National Maternity and Neonatal Investigation

International Comparisons

Supplementary Evidence

Case Studies

The examples below were compiled by the European Observatory on Health Systems and Policies.

Note for reader: in our final report and supplementary evidence, we have used an additive approach to language. By this, we mean that we have sought to centre the experiences of women and mothers, while also recognising that not everyone who is pregnant, gives birth, or uses maternity and perinatal services identifies as a woman or mother. Further information on our approach to inclusive language and terminology is provided at Annex 1 in the final report.

The Netherlands' approach to clinical negligence in maternity and neonatal care

The Netherlands addresses clinical negligence in maternity and neonatal care through a fault-based legal system combined with strong complaints, transparency, and professional accountability mechanisms.

Families can pursue compensation through civil law if they can prove substandard care and causation, but in practice most concerns are resolved through mandatory, low-threshold complaints and disputes procedures under the Healthcare Quality, Complaints and Disputes Act (Wkkgz), which came into force in 2016 and emphasises early resolution, explanation, and learning.

Providers have a legal duty of openness when things go wrong and serious incidents must be reported and investigated with a focus on system improvement. Alongside this, clinicians are subject to independent professional disciplinary law, which assesses standards of practice regardless of compensation.

While the Netherlands does not operate a no-fault compensation scheme, its approach is deliberately less adversarial than litigation-led systems, prioritising transparency, quality improvement and professional accountability over court action.

Perinatal pathway coordinator in France

The "Perinatal Care Pathway Coordinator" (Référent Parcours Périnatalité, RéPAP) initiative was a French pilot programme in four territories designed to improve continuity, coordination, and support in perinatal care, particularly for vulnerable women. Introduced under Article 51 of the 2018 Social Security Financing Act and funded by the National Health Insurance Fund, the initiative formed part of France's broader "First 1,000 Days" strategy launched in 2020 and which ran from 2021 to 2023.

The initiative aimed to develop a personalised, coordinated perinatal pathway, from pregnancy until the child is three months old, with support from a perinatal pathway

coordinator (RéPAP). The RéPAP may have been a midwife, general practitioner, nurse, social worker, health mediator, or another professional with expertise in perinatal care. Beyond direct support, the RéPAP also had a coordinating role, linking hospital, community, social, and maternal and child protection services.

All pregnant women living in one of the pilot territories and enrolled before seven months of pregnancy could participate voluntarily. The standard care pathway included four additional interviews: two during pregnancy and two postpartum. These interviews were intended to improve follow-up, identify vulnerabilities early, strengthen postpartum care and better detect postnatal depression, the first signs of which often appear during pregnancy. Participants also benefitted from telephone support and coordinated communication between professionals involved in their care.

Women identified as vulnerable could receive additional support, including additional interviews, extended telephone contact and increased coordination time. This applied particularly in cases involving psychological vulnerability, disability, addiction, violence, or social difficulties. The programme relied heavily on multidisciplinary collaboration and territorial networks, with coordinators expected to maintain close contact with maternity services, general practitioners, social services and local support organisations.

While the pilot programme was not rolled out nationwide, some of its features have been included in care pathways through bylaws. Midwives are now authorized to conduct postnatal interviews to identify women at risk for postnatal depression and pregnant women can designate a referring midwife to be in charge of prenatal care coordination and prenatal consultations.

Integrated maternity care in the southwestern region of the Netherlands

Influenced by national policies emphasising integrated maternity care models and the need to improve the quality of maternity care, the Breda region in the southwest Netherlands implemented several initiatives to strengthen interdisciplinary collaboration. In 2012, an integrated ultrasound centre was established, along with a shared ultrasound record system for all pregnant women in the region, regardless of whether they received midwife-led or obstetrician-led care. This created the foundation for expanding interprofessional collaboration, which advanced further in 2016 with the establishment of Annature, an integrated maternity care organisation operating through ‘bundled payment’ (reimbursement of healthcare providers for a set of services). Annature is a multidisciplinary network comprising primary care midwives, a hospital maternity care unit, consultant obstetricians and local maternity care organisations. These professionals work with joint protocols, integrated patient records and shared quality evaluation systems.

Additional initiatives included ‘buddy consultations’, in which consultant obstetricians and community midwives jointly conduct prenatal consultations, particularly aimed at socially

vulnerable pregnant women and women with intermediate-risk pregnancies. Furthermore, obstetric professionals from primary and secondary care developed integrated maternity care protocols and care pathways to enhance woman-centred care. Within these care pathways, prenatal consultations are systematically planned, and the respective responsibilities of community midwives, clinical midwives, and consultant obstetricians are clearly defined.

For every pregnant woman in the first trimester, a multidisciplinary meeting is held involving the community midwife and the 'buddy consultant obstetrician'. Together, they assess the woman's physical, social, lifestyle and mental health circumstances to identify potential pregnancy-related risk factors. Based on this assessment, women are assigned to a personalised care pathway to ensure appropriate and coordinated maternity care.

A 2024 study examined whether the integrated maternity care organisation Annature was associated with reductions in preterm births (PTBs) and fewer small-for-gestational-age infants (SGA), and whether it led to fewer hospital-based prenatal consultations with obstetricians. The results suggested that the implementation of integrated maternity care was associated with reductions in PTBs and/or low birth weight, as well as fewer secondary care consultations.

Antenatal education in Sweden

Antenatal education aims to prepare expectant mothers and their partners for childbirth and early parenthood. Sweden has a long tradition of providing antenatal education, including health promotion and birth preparatory courses, offering it to expectant women since the 1940s, and since the 1970s also to their partners.

The provision of antenatal education follows national guidance and recommendations from the National Board of Health and Welfare and Sweden's Public Health Agency. Antenatal classes are offered for free by public maternity clinics and hospitals and are integrated into antenatal care. Antenatal education is commonly led by midwives and includes individual counselling, group classes and online options, covering the labour and birth process, pain relief, breathing/relaxation, partner support, breastfeeding, newborn care and parental transition. Extra support is available for those with a fear of childbirth or other specific needs. Classes are usually offered in the second to third trimester, but frequency and details differ between the country's regions.

In 2021, maternal health services in the region of Halland, for example, launched a mobile app for digital antenatal education to improve access to support during and after pregnancy, as a standard part of antenatal education. The content is in Swedish, but all videos are subtitled in English and Arabic to enhance accessibility. The tool has been perceived by users to enhance maternal knowledge, confidence and individuals' motivation to breastfeed.

Postnatal support by Maternity and Child Health Care Centres in Norway

In Norway's health system, the country's 357 municipalities play an important role in the provision of health services. They are responsible for providing primary care and a wide range of public health services and run public Maternity and Child Health Care Centres. These centres are a cornerstone of pre and postnatal care, as well as the infant healthcare programme in Norway.

All pregnant women are entitled to free follow-up with a midwife or general practitioner (GP). They are offered seven routine pregnancy consultations. In addition, they are offered early ultrasound and possibly non-invasive prenatal testing (NIPT) and an ultrasound in week 18-20.

Usually, the mother and child stay at the maternity ward from 1 to 3 days after the birth, where the mother will receive information and guidance. The hospital is responsible for notifying the Maternity and Child Health Care Centre, the GP and the midwifery service that woman and baby have been discharged and gone home. Women should be offered a home visit by a midwife during the first three days after returning home. They will then be visited by a health nurse on day 7–10 after the birth.

Women are entitled to one free check-up 6-8 weeks after birth, either with a midwife at the Maternity and Child Health Care Centre or with the GP. This check-up focuses on the health of the mother and should also include information on and an offer of contraception. Mothers must schedule this check-up themselves. Sometimes mothers would need an appointment with the GP earlier, either because the hospital recommended it or because the mother sees the need herself.

The Maternity and Child Health Care Centre also provides the infant healthcare programme for children aged 0–5 years, which is a free and legally required health service for children and parents, from birth until they start school. Attendance is high: 98.8% of children attend postnatal follow-up within eight weeks and attendance at the age of four years is approximately 96%. This universal reach makes the Maternity and Child Health Care Centre a critical platform for early identification of health needs, family support and preventive care.

Country Profiles

France[1]

The health system is primarily centralised, with some responsibilities devolved to regions

The French health system is of a mixed type. While it is structurally based on a social health insurance (SHI) approach, it shares many characteristics of a National Health System, including a single public payer model, the importance of tax-based revenues to complement social contributions, strong state intervention and residency-based benefits. While regional health agencies have played a greater role in managing the provision of healthcare (especially hospital care) at the local level since 2009, the SHI and central government play a strong role in organising the health system and determining its operating conditions. Over the past two decades, the state has also become more involved in controlling health expenditure funded by the SHI system by setting an annual national health spending target (ONDAM).

