European Commission

State of Health in the EU

The Netherlands

Country Health Profile 2021

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's Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

The 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 the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

Contents

1. HIGHLIGHTS 3
2. HEALTH IN THE NETHERLANDS 4
3. RISK FACTORS 7
4. THE HEALTH SYSTEM 8
5. PERFORMANCE OF THE HEALTH SYSTEM 11
   5.1 Effectiveness 11
   5.2 Accessibility 14
   5.3 Resilience 17
6. KEY FINDINGS 22

Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated 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 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in September 2021, based on data available at the end of August 2021.

Demographic and socioeconomic context in The Netherlands, 2020

Demographic factors	The Netherlands	EU
Population size (mid-year estimates)	17 407 585	447 319 916
Share of population over age 65 (%)	19.5	20.6
Fertility rate[1] (2019)	1.6	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	39 641	29 801
Relative poverty rate[3] (%, 2019)	13.2	16.5
Unemployment rate (%)	3.8	7.1

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 60 % of median equivalised disposable income. Source: Eurostat database.

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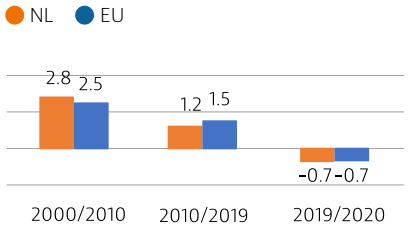
1 Highlights

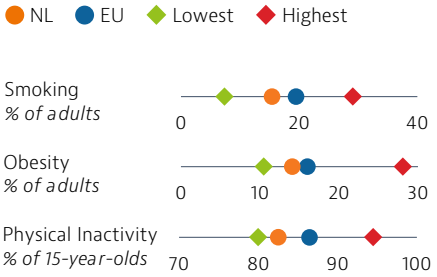
Three coverage schemes provide broad health coverage to nearly all the Dutch population. These include a competitive social health insurance system for curative care, a single-payer system for long-term care and municipal systems for social care. Like the rest of Europe, the Netherlands faced high pressures from the COVID-19 pandemic, and experienced a temporary drop in life expectancy in 2020. The unprecedented strain caused by COVID-19 posed a clear challenge at all levels of the Dutch health system.



Life expectancy gains, years

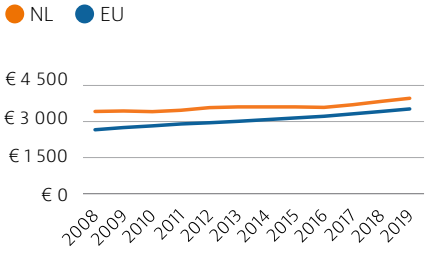
Health Status

Life expectancy in the Netherlands is higher than the EU average by about one year, but gains have slowed over the past decade. As a result of the COVID-19 pandemic, life expectancy fell by 0.7 years between 2019 and 2020 – the same as the EU average. Lung cancer, stroke and ischaemic heart disease made up the highest share of mortality in 2019. In 2020, 1 in 15 deaths were attributed to COVID-19.



Risk factors

Behavioural risk factors in the Netherlands account for a lower share of deaths than the EU average. Smoking and obesity rates are both below the EU averages. However, one in five deaths in 2019 resulted from tobacco consumption – a higher share than in the EU – and obesity levels among adults have increased over the last two decades. Dutch adults and adolescents are more physically active than those in most other EU countries.



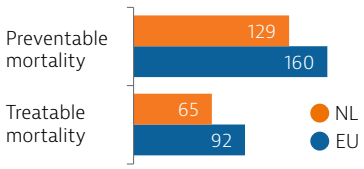
Per capita spending (EUR PPP)

Health system

The Netherlands spends more per capita (EUR 3 967) on health than the EU average (EUR 3 523), with a considerable share dedicated to long-term care. Expenditure on outpatient pharmaceuticals and medical devices is kept low, aided by volume and price control policies and well-established health technology assessment processes. Public sources cover a high percentage of health expenditure, resulting in a lower share of out-of-pocket spending for health care than the EU average.

Effectiveness

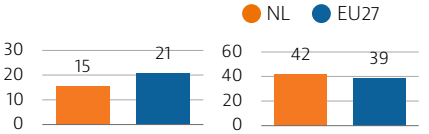
The Netherlands has among the lowest mortality rates from preventable and treatable causes in the EU. Most preventable deaths are from lung cancer, while colorectal cancer and breast cancer account for 40 % of deaths from treatable causes. Mortality rates from ischaemic heart disease, stroke and pneumonia are among the lowest in the EU.



Age-standardised mortality rate per 100 000 population, 2018

Accessibility

The Dutch population has historically reported low unmet needs for medical treatment, but this changed during the COVID-19 pandemic when many non-urgent services were cancelled or postponed. Evidence suggests that 15 % of people had to forgo care during the first 12 months of the pandemic. Teleconsultations were used to help maintain access to services.

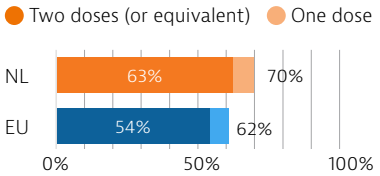


% reporting forgone medical care during first 12 months of pandemic

% using teleconsultation during first 12 months of pandemic

Resilience

The health system response to COVID-19 encountered obstacles, including fragmentation in testing, contact tracing and vaccination efforts. After a slow start, the vaccination campaign accelerated, and 63 % of the population had received two doses (or equivalent) by the end of August 2021.



Share of total population vaccinated against COVID-19 up to the end of August 2021

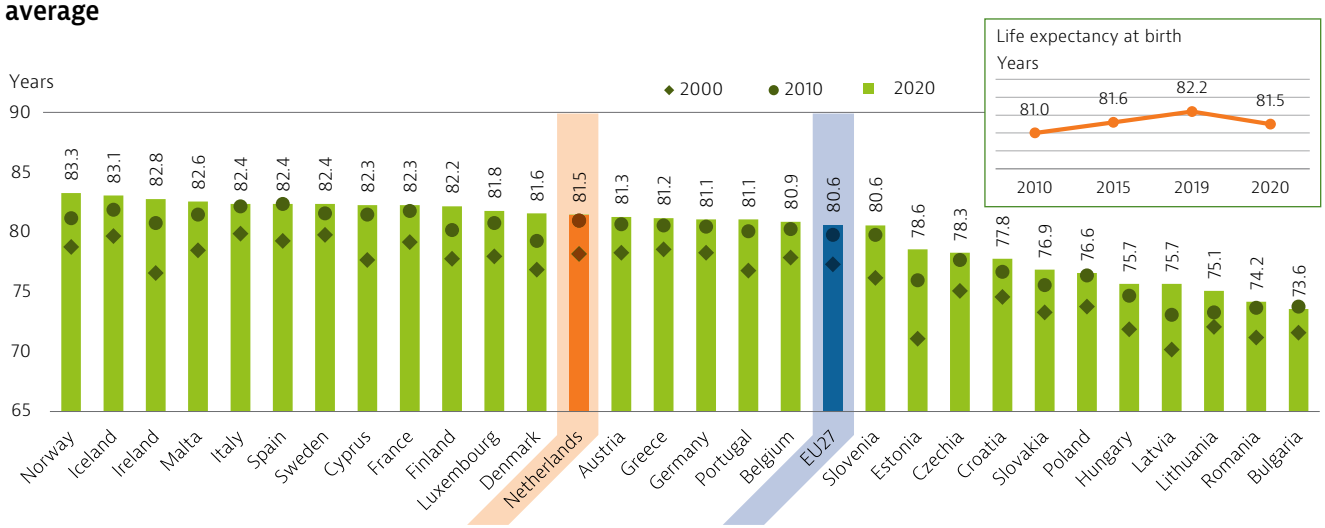
2 Health in the Netherlands

Life expectancy temporarily dropped by 0.7 years in 2020 during the COVID-19 pandemic

In 2020, life expectancy at birth for the Dutch population was 81.5 years, almost one year higher than the average in the EU as a whole (80.6 years), but lower than many of the top performing countries (Figure 1). Men in the Netherlands live almost two years longer than the EU average, while Dutch women live almost five months less. This comparatively weak performance for women reflects the legacy of high smoking rates in previous generations (see Section 3) and which has increased the number of women with lung cancer.

Progress in life expectancy in the previous two decades was significant, but between 2010 and 2019, women only gained 0.7 years in life expectancy, while men gained 1.7 years, a slowdown that is not unique to the Netherlands. Owing to the COVID-19 pandemic, overall life expectancy fell temporarily from 82.2 years in 2019 to 81.5 years in 2020, representing a decline of nearly 8.5 months.

Figure 1. Dutch life expectancy is 1.3 years below the best performing EU country but higher than the EU average



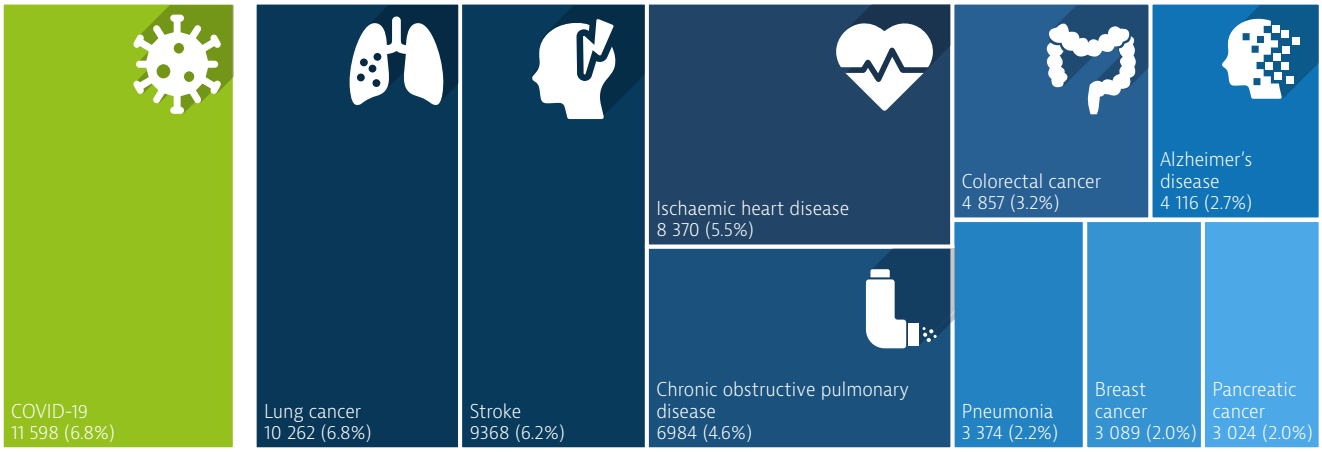
Note: The EU average is weighted. Data for Ireland refer to 2019.
Source: Eurostat Database.

COVID-19 accounted for a large number of deaths in the Netherlands in 2020

In 2019, the leading causes of death in the Netherlands were lung cancer, stroke and ischaemic heart disease (Figure 2). Mortality rates from lung cancer and chronic obstructive pulmonary disease (COPD) continue to be among the highest in the EU, despite some reductions over the years. In contrast, mortality rates from stroke and ischaemic heart disease remain among the lowest in the EU (see Section 5.1).

