European Commission



State of Health in the EU

The Netherlands

Country Health Profile 2023

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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 policy makers and influencers with a means for mutual learning and voluntary exchange. For the first time since the series began, the 2023 edition of the Country Health Profiles introduces a special section dedicated to mental health.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation 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).

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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 finalised in September 2023, based on data that were accessible as of the first half of September 2023.

Demographic and socioeconomic context in The Netherlands, 2022

Demographic factors	The Netherlands	EU
Population size	17 590 672	446 735 291
Share of population over age 65 (%)	20.0	21.1
Fertility rate[1] (2021)	1.6	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	46 093	35 219
Relative poverty rate[3] (%)	14.5	16.5
Unemployment rate (%)	3.5	6.2

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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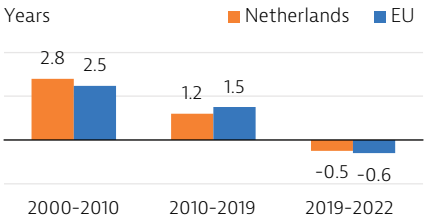
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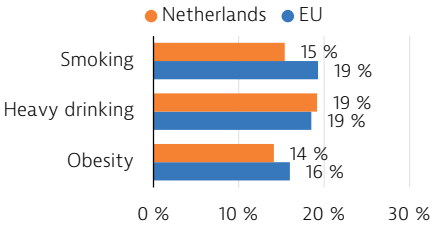
1 Highlights



Changes in life expectancy at birth

Health Status

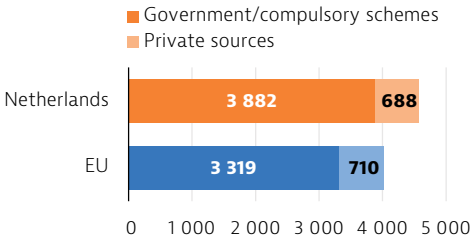
Life expectancy in the Netherlands increased in line with the EU average in the two decades preceding the COVID-19 pandemic, and its reduction throughout the pandemic was slightly less severe than the EU average. Life expectancy in 2022 stood at 81.7 years – 6 months below its 2019 level. Throughout the pandemic, excess mortality remained close to the EU average, peaking at almost 14 % in 2020.



% of adult population, 2019

Risk Factors

Mortality linked to behavioural risk factors in the Netherlands is slightly lower than the EU average. Prevalence of smoking and obesity is comparatively low, while heavy episodic drinking is on a par with the EU average. Smoking and obesity are more prevalent among those with a low level of education, while heavy drinking is more common among the most educated.



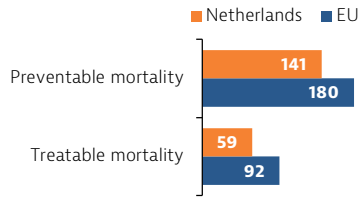
EUR PPP per capita, 2021

Health System

In 2021, health spending per capita stood at EUR 4 570 – the third highest amount in the EU, although spending was only marginally above the EU average when measured as a share of GDP. COVID-19-related public spending drove significant health expenditure increases in 2020 and 2021. Public sources accounted for nearly 85 % of health expenditure – above the EU average of 81 %.

Effectiveness

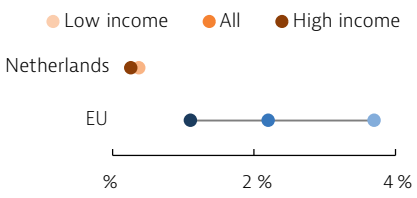
Mortality rates from causes deemed preventable and treatable in the Netherlands were 21 % and 36 % lower than the EU averages in 2020. Over the last decade, treatable mortality rates declined much faster than the EU average, driven by mortality reductions from ischaemic heart disease and breast cancer.



Age-standardised mortality rate per 100 000 population, 2020

Accessibility

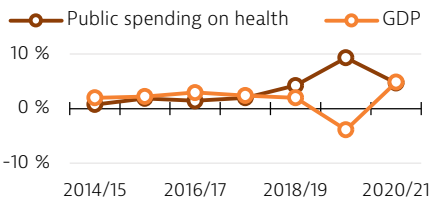
Only 0.2 % of the population in the Netherlands reported unmet medical care needs in 2022 – the lowest share across EU countries and equal to the rate reported before the start of the pandemic. However, the deferral of a substantial volume of surgical activity during the pandemic had an adverse effect on waiting times.



% reporting unmet medical care needs, 2022

Resilience

In the years before the pandemic, public health spending in the Netherlands increased in line with GDP. The pandemic temporarily upended this trend, as the former increased by over 9 % against a near 4 % decline in GDP in 2020. In 2021, public health spending kept rising at a more moderate rate, driven in large part by COVID-19-related costs.



Annual change in real terms

Mental Health

Mental health illnesses are more prevalent in the Netherlands than in most other EU countries, with nearly one in six Dutch people suffering from one in 2019. In contrast to the EU trend, over the past decade suicide rates in the Netherlands increased by nearly 5 %, and were slightly above the EU average in 2020. The Dutch mental healthcare system is struggling to meet increased demand in the aftermath of the pandemic due to limited capacity and a shortage of mental health professionals.

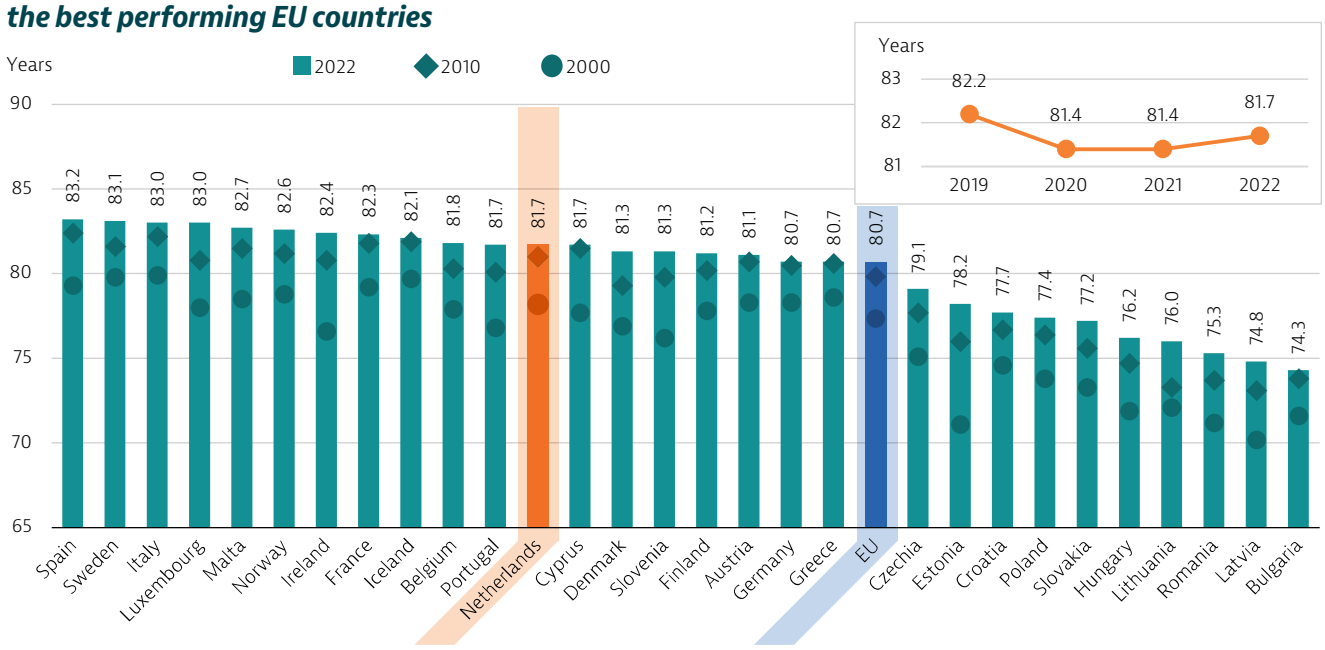
2 Health in the Netherlands

Life expectancy in 2022 was 6 months lower than before the COVID-19 pandemic

In 2022, life expectancy at birth in the Netherlands was 81.7 years, positioning it in the middle range among EU countries and surpassing the EU average by one year (Figure 1). In the decade prior to the COVID-19 pandemic, life expectancy in the Netherlands increased at a slightly slower rate than in other EU countries with similar levels in 2010. By 2019, life expectancy in the Netherlands had surpassed the EU average by almost a year. The onset of the COVID-19 pandemic resulted in a 0.8-year drop in life expectancy in 2020, aligning with the decline observed on average across the EU. In 2021, life expectancy in the Netherlands remained flat against the backdrop of a further 0.3-year average decline across the EU. Reflecting a sizeable reduction in COVID-19 mortality in 2022, life expectancy in the Netherlands rebounded by 0.3 years. Against this backdrop, in 2022 the life expectancy of the Dutch population was still 6 months below its pre-pandemic level.

As in other European countries, men in the Netherlands generally have shorter lifespans than women. However, the gender gap in life expectancy in 2021 was 2.5 years narrower than the EU average, owing to the comparatively low life expectancy of Dutch women, which was 0.2 years below the respective EU average. The legacy of higher smoking rates in previous generations is partly responsible for Dutch women's relatively low life expectancy. While smoking rates among Dutch men have declined since the 1950s, smoking rates among women climbed during the 1960s.

Figure 1. Life expectancy in the Netherlands is one year above the EU average, but over one year below the best performing EU countries

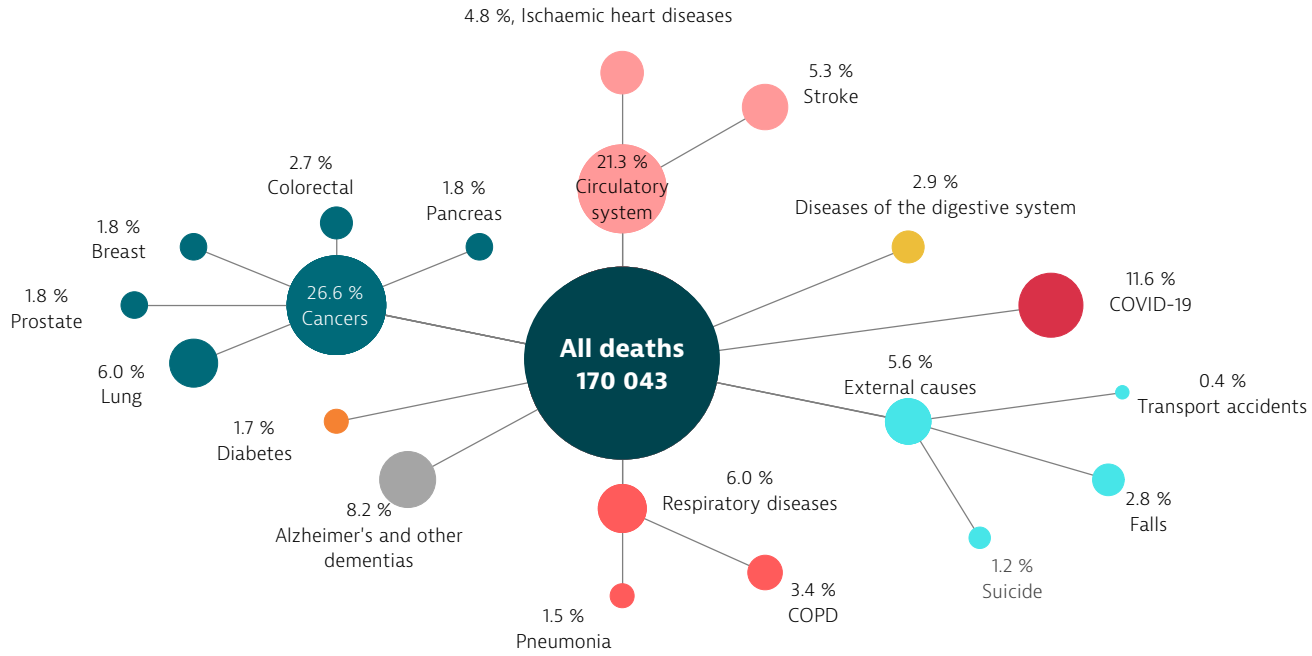


Notes: The EU average is weighted. Data for Ireland refer to 2021.
Source: Eurostat Database.