Universal health coverage is financed through a wide range of revenue sources

The SHI system offers coverage to the whole population based on residence through various compulsory schemes. Revenues for healthcare come from social security contributions, earmarked income taxes, value-added taxes and other sources such as tobacco and alcohol taxes. Nearly all the population (96%) has complementary health insurance (compulsory through employment or voluntary) to cover copayments and services less covered by SHI, such as dental and optical care (though public coverage for these improved substantially in 2021). In 2023, public and private compulsory health insurance schemes funded 84% of all health spending in France, a higher share than the EU average of 80%.

Health spending in France is higher than the EU average, particularly as a share of GDP

In 2023, health spending in France accounted for 11.5% of GDP—the second highest share in the EU after Germany (11.7%) and above the EU average (10%). Per capita health spending reached EUR 4,360 (adjusted for purchasing power), placing France in the top third of EU countries and above the EU average (Figure 1). Since 1996, SHI spending has been controlled by annual national targets. ONDAM, the national public health spending objective, grew by 4.8% annually during the period 2019- 2025 mostly because of pandemic-related measures, up from 2.4% during the 2015–2019 period (Cour des comptes, 2025).

[1] Source: Extracted from OECD/European Observatory on Health Systems and Policies (2025), Country Health Profile 2025: France. State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

France spends nearly the same amount on inpatient and outpatient care

Looking at the composition of health spending, expenditure on outpatient care (including primary care, specialist and dental care) accounted for 30% of France's health spending while inpatient care reached 28% in 2023 (Figure 2). Retail pharmaceuticals and medical devices also took up a considerable share of spending, absorbing 19 % of health expenditure, while long-term care made up 16%. Spending on prevention was around 2%, which is lower than the pre-pandemic level (about 3%) and below the EU average of 4% in 2023.

The number of hospital beds in France has declined steadily since 2000

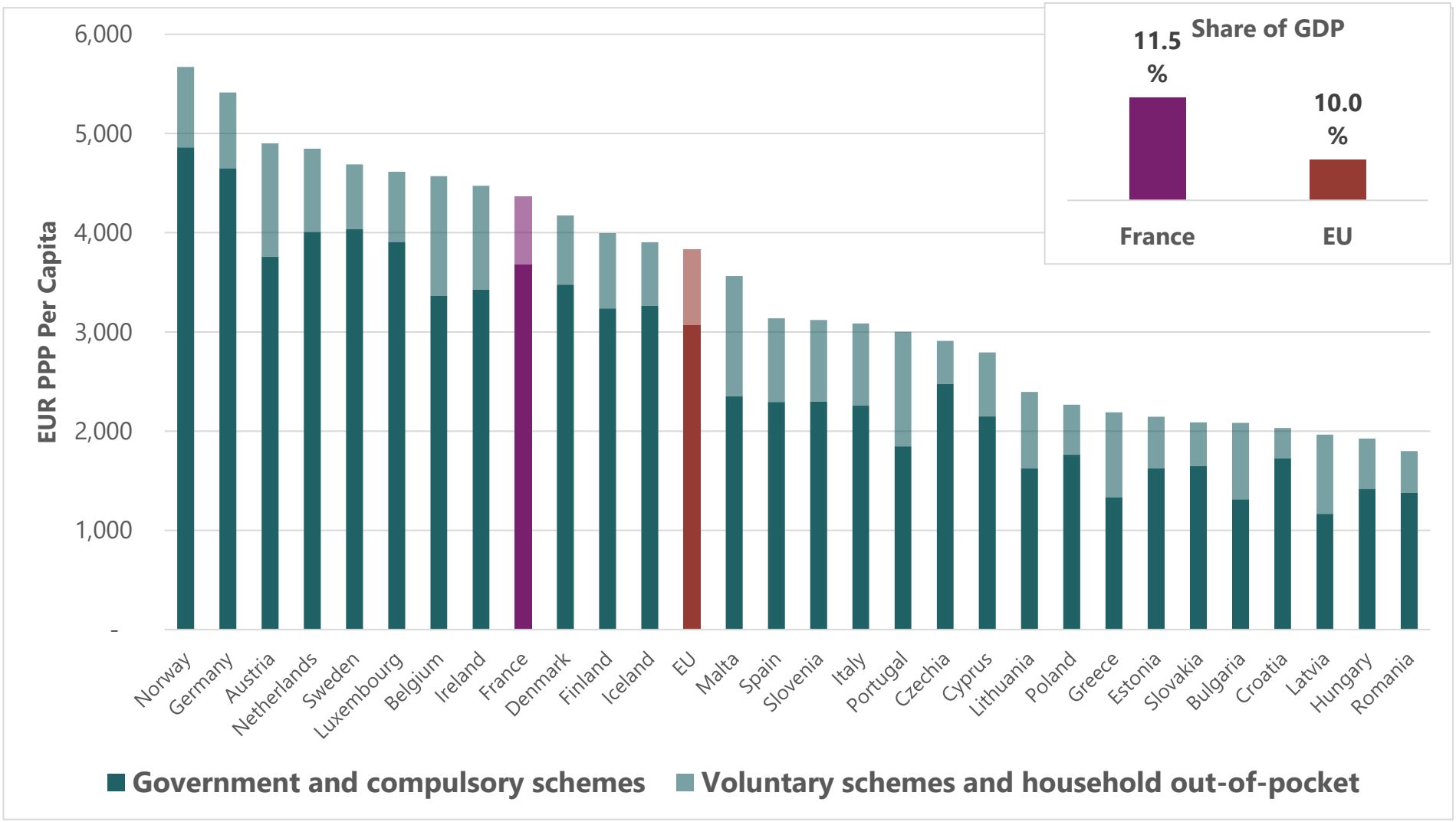
In 2023, France had 5.4 hospital beds per 1,000 population, which is slightly above the EU average (5.1), but much lower than in Germany (7.7). Over the past two decades, the number of hospital beds per population has decreased from 8 hospital beds per 1,000 population in 2000. At the same time, both partial hospitalisation places and home hospitalisation capacity have expanded rapidly in recent years, by over 4% in 2023 compared to 2022 (DREES, 2024a). The reduction in hospital beds relates to several trends: increased ambulatory hospitalisations and shorter stays; increased home hospitalisations, mainly for perinatal and palliative care; and decreased long-term care beds in hospitals linked to nursing home expansion for older people.

Doctor density is below the EU average, while nurse density is slightly above

Unlike most EU countries where the density of doctors has increased, the number of doctors per population (not including residents, physicians-in-training) has remained stable in France over the last decade. In 2023, there were 3.9 doctors per 1,000 population (including residents), below the EU average of 4.3 (Figure 3). This density has contributed to 'medical deserts', especially in rural and peri-urban areas. Successive governments have introduced series of measures to address GP shortages in certain areas.

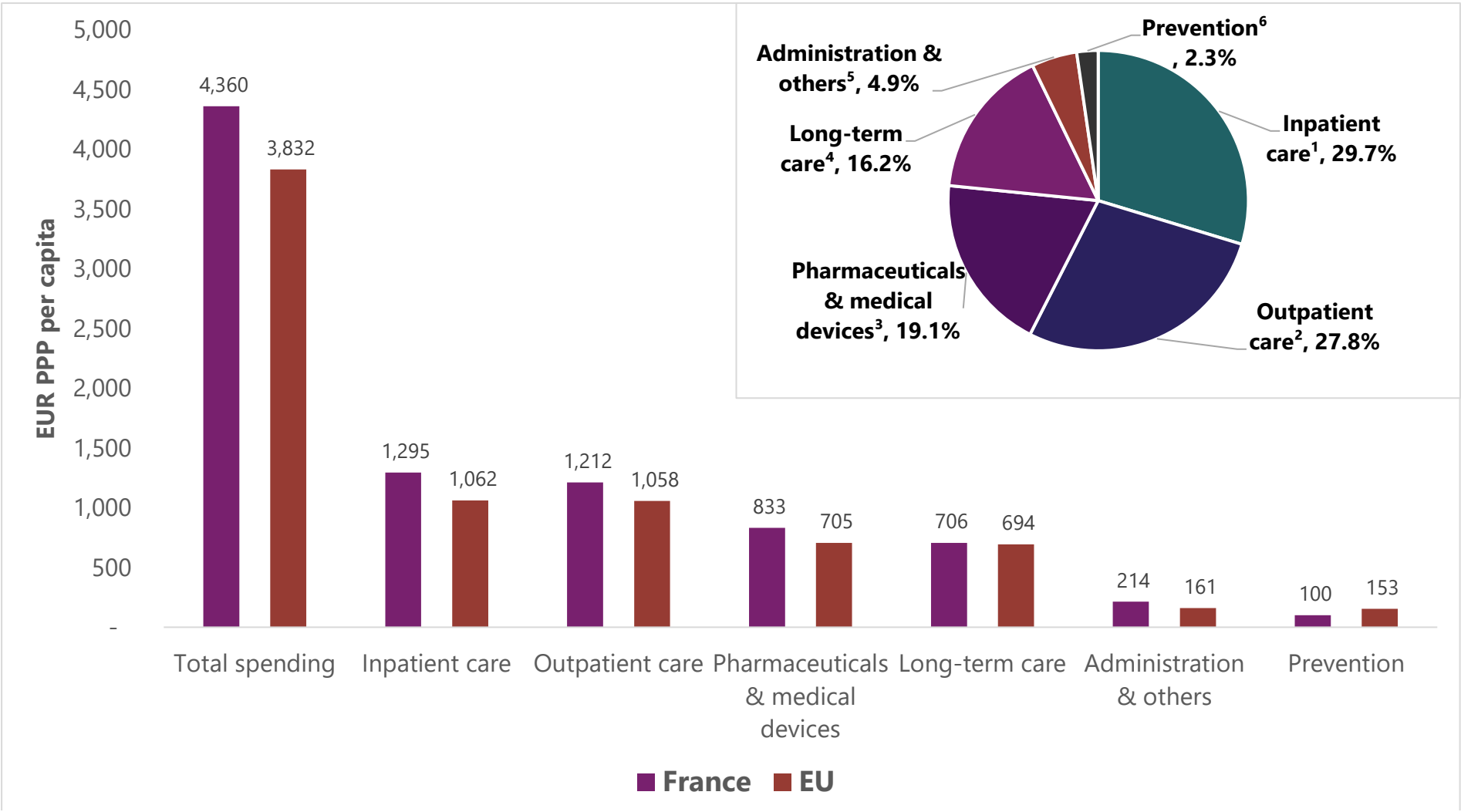
The number of nurses grew slightly over the past decade to reach 8.8 per 1,000 people in 2023, which is slightly higher than the EU average of 8.5. A new law adopted in 2025 redefines and expands the role of nurses to improve recruitment and retention.