In 2020, COVID-19 accounted for about 11 600 deaths in the Netherlands – almost 7 % of all deaths – while an additional 6 400 deaths were attributed to COVID-19 by the end of August 2021. The majority of deaths were among people aged 60 and over. Overall, the mortality rate from COVID-19 up to the end of August 2021 was about 35 % lower in the Netherlands than the average across EU countries (approximately 1 035 per million population compared with about 1 590 for the EU average). However, the broader indicator of excess mortality suggests that the direct and indirect death toll related to COVID-19 in 2020 may have been higher (Box 1).

Figure 2. Lung cancer, stroke and ischaemic heart disease are the leading causes of death in the Netherlands



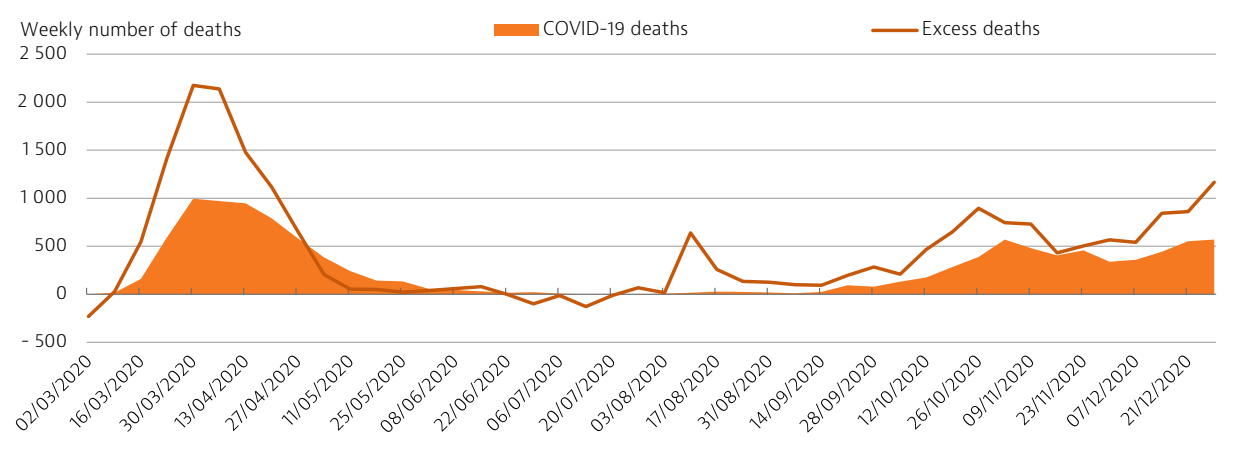
Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2019. The size of the COVID-19 box is proportional to the size of the other main causes of death in 2019.
Sources: Eurostat (for causes of death in 2019); ECDC (for COVID-19 deaths in 2020, up to week 53).

Box 1. Some gaps between COVID-19 deaths and excess mortality in 2020 are evident in the Netherlands

In the Netherlands, as in many other countries, the actual number of deaths from COVID-19 is likely to be higher than the number of reported deaths, especially because there is no obligation to report COVID-19 as a cause of death until it appears on death certificates, which are only available several months later. The number of COVID-19 deaths reported also does not take into account the possible increase in deaths from other causes that may arise during or after the pandemic. These may be due, for example, to reduced access to health services for non-COVID-19 patients or fewer people seeking treatment because of fear of catching the virus (indirect deaths). The indicator of excess mortality (defined as the number of deaths from all causes over and above what would have been normally expected, based on baseline data from the previous five years) can provide a broader measure of the direct and indirect impact of COVID-19 on mortality that is not affected by issues related to testing and cause-of-death registration practices.

In the Netherlands, between March and December 2020, trends for excess deaths and reported COVID-19 deaths were generally consistent, but with some increases in the gap between the two in April and from mid-October 2020 (Figure 3). A heatwave in August 2020 was probably the cause of a relatively steep rise in excess deaths at that time, and was not connected with COVID-19. Overall, excess mortality accounted for about 20 000 deaths between March and December 2020..

Figure 3. COVID-19 and excess deaths peaked in spring 2020 in the Netherlands



Note: The calculation of excess deaths is based on the average for the previous five years (2015-2019).
Sources: ECDC (for COVID-19 deaths); OECD based on Eurostat data (for excess deaths).

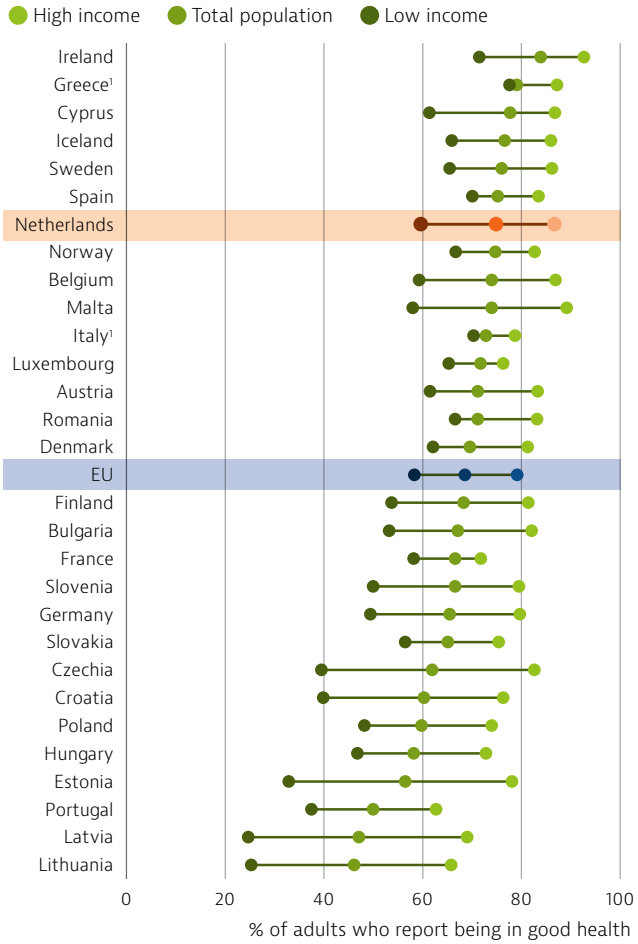
Most Dutch people report good health, but sizeable disparities exist across income groups

In 2019, about 75 % of Dutch people reported that they were in good health – a greater share than in the EU as a whole (69 %). However, as in other countries, people on lower incomes are less likely to report good health; only 60 % of those in the lowest income quintile reported good health compared to 87 % of those in the highest (Figure 4).

The burden of cancer in the Netherlands is considerable

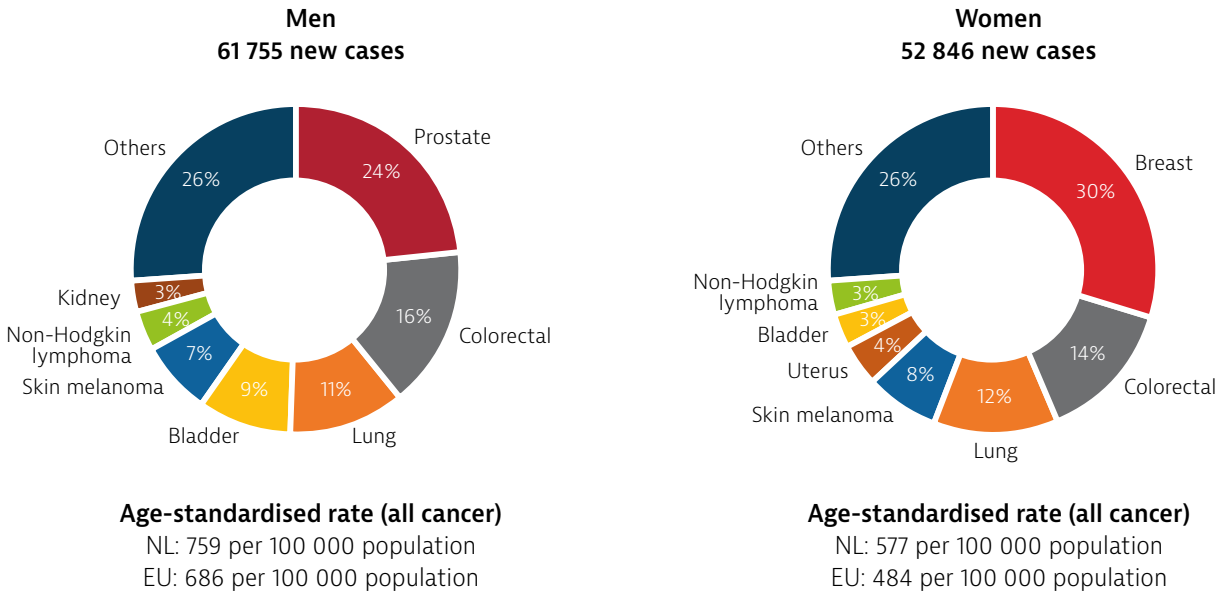
According to estimates from the Joint Research Centre based on incidence trends from previous years, around 110 000 new cases of cancer were expected in the Netherlands in 2020. However, fewer people were newly diagnosed with cancer than in previous years, probably as a result of the pause in cancer screening programmes in spring 2020 during the pandemic. Prostate cancer is the main cancer among men, while breast cancer is the leading cancer among women. Colorectal and lung cancers are the second and third leading cause of cancer among both sexes (Figure 5). Despite having a substantial disease burden, with over 45 000 deaths from cancer in 2019, cancer survival rates in the Netherlands are higher than the EU average (see Section 5.1).

Figure 4. Inequalities in self-reported health by income level are relatively large in the Netherlands



Note: 1. The shares for the total population and the population on low incomes are roughly the same.
Source: Eurostat Database, based on EU-SILC (data refer to 2019).

Figure 5. An estimated 110 000 people in the Netherlands were expected to be diagnosed with cancer in 2020



Age-standardised rate (all cancer)
NL: 759 per 100 000 population
EU: 686 per 100 000 population

Age-standardised rate (all cancer)
NL: 577 per 100 000 population
EU: 484 per 100 000 population

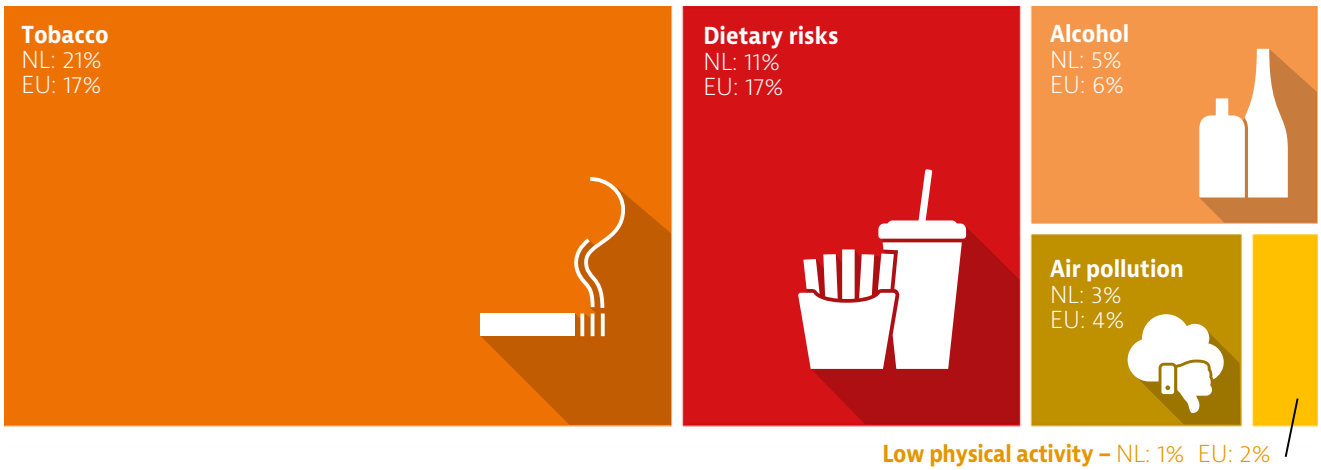
Note: Non-melanoma skin cancer is excluded. Uterus cancer does not include cancer of the cervix.
Source: ECIS – European Cancer Information System.

