ALIGN CONSORTIUM

CASE STUDY

The Health Technology Assessment System in the Netherlands

A short study of how one country decides which health products to introduce and fund—part of a series across countries.

Health leaders in all health systems must make critical decisions about which products—including diagnostics, medical devices, medicines, and vaccines—and services to provide within the constraints of their health budget. Between the global pipeline that brings technologies to market and the national systems that must deliver them at scale lies a critical inflection point: health innovation introduction. Prioritization—which often includes health technology assessment (HTA) processes—is an essential function of innovation introduction, as are the coordinated set of national and subnational processes through which innovations are prepared for sustained, scaled access (e.g., regulatory review, procurement, supply chain planning, etc).

The Netherlands offers a case of disciplined innovation introduction in a high-income system, where insurance coverage is never automatic on regulatory approval but earned by first demonstrating value through a defined sequence of assessment, coverage, and purchasing decisions. The Dutch model links national health technology assessment (HTA) to benefits-package decisions and strategic purchasing through regulated competition, with private insurers as the central purchasers. Its specific institutions are distinctively Dutch—but they are not the point of the case. What is transferable to other systems, whatever their income level, is the set of functions beneath them: value assessment paired with real coverage authority, purchasing tied to financial accountability, and innovations assessed at the level of the care pathway rather than the individual product.

Approach

Disciplined innovation introduction through regulated competition—national HTA defines what is eligible for coverage; risk-bearing insurers decide how, and whether, to buy it.

Stage

Mature; HTA, managed competition, and selective contracting were in use well before the 2006 reform that unified them into a single framework.

Home

Zorginstituut Nederland (ZN), the independent statutory body that assesses and manages the basic benefits package. Its verdicts bind coverage—insurers may reimburse only what ZN judges effective—while the Minister of Health formally sets the package on ZN's advice.

Takeaway

What transfers are the functions, not the Dutch institutions: value assessment paired with real coverage authority, purchasing tied to financial accountability, and pathway-level (rather than product-level) assessment.

Figure 1: Summary of the Dutch health technology assessment system.

CURRENT SYSTEM

Health product prioritization structures and processes

The Dutch health system combines public financing, private insurance, and predominantly private, not-for-profit service provision—a configuration shaped by the 2006 Health Insurance Act (discussed later under "How did this system come about?"). Insurers and providers are private, but the rules governing coverage, financing, and fairness are centrally defined and enforced, so public objectives are pursued through private delivery.

Prioritization of health innovations—diagnostics, medical devices, medicines, vaccines, and digital tools—sits across both the public and private parts of that system. **Innovation does not enter through government mandate or automatic nationwide roll-out.** It moves through a layered decision structure: prioritization, HTA assessment, coverage decision, and insurer purchasing, drawing in actors at each level (Figure 2).

National value assessment: how coverage eligibility is earned

At the national level, the Ministry of Health, Welfare, and Sport prioritizes topics through benefit-package management and horizon scanning, especially where expected budget impact is high. (Budget impact is the estimated total cost to the system—the eligible patient population multiplied by the product's unit price—so technologies reaching large populations or carrying high unit costs attract earlier, more intensive review.)

Horizon scanning is conducted by Zorginstituut Nederland (ZN), the independent statutory body responsible for HTA and safeguarding the basic benefits package, which monitors the pipeline alongside bodies such as the International Horizon Scanning Initiative, enabling the system to prepare for high-impact innovations before they reach the market.