Figure 1: France's health expenditure per capita is higher than in most EU countries



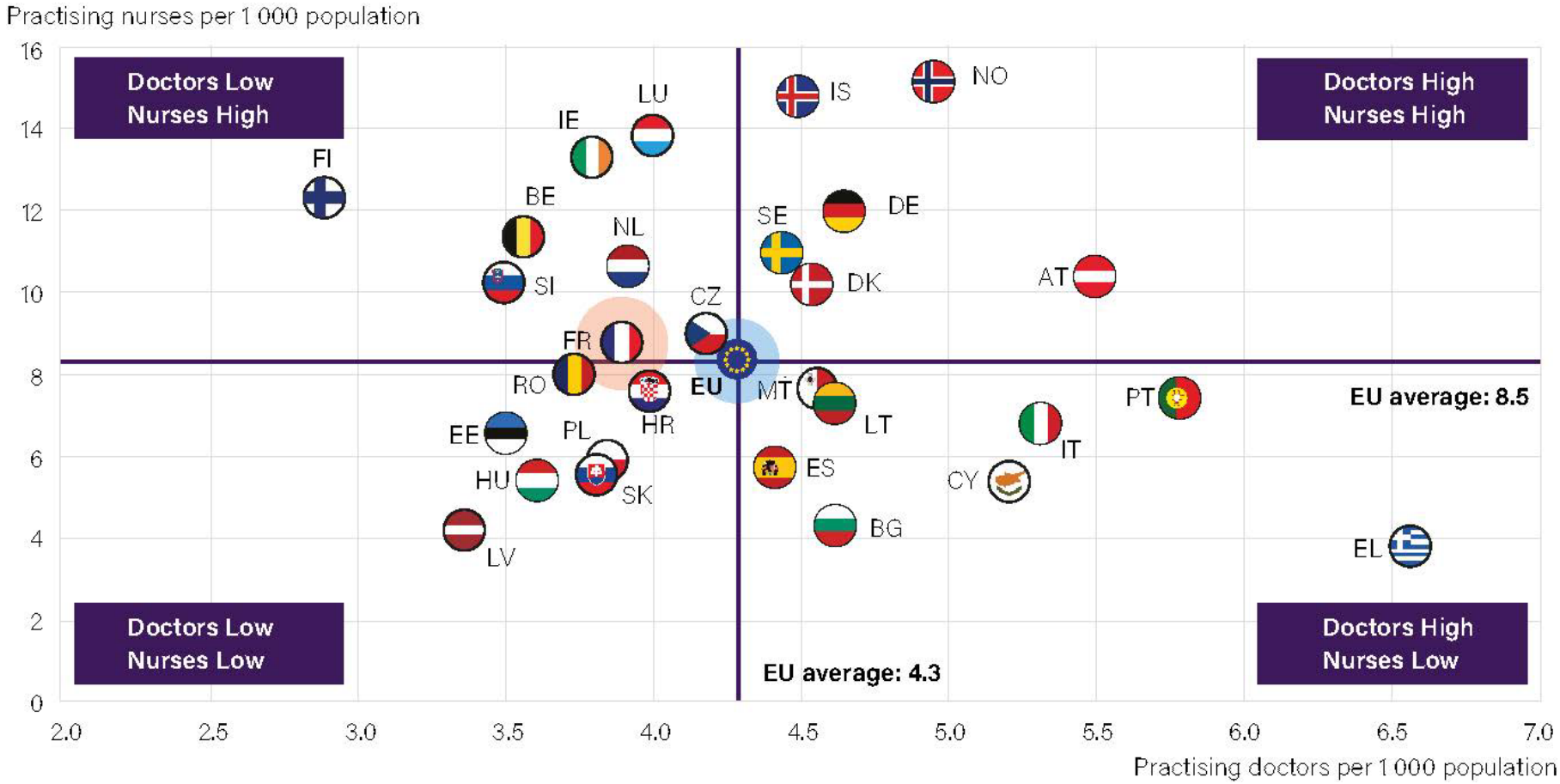
Note: The EU average is weighted (calculated by OECD).
Sources: OECD Data Explorer (DF_SHA); Eurostat Database (demo_gind). Data refer to 2023

Figure 2: Almost 60% of health spending goes to inpatient and outpatient care



Note: 1.Includes curative-rehabilitative care in hospital and other settings; 2. Includes home care and ancillary care services (e.g. patient transportation); 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes health system governance and administration and other spending. 6. Includes only spending for organisational prevention programmes; The EU average is weighted (calculated by OECD).
Sources: OECD Data Explorer (DF_SHA). Data refer to 2023.

Figure 3: The density of doctors in France is below the EU average, while nurse density is slightly above



Notes 1 The EU average is unweighted. 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 practice, resulting in a large overestimation of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospital. *Source:* OECD Data Explorer (DF_PHYS, DF_NURSE). Data refer to 2023 or nearest year.

Norway[2]

Norway's health system is partially decentralised

Norway's health system is semi-decentralised. The Ministry of Health and Care Services and its agencies plan, regulate and supervise the system. Four regional health authorities (RHAs) manage specialist services and own the public hospitals, which are organised as health trusts; care is provided in hospitals and in outpatient polyclinics. Norway's 357 municipalities organise primary care, including general practice, home care and nursing homes. Primary care is mainly delivered by independent general practitioners (GPs) contracted by municipalities, who act as gatekeepers to specialist care. Primary care operates through a list-based system where residents can choose a regular GP, and municipalities contract with individual GPs to ensure this right. GPs provide a wide range of health services, as well as coordinate patient care and act as gatekeepers to the rest of the healthcare system. Municipalities also provide out-of-hours emergency primary care.

As part of the National Health and Hospital Plan (2020– 2023), Norway established 19 Healthcare Communities (helsefellesskap) - formal partnerships between each hospital trust and its surrounding municipalities - to strengthen joint planning and improve coordination across services. The communities were asked to prioritise improved pathways for children and young people, people with multiple chronic conditions, those with severe mental illness or substance use disorders and frail older people. The National Health and Coordination Plan (2024–2027) further prioritises improved coordination of services for women during pregnancy, childbirth and postpartum.

Public financing underpins Norway's universal healthcare system

Norway relies on a public universal healthcare system, administered through the Norwegian National Insurance Scheme (Folketrygden) by the Norwegian Labour and Welfare Administration (NAV). All legal residents of Norway are automatically covered by the National Insurance Scheme. Documented migrants gain full access after six months of residence, though access may be limited during the initial period. For undocumented migrants, basic services such as vaccinations and examinations are covered for children, while only emergency acute care is covered for adults. Financing is predominantly from general taxation, complemented by National Insurance contributions. Co-payments exist for most outpatient services. To protect the population from excessive user charges, there is an annual cost-sharing ceiling adjusted regularly and exemptions for certain population groups (Saunes, 2025).

