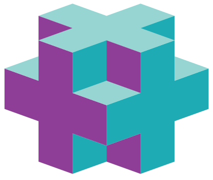

Partnership for Health System Sustainability and Resilience

THE NETHERLANDS

EXECUTIVE SUMMARY

Sustainability and Resilience in the Dutch Health System

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INTRODUCTION

The Dutch health system provides broad universal health care coverage and is based on the principles of regulated competition. According to the OECD[1], it is one of the best health systems in the world with regard to access to health care, equity and clinical outcomes. However, as also concluded by the Netherlands Scientific Council for Government Policy[2] (WRR, 2021), as with other health systems, it faces important sustainability and resilience challenges, some of which were exposed and exacerbated during the COVID-19 pandemic.

The full report is based on desk research and serves two audiences. First, it provides an international audience with a broad overview of the Dutch health system. Second, it contributes to the national policy debate on how to improve the sustainability and resilience of health care in the Netherlands.

Sustainability concerns a health system's ability to improve population health, by continually delivering the key functions of providing services, generating resources, financing and stewardship, incorporating principles of financial fairness, equity in access, responsiveness and efficiency of care, and to do so in an environmentally sustainable manner.

Resilience refers to a health system's ability to prepare for, absorb, adapt to, learn, transform and recover from crises born of short-term shocks and accumulated stresses, in order to minimise their negative impact on population health and disruption caused to health services.

The report provides a comprehensive overview of the Dutch health system's key features across the seven domains of the PHSSR framework:

- Governance
- Financing
- Workforce
- Medicines and technology
- Service delivery
- Population health
- Environmental sustainability.

For each of these domains, the report aims to:

1. Produce a critical assessment of the country's most salient strengths, weaknesses and threats regarding the sustainability and resilience of its health system
2. Derive recommendations for health care policy.

In addition to the seven domains, the full report presents two case studies with accompanying recommendations. The first focuses on the resilience of the Dutch health system to the financial shock caused by the COVID-19 pandemic. The second examines whether collaboration (aimed at reducing coordination problems and facilitating integrated health care) and competition are reconcilable in the Dutch health system.

We hope the report, including the non-exhaustive set of recommendations, will be a useful starting point for a fruitful dialogue with stakeholders including current and former policy makers, health system researchers, health economists, patients and physicians.

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[1] OECD, Health at a Glance: Europe 2022, Paris: OECD Publishing, Paris, 2022 https://doi.org/10.1787/507433b0-en

[2] WRR, Kiezen voor houdbare zorg: mensen, middelen en maatschappelijk draagvlak, WRR Rapport 104, Wetenschappelijke Raad voor het Regeringsbeleid, Den Haag,2021 www.wrr.nl/adviesprojecten/houdbare-zorg

Findings

Key themes for sustainability and resilience

DOMAIN 1: **GOVERNANCE**

Sustainability

Strengths

- Access to care, solidarity and high-quality health care services are ensured through four basic health care acts.
- Various government agencies have delegated responsibility to ensure adherence to the key principles underlying the Dutch health system

Weaknesses

- Due to decentralised responsibilities and highly autonomous health care organisations, a lack of coordination and collaboration hampers innovation.
- The interplay of four different health care acts results in conflicting interests and misalignment of financial incentives.

Resilience

Strengths

- During the COVID-19 pandemic, public and private interests were initially successfully aligned but this later changed.

Weaknesses

- In the absence of a decisive central authority, the national crisis structure is not fully capable of tackling a health care crisis.

DOMAIN 2: FINANCING

Sustainability

Strengths

- Funding of the Dutch health system is ensured through mandatory social health insurance premiums and taxation.
- Redistribution (i.e., from healthy to sick, young to old and rich to poor) is built into the financing of health care.
- Everyone has access to universal comprehensive coverage and out-of-pocket payments are low.
- Over the past 10 years, spending growth has been effectively contained due to national stakeholder agreements regarding annual restrictions on expenditure.

Weaknesses

- Health care spending, both as a share of GDP and as euros per capita, is relatively high.
- Health care insurers have few incentives to invest in improving care for people who are chronically ill because those insured are insufficiently compensated by the current system of risk equalisation.
- Health care insurers are legally required to reimburse most of the costs of care offered by non-contracted providers; this hampers financial sustainability.
- Within long-term care, financial incentives are not well aligned across national government, health care insurers and municipalities.