Cancer accounted for over one fourth of all deaths in the Netherlands in 2021

Life expectancy gains witnessed in the Netherlands throughout the decade before the pandemic are primarily attributed to reductions in mortality related to circulatory diseases – particularly cerebrovascular diseases and, to a lesser extent, cancer. Against the backdrop of an ageing population and the consequent rise in the incidence of chronic conditions, in 2021 cancer was the leading cause of death in the Netherlands, accounting for 26.6 % all deaths. Diseases of the circulatory system ranked second, being responsible for over a fifth of all fatalities. In 2021, COVID-19 was the third most prevalent cause of death in the Netherlands, accounting for over 19 600 deaths or 11.6 % of the total (Figure 2) – a comparable figure to the number of officially reported COVID-19 deaths in 2020. Of all COVID-19 deaths recorded in the Netherlands in 2020 and 2021, over 90 % occurred among individuals aged 65 and older.

Figure 2. COVID-19 was responsible for over one in every 10 deaths in 2021

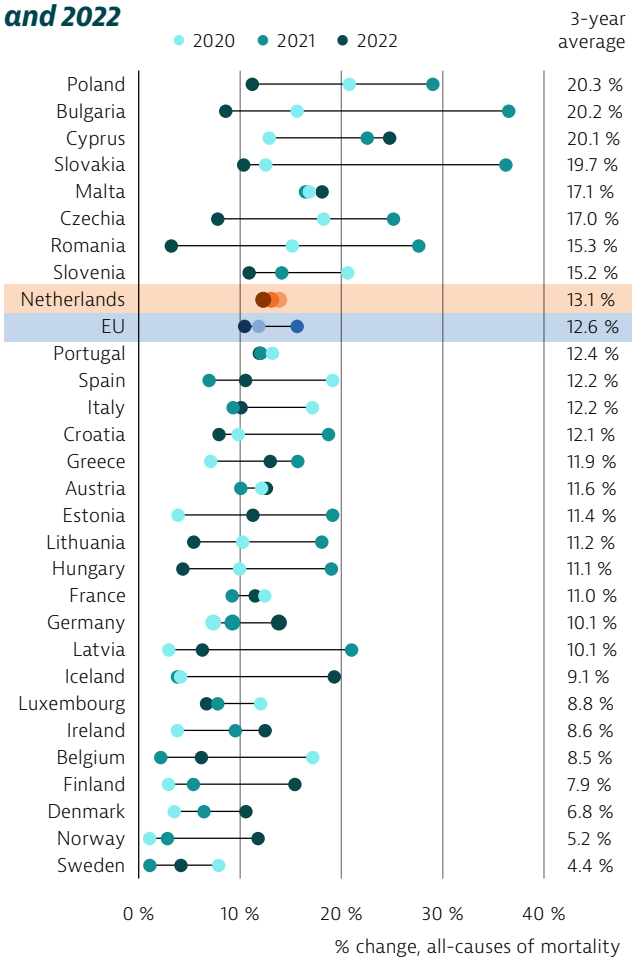


Note: COPD refers to chronic obstructive pulmonary disease.
Source: Eurostat Database.

The broader indicator of excess mortality, defined as deaths occurring (regardless of their cause) above a baseline derived from pre-pandemic levels, provides a more comprehensive picture of the pandemic's mortality impact. The more than 58 900 excess deaths that occurred in the Netherlands between 2020 and 2022 account for a level 13.1 % above their historic baseline, which is slightly higher than the average excess mortality observed on average in the EU during the same period. Throughout the first three years of the pandemic, excess mortality in the Netherlands showed comparatively minimal fluctuations, peaking at 13.8 % in 2020 and slightly declining in both 2021 and 2022 (Figure 3).

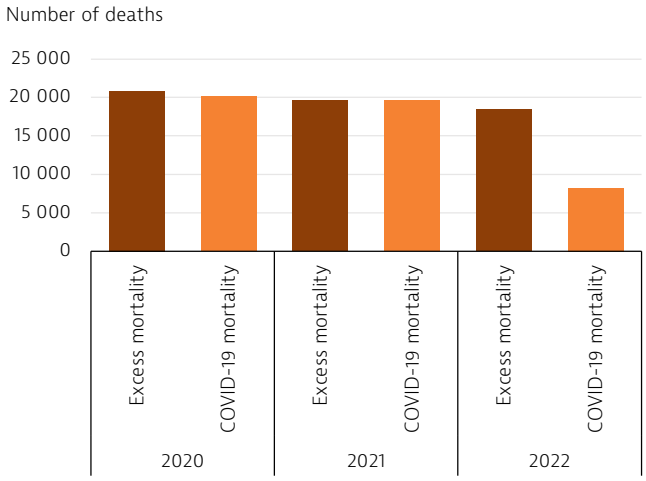
Confirmed COVID-19 fatalities slightly exceeded the tally of excess deaths in 2020, indicating a lower occurrence of deaths from other, non-COVID-19-related causes. While excess deaths nearly equalled the number of confirmed COVID-19 deaths in 2021, in 2022 the gap between confirmed COVID-19 deaths and excess mortality widened significantly, with the latter declining only slightly as the number of confirmed COVID-19 deaths decreased by more than 50 % (Figure 4). The persistently high excess mortality in 2022 can be attributed at least partly to the return, after two years of near-absence, of a severe flu epidemic extending from March to June, followed by another flu wave beginning in mid-December 2022 (CBS, 2023a).

Figure 3. Excess mortality in the Netherlands peaked in 2020 and declined marginally in 2021 and 2022



Note: Excess mortality is defined as the number of deaths from all causes exceeding the average annual number of deaths in the five years preceding the pandemic (2015-19).
Source: OECD Health Statistics 2023, based on Eurostat data.

Figure 4. Despite a substantial decline in COVID-19 deaths in 2022, excess mortality decreased only slightly



Note: Excess mortality is defined as the number of deaths from all causes above the average annual number of deaths over the previous five years before the pandemic (2015-19).
Sources: CBS (for COVID-19 mortality) and OECD Health Statistics 2023, based on Eurostat data (for excess mortality).

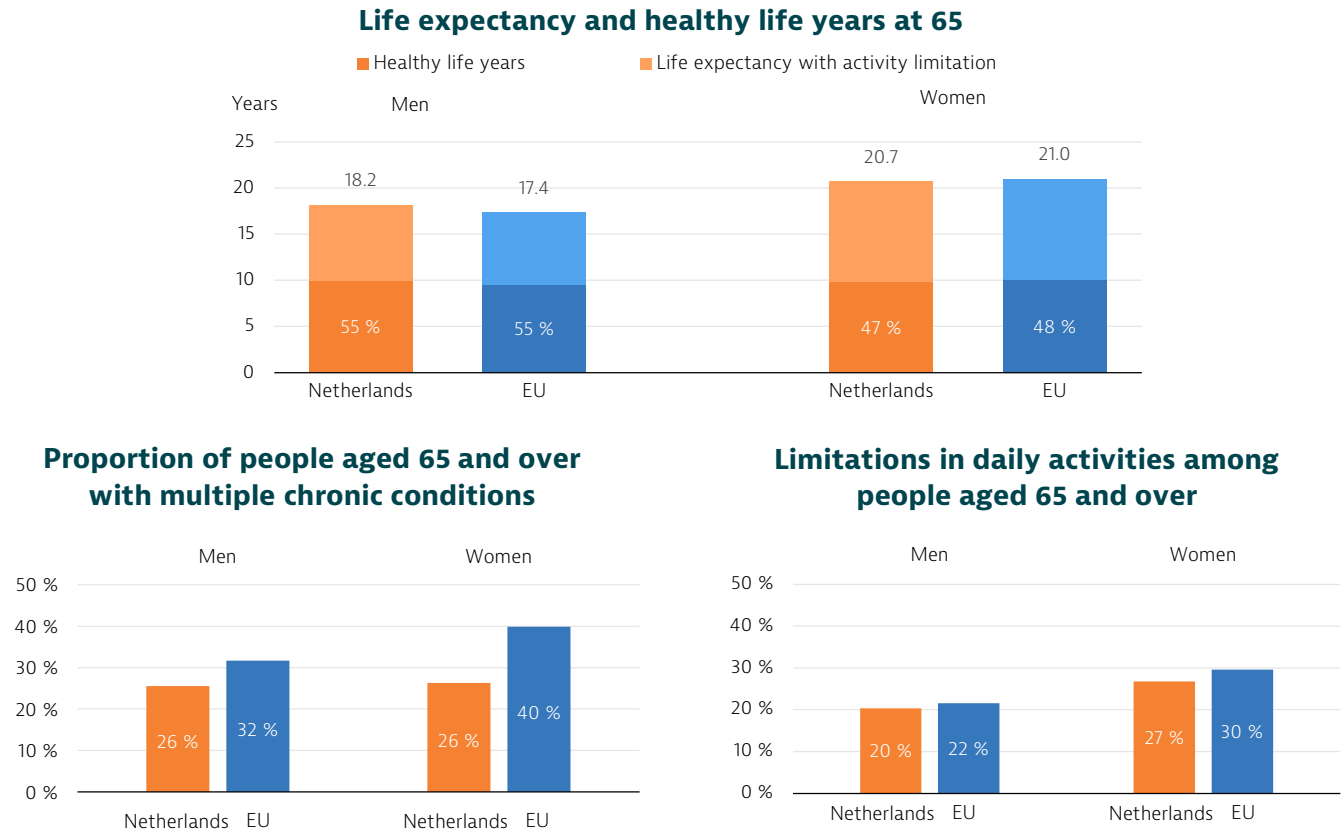
Women live a greater portion of their lives after age 65 with disabilities

Due to the combination of increasing life expectancy, a fertility rate below the replacement level and the ageing baby-boom generation, the share of people aged 65 and over in the Netherlands has grown from 13.6 % in 2000 to 19.8 % in 2020. This share is projected to increase to more than one in four by 2050.

In 2020, women in the Netherlands at age 65 were projected to live for another 20.7 years – slightly below the EU average, while men at the same age had a life expectancy of 18.2 years – slightly above the EU average (Figure 5). Women were expected to live less than half of their remaining years of life free from disabilities and activity limitations –for men this was 55 % . As a result of women being expected to live longer and spend a smaller portion of their remaining lives without disabilities compared to men, the gender gap in healthy life years at 65 was nearly non-existent.

In 2020, an equal proportion of Dutch men and women aged 65 and over reported having more than one chronic condition (26 %). This figure was considerably lower than the EU average (32 % among men and 40 % among women). However, a higher proportion of women in the Netherlands reported experiencing limitations in daily activities (27 % compared to 20 % of men), as is also the case in other EU countries.

Figure 5. Fewer older people in the Netherlands report having chronic conditions than the EU average

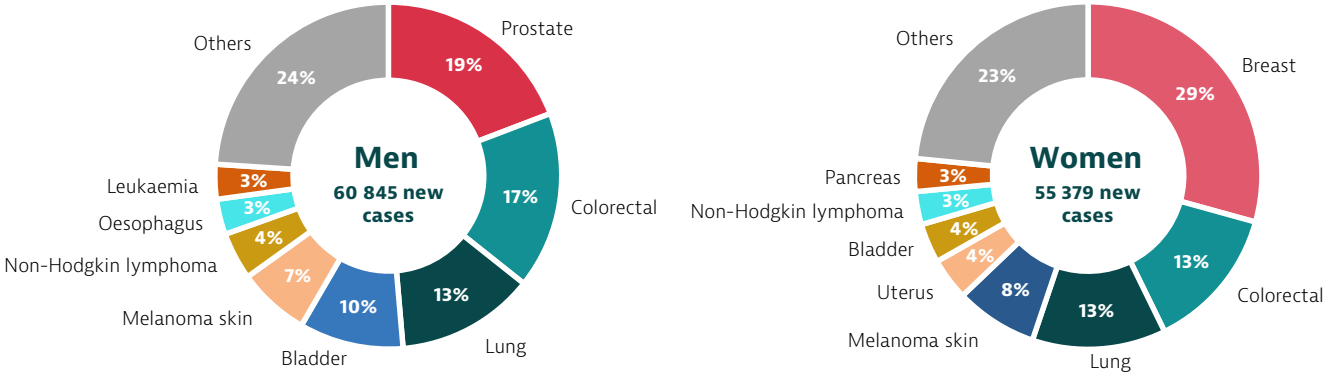


Sources: Eurostat Database (for life expectancy and healthy life years) and SHARE survey wave 8 (for multiple chronic conditions and limitations in daily activities). All the data refer to 2020.