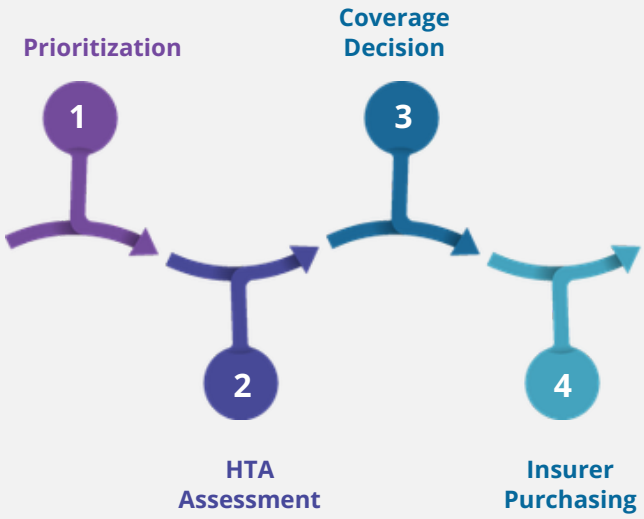
Once a topic is prioritized, ZN conducts the assessment—formal evidence review—and judges whether an intervention is eligible for the legally defined care package against four criteria: necessity, effectiveness, cost-effectiveness, and feasibility. Effectiveness is whether a decision is evidence-informed, aligned with population need, fairly distributed across those who would benefit, and compatible with system capacity. Economic evaluations follow the Dutch Guideline for Economic Evaluations in Healthcare, which requires a cost-utility analysis measured in QALYs (quality-adjusted life years), alongside budget-impact modelling. **ZN's verdict is more than advice; for care whose effectiveness is uncertain, insurers may reimburse only what ZN judges effective, while the Minister of Health, Welfare, and Sport formally sets the package on ZN's recommendation.**

Pathway-level assessment: judging a technology in context

Crucially, ZN assesses a technology by its effect on the whole care pathway, weighing it against the care already covered, rather than on its standalone merits. Dutch packages often take the form of organized pathways and bundles—particularly in chronic disease management in primary care, such as diabetes and cardiovascular disease—where a bundle covers multiple services across a patient's pathway rather than a single intervention. A new diagnostic or device is judged by how it changes outcomes and costs across that pathway; components may vary in cost, but the question is whether the bundle as a whole delivers sufficient value for money.

> ***What is HTA?***
>
> *Health technology assessment (HTA) is a multidisciplinary process that uses explicit methods to determine the value of a health technology at different points in its lifecycle. The purpose is to inform decision-making to promote an equitable, efficient, and high-quality health system (HTAi).*

The diabetes pathway shows this in practice. When ZN issued a coverage position on flash glucose monitoring, it did not assess the device in isolation; it weighed it against real-time continuous glucose monitoring already in the package and against finger-prick self-monitoring, asking whether it improved outcomes, reduced costs, or substituted for more expensive care within the existing pathway. Coverage was granted with defined indications—people with type 1 or type 2 diabetes on an intensive insulin regimen qualified for reimbursement—while those with hypoglycemia unawareness were directed to real-time monitoring for its alarm function. The logic reflects the system's



1. Benefit package management and horizon scanning. **Key actors:** Zorginstituut Nederland and the Ministry of Health, Welfare, and Sport.
2. ZN evaluates necessity, effectiveness, cost-effectiveness and feasibility. **Key actor**: Zorginstituut Nederland.
3. Inclusion in the basic benefits package. Establishes eligibility—not automatic access. **Key actors**: Zorgpakket and the Ministry of Health, Welfare, and Sport.
4. Selective contracting by private insurers. Determines pace, scale, and conditions of uptake. **Key actors**: private insurers.

Figure 2: The Dutch four-step innovation decision pathway.
(Source: Zorginstituut Nederland; European Observatory on Health Systems and Policies, 2024)

broader ethos: not merely treating diabetes, but organizing care from prevention through complication management, and adding technologies not because they are new, but rather because they demonstrably improve that pathway.

Strategic purchasing: how risk-bearing insurers turn eligibility into access

Inclusion in the package establishes eligibility, not access. Health insurers act as the central purchasers and the primary gatekeepers for adoption. Financing is publicly pooled through mandatory contributions and general taxation, but insurers translate those funds into delivery through selective contracting: their decisions determine which providers deliver which services, under what conditions, at what price, and at what scale. Adoption, therefore, depends less on regulatory approval than on whether an intervention fits insurers' purchasing logic and care-design strategies. Because insurers bear financial risk, they can support pilots, selective roll-out, or conditional reimbursement, arrangements that let evidence accumulate while care is delivered, creating room for "learning while doing" without exposing the whole system to financial or clinical risk.

