Heart failure
policy and
practice
in Europe

Heart failure policy and practice in the
Netherlands

The Heart Failure Policy Network

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November 2025

ABOUT THIS REPORT

This report aims to assist heart failure (HF) advocates in the Netherlands in engaging health system leaders to demand constructive changes to HF policy and care provision. It builds on previous pan-European work.

In 2020, the HFPN developed Heart failure policy and practice in Europe, a comprehensive analysis of best practice and significant gaps in HF policy and clinical performance in 11 European countries. We investigated each country's progress in addressing the HF challenge – for example, in terms of the existence and implementation of HF policies and the provision of multidisciplinary and integrated care. Findings were presented in an overarching report, which outlines the methodology for this work and includes a pan-European narrative. The report was accompanied by standalone country profiles with dedicated national-level analysis.

This country profile was commissioned by the Netherlands Heart Institute, and the structure and approach are closely aligned with the original project. Some components of best-practice care have been updated to reflect current evidence, recommendations and standard practice in 2025. The report's development was guided by a dedicated advisory board of Dutch experts in HF, who provided their time for free. See back cover for full disclaimer.

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Summary

The burden of heart failure (HF) in the Netherlands is high, both in terms of pressure on the healthcare system and its impact on people living with HF; almost 2% of the population has been diagnosed with HF.[1]

The country benefits from a robust healthcare infrastructure and a strong tradition of chronic disease management in primary care.[2,3] However, HF is not a political priority and there is no government-endorsed national strategy for cardiovascular disease. Against this background, it can be difficult to coordinate care pathways. People living with HF frequently experience delays in diagnosis, inconsistent access to specialist care and limited support for innovative treatments.[4-6]

National organisations and professional societies are leading a range of promising initiatives to address these gaps, and awareness among healthcare professionals is growing.[5] However, political support is urgently needed to enable a more integrated, person-centred and nationally coordinated approach, addressing the burden of HF and ensuring equitable, high-quality care and better outcomes for all.[7]

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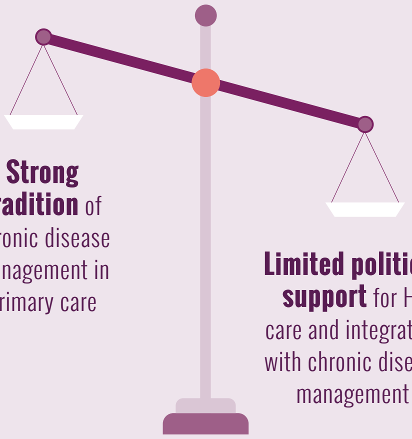

Strong tradition of chronic disease management in primary care

Limited political support for HF care and integration with chronic disease management

Heart failure in the Netherlands

HF has a significant impact on people's quality of life, hospitalisations and healthcare costs

People living with HF face physical, social and mental health challenges daily.[8] Symptoms such as fatigue and breathlessness limit mobility and independence,[9] and many people experience anxiety and depression due to the chronic nature of the disease.[8] HF often leads to reduced participation in work and community life, and increased reliance on carers, which has a substantial impact on people with HF and their loved ones.[8]

HF is a growing public health concern in the Netherlands.[1,6] Each year, more than 43,000 people are diagnosed with HF for the first time; in 2023, more than 8,000 people died from the condition.[10] It is estimated that almost 500,000 people are currently living with HF, although almost 50% may be unaware of this.[4] As a person ages they are more likely to develop HF – 83% of people living with HF are aged 65 or older;[10] therefore, the total number of people with HF is expected to rise as the population in the Netherlands ages.

HF accounts for nearly 34,000 hospital admissions each year.[10] Direct healthcare expenditure for HF is €500 million per year,[4] and recent research suggests that the average lifetime cost per person with HF reaches approximately €64,000.[11] Hospital care accounts for 60% of these costs, while 30% can be attributed to long-term community care, emphasising the significant pressure on both acute and long-term care services.[11] With this prevalence and impact, there is a need for integrated care that supports both clinical and quality-of-life outcomes.[9]

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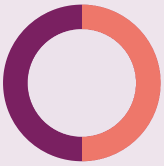

may be unaware of their condition

Direct healthcare expenditure for HF is

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Inequities in HF care exacerbate health disparities

