medical care.




### Resilience

Despite stable funding, concerns over cost control continue. There is also significant room to improve efficiency. Governance seems effective but disagreement on the proper role of market mechanisms persists.

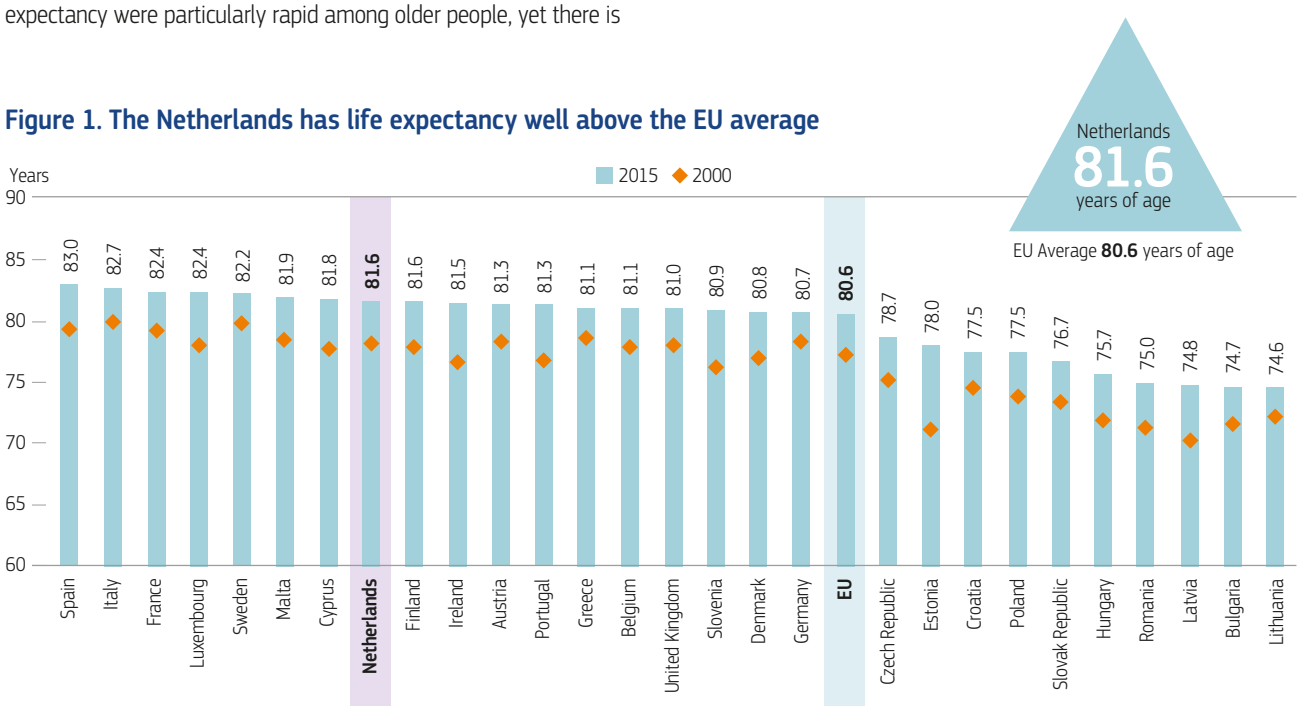
# 2 Health in The Netherlands

## People live longer but not always healthier lives, while women are lagging behind

Over the past decade, people in the Netherlands have enjoyed steady improvements in life expectancy. In 2015, it was higher than the EU average, but still lower than countries such as Spain, Italy and France (see Figure 1). Less positive, however, is that life expectancy for women is below the EU average, which is mostly related to smoking (see also Section 3). Improvements in life expectancy were particularly rapid among older people, yet there is a six-year gap in life expectancy between people with low and high educational attainment.[1]

Furthermore, the overall time spent in good health has been declining, again affecting women more than men.[2] At age 65, remaining life expectancy was 18.4 years for men (up from 15.4 in 2000) and 21.1 years for women (up from 19.3 in 2000), although men could expect to spend 57% of that time in good health and women only 45% (2015).

**Figure 1. The Netherlands has life expectancy well above the EU average**




**Source:** Eurostat Database.

## With cardiovascular diseases lower than ever, lung cancer and dementia are leading causes of death

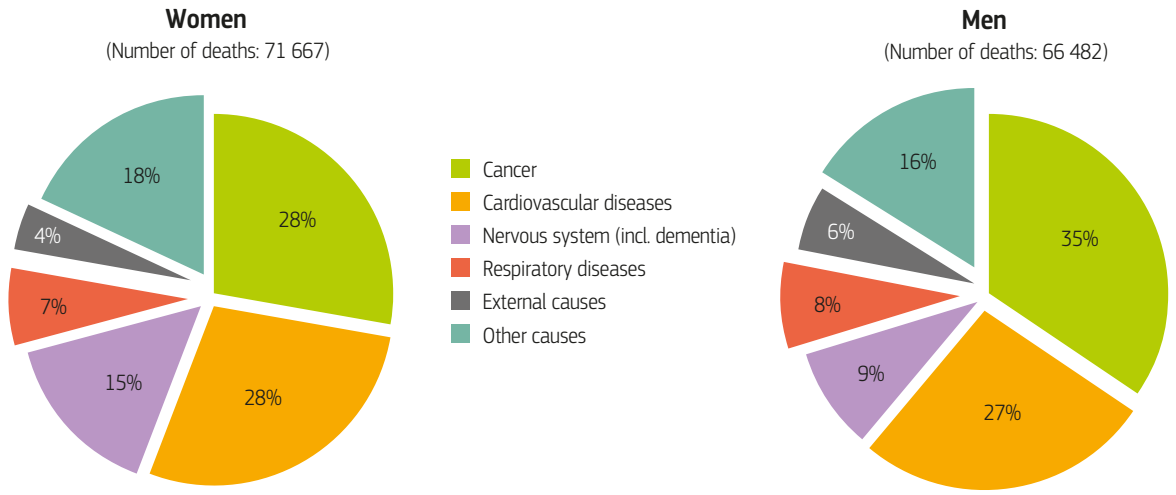
Increases in life expectancy are mainly the result of a consistent reduction of premature deaths from cardiovascular diseases (CVD), resulting in one of the lowest overall rates in Europe. Indeed, for men cancer has now become the main cause of death in the Netherlands while for women cancer and CVD as a cause of death are about the same level (see Figure 2). Still, there were over 5 000 deaths from these conditions in 2013 in people under 75 years of age (in a population of almost 17 million), which might have been avoided through improved treatment or prevention. For both men and women combined, Alzheimer's and other dementias have become the second cause of deaths, after other heart diseases and before lung cancer (see Figure 3).

Looking in more detail and at standardised death rates, lung cancer is the single most important cause of death (7%) (2013). Importantly, while lung cancer deaths are falling in men, they have been rising for women, reflecting the long-term consequences of tobacco use in previous generations. This has to be seen in conjunction with mortality from chronic obstructive pulmonary disease (COPD), which is also largely preventable, but decreasing. Mortality from Alzheimer's and other dementias has become the second leading cause of death, reflecting population ageing as well increased recognition in mortality coding.

1. Lower education levels refer to people with less than primary, primary or lower secondary education (ISCED levels 0–2) while higher education levels refer to people with tertiary education (ISCED levels 5–8).

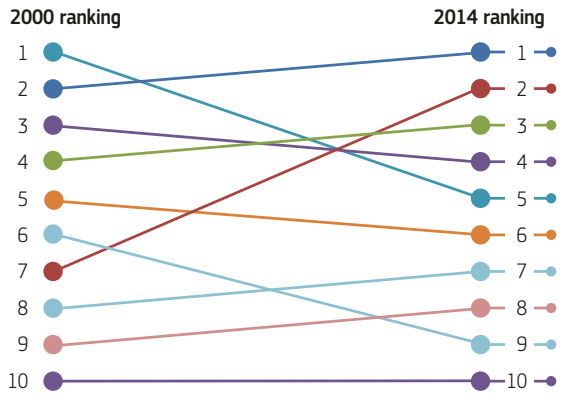
2. These are based on the indicator of 'healthy life years', which measures the number of years that people can expect to live free of disability at different ages.

### Figure 2. Cancer now accounts for one out of three deaths for men and over a quarter in women




**Note:** The data are presented by broad ICD chapter. Dementia was added to the nervous system diseases' chapter to include it with Alzheimer's disease (the main form of dementia).
**Source:** Eurostat Database (data refer to 2014).

### Figure 3. Heart diseases and Alzheimer's and other dementias account for the majority of deaths




| | % of all deaths in 2014 |
|---|---|
| Other heart diseases | 11% |
| Alzheimer and other dementias | 9% |
| Lung cancer | 8% |
| Stroke | 7% |
| Ischaemic heart diseases | 6% |
| Lower respiratory diseases | 4% |
| Colorectal cancer | 4% |
| Breast cancer | 2% |
| Pneumonia | 2% |
| Diabetes | 2% |

**Source:** Eurostat Database.

## Wide disparities exist in the prevalence of chronic diseases

Based on self-reported data from the European Health Interview Survey (EHIS), one in six people in the Netherlands live with hypertension, one in eighteen with asthma, and one in twelve with chronic depression. Wide disparities exist in prevalence by education level. People with the lowest level of education are nearly three times as likely to live with diabetes and 35% more likely to live with asthma as those with the highest level of education.[3]

## Very few people describe their health as poor, but there are large differences based on income

The Dutch tend to rate their general health fairly high, with only 5% perceiving their health as poor or very poor (the fourth lowest proportion in the EU). However, this differs according to socioeconomic factors such as income, with only 2% of those in the highest income quintile describing their health as poor, compared to 10% in the lowest income quintile.