[2] Source: Extracted from OECD/European Observatory on Health Systems and Policies (2025), Country Health Profile 2025: Norway. State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

Norway's health spending per capita is the highest among European countries

Norway recorded the highest health expenditure per capita among European countries in 2023, at around EUR 5,672 (adjusted for purchasing power). This level is nearly 1.5 times higher than the EU average of EUR 3,832. Relative to the size of its economy, health expenditure as a share of GDP in Norway (9.4%) was slightly below the EU average of 10.0% in 2023 (Figure 4), reflecting the country's relatively high GDP and robust economic performance. Health expenditure in Norway has grown steadily over time, with an average annual growth rate of 2.9% in the decade preceding the COVID-19 pandemic (2009-2019). Unlike in most other European countries, the pandemic did not significantly disrupt health spending trends. Public sources are the dominant source of funding for Norway's health system, accounting nearly 86% of current health expenditure in 2023 - a higher share compared to the EU average (80%). Out-of-pocket (OOP) payments contributed 14% to Norway's health expenditure in 2023, lower than the EU average of 16%. OOP expenditure is driven by co-payments for nearly all publicly funded health services. The role of voluntary health insurance is marginal, accounting for only 0.2% of total health spending in 2023.

Norway spends more on long-term care than many other European countries

In 2022, outpatient care (30%) and long-term care (29%), followed by inpatient care (26%), accounted for the largest shares of health spending in Norway. On a per capita basis, expenditure on long-term care was more than double the EU average, while expenditure on outpatient care was over 50% higher. This reflects demographic changes and a shift towards the provision of services away from inpatient settings.

In contrast, Norway allocated 10% of its health budget to retail pharmaceuticals and medical devices, equivalent to EUR 545 per capita - 23% lower than the EU average of EUR 705 per capita. Only 3% of the health budget is allocated to prevention services.

Norway has one of the highest ratios of health professionals in Europe

Norway has consistently invested in its health workforce, resulting in increasing numbers of practising doctors and nurses. In 2023, Norway had 5.0 practising doctors per 1,000 population, above the EU average of 4.3, and 15.6 nurses per 1,000 population, almost double the EU average of 8.5.

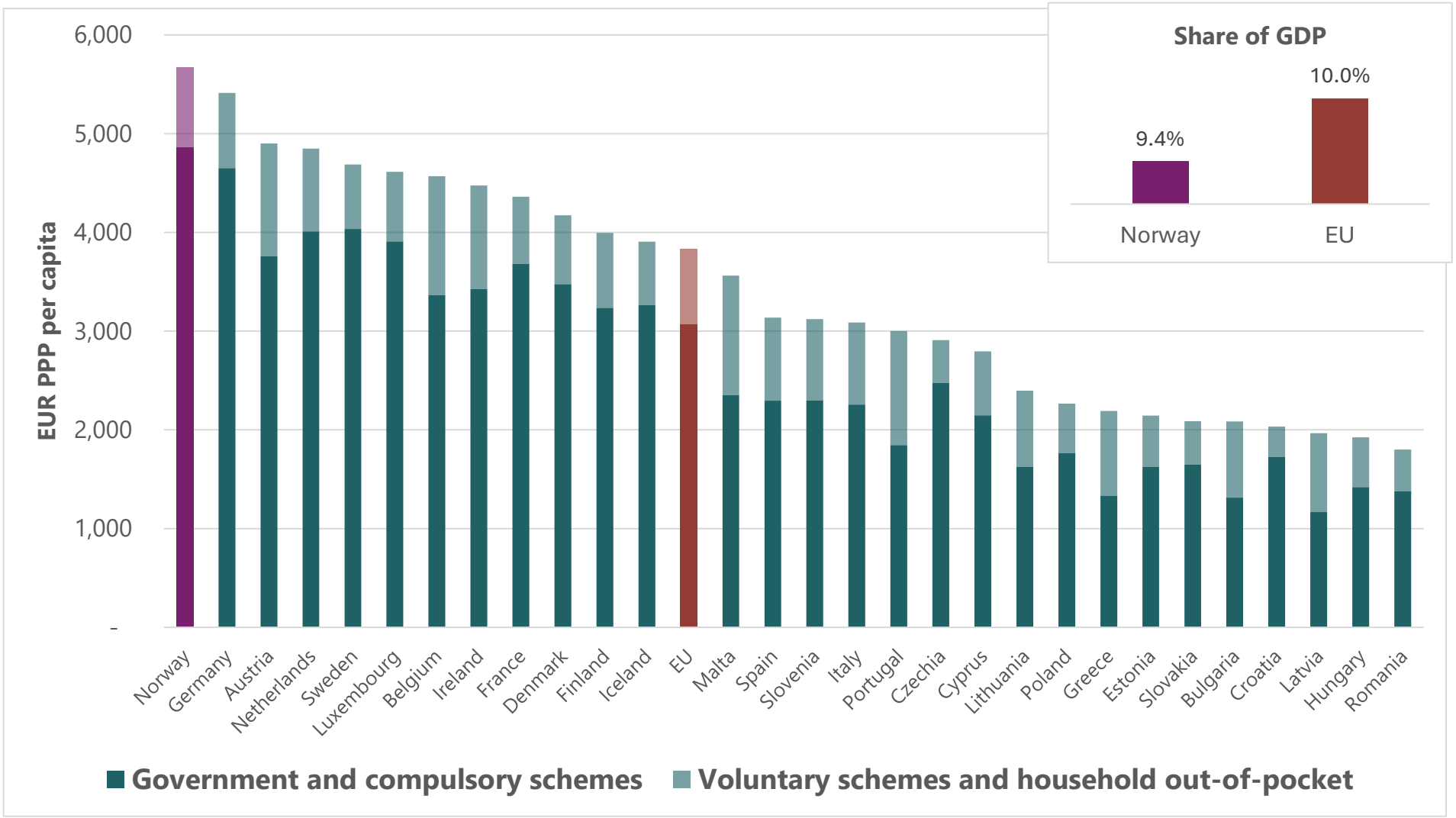
Regarding the number of general practitioners (GPs) relative to the size of its population, Norway had 0.89 GPs per 1,000 population in 2023, slightly above the EU average of 0.85. Since 2010, the density of GPs in Norway has increased by over 20%.

Despite high overall density, Norway faces challenges in recruiting and retaining healthcare professionals. Hospitals and municipalities struggle to fill nursing posts, not only in remote districts but increasingly in urban areas.

Norway also struggles with geographical inequalities in access to GPs, particularly in rural areas and smaller municipalities.

At the end of 2023, 7 out of 357 municipalities had no GPs at all, and in three counties (Finnmark, Nordland and Møre & Romsdal) GP shortages have left 2-4% of their populations without a GP (Statistics Norway, 2024). When patients are without a GP, they receive care from a substitute GP, or in some cases, rely on urgent or emergency care services.

Figure 4: Norway has the highest per capita health spending in Europe



Note: The EU average is weighted (calculated by OECD).
Sources: OECD Data Explorer (DF_SHA); Eurostat Database (demo_gind). Data refer to 2023.

Sweden[3]

Sweden's decentralised healthcare system combines public financing with growing private provision in primary care

Sweden's healthcare system is structured around a highly decentralised model of governance. While the national government sets the overarching policy and regulatory framework, the 21 regional authorities are responsible for financing and delivering the majority of health services. A third tier of governance, the 290 municipalities, is mandated to provide long- term care, home- based services for older people and individuals with disabilities. Sweden's publicly- financed, universal system has been undergoing a significant transformation. Although public institutions continue to dominate hospital care, the private sector's role in primary care has grown substantially over time, with private providers now operating approximately 44% of primary care centres, albeit with considerable regional variation (Fredriksson & Isaksson, 2022). This expansion was accelerated by the 2010 Act on Patient Choice, which empowered individuals to select any accredited public or private provider.

Building on this framework, Sweden launched a major reform initiative in 2018, 'Good quality, local healthcare' (God och nära vård). Supported by significant state financing, representing over 20% of the public healthcare budget in 2025, the policy aims to reorient the system from hospital- centric services towards more accessible, person-centred local care by strengthening collaboration between primary care, specialised outpatient services and municipal care.

Sweden maintains high health spending, driven by sustained public funding

Sweden's health spending ranks fourth highest in the EU, both in per capita terms and as a share of GDP (Figure 5). In 2023, per capita expenditure reached EUR 4,688 (adjusted for purchasing power), about 22% above the EU average of EUR 3,844; health spending accounted for 11.3% of GDP in the same year. Recent trends reflect both long- term structural shifts and the short- term impact of the COVID- 19 pandemic: between 2015 and 2023, real per capita health spending grew at an annual average of 0.9%, driven by a 1.2% rise in public expenditure that offset a 1.0% decline in private spending. The pandemic caused sharp fluctuations, with real per capita spending rising by 4.1% in 2021 to fund emergency measures, then falling by 3% in 2022 before returning to modest growth in 2023, again led by public financing. Preliminary estimates for 2024 suggest that real per capita spending has stabilised at a level about 5% higher than in 2019, with the entire net increase attributable to sustained public expenditure.