The burden of cancer in the Netherlands is considerable

According to incidence estimates from the Joint Research Centre based on historical trends, about 116 200 new cancer cases were expected to have arisen in the Netherlands in 2022.[1] Cancer incidence among Dutch men was expected to be about 20 % higher than among women, a gap that was nearly half the EU average. This smaller difference reflects a comparatively higher projected cancer incidence among Dutch women, which exceeded the EU average by over 20 %, while the cancer incidence rate among Dutch men stood at less than 4 % above its EU average. Prostate cancer was projected to be the single most common cancer site among men, comprising nearly one fifth of all new cancers in 2022. For women, breast cancer was expected to account for nearly 30 % of all new cancer cases. Both among Dutch men and women, colorectal and lung cancers were anticipated to be the second and third most frequent cancer sites (Figure 6).

Figure 6. Over 116 000 new cancer cases in the Netherlands were estimated in 2022



Age-standardised rate (all cancer): 710 per 100 000 population
EU average: 684 per 100 000 population

Age-standardised rate (all cancer): 589 per 100 000 population
EU average: 488 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

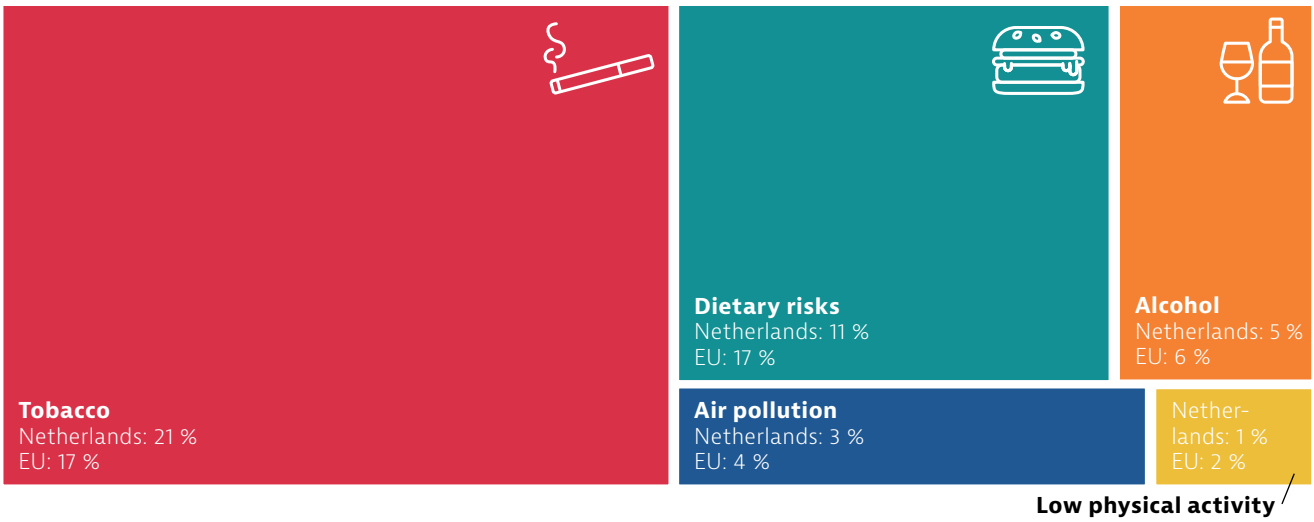
More than one third (35 %) of all deaths in the Netherlands in 2019 could be attributed to behavioural risk factors – a proportion slightly lower than the EU average of 39 %. These behaviours include smoking, dietary risks, alcohol consumption and low physical activity (Figure 7). Tobacco consumption was the main behavioural risk factor contributing to mortality in the Netherlands, responsible for over one in five deaths and surpassing the EU average of 17 %. Dietary risks, encompassing factors like inadequate fruit and vegetable intake along with high sugar and salt consumption, accounted for 11 % of deaths in 2019 – notably below the EU average of 17 %. About 5 % of deaths were linked to alcohol consumption, closely aligning with the EU average of 6 %. Environmental factors such as air pollution – in the form of exposure to fine particulate matter ($PM_{2.5}$) and ozone – accounted for nearly 5 000 deaths in the Netherlands in 2019 (or 3 % of all deaths, compared to 4 % in the EU).

Smoking in both adults and teenagers have decreased, but heavy drinking remains an issue

In the five years preceding the COVID-19 pandemic, the adult smoking rate in the Netherlands declined significantly from over 19 % in 2014 to 15.5 % in 2019, falling below the EU average of 18.7 %. This accomplishment can be attributed, at least in part, to the implementation of stricter tobacco control measures that commenced in 2015, which aim to achieve a smoke-free generation by 2040 (RIVM, 2023). The downtrend continued during the pandemic, with smoking rates reaching 14.7 % in 2021 following the introduction of increased tobacco taxation, plain packaging and other

1 *According to preliminary data from the Netherlands Cancer Registry (2023), 124 109 new cancer cases arose in the Netherlands in 2022. This figure is 6.8 % higher than the estimated count by the Joint Research Centre.*

Figure 7. Tobacco use is the leading behavioural risk factor for 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.
Source: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

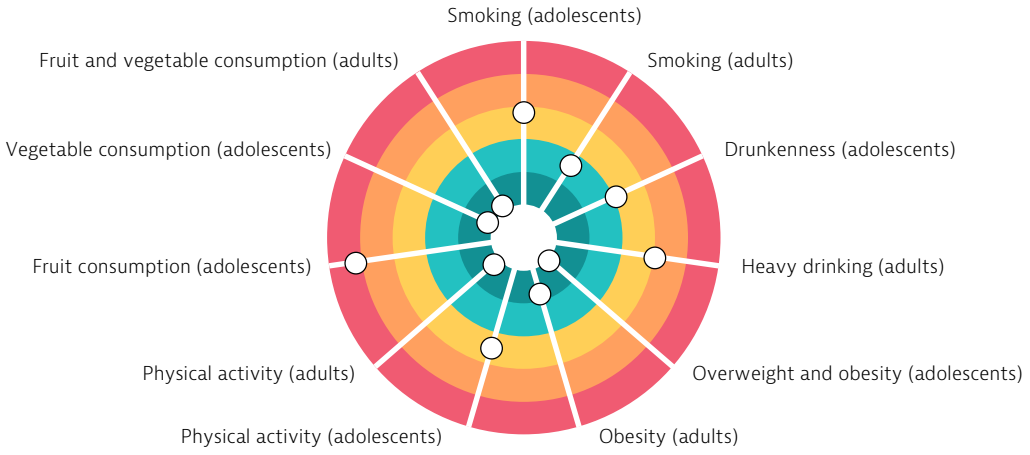
tobacco control measures in 2020 and 2021. Smoking among adolescents followed a similar pattern, with 15 % of Dutch 15-year-olds reporting regular smoking in 2022, marking a decline from the 20 % reported in 2014.

While overall alcohol consumption among adults has declined over the past two decades and is now lower than in most other EU countries, heavy drinking remains relatively high. Nearly one in five adults (19 %) reported heavy episodic drinking in 2019, a higher proportion than in most EU countries.[2] Similarly, the rate of repeated drunkenness among Dutch teenagers is comparable to the EU average, with nearly 20 % of 15-year-olds reporting having been drunk more than once in their life in 2022.

Overweight and obesity rates in the Dutch population are low, especially among adolescents

Although the prevalence of overweight and obesity in the Netherlands is low compared to most other EU countries, there has been a slight increase in obesity rates among adults over the past decade. In 2021, nearly 14 % of Dutch adults were classified as obese – a higher rate than the 11.4 % recorded in 2011, but still below the EU average of 16.3 %. Likewise, among Dutch 15-year-olds in 2022, 14 % were identified as either overweight or obese. Notably, this percentage was the lowest in the EU, standing over 7 percentage points below the EU average (Figure 8).

Figure 8. The Netherlands performs relatively well on most behavioural risk factors for health



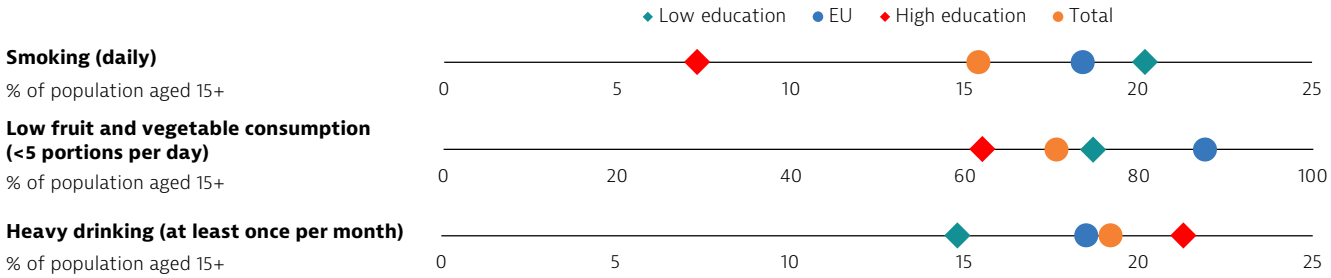
Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.
Sources: OECD calculations based on HBSC survey 2022 for adolescents indicators; and EHIS 2019 for adults indicators.

2 *Heavy drinking is defined as consuming six or more alcohol drinks on a single occasion for adults.*

People with lower education are more likely to smoke while higher educated people are more often heavy drinkers

Similar to trends in other EU countries, the prevalence of behavioural risk factors in the Dutch population varies significantly across socioeconomic groups. In 2019, 19 % of adults with lower education levels smoked daily, compared to only 7 % of those with higher education levels. People with lower educational attainment were also less likely to eat five portions of fruit and vegetables per day. Conversely, people with a higher level of education were more likely to report heavy drinking (Figure 9).

Figure 9. Dutch people with lower levels of education are more inclined to smoke and less likely to engage in regular heavy drinking



Note: Low education is defined as people who have not completed their secondary education (ISCED 0-2), whereas high education is defined as people who have completed a tertiary education (ISCED 5-8).
Source: Eurostat Database (based on EHIS 2019).

4 The health system

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

The Dutch government oversees four coverage schemes (or Acts) that collectively ensure healthcare coverage. As part of the first scheme (Health Insurance Act), competing health insurers administer an insurance system for curative care. The system, introduced in 2006, mandates all residents to purchase insurance encompassing a government-defined benefits package. Insurers are obliged to accept all applicants, engaging in negotiations and contracting with providers based on quality and cost considerations. In addition, health insurers provide voluntary, supplemental insurance care not covered in the basic package. The scope of this scheme is broad, as it covers most specialist care, primary care, pharmaceuticals and medical devices, as well as some adult mental healthcare services, allied care services and community nursing. Individuals over the age of 18 are subject to a mandatory deductible of at least EUR 385 per year. This deductible does not apply to maternity care, district nursing, care for minors and general practice care, but pertains to prescribed medications and diagnostic tests in primary care.

The second scheme (Long-term Care Act) entails a single-payer social insurance system for long-term care, which is administered regionally by the dominant health insurer in each area. This scheme covers long-term, often residential, care that should be available 24 hours a day. The third scheme (Social Support Act) is a tax-funded social care scheme implemented by municipalities and covers social care at people's home or in small-scale settings. Lastly, the fourth scheme (Youth Act) covers support, assistance and social care for children and adolescents, overseen by local authorities and encompassing a spectrum from general prevention to specialised voluntary or compulsory care. Health services are mostly provided by private non-profit providers, and most physicians are self-employed.

On top of these four schemes, the Public Health Act covers public health, prevention and control of infectious diseases. Examples include the large-scale vaccination campaign during the COVID-19 pandemic and general activities of municipal health services.