3. Inequalities by education may partially be attributed to the higher proportion of older people with lower educational levels; however, this alone does not account for all socio-economic disparities.

# 3 Risk factors

## Behavioural risk factors are still a major public health concern

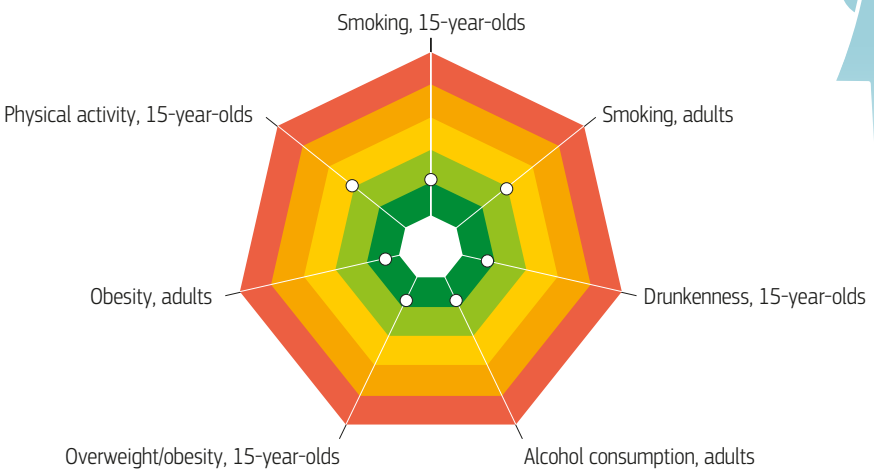
The good health status of the Dutch population is linked to a range of determinants, including the living and working conditions of people, their physical environment, and an array of behavioural risk factors. Data from IHME suggests that more than a quarter (26%) of the overall burden of disease in the Netherlands in 2015 (measured in terms of DALYs)[4] is linked to behavioural risk factors – including smoking, poor diet, low physical activity, and alcohol use. Of risky behaviours in the Netherlands, smoking and dietary factors contribute the most to poor health (IHME, 2016), the latter by impacting on overweight and obesity.

## Smoking rates are falling and the Netherlands performs well on several other risk factors

Although behavioural factors contribute to more than a quarter of all burden of disease, and despite the fact that smoking alone was responsible for some 13% of all ill health in 2015 (IHME, 2016), there is progress. Regular smoking has declined by a third over the past 15 years, with one in five adults smoking in 2014. This corresponds with the introduction of smoke-free working environments and other policy changes. Yet, as noted above, mortality from lung cancer among women is still rising, mostly due to high smoking rates in previous generations. Alcohol consumption has declined to one of the lowest levels in the EU (see specific policies in Section 5.1). Several other risk factors show generally good performance compared to other countries (Figure 4).

4. DALY is an indicator used to estimate the total number of years lost due to specific diseases and risk factors. One DALY equals one year of healthy life lost (IHME)..

**Figure 4. The Netherlands compares well with other EU countries on most risk factors***




## Although overweight and obesity are fairly low, rates are rising

The Netherlands has a lower proportion of its population self-reporting as overweight and obese than other EU countries however, the proportion of obese people in the population has been rising as in many other EU countries. Obesity has risen from under 10% in 2000 to nearly 13% in 2014 (compared to 15.9% in the EU) which has important implications for health, contributing for example to diabetes, CVD and selected cancers. In response, the Dutch government has instituted a range of policies to address the issue (Section 5.1).

## Inequalities in risk factors persist according to education and income

Behavioural risk factors tend to be more common among people at a disadvantage because of a lesser education or lower income. In 2014, almost a quarter of those without upper secondary education were daily smokers compared to 11% of those with higher degrees. Likewise, over 15% of those with lower education were obese compared to 8.6% with higher education. Policies seeking to reduce socioeconomic inequalities in health at individual and population level have been on the agenda in the Netherlands since the 1980s, with recent initiatives seeking to explicitly address inequalities at the local level, such as the national programme Health in the City (2014).

*Data on physical activity among adults are not available for the Netherlands.

**Note:** The closer the dot is to the centre the better the country performs compared to other EU countries. No country is in the white 'target area' as there is room for progress in all countries in all areas.

**Source:** OECD calculations based on Eurostat Database (EHIS in or around 2014), OECD Health Statistics and HBSC survey in 2013–14. (Chart design: Laboratorio MeS).

# 4 The health system

## Health system organisation and governance have changed and are evolving after two major reforms

A comprehensive reform in 2006 established a single private insurance market under regulated competition. Before 2006, the Dutch health system was based on social insurance combined with a private insurance scheme covering the better-off. All residents are now mandated to purchase insurance policies, which cover a defined benefit package. Insurers must accept all applicants and are expected to contract providers based on quality and price.

The government acts as supervisor of the health insurance, purchasing and provision markets aided by watchdog agencies such as the Authority for Consumers and Markets (fair competition), Health Care Authority (supervision and price regulation) and the Health Care Institute (care quality standards and insurance package advice). Both insurers and providers have been consolidating, in part to strengthen their market positions, and four insurers, each carrying various brands, now cover almost 90% of the market.

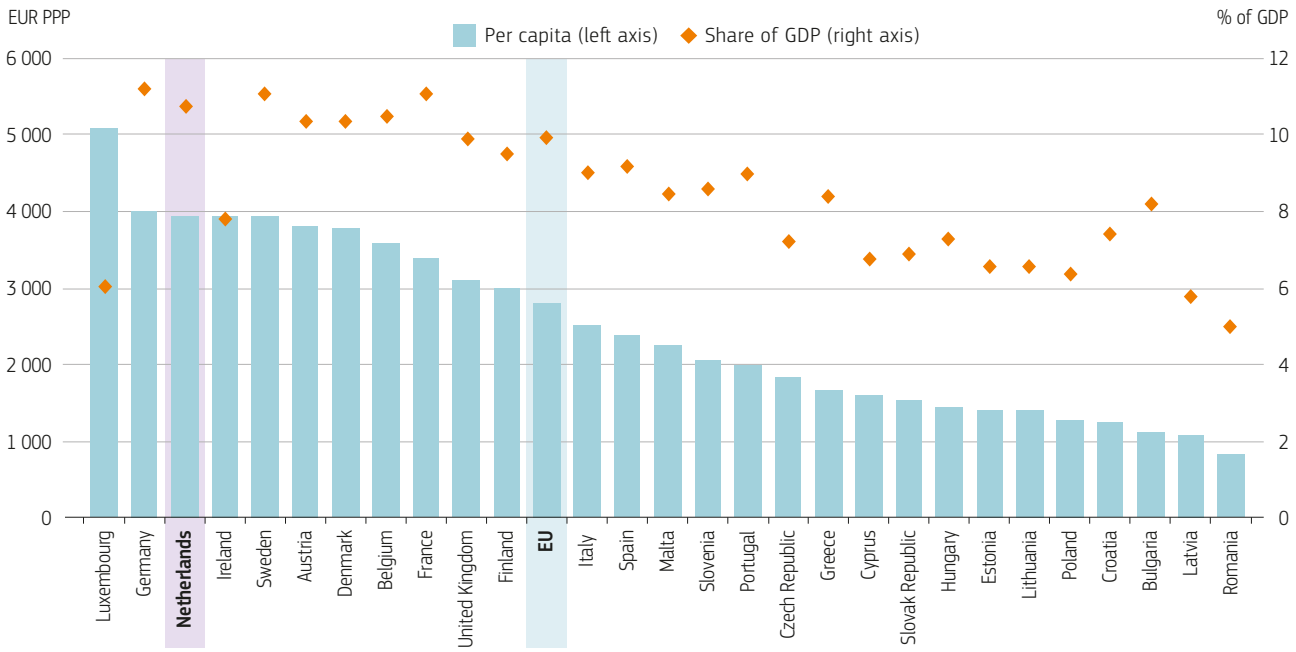
Long-term care was reformed in 2015 in order to contain costs (in line with a European Semester recommendation) but also to deinstitutionalise this care and make it more patient centred. Municipalities took on responsibility for social care, but with a reduced budget – on the assumption that locally organised care will be more efficient. Health insurers took over responsibility for home nursing, with district nurses playing a key role in integrating different aspects of care and support.

## Broad sectoral agreements have helped to bring spending under control

The Dutch health system is among the most expensive in Europe (see Figure 5), although growth has levelled off since 2012 after reverting to a system of sector agreements on spending. High overall spending is mainly due to a comparatively large long-term care sector (see Section 5.3). With the 2006 abolition of the private insurance scheme, public expenditure has increased from about two-thirds of the total in 2005 to 82.7% in 2006 and since then has come down slightly to 80.7% in 2015 (the EU average is 78.7%).