Providers retain clinical and organizational autonomy but operate within tightly regulated financing boundaries. They decide how care is delivered and whether to join innovation pilots, but they cannot unilaterally scale non-reimbursed technologies, define coverage, or set prices outside negotiated contracts. Innovation thus enters through a whole-of-government and whole-of-market process rather than by decree. National HTA defines what is eligible, insurers operationalize adoption through contracting, and providers implement within negotiated pathways. This can slow diffusion, but once embedded, uptake tends to be more durable and better aligned with system capacity and long-term sustainability.

In short, the Netherlands decides what is worth covering nationally, and how and whether to pay for it through purchasing. Innovation succeeds by fit, not speed.

The same logic is now turning inward. Having built a disciplined assessment for what *enters* the package, the Dutch system is extending it to what *stays*—and how care is delivered. Under the appropriate-care agenda (*passende zorg*), ZN is shifting from one-off coverage decisions toward active package management: attaching conditions to how and by whom covered care is provided, and revisiting low-value care that no longer earns its place. In parallel, the government aims to broaden systematic HTA beyond outpatient medicines—where it is most established—to devices, inpatient drugs, and other interventions. Both moves apply the case's core pairing, value assessment with real coverage authority, to the standing package rather than only its newest entrants.

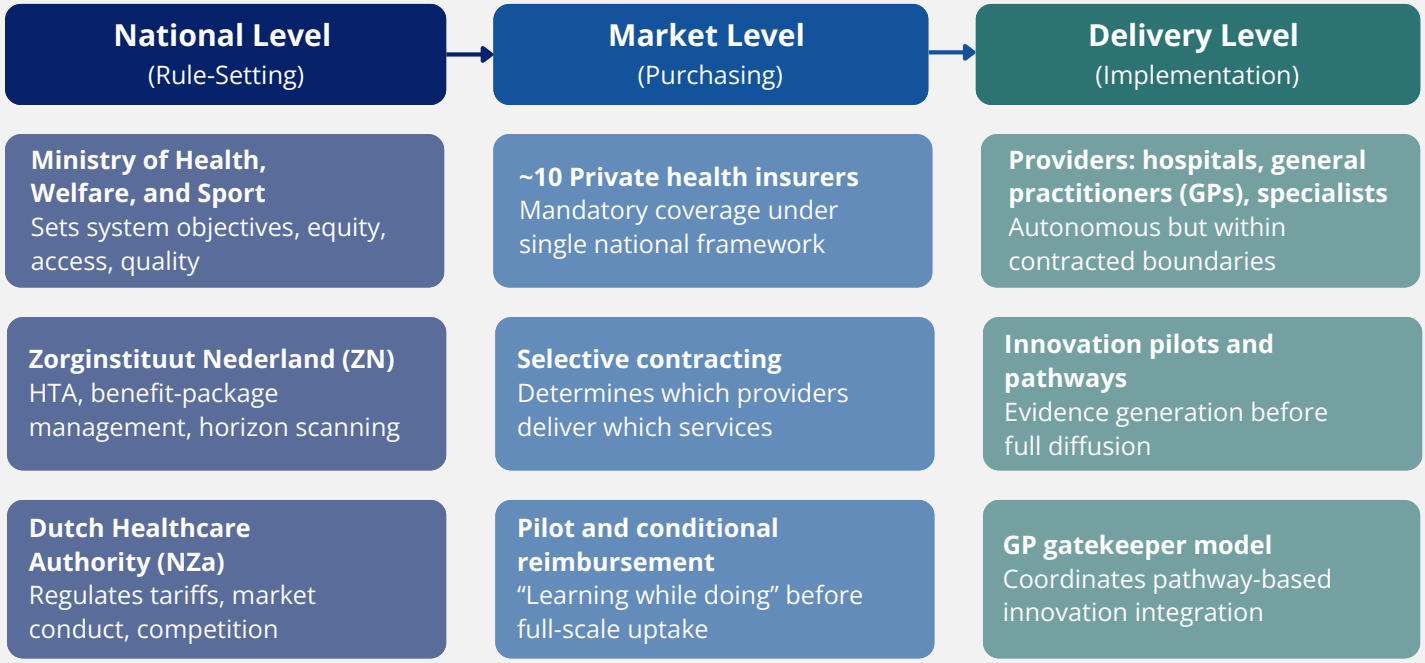


Figure 3: Innovation Flow in the Dutch Health System.
(Source: European Observatory on Health Systems and Policies, 2024; Commonwealth Fund, 2020)

HOW DID THIS SYSTEM COME ABOUT?

