The Dutch Recovery and Resilience Plan interventions on the most private-based National Healthcare System in the European Union*

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"*I think* [the Netherlands has] *a very good combination: you get to choose your private insurer, and you get to choose your primary care doctor. And their primary care doctors are really gatekeepers to a higher level of care*"

Ezekiel Emmanuel[1].

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1 See E. Klein, *Which country has the world's best health care system? Ezekiel Emanuel discusses global health care, pandemic response, and presidential leadership on The Ezra Klein Show*, 2020, https://www.vox.com/podcasts/2020/6/23/21298942/best-healthcare-germany-uk-france-the-ezra-klein-show. Ezekiel Emmanuel is a bioethicist, an oncologist, and the current co-director of the University of Pennsylvania's Health Transformation Institute, who served as a health policy adviser to former President Barack Obama.

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1. The Dutch National Private Healthcare Insurance System of "regulated competition" and the role of Municipalities

Applying Welfare State studies to health protection policy yields from three to seven healthcare system models.[2] The four major models are the Bismarck model (social health insurance), the Beveridge model (national health service) and a third model alternative to both Bismarck and Beveridge based on private health insurance and last, the out-of-pocket purchase of healthcare services. The Bismarck model was conceived as a system of social insurance whose premiums are paid into nonprofit funds against sickness. The State exercises control over the prices of health services and health providers are private (this model is typical of Germany, France, Belgium, Austria and Switzerland). Then, there is the Beveridge model (established in 1942 by Lord Beveridge in the United Kingdom), which was modelled on the UK National Health Service and which allows all patients universal access to health services regardless of their ability to pay or their employment. This model is tax-funded. Health providers (mainly hospitals) are state-run (this model is typical of the UK, Italy, Spain, Canada and Australia). The third model is based on voluntary insurance and the most typical example is given by the United States.

An important point to emphasize is that though within the same country there may be one main healthcare system model, this does not prevent the coexistence of other models on a residual or supplementary basis (multi-pillar healthcare systems). For example, health protection in the United States is mainly based on voluntary insurance, yet the Federal State still plays a key role by funding the Medicare and Medicaid programs that address children, the elderly, and low-income citizens. The *Affordable Care Act 2010* (better known as Obamacare) provides access to public insurance plans, with the US healthcare system therefore based on three pillars. In Italy, the Beveridge model does not exclude the possibility for patients to buy healthcare services on the private market and pay for them through private insurance or direct payments. In any event, since private insurance and providers are conceived as complementary and not substitutes for the National Health Service, it is still based on a single public pillar.

Considering at least the three main models listed above, it can be said that the *Netherlands Healthcare System* (NHS) has no correspondence to any of them, since it appears to be

[2] M. Terris, *The Three World Systems of Medical Care: Trends and Prospect*, in *American Journal of Public Health*, vol. 68, n. 11, 1978, pp. 1125- 1131; M. Chung, *Health Care Reform: Learning from Other Major Health Care Systems*, in *Princeton Public Health Review*, 2017, https://pphr.princeton.edu/2017/12/02/unhealthy-health-care-a-cursory-overview-of-major-health-care-systems/; F. Toth, *Non solo Bismark contro Beveridge: sette modelli di Sistema sanitario*, in *Riv. It. di Politiche Pubbliche*, n. 2, 2016, p. 279 ss.

the result of all five models being implemented at once.[3] To better understand the NHS, it would be useful to recall the studies of the American economist Alain Enthoven who sought to introduce more universal access into the US private healthcare system together with a higher level of competition: the Dutch NHS took inspiration from the Enthoven model of controlled or regulated competition.[4] The universal NHS emerges as a controlled private national insurance system regulated by the State with a public single-payer national system covering long-term care and placed under the responsibility of the Municipalities. Dutch healthcare is divided into three distinct compartments: the basic package of essential care entrusted to a mandatory private national insurance system; long-term care for disabled and elderly people, covered by a universal, decentralized and tax-funded single-payer scheme; some special residual public programs for selected categories (such as children up to the age of 18, members of the armed forces and refugees). Then there is a fourth (and fifth) segment of "supplementary" benefits (dental care, physiotherapy, alternative medicine, cosmetic surgery, etc.) which are left to the market or to voluntary insurance.