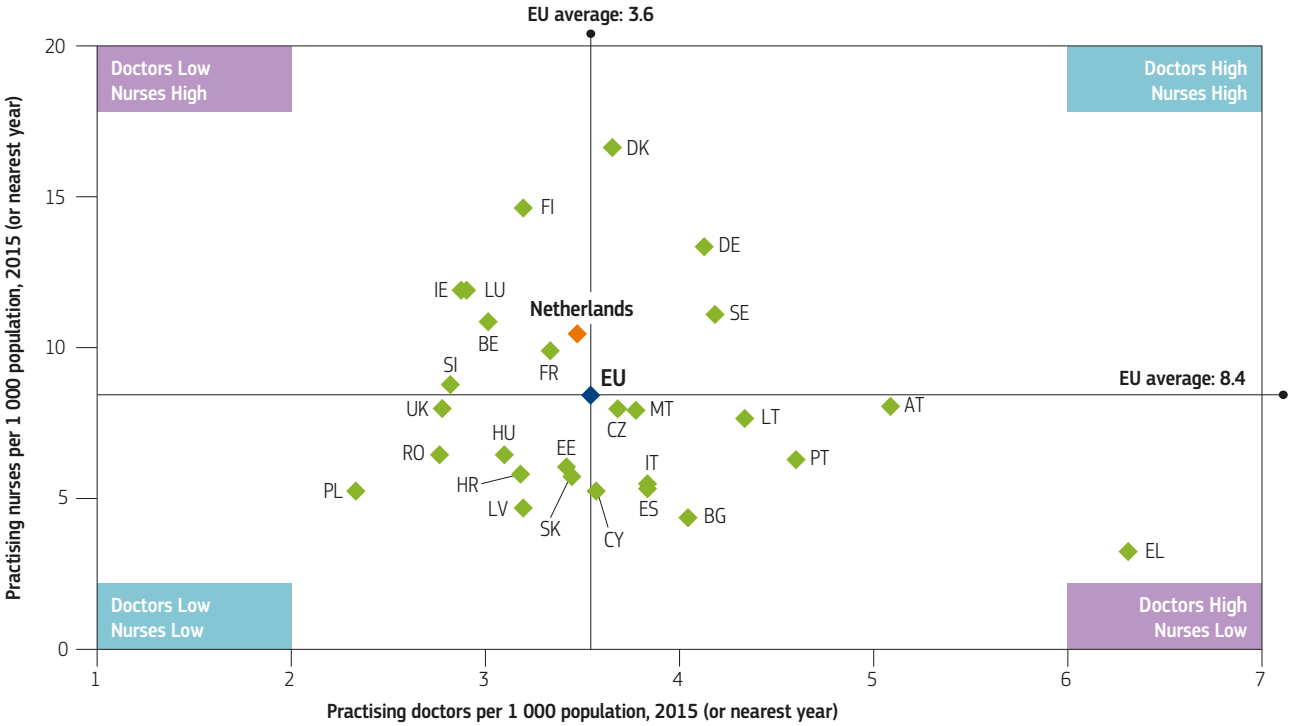
Adults pay a community-rated premium to their insurer (all children are covered from a government contribution), plus an income-dependent employer contribution into a central fund, which is redistributed among insurers on a risk-adjusted basis. About 40% of the insured receive a tax subsidy to purchase insurance, which

**Figure 5. Dutch health care expenditure per head is among the highest in Europe**




**Source:** OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2015).

**Figure 6. The Netherlands has average numbers of physicians and nurses as compared to other EU countries**




**Note:** In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30% in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.

**Source:** Eurostat Database.

compensates the lowest incomes for 70% of the premium and the average deductible (2017). Long-term care is funded through a separate single payer scheme (Wlz) funded from income-dependent contributions.

Cost-sharing requirements have been rising (see Section 5.2), but general practitioner (GP) care as well as maternal care and care from district nurses continue to be free at the point of delivery. In 2015, 84.1% of all those insured, purchased additional voluntary health insurance (VHI), which typically covers dental care and physiotherapy (NZA, 2016).

## So far purchasers have made little use of quality indicators

Health insurers and providers increasingly negotiate on price, volume and quality of care, although purchasing on the basis of quality is still in its infancy. Hospitals are paid through a system similar to diagnosis-related groups. For 30% of hospital care, which is deemed either to be 'unplannable' like emergency care (the bulk of the 30%) or offered by too few providers to have meaningful competition, such as organ transplantations, the Dutch Health Care Authority establishes maximum prices. GPs are paid by a combination of fee-for-service, capitation, bundled payments for integrated care, and pay-for-performance.

## There are no significant infrastructure shortages and new outpatient clinics have opened

Since the abolition of central planning in 2008, the number of acute hospital beds has been rising, reaching 361 per 100 000 in 2013, which is, however, still below the EU average (424 in 2013). The number of hospital sites has remained stable since 2008, but the number of outpatient clinics has increased substantially (from 61 to 112) as more hospitals open these to compete with other hospitals. The availability of diagnostic imaging is unusual in international terms, with relatively few MRI and CT scanners by EU standards but many PET scanners.

## Health workforce numbers seem adequate but nurse shortages are emerging

There is no sign of acute shortages of health professionals, which reflects on adequate incomes and good working conditions, and perhaps on the fact that central planning remains in place. Physician density is rising and is now nearing the EU average, while nurse density was well above the EU average in 2015 (see Figure 6). However, education capacity needs to be doubled to prevent shortages from emerging in the future (Van der Velden and Batenburg, 2016). Recently, shortages have been emerging in home nurses and health

care assistants, but new intersectoral labour market policies seek to address this. There are several new developments in terms of workforce and professional roles (see Box 1).

**BOX 1. TRENDS IN WORKFORCE AND PROFESSIONAL ROLES**

Professionals in primary care increasingly work in larger organisational settings (such as primary health care centres) and in multidisciplinary teams. Community pharmacists increasingly work in structured collaboration with GPs in their catchment area. Task shifting has led to new occupations, such as practice nurses, nurse practitioners, nurse-specialists (who can also prescribe medicines) and physician assistants. Furthermore, since 2002 there has been a focus on shifting care from secondary care to primary care, mainly for chronic diseases and for simple, low-risk treatments, such as minor surgery.

## Primary care is strong and integrated care is being addressed

Public health services are primarily the responsibility of municipalities and include services such as health promotion, screening and vaccination, and youth health care. Population screening programmes are available for cervical cancer, breast cancer and (since 2013) colon cancer. Hospital care and specialist care require referral from a GP and patients have a free choice of hospital. Primary care seems strong compared to other European countries as also reflected in the low number of hospital discharges (see Figure 7). The average length of stay in inpatient hospitals (6.2), on first sight seems well below the EU average (8.0) in 2015, but the Dutch number is an underestimation as it only refers to acute care. Several pilots concentrate on integrated care for chronic diseases and care for people with multi-morbidities, and the shift of care to lower levels.

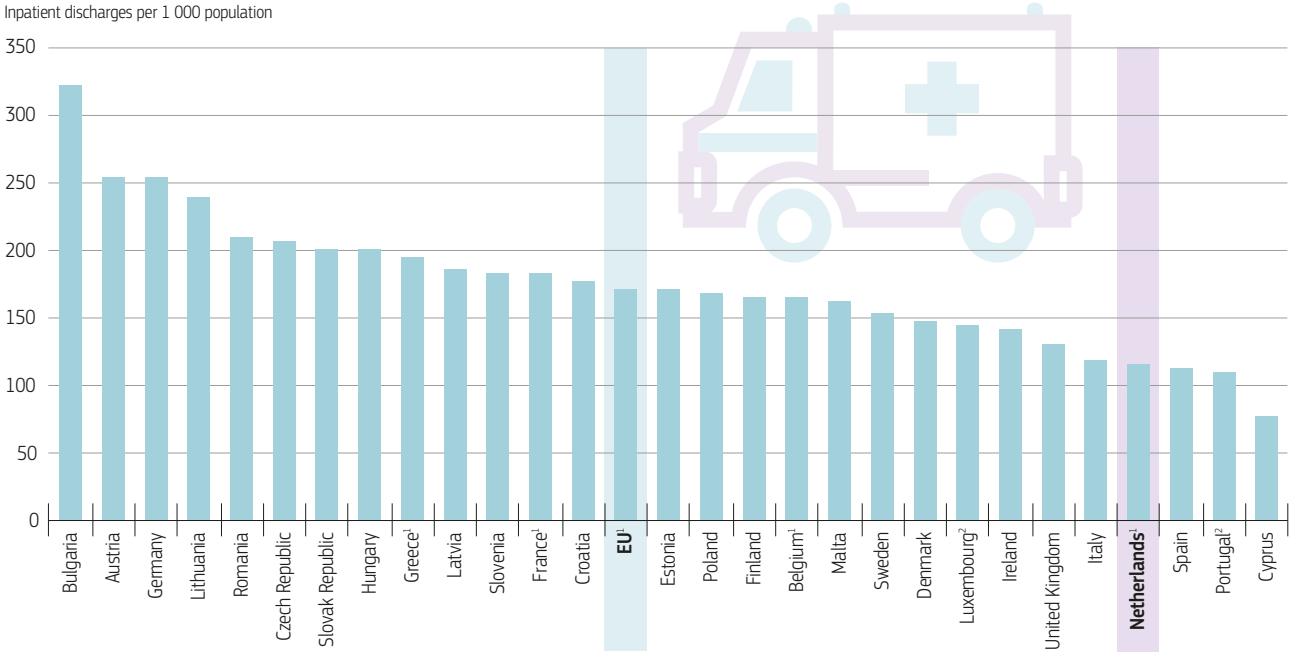
## There are growing concerns for long-term care quality

There has been increasing debate about the quality of care in nursing homes, yet extra investments are being allocated to the sector. Access to domestic and residential long-term care is subject to assessments, which are meant to explore the options for supporting patients' self-sufficiency and keeping them in their own social environment first. Although a more central role for informal carers in caring for the sick and disabled is envisaged, financial compensation is limited.

## A deinstitutionalisation of mental care should stimulate ambulatory treatment

Mental health care is in the process of deinstitutionalisation, a response to figures which suggest that the Netherlands has about twice the EU ratio of psychiatric hospital beds. GPs have first-line responsibility for mental health care, and some 80% of GP practices employ a specialised mental care practice nurse to help.