In the Netherlands, there are significant disparities in HF outcomes between ethnic groups.[12] People from certain ethnic minority communities often experience delayed diagnoses and limited access to culturally appropriate care, which contributes to worse outcomes.[12] For example, people from South Asian backgrounds have a higher risk of certain types of HF and death from HF.[12 13]

Generally, there are higher rates of HF and HF deaths among people of low socioeconomic position.[14] This is because of myriad factors: people in lower-income areas or regions with limited healthcare infrastructure often face barriers such as low health literacy and reduced access to specialists.[4] People of low socioeconomic position are also more likely to experience worsening HF and have lower rates of prescription for guideline-directed medical therapy.[14]

Addressing these issues to ensure that all communities in the Netherlands receive timely and effective HF care requires a comprehensive approach that includes culturally sensitive care models that can be adapted to meet changing population needs.[15]

Heart failure policy in the Netherlands

Formal plans on HF

Although professional and patient organisations have created agendas for cardiovascular health, cardiovascular diseases are still not a political priority

The Netherlands does not currently have a government-endorsed, formal national strategy or action plan specifically targeting HF or cardiovascular disease.[7] Government-supported public health initiatives address lifestyle-related risk factors – including smoking, obesity and physical inactivity – but they are not tailored to the specific needs of people with HF.[7] The absence of a national government strategy or widespread political support for strategies is a barrier to coordinated investment in prevention, early diagnosis and integrated care.[5 16] The limited prioritisation of HF in the political healthcare agenda can also lead to inadequate awareness of the disease among the public and healthcare professionals.[7]

National organisations – including the Dutch Society of Cardiology (Nederlandse Vereniging voor Cardiologie, NVVC), the Dutch CardioVascular Alliance (DCVA), the Netherlands Heart Institute, the Dutch Cardiovascular Investigator Network (Werkgroep Cardiologische centra Nederland, WCN) and the Dutch Heart Foundation (Hartstichting) – are working to create a cohesive strategy for HF care.[4] The Dutch Heart Foundation brought together healthcare professionals, researchers, policymakers, and people with cardiovascular disease and their loved ones to co-create the Dutch Cardiovascular Agenda. Presented in 2024, it includes HF as one of seven core areas of work, with a focus on recognising and diagnosing HF earlier, and improving understanding and treatment of the condition.[4] However, the Dutch Cardiovascular Agenda has not yet been endorsed by the Dutch government.[17]

National organisation of HF care delivery

HF care models are shaped by national and regional transmural agreements

The National Transmural Agreements for HF (Landelijke Transmurale Afspraak Hartfalen, LTA HF) set out a framework for organising and coordinating HF care across primary and secondary care.[18] Developed by professional societies, hospitals and healthcare professionals, the agreements outline roles, responsibilities, competencies and referral criteria based on national guidelines and guidelines from the European Society of Cardiology (ESC).[18] The LTA HF aims to support smooth transitions of care, optimise treatment and improve quality of life for people with HF, including high-risk groups such as people who are also living with chronic obstructive pulmonary disease (COPD), type 2 diabetes or hypertension.[7 18]

To translate the LTA HF into practice, local general practitioners (GPs), cardiologists and HF nurses develop regional transmural agreements (RTAs), which tailor care delivery to regional needs while following national guidelines.[19] Supported by organisations such as the Dutch General Practitioners' Association (Nederlands Huisartsen Genootschap), NVVC and the Dutch Heart Foundation, RTAs are considered the standard for integrated chronic disease management.[4 18 19] The NVVC Connect programme facilitates the development of RTAs by offering examples and practical resources to help regions implement the agreements.[20]

Despite this structured approach, difficulties remain – especially in sharing health data and integrating RTAs into everyday clinical routines.[7 21] Additionally, ensuring long-term sustainability and consistent follow-up of RTAs across regions remains a challenge, particularly when local leadership or structural support is lacking.[7]

HF care planning and improvement initiatives are led by cardiovascular organisations and societies

Dutch healthcare professionals, policymakers and patient organisations are increasingly aware of the need for more integrated and better funded HF care, with initiatives now underway to improve this.[16 21] For example, the NVVC Connect programme is a long-standing cardiovascular care initiative focused on establishing regional networks of care providers with a shared approach to specific cardiovascular conditions.[22] The programme is open to providers from primary and secondary services and has a workstream dedicated to HF, with a range of resources including guidelines, training documents and patient information.[20] Alongside such initiatives, Deltaplan Heart Failure (Deltaplan Hartfalen, see *Case study 1*) serves as a leading nationwide effort to coordinate action that shapes HF care.[4 23]