3 Risk factors

Behavioural risk factors account for more than one third of all deaths

More than one third (35 %) of all deaths in the Netherlands can be attributed to behavioural risk factors – below the EU average of 39 %. These behaviours include smoking, dietary risks, alcohol consumption and low physical activity (Figure 6). One in five deaths in 2019 could be attributed to tobacco consumption (including direct and second-hand smoking), which is higher than the EU average (21 % compared to 17 %). The second major risk factor is dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption), which were responsible for an estimated 11 % of deaths in 2019 – well below the EU average (17 %). About 5 % of deaths that year were associated with alcohol consumption, which is close to the EU average (6 %). Environmental factors such as air pollution, in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone accounted for nearly 5 000 deaths in the Netherlands in 2019 (or 3 % of all deaths, compared to 4 % in the EU).

Figure 6. Tobacco consumption is the leading behavioural risk factor contributing to mortality in the Netherlands



Note: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverage consumption. Air pollution refers to exposure to $PM_{2.5}$ and ozone.
Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Smoking and drinking rates in both adults and adolescents have decreased

Adult smoking rates have declined following the introduction of smoke-free working environments and other policy changes (see Section 5.1), and are below the EU average. In 2018, about one in eight 15-year-olds in the Netherlands reported smoking cigarettes in the past month – a substantial decline from 2014, when it was one in five.

Overall consumption of alcohol among adults has declined by about 20 % since 2000, and is now lower than in most other EU countries. Repeated drunkenness among 15-year-olds is also slightly less widespread in the Netherlands than across the EU, with 19 % of 15-year-olds reporting having been drunk more than once in their life in 2018, compared with a 22 % EU average.

Overweight and obesity rates are rising

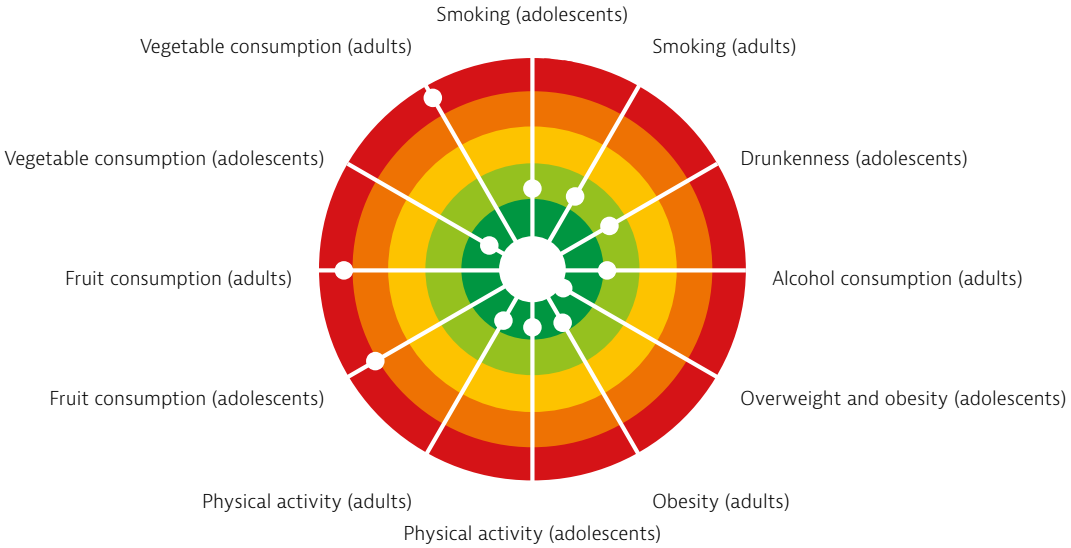
The overweight and obesity rate among Dutch teenagers and adults is lower than in most EU countries (Figure 7). More than one in eight adults (14 %) in the country were obese in 2019, up from 10 % in 2002. These trends are a cause for concern, given that obesity carries a significant risk for diabetes, cardiovascular diseases and several different cancers. This highlights the need to increase efforts to change dietary habits among both children and adults.

Adults in the Netherlands have among the lowest fruit and vegetable consumption in the EU, with around 6 out of 10 reporting that they do not eat at least one portion per day. A higher proportion of adolescents report eating at least one vegetable each day compared with the EU average, but it is the opposite for fruit consumption: only about one quarter (27 %) of 15-year-olds reported eating at least one fruit per day in 2018 – a lower proportion than the EU average (31 %).

Fewer than one in five teenagers engage in moderate physical activity every day

While most adults in the Netherlands report at least 150 minutes of moderate physical activity per week, this is not the case among 15-year-olds. Only 18 % of Dutch teenagers reported engaging in moderate physical activity on a daily basis in 2018, with a lower rate among girls: only 14 % of girls reported doing at least moderate activity each day, compared to 21 % of boys. While this exceeds the EU averages of 10 % of girls and 18 % of boys, low physical activity can affect other health outcomes and increases the risk of overweight and obesity.

Figure 7. The Netherlands performs better than most other EU countries on many risk factors



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.
Sources: OECD calculations based on HBSC survey 2017-18 for adolescents indicators; and EHIS 2019 and Dutch HIS for adults indicators.

4 The health system

Three separate coverage schemes form the basis of the Dutch health system

The Dutch government regulates and oversees three schemes that together provide broad universal health coverage. First, competing health insurers administer a social health insurance (SHI) system for curative care. The system, introduced in 2006, mandates all residents to purchase insurance policies that cover a defined benefits package set by the government. Insurers must accept all applicants, and they negotiate and contract with providers based on quality and price. The SHI scheme covers all specialist care, primary care, pharmaceuticals and medical devices, adult mental health care, some allied care services and community nursing. The second scheme is a single-payer social insurance system for long-term care, which is carried out by the regionally dominant health insurer, and which was the subject of a large reform in 2015 to rein in the scope of the scheme and spending. The third is a tax-funded social care scheme implemented by the municipalities. The National Institute for Public Health and the Environment (RIVM) provides guidance for public health services at the national level, while municipalities cover most services such as screening, vaccination and health promotion (Box 2).

Spending on health as a share of GDP is slightly above the EU average

In 2019, the Netherlands spent 10.2 % of GDP in health – slightly above the EU average of 9.9 %. This translates to EUR 3 967 per capita (adjusted for differences in purchasing power), which is well above the EU average of EUR 3 523. Expenditure growth between 2013 and 2017 only increased by 1.0 % on average per year, following the introduction of a reform package that increased financial risk

Box 2. The Netherlands took steps to implement a national-level response to the COVID-19 crisis

In accordance with the national pandemic response plan in place before the COVID-19 outbreak, the first response focused on the regional level in the province of Noord-Brabant, where the first COVID-19 outbreak occurred. Soon, the response was scaled up to the national level under the management of the RIVM (see Section 5.3), which coordinates the regionally conducted testing, contact tracing and reporting of cases. The RIVM also hosts the Outbreak Management Team, which advises the Prime Minister and the Cabinet on necessary measures, and consists of medical specialists, virologists, medical microbiologists and representatives of the national reference laboratory. Throughout the autumn of 2020, the Netherlands did not pass any national emergency legislation, and municipal authorities could determine whether to implement emergency decrees. However, the country introduced the COVID-19 Temporary Measures Act on 1 December 2020, which enables national decision making. The Act can be extended and stopped at any time with the agreement of the parliament.

Source: COVID-19 Health Systems Response Monitor.

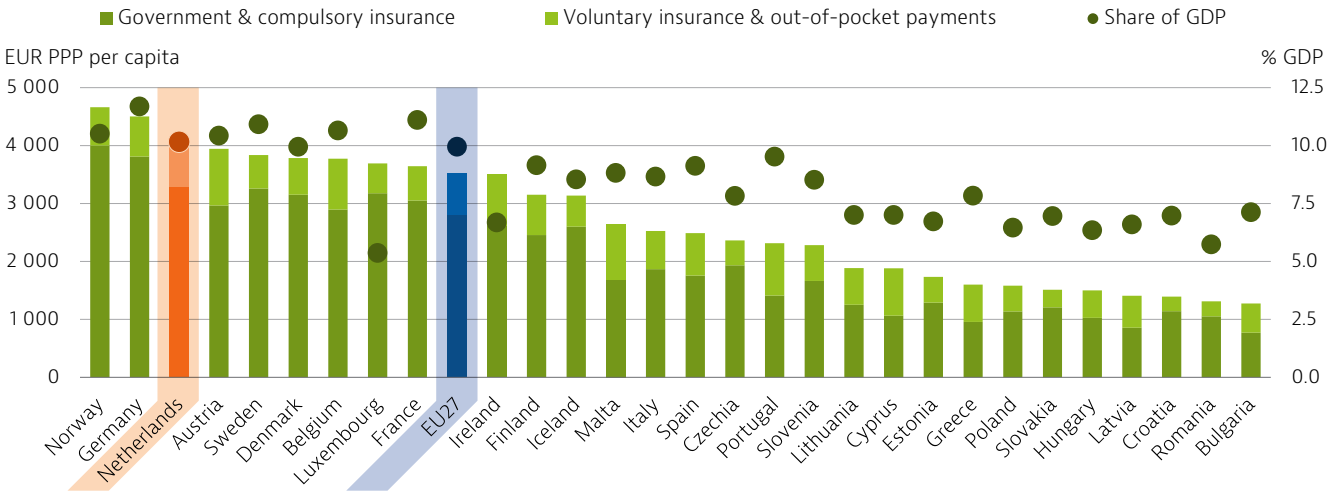
for insurers and providers and increased the share of out-of-pocket (OOP) health expenditure. In addition, the Dutch Ministry of Health signed several agreements with stakeholders that aim to keep spending growth within predefined levels. However, between 2017 and 2019, annual health expenditure growth rose to 2.3 % per year. During the COVID-19 pandemic, insurers and providers agreed on measures to compensate revenue losses and extra spending due to COVID-19. The government allocated additional tax revenues for 2020 and 2021 to the health sector, including for testing and contact tracing (EUR 476 million in 2020 and EUR 450 million in 2021) and intensive care unit (ICU) beds (EUR 80.1 million and EUR 93.9 million).

A relatively large voluntary health insurance sector contributes to low OOP payments

Following the abolition of the private insurance scheme in 2006, public expenditure (government spending and compulsory insurance) increased from about two thirds (68.4 %) of health spending in 2005 to 83.8 % in 2006, before falling slightly to 82.6 % in 2019. This remains slightly above the EU average of 79.7 % (Figure 8).

OOP spending as a share of current health expenditure was about two thirds of the EU-wide average in 2019, at 10.6 % in the Netherlands compared to 15.4 % in the EU. Around 57 % of OOP payments are due to cost-sharing, although general practitioner (GP) care, maternal care and care from district nurses remain free at the point of delivery. In the Netherlands, health insurers may offer voluntary health insurance (VHI) policies to cover services outside the benefits package. This contributes to a relatively large VHI sector (6.8 % of health spending compared to 4.9 % in the EU in 2019), as individuals who expect to incur high OOP payments usually take out VHI (see Section 5.2).