**Figure 7. Very low numbers of hospital discharges point to strong primary care**




**Note:**
1. These values have been estimated by OECD to calculate the EU28 weighted average.
2. Estimated values.

**Source:** Eurostat Database (data refers to 2015).

# 5 Assessment of the health system

## 5.1 EFFECTIVENESS

### Low amenable mortality shows positive impacts of the health care system on health outcomes

The Dutch health care system has made major contributions to the health of the Dutch population as reflected in low levels of amenable mortality[5] among men and women, which are among the best in Europe (particularly for men) (Figure 8). Looking at trends over time, the Netherlands has witnessed a steady decline in amenable mortality under the age of 75, at around 30% between 2000 and 2013. This points to steady improvements in the access to and quality of health care overall.

For people diagnosed with the types of cancer for which screening programmes are in place – breast, cervical and colorectal cancer – five-year relative survival remained stable or increased mildly in the 2000–11 period. In an international comparison, Dutch survival rates for these forms of cancer are in the middle range of countries with data available.

### Deaths from preventable causes suggest a mixed picture on the effectiveness of prevention policies

Preventable mortality, including lung cancer, alcohol-related deaths and transport injuries, show a more diverse pattern. There are falls in death rates yet persistent mortality from causes that could be prevented (Section 2). At the same time, mortality that can be attributed to alcohol misuse has remained stable over the past decade at levels that, at least among men, have remained well below the EU average. In contrast, a small increase was seen in women during recent years, although levels remain lower compared to men and are close to the EU average.

### New policies on the wider determinants of health may need time to take effect

As noted in Section 3, several policies aim to address behavioural and social determinants of health. For example, policies have been implemented to address smoking and alcohol use, including a smoking ban in offices (2004), pubs and restaurants (2008) and measures to reduce teenage alcohol use (2013). Particular priority has now been given to reduction of smoking and alcohol use among children because a much greater increase in risk factors was observed than in their peers in other EU countries.

Furthermore, in 2011, a national policy paper ('Health Nearby') identified high body mass index, diabetes, depression, smoking, and harmful alcohol use as the main challenges and explored policies to promote more exercise and sports to tackle these. Progress may take some time but the Netherlands is tackling the underlying issues in many of the key areas.

### Low numbers of avoidable hospitalisations suggest effective primary care

The Netherlands has a low number of avoidable hospitalisations, indicating that primary care and outpatient secondary care help to prevent serious symptoms from developing, as well as relatively low avoidable mortality. The numbers of avoidable hospital admissions for asthma, congestive heart failure, COPD and acute complications of diabetes are lower than in most other EU countries. Efforts to improve (coordination in) maternal care have resulted in a reduction of perinatal and neonatal mortality rates since 2000. Furthermore, the 30-day case fatality ratios following hospital admissions for acute myocardial infarction and stroke are generally better than those of countries with data available.

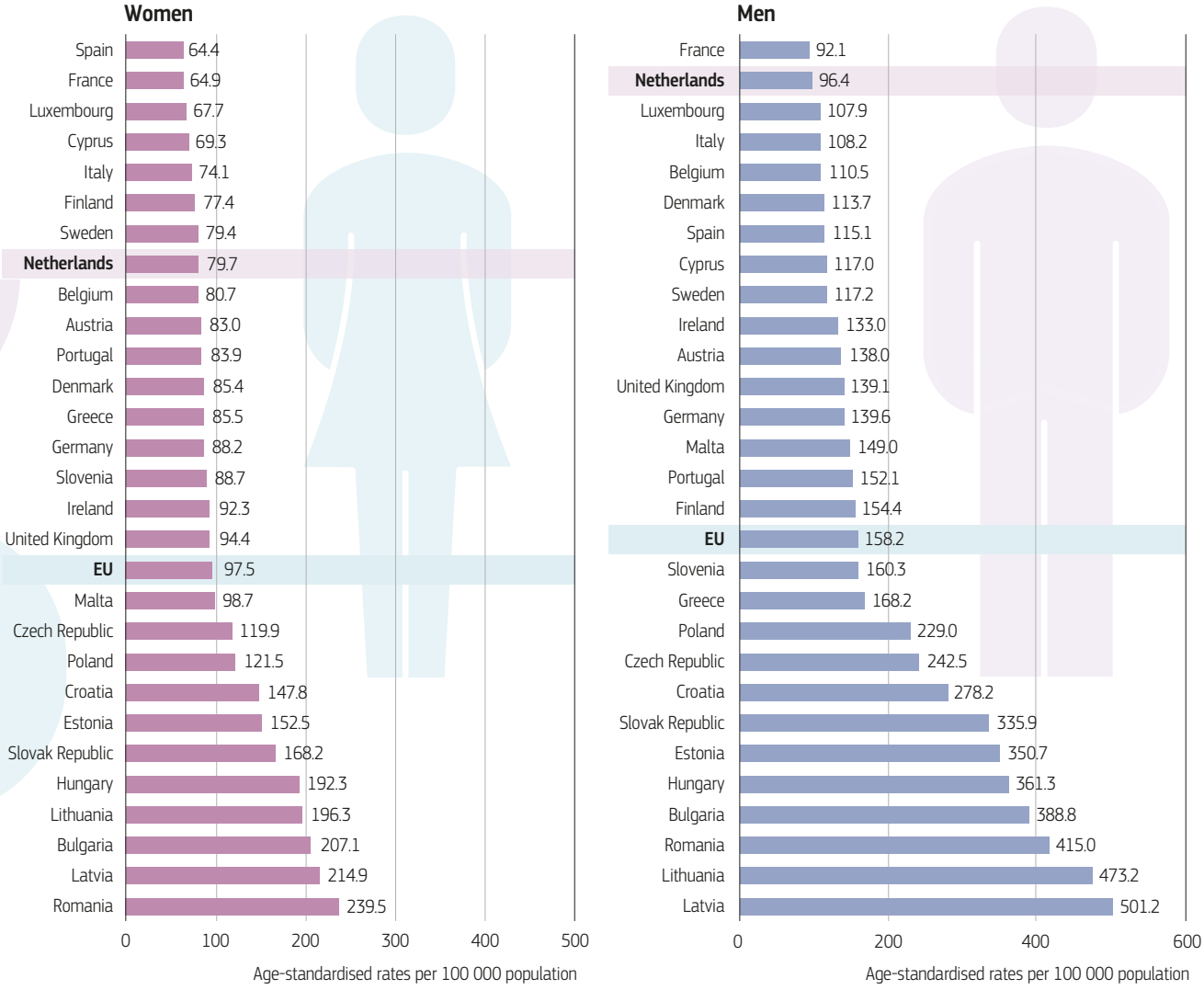
### The safety and quality of the Dutch health system has been improved by policy initiatives

Safety has become a greater policy priority in recent years. One study showed that, compared to 2008, potentially avoidable adverse events were reduced by 45% and potentially preventable in-hospital deaths by 53% as a result of the implementation of a nationwide safety improvement programme in all Dutch hospitals (Langelaan et al., 2013).

Currently, consumers do not make informed choices with regard to the quality of their care or insurance policies. A key policy priority in terms of quality improvement is therefore to develop reliable quality indicators that are readily available and understandable to citizens and actionable for health actors. There are numerous examples of projects that seek to foster transparency. For example, the Institute for Health Care Quality (2014) aims to

5. Amenable mortality is defined as premature deaths that could have been avoided through timely and effective health care.

## Figure 8. Amenable mortality rates in the Netherlands are among the best in Europe

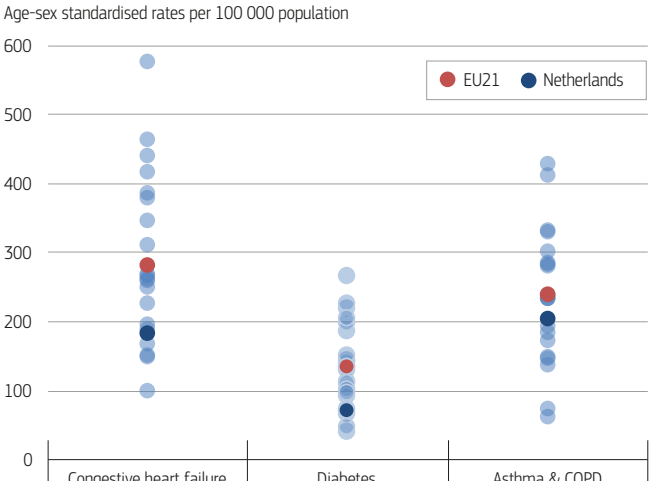



**Source:** Eurostat Database.(data refer to 2014.

promote the development and implementation of quality standards; encourage the appropriate use of care; and improve access to reliable patient information.

Furthermore, insurers, as purchasers of care, are supposed to contract care on the basis of quality, although the process is yet to make real inroads (Section 4), partly because of a lack of agreed quality indicators. Finally, the Netherlands has been a pioneer in assessing the performance of the health system as a whole, producing regular national reports (Van den Berg et al., 2014) that have helped identify areas and levers for improvement.

## Figure 9. Avoidable hospitalisation rates for ambulatory care sensitive conditions are lower than the EU average




**Note:** Rates are not adjusted by health care needs or health risk factors.

**Source:** OECD Health Statistics (data refer to 2015 or latest year).

## 5.2 ACCESSIBILITY

### There has been a return to universal coverage but defaulters are a persistent problem

The Dutch population reports very low levels of unmet need for medical care, with little variation across income quintiles when compared to other EU countries (see Figure 10). Some 99.8% of the population were covered by the system in 2014.

Purchasing health insurance is mandatory for all Dutch residents with three exceptions (see Box 2).