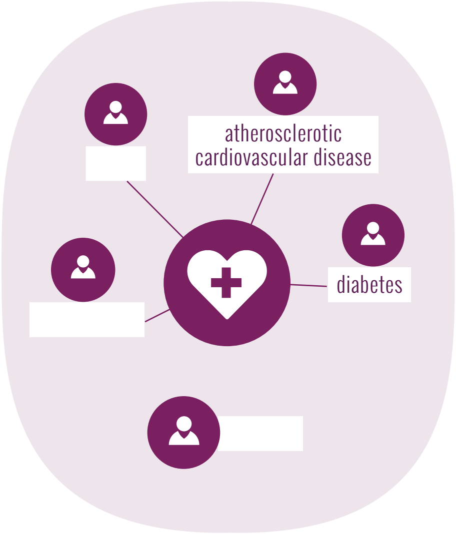
Case study 1. **The role of Deltaplan Heart Failure in shaping HF care**

Deltaplan Heart Failure (Deltaplan Hartfalen) is a leading national initiative that was developed in response to the increasing burden of HF in the Netherlands.[4 23] It aims to improve public awareness, promote earlier detection, optimise treatment, enhance multidisciplinary care, support innovative research and strengthen palliative care.[23] The initiative supports the achievement of the goals set out in the Dutch Cardiovascular Agenda.[4 23]

In 2022, the strategic platform for Deltaplan Heart Failure was set up to connect people with HF, healthcare professionals, researchers and policymakers.[23] The platform is used to gather data about HF care to identify gaps and opportunities across the health system.[23] It facilitates collaboration between disciplines and supports national campaigns such as National Heart Failure Week to raise awareness and drive action.[23]

The initiative is a programme of the Dutch CardioVascular Alliance, initiated and funded by the Dutch Heart Foundation and the Netherlands Heart Institute.[23]

There are gaps in insurance coverage of HF care



In the Netherlands, disease management programmes are largely shaped by providers of social health insurance, who operate under a regulated competition model led by the Ministry of Health, Welfare and Sport.[3] Insurers aim to support cost-effective and high-quality care through contracts that include bundled payment-based programmes.[5,24] These disease management programmes are designed to support proactive multidisciplinary care and are widely used in primary care to manage chronic conditions such as diabetes, hypertension, COPD and atherosclerotic cardiovascular disease.[7] However, HF is generally not included, despite the condition's prevalence and burden.[7,21] Where HF is incorporated into broader disease management programmes, this integration has required separate agreements initiated by local care groups.[21] Without such advocacy, HF is often left out and, as a result, deprioritised in primary care. This then leads to delayed diagnoses, inconsistent follow-up and missed opportunities for early intervention in some regions.[21,25]

Current payment arrangements also mean that primary and hospital care are usually funded separately.[21] This impedes coordination of care across settings, resulting in siloed care, worse experience for people with HF, and either gaps or duplication in follow-up.[21] Some hospitals are working to address this fragmentation by establishing multidisciplinary outpatient clinics.[21]

Development of the HF healthcare workforce and resources

Specialist training and resources are available for some healthcare professionals, but greater investment in the HF workforce is needed

HF nurses are a cornerstone of HF care in the Netherlands and their current capacity largely meets population needs,[6] although the growing HF burden might be a challenge in the future.[21] HF nurses are well integrated, mostly in hospital settings.[7] However, in certain cases – for example, for people with the most stable type of HF – they serve alongside GPs and cardiologists as the first point of contact, monitoring disease progression and supporting self-management.[6] HF nurses also lead post-discharge care, including prescribing and adjusting medications.[6,21] The strong involvement of HF nurses in the Dutch health system has led to demonstrable improvements in sharing information with people with HF and adherence to guideline-directed therapy; it is widely recognised as best practice.[6]

