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5.1.2e

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Switch language to

- EN English current language
- NL Nederlands niet beschikbaar

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Tuesday, 14 Apr 2020
 Blogpost

The Netherlands Response to the Coronavirus Pandemic



In the Netherlands, Covid-19 presented itself on a paper note in late February, read out loud by the Minister of Health during a live talkshow on the threatening virus outbreak. The note confirmed the positive test of what was later called ‘patient zero’. In the following days, more people tested positive. Most people had become sick after a skiing trip to Northern-Italy or Austria, and carnival parties that traditionally happen in the Southern region appeared a main source of contamination. In early March, all patients were still located in the South, and policies particularly focused on this region. People testing positive were forced to stay at home and refrain from any physical contact with the outside world. When more people got sick on a national scale, policies shifted from testing and isolating patients and their relatives to containing the disease. On April 5th, more than 16,500 patients have been diagnosed with Covid-19 countrywide, yet the exact number is unknown as tests are only done in specific cases due to scarcity of lab resources.

A few topics stand out in the Dutch approach of fighting Covid-19. First is the strong reliance on experts in combination with improvised consultations of professional associations. Politicians (and the King, for that matter) explicitly refer to expert advice when announcing new measures, particularly the epidemiologists of the National Institute for Public Health and the Environment (*Rijksinstituut voor Volksgezondheid en Milieu, RIVM*). A striking example is the Prime Minister’s explanation of the ‘herd immunity’ policy strategy during a television speech on March 16th. In his speech, Prime Minister Rutte explained to the nation that it would be impossible to protect all citizens against the virus, and that it was inevitable that many people would turn sick in the weeks and months to come. Meanwhile, the most vulnerable citizens (frail elderly) needed protection. It was argued that schools could remain open to enable parents to go to work, particularly those in so-called ‘vital occupations’ (i.e. healthcare, police, logistics). This somewhat quirky policy was first embraced and then heavily criticized by educational and medical specialist associations, as well as by experts from abroad. Teachers, supported by the educational associations, felt ‘unsafe’ and threatened to close their schools. The medical specialist association publicly urged to close schools to prevent a national disaster. After a weekend of heated debate, it was decided to close down all schools and universities, together with restaurants, bars, coffeeshops ‘contact-occupations’ (like hairdressers) and other social meeting places to slow down the spread of the virus. Illustrative for the Dutch negotiated approach was the announcement to partly reopen restaurants and coffeeshops one day later, allowing for ‘take away services’.

A second main feature, and relating to the former, is what has turned into an “intelligent lock down”. Instead of forcing citizens to remain in their houses (as is opted for in most European countries), ‘social distancing’ rules have been issued. People should not shake hands, work from home (except for people working in vital occupations), keep 1.5 meter distance, and stay at home in case of a cold or fever. Group gatherings (three people or more) are forbidden – families excluded. Social distancing has been strengthened by private initiatives to close shops, also encouraged by generous economic measures to financially compensate companies. Noticeably, social distancing takes place ‘under a shadow of hierarchy’: during a press conference the Prime Minister, the Minister of Justice and Safety and the Minister of Health stood together, forcefully warning citizens to obey the social distance rules to make it work. They even called (young) people who had gone to the beaches and forests during the first spring weekend “antisocial”, and high fines were announced for people breaking the rules.

Thirdly, and a very strong element of the Dutch approach, is the ‘flattening the curve’ principle. A main goal is to avoid a demand peak on the healthcare system and especially ICU beds. The number of beds is scarce (6.4 beds per 100,000 inhabitants; whereas the EU average is 11.5; and neighboring Germany has 30 beds per 100,000 inhabitants), and the lack of specialized nurses is an already known and now even more urgent policy problem. Scarcity has turned former professional rules and jurisdictions into fluid ones; general practitioners service as nurses on hospital wards, and OR-nurses are trained to perform ICU-tasks. The healthcare inspectorate seeks to cope with these changes, allowing healthcare organizations to bend quality rules to enable care provision.

Scarcity has furthermore sped up discussions about triage and protection. Hospitals and nursing homes no longer allow visitors, except when patients are dying. Increasingly, vulnerable patients and their relatives are advised to stay at home or in a nursing home to receive care when they are considered not to survive ICU treatment. At the moment of writing, hospitals and nursing homes are establishing palliative wards to provide decent end-of-life care. To that end, the Covid-19 crisis also reveals the peculiarities of the Dutch approach in normal times when it comes to unnecessary, burdening clinical treatment and end-of-life situations.

Commentary

Is there a typical Dutch approach towards the Covid-19 crisis? Well, yes. Take for example the measure to close all restaurants and bars, including coffeeshops, resulting in queues for coffeeshops followed by the decision that coffeeshops could stay open for serving their clientele on a take-out basis. The government aims to frame its measures as an intelligent – controlled – approach, based on the informed opinions of experts. Public opinion and especially organised interest however play a large part in the ‘tinkering’ approach taken, and the government is highly responsive to citizen behavior and reflexive towards the consequences of its decisions. Writing this piece in early April, we may carefully argue that the government tinkering approach is successful; the daily number of patients admitted to the hospital has slowed down, and hospitals (and nursing homes alike) start to worry about the empty beds (reserved for ‘Corona patients’) and ‘normal’ care left undone.

The current shortage of ICU beds shed more light on a typical characteristic of the Dutch healthcare system, where the world’s largest long-term care sector goes alongside a modest curative care sector, especially with respect to inpatient hospital care. Decentralized governance and the focus on managed competition now witness the buildup of (temporary) central stewardship structures taking over private arrangements – mirroring the traditional Dutch corporatist approach. The flexibility with which telehealth and hospital-at-home techniques are now being implemented after years of quarreling is another trend that may not be redressed after things turn back to normal.

Finally, and as the crisis unfolds, new voices emerge. The “whatever it takes” approach (to combat the new virus) is accompanied with other voices that warn of real social problems (e.g. vulnerable children not able to go to school, which is often a safer place than at home) and economic decline – perhaps leading to even more deaths in the future due to budget cuts and rising unemployment. The effects of contemporary measures are thought to be huge, with the Netherlands Bureau of Economic Policy Analysis predicting a decline in GDP of up to 7,7% in 2020 alone. However, the exact numbers are hard to tell – not least because traditional economic forecast techniques are not designed to cover such a shock.

More information

This blog is written by 5.1.2e 5.1.2e 5.1.2e (ESHPM), 5.1.2e
5.1.2e 5.1.2e (Radboud University Nijmegen, and 5.1.2e (Radboud University Nijmegen).

Health Economics, Policy and Law serves as a forum for scholarship on health and social care policy issues from these perspectives, and is of use to academics, policy makers and practitioners. HEPL is international in scope and publishes both theoretical and applied work.

New country responses to Covid19 Pandemic are added daily on [their website](#).

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