Resilience

Strengths

- The financial challenges of the COVID-19 pandemic were effectively addressed by a combination of structural provisions (i.e., the catastrophic cost compensation clause in the Health Insurance Act) and ad-hoc measures.

Weaknesses

- The various measures taken to absorb the financial shock caused by the COVID-19 pandemic were unnecessarily complex and market distorting (see Case study 1).

DOMAIN 3: WORKFORCE

Sustainability

Strengths

- Long term workforce planning is high on the political agenda and government programmes have a positive effect on labour shortages in the health care sector.
- A variety of policy measures have been announced to substantially invest in health care workforce sustainability.

Weaknesses

- Across health care sectors (GPs, home care, hospitals, nursing homes), labour shortages are substantial and persistent.
- The payment of higher salaries, aimed at improving health care workforce sustainability, is at odds with the public goal of financial sustainability.
- The benefits of innovative labour-saving medical technologies are not fully utilised.
- A substantial growth in self-employed medical professionals is causing problems, such as higher spending on payments for health care workers.

Resilience

Strengths

- The COVID-19 pandemic encouraged the use of e-health and other new technologies which contribute to effectively alleviating the workload of clinicians (see also Domain 5).
- In 2020 and 2021, all health care workers received an extra bonus payment from the government.
- As part of the broader pandemic preparedness programme, a National Health Reserve (i.e., regional communities of former health professionals) will be formalised as a public task.

Weaknesses

- At the start of the COVID-19 pandemic, in particular, the Dutch government failed to protect health care workers from SARS-CoV2 infection, which contributed to a much higher workload.

DOMAIN 4: MEDICINES AND TECHNOLOGY

Sustainability

Strengths

- Effective price regulation and tendering for low-priced preferential generic drugs by health care insurers together with reluctant prescription behaviour by physicians make pharmaceutical spending in the Netherlands among the lowest within the OECD.
- Universal and relatively fast access to new in-patient drugs and innovative health technologies are guaranteed for the Dutch population through the open system basic benefit package of the social health care insurance scheme which ensures almost automatic eligibility for reimbursement.
- The sluice system for expensive innovative in-patient medicines – requiring a cost-effectiveness analysis before being approved for reimbursement from social health insurance – in combination with collective price negotiations at the national level, mitigates the rapid growth of expenditure on these medicines.

Weaknesses

- For both medicines and technology, the social health insurance scheme's basic benefit package open system threatens financial sustainability.
- Low prices for generic medicines make the Netherlands relatively unattractive to pharmaceutical suppliers and, thus, vulnerable to supply shortages.
- A lack of information regarding the relationship between prices and the production costs of expensive new medicines renders it difficult to establish whether the prices paid are actually 'socially acceptable' and cost-effective.
- In contrast to other hospital services, effective budgetary restrictions on the utilisation of expensive new drugs are lacking.
- Increasing expenditure on expensive medical technology and health technology with a high budget impact poses a risk to financial sustainability, particularly as new medical and health technologies are often not cost-effectively implemented.

Resilience

Strengths

- Following the lessons learned during the COVID-19 pandemic, the government's agenda on pandemic preparedness includes several policy measures aimed at improving access to and supply security for essential drugs and medical technology.

Weaknesses

- The COVID-19 pandemic clearly revealed the vulnerability of a relatively small country with a limited domestic production capacity to safeguard a timely and sufficient supply of critical medicines and health technologies.

DOMAIN 5: SERVICE DELIVERY

Sustainability

Strengths

- The Dutch reimbursement system incentivises providers to reduce readmission rates, which contributes to declining average lengths of hospital stay.
- The quality of delivered health care services in the Netherlands is protected by quality standards embedded in several laws.
- Primary care plays an important role in the Dutch health system.
- The government-supported initiative Right Care at the Right Place (JZOJP) stimulates providers and insurers to seek ways to effectively improve health service delivery.

Weaknesses

- Current provider-insurer contracts often do not explicitly reward quality.
- A lack of supporting integrated and outcome-based payment models and the absence of a national electronic patient records system hamper potential substitution of care (e.g., shifting care from hospitals to GPs).
- A shortage of GPs in some regions threatens the sustainability of primary care provision.

Resilience

Strengths

- The temporary National Coordination Centre for Patient Distribution succeeded in distributing COVID-19 patients equally across Dutch (and some German) hospitals.
- The outbreak of COVID-19 clearly acted as a catalyst for the digitalisation (e.g., e-consultations and video calling) of Dutch health care (see also Domain 3).