The Dutch Constitution does not provide for a right to health, but only for State responsibility for the health of its residents, by stating that "the authorities shall take steps to promote the health of the population" (Article 22, paragraph 1 Dutch Constitution). Consequently, the Constitution gives the State broad discretionary power in deciding how to organize the healthcare system. At the same time, the Dutch Constitution prevents the Courts from scrutinizing the law passed by Parliament by providing that "the constitutionality of Acts of Parliament and Treaties shall not be reviewed by the Courts" (Article 120 Dutch Constitution).[5] It is therefore ordinary Dutch legislation that provides the basis for the *NHS* on the principle of solidarity, according to which care is to be guaranteed universally, the

[3] F. Toth, *Non solo Bismarck contro Beveridge*, cit. p. 297-299, who observes that under the National Insurance Model all residents must purchase private insurance by choosing from multiple insurance companies that can be both for-profit and nonprofit. The Netherlands embraced the Bismarck model in 1941, and by 1960, the healthcare system consisted of "*private insurance for the wealthy and social insurance for the rest*", which increased health inequalities and created tension between supply and demand for healthcare, cost-containment, accessibility and the principle of solidarity. It determined the passage to the National Insurance Model by approving the *Health Insurance Act* in 2006, see T. Kuipers, R. van de Pas, A. Krumeich, *Is the healthcare provision in the Netherlands compliant with universal health coverage based on the right to health? A narrative literature review*, in *Global Health*,18, 38, 2022, p. 1, https://doi.org/10.1186/s12992-022-00831-7.

[4] A.C. Enthoven, *Introducing Market Forces into Health Care: A Tale of Two Countries*, Fourth European Conference on Health Economics, 2002, https://www.nuffieldtrust.org.uk/sites/default/files/2017-01/introducing-market-forces-into-healthcare-web-final.pdf. According to the Enthoven's National Insurance Model the State acts as a third-party regulator of the health market competition instead of as a direct purchaser of health services (as happens instead in the Beveridge model).

[5] J. Gerards, The Irrelevance of the Netherlands Constitution, and the Impossibility of Changing It, in *Revue interdisciplinaire d'études juridiques*, no. 2, vol. 77, 2016, p. 207 et seq., J. Uzman, T. Barkhuysen, M. Van Emmerik, *Netherlands: The Dutch Supreme Court: A Reluctant Positive Legislator?*, in A. Brewer-Carías, *Constitutional Courts as Positive Legislators: A Comparative Law Study*, Cambridge, Cambridge University Press, 2011, p. 645 et seq.

principle of mandatory and affordable medical insurance for all and the principle of access to high quality health services.[6]

The system refers to five fundamental laws.[7] The main laws regulating the NHS are the *Health Insurance Act* (*Zorgverzekeringswet, Zvw*) passed in 2006, which is mainly related to hospital care, and the *Health Care Market Regulation Act* (*Wet marktordening gezondheidsorg*, *Wmg*), which together with the former, provides for a system of mandatory private insurance premiums paid for by individuals that must meet certain requirements according to a national insurance system of "regulated competition".[8] Therefore, the State acts as controller of private insurers and health providers in order to guarantee the individual and public interest in the protection of health. Private insurers, which must be nonprofit, are required to accept all applicants and are financed by community-rated premiums and employer contributions. The national Government decides which health services are to be insured and monitors access, quality, and costs (mainly through independent health agencies and authorities). Standards of care are defined jointly between patient organizations, private healthcare providers and insurance companies.

Everyone is given the faculty to choose which health insurance to purchase and the mandatory basic package of healthcare benefits (including hospitals, general practitioners – GP, home nursing care, maternal care, mental health care and prescription drugs) must be insured and available to everyone regardless of one's condition of health. In addition to private financing of insurance premiums (basic health insurance for all residents over 18 costs approximately 1200 euros per year), coinsurance or copayments are required on select services and drugs according to each insurer (there are no patient cost-sharing for GP visits and preventive services).[9] Public financing is granted by general taxation (22%) and earmarked payroll taxes paid by employers (46%) for equalization purposes of the risk

[6] Healthcare Financial Management Association (HFMA), *Healthcare in the Netherlands. An overview and comparison with the United Kingdom*, 2022, p. 2, at https://www.hfma.org.uk/docs/default-source/publications/briefings/hfma-logex-netherlands-briefing.pdf?sfvrsn=814648e7_2.