[3] Source: Extracted from OECD/European Observatory on Health Systems and Policies (2025), Country Health Profile 2025: Sweden. State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

High public financing combined with structured cost-sharing ensures high financial protection

Sweden's healthcare financing is dominated by the public sector and supported by carefully designed cost-sharing arrangements. In 2023, public expenditure accounted for 86% of total health spending, well above the EU average of 80%. This strong tax-based commitment to universal coverage keeps the financial burden on households comparatively low: out-of-pocket (OOP) payments represented 13% of total spending compared with 16% across the EU. The system combines modest, uniform patient fees with annual expenditure caps that protect individuals from excessive costs. For example, primary care visits typically cost SEK 150- 300 (about EUR 14- 28) depending on the region, while annual limits apply separately to consultation and prescription fees. To reinforce long-term fiscal sustainability, the government introduced major revisions to the medicine cost-sharing scheme in July 2025, including a higher annual OOP payments ceiling that has prompted criticism from patient groups. Despite these planned cost increases, Sweden maintains targeted protections for vulnerable groups, with children, pregnant women and older people continuing to benefit from exemptions or reduced fees.

Sweden's health spending profile reflects a shift toward outpatient care, supported by cost containment in pharmaceuticals

Sweden's health spending pattern reflects distinct policy choices that set it apart from most EU countries. Most notably, the country has successfully shifted care away from traditional hospital settings: in 2023, outpatient services accounted for 33% of total health spending - one of the highest shares among EU countries with above-average per capita expenditure (Figure 5). In contrast, inpatient care absorbed only 22%, well below the EU average of 28%. A defining feature of Sweden's spending mix is the high share devoted to long- term care (LTC), which represented 28% of total health expenditure in 2023 compared with an EU average of 18%. This reflects Sweden's longstanding integration of support for older people as a central component of its health system and broader welfare model. Conversely, spending on retail pharmaceuticals (12%) remains relatively low due to effective price regulation and strong generic uptake, while preventive care accounts for a slightly smaller share of total spending (3%) than the EU average.

Sweden sustains high health workforce levels, but regional and specialty shortages persist

Sweden has a comparatively robust health professional workforce, with 4.5 doctors per 1,000 population in 2022 - about 5% above the EU average, and 11.0 nurses per 1,000 population - nearly 30 %higher than the EU average of 8.4 (Figure 7). The number of doctors grew by 12% over the past decade, supported by foreign-trained physicians who now account for around 30% of the total. The nursing workforce has remained stable over the same period but continues to stand well above EU levels. These aggregate figures, however, mask substantial regional disparities that compromise equitable access to care. All 21 regions report shortages of both general practitioners and specialist doctors,

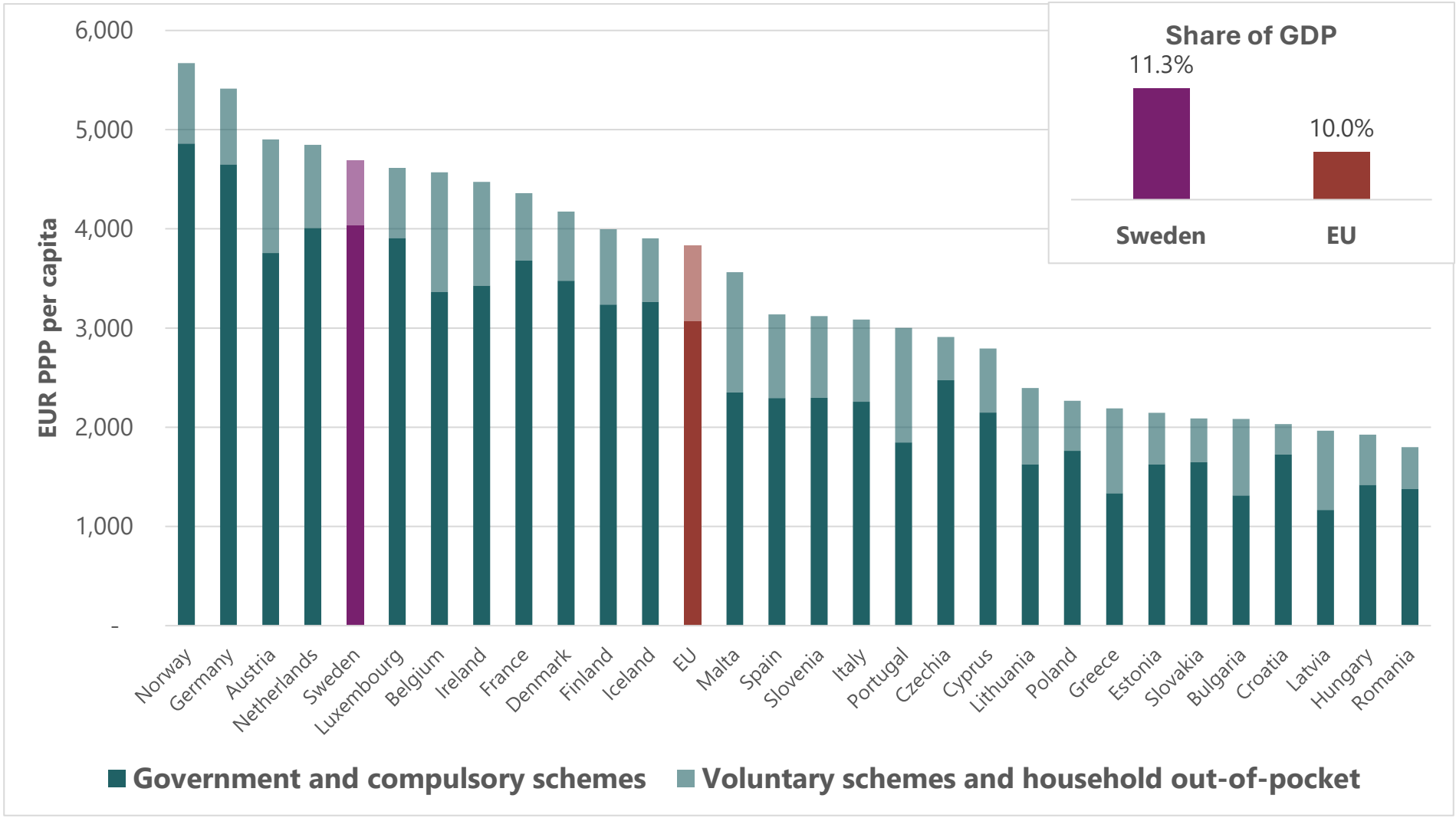
with the most severe gaps in rural and northern areas. More fundamentally, general practitioners (GPs) account for only 14% of the physician workforce compared with an EU average of 20%, reflecting difficulties in strengthening primary care capacity.

Hospital bed shortages reflect a decades-long strategy now under strain

Sweden's healthcare system is characterised by the lowest hospital bed density in the EU, a direct result of a long- standing policy to shift care towards outpatient, community and digital settings. While this lean model has successfully contained costs and fostered integrated care, it is now strained by rising demand, leading to significant capacity constraints.