Figure 8. Health spending per capita is above the EU average

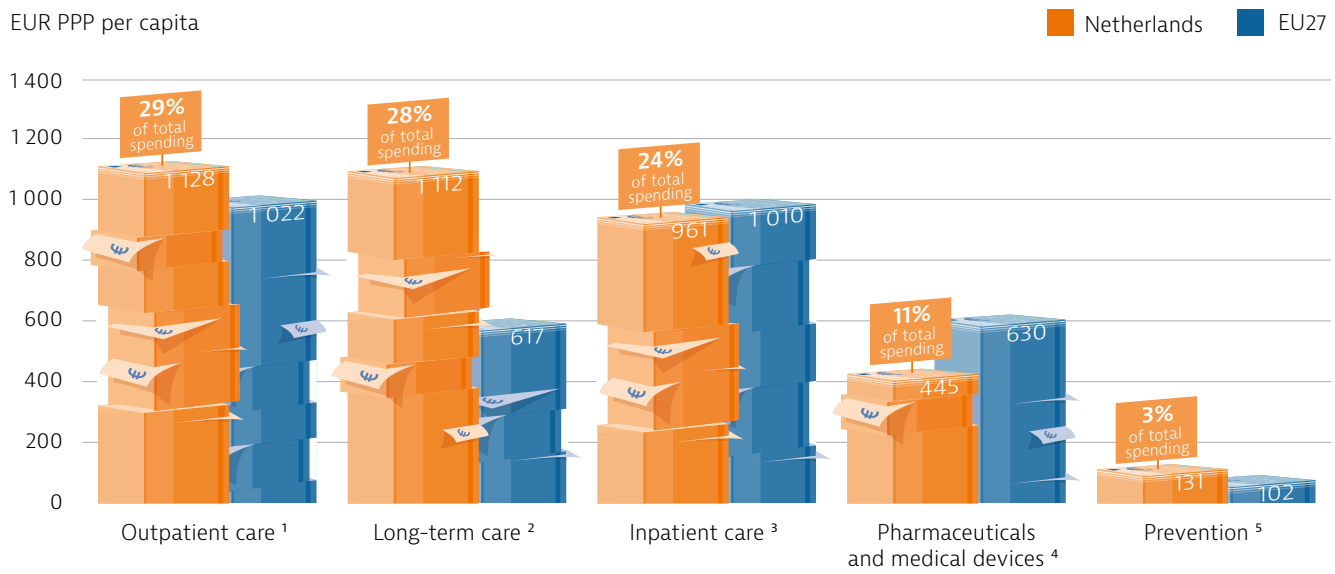


Note: The EU average is weighted.
Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta 2018).

The Netherlands has the second highest share of spending on long-term care in the EU

When measured in per capita terms, health spending in the Netherlands is above the EU average for outpatient care, long-term care and prevention, and is below the average on inpatient care, retail pharmaceuticals and medical devices (Figure 9). A large long-term care sector, which covers elderly care, care for disabled people and long-term mental care, contributes to the relatively high overall spending on health. Spending on retail pharmaceuticals and medical devices is well below the EU average and even decreased from 13.9 % of total health spending in 2010 to 11.2 % in 2019. The Netherlands has among the highest levels of spending on prevention, at EUR 131 per person, compared to an EU average of EUR 102, but this amount has not increased over time. Between 2010 and 2019, the share of spending on prevention dropped from 4.3 % to 3.3 % of total health spending.

Figure 9. Long-term care expenditure exceeds that of most other EU countries



Note: The cost of health system administration is not included. 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes only the health component; 3. Includes curative-rehabilitative care in hospital and other settings; 4. Includes only the outpatient market; 5. Includes only spending for organised prevention programmes. The EU average is weighted.
Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019).

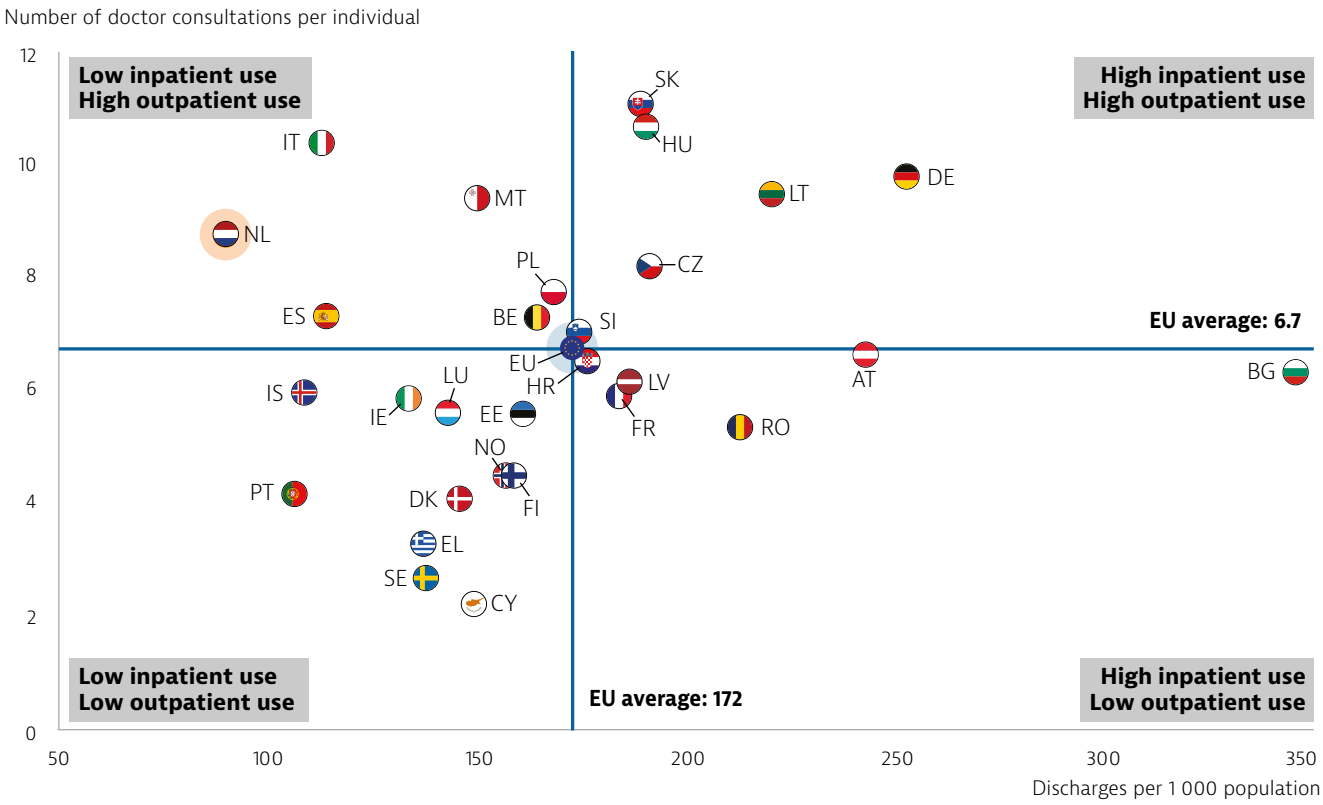
Nursing attracts more people to the profession than in many other EU countries

In the last 10 years, the ratio of doctors to population has increased from 3.4 to 3.7 per 1 000 population, close to the EU average of 3.9. The ratio of nurses grew from 8.7 to 10.7 per 1 000 population, which is well above the EU average of 8.4. In 2019, 60 % more nurses graduated than in 2009, while doctors' graduation rates rose by a more modest 26 %. Nurses in the Netherlands participate in task-shifting and advanced nursing practices, creating a more attractive work environment. Nurse specialists were granted the authority to practise independently in 2012, and this was codified in law in 2018. They are empowered to prescribe all medicines within their competence and to perform endoscopies, among other specified services. However, the nursing workforce is overburdened in hospitals, and nursing and home care personnel also face shortages, which became more pronounced during the COVID-19 pandemic (see Section 5.3). An above-average share of doctors work as GPs – 24 % of all physicians compared with 21 % across the EU.

Strong primary care and gatekeeping contribute to low hospital admission rates

Health services are overwhelmingly provided by private non-profit providers, and most physicians are self-employed. The Netherlands operates a strict gatekeeper system. Patients require a referral from a GP to visit hospital and specialist care, including for COVID-19 (see Section 5.3). Although the Netherlands reports comparatively high numbers of outpatient contacts, it also has relatively low rates of hospital discharges, suggesting that strong primary care and outpatient specialist treatment manage to keep people out of hospitals (Figure 10). Both long-term care and mental health care reforms were designed for delivery in outpatient settings to respond to historically high institutionalisation rates (Kroneman et al., 2016).

Figure 10. The Netherlands has the lowest inpatient use in the EU



Note: The EU average is unweighted.
Source: OECD Health Statistics and Eurostat Database (data refer to 2019 or nearest year).

5 Performance of the health system

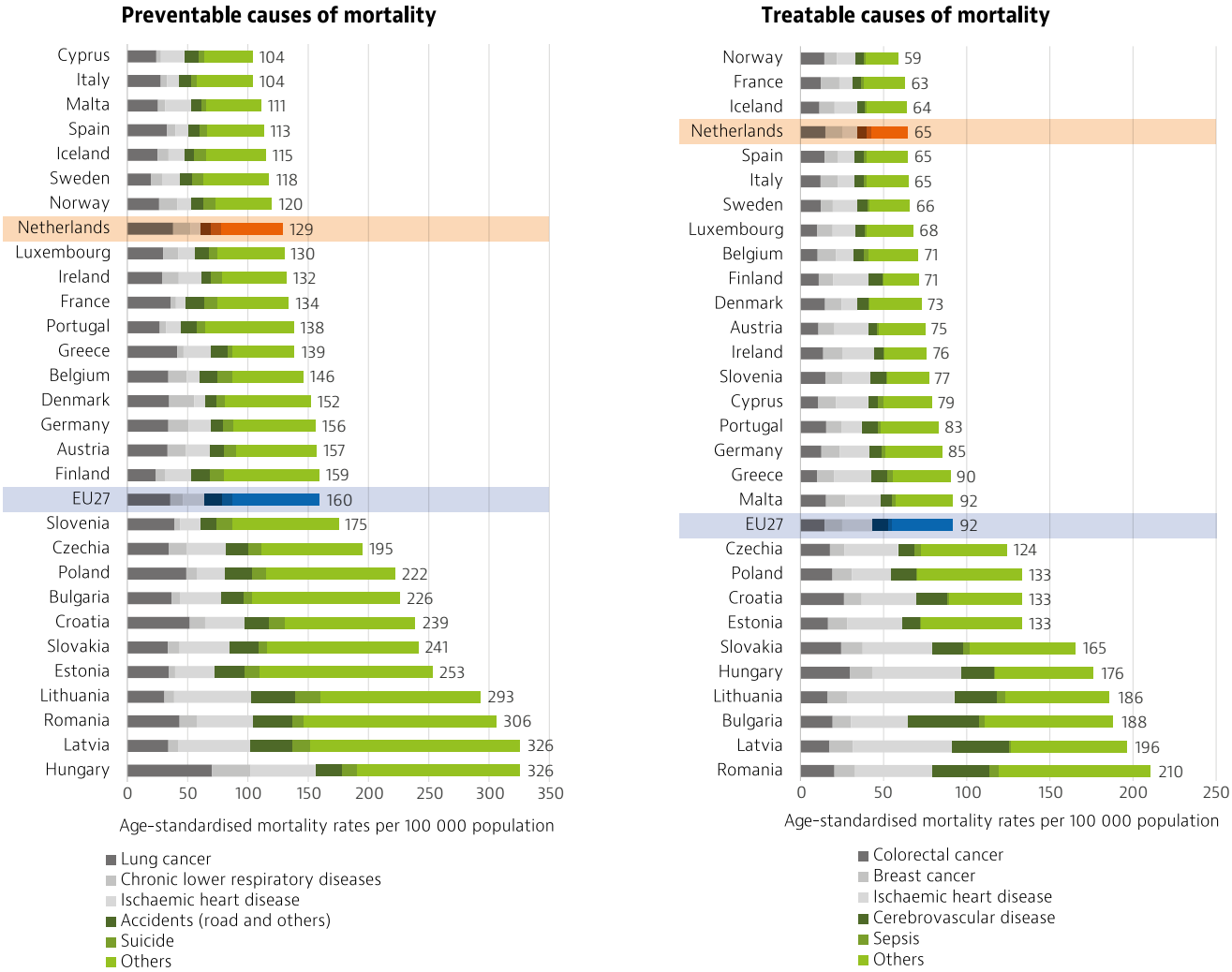
5.1 Effectiveness

Low mortality from preventable and treatable causes point to effective health interventions