[7] J. Wammes, N. Stadhouders, G. Westert, *Health system overview, Netherlands*, Report of The Commonwealth Fund, 2020 and Id., *The Dutch health Care System*, in R. Tikkanen, R. Osborn, E. Mossialos, A. Djordjevic, G. Wharton (Editors), *International Profiles of Health Care System*, 2020, p. 137 et seq., https://www.commonwealthfund.org/sites/default/files/2020-12/International_Profiles_of_Health_Care_Systems_Dec2020.pdf.

[8] See M. Kroneman, W. Boerma, M. van den Berg, P. Groenewegen, J. de Jong, E. van Ginneken, *Netherlands. Health system review*, in *Health System in Transition*, 2016, vol. 18, 2, 2016, p. 15 ss. at https://apps.who.int/iris/bitstream/handle/10665/330244/HiT-18-2-2016-eng.pdf?sequence=5&isAllowed=y.

[9] GPs are the gatekeepers of the Dutch healthcare system as they are responsible for access to all healthcare service in hospitals and outpatient care. The NHS has relatively low rates of hospital discharges (corresponding to the lowest inpatient use in the EU), suggesting that strong primary care and outpatient specialist treatment manage to keep people out of hospitals as reported in OECD/European Observatory on Health Systems and Policies, *The Netherlands: Country Health Profile 2021, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, 2021, p. 10, at https://health.ec.europa.eu/system/files/2021-12/2021_chp_nl_english.pdf. In order to maintain their registration, GPs must provide assistance in walk-in-centers between 5:00 p.m. and 8:00 a.m. for at least 50 hours per year. See HFMA, *Healthcare in the Netherlands. An overview and comparison with the United Kingdom*, cit., p. 2.

of illness.[10] General taxation is allocated toward financing health insurance for everyone under the age of 18. Low-income residents are entitled to a public health allowance, but this only covers basic healthcare, while on top of mandatory private insurance eighty-four per cent of residents also voluntarily purchase private complementary insurance to cover dental care, vision care and drug copayments (in this case management is completely private and insurance companies can refuse to take out policies with certain parties).
Another fundamental law is the *Long-term Care Act* passed in 2015 (*Wet Langdurige Zorg*) with which the Dutch Government has secured the financing for long-term care with a health program publicly funded through general taxation and administered by Municipalities (which receive unrestricted contributions from the national Government). Starting in 2015 long-term care has been regulated by the *Health Insurance Act* (for medical home care, home nursing care and mental healthcare), the *Social Support Act* (*Wet Maatschappelijke Ondersteuning, Wmo*, for additional home support and youth mental health) and the *Long-term Care Act* itself (for vulnerable elderly and disabled people).[11] Long-term care is provided mostly by private, nonprofit nursing homes and residential homes and by nonprofit and for-profit home care organizations. The *Long-term Care Act* also takes care of chronic diseases and palliative care, about which the Government is encouraging the formation of centers at the Municipal level that can provide the necessary services to respond to various types of chronicity (diabetes, asthma, cardiovascular diseases).
One of the aims of the 2015 *Long-term Care Act* was to encourage home-based care and social care as an alternative to historically institutionalized long-term care facilities. Another relevant aspect was the objective to increase the decentralization of social assistance and healthcare by placing the relevant services under the responsibility of Municipalities in order to improve efficiency, affordability and to reduce costs.[12] The guiding principle of the 2015 decentralization of long-term care in the Netherlands was "*local as far as possible; regional where necessary*",[13] which is very similar to the subsidiarity principle that inspires other national healthcare systems such as in Italy.
Starting in 2015 it has also been the responsibility of the Municipalities to provide community-based care such as household services, medical aids, home modifications, services for informal caregivers, preventive mental health care, transport facilities, and other as-

[10] Private mandatory insurance and copayments amount respectively to 21% and 11% of total expenditure, see J. Wammes, N. Stadhouders, G. Westert, *The Dutch Healthcare System*, cit., p. 138.

[11] Until 2015 long-term care was regulated by a separate legislation under the *Exceptional Medical Expenses Act*, see M. Kroneman, W. Boerma, M. van den Berg, P. Groenewegen, J. de Jong, E. van Ginneken, *Netherlands. Health system review,* cit., p. 22.

[12] See T. Kuipers, R. van de Pas, A. Krumeich, *Is the healthcare provision in the Netherlands compliant with universal health coverage based on the right to health? A narrative literature review*, cit., p. 4, who observe that "municipalities are in a better position to more efficiently tailor care to the citizens' needs".