Weaknesses

- The relatively low number of ICU beds in the Netherlands severely impacted health care delivery during the (first months) of the COVID-19 pandemic.
- During the first wave of the COVID-19 pandemic, in particular, almost all elective care was cancelled owing to capacity constraints and staff shortages.
- The Netherlands lacked a centralised, nationally coordinated strategy to protect and coordinate health care delivery during the COVID-19 pandemic.

DOMAIN 6: POPULATION HEALTH

Sustainability

Strengths

- Overall, most Dutch people report good health.
- In addition to its extensive vaccination programme for children, the central government initiates, organises and finances three cancer and five prenatal and neonatal population screening programmes.
- Municipalities and regional Public Health Services support policy makers and professionals by promoting the use of recognised interventions.

Weaknesses

- There are sizeable health disparities across socio-economic groups. Health risk factors, such as smoking, financial distress, (perceived) social exclusion and low health literacy, are much more prevalent among lower socio-economic groups.
- One in every five deaths in the Netherlands can be attributed to direct and second-hand smoking, which is higher than the EU average.
- Although the Netherlands has among the highest health care spending levels per capita compared to the EU average, spending on prevention as a percentage of total health expenditure has declined over the last 10 years.
- Activities aimed at health promotion and prevention are most often focused on primary prevention only.
- The National Prevention Agreement, signed in 2018 between the Dutch national government and more than 70 stakeholders, is temporary and its targets are not legally binding.

Resilience

Strengths

- In 2022, the government announced "a greater focus on prevention and on a healthy lifestyle from an early age".

Weaknesses

- Life expectancy temporarily dropped due to the COVID-19 pandemic.
- In 2020, COVID-19 was the third leading cause of death.

DOMAIN 7: ENVIRONMENTAL SUSTAINABILITY

Sustainability

Strengths

- Dutch health care organisations, similar to businesses in other sectors, are obligated by law to meet a set of basic rules and regulations regarding the environment.
- In addition to other bottom-up initiatives, in November 2022, a third Green Deal, which includes goals for improving environmental sustainability in health care, was signed by the national government and stakeholders.

Weaknesses

- Annually, a substantial quantity of pharmaceutical residue and contrast agent cause contamination of surface water.
- A more centralised strategy with a clear vision for environmental sustainability is lacking.
- Although highly relevant for the Netherlands, air quality and its effects on health are not specifically addressed in the Green Deal goals.

Recommendations

We suggest recommendations for each of the seven domains and for both case studies.

DOMAIN 1:	GOVERNANCE
1A	Introduce a centralised decisive overriding authority at the national government level to avoid situations in which conflicting stakeholder interests may obstruct the fundamental changes required to improve health system sustainability.
1B	Develop cross-sectoral payment methods within the health care sector to facilitate and incentivise coordination of care for patients who are chronically ill and in need of multiple different providers.
1C	Implement the recommendations of the Dutch Safety Board aimed at ensuring effective governance and control during a crisis, including explicitly describing overall government responsibility and giving the Minister of Health greater authority.

DOMAIN 2:	FINANCING
2A	Social health insurance coverage should be more closely tied to clinical and cost-effectiveness analyses. To this end, service offerings in the social health insurance benefits package should be continuously evaluated based on clinical effectiveness and cost-effectiveness.
2B/C	Encourage and facilitate integrated (or bundled) outcome-based payment methods across providers, sectors and financing regimes to stimulate effective collaboration among providers and insurers within the system of regulated competition (see Case study 2).
2D	Improve or augment the system of risk equalisation to eliminate predictable losses for insurers on patients who are chronically ill. To this end, new promising methods, such as constrained regression, high-risk pooling and machine learning, should be explored.
2E	Allow health insurers to reduce the level of reimbursement for non-contracted providers and specify which minimum level of reimbursement is socially acceptable.
2F	Better align financial incentives for prevention with the efficient provision of long-term care across government, health insurers and municipalities.

DOMAIN 3:	WORKFORCE
3A	A variety of factors underlie health care staff shortages. Therefore, avoid focusing on a single policy measure (e.g., higher salaries) when attempting to solve these shortages.
3B	Consider financial incentives (e.g., childcare subsidies and income tax reforms) other than higher salaries when seeking to attract and retain a health care workforce.