Mortality from preventable causes in the Netherlands compares favourably with the rate across the EU as a whole, at 129 deaths compared to 160 per 100 000 population (Figure 11), reflecting both a lower prevalence of risk factors and a lower incidence of many of these health issues compared to most other EU countries. Lung cancer accounts for 30 % of preventable deaths in the Netherlands, making it the largest contributor to preventable mortality. Since the early 2000s, the government has implemented several public health policies aiming to minimise the impact of behavioural risk factors and social determinants of health. Smoking was banned in workplaces in 2004, and in cafés and restaurants in 2008, while alcohol control measures implemented in 2013 focused on reducing alcohol use among teenagers. The National Prevention Agreement concluded in 2018 prompts municipalities to implement regional and local agreements to improve health outcomes and reduce health inequalities in their populations. So far, 14 initiatives with an average of 41 participating organisations have been developed, working towards the 2040 targets to have a smoke-free generation, reduce the share of the overweight and obese population from 50 % to 38 % and decrease problematic alcohol abuse.

The Netherlands reports one of the lowest mortality rates from treatable causes – that is, deaths that could have been avoided through effective health care interventions (Figure 11). These rates remain low compared to the rest of the EU in spite of the above-average mortality from colorectal and breast cancer in the Netherlands, which accounted for more than 40 % of treatable deaths in 2018. Mortality rates from other treatable causes – such as ischaemic heart disease, stroke and pneumonia – were among the lowest in the EU.

Figure 11. Deaths from preventable and treatable causes are lower than in most EU countries



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.
Source: Eurostat Database (data refer to 2018, except for France 2016).

The Netherlands faces increasing numbers of avoidable admissions for chronic conditions

While the Netherlands reports an overall low number of avoidable hospitalisations, avoidable admissions for asthma and COPD have increased between 2007 and 2019 from 182 to 208 avoidable admissions per 100 000 population. The Netherlands has responded to this with information campaigns and several policy actions over the past decade. Initial results bode well for the effect of these policies, as avoidable admissions for COPD dropped from 213 to 200 avoidable hospitalisations per 100 000 population between 2015 and 2016. Additional measures implemented in 2020 introduced neutral packaging for cigarettes, a ban on flavoured e-cigarettes, a prohibition of smoking in schoolyards, a ban on displays of tobacco products in supermarkets and raised excise duties on tobacco products. In addition, strong primary care and outpatient care contribute to minimising hospital admission rates for diabetes and congestive heart failure, which are about half the EU average. Bundled payments, whereby a single payment covers all costs of services supplied by multiple providers for a defined episode of care, also play a role in coordinating care for diabetes, COPD and cardiovascular disease patients.

Although above the EU average, influenza vaccination rates were on a downward trend before the pandemic

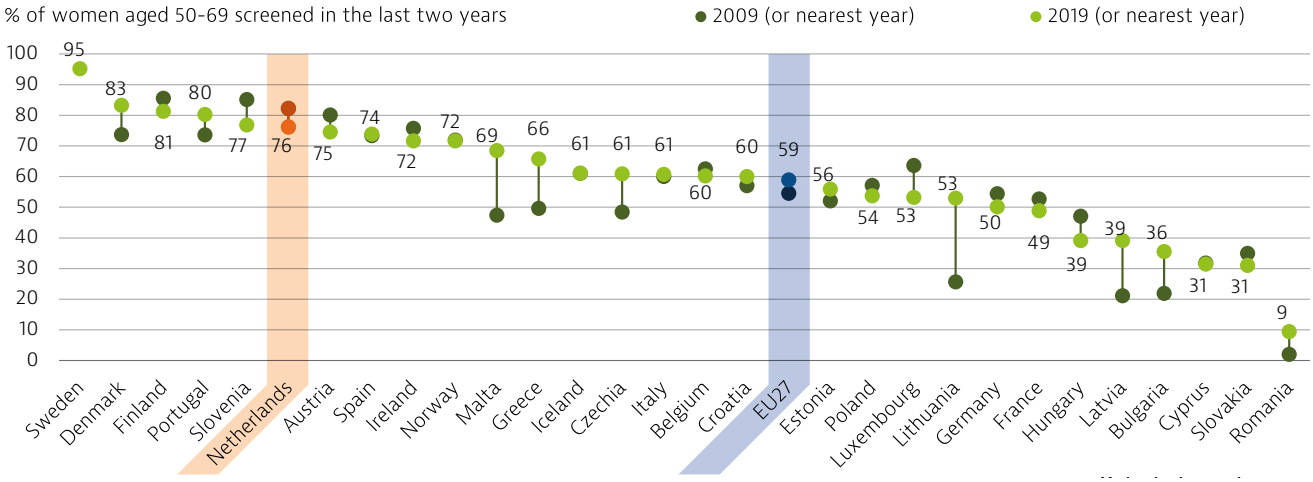
In 2019, the Netherlands vaccinated 61 % of its population over the age of 65 for seasonal influenza – well above the EU average of 42 %, although still below the target of 75 % recommended by the

WHO. However, influenza vaccination rates in the Netherlands among those aged 65 and over have decreased by nearly 20 percentage points in the last 10 years. Influenza vaccinations are free for people over the age of 60, yet vaccination campaigns are obstructed by uncertainty about the effectiveness and side effects of the vaccine, as well as the perceived low risk of contracting or dying from influenza. This perception may have changed during the COVID-19 pandemic, however, as demand for the flu vaccine grew. Some GP practices temporarily asked individuals between 60 and 70 years old with no underlying conditions to refrain from getting a flu vaccination to prioritise doses for those over 70 years old.

Dutch cancer survival rates are high but screening rates for breast and cervical cancer are decreasing

The Netherlands offers population screening programmes for cervical cancer, breast cancer and colorectal cancer. Cervical cancer screening has a participation rate similar to the EU average, with 56 % of women aged 20-69 screened within the past two years, although participation has declined over recent years from 68 % in 2007. Similarly, breast cancer screening rates are higher than the EU average (76 % compared to 59 %), but participation has also decreased over the last decade (Figure 12). The relatively new Colorectal Cancer Screening Programme (2014) covers all individuals between 55 and 75 years of age. A programme evaluation in 2019 found that participation rates (73 %) were above expectations, with 3.9 million people sending in self-screening tests between 2014 and 2017, contributing to higher than anticipated detection of new colorectal cancer cases. Based on these results, it is predicted that by 2030 nearly one in five colorectal cancer cases and over one in three colorectal cancer deaths may be prevented (RIVM, 2019).

Figure 12. Breast cancer screening rates are high, but have declined over the last 10 years



Note: The EU average is unweighted. For most countries, the data are based on screening programmes, not surveys.
Sources: OECD Health Statistics 2021 and Eurostat Database.

Five-year cancer survival rates have improved over the last decade and are generally above the EU average (Figure 13). Although the Netherlands does not have a national cancer plan, health care professionals, researchers, policy makers and patient organisations have come together in the Cancer Survivorship Care Taskforce to advocate a national action plan that recognises the continuing needs of cancer patients and survivors. This aligns with one of the key action areas of the recent Europe's Beating Cancer Plan to improve quality of life of cancer patients and survivors, including rehabilitation and measures to support social integration and re-integration in the workplace (European Commission, 2021a).

Figure 13. Five-year survival rates across six cancers exceed the EU23 average

Prostate cancer	Childhood leukaemia	Breast cancer	Cervical cancer	Colon cancer	Lung cancer
Netherlands: 89 %	Netherlands: 90 %	Netherlands: 87 %	Netherlands: 68 %	Netherlands: 63 %	Netherlands: 17 %
EU23: 87 %	EU23: 85 %	EU23: 82 %	EU23: 63 %	EU23: 60 %	EU23: 15 %

Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer.
Source: CONCORD Programme, London School of Hygiene & Tropical Medicine.

Promising initiatives have arisen to improve the quality of health care

In the Dutch health care system, competing insurers are expected to play a key role in improving quality through contract negotiations with health care providers (see Section 4). In practice, insurers emphasise volume and price more than quality in their contracting decisions, partly due to the fragmentation and administrative burden of collecting quality indicators. The Dutch Health Care Institute has been tasked with developing reliable and meaningful quality indicators and drawing up a multi-year care improvement agenda, in consultation with all parties involved in health care. These initiatives can then be used to improve care, enhance shared decision making and ultimately guide contracting with providers.

Furthermore, some insurers have started creating bottom-up longer-term contracts with providers centred on value-based care, where providers and professionals can define key performance indicators for quality of care and delivery innovations. Medical professional groups and the government also contribute to quality improvement activities, such as a new long-term care quality framework aims to improve the quality of care in nursing homes. An initiative to provide "the right care at the right place" (de juiste zorg op de juiste plek) also has gained momentum, and has helped physicians and patients to determine the appropriate setting for COVID-19 treatment (see Section 5.3).

5.2 Accessibility

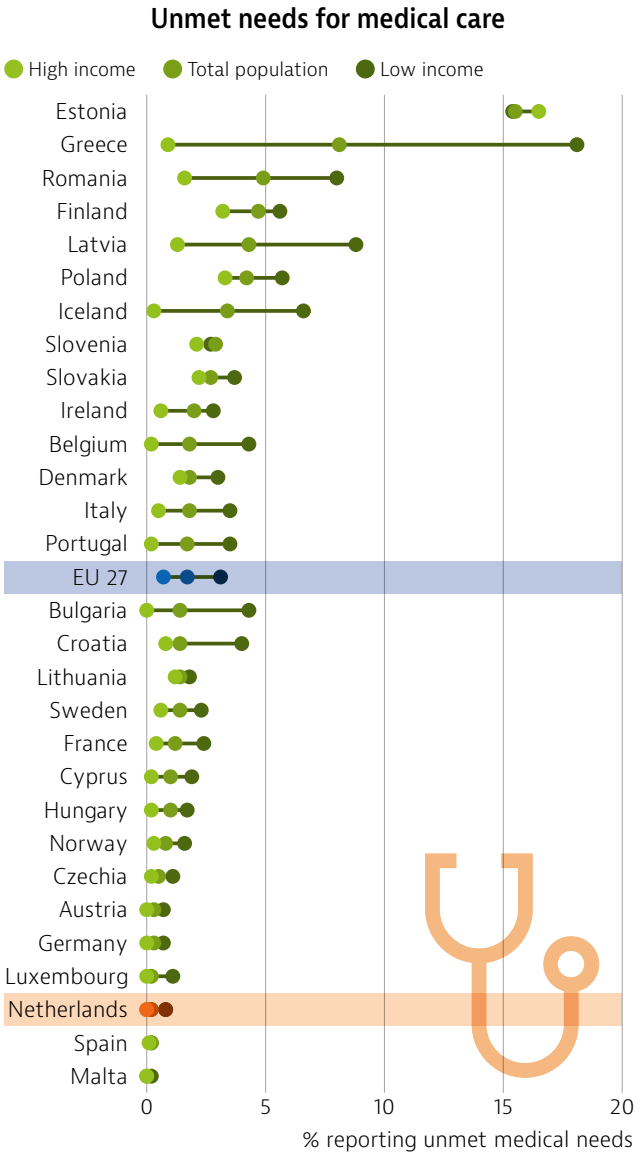
Very few Dutch people reported unmet needs for medical treatment until the COVID-19 pandemic

In the Netherlands, government regulation guarantees universal and equal access to affordable care. As a result, the Dutch tend to report very low levels of unmet needs for medical care (Figure 14). However, this changed during the COVID-19 pandemic: according to the Eurofound (2021) survey[1], 15 % of respondents reported that they needed a medical examination or treatment that they had not received during the first 12 months of the pandemic. The average reported for the EU as a whole was 21 %.