[13] M. Kroneman, W. Boerma, M. van den Berg, P. Groenewegen, J. de Jong, E. van Ginneken, *Netherlands. Health system review*, cit., p. 33.

sistance all financed by the Government's block subsidies. The NHS is completed by the aforementioned *Social Support Act* and the *Youth Act* (*Jeugdwet*) which also fall under the responsibility of Dutch Municipalities. As a result of this, long-term care and social services may vary considerably from one territory to another. Regardless, the 2015 reform brought into the Dutch NHS - mainly based on regulated competition - a second tier corresponding to a decentralized and tax-funded national healthcare care system.

The Dutch *NHS* is therefore based on a controlled or regulated private market system in which the State acts as controller of an essentially private health care system in order to protect the individual and the public interest in healthcare. This system requires less political involvement in the management of the health service (such as day-to-day decision making and financial flows) and it allows for a greater empowerment of residents regarding their own health choices. Though it ends up guaranteeing healthcare that will cover almost all residents (in 2016 less than 0.2 per cent of residents were uninsured), at the same time, it allows for a high risk of health inequalities mostly depending on individual wealth. Only more wealthy residents are given the possibility of buying more comprehensive insurance than the basic coverage, while less wealthy residents cannot afford any cover beyond the basic. What is more, less expensive insurance policies are generally contracted with a more limited number of health providers, thereby limiting patients' freedom of choice while they often offer poorer quality health services.[14]

Prevention has a limited presence in basic health packages (such as giving up smoking and weight reduction included in 2013), since these are the responsibility of municipalities together with social assistance (both financed by general taxation).[15] However, it is also in the interest of insurance companies to promote healthier lifestyles and encourage prevention.

2. The Dutch Recovery and Resilience Plan: Institutional Profiles at an EU and National level

The Dutch Recovery and Resilience Plan (RRP) is one of the least funded of the EU Member States, much more limited, for example, than the Italian RRP. Comparing the Dutch and Italian RRPs, the Dutch is supported by 4.7 billion euros in grants and no loans (this was a

[14] As reported in OECD/European Observatory on Health Systems and Policies, *The Netherlands: Country Health Profile 2021, State of Health in the EU*, cit., p. 16, usually insurance companies reimburse only 75 per cent of costs of treatments provided by non-contracted providers. Anyway, during the covid-19 pandemic in 2020 and 2021, insurers covered the health treatments delivered by all hospitals even outside their contracted providers.

[15] According to the *Public Health Act*, prevention includes national prevention programs, vaccinations and infectious disease management. The municipalities are free to initiate other prevention programs, which is why they differ so much from one municipality to another, see J. Wammes, N. Stadhouders, G. Westert, *Health system overview, Netherlands*, cit., p. 140.

0.55% share of GDP in 2019 or 269.00 euros per person),[16] whereas the Italian RRP is supported by 68.9 billion euros in grants and 122.6 billion euros in loans (this was a 10.79% share of GDP). The Dutch RRP provides for 28 investments and 21 reforms, whereas the Italian RRP provides for 132 investments and 58 reforms. Dutch expectations for the RRP are also quite limited, as the national GDP is expected to rise from 0.4 to 0.6% (including the spillover-effect of other States' RRPs).[17]

With regard, more specifically, to healthcare, the Italian RRP has allocated 7 billion euros to the development of proximity networks, facilities and telemedicine for territorial healthcare and 8.63 billion euros to innovation, research and digitization of the national health service, in order to respond to the main changes in health care resulting from an increasingly elderly population and the presence of around forty per cent chronically ill patients. The Dutch RRP also allocated a relatively modest sum to healthcare and long-term care envisaging only four investments, mostly addressed to strengthening public healthcare and to improving pandemic preparedness yet with no reforms.

Given this premise, what are the main points of interest of the Dutch RRP? The Dutch RRP has at least two main aspects of interest: first, from an institutional perspective, the Netherlands gave little support to the Next Generation EU and the Dutch RRP was the last one to be submitted to the European Commission on July 8, 2022. Second, shifting the focus to health provisions, the Dutch RRP is the only system in the EU area that intervenes in a truly private healthcare system in which private actors play a central role, both in terms of insurance and provision of healthcare services, while the Government defines the general rules within which the private sector can act and checks that they are properly implemented in order to protect the public interest.