Still, not every citizen is insured. In 2016, about 22 500 people were uninsured and there were 277 000 defaulters, that is, people with a payment delay of at least six months (Statistics Netherlands, 2017). The number of uninsured individuals has been declining since 2011 when, after years of gradual growth, the government started to track down the uninsured and automatically enrol them. The number of defaulters peaked at 329 000 people in 2014 and the government now seeks to protect them from losing coverage by placing them under forced administration by a separate government agency.

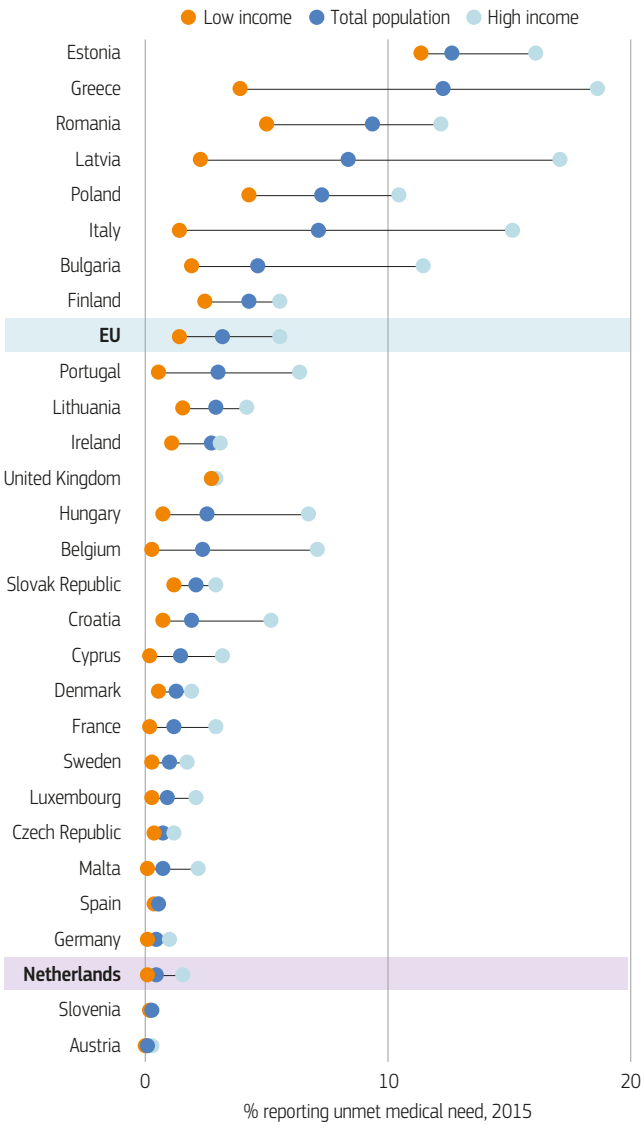
**BOX 2. THREE GROUPS DO NOT HAVE TO PURCHASE INSURANCE AND ARE COVERED BY SPECIAL REGULATIONS**

First, those who refuse to insure themselves on grounds of religious beliefs or their life philosophy (conscientious objectors) have to pay an income tax that is deposited in a personal savings account, which will be used if they incur health costs (around 12 500 people or 0.07% of total population). Their children are not automatically registered as conscientious objectors but have to be registered separately or they will be deemed uninsured.

Second, irregular migrants have to pay their incurred health costs out-of-pocket. If they cannot pay, separate funding is available to compensate providers. Obviously, this may pose an insurmountable administrative and financial barrier for undocumented migrants, which could de facto leave them without necessary care.

Third, registered refugees are covered by a special insurance policy for which they do not pay premiums or a deductible. It covers almost the same benefits as the usual system but restricts choice of provider.

**Figure 10. Dutch residents report the third lowest level of unmet need for medical care in the EU**




**Note:** The data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.

**Source:** Eurostat Database, based on EU-SILC (data refer to 2015).

### The benefits basket is broad but many purchase coverage for dental care and physiotherapy

A broad benefits package covers most common medical care (see Box 3). The main services excluded are dental care (for adults) and allied health care (e.g. physiotherapy). People may purchase VHI to cover these and many do so. The Long-term Care Act provides institutional care (which can also be provided at home) for all citizens who need 24-hour supervision.

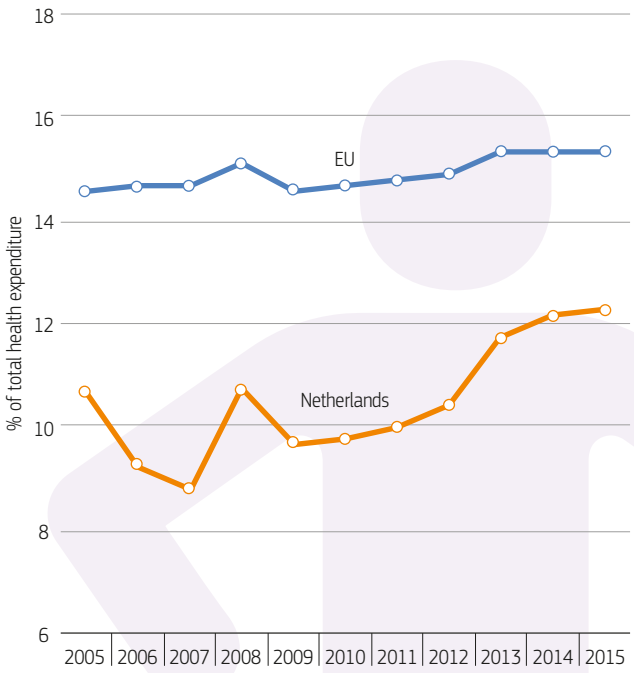
## Out-of-pocket payments are rising but do not translate into elevated unmet need

The mandatory deductible has increased substantially, from EUR 150 in 2008 to EUR 385 in 2016 and 2017 but does not apply to GP care, maternity care, district nursing, and care for children under the age of 18. Reimbursement for drugs is based on reference pricing and insurers may list preferred medicines, meaning that patients who use an alternative drug may have to pay the difference in costs or the total amount. Some insurers do not charge the deductible when the patient uses the company's preferred providers or pharmaceuticals. For residential long-term care income-dependent cost-sharing is applicable, ranging from 0 to EUR 2 312 per month (2017).

As a result of the rising deductible, out-of-pocket spending has been rising as a share of total health expenditure – although at 12.3% in 2015 it still remained below the EU average of 15.3% (Figure 11). Looking at out-of-pocket payments as a share of final household consumption though (and excluding long-term care) the Netherlands is slightly above the EU average (see Figure 12). Rising out-of-pocket payments does not however translate into elevated unmet medical need for financial reasons, as this proportion stood at 0.4%, compared to 2.4% in the EU (2014). Unmet need for dental care due to cost (1.5%) is also far below the EU average (5.3%).

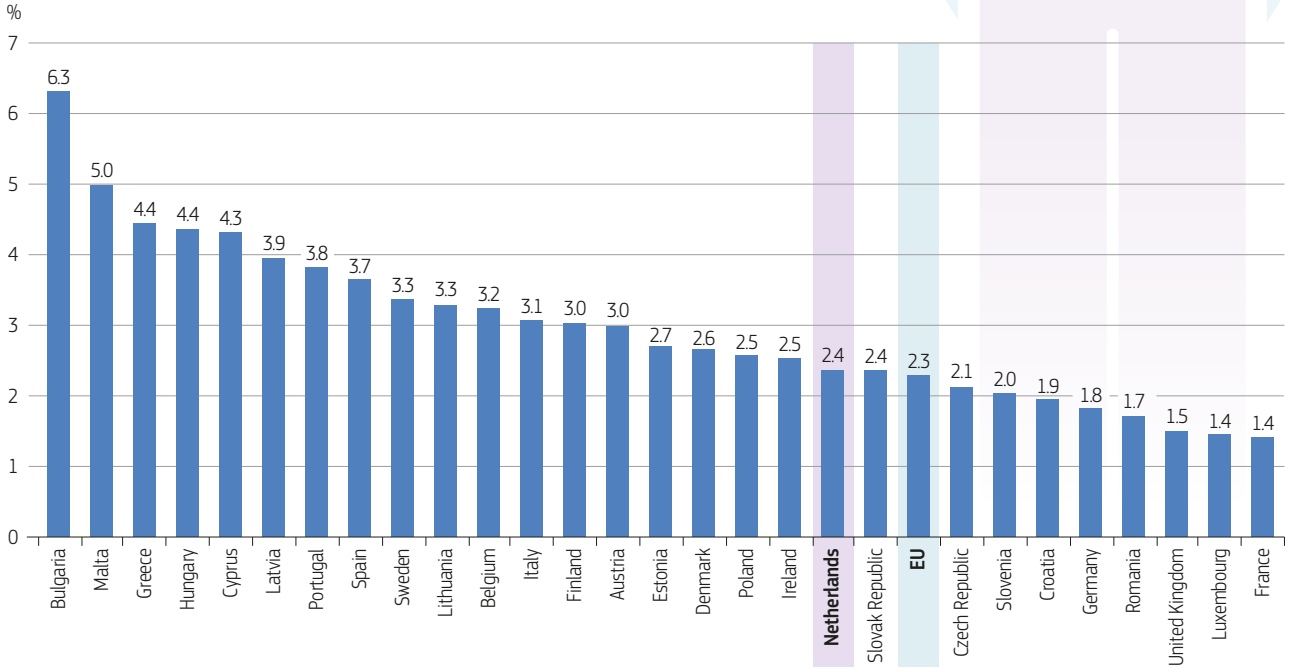
These impressive values perhaps relate to the fact that primary care is excluded from the deductible, that those under 18 are covered without the deductible, and that 73% of Dutch people purchase VHI for dental care (NZA, 2016). Despite the fact that financial barriers to access are low, increasing out-of-pocket payments have become a topic for heated public debate, with several political parties seeking to abolish or drastically reduce the deductible.