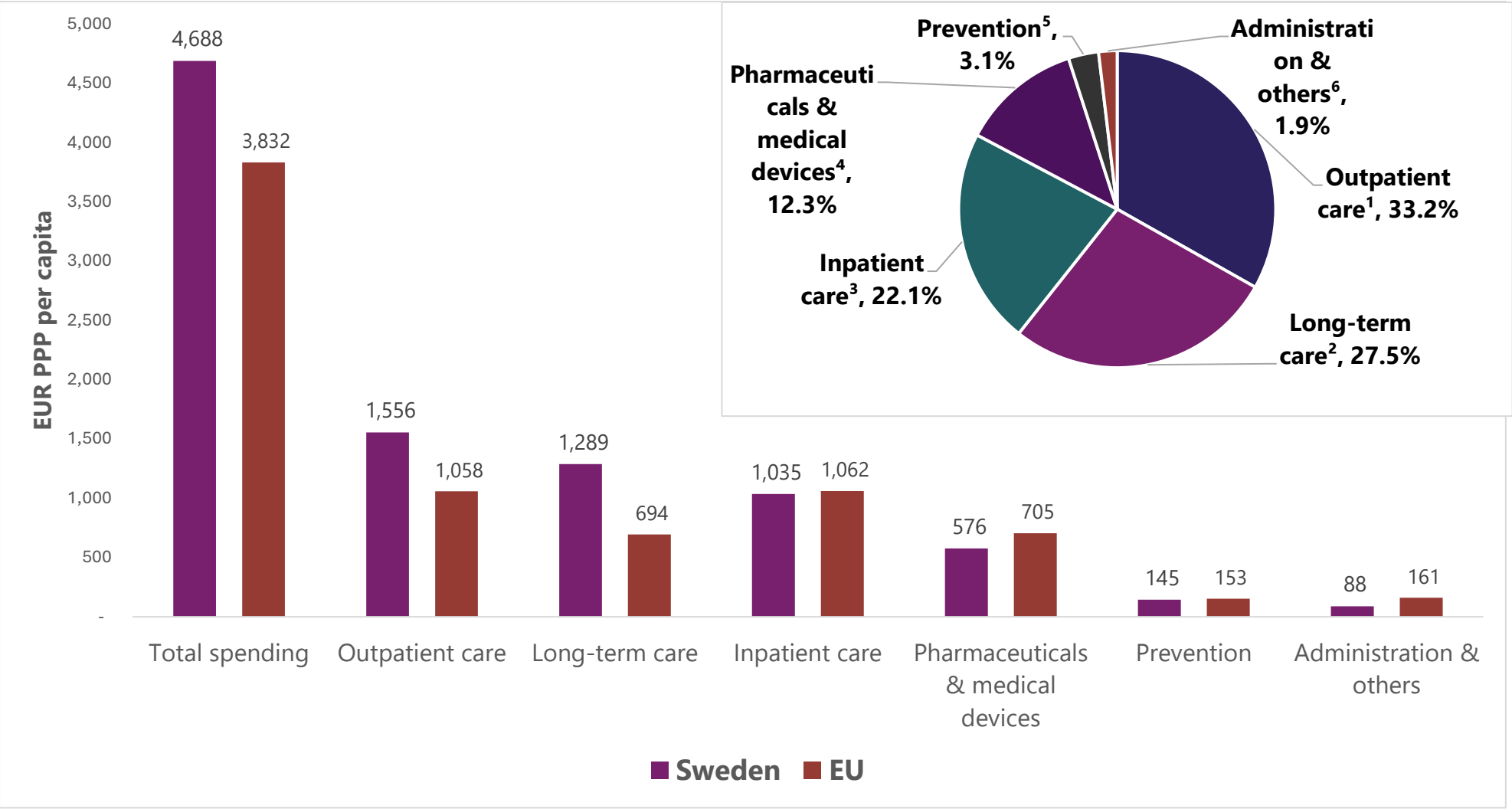
The government is tackling this issue on two fronts. The 2025 budget allocated SEK 3.7 billion to strengthen primary and local specialised care under the God och nära vård initiative, SEK 1 billion to reduce surgical waiting lists and another SEK 1 billion distributed to the 21 regions based on several performance indicators. In parallel, a more structural challenge stems from reimbursement mechanisms that do not adequately incentivise home-based and digital services that could ease hospital demand. To address this structural gap, an EU- funded project led by Karolinska University Hospital is developing a new payment model to support Sweden's transition toward a more distributed and sustainable care system.

Figure 5: Sweden ranks fourth in the EU for health spending per capita and as a share of GDP



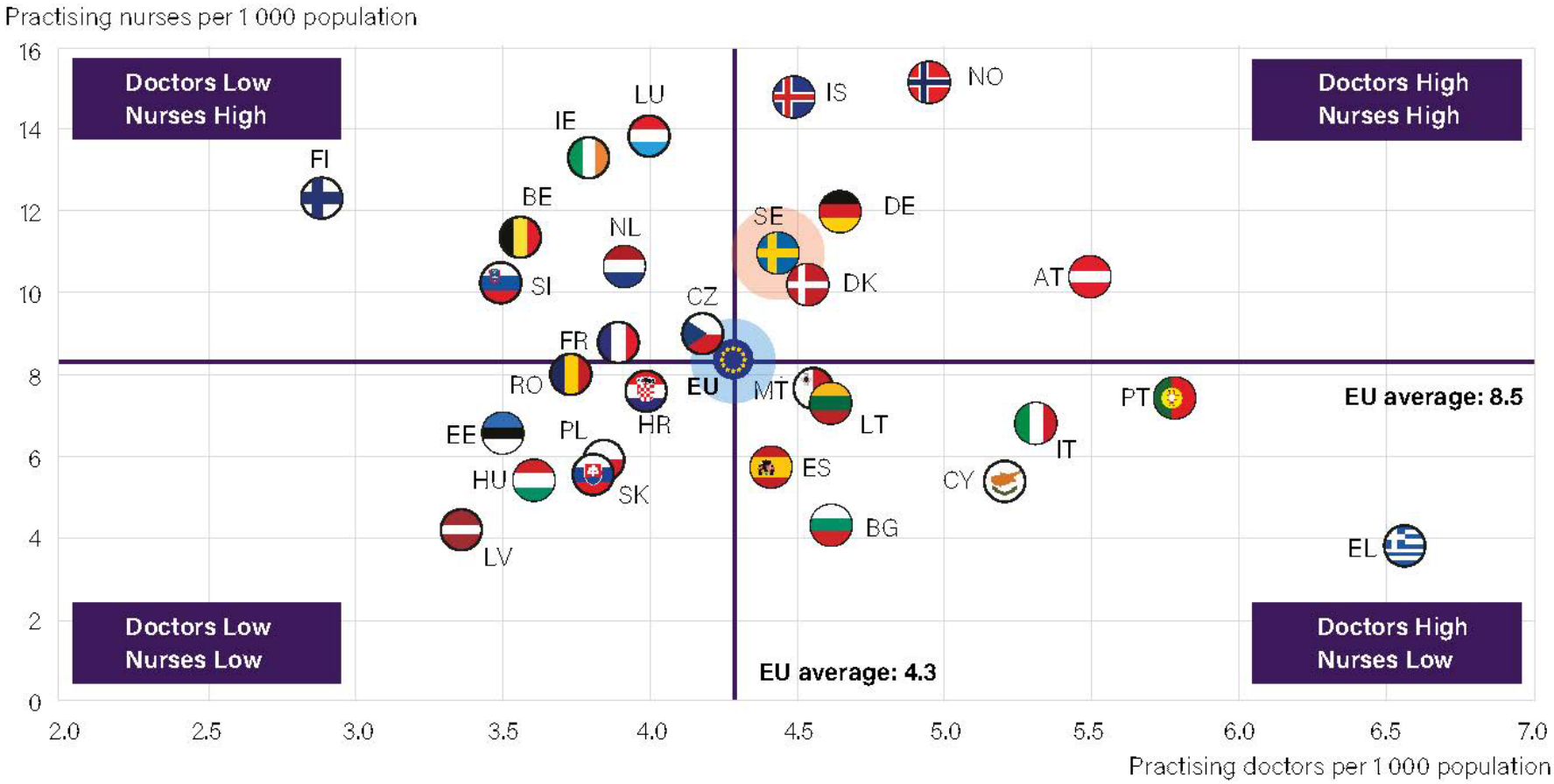
Note: The EU average is weighted (calculated by OECD).
Sources: OECD Data Explorer (DF_SHA); Eurostat Database (demo_gind). Data refer to 2023.

Figure 6: Outpatient medical care accounts for one-third of Sweden's healthcare spending



Notes: 1 Includes home care and ancillary services (e.g. patient transportation); 2. Includes only the health component; 3: Includes curative-rehabilitative care in hospital and other settings; 4. Includes only 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 (calculated by OECD).
Sources: OECD Data Explorer (DF_SHA). Data refer to 2023

Figure 7: Sweden has a comparatively high number of doctors and nurses



Note: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospital.
Source: OECD Data Explorer (DF_PHYS,DF_NURSE). Data refer to 2023 or nearest year.

The Netherlands[4]

The Dutch health insurance system ensures universal coverage through regulated competition and risk equalisation

The Health Insurance Act, introduced in 2006, mandates that all residents in the Netherlands purchase health insurance from competing private not-for-profit insurers, which must offer a standardised benefits package defined by the government. This comprehensive package covers most specialist and primary care, pharmaceuticals, medical devices, adult mental health services, allied health services, and community nursing. Health insurers are required to accept all applicants and negotiate contracts with providers based on quality and cost, within the framework of national regulations. Insurers may also offer voluntary supplementary insurance for services not included in the basic package.

Dutch residents choose their insurer and pay a community rated premium covering half of the insurance cost; the remaining half is financed by an income-dependent contribution collected by the tax office, pooled in the Health Insurance Fund, and redistributed to insurers through a risk-equalisation scheme. The government pays a contribution for children under 18. Adults are subject to a mandatory deductible of EUR 385 per year for eligible curative services.