Starting with the first aspect, it should be pointed out that the Dutch Government, along with other so-called *frugal States* (Austria, Denmark and Sweden), opposed the approval of the Next Generation EU from the outset (non-performing loans were then reduced from 500 to 390 billion euros).[18] In contrast to the Commission proposal, for which the States' RRPs should have been assessed and approved exclusively by the Commission itself, the Netherlands even requested that RRPs be unanimously approved by the EU Council. The proposal to refer the final decision to a representative body of national Governments, such as the EU Council, raised concerns in the negotiations, especially from France, Spain and

[16] K. Smit Jacobs, M. Sapała, *The Netherlands' National Recovery and Resilience Plan. Latest state of play*, in *Next generation EU (NGEU) delivery - How are the Member States doing?*, European Parliament Next Generation EU Monitoring Service, PE 739.275, December 2022, p. 1, at https://www.europarl.europa.eu/RegData/etudes/BRIE/2022/739275/EPRS_BRI(2022)739275_EN.pdf.

[17] The Italian RRP provides for 37.5% to be allocated toward climate objectives (minimum was 37%) and for 25.1% to go to the digital transition (the minimum was 20%). For more detailed information, see the Country overview of the EU Commission at https://ec.europa.eu/economy_finance/recovery-and-resilience-scoreboard/country_overview.html?lang=en.

[18] B. Vanhercke and A. Verdun, with A. Atanasova, S. Spasova and M. Thomson, *From the European Semester to the Recovery and Resilience Facility. Some social actors are (not) resurfacing*, Working Paper 2021.13, Brussels, ETUI, p. 7.

Italy. In the final *Conclusion of the extraordinary EU Council* of 17-20 July 2020, according to President Michel's proposal, the EU Member States finally agreed on the approval of RRPs by the EU Council by a qualified majority, following the proposal of the EU Commission.

The Netherlands also demanded that States should be able to veto the EU Commission's decision to proceed with the payment of EU funds to States in the event of a discrepancy between the Recovery and Resilience Facility objectives and their execution (this was mainly directed to Italy, Spain and France). A legal opinion of the EU Council's Legal Service recognized the full prerogatives of the EU Commission under the EU Treaties regarding the validation and authorization of payments and ruled out the possibility of vetoes by EU States. According to the legal opinion, the EU Commission under Article 17, paragraph 1 TEU has the power to "*execute the budget and manage programs*" and under Article 317, paragraph 1 TFEU "*to implement budget*" "*within its own responsibility*" and in accordance with "*the principles of financial management*".[19]

According to the final *Conclusion of the extraordinary EU Council* of 17-20 July 2020, the EU Commission took those decisions on the assessment of the satisfactory achievement of the relevant interim and final targets and on the approval of payments to the States, after requesting the opinion of the Economic and Financial Committee. If, exceptionally, one or more Member States had considered that there were serious deviations from the satisfactory achievement of the relevant intermediate and final targets, they may have requested that the President of the European Council refer the matter to the next European Council, which would then have had to discuss the matter thoroughly and the EU Commission would have had to suspend its decision.[20]

As mentioned above, the Netherlands was the last State to submit its RRP to the European Commission on July 8, 2022. The explanation for this depends partly on institutional reasons and partly on the procedure followed to approve the RRP. In accordance with the rules of the parliamentary form of government enshrined in the Dutch Constitution, the Dutch Government (which must enjoy the confidence of Parliament) resigned in January 2021 and new elections were held on March 17, 2021. In January 2022 the King appointed the fourth Government led by the Premier Mark Rutte who had therefore been in power for about ten years. It took no less than 271 days to form the new government, thus achieving the record time needed to appoint a government in the Netherlands. Since then, the

[19] See the opinion of the EU Legal Counsel, *Paragraph A19 of the Conclusions of the Special European Council of 17 to 21 July 2020*, 21 July 2020, EUCO 12/20 LIMITE JUR 346, at https://data.consilium.europa.eu/doc/document/ST-12-2020-INIT/en/pdf.

[20] See the *Conclusions of the extraordinary EC of 17-20 July 2020,* https://www.consilium.europa.eu/media/45118/210720-euco-final-conclusions-it.pdf, p. 6.