The current Dutch approach to health innovation evolved within a system that had already committed to broad social solidarity and near-universal coverage, well before the 2006 reform (Figure 4). Since the mid-20th century, statutory sickness funds covered lower- and middle-income populations, while higher-income groups purchased private insurance. Although fragmented, this dual structure reflected an early and sustained political commitment to universal access, public pooling, and regulated provision. The 2006 reform did not introduce universal coverage from scratch; rather, it consolidated and redesigned existing arrangements into a single, mandatory framework.

The 2006 Health Insurance Act did not emerge in isolation. It was triggered by converging pressures that made reform politically and fiscally necessary. Rising healthcare expenditures, sustainability concerns, and variation in quality and efficiency across providers exposed limits of the dual insurance system. An aging population and growing chronic disease burden increased pressure to improve coordination and value for money. While coverage was already broad, fragmentation across sickness funds and private insurers created inequities and inefficiencies that required structural consolidation.

From a policy standpoint, viable institutional solutions already existed. The Netherlands had strong regulatory capacity and a tradition of consensus governance: a political culture of reaching decisions through structured, multi-stakeholder dialogue among government, insurers, providers, and industry, alongside deep experience with social insurance. **Importantly, HTA, managed competition, and selective contracting were not invented in 2006.** They had been in use in various forms under the sickness fund system that later formalized, scaled, and embedded them into a single unified framework.

The political conditions had been forming for nearly two decades. The blueprint came early: in 1987, a government commission chaired by Wisse Dekker—the chief executive of Philips, not a health official—published "Willingness to Change," proposing that the system be rebuilt around regulated competition to cure its persistent inefficiency and the uneven distribution of its financial burden. The idea proved far easier to publish than to enact. Two successive governments failed to turn it into law, and by the early 1990s, the reform was widely considered politically dead. Advocates saw competition as the discipline the

system lacked, while opponents argued that healthcare was not fit for competition and that markets would erode public values. What kept it alive was modification rather than abandonment—to meet the Labor Party's objection to privatizing health financing, Deputy Health Minister Hans Simons reshaped the plan to preserve solidarity within a more competitive frame.

Open enrollment obligations and selective contracting were layered in across the 1990s and early 2000s. By the time Health Minister Els Borst (1994–2002) had entrenched regulated competition as the organizing principle and her successor Hans Hoogervorst (2003–2007) drove the Health Insurance Act through parliament, the 2006 reform did not so much introduce a new system as consolidate tools already built and tested. Contested for 20 years, the settlement was nonetheless durable enough that the center-left coalition taking office in 2007 continued it rather than unwinding it.

A policy window opened through the convergence of fiscal pressure, institutional readiness, and political consensus. The 2006 reform unified insurance arrangements into a single mandatory system, strengthened insurer purchasing power, and formalized the role of HTA in safeguarding the benefits package. **Innovation governance was not added later as a corrective tool; it was embedded into financing and purchasing structures at the moment of system consolidation.**

Key enabling factors for reform

Several conditions made this consolidation possible—and made HTA a durable part of it rather than an accessory:

- **A pre-existing commitment to social solidarity and universal coverage.** Broad political consensus on solidarity and public pooling created legitimacy for technocratic prioritization.
- **Regulated competition with strong purchasing power.** Selective contracting enabled cost control and disciplined diffusion without state ownership of providers.
- **Institutionalized HTA and evidence appraisal.** HTA capacity existed before 2006 but was formalized and strengthened through the reform. ZN reached its current form in 2014, consolidating earlier bodies including the College voor Zorgverzekeringen (CVZ). By the time the system needed disciplined value assessment, the machinery to provide it was already in place.
- **Consensus-based policymaking culture.** Early dialogue between government, insurers, providers, and industry reduced conflict and facilitated predictable adoption pathways.
- **Stable financing and strong administrative capacity.** Reliable revenue and mature institutions reduced reform volatility and enabled incremental system alignment.