**Figure 12. Even with a rising deductible, out-of-pocket spending remains below the EU average**



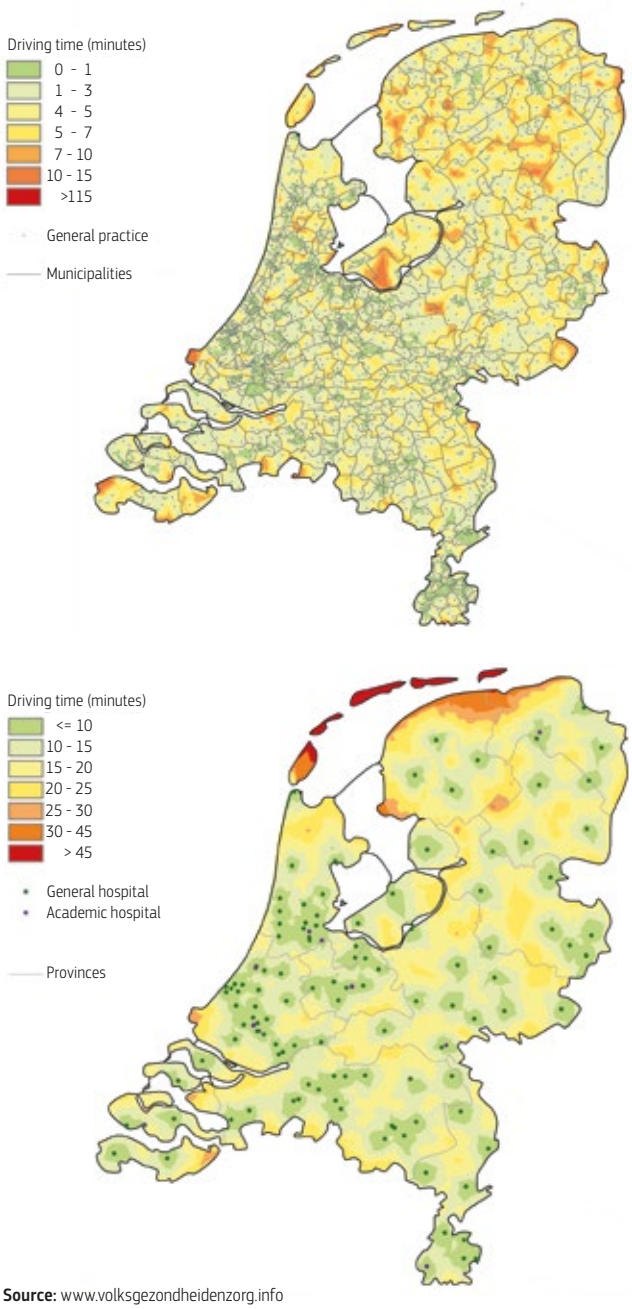

**Source:** OECD Health Statistics.

**Figure 11. Dutch out-of-pocket payments as a share of final household consumption is little above the EU average**




**Source:** OECD Health Statistics, Eurostat database, WHO Global Health Expenditure database.

**Figure 13. A large majority can reach their GP practice within 7 minutes and hospitals within 25 minutes**




**Source:** www.volksgezondheidenzorg.info

## A dense network of providers gives good geographic access

The Dutch health system is characterised by good geographical availability of services (see Figure 13). Some 122 GP out-of-hours centres cover care outside office hours, with one within (an average of) 6.2 kilometres of all citizens. In case of emergency, there are 89 hospital locations offering 24/7 emergency services, which more than 99% of the population can reach within 45 minutes. A helicopter is available for emergencies for those living on the islands in the north. Virtually no Dutch people report an unmet need for medical care due to distance.

## Waiting times are low but recent rises are worrisome

Waiting times, have been a long-standing policy issue, but are currently at a historically low level. It seems, however, that they may be on the rise again for some outpatient treatments and diagnostic services, as well as mental health care. Since 2009, care providers and insurers have agreed acceptable waiting times (Treek Standards), specifically four weeks for consultations and diagnostics, and seven weeks for treatments. Moreover, all special medical care providers have had to publish their waiting times and virtually all insurers offer waiting list mediation services. As a result, waiting times reduced sharply and appear to have become low in comparison with other countries (Siciliani, Moran and Borowitz, 2014). This is borne out by the percentage of people reporting an unmet need for medical care due to waiting lists, which at 0.1%, is below the EU average of 1.1% (2014).

## Limited network insurance policies could affect access negatively

Depending on the health insurance policy chosen, access to 'out of network' providers may be limited. Insurers are entitled to set the reimbursement rate for non-contracted care, that is, care given by a provider that they do not have an agreement with, although this rate should be above 75% of the official reimbursement rate. In 2014, the government sought to encourage more selective contracting by allowing insurers to issue 'budget' policies that would restrict choice to contracted providers only. The bill failed to pass the senate after criticism that it undermined solidarity and gave insurers too much power to decide which care is good enough. Still, there are vast differences in the way groups with different education levels use health services, with prima facie evidence that ability to pay is a factor (see Figure 14). However, different patterns of disease and ageing in different educational groups will probably contribute to these differences as well.

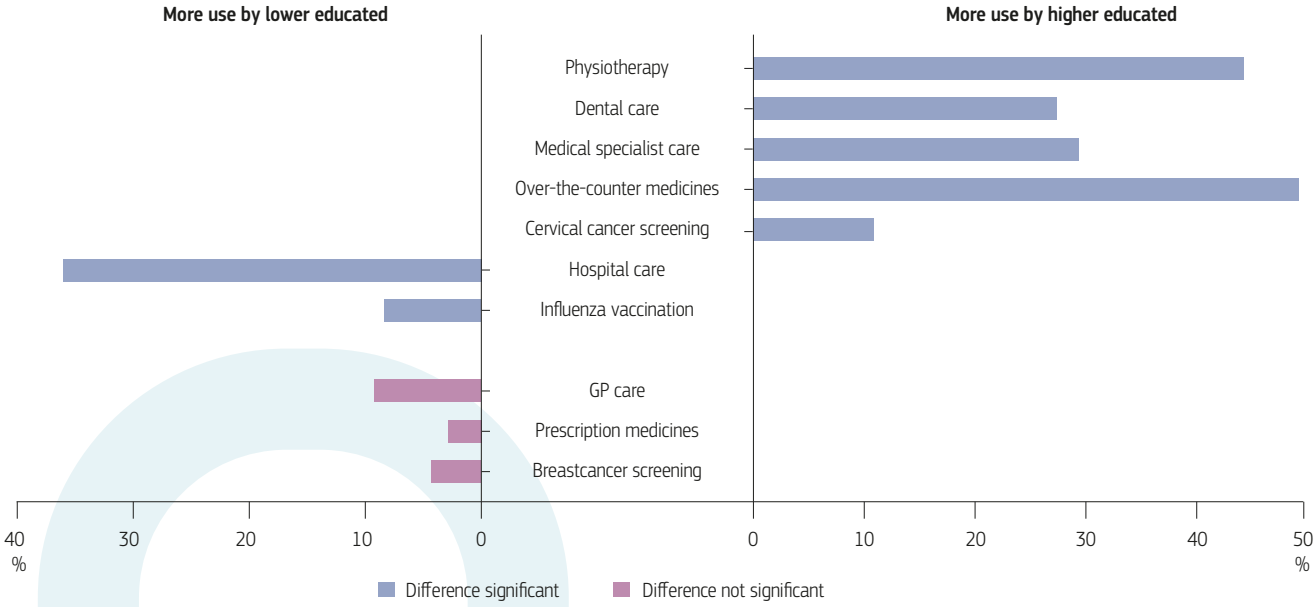
### 5.3 RESILIENCE[6]

## Resources have been stable long term, but high costs have prompted cost control measures

As seen in previous sections: health is well funded; there is a dense network of providers; waiting times have been historically low; and there are no acute shortages in human resources. Capital investment has had to be covered through reimbursements for service delivery since 2008 but this has not created undue obstacles to development. Gross fixed capital formation in the health care sector as a share of GDP (2014) in the Netherlands was above the EU average.

6. Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises..

**Figure 14. Higher educated and lower educated people use more of different sorts of care**




**Notes:** Medical specialist care refers to medical specialist consultations; hospital care to inpatient admissions. Adjusted for age, gender and health status.

**Source:** van den Berg et al., 2014 (Data refer to 2012).

A major potential challenge to the resilience of the health care system is the high level of health spending, which could threaten the affordability of the system in the long term. This is expected to worsen with the continuing introduction of high-cost technologies, and with the ageing of the population and the likely increase in chronic disease prevalence. Cost control has been a long-standing concern and was one of the main reasons for the 2006 health system reform. The concerns were reinforced when the financial crisis struck in 2009 and the Stability and Growth Pact criteria were breached in 2010. A broad range of cost control measures has been implemented since 2012, including the new long-term care reform of 2015 (see Box 3).

## Policy instruments focus on the role of competition but with government steering

Generally, the government sees competition and active purchasing by health insurers as the main instrument to improve health system efficiency.[7] However, the Ministry of Health can intervene if it deems this to be necessary. For example, in 2013 it stepped in to agree ceilings for the annual growth rate of spending in various health subsectors with a number of stakeholders, which had to be accomplished by improvements in quality and efficiency. Specific requirements included: reducing referrals to hospitals, further concentration of top-clinical care and a more stringent compliance with guidelines.

7. Allocative efficiency indicates the extent to which limited funds are directed towards purchasing an appropriate mix of health services, whereas technical efficiency focuses on the extent to which a health system is providing the maximum level of output in relation to its given inputs.

The risk-adjustment system also remains a continuous challenge. Although one of the most sophisticated internationally, it might still perform better. There are groups of patients, who are easy to identify, for which under- or overcompensation exists, which could make risk-selection a profitable strategy, which would affect system efficiency negatively.

**BOX 3. MEASURES SINCE 2012 HAVE SOUGHT TO REIN IN PUBLIC SPENDING**

Since 2012, cost control has focused on:

- shifting costs from public to private sources (for example by increasing the compulsory deductible);
- shifting costs between various statutory sources in combination with major cuts in budgets (most notably the current long-term care reform);
- substitution between different types of care: institutional care with home care, and secondary care with primary care (as visible in mental and long-term care);
- increased focus on improving efficiency (e.g. tendering of generics) and eliminating fraud; and e) the use of broad sectoral agreements (with insurers and providers) to curb costs. These efforts together have led to slowing growth in health expenditure in recent years, although it is still among the highest in Europe.

## There is room to improve efficiency

There are several ways of assessing efficiency of the Dutch system, many of which seem to point towards room for efficiency gains. A basic insight is gained by relating amenable mortality to health spending for example (see Figure 15), which reveals that many countries achieve similar or lower amenable mortality against lower per capita cost. However, the Dutch position is influenced by the comparatively large long-term care sector, pushing up per capita spending.

Another efficiency indicator is avoidable hospitalisation (Section 5.1), although the Netherlands performs consistently below the EU average on available indicators, improvements are nevertheless feasible as other countries show. Furthermore, the substantial variations in ALOS for a single diagnosis between hospitals suggest there is room for efficiency gains (Van de Vijzel, Heijink and Schipper, 2015). On the other hand, the Dutch share of cataract surgeries and tonsillectomies performed as ambulatory cases are among the highest in the EU (at 99% and 68% respectively).

Generic medicine penetration is comparatively high (72% compared to 48% for the 19 countries with data available) while Dutch pharmaceutical policies (and specifically the pricing act and the preferred medicines policies) have already yielded notable efficiency improvements (CVZ, 2013).

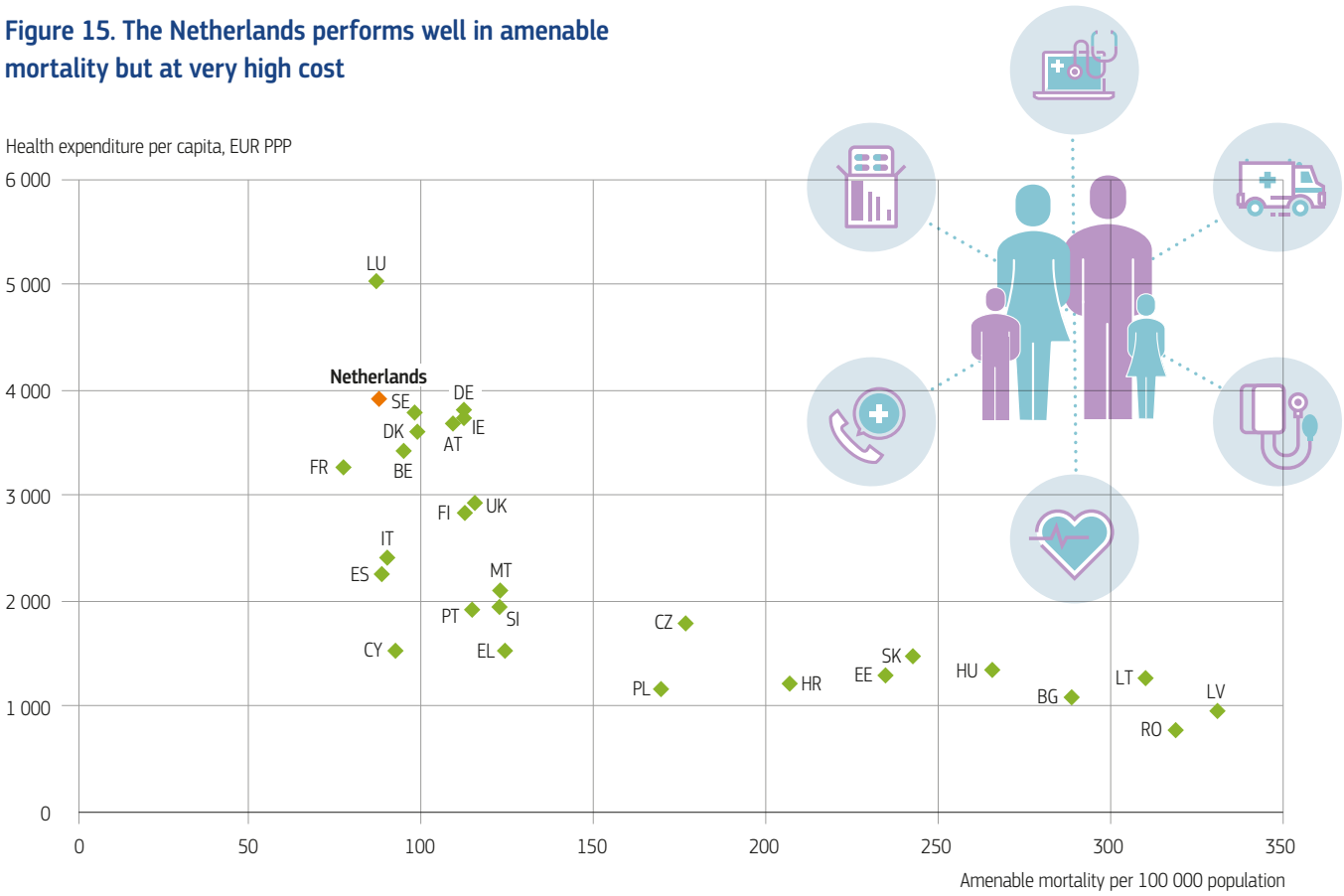
## Long-term care is a key driver of expenditure

There is no under-spending in any particular sector when compared to other countries, but the Dutch long-term care sector is the largest in the EU (see Figure 16). The 2015 long-term care reform sought to rein in growth, but debate has arisen whether there will be enough funding to meet the current needs and high expectations of the population. It introduced deep cuts, although some have been rolled back in the meantime, and a tight implementation schedule. Moreover, new long-term care governance responsibilities, particularly those of municipalities and health insurers, run the risk of encouraging different actors to push care on to each other, undermining efficiency.

## Governance seems effective

Generally, governance of the Dutch health system is characterised by ample policy capacity, several watchdog agencies and advisory bodies. This capacity bodes well for resilience, as demonstrated in the last decade where the complex 2006 and 2015 reforms have led (and are still leading) to several short- and medium-term problems. Although this has been demanding on all stakeholders involved, several ad hoc changes were made and measures taken, and, on balance, the situation was managed well and certainly never turned into prolonged chaos. However, strong governance does not automatically lead to good policy decisions, and, on many

**Figure 15. The Netherlands performs well in amenable mortality but at very high cost**




**Sources:** OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2014).

levels, the jury is still out as to whether the large reforms – and subsequent smaller reforms and measures – will eventually deliver what was envisaged.

Furthermore, eHealth and data governance, needed to improve integration and introduce labour-saving technologies, is an area where the Netherlands has been lagging behind. After attempts to introduce a national electronic patient record failed mainly for reasons of privacy, data is now mostly shared on a voluntary basis but only at the regional level. A recent sectoral agreement (2017) between providers, patients, insurers and the Ministry of Health see exchange of information as a key cornerstone for the further adoption of eHealth technology and some agreements have been made to further advance this.

## Disagreement on the proper role of market mechanisms persists

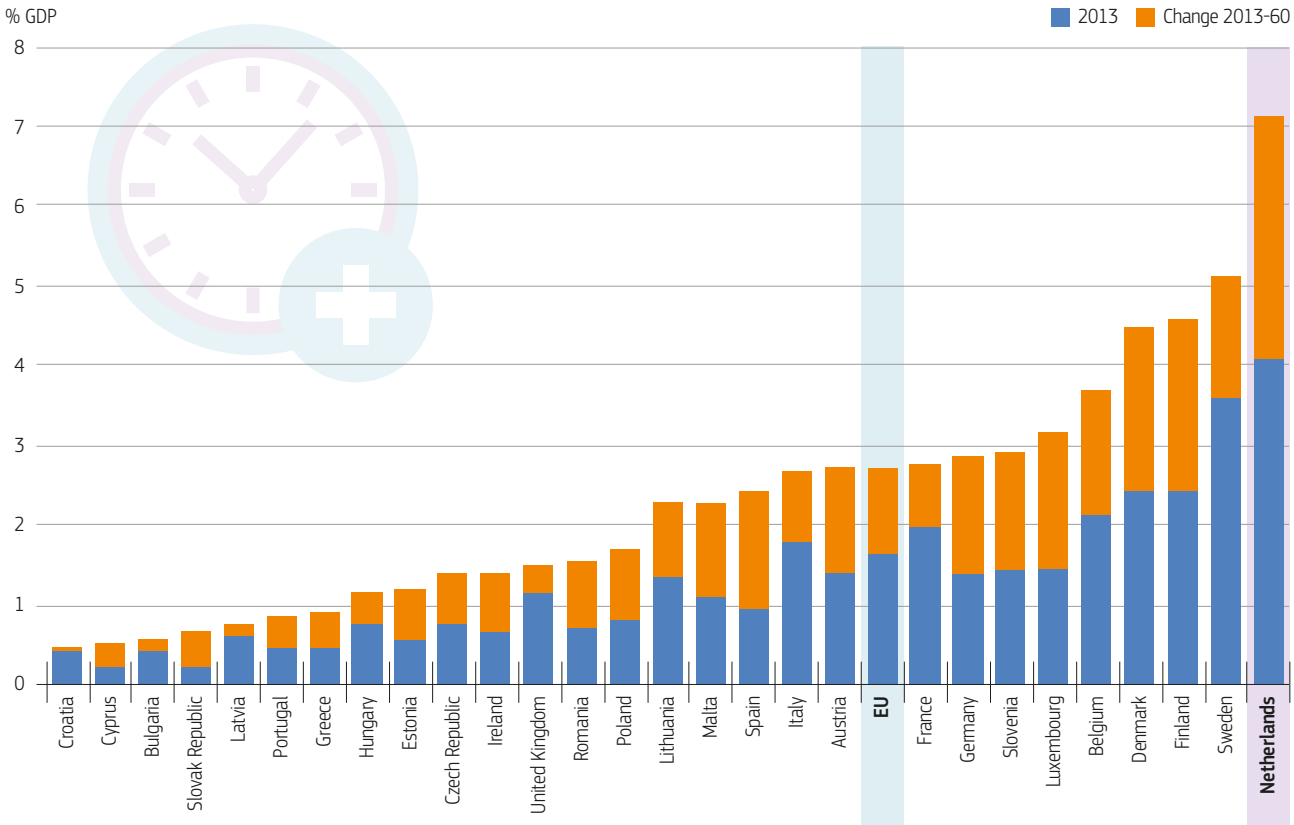
The role of government changed in 2006 from direct control of volumes and prices to rule-setting and overseeing the proper functioning of markets. The government retained responsibility for three long-standing system goals: quality of care, accessibility of care and affordability. Although there is broad consensus over these, how best to achieve them has been understood in different ways. Currently, there is a reliance on market mechanisms, but several political parties run on a platform of reducing market mechanisms in health care, and future directions may change.

Furthermore, friction seems to be growing between competition as the driver of the health care system and reforms that demand cooperation and integration among actors. Certainly, the expectations for hospital specialisation, substitution of primary for secondary care and care integration require mutual trust and harmonious collaboration, which do not sit easily with market mechanisms. It may prove challenging to create the conditions for better integration in a system where competition is the ruling principle.

## Patient involvement and transparency are being improved

The 2006 health care reform made patients a major market actor. They were expected to make well-informed decisions and, by doing so, influence quality in care. As a consequence, patient participation and patient choice have become important policy priorities. Since 1996, publicly financed health and social care providers have been obliged to have a representative client council. Furthermore, health insurers are required to involve patients in purchasing decisions. More recently there have been efforts from the Ministry of Health (together with insurers) to make the choice of insurance policies simpler and improve availability of quality data.

**Figure 16. The Dutch long-term care sector is the largest in the EU and expected to grow even further**




**Source:** European Commission and Economic Policy Committee, 2015.

# 6 Key findings

- The Dutch health care system has contributed to improved population health with better amenable mortality rates than the EU average and other favourable indicators. Low numbers of avoidable hospitalisations and generally good survival rates suggest there is effective primary and secondary care. Preventable mortality indicators reveal a more mixed picture, not least because of the long-term consequences of past tobacco use, with mortality from lung cancer among women still rising, although smoking, drinking and obesity are all now being addressed. Large inequalities in health persist according to education and income. On the positive side, public health policies are starting to tackle this, but may need time to become effective.

- Access is good with few geographic, waiting time or financial barriers. There are, however, concerns about increasing waiting times and workforce shortages, particularly nurses. GP care remains free of charge at the point of delivery, but there is a great deal of public debate on rising cost-sharing, mostly due to the compulsory deductible, even though out-of-pocket spending remains comparatively low.

- The high levels of health spending have been a long-standing concern in the Netherlands. More market mechanisms were introduced as a way of achieving (among others) better cost control, but have yet to lead to the desired results. Instead, broad sectoral agreements were needed and helped to flatten the cost curve. Still, the system remains expensive, prompting worries over future growth and sustainability.

- Long-term care needs are perceived as a threat to future sustainability. The 2015 reform tried to address the comparatively large and generous long-term care sector by shifting more responsibility to citizens. This makes demands on the population and other health actors, and will test the resilience of the system. It may also undermine efficiency as new governance arrangements create the risk that municipalities and health insurers try to push the responsibility for long-term care onto each other. Accessibility and quality will need careful monitoring and it is likely that ad hoc fixes will be needed.

- Data governance is an area where large gains can be made. Patient data is now shared on a voluntary basis but only at the regional level. Better data exchange would help facilitate care integration and the adoption of new eHealth technologies. A broad sectoral agreement has put this on the agenda, but it will have to be carefully monitored to ensure progress.

- The government sees competition and active purchasing by insurers as the main instrument for improving efficiency. Although insurers increasingly negotiate on price and volume, negotiation on quality is limited. This is now being addressed, at least in part, through a new quality institute, and a new policy goal that, within five years, the treatment of 50% of the disease burden will be made transparent with outcome indicators.

- These efforts to increase transparency about cost and quality will be crucial if competition is to work as envisaged, and to enable insurers and consumers to take full advantage of their respective roles. Nevertheless, disagreements on the proper place of market mechanisms, as well as tensions around how to reconcile competition with the need to facilitate greater care integration and the concentration of specialist skills, are likely to persist.

# Key sources

Kroneman, M. et al. (2016), "Netherlands: Health System Review", *Health Systems in Transition,* Vol. 18(2), pp 1-240.

OECD/EU (2016), *Health at a Glance: Europe 2016: State of Health in the EU Cycle,* OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264265592-en.

# References

CVZ (2013), *GIPeilingen* (2012). *Ontwikkelingen genees- en hulpmiddelengebruik* [Medicines and Medical Appliances Information Project (2012), Developments in the use of medicines and medical appliances], College voor Zorgverzekeringen, Diemen.

European Commission (DG ECFIN) and Economic Policy Committee (AWG) (2015), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013–2060)", *European Economy 3*, Brussels, May.

IHME (2016), "Global Health Data Exchange", Institute for Health Metrics and Evaluation, available at http://ghdx.healthdata.org/gbd-results-tool.

Langelaan, M. et al. (2013), *Monitor Zorggerelateerde Schade 2011/2012: dossieronderzoek in Nederlandseziekenhuisen* [Monitor care related damage 2011/2012: patient file research in Dutch hospitals], NIVEL/EMGO+ Instituut, Utrecht/Amsterdam.

NZA (2016), *Marktscan van de Zorgverzekeringsmarkt 2015*, Nederlandse Zorgautoriteit, May 2016 update, https://www.nza.nl/1048076/1048181/Marktscan_Zorgverzekeringsmarkt_2015_update_mei_2016.pdf

Siciliani, L., V. Moran and M. Borowitz (2014), "Measuring and Comparing Health Care Waiting Times in OECD Countries", *Health Policy*, Vol. 118, pp 292-303.

Statistics Netherlands (2017), "StatLine [online database]", Statistics Netherlands, The Hague/Heerlen, available at http://statline.cbs.nl/Statweb/?LA=en.

Van den Berg, M.J. et al. (2014), *Zorgbalans 2014. Prestaties van de Nederlandse Gezondheidszorg* [Dutch Health Care Performance Report 2014], Vol. 2014-0038, RIVM, Bilthoven.

Van der Velden, L. and R. Batenburg (2016), *FZO-onderzoek 2016: ramingrapport,* NIVEL, Utrecht, 31 August.

Van de Vijsel, A.R., R. Heijink and M. Schipper (2015), "Has Variation in Length of Stay in Acute Hospitals Decreased? Analysing Trends in the Variation in LOS Between and Within Dutch Hospitals", *BMC Health Services Research*, Vol. 15:438.

## Country abbreviations

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Austria | AT | Denmark | DK | Hungary | HU | Malta | MT | Slovenia | SI |
| Belgium | BE | Estonia | EE | Ireland | IE | Netherlands | NL | Spain | ES |
| Bulgaria | BG | Finland | FI | Italy | IT | Poland | PL | Sweden | SE |
| Croatia | HR | France | FR | Latvia | LV | Portugal | PT | United Kingdom | UK |
| Cyprus | CY | Germany | DE | Lithuania | LT | Romania | RO | | |
| Czech Republic | CZ | Greece | EL | Luxembourg | LU | Slovak Republic | SK | | |

European Commission

# State of Health in the EU

## Country Health Profile 2017

The Country Health Profiles are an important step in the European Commission's two-year *State of Health in the EU* cycle and are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies. This series was co-ordinated by the Commission and produced with the financial assistance of the European Union.

The concise, policy relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU Member State. The aim is to create a means for mutual learning and voluntary exchange that supports the efforts of Member States in their evidence-based policy making.

Each Country Health Profile provides a short synthesis of:

- health status
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

This is the first series of biennial country profiles, published in November 2017. The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: **ec.europa.eu/health/state**

Please cite this publication as:

OECD/European Observatory on Health Systems and Policies (2017), *Netherlands: Country Health Profile 2017, State of Health in the EU,* OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.
http://dx.doi.org/10.1787/9789264283503-en

ISBN 9789264283503 (PDF)

Series: State of Health in the EU
ISSN 25227041 (online)

OECD
BETTER POLICIES FOR BETTER LIVES

European Observatory on Health Systems and Policies
a partnership hosted by WHO