Dutch Government has had a very short life, as it tendered its resignation to the King on July 7, 2023[21] and new elections are expected in November 2023.
The Rutte Government had the time to submit the Dutch RRP to the EU Commission in any event. Before being submitted to the EU Commission, the Dutch draft RRP went through a public consultation process during which the opinions of many stakeholders were sought, such as the Municipalities, Provinces, organizations responsible for water management in the Netherlands, social partners, and organizations working to promote gender equality and equal opportunities for all.[22] Citizens were also asked to give their input on the plan's draft through an online public consultation. This led to the presentation of the Dutch RRP to the EU Commission on July 8, 2022, which endorsed it on September 8, 2022, followed by the EU Council approval on October 4, 2022.

3. The Dutch Recovery and Resilience Plan: The Component 5 – Health

Moving on to examine the profiles related to *Component 5 – Health* of the Dutch RRP, the first aspect to be emphasized is that the Netherlands RRP is part of a healthcare system in which private healthcare plays a central role, both in terms of insurance and the provision of healthcare services, while the State defines the general rules within which the private sector can act and checks that they are properly implemented. During the 2020-21 pandemic the Dutch system proved its worth in terms of universal access to quality care at a reasonable price, but it also highlighted some shortcomings such as for certain health workers (resulting in problems of access to care) and the lack of e-health services.[23]
According to the Dutch RRP, investments in the health sector account for 4 per cent of the total RRP's budget and the priorities are to strengthen the public health sector and pandemic preparedness through temporary additional human resources' capacity for care in times of crisis, to extend intensive care (by supporting 54 hospitals to increase fixed and flexible intensive care beds and 67 hospitals to train their staff to increase the capacity of intensive and clinical care units) and the use of e-health tools, to integrate national health data and research infrastructure. The objective of tackling the shortage of health professionals is being pursued by a national reserve of health professionals to be employed

[21] The Dutch Government collapsed due to the very different views of the four coalition parties on asylum policies, see the Prime Minister press release at

[22] K. Smit Jacobs, M. Sapała, *The Netherlands' National Recovery and Resilience Plan. Latest state of play*, cit., p. 9.

[23] Commission staff working document, Analysis of the recovery and resilience plan of the Netherlands Accompanying the document Proposal for a Council Implementing Decision on the approval of the assessment of the recovery and resilience plan for the Netherlands, COM (2022) 469 final, September 8, 2022, p. 8.

during crises.[24] More generally, the aim is to achieve a more resilient healthcare system, capable of absorbing any peaks in access to healthcare facilities.

These measures are also expected to foster territorial cohesion and convergence both during a time of pandemic and in normal times. E-health applications are expected to allow people living in less densely populated areas, especially more vulnerable groups, to receive health care at a distance.[25] Furthermore, on the Dutch Government webpage, it is stated that digital health can have a positive effect on healthcare expenditure without diminishing the quality of services while its application can also encourage prevention via apps specifically designed for this purpose. Strengthening digital health is also part of the RRP's *Component 2* on the digital transition to which the Dutch RRP has allocated 20 per cent of its total resources.

At the time of the covid-19 outbreak the mortality rate in the Netherlands was thirty-five per cent lower than the EU average,[26] but the main problems during the pandemic concerned the tracking of infections, the collection and sharing of health data, the collaboration between different research facilities, and the lack of insurance cover for covid patients both for testing and after recovering (due to the so-called *long-covid*). As regards covid-19 testing during the pandemic, the Government covered the related costs, while treatments for long-covid were included in the basic health care package. Deficiencies in the digitization of healthcare and data sharing between health institutions for contact tracing and research purposes, were mostly due to the private structure of the Dutch NHS, in which healthcare providers work independently of each other and are not networked into a single national electronic health record system. A dedicated measure of the *Component 5 – Health* is therefore addressed to develop nationally integrated health data, research infrastructure and e-health applications. One of the needs that emerged from the pandemic was indeed that of building integrated health networks not only in terms of data sharing but also with respect to healthcare organization.[27]

[24] K. Smit Jacobs, M. Sapała, *The Netherlands' National Recovery and Resilience Plan. Latest state of play*, cit., pp. 4 and 6, reports that the health personnel shortfall is being addressed by hiring 6,300 former healthcare staff and by temporarily recruiting 5,000 support staff to relieve health and care professionals.