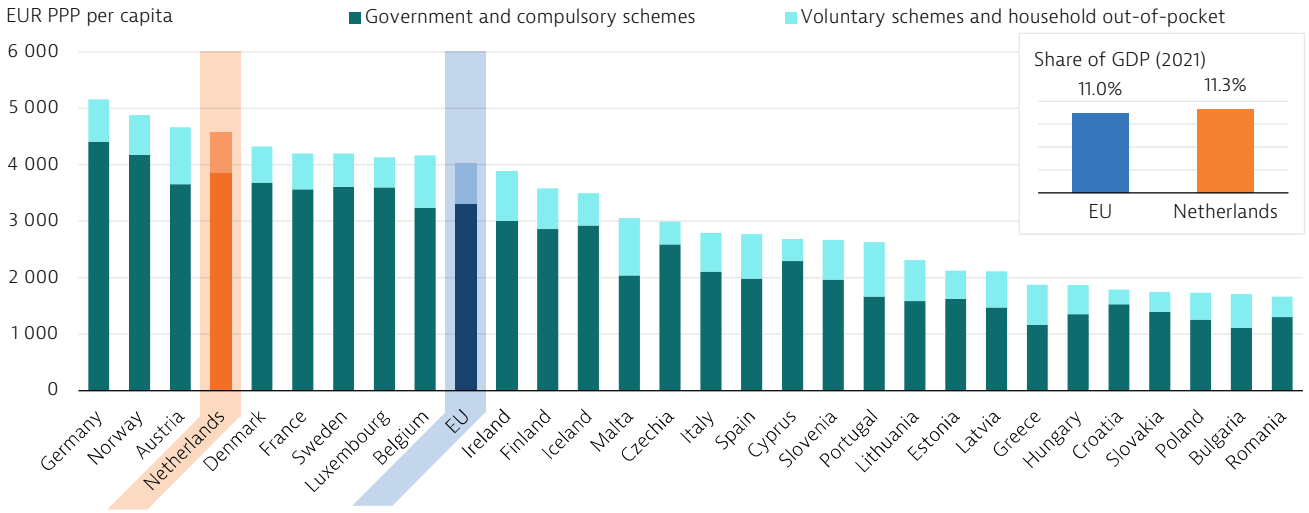
Spending on health as a share of GDP is slightly above the EU average

In 2021, health expenditure in the Netherlands reached an unprecedented 11.3 % of GDP, a level slightly above the EU average of 11 %. On a per capita basis (adjusted for differences in purchasing power), health expenditure in the country amounted to EUR 4 570, surpassing the EU average by over 13 % (Figure 10). Government and compulsory insurance schemes funded 85 % of health expenditure – a higher share than the EU average of 81 %. Between 2010 and 2019, health expenditure in the Netherlands rose by a modest average of 1.3 % annually. In 2020, health expenditure surged by 6.5 % in real terms, driven by a 9.3 % increase in public funding implemented to address the COVID-19 emergency (see Section 5.3). Concurrently, private expenditure fell by 6.8 %, reflecting disruptions in non-COVID-19 care from private providers and changes in patients' healthcare-seeking behaviour.

In 2021, health expenditure in the Netherlands experienced a second significant increase of 4.6 %, reflecting continued growth in public spending and a partial rebound in private health expenditure, as volumes of non-COVID-19-related care began resuming towards pre-pandemic levels. Despite this increase, the share of health spending financed out of pocket remained low, at 9.3 % relative to the EU average of 14.5 %. The remainder of health expenditure in the Netherlands was funded through voluntary health insurance (VHI), which covers services outside of the standard benefits package, such as adult dental care and physiotherapy and accounts for a relatively large share of total health expenditure (5.8 % in 2021 compared to 4.4 % in the EU) (see Section 5.2).

Preliminary data for 2022 indicates a slight 1.2 % rise in total health expenditure compared to 2021. This slowdown in the growth of healthcare spending can be primarily attributed to the cessation of a substantial portion of COVID-19-related expenditures incurred in 2020 and 2021 (CBS, 2023b).

Figure 10. Health spending per capita in the Netherlands is among the highest in the EU



Note: The EU average is weighted.
Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

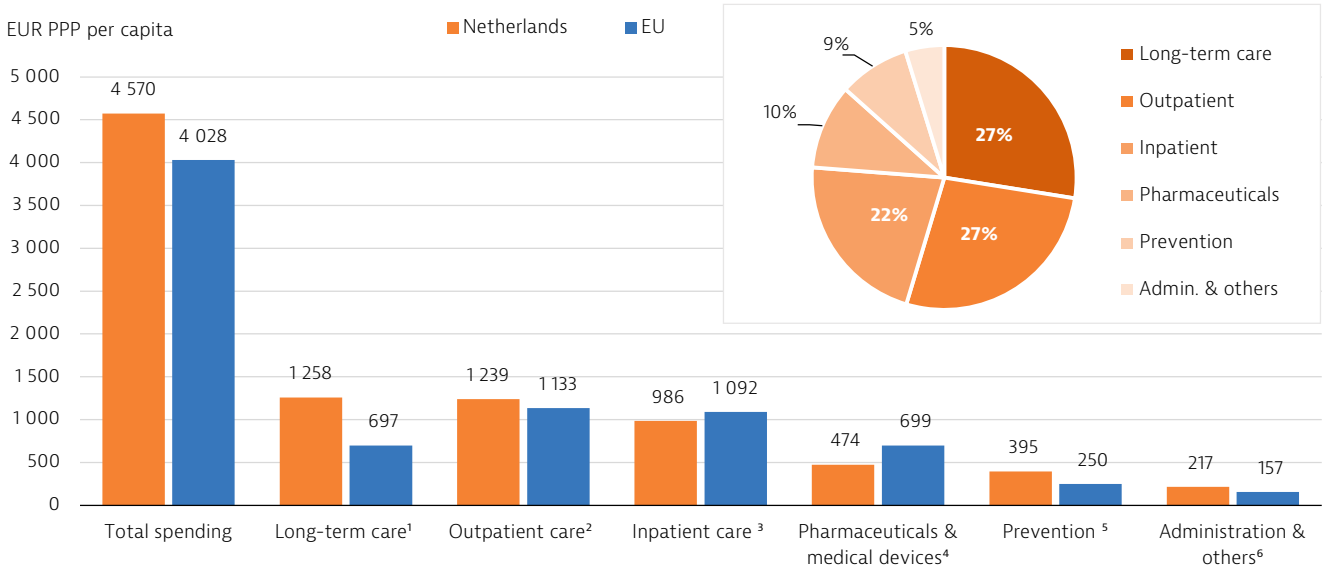
The Netherlands allocates nearly 28 % of its health budget to long-term care

In 2021, the Netherlands' expenditure on long-term care (LTC) surpassed the EU average in both per capita terms and as a proportion of its total health budget. In contrast, spending on inpatient care and retail pharmaceuticals was comparatively lower, with the latter constituting only slightly more than 10 % of overall health expenditure in contrast to the almost 18 % on average across the EU. LTC was the largest health spending category, accounting for 27.5 % of total health expenditure – the largest share in the EU (Figure 11). High LTC expenditure reflects the wide scope of coverage of the Dutch LTC scheme, which covers elderly care, care for disabled people and long-term mental healthcare.

During the COVID-19 pandemic, the share of the Netherlands' health budget dedicated to prevention increased from 3.3 % in 2019 to 4.7 % in 2020. In 2021, expenditure on prevention more than

doubled, reaching 8.7 % of total health spending – a share above the EU average of 6 %. This increase was attributable to expenditure on COVID-19 testing, tracing and vaccines, which collectively accounted for more than two thirds of spending on preventive care in 2021.

Figure 11. Long-term care absorbs the largest share of health spending in the Netherlands



Notes: 1. Includes only the health component; 2. Includes home care and ancillary services (e.g. patient transportation); 3. Includes curative-rehabilitative care in hospital and other settings; 4. Includes only the outpatient market; 5. Includes only spending for organised prevention programmes; 6. Includes health system governance and administration and other spending. The EU average is weighted.
Source: OECD Health Statistics 2023 (data refer to 2021).

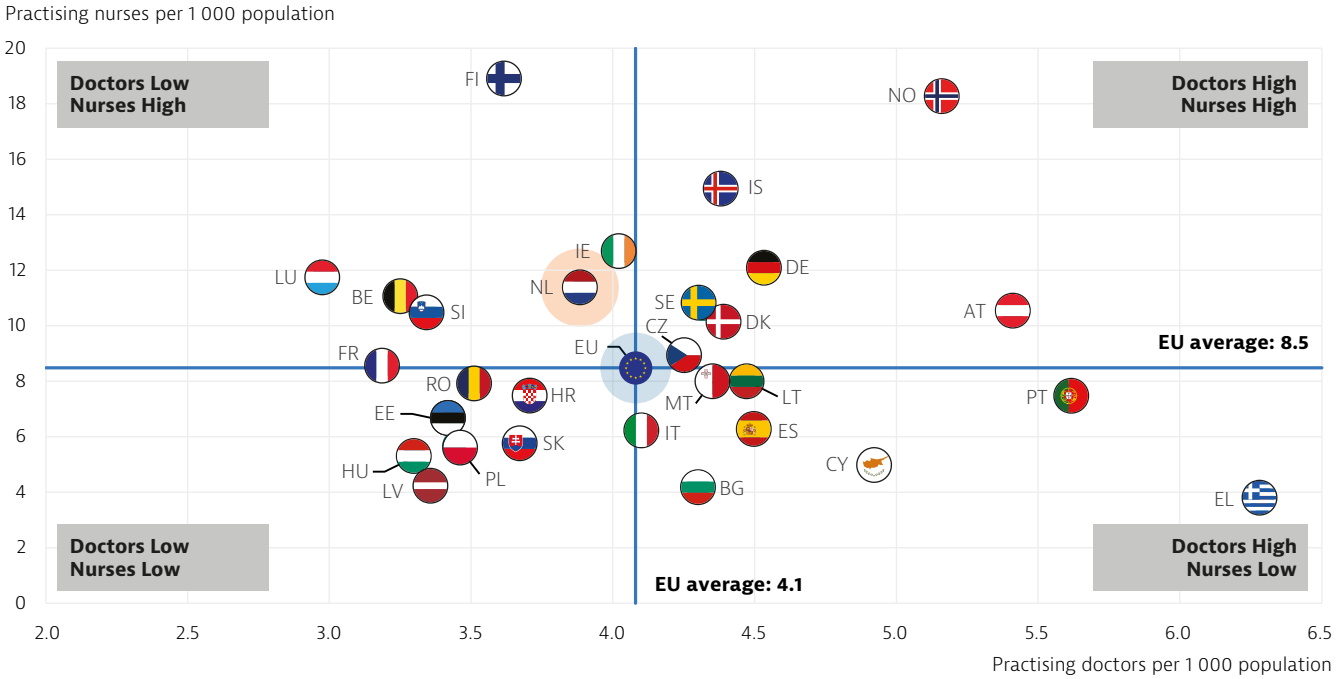
Workforce shortages worsened during the COVID-19 pandemic

In 2021, the Netherlands had 3.9 practising doctors per 1 000 population – a marginally lower density than the EU average (Figure 12). However, this represented an increase from 3.4 doctors per 1 000 population in 2010. Nearly a quarter of doctors are general practitioners (GPs) – a share that surpasses the EU average of 20 %. Against this backdrop, the Dutch healthcare system faces a scarcity of GPs, a situation projected to intensify in the coming years (RVS,2023). Shortages of doctors extend to varying degrees across other specialties as well, including psychiatry, paediatrics, addiction medicine and geriatrics, among others.

The relative number of nurses also increased in the Netherlands over the last decade, rising from 10.3 per 1 000 population in 2014 to 11.4 per 1 000 in 2021 – nearly a third higher than the EU average. A growing number of nurses in the Netherlands practice at a more advanced level and take over tasks from doctors, resulting in greater opportunities for career progression. In 2012, nurse specialists were granted the right to practice independently, a legal status that was ratified in 2018 which allows them to prescribe certain medications and perform selected non-surgical procedures (e.g. endoscopies). Despite this expansion in the availability and scope of practice of nurses, the nursing workforce within hospitals remains overstretched. Shortages of nursing and home care staff have also persisted and were further amplified during the COVID-19 pandemic.

In recent years, there has been a sharp increase in the number of healthcare workers, constituting 15 % of the total workforce, and hospitals have increasingly turned to enlisting freelance nurses to offset staffing shortages. In response to this trend, health insurers in the Netherlands called on the government to improve conditions for employees and to curb the growth of this practice due to its adverse impact on costs and care quality (ZN, 2022).

Figure 12. The Netherlands has a higher number of nurses than the EU average



Notes: The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: OECD Health Statistics 2023 (data refer to 2021 or the nearest available year).