Preventive care, including public health measures and infectious disease control, is financed separately through general taxation under the Public Health Act.

Private provider choice coexists with publicly funded long-term and social care schemes in the Netherlands

In the Netherlands, the healthcare system is organized around predominantly private providers, with patients having unrestricted choice. General practitioners (GPs) and hospitals operate under mixed payment and governance models. The majority of GPs work in group practices or multidisciplinary health centres and act as gatekeepers for access to most specialist services. They are remunerated through a combination of payments for enrolled patients, fee-for-service payments, bundled payments, and pay-for-performance incentives (Lefevre et al., 2023). Hospitals are typically non-profit foundations, and the medical specialists working within them are either self-employed professionals contracting with the hospital (accounting for approximately 60%) or salaried employees, particularly in academic medical centres.

The Netherlands has dedicated financing schemes for specific care needs, most notably for long-term care. The Long-term Care Act (LTCA) functions as a single-payer social insurance system covering round-the-clock care for people who need extensive, often

[4] Source: Extracted from OECD/European Observatory on Health Systems and Policies (2025), Country Health Profile 2025: The Netherlands. State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

residential, support. This public scheme, in which all Dutch residents are automatically enrolled, is administered regionally by the dominant health insurer and includes elderly care, care for disabled people and longer-term mental healthcare. Contributions are income and wealth-related and are collected by the tax office, with tax revenues supplementing these funds to cover total expenditure. This is further supplemented by the Social Support Act, a tax-funded programme implemented by municipalities to cover social care at home or in small-scale settings. Lastly, a fourth scheme, the Youth Act, is overseen by local authorities and covers a spectrum of support, assistance and social care for children and adolescents.

Dutch per capita health spending is 26% above the EU average

In 2023, health expenditure in the Netherlands accounted for 9.8% of GDP, slightly below the EU average of 10% (Figure 8). However, the Netherlands has one of the highest levels of health spending per capita in the EU, with per-capita expenditure reaching EUR 4,848 (adjusted for PPP). This is 26% above the EU average, ranking the highest after Norway, Germany and Austria.

Statutory schemes cover most health spending in the Netherlands, with modest out-of-pocket costs and widespread supplementary insurance. In 2023, government and compulsory insurance schemes financed 83% of current health expenditure in the Netherlands, well above the EU average of 80%. Out-of-pocket (OOP) payments represented 12% of spending, a comparatively low share relative to the EU average of 16%. Voluntary health insurance (VHI) accounted for the remaining 5%. These financing patterns reflect the comprehensive scope of the statutory benefits package, which covers a wide range of services, and the high uptake of supplementary insurance to address residual coverage gaps.

The Netherlands allocates a large share of health spending to long-term care. The Netherlands devotes one third of its health spending to outpatient care but a substantial share of health spending is allocated to long-term care, which accounted for 29% of total health expenditure in 2023, well above the EU average of 18%. This reflects the wide coverage of Dutch long-term care services, which encompass institutional and home-based care for older people, individuals with disabilities, and those requiring prolonged mental health support. In contrast, the shares of expenditure allocated to inpatient care (18%) and retail pharmaceuticals (10%) are much lower than in most other EU countries (Figure 9).

Spending on preventive care rose markedly during the pandemic, increasing from 3.3% of total health expenditure in 2019 to 8.7% in 2021, driven by large-scale testing, contact tracing and vaccination efforts. Although this declined to 5.2% in 2023, it remained above the EU average of 4.2%.

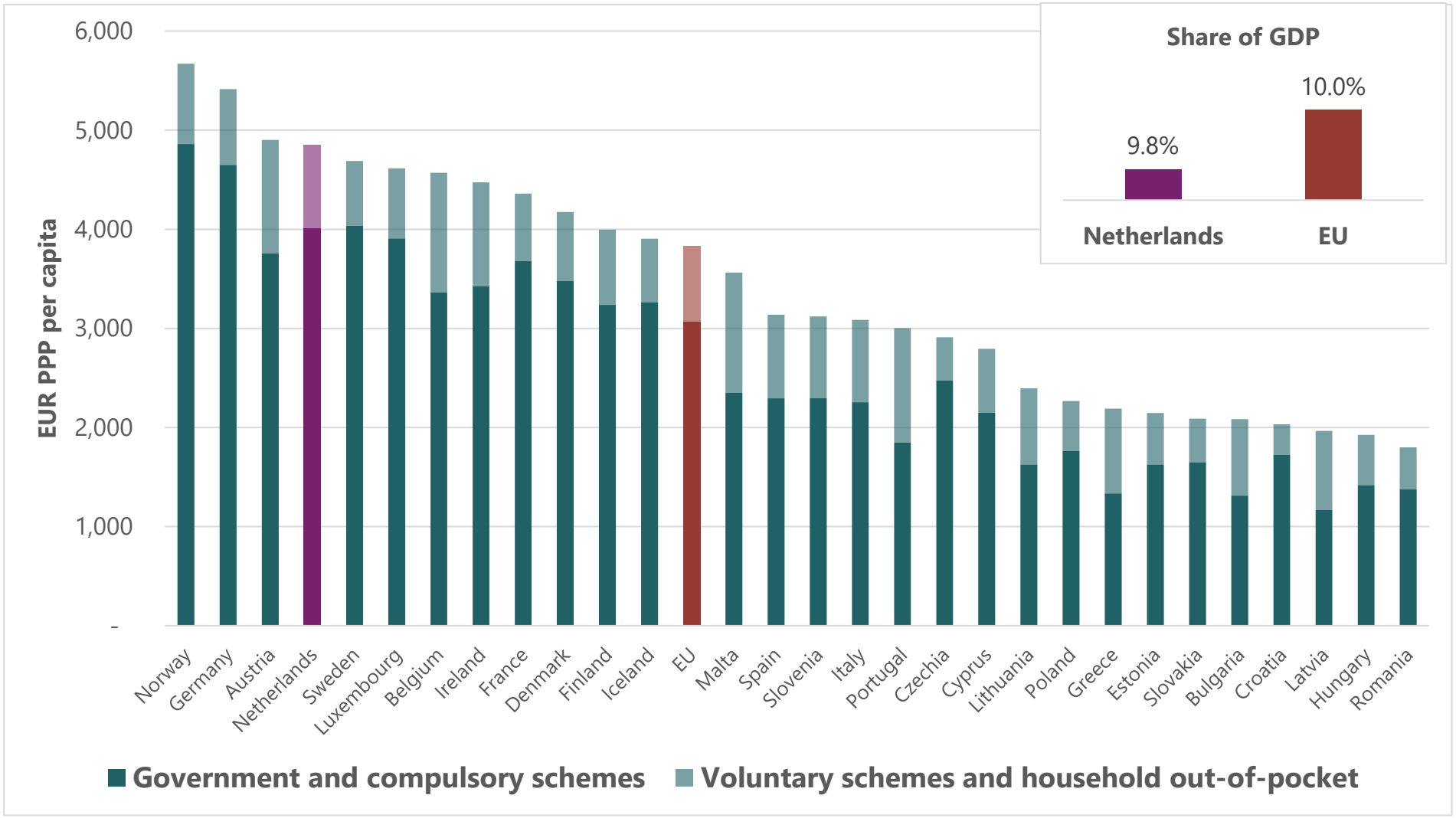
Despite recent rises in GPs and nurses, the health system continues to face health workforce shortages

In 2023, the Netherlands had 3.9 practising doctors per 1,000 population, up from 3.4 in 2014, but below the EU average of 4.3. The Dutch healthcare system stands out for its emphasis on primary care, with approximately one in four physicians serving as general practitioners (GPs) - a significantly higher proportion than in many other EU countries. Nonetheless, the country continues to face escalating shortages of GPs to respond to growing primary care needs, and these shortages are expected to worsen in the coming years as many GPs are approaching retirement age and also because of earlier exit from the profession. The workforce challenges extend beyond primary care to critical specialisations including psychiatry, paediatrics and geriatrics.

The number of nurses in the Netherlands has also increased over the past decade, from 10.3 nurses per 1,000 population in 2014 to 11.1 nurses in 2023, above the EU average of 8.4 (Figure 10). This expansion has been strategically enhanced by the growing deployment of nurse specialists with advanced qualifications, who are authorised to prescribe medications and perform selected non-surgical procedures, thereby helping to alleviate pressure on doctors. Despite these positive developments, significant staffing difficulties persist. Hospitals continue to struggle with nursing workforce gaps, and shortages are also particularly acute in nursing homes and home care services.