CRITICAL CONTEXT

- **Coverage and financing.**
  - **Who's covered.** A single mandatory basic insurance scheme covers nearly the entire population, 99.9% of the roughly 18 million people in the Netherlands. Every resident must buy basic insurance from a private insurer, which is obliged to accept all applicants regardless of age or health; income-related contributions and risk equalization across insurers preserve access.
  - **What's covered.** The statutory basic package (*basispakket*) is defined nationally and covers general practitioner (GP) care, hospital and specialist treatment, prescription drugs, maternity, mental health, and district nursing—with GP, maternity, and district-nursing care free at the point of use. Depth is shaped deliberately through HTA at the level of the care *pathway*, not the individual product. When ZN issued its coverage position on flash glucose monitoring, the device was reimbursed for defined patient groups (people with type 1 or type 2 diabetes on an intensive insulin regimen) as part of the diabetes pathway rather than as a standalone item. Long-term care is funded separately under its own statutory scheme and is among the most generous in the EU.
  - **Who pays.** The Netherlands spends about 10% of GDP on health (2022), about $6,555 per capita (2021). Most expenditure, roughly 83%, is publicly financed through income-related social insurance contributions and general taxation; external financing is nil. Out-of-pocket spending is about 10% of current health expenditure (2022).

- **Coverage and purchasing decisions sit within a regulated competitive insurance model.** Multiple private insurers operate under a single mandatory framework. National HTA defines what is eligible for coverage within the basic benefits package, while insurers determine how and at what pace innovations are purchased and implemented through selective contracting.
- **The system is decentralized in delivery but centralized in rule-setting.** The Ministry of Health, Welfare, and Sport sets system-wide objectives—including fairness—and the rules that carry them: the statutory benefits package (*zorgpakket*), mandatory insurance with risk equalization, and nationally defined quality and safety standards. Purchasing and delivery decisions sit with private insurers and providers within that framework.
- **The Netherlands is considered a mature HTA and managed competition system.** Strong institutional capacity, risk equalization across insurers, and a GP gatekeeper model—general practitioners are the first point of contact and the gateway to specialist care—support pathway-based care and disciplined innovation uptake.