5 Performance of the health system

5.1 Effectiveness

Preventable and treatable mortality rates remain consistently below the EU average

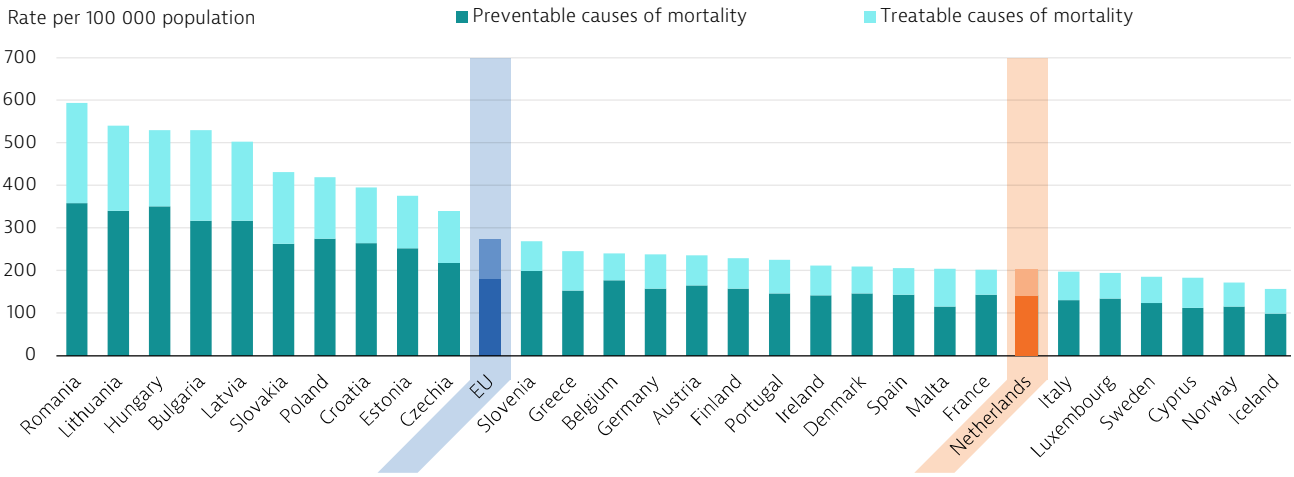
In 2020, the mortality rates from causes deemed to be preventable and treatable in the Netherlands were 21 % and 36 % lower than their respective EU averages (Figure 13). Against the backdrop of a nearly 17 % surge in the EU's preventable mortality rate in 2020, the Netherlands saw its rate increase by 14.5 %, reflecting slightly lower COVID-19 mortality among its population under 75 years of age compared to most other EU countries. The primary single causes of preventable mortality in the Netherlands were lung cancer and COVID-19, accounting for 40 % of all preventable deaths in 2020.

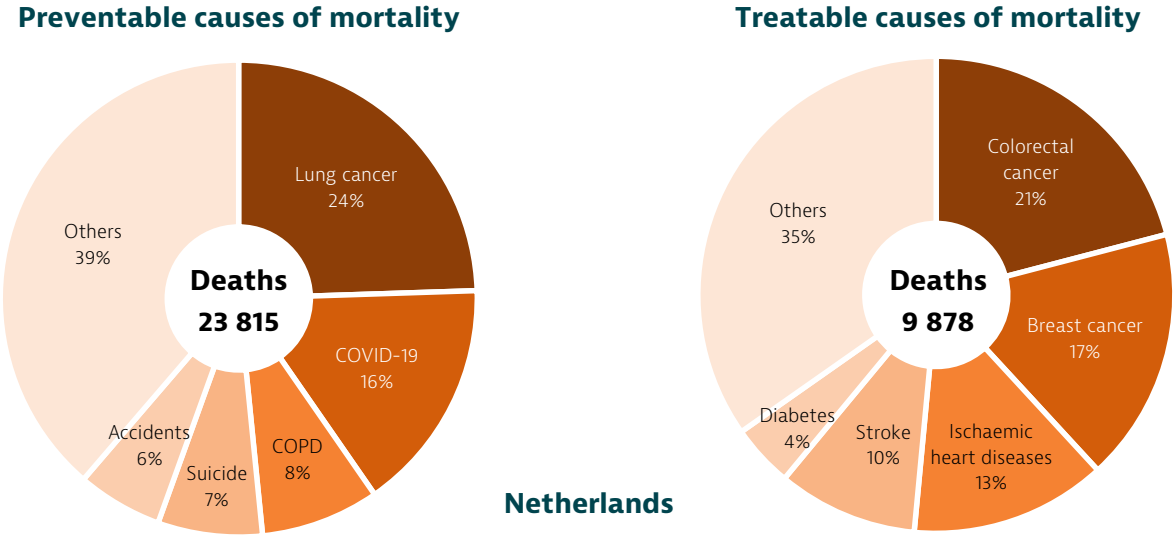
In 2020, the Netherlands had the lowest mortality rate from treatable causes in the EU. This accomplishment can be attributed to a significantly more rapid decline over the past decade compared to the EU average, largely driven by mortality reductions from ischaemic heart disease and breast cancer. Together with colorectal cancer, these conditions were the leading causes of death that could be mitigated through timely healthcare interventions, accounting for approximately half of all deaths from treatable conditions in the Netherlands.

The flu vaccination rate among Dutch people aged 65 and over increased significantly during the pandemic

As in other EU countries, Dutch health authorities have long advised older people to get the influenza vaccine, which is available free of charge from GPs for several at-risk groups, including people aged 60 and older. Throughout the last decade, the Netherlands consistently maintained a flu vaccination coverage rate among this target group that exceeded the EU average. However, its coverage rate declined significantly from a high of over 80 % in 2010 to a low of 60 % in 2018 among people of 65 years and older. The emergence of the COVID-19 pandemic contributed to reigniting interest in receiving the flu vaccine among people at higher risk of complications and hospitalisation: in 2021, the flu vaccination coverage rate for people

Figure 13. Avoidable mortality in the Netherlands was lower than in most other EU countries in 2020



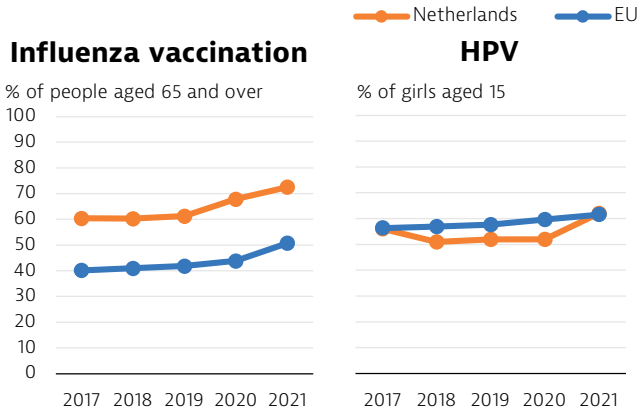


Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death. COPD refers to chronic obstructive pulmonary disease.
Source: Eurostat Database (data refer to 2020).

aged 65 and above surged to nearly 73 %, marking an increase of over 12 percentage points from 2019 (Figure 14).

In recent years, the Netherlands has also undertaken various initiatives to boost human papillomavirus (HPV) vaccine uptake among adolescent girls, resulting in an increase from 52 % in 2019 to 66 % in 2022. This figure, however, falls short of meeting the WHO target for cervical cancer eradication, which foresees achieving 90 % HPV vaccination coverage among 15-year-old girls. In 2023, the Netherlands launched a large-scale catch-up HPV vaccination campaign for people up to 18 years old. Additionally, starting in 2022 the eligibility for free HPV vaccination was extended to include adolescent boys.

Figure 14. The uptake of influenza and HPV vaccines has increased significantly in recent years



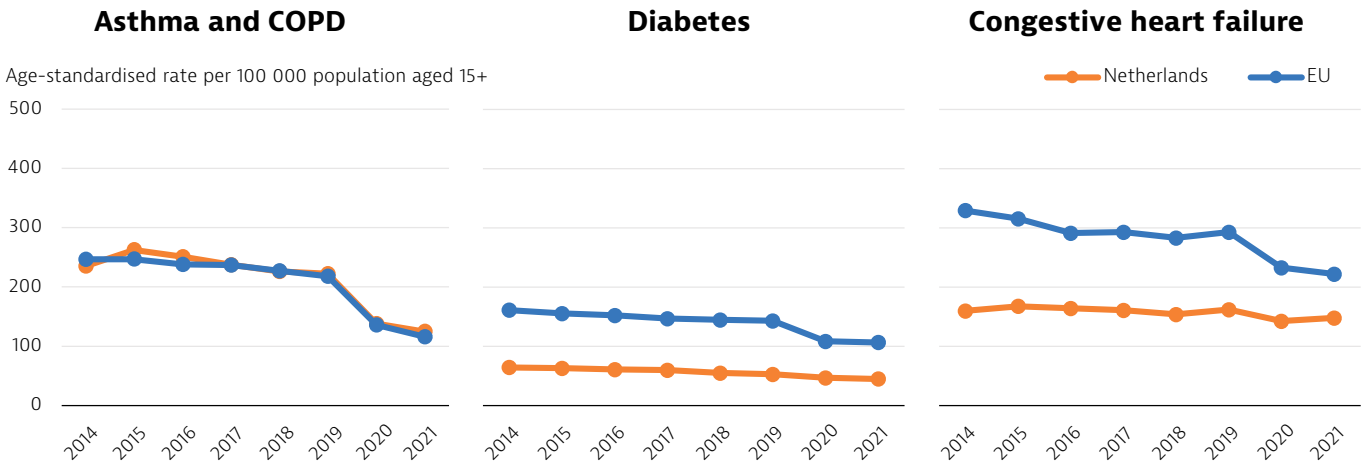
Sources: OECD Health Statistics 2023 and Eurostat Database (influenza) and WHO (HPV).

Low potentially avoidable hospitalisations attest to the quality and accessibility of outpatient care

Hospital admissions volumes for conditions that are generally manageable outside of hospital settings provide insights into the availability and effectiveness of outpatient care services. In this regard, the Netherlands performs better than most other EU countries. In 2019, its combined hospitalisation rate for diabetes, congestive heart failure (CHF), asthma and chronic obstructive pulmonary disease (COPD) was nearly 29 % below the EU average. While admission rates for diabetes and CHF were significantly lower than their respective EU averages, rates for asthma and COPD had been on a par with the EU average in recent years (Figure 15). To some extent, relatively high hospitalisation rates for asthma and COPD in the Netherlands reflect the notable prevalence of these conditions, which affected over 6 % of the Dutch population in 2021 (VZinfo, 2021).

The large decline in hospital admissions for asthma and COPD observed between 2019 and 2021 should be interpreted in the context of the disruption caused by COVID-19, which severely impacted the capacity of hospitals to provide acute care and altered patients' healthcare-seeking behaviour (see Section 5.3). These declines cannot therefore be understood as indicative of improved accessibility or quality of care for these chronic conditions in outpatient settings.

Figure 15. Except for asthma and COPD, avoidable hospital admissions rates are notably lower than the EU average



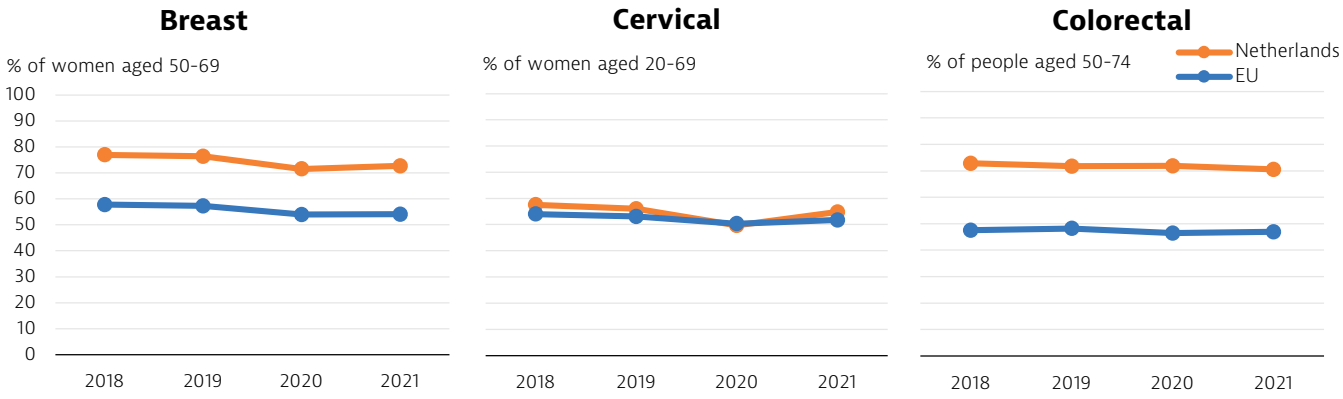
Note: Admission rates are not adjusted for differences in disease prevalence across countries.
Source: OECD Health Statistics 2023.

The impact of the COVID-19 pandemic on cancer screening services was limited

As in most other EU countries, the pandemic-induced reconfiguration of health services had a negative impact on cancer screening programmes in the Netherlands (OECD, 2023). Screening was temporarily halted in March 2020 and gradually resumed in late June. As a result, breast cancer screening rates declined by four percentage points to 72 % in 2020. As screening volumes picked up in 2021, the rate partially recovered to 73 % in 2021 – below pre-pandemic levels, but notably above the EU average (Figure 16). Cervical cancer screening rates experienced a more significant drop of over six percentage points in 2020, but rebounded in 2021 close to pre-pandemic levels. In contrast, the colorectal cancer screening rate was minimally affected, owing to an earlier resumption of screening activities and the use of the faecal immunochemical test, which does not require in-person visits to healthcare facilities.