3C	Reduce the need to expand the health care workforce through (1) a stronger focus on provision of labour-saving 'appropriate care', de-medicalisation and prevention and (2) facilitating innovative labour-saving medical technologies, digitalisation and the use of medical devices/tools as substitutes for current care.
3D	Prioritise the process of formalising the National Health Reserve (NHR) as a public task to strengthen the resilience of the Dutch health system.

DOMAIN 4: MEDICINES AND TECHNOLOGY

4A	Maintain the open system of admitting new in-patient medicines and medical technologies into the basic benefits package. This is crucial to facilitating the adoption and use of these innovations while counteracting their cost-ineffective use.
4B	Make the Dutch 'sluice procedure' for new expensive in-patient drugs more effective (i.e., the requirement that a cost-effectiveness analysis is performed before drugs are included for reimbursement from social health insurance) and develop new pricing models for innovative high-cost drugs. This approach has proven effective in the recently proposed pricing model for anti-cancer drugs in which maximum prices reflect the clinical value of the drugs (compared to other available treatments).
4C	Retrospectively compensate manufacturers for delivering new expensive drugs during central price negotiations with the government.
4D	Introduce a system of horizon scanning to identify expensive medical technologies in clinical development that may be excessively priced or not cost-effective in order to prevent these technologies from being admitted to the basic benefit package.
4E	Adopt more systematic and transparent procedures when using Special Medical Procedures Act (WBMV) licenses to restrict the non-efficient use of new health technologies.
4F	Restrict entitlement to reimbursement from social health insurance of potentially cost-effective innovative medicines and health technologies to indications and patient groups for which cost-effectiveness has been convincingly established. Health insurers should include these restrictions in their contracts with health care providers or, in cases of uncertainty regarding cost-effectiveness, make arrangements with regard to desired outcomes or treatment duration and clearly communicate this with enrolees.
4G	Strengthen international cooperation within the EU and with other strategic international partner countries to (1) counteract the vulnerability of the health system due to its limited domestic production capacity and restricted direct access to essential raw materials, (2) gather more evidence regarding the cost-effectiveness of medical technologies and (3) maintain a level playing field for investments in R&D.

DOMAIN 5: SERVICE DELIVERY

5A	Improve the coordination of care and adjust payment models to reward multidisciplinary care (see also Domains 1 and 2).
5B	Make health care quality more transparent by improving the public availability of reliable and comprehensible quality information.

5C	Invest in a centralised, nationally coordinated strategy to improve health service delivery in times of crisis.

DOMAIN 6: POPULATION HEALTH

6A	Recognise that population health is largely determined by policies that guide actions beyond the health sector (Health in All Policies) and act upon this by not focusing exclusively on disease management and health sector programmes.
6B	Establish a national framework with legally binding measurable health goals and implement appropriate financial incentives for investing in prevention.
6C	Strengthen prevention by (1) seriously considering the use of hard measures such as a sugar tax, (2) eliminating the influence of the alcohol and food industries on health policy by not allowing their participation in the formulation of policy interventions aimed at health promotion and (3) considering the potential benefits of secondary and tertiary prevention.

DOMAIN 7: ENVIRONMENTAL SUSTAINABILITY

7A	Take responsibility for a national policy with binding goals to reduce the environmental impact of health care, together with rules and regulations for meeting these goals (e.g., reducing CO_2 emissions, improving circularity, reducing pharmaceutical residues), and establish a centralised decisive authority at the national government level to ensure that sufficient progress is made.
7B	Adopt the most recent WHO air quality standards into the Green Deal.

CASE STUDY 1: FINANCING COVID-19-RELATED HEALTH CARE COSTS

CS1	Improve the current catastrophic cost regulation for health insurers.
CS2	Consider redesigning the current method for risk equalisation between insurers to reduce vulnerability to unforeseen catastrophic health care costs.
CS3	Evaluate and reconsider financial risk-sharing between government and private stakeholders in health care during a pandemic.

CASE STUDY 2: COMPETITION AND COLLABORATION

CS4	Encourage effective collaboration between providers and insurers, while also effectively eliminating strategic anticompetitive agreements.
CS5	Monitor and evaluate the (competitive) effects of collaborations that contribute to health care transformation goals.
CS6	Continue to provide the guidance that explains how also in the health care sector collaboration and competition are, to a large extent, reconcilable with competition law.

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