[25] See *Summary of the Commission's assessment of the Dutch recovery and resilience plan*, based on the documents COM(2022) 469 final and SWD (2022) 292 final, p. 6, at https://commission.europa.eu/system/files/2023-03/NL%20RRP%20Summary.pdf.

[26] OECD/European Observatory on Health Systems and Policies, *The Netherlands: Country Health Profile 2021, State of Health in the EU*, cit., p. 4.

[27] See R. Balduzzi, *Diritto alla salute e sistemi sanitari alla prova della pandemia. Le "lezioni" di alcuni Piani nazionali di ripresa e resilienza*, in *DPCE online*, 1, 2023, p. 429, who analyses in a comparative perspective Italy, France, Germany and the United Kingdom.

Conclusion

In the opinion of Ezekiel Emmanuel, The Netherlands has the best healthcare system in the world.[28] The Dutch NHS can be seen as the most private-based national healthcare system in the European Union, and from the analysis conducted above it is possible to identify several of its positive aspects. Firstly, it requires little political involvement in the day-to-day management of the health system, as it relies on private insurers and private healthcare providers competing against each other. Secondly, the Dutch NHS is designed to guarantee the three basic principles of solidarity – which means that healthcare must be universally guaranteed - the principle of mandatory and affordable medical insurance for all and the principle of access to high quality health services. To this purpose the Government sets the rules, acts as the supervisor of private insurers and health providers and as the facilitator for the health markets. The NHS ends up ensuring healthcare coverage and good access to care for almost all residents.[29]

The Dutch NHS has also shown some weaknesses. The main issue seems to be its greater propensity to create health inequalities based on residents' wealth. More wealthy residents can buy more comprehensive insurance than what is offered by basic coverage, while less wealthy residents cannot afford any cover beyond what is offered by basic cover. In addition, cheaper insurance allows access to a more limited number of health care providers, which limits patients' freedom of choice and sometimes results in lower quality health services.

Starting in 2015, the Dutch national private healthcare insurance system of "regulated competition" was complemented by a second-tier universal and tax-funded national healthcare system administered by the Municipalities and intended for long-term care.

Through the *Component 5 – Health* of the RRP the Dutch Government has no plans to implement structural reforms of the NHS which seems to have proven itself after the 2006 and 2015 reforms, and even during the pandemic.[30] Dutch RRP interventions have then

[28] See E. Klein, *Which country has the world's best health care system?*, cit.

[29] According to OECD/European Observatory on Health Systems and Policies, *The Netherlands: Country Health Profile 2021, State of Health in the EU*, cit., pp. 3 and 15, life expectancy at birth in the Netherlands in 2020 was higher than the EU average by about one year (81.5 years in The Netherlands against 80.6 years in the EU, but lower, for example, than that of other top performing countries, like Italy, whose life expectancy is 82.4, and Norway, 83.3). Data also refer that in 2019 Dutch residents had among the lowest levels of unmet needs in the EU (while, for example, the same data for Italy show a higher average than the EU).

[30] Apart from the RRP, the Dutch government is trying to improve social protection for the self-employed by approving a reform that introduces mandatory illness/disability insurance for self-employed professionals (thus aligning social protection conditions for employees and the self-employed) to protected them against the consequences of occupational disability. The bill is currently being drafted by the Dutch Ministry of Social Affairs and is expected to enter into force in 2027, see KVK, *The mandatory disability insurance (AOV) explained,* 2022, at https://www.kvk.nl/en/rules-and-laws/the-mandatory-disability-insurance-aov-explained/.

been closely related to the inefficiencies encountered during the pandemic and to implement the digital transition in the health sector[31].
At the time of the covid-19 outbreak the Netherlands had a national pandemic response plan in place and demonstrated a high level of preparedness before the pandemic. Still, the NHS response to covid-19 encountered few obstacles such as health professional shortages, the lack of e-health services and the fact that testing and treatments for long-covid were not originally included in the basic health packages. One of the main problems that emerged during the pandemic was that private healthcare providers were not networked with each other, which made it difficult to collect data for contact tracing and scientific research purposes.

[31] R. Balduzzi, *Diritto alla salute e sistemi sanitari alla prova della pandemia. Le "lezioni" di alcuni Piani nazionali di ripresa e resilienza*, cit., p. 417, observes that the pandemic provided an opportunity for States to restructure their health systems (Italy, France, United Kingdom) or to intervene only on those aspects that proved most critical during the pandemic (Germany).