The combined effect of disruptions to cancer screening, reduced GP availability and patients' hesitancy to consult GPs at the height of the pandemic was reflected in the number of new cancers diagnosed in the Netherlands in 2020, which declined for the first time in a decade by 5.6 % compared to 2019 (IKNL, 2023). Following the significant rebound in cancer screening activities in 2021, the number of new diagnoses climbed by nearly 8 % year-on-year. Preliminary data on the observed incidence of cancer from 2022 indicates a continued increase at a rate in line with the decade-long trend, suggesting a substantial resolution of the diagnostic backlog from 2020.

Figure 16. COVID-19 had a limited impact on routine cancer screening programmes in the Netherlands



Note: Rates refer to the share of individuals within the target groups who have undergone screening in the last two years (or within the specific screening interval recommended in each country)
Source: OECD Health Statistics 2023 (based on national programme data).

5.2 Accessibility

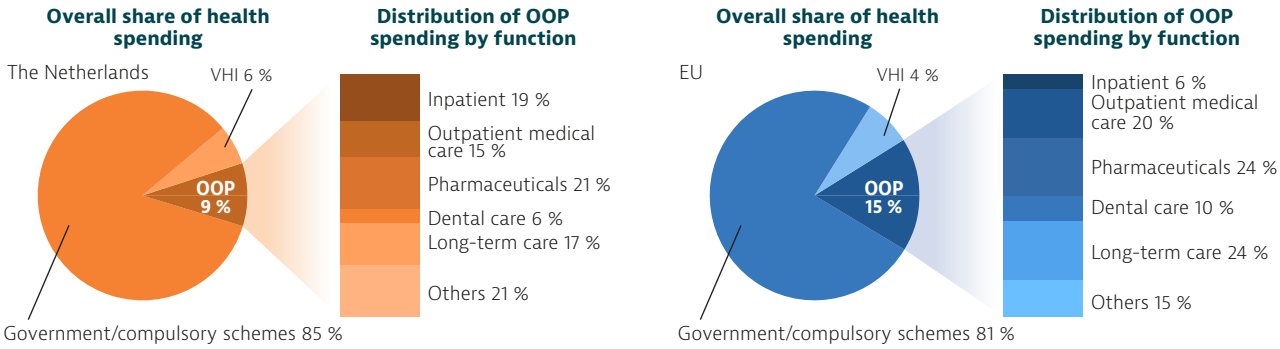
Unmet needs for medical care in the Netherlands are the lowest in the EU

In 2022, only 0.2 % of the Dutch population reported unmet needs for medical care either due to excessive costs, travel distance or waiting times – the lowest proportion across EU countries and equal to the proportion reported before the pandemic in 2019. A slightly higher proportion of Dutch women reported unmet needs compared to men, with excessive waiting times being the primary driver for both genders. The Dutch healthcare system's below-average reliance on out-of-pocket (OOP) spending for funding is reflected in the distribution of unmet medical needs reported across income groups, with virtually no difference between the proportion of individuals in the top and bottom 20 % income brackets experiencing them.

Fixed deductibles and a comparatively large voluntary health insurance sector limit out-of-pocket health spending

As noted in Section 4, the financing mix of the Dutch healthcare system stands out, with an above-average proportion of spending funded through VHI and a low share of OOP expenditure. A large part of OOP spending relates to the cost for care subject to the mandatory yearly deductible of EUR 385 – which policyholders can opt to increase to EUR 885 to reduce their premium. As a result, the distribution of OOP expenditure across services differs notably from the EU average. In 2021, dental care absorbed a relatively small proportion of OOP spending, which can be attributed to the widespread adoption of complementary VHI among the Dutch population. A similar pattern was observed with OOP spending on brand-name pharmaceuticals, which is capped at EUR 250 per patient annually on top of the insurance deductible (Figure 17). Conversely, inpatient care accounted for 19 % of total OOP spending – a share over three times the EU average. To reduce the financial barrier for accessing hospital care and retain the deterrent effect of the deductible in disincentivising unnecessary care use among individuals liable for their full deductible upfront, in 2025 the Dutch government plans to introduce a fixed threshold of EUR 150 per specialist care service (Government of the Netherlands, 2023a).

Figure 17. Inpatient care and pharmaceuticals account for 40 % of out-of-pocket health spending

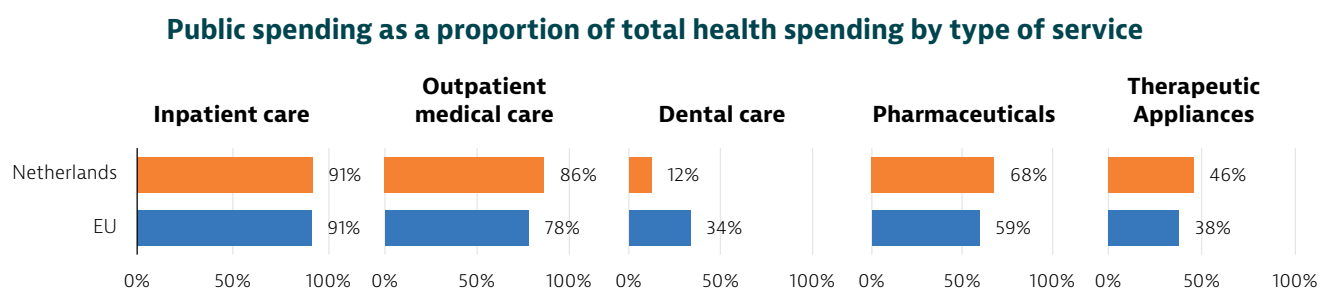


Notes: VHI also includes other voluntary prepayment schemes. The EU average is weighted.
Sources: OECD Health Statistics 2023; Eurostat Database (data refer to 2021).

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

Virtually the entire Dutch population (99.9 %) benefits from health insurance that encompasses a wide range of services. The benefits package includes primary care, outpatient specialist care, hospital care, maternal services, physiotherapy for chronic illness, mental health services and ambulance transport. In 2021, public spending accounted for 91 % of inpatient care, 86 % of outpatient care and 68 % of pharmaceuticals. These rates align with or surpass their respective EU averages (Figure 18). As dental care for adults falls outside of the scope of the standard benefits package, nearly 60 % of the Dutch population purchase supplementary VHI for dental care (CBS, 2022c). Only 0.1 % of the Dutch population reported unmet needs for dental care in 2022 – a markedly lower share than the EU average of 2.9 %.

Figure 18. The public share of financing is higher than the EU average across all areas of healthcare, except dental care



Notes: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines and medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices.
Source: OECD Health Statistics 2023 (data refer to 2021).

5.3 Resilience

The COVID-19 pandemic has proved to be the most significant disruption to health systems in recent decades. It has shed light on the vulnerabilities and challenges within countries' emergency preparedness strategies and on their ability to provide healthcare services to their populations. In response to the enduring effects of the pandemic – as well as other recent crises, such as cost-of-living pressures and the impact of conflicts like the war against Ukraine – countries are implementing policies to mitigate the ongoing impacts on service delivery, invest in health system recovery and resilience,[3] improve critical areas of the health sector and fortify their preparedness for future shocks.

Following a decline of over 13 % in 2020, hospital admissions recovered partly in 2021

Hospital capacity in the Netherlands is lower than in most other EU countries, owing in part to effective outpatient care and strict gatekeeping at the primary care level. In line with the general EU trend, hospital bed density decreased steadily in the decade preceding the COVID-19 pandemic, falling from 4.0 beds per 1 000 inhabitants in 2010 to 3.0 per 1 000 in 2019 – significantly below the EU average of 4.9 per 1 000. This trend reversed in 2021, when bed capacity in Dutch hospitals increased marginally from 2.9 beds per 1 000 people in 2020 to 3.0 per 1 000 in 2021. Throughout the past decade, hospital admission rates consistently ranked among the lowest in the EU. Bed occupancy rates stood at approximately 10 % below the EU average, with substantial efficiency gains achieved through patient transfers between hospitals.

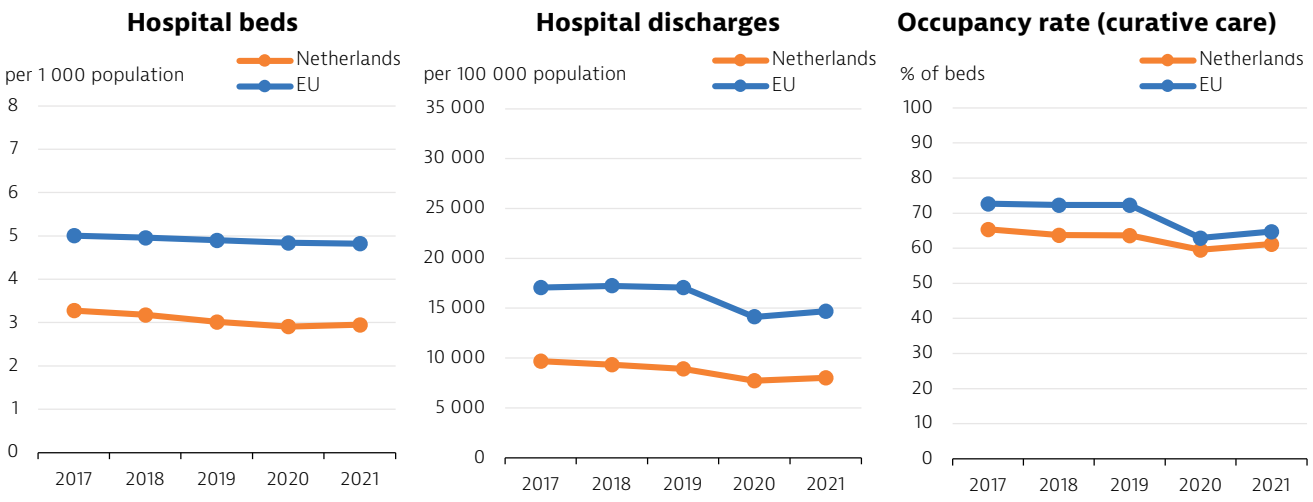
In response to the surge in demand for acute care prompted by the pandemic, the Netherlands took various measures in 2020 to expand its general hospital bed capacity and intensive care unit (ICU) capacity, which increased temporarily by over 20 % compared to 2019. To minimise the risk of hospital outbreaks and establish a resource buffer of beds, personnel and equipment, substantial volumes of non-urgent, planned hospital services were postponed.

These contingency measures resulted in sizeable declines in both inpatient discharges (by over 13 %) and average bed occupancy rates (by 6.4 %)

3 *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).*

between 2019 and 2020 (Figure 19). The magnitude of declines in hospital discharges varied markedly across diagnostic categories. Cancers (-5 %) and cardiovascular diseases (-8 %) saw the smallest year-on-year declines, while infectious diseases (-27 %) and non-COVID-19 respiratory diseases (-34 %) witnessed the most significant ones. By 2021, the hospital discharge rate had recovered to approximately 90 % of its 2019 level.

Figure 19. Hospital discharges in the Netherlands were roughly half the EU average in 2019

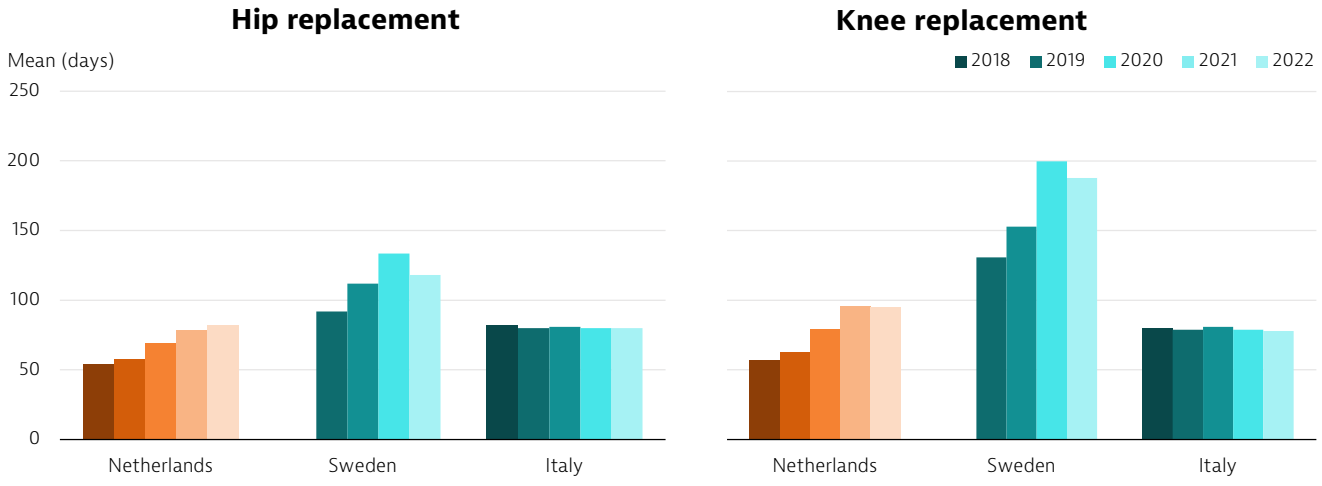


Sources: OECD Health Statistics 2023; Eurostat Database

COVID-19-related hospital disruptions increased patient backlogs for elective care

The deferral of a substantial volume of hospital activities during the pandemic had an adverse effect on waiting times for elective care in the Netherlands. The pent-up demand generated by both the reduction in elective surgical procedures and changes in referral patterns in 2020 hindered efforts to clear patient backlogs throughout 2021 and 2022, as demand rebounded strongly with the progressive restoration of elective care activities. This resulted in an increase in waiting times for planned surgeries, such as hip and knee replacement (Figure 20).