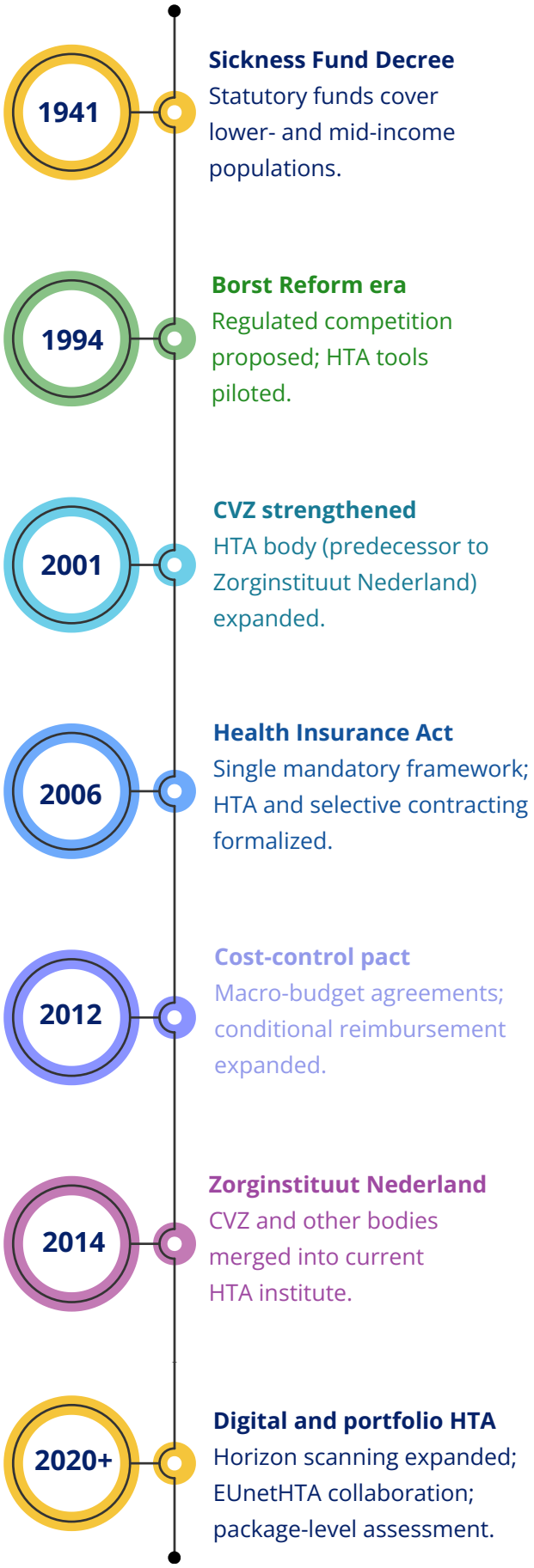


Figure 4: History of key reforms in health innovation prioritization and institutionalizing HTA in the Netherlands.

INSIGHTS & IMPLICATIONS FOR OTHER COUNTRIES

The Dutch experience offers five transferable lessons for other countries seeking to institutionalize evidence-based decision-making for health innovation introduction (also summarized in Figure 5):

1. **Link value assessment directly to coverage authority.** HTA that is advisory only and disconnected from who decides coverage rarely changes adoption patterns. In the Netherlands, ZN does not merely *recommend*—its assessments *bind* coverage directly, and the Minister of Health formally sets the package on its advice. Countries should ensure that whoever conducts value assessment either makes or directly binds coverage decisions; otherwise the assessment becomes a bureaucratic step rather than a decision tool.

2. **Assign purchasing authority to a body that bears financial risk.** Efficiency in the Dutch model is produced through purchasing, not just coverage

eligibility. Because insurers bear financial responsibility for what they contract, they have strong incentives to favor cost-effective innovations and resist premature scale-up. Countries should identify which actor in their system controls purchasing and ensure that actor also carries financial accountability for adoption outcomes. Separating these two creates a gap where spending discipline breaks down.

3. **Organize assessment around care pathways, not individual products.** The Netherlands evaluates innovations by how they change outcomes and costs across a whole care pathway, not in isolation. This prevents costly technologies from entering the system without demonstrating pathway-level value, and encourages bundled, coordinated care. Countries can adopt this logic by requiring that coverage submissions demonstrate where a technology fits in an existing care pathway, and what it replaces or improves.

4. **Define institutional roles clearly, and link them deliberately.** Coordination in the Dutch system does not happen through hierarchy; it emerges because each institution has a non-overlapping function with clear legal authority. The Ministry of Health, Welfare, and Sport sets the agenda, ZN's assessments bind coverage (with the Minister formally setting the package on that advice), insurers hold purchasing authority, and providers implement. Countries seeking to replicate this approach should map which body holds each function—agenda-setting, assessment, coverage, and purchasing—then design explicit linkages among them, rather than assuming coordination will happen organically.

5. **Pool financing and purchasing functions as preconditions.** The Dutch model depends on publicly pooled financing that flows through regulated insurers with clear purchasing mandates. Where financing is fragmented or largely out-of-pocket, the mechanisms that drive disciplined innovation adoption—selective contracting, risk equalization, and bundled care—cannot function. However, countries should first assess whether their financing architecture can support strategic purchasing before attempting to replicate Dutch-style HTA governance.

The lesson is not to copy Dutch institutions but to adapt the functions beneath them: value assessment paired with real coverage authority, purchasing tied to financial accountability, and feedback loops linking assessment, reimbursement, and delivery. What transfers are those functions, not the org chart. Whether they can be replicated matters less than whether they reinforce one another within a country's own political, fiscal, and institutional constraints. Reform succeeds when the functions fit together, not when individual policies are copied.