HF is an integral part of the core curriculum for resident cardiologists in the Netherlands, meaning that they develop competencies in the diagnosis, treatment and multidisciplinary management of HF during their specialist training.[26] For those wishing to further specialise in HF, the NVVC offers a formalised training pathway.[26] The 2025 pathway, outlined in the *Area of focus: Heart failure (Aandachtsgebied Hartfalen)*, defines a two-level curriculum that covers core competencies in HF management, complex comorbidities, device therapy and multidisciplinary coordination.[26] The training includes clinical rotations, assessments and certification, ensuring a high standard of specialist care.[26] However, completion of this HF training is not a mandatory requirement to provide care for people with the condition.[26]

Continuing professional development in HF care is supported by programmes such as NVVC Connect and the Cardiovascular Education Institute's (CardioVasculair Onderwijs Instituut, CVOI) Masterclass Heart Failure, which offer modular education on the latest treatments through accredited live webinars, case studies and self-study for cardiologists.[27]

Despite these opportunities, healthcare professionals and scientific societies recognise the need for multidisciplinary education and upskilling to support integrated HF care and meet increased capacity needs.[21 28] This may require greater investment in GPs and HF nurses, and improved training and integration of HF into existing education programmes for chronic care such as those for diabetes, COPD and cardiovascular risk management.[4 7] Changes that would facilitate such multidisciplinary workforce planning depend on policymakers having a centralised and shared vision, and insurers supporting systematic reimbursement of such initiatives.[7]

Healthcare professionals and scientific societies recognise the **need for multidisciplinary education**

Data infrastructure and public audits of performance

Data on hospital-based HF care can be captured in comprehensive systems, but insights from primary care are limited

Data on care for cardiovascular disease in hospitals are gathered through the Netherlands Heart Registration (Nederlandse Hart Registratie, NHR), set up in 2012 to centralise data collection.[29] As of 2024, the NHR included data from over 1.5 million cardiac procedures across 75 centres, making it a leading example of high-value data collection in Europe.[29 30] NHR data are used to benchmark hospital performance and support quality improvement.[29] Hospitals use the data set to monitor patient adherence to guideline-recommended therapies, reduce unwarranted variation in outcomes and support internal audit processes.[29 31]

In a recent development, the NHR now includes detailed hospital-based data on HF: patient demographics, HF classification (for example, HF with reduced ejection fraction, HFrEF, and HF with preserved ejection fraction, HFpEF), diagnostics used (natriuretic peptide testing, echocardiography), treatment details, and outcomes (readmissions, mortality).[31 32] Despite efforts by the NHR,[6] data collection and sharing are restricted: there is limited interoperability between hospital systems for electronic patient records, and records cannot be uploaded directly to the NHR.[32] As a result, HF nurses often need to enter data manually, which can be time-consuming.[7] Additionally, participation in the HF registry is not currently mandatory, resulting in inconsistent and sometimes inadequate data collection.[31]

Beyond the NHR, the Netherlands is investing in data infrastructure at a local level in hospitals. Examples include initiatives such as Heart4Data, which is part of the DCVA, and national HF registry studies such as CHECK-HF and TITRATE-HF (*Table 1*).[33-35] Many of these programmes aim to create a transparent ecosystem for cardiovascular data by combining hospital data while supporting research and innovation in HF care.[33]

TABLE 1. **Real-world data collection on HF and HF care**

Initiative	Role in HF care and research	Key registry	Focus areas
NHR[31]	National registry for cardiac interventions and outcomes	NHR HF registry	Collects real-world data on cardiac procedures and outcomes, including HF-specific data
CHECK-HF[34]	Nationwide cross-sectional cohort study	CHECK-HF registry	Real-world data on over 10,000 people living with HF, describing their treatment adherence and outcomes
TITRATE-HF[35]	Clinical trial embedded in registry infrastructure	TITRATE-HF trial	Evaluates treatment strategies and use of guideline-directed medical therapy in HF using registry-based clinical trial design

While the NHR provides comprehensive hospital-based data, there is no equivalent national infrastructure for accurate data collection in primary care.[21 29 31] Detailed HF data are only collected in select primary care practices.[36 37] This results in significant gaps in knowledge about the burden, diagnosis and ongoing management of the condition.[21 37] Efforts to link GP and hospital data, such as by identifying and profiling cohorts of people with HF, have highlighted inconsistencies in HF data collection and inaccuracy of primary care records.[37] The limitations in primary care data infrastructure within practices are mirrored in the broader challenges