Figure 20. Average waiting times for elective surgical procedures increased during the pandemic

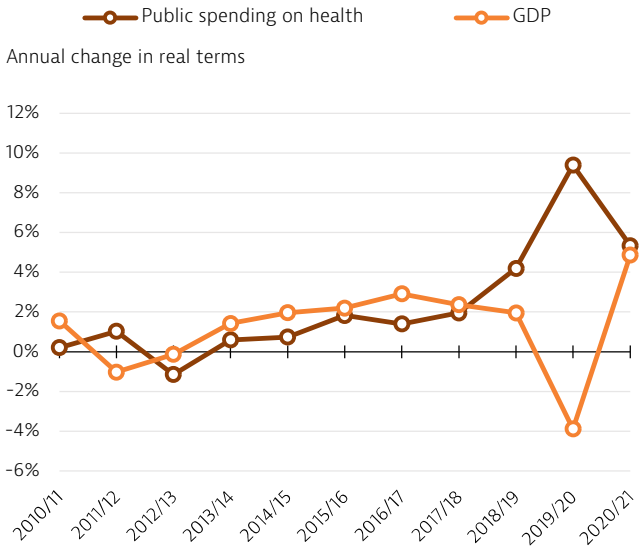


Source: OECD Health Statistics 2023.

COVID-19 responses led to significant increases in public spending on health in 2020 and 2021

Between 2010 and 2019, health expenditure financed by government and social health insurance (SHI) schemes in the Netherlands grew at an average annual rate of 1.2 % in real terms – slightly below the country's average yearly GDP growth during the same period. The COVID-19 pandemic disrupted this trend temporarily, causing public spending on health to surge by over 9 % in 2020, while GDP experienced a nearly 4 % contraction (Figure 21). As GDP rebounded strongly in 2021, public health expenditure continued rising at a more moderate rate of 5.3 %, driven in large part by COVID-19-related costs – including vaccines, tests and increased staff expenses. The magnitude of the impact of the pandemic on the Dutch healthcare system was also evident in changes to its financing mix. In the face of an increase of over 15 % in public health expenditure between 2019 and 2021, private health expenditure declined by nearly 2 %, driven primarily by lower spending funded through VHI. In 2021, 85 % of total health expenditure in the Netherlands was financed by government and Health insurers under the Health Insurance Act – the highest share in the data series available since 2000.

Figure 21. The pandemic temporarily decoupled public health expenditure and GDP trajectories in 2020



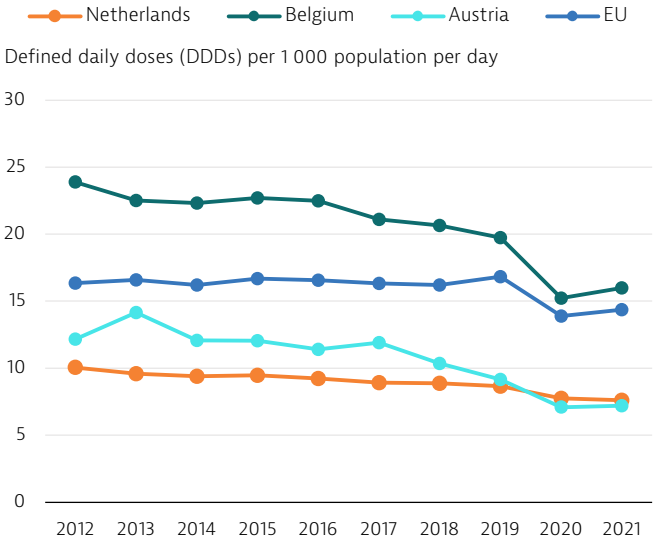
Source: OECD Health Statistics 2023.

Antibiotic consumption in the Netherlands is the lowest in Europe

Antimicrobial resistance (AMR) is a major public health concern in the EU, with estimates of approximately 35 000 deaths due to antibiotic-resistant infections and healthcare costs of around EUR 1.1 billion per year (OECD/ECDC, 2019). Because antibiotic overprescription and overuse in humans are major contributors to the development of antibiotic-resistant bacteria, antibiotic consumption data are a useful tool to evaluate the risk of AMR and the efficacy of programmes to promote their appropriate use.

In this context, the Netherlands outperforms all other EU countries, boasting the lowest total antibiotic consumption rate in the EU in 2021. In the past five years, antibiotic consumption in the Netherlands decreased at an average rate of 3.8 % per year. This rate was only moderately slower than the EU average, despite the fact that the Netherlands' total antibiotic consumption was already less than half the EU average in 2016. This achievement reflects the country's longstanding commitment to enforcing stringent regulations and guidelines to curtail inappropriate prescribing. In 2021, antibiotic consumption in the Netherlands was 49 % below the EU average. This decline was primarily driven by prescriptions in community settings, which account for over 90 % of total antibiotic consumption. The COVID-19 pandemic played a significant role in reducing antibiotic consumption in the community, with the Netherlands experiencing a decline of over 12 % between 2019 and 2021 (Figure 22). This decline is in large part attributed to pandemic containment measures resulting in fewer infections.

Figure 22. Outpatient antibiotic use declined at a rate more than double the EU average over the past decade



Note: Data only include antibiotic consumption in the community (outpatient).
Source: ECDC ESAC-Net.

The Dutch Recovery and Resilience Plan will support development of national health data infrastructure in the coming years

The Dutch healthcare system is set to receive a funding boost in the upcoming years as part of the Netherlands' Recovery and Resilience Plan (RRP), a pivotal element of the EU's response to the COVID-19 crisis. Under its RRP, the Netherlands has allocated EUR 172 million to healthcare, representing around 4 % of its total grant allocation from the EU Recovery and Resilience Fund. Of these funds, over 40 % will be directed towards developing an integrated national health data infrastructure, enabling greater use of health data for policy making, clinical and research purposes. Additionally, close to 30 % of the allocated funds will be used to cover expenses incurred by hospitals at the peak of the pandemic to expand ICU capacity. This investment aims to consolidate the enhancements made to infrastructure and staff training during this period, ultimately enhancing future pandemic preparedness. Lastly, nearly 30 % of the funds will be dedicated to establishing a national reserve of healthcare professionals and stockpiling necessary equipment to address potential future health crises.

6 Spotlight on mental health

The burden of mental ill health in the Netherlands is greater than in most other EU countries

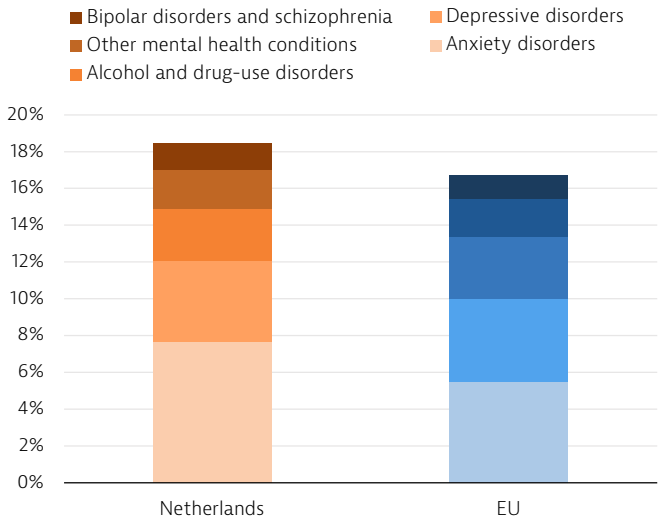
As in other countries, determining the exact proportion of the Dutch population affected by a mental health disorder at any point in time is challenging due to methodological limitations specific to mental disorders, which often result in undercounting their true burden.

According to prevalence estimates from the Institute for Health Metrics and Evaluation (IHME), over three million individuals in the Netherlands had a mental health disorder in 2019, representing 18 % of the population – higher than the EU average of 16.7 %. Among these, anxiety disorders were the most prevalent, affecting around 8 % of the population. Depressive disorders followed, at 4 %, while alcohol and drug-use disorders affected 3 % of the population (Figure 23). During the COVID-19 pandemic, a significant increase in symptoms associated with mental health issues was observed, particularly among women aged 15-24 (Bosmans et al., 2022).

Depression tends to be more prevalent among those on lower incomes and women

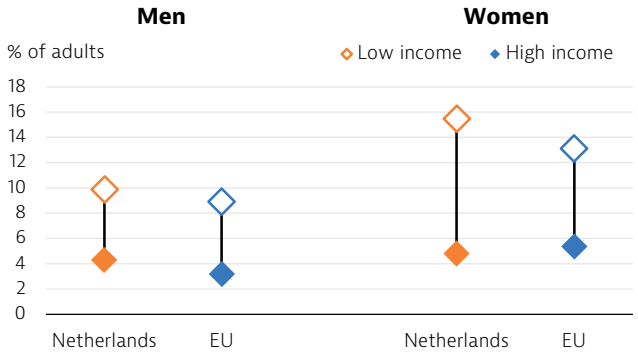
According to survey data from 2019, more than 8 % of the Dutch population reported experiencing depression – a slightly higher share than the EU average of 7.2 %. Similar to other EU countries, men in the Netherlands reported lower rates of depression (7.2 %) than women (9.3 %). However, the gender gap was noticeably narrower than the average reported across EU countries. As in other EU countries, individuals with lower incomes were more likely to report depression, with nearly 10 % of men and 15.5 % of women in the lowest income quintile compared to only 4.3 % of men and 5.3 % of women in the highest quintile (Figure 24). These findings align with the results of Nemesis-3, a national prevalence study which reported a similar pattern for the 12-month prevalence of depressive disorder (ten Have et al., 2023). The study also found that Dutch people in employment typically reported lower levels of depression, and that individuals with mental health disorders were more likely to be unemployed.

Figure 23. More than one in six people in the Netherlands had a mental health issue in 2019



Source: IHME (data refer to 2019).

Figure 24. Differences in depression prevalence by income were greater among Dutch women compared to the EU average



Note: High income refers to people in the top income quintile (20 % of the population with the highest income), whereas low income refers to people in the bottom income quintile (20 % of the population with the lowest income).
Source: Eurostat Database (based on EHIS 2019).