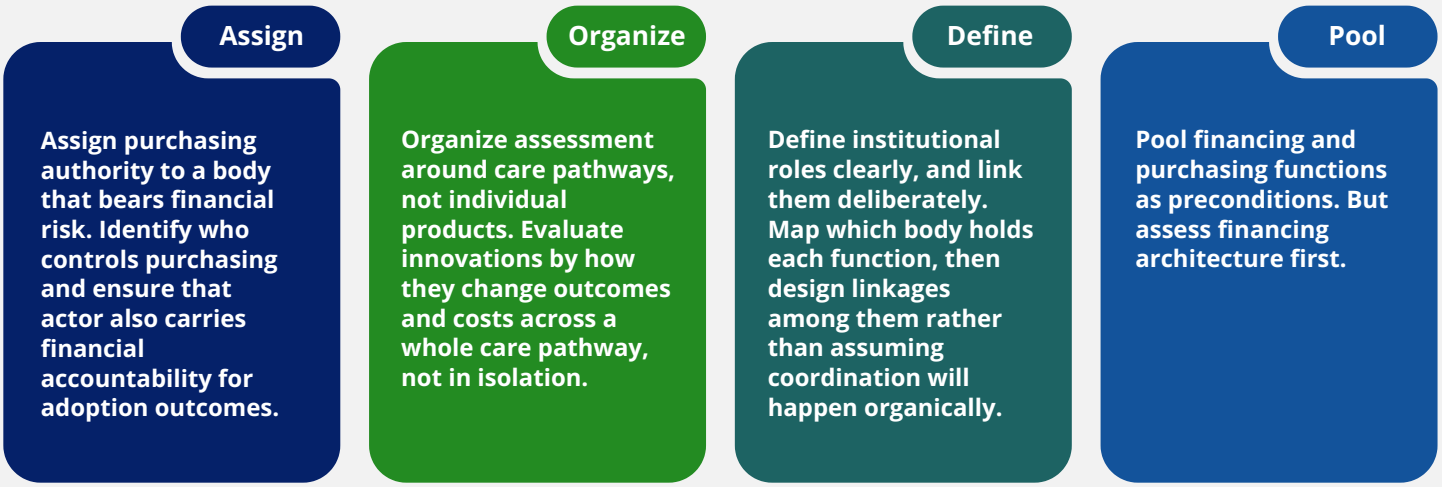


Figure 5: Summary of insights and implications for other countries about the Dutch experience with HTA.

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ABOUT THIS SERIES

This case study is one in a series of decision-making deep dives produced by the ALIGN Consortium as part of our shared learning agenda. Each examines how a particular country has navigated the persistent challenge of introducing new health innovations—how it evaluates, prioritizes, finances, and sustains them within real fiscal and political constraints. Our aim is not to rank systems or prescribe a single model, but to understand how reform actually unfolds: what enables it, what constrains it, and what does and does not transfer across contexts. These cases inform ALIGN's work alongside national partners and are offered in the spirit of mutual learning. We welcome reactions, corrections, and counter-examples from colleagues who know these systems first-hand.

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ABOUT THE ALIGN CONSORTIUM

The ALIGN Consortium aims to improve health outcomes by strengthening the critical decision-making systems that determine how health product innovations are prioritized and introduced in countries, to make those systems more effective and efficient. Comprised of the Duke Global Health Innovation Center, the South African Medical Research Council (SAMRC), the Kenya Paediatric Research Consortium (Keprecon), and ENDA Santé, the ALIGN Consortium supports national governments in Kenya, Senegal, and South Africa to enhance innovation introduction, looking at four focus areas: whole-of-government coordination and capacity, data-driven decision-making, whole-of-market engagement (including national, regional, and global engagement), and portfolio-based planning. The goal is to create more accountable, resilient health systems that deliver better health outcomes faster for all, and to generate insights, tools, and resources that can be used by stakeholders around the world.

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