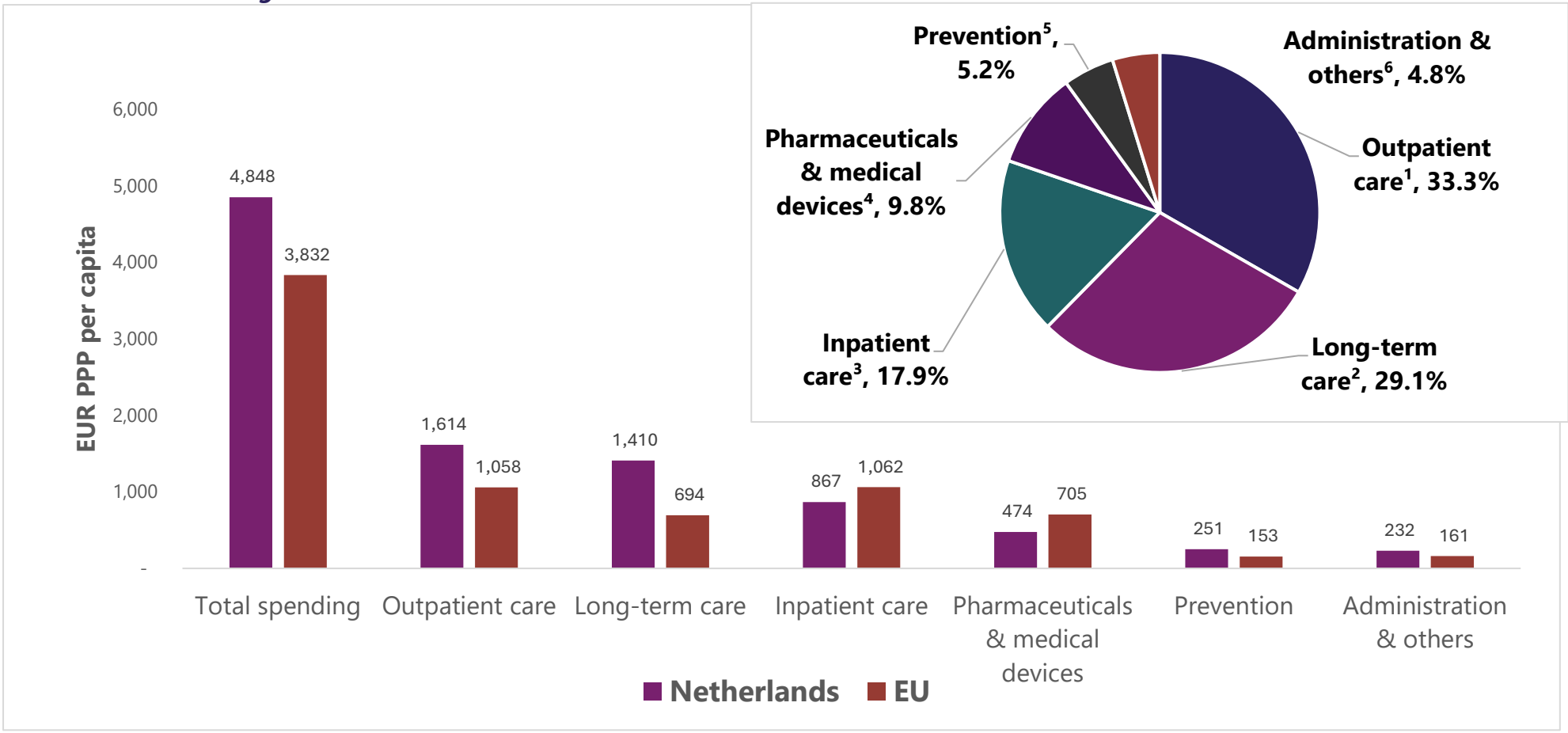
To address persistent staffing gaps, many hospitals have turned to freelance nurses as a stopgap solution. However, this approach raised serious concerns about escalating costs and potential negative impacts on care continuity and quality. While freelance nursing remains possible, Dutch authorities have introduced stricter measures since January 2025 to clarify work relationships and encourage more stable, salaried positions in healthcare.

Figure 8: Health spending per capita in the Netherlands is among the highest in the EU



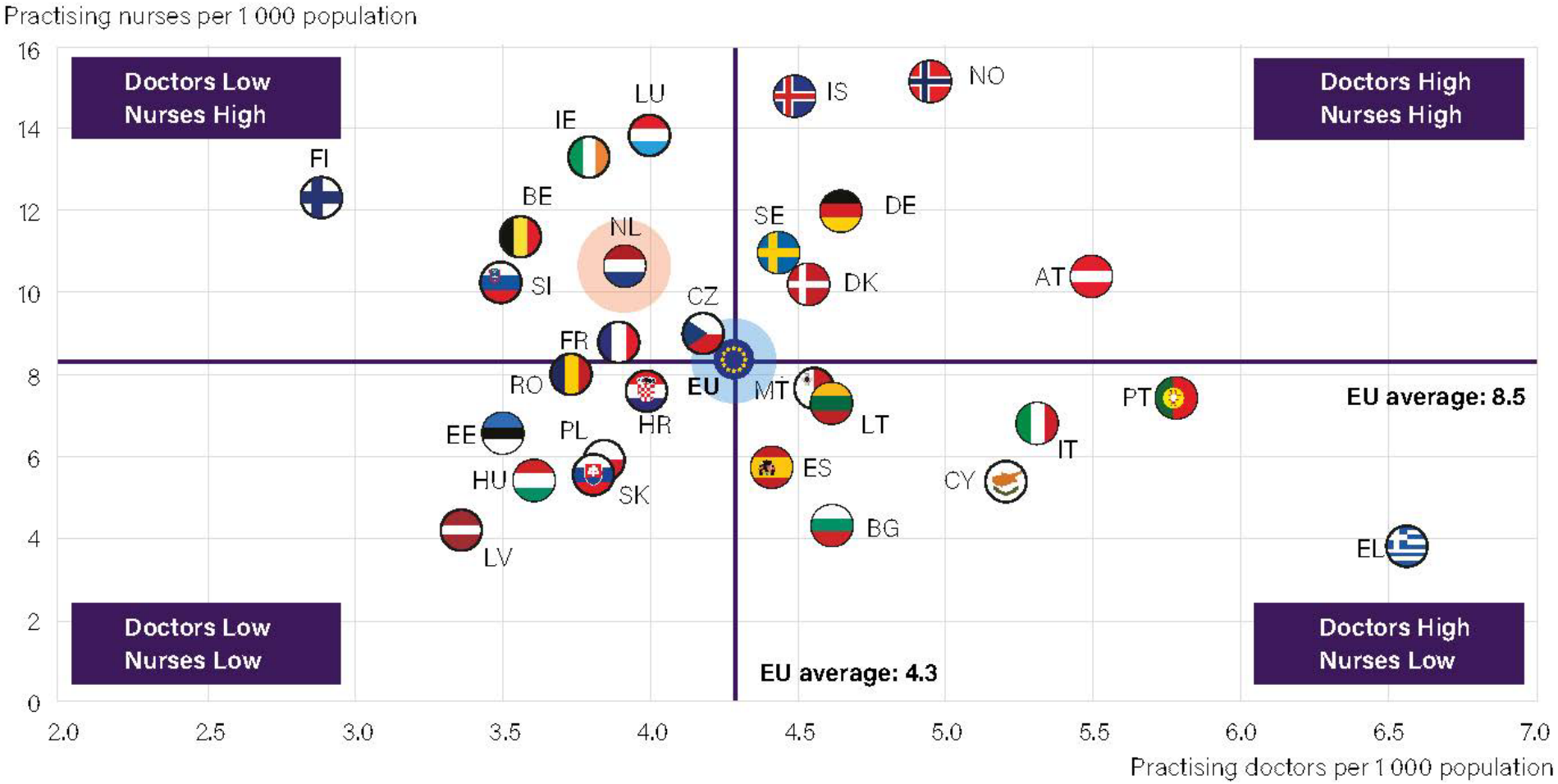
Note: The EU average is weighted (calculated by OECD).
Source: OECD Data Explorer (DF_SHA); Eurostat Database (demo_gind). Data refer to 2023

Figure 9: Outpatient and long-term care absorb most health expenditure, while pharmaceutical spending is much lower than the EU average



Note: Includes home care and ancillary services (e.g. patient transportation); 2. Includes only the health component; 3. Includes curative-rehabilitative care in hospital and other settings; 4. Includes only the outpatient market; 5. Includes only spending for organised prevention programmes; 6. Includes health system governance and administration and other spending. The EU average is weighted (calculated by the OECD)
Sources: OECD Data Explorer (DF_SHA). Data refer to 2023

Figure 10: The Netherlands has fewer doctors but more nurses per capita than the EU average



Note: The EU average is unweighted. 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 practice, resulting in a large overestimation of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospital.
Source: OECD Data Explorer (DF_PHYS, DF_NURSE). Data refer to 2023 or nearest year.

National Maternity and Neonatal Investigation