General practitioners serve as gatekeepers for accessing mental health services

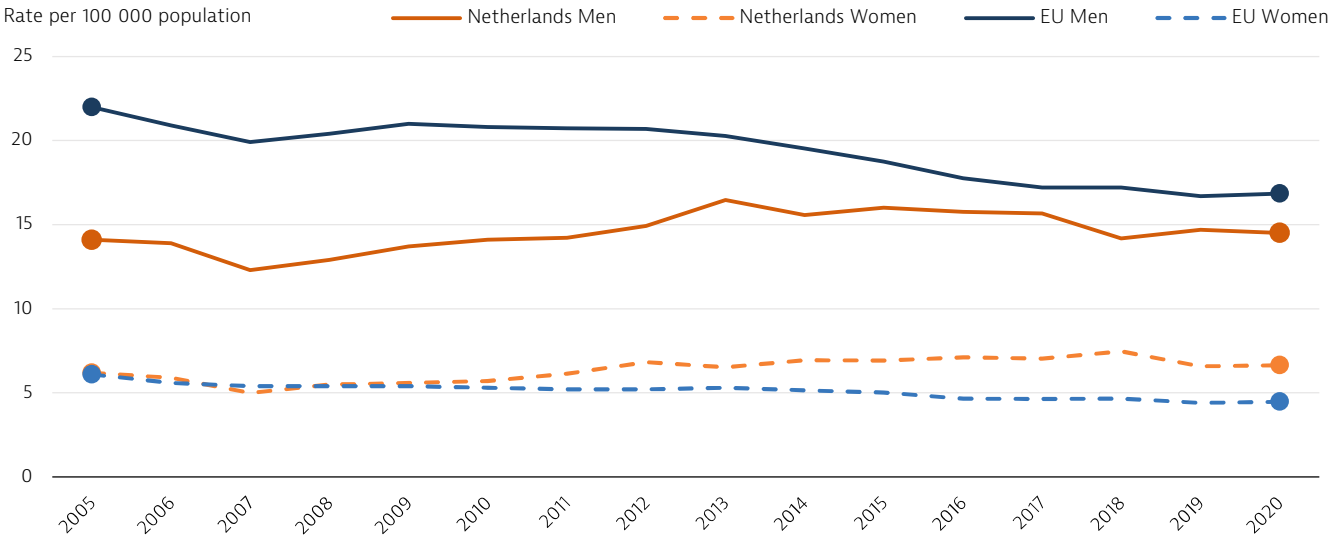
In 2014, the Dutch mental healthcare system underwent a reform to introduce a stepped-care model for mental health services. Under this framework, GPs are the initial point of contact for most patients, and act as gatekeepers to more advanced mental health services. Approximately 80 % of primary care facilities are equipped with specialist mental health nurses, who offer diagnostic assessments, short-term treatment, longer-term support and guidance and therapeutic counselling. The second step of care involves basic mental healthcare provided by psychologists, psychotherapists, social-psychiatric nurses and nurse specialists. The third level of specialist mental healthcare services consists of treatment from highly specialised professionals, often within a multidisciplinary team operating in mental healthcare institutions.

The basic benefits package provided by SHI covers the costs for GP-based and ambulatory mental healthcare. The costs of inpatient care provided by mental healthcare institutions or psychiatric departments of general hospitals are also covered, but they are subject to the mandatory deductible stipulated by the Health Insurance Act (see Section 4). Cost-sharing arrangements for severe patients with long-term conditions is regulated by the provisions of the Long-term Care Act.

Suicide rates in the Netherlands increased slightly in the past decade

Suicide is significant public health problem across the EU, including in the Netherlands. In 2021, suicide accounted for 1.15 % of all deaths in the country, and it was the main cause of death among Dutch people under the age of 30. The factors contributing to suicide are complex, but extensive research and clinical practice have established that mental health problems play a substantial role as risk factors for suicide. In 2020, the suicide rate in the Netherlands stood at 10.48 per 100 000 population, marginally above the EU average of 10.24 per 100 000. As in other EU countries, suicide rates in Netherlands are characterised by a marked gender split, with higher incidence among men. Between 2016 and 2020, the average suicide rate among Dutch men was more than double that among women (Figure 25).

Figure 25. The Netherlands' suicide rate exceeded the EU average in 2016



Source: Eurostat Database.

In contrast to the declining trend observed across the EU, over the past decade deaths by suicide in the Netherlands increased by nearly 5 %, reflecting a surge of nearly 17 % in Dutch men's suicide rate between 2010 and 2013 which was followed by a gradual decline, as well as a gradual increase in Dutch women's suicide rate until 2018, when it was the fifth highest in the EU. Preliminary mortality data for 2022 indicates that the Netherlands' suicide rates increased by 3 % compared to 2019, with a larger increase for men (4.2 %) than for women (3.0 %). (CBS, 2023c).

Long waiting times undermine timely access to specialist mental health services

The Dutch mental healthcare system is struggling to meet rising demand for mental healthcare in the aftermath of the COVID-19 pandemic, owing to limited care capacity and a persistent scarcity of mental health professionals. In 2022, over 60 % of patients referred to specialist mental healthcare waited more than the four-week threshold for an initial consultation, and 30 % waited longer than the 10-week maximum for receiving treatment. As of December 2022, nearly 84 000 people in the Netherlands were on a waiting list for mental health services – approximately the same number as in December 2021 (NZA, 2023).

Aside from insufficient care capacity, an inquiry by the Dutch Court of Auditors (2020) found that waiting times were exacerbated by perverse financial incentives, as the established fixed payment scheme between mental healthcare providers and insurers incentivised the former to prioritise patients with less severe conditions.

Waiting times are more severe for child mental health services, with multidisciplinary mental health institutions facing shortages of psychiatrists, fragmented governance and high staff turnover (SER, 2021).

The government is taking steps to address the mental health patient backlog

In 2021, the Dutch government issued a plan to address long waiting times for mental healthcare through better co-operation among healthcare providers, GPs, municipalities and healthcare insurers. The plan requires the largest mental healthcare providers that fail to meet the maximum statutory waiting times to coordinate an intra-regional patient transfer mechanism. Through this mechanism, providers with the longest average waiting times are responsible for redirecting patients to providers with available treatment capacity within their region. Together with a revamped remuneration system for mental healthcare providers, this initiative is expected to reduce the persistent mental health backlog of patients in the forthcoming years. In 2022, the Dutch government took further steps to formulate an additional plan to promote mental well-being among young people, the working population and vulnerable groups (Box 1).

Box 1. The Netherlands launched a new mental well-being initiative in 2022

Recognizing the pressing need to strengthen mental health services in the aftermath of the COVID-19 pandemic, in 2022 the Dutch government introduced the Good Mental Health for All action plan. This outlines a range of measures aimed at enhancing public awareness of mental health, improving the availability of mental health services and support systems, and facilitating the early detection of mental health issues. Building on the groundwork laid by previous prevention programmes, the action plan is structured around five core areas, which focus on fostering mental well-being within society, local communities, educational institutions, workplaces and online. Each of these domains outlines specific objectives, such as the expansion of accessible walk-in facilities at the municipal level, the establishment of collaborative ventures with sports organizations targeting vulnerable populations, and the introduction of a pilot program to prevent burnout among healthcare professionals. The proposed actions will be continually monitored and revised based on their implementation progress.

Source: Government of the Netherlands (2023b).

7 Key findings

- In 2022, life expectancy at birth in the Netherlands stood one year above the EU average at 81.7 years, reflecting gains in line with the EU average in two decades preceding the COVID-19 pandemic and a slightly below-average decline throughout the pandemic years. Cancers and diseases of the circulatory system were the most common causes of death in 2021, collectively accounting nearly half of all deaths, while COVID-19 was responsible for over one in every ten fatalities. Between 2020 and 2022, excess mortality in the country stabilised around 13 % above pre-pandemic levels, declining only marginally following its peak in 2020.
- The prevalence of behavioural risk factors was linked to more than a third of all deaths in the Netherlands in 2019 – a share slightly below the EU average. In recent years, new tobacco control measures led to reduced smoking rates in the country, which now stand below the EU average. While alcohol consumption declined over the past two decades and is lower than in most other EU countries, heavy drinking remains prevalent, with almost 20 % of Dutch adults reporting regular heavy consumption in 2019.
- Between 2019 and 2021, health spending in the Netherlands rose by over 12 % in real terms, in large part due to increased spending from government and social health insurance required to address the COVID-19 crisis. In 2021, health expenditure constituted 11.3 % of GDP – slightly above the EU average – but in per capita terms it was the third highest in the EU after Germany and Austria. Nearly 28 % of health spending was allocated to long-term care, which exceeded the EU average both in per capita terms and as a share of total health spending. Private sources contributed to 15 % of total health spending, which is below the EU average of 19 %.
- In 2021, the Netherlands had a slightly lower density of doctors compared to the EU average, while the density of nurses was higher. Although the share of doctors working as general practitioners is slightly above the EU average, the Dutch healthcare system faces a shortage of general practitioners, which is projected to intensify in the coming years. Shortages of nurses in hospitals also emerged during the pandemic, which saw a concomitant rise in the number of nurses opting for self-employment as a means to obtain better working conditions.
- The Netherlands outperformed most EU countries in averting mortality from generally preventable and treatable causes in 2020, with mortality rates 21 % and 36 % below their respective EU averages. The pandemic adversely impacted cancer screening programmes in the Netherlands, yet its impact was comparatively limited. Following a decline in new cancer diagnoses in 2020, screening activity rebounded in 2021 and 2022, with observed incidence rates suggesting a substantial clearance of the diagnostic backlog accumulated in 2020.
- The prevalence of mental health disorders in the Netherlands is higher than the EU average, with an estimated 18 % of the population affected in 2019. Depression rates were higher among Dutch women, whereas men were more than twice as likely to die by suicide than women. Suicide remains a public health concern in the Netherlands, constituting over 1 % of deaths in 2021 and rising slightly over the past decade in contrast with the EU trend. As demand for specialist mental health services increased in the aftermath of the pandemic, an insufficient supply of mental health professionals resulted in waiting times that consistently surpass the established threshold for a large share of patients. In 2021, the Dutch government rolled out an action plan to alleviate waiting lists for specialist mental healthcare through an intra-regional mechanism of patient transfers.

Key sources

OECD/EU (2022), Health at a Glance: Europe 2022 – State of Health in the EU Cycle. Paris, OECD Publishing, https://doi.org/10.1787/507433b0-en

European Observatory on Health Systems and Policies, Netherlands, Health Systems and Policy Monitor, https://eurohealthobservatory.who.int/monitors/health-systems-monitor/countries-hspm/hspm/netherlands-2016

References

Bosmans M et al. (2022), Kort-cyclisch Cijferoverzicht gezondheidsmonitor COVID-19: 4e gegevensrapportage jeugd (April-Juni 2022) [Overview of figures, COVID-19 health monitor].

Central Bureau of Statistics (CBS)(2023a), Excess mortality for the third consecutive year in 2022.

Central Bureau of Statistics (CBS)(2023b), Care expenditure up by 1.2 percent in 2022.

Central Bureau of Statistics (CBS) (2023c), General Database.

Dutch Court of Auditors (2020), Mental healthcare: the bigger the problem, the longer the waiting list.

EU Expert Group on Health Systems Performance Assessment (HSPA) (2020), Assessing the resilience of health systems in Europe: an overview of the theory, current practice and strategies for improvement.

Government of the Netherlands (2023a), Proposal for a smarter use of health insurance deductible in medical specialist care.

Government of the Netherlands (2023b), "Good Mental health for All" Action Plan.

Health Behaviour in School-aged Children study (2023), Data browser (findings from the 2021/22 international HBSC survey): https://data-browser.hbsc.org

Health and Youth Care Inspectorate (IGJ) and the Dutch Healthcare Authority (Nza) (2022), Problems due to shortage of staff in care and youth care.

Integraal Kankercentrum Nederland (IKNL) (2023), Cancer incidence data repository.

Netherlands Cancer Registry (NCR) (2023), Cancer incidence estimates https://iknl.nl/projecten/de-impact-van-de-covid-19-uitbraak

OECD (2023a), EU Country Cancer Profile: Netherlands 2023.

OECD/ECDC (2019), Antimicrobial resistance: Tackling the burden in the European Union.

RIVM (National Institute of Public Health) (2023), Towards a smoke-free generation: Options to make cigarettes less appealing and addictive.

RVS [Council of Public Health & Society] (2023), De Basis op orde. Den Haag: Raad voor Volksgezondheid & Samenleving [The basics in order. The Hague: Council for Public Health & Society]

SER, Social and Economic Council of the Netherlands (2021), Youth care: from systems to people https://www.ser.nl/-/media/ser/downloads/adviezen/2021/van-systemen-naar-mensen.pdf

Ten Have M et al., Prevalence and trends of common mental disorders from 2007-2009 to 2019-2022: results from the Netherlands Mental Health Survey and Incidence Studies (NEMESIS), including comparison of prevalence rates before vs. during the COVID-19 pandemic.

VZinfo (2021) – Prevalence estimates for asthma and COPD by the National Institute of Public Health. https://www.vzinfo.nl/astma and https://www.vzinfo.nl/copd

ZN [Health Insurers Netherlands] (2022), Letter to the Parliamentary Commission for Health, Welfare and Sports. https://assets.zn.nl/p/32768/none/huisarts/ZN-brief%20commissiedebat%20Arbeidsmarkt%20in%20de%20zorg_20220701%20(002).pdf

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 2023

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2023 edition of the Country Health Profiles provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- For the first time in the series, an account of the state of mental health and related services within the country.

Complementing the key findings of the Country Health Profiles is the Synthesis Report by the European Commission.

For more information, please refer to: ec.europa.eu/health/state

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