The Netherlands did not shut down providers at a national level, yet at various points during the pandemic some hospitals postponed non-urgent treatments due to regional outbreaks. The professional organisations of dentists and paramedical care providers decided to postpone all non-emergency treatments from mid-March until early May 2020. Cancer screening appointments were also postponed from the onset of the pandemic until mid-May (colon cancer), mid-June (breast cancer) and July 2020 (cervical cancer). To resume care, multiple stakeholder groups worked together to create a list of diagnoses with an urgency indication, aiming to address the most urgent plannable care first. The Netherlands also encouraged teleconsultations as much as possible, with about 40 % of the population taking part in a remote consultation (Eurofound, 2021).

1. *The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.*

Figure 14. The Dutch population had among the lowest levels of unmet needs in the EU in 2019



Note: 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 2019, except Iceland 2018)

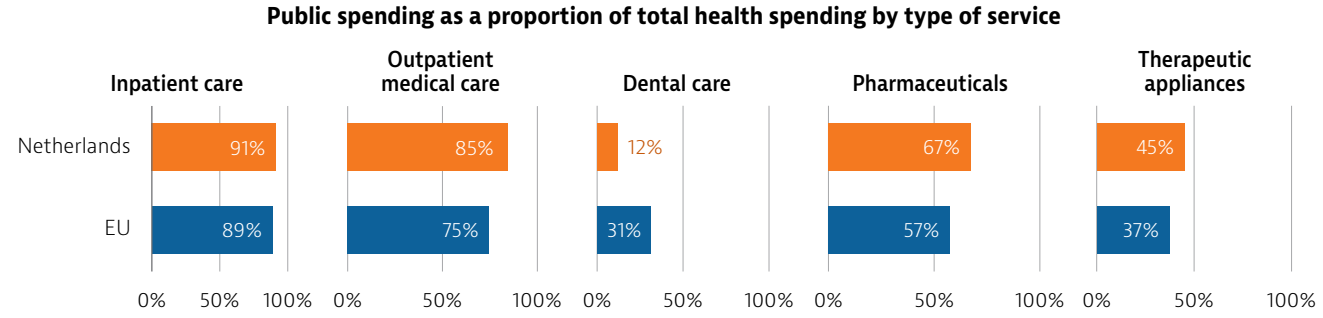
The health system provides broad coverage, with voluntary health insurance covering some gaps

Around 99.9 % of the Dutch population has health insurance, which covers a wide range of services. Among other things, the benefits package includes primary care, outpatient specialist care, hospital care, maternal services, in vitro fertilisation (maximum of three cycles), physiotherapy for chronic illness, mental health treatment and ambulance transport. Public spending accounts for 91 % of inpatient care, 85 % of outpatient care and 67 % of outpatient pharmaceuticals – all above the EU averages (Figure 15).

The Netherlands covered the costs of COVID-19 testing, but individuals needed a physician referral for a test until June 2020 (see Section 5.3). In an unprecedented yet far-sighted measure, the Dutch Healthcare Institute, which advises the Minister of Health on the services to include in the basic benefits package, determined that rehabilitation care for COVID-19 patients should be included if recommended by a physician. Specifically, a maximum of 50 physical therapy sessions, 8 occupational therapist treatments and 7 dietician sessions are reimbursable for up to six months after COVID-19 infection.

Dental care for adults and some paramedical care are not covered by the benefits package. Many Dutch people purchase VHI to cover these services – particularly dental care. Despite not being covered in the benefits package, a very low proportion of the population (0.4 %) report unmet needs for dental care, which is substantially below the EU average of 2.8 %.

Figure 15. The public share of financing is higher than the EU average across all areas of health care, with the exception of dental care



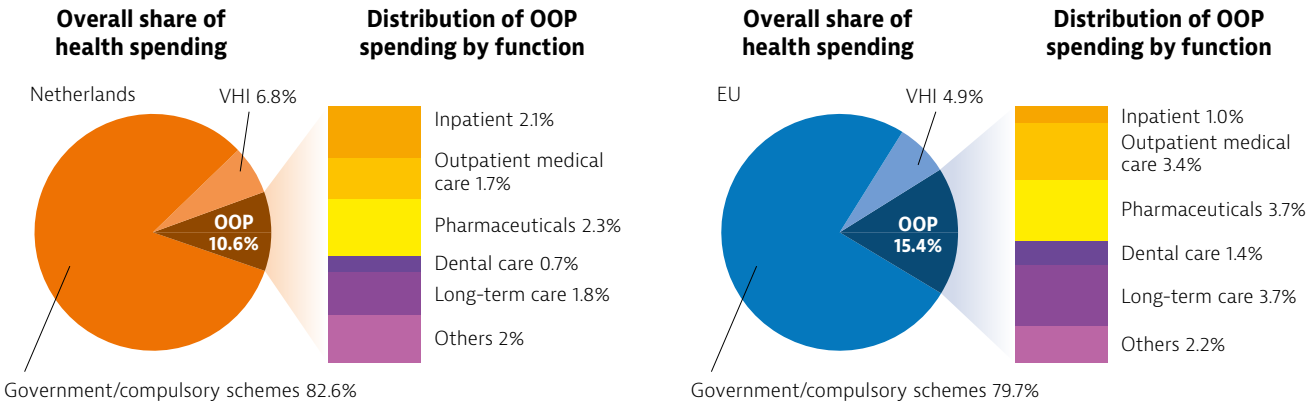
Note: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices.
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

Health care costs are partly paid through an out-of-pocket mandatory deductible

OOP spending fell from a peak of 11.6 % of total health spending in 2014 to 10.6 % in 2019, and stands well below the EU average of 15.4 % (Figure 16). A large share of OOP spending in the Netherlands comes from the mandatory deductible, which requires patients to pay a minimum amount before the insurer begins to cover services. The mandatory deductible increased from EUR 150 in 2008 to EUR 385 in 2016. The intention was that it should grow in line with other items in the health budget, but in 2017 the government coalition decided to keep the deductible at its current level, while some opposition parties wanted to abolish it entirely. The deductible does not apply to GP care, maternity care, district nursing and care for children under the age of 18, which are all available without cost-sharing.

The main categories of OOP spending include pharmaceuticals, inpatient and long-term care contributions under the Long-term Care Act. Since 2019, the Netherlands has capped OOP spending on pharmaceuticals at EUR 250 per year. For residential long-term care, the country applies income-dependent cost-sharing, ranging from no cost-sharing to EUR 2 419 per month, although not all OOP payments are related to care delivery and may include housing costs. Furthermore, the Social Support Act offers the opportunity for municipalities to provide financial compensation for health care costs incurred by patients with chronic conditions on low incomes, and some municipalities negotiate insurance policies with generous benefits targeted at low-income groups.

Figure 16. Inpatient care and pharmaceuticals account for over 40 % of out-of-pocket payments



Note: The EU average is weighted. VHI also includes other voluntary prepayment schemes.
Source: OECD Health Statistics 2021; Eurostat Database (data refer to 2019).

The Netherlands has easily accessible health care services

The Netherlands has a dense network of health care providers, ensuring high geographical availability of services. In 2020, fewer than 0.15 % of the population had to travel more than 10 minutes by car to the nearest GP practice, and GP out-of-hours centres cover care outside office hours. However, GP practices struggle to replace GPs after retirement, and shortages are becoming a concern.

Although there have been a substantial number of mergers between hospitals over the last decade, this has not yet affected the number of locations for accessing health care. In the Netherlands, 99 % of the population lived within 30 minutes from a hospital by car in 2020 (Volksgezondheidenzorg, 2021). However, the Dutch system has been experiencing excessive waiting times in some outpatient departments.

Mental health care for children is of particular concern, as waiting times can exceed one year. It remains unclear how the pandemic will affect waiting times in the longer term.

Typically, insurance companies have the option of reimbursing only 75 % of costs of services provided by non-contracted providers. This could result in financial barriers to accessing some hospitals for patients who purchase cheaper ("budget") insurance policies that contract a limited number of providers. During the COVID-19 pandemic, insurers agreed to cover care delivered by all hospitals in 2020 and 2021, even if they are outside their networks (see Section 5.3).

Concerted policy efforts to reduce pharmaceutical expenditure have paid off

The Netherlands spends less on outpatient pharmaceuticals than most other EU countries (see Section 4). Several factors – including a long history of volume and price control policies, a conservative approach by GPs to issuing prescriptions and well-established health technology assessment (HTA) processes – have contributed to this result. Further, the share of generic medicines by volume in the pharmaceuticals market is the second highest after Germany among EU countries for which data are available. These efforts to control prices and promote generics contribute to more affordable medicines for patients.

A promising development is the BeNeLuxA initiative, which aims to improve collaboration on pharmaceutical policy and procurement; it includes co-operation between Belgium, the Netherlands, Luxembourg, Austria and Ireland in the fields of horizon scanning, information sharing and policy exchange, HTA, and pricing and reimbursement. The BeNeLuxA initiative's goals are consistent with the European Commission's pharmaceutical strategy for Europe, adopted in November 2020, which aims to ensure that patients have access to innovative and affordable medicines while supporting the competitiveness, innovative capacity and sustainability of the EU's pharmaceutical industry (European Commission, 2020).

5.3 Resilience

This section on resilience focuses mainly on the impacts of and responses to the COVID-19 pandemic[2]. As noted in Section 2, the pandemic had a major impact on population health and mortality in the Netherlands, with around 18 000 COVID-19 deaths recorded between January 2020 and the end of August 2021. Measures taken to contain the pandemic also had an impact on the economy, and Dutch GDP is estimated to have declined by 3.8 % in 2020, compared to an EU average fall of 6.2 %.

The Netherlands' response to COVID-19 included measures at both regional and national levels

The first case of COVID-19 was identified on 27 February 2020 in the province of Noord-Brabant. By 6 March, residents of the province were advised to stay at home and limit social contacts. This was scaled up to the entire country by 12 March as the number of cases rose; the Netherlands quickly implemented a 1.5-metre physical distancing requirement and closed schools, restaurants and non-essential in-person work, as well as implementing other restrictive measures in the following days (Figure 17). The measures to prevent transmission remained in place through April 2020, and primary schools were the first to reopen on 11 May.

Further relaxation of measures continued through summer 2020, but high infection rates in large cities prompted some regional measures in August. As September and October brought progressively higher case numbers, restrictive measures heightened, limiting the number of people who could gather in a group and shutting down public venues. On 15 December 2020, the Netherlands imposed the strictest national restrictions to date, followed by a curfew lasting from 23 January 2021 until 28 April 2021. Again, primary schools reopened first, on 8 February 2021. The Netherlands progressed through its four phases of reopening between 28 April 2021 and 26 June 2021. Shortly after the final reopening phase, the Netherlands saw an exponential rise in cases, mostly among young adults. This dropped sharply in late summer after a reimposition of measures restricting nightlife and large events.

The Netherlands had pandemic preparedness tools in place prior to COVID-19

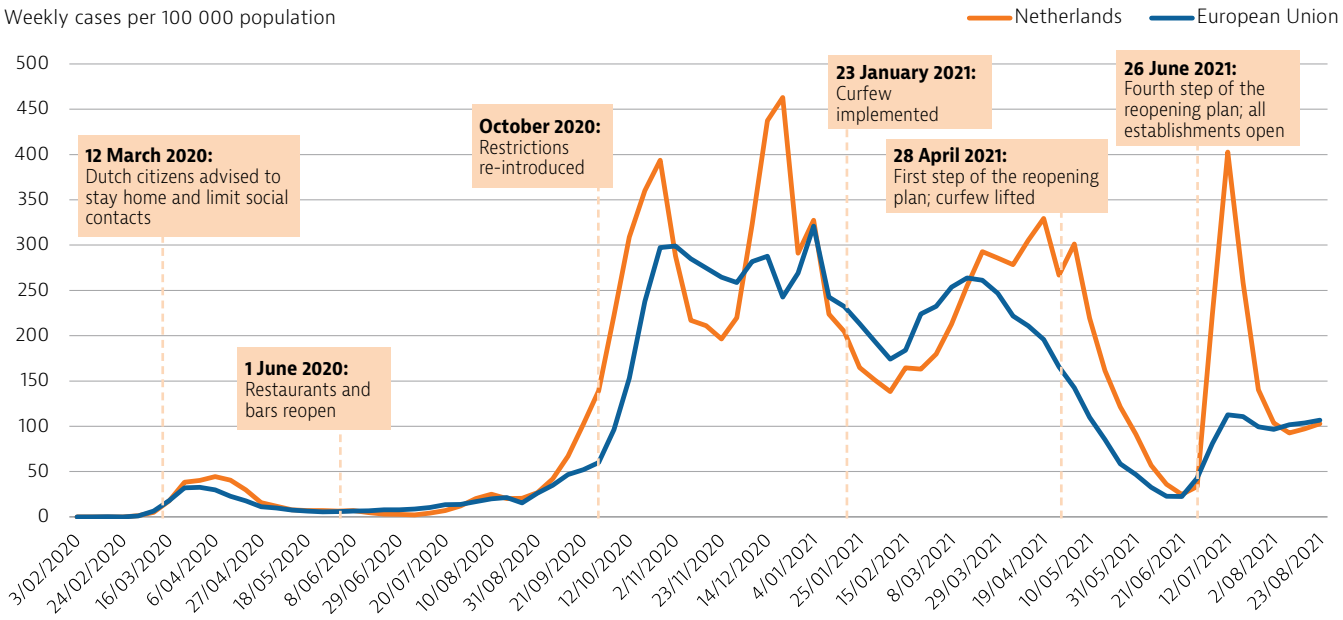
The Netherlands has a comprehensive pandemic response plan, which was a key plank in the country's preparedness toolkit. Coordinated by the RIVM, it describes in detail the general actions to take in the case of an infectious disease crisis, including which measures should be taken in which phase of the crisis, and who is responsible for determining the crisis phase.

A fragmented laboratory landscape initially limited the number of tests performed

Prior to June 2020, testing for COVID-19 required individuals to obtain a physician referral. After 1 June, those with symptoms could register for testing using a dedicated phone number without a referral, but bottlenecks in testing capacity caused some accessibility gaps. Generally, testing is performed at the central test locations of the public health services, under the coordination of the RIVM. At the end of 2020, "XL" testing facilities were opened at the national airport and in large cities; these operated as public–private partnerships. Self-tests started to become available at the end of March 2021 in some pharmacies, with further expansion to all supermarkets and pharmacies in April 2021.

2. In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).

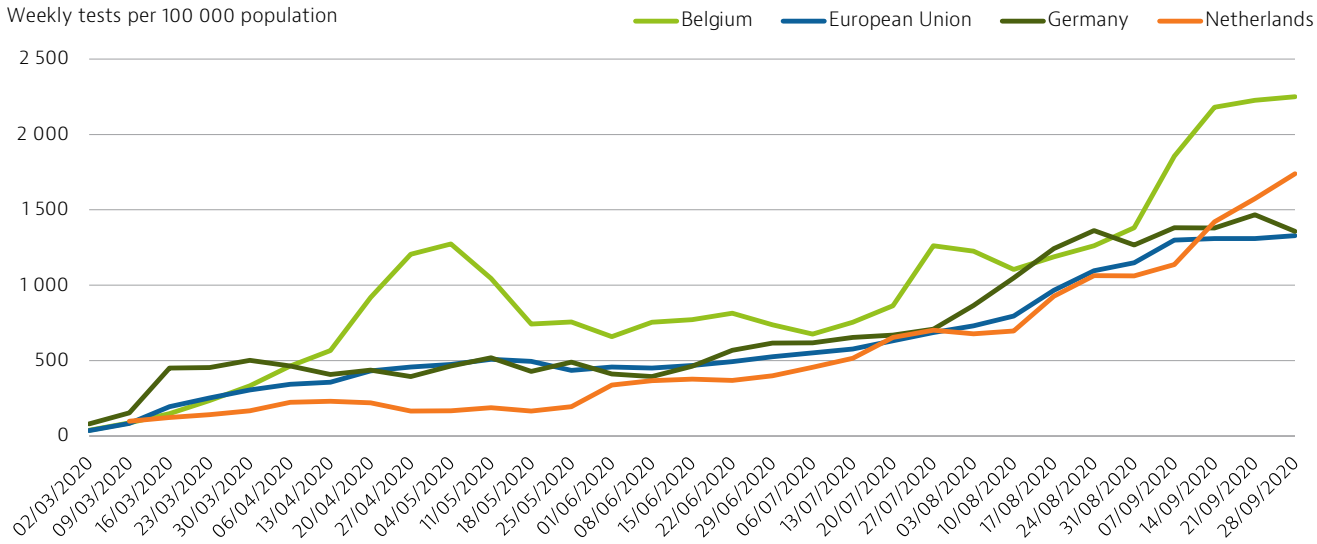
Figure 17. The number of COVID-19 cases reported in the second wave far exceeded that in the first wave



Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Sources: ECDC for COVID-19 cases and authors for containment measures.

In September 2020, the Netherlands Court of Audit published an evaluation of the country's testing policy (Algemene Rekenkamer, 2020). The report revealed that the government did not have a clear view of the capacity of the Dutch testing laboratories and the supplies necessary for testing. The Netherlands has a fragmented landscape of labs that use a multitude of testing systems, which have experienced varying problems with acquiring sufficient supplies. As a result, the number of tests performed has lagged behind the available capacity. For example, in September 2020 the total testing capacity was 28 000 per day, but the number of tests conducted on average every day was 10 000 below this capacity. This contributed to the Netherlands having lower weekly testing rates for much of 2020, but by September it had surpassed the EU average (Figure 18).

Figure 18. Testing activity in the Netherlands caught up to the EU average in September 2020



Note: The EU average is weighted (the number of countries included in the average varies depending on the week).
Source: ECDC.

Some public health services had to limit contact tracing activities due to capacity constraints

In addition to running testing locations, the 25 regional public health services oversee contact tracing activities. The services temporarily reassigned nearly all health care-related personnel to perform contact tracing and staff helplines. Contact tracing started when the Netherlands recorded its first case in February 2020. When case numbers peaked in the middle of September 2020, 10 of the public health services announced that they had to limit contact tracing: at this time, they only had the capacity to call individuals living in the same household or those at high risk. In addition, informed contacts were asked to report to the public health service only if they had symptoms.

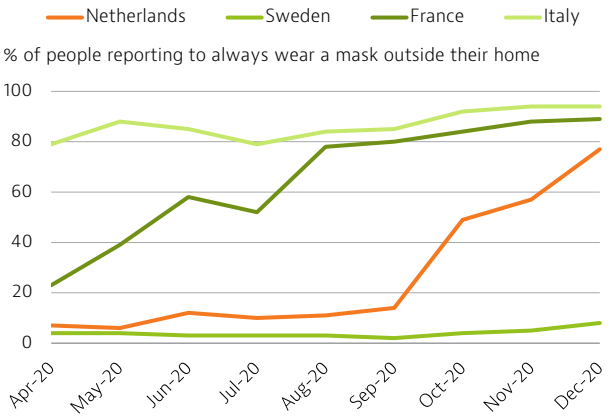
The Dutch contact tracing app experienced delays in launching due to regulatory hurdles

The Dutch government developed the "Coronamelder" (Corona detector) application to support tracing of contacts of people confirmed to have COVID-19. Downloading and using the app is voluntary, and infections can be reported anonymously. At first, the Netherlands issued a tender and evaluated seven apps, but after an initial assessment none of these appeared to meet the necessary privacy criteria. Therefore, the Dutch government started developing its own open source app with a group of in-house experts. It was piloted in a few regions in August 2020 in a testing phase, and the national launch was originally planned for 1 September. After delays in legislative approval, the app was launched nationally on 10 October 2020, and it became inter-operable with apps from other European countries at the end of November 2020.

Debates on the value of wearing face masks continued until autumn 2020

Initially, the RIVM stated that face masks have a limited effect on preventing transmission and could lead to a misperception of safety, compromising physical distancing rules. The government supported this view, but made face masks compulsory on public transportation from 1 June 2020, as physical distancing was not feasible. The government also granted local mayors discretion on requiring face masks, following petitions by several mayors, who pointed out that physical distancing was not feasible owing to the concentration of people. As evidence on the efficacy of face masks increased, on 14 October 2020, the Netherlands made mask-wearing compulsory for everyone aged 13 and older inside public buildings, with some exemptions. The conflicting guidance about whether to wear a face mask contributed to fewer than 20 % of Dutch people wearing a mask outside the home between April and September 2020, but mask-wearing rose sharply by the end of 2020 (Figure 19).

Figure 19. The mask-wearing rate shot up after it became obligatory in October 2020

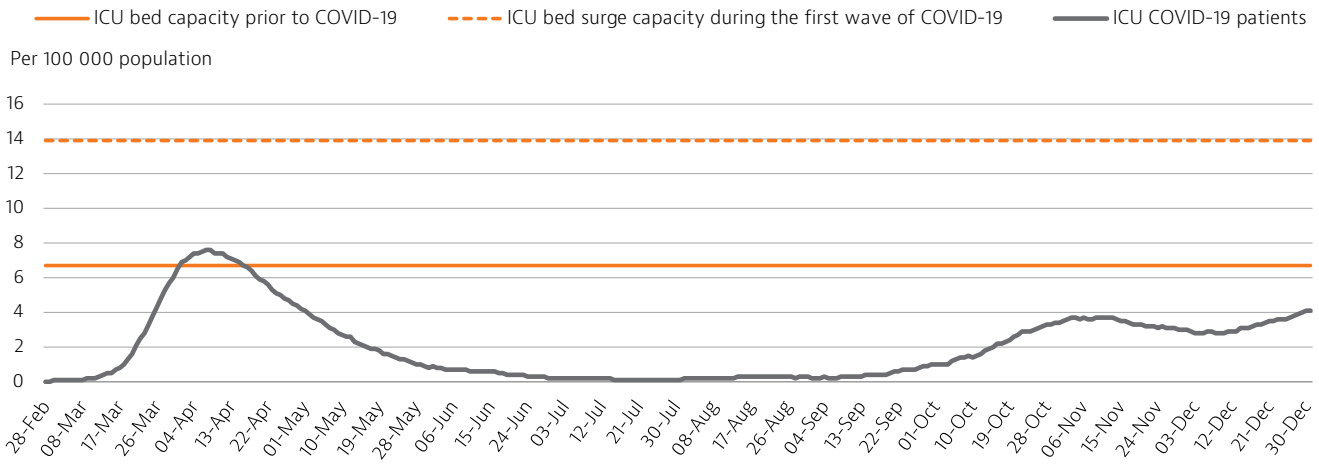


Source: YouGov data (http://www.coviddatahub.com/).

The Netherlands rapidly scaled up its intensive care unit bed capacity to accommodate COVID-19 patients

Before the COVID-19 pandemic, the Netherlands had 1 150 available ICU beds occupied at a 70 % rate on average. The number of ICU beds in the Netherlands, at 6.7 beds per 100 000 population, falls below many other countries in Europe, including neighbouring Germany (33.4) and Belgium (17.4). At the beginning of April 2020, the number of patients with COVID-19 treated in ICUs exceeded pre-existing capacity (Figure 20). In response, the country quickly made a plan to increase its ICU bed capacity progressively in March and April, surpassing 1 700 beds to treat COVID-19 patients in the second week of April. In June 2020, the number of COVID-19 patients in ICUs dropped below 100 and remained low over the summer. The National Coordination Centre for Distribution of Patients took on a steering role in the allocation of COVID-19 patients among Dutch hospitals.

Figure 20. Intensive care unit occupancy rates exceeded pre-existing capacity only for a short period



Note: The blue line represents the daily number of COVID-19 patients in ICU units; the orange line represents the initial bed capacity in ICU units before the pandemic; the orange dashed line represents the additional bed capacity mobilised during the pandemic.
Sources: OECD/European Union (2020); Lailor (2020).

Patients were transferred within and outside the Netherlands for treatment

To ensure optimal use of ICU beds, COVID-19 patients and other patients who potentially required ICU care were sometimes transferred to other hospitals. For instance, at one point during the first wave, 32 of the 34 COVID-19 patients in the Groningen hospitals in the north of the Netherlands were from the southern provinces of Noord-Brabant and Limburg. These transfers involved up to 100 patients per day at the end of March 2020, but tapered off by the end of April. The army coordinated the operation using ambulances, mobile ICUs, a special ICU bus and two helicopters, with assistance from police escorts to ensure smooth transfers. The Netherlands also transferred patients to Germany, and included the use of ICU beds in Germany in its preparation plans for the second wave.

General practitioners coordinated COVID-19 care while implementing measures to maintain routine services

Outside of hospitals, GPs are the first contact point for potential COVID-19 cases. GPs determine whether the patient should be admitted to hospital, and until June 2020 decided whether the patient should receive testing. If possible beforehand, the physician discusses the consequences of an ICU admission in a shared decision-making process with the patient, which is standard practice in the Netherlands. Based on this discussion, patients are able to decide for themselves whether to receive treatment in an ICU or at home.

To maintain routine care, GPs were advised to organise separate office hours for patients with respiratory complaints, to abolish walk-in office hours and to use video instead of face-to-face consultations whenever possible. Despite these care adaptations, the volume of services provided decreased significantly, particularly in the first wave. Between 12 March and 20 April, GPs issued approximately 360 000 fewer referrals than usual, and about 290 500 previously issued referrals did not lead to a specialist consultation.

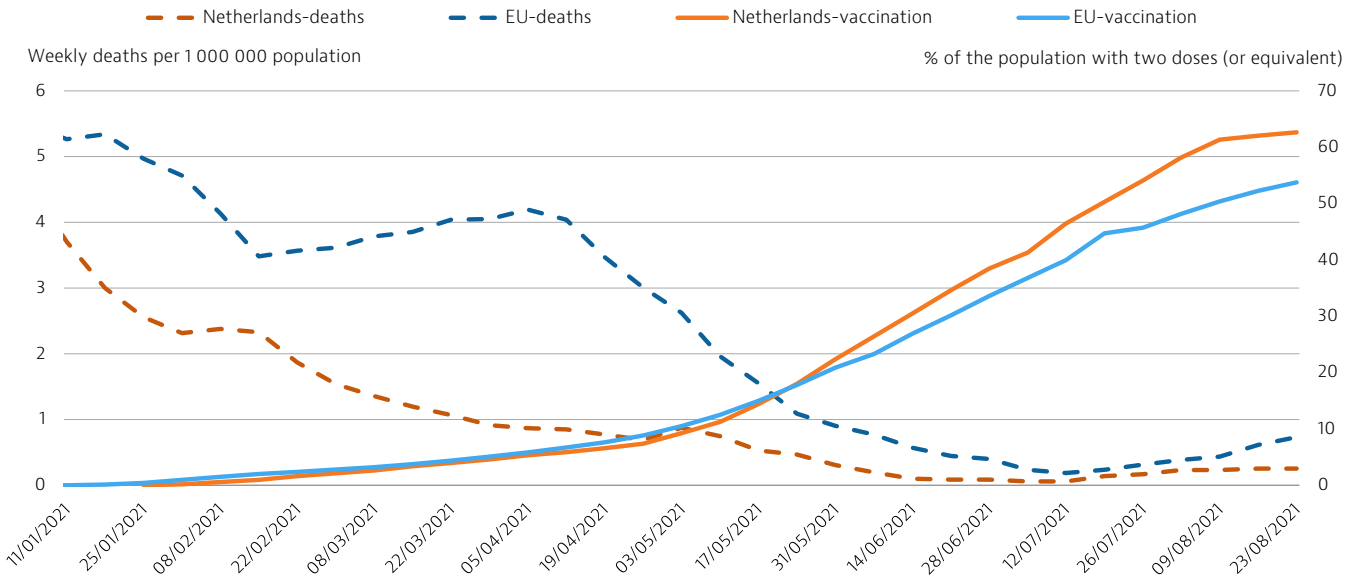
The COVID-19 vaccination rollout encountered some initial obstacles but accelerated quickly

The initial vaccination plan created by the Dutch Health Council prioritised individuals over the age of 60 and at-risk groups as the first to receive a COVID-19 vaccination. This prioritisation largely reflected the risk of COVID-19 mortality for these groups, particularly those living in long-term care facilities. However, hospital organisations emphasised that health workers in COVID-19 wards and ICU units should receive the first vaccinations, followed by nursing home personnel and GPs. This conflicting advice, combined with delays in procuring the vaccine, led to a slower start to vaccinations than in many other EU countries. After a slow start, the vaccination rate increased and surpassed the EU average in May 2021. This contributed to a reduction in the number of deaths due to COVID-19 in the Netherlands (Figure 21).

The RIVM oversees the vaccination campaign, and initially planned to use channels for other vaccination efforts, such as seasonal influenza, which function at the local level. However, the low storage temperatures

of some vaccines and the small scale of GP practices made this impractical, and the strategy had to adjust rapidly to include larger-scale vaccination centres. The first COVID-19 vaccinations were performed for acute care staff and elderly people over the age of 75, followed by nursing home personnel. GPs began administering vaccines on 16 February 2021 when the first vaccine that did not require low storage temperatures became available. By the end of August 2021, 63 % of the population had received two doses (or equivalent) of a COVID-19 vaccine – nearly 10 percentage points above the EU average.

Figure 21. COVID-19 deaths dropped during the vaccination campaign



Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Sources: ECDC for COVID-19 cases and Our World In Data for vaccination rates.

A highly decentralised data structure and privacy protection groups limit sharing of health information

The Netherlands does not have a centralised electronic health records system, and many different providers offer electronic health record systems that lack interoperability. An organisation facilitates access to patient medical records in the case of emergency care. Normally, this requires acquiring an explicit written consent from patients in their place of residence. During the COVID-19 pandemic, patients were transferred to different regions, and asking for consent was not always possible, so temporary guidance permitted GPs to share patient data with other providers without prior consent. Privacy protection organisations considered this a controversial measure, as they are concerned that third parties could have access to the data besides the treating physician. This conversation is likely to continue in the context of the European Health Data Space, which is designed promote better exchange and access to different types of health data to support health care delivery and health research and policy making (European Commission, 2021b).

6 Key findings

- At 81.5 years in 2020, life expectancy in the Netherlands remains higher than the EU average by about one year. Gains have slowed over the last decade, and life expectancy temporarily fell by over 8 months between 2019 and 2020 during the COVID-19 pandemic. Lung cancer, stroke and ischaemic heart disease accounted for nearly one fifth of deaths in 2019, but 1 in 15 deaths in 2020 were attributed to COVID-19.

- The Netherlands has lower mortality from preventable and treatable causes than the EU average. Lung cancer contributes to 30 % of all preventable deaths, while colorectal cancer and breast cancer account for 40 % of treatable deaths. Mortality rates from other treatable causes – such as ischaemic heart disease, stroke and pneumonia – are among the lowest in the EU. Even though cancer causes a large share of preventable and treatable deaths, five-year cancer survival rates in the Netherlands exceed the EU average.

- The Dutch population generally reports low unmet needs for medical treatment, and government regulation guarantees universal and equal access to affordable care. In 2019, only 0.2 % of the surveyed population reported unmet medical needs, but additional survey evidence shows that over 15 % of respondents had to forgo care in the first 12 months of the COVID-19 pandemic. Many non-urgent services were cancelled or postponed, which may further increase waiting times that had already been rising in outpatient settings.

- The Netherlands is among the highest spenders on long-term care and prevention in the EU, and among the lowest spenders on outpatient pharmaceuticals and medical devices. Several factors may have contributed to low pharmaceutical spending, including a long history of volume and price control policies, a conservative approach by general practitioners to issuing prescriptions and well-established health technology assessment processes. International collaboration through the BeNeLuxA initiative also aims to improve collaboration on pharmaceutical policy and procurement. Public spending covers a high percentage of health care expenditure, with the exception of dental care, and many people have dental coverage through voluntary health insurance. Out-of-pocket expenditure in the Netherlands, at just over 10 %, is considerably below the EU average of 15 %, while voluntary health insurance spending exceeds the EU average.

- While the Netherlands had a national pandemic response plan in place and a high level of preparedness before the COVID-19 pandemic, the health system response encountered obstacles. In particular, testing, contact tracing and vaccination efforts suffered from limited capacity, fragmentation and lack of coordination. More positively, the pre-existing primary care gatekeeper system offered shared decision making between the patient and provider to determine the desired treatment for COVID-19 patients.

- The need for a coordinated response to the COVID-19 pandemic – for example, in contact tracing and testing – overruled pre-existing structures in the Dutch health care system that separated payers and providers and distanced the Ministry of Health from direct intervention in the system. Temporary legislation updated financial relationships and patient management to enable the necessary national-level responses, such as transferring patients between regions and sharing patient data.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

European Commission

State of Health in the EU
Country Health Profile 2021

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles 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, in cooperation with the European Commission.

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/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

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

The Commission is complementing the key findings of these country profiles with a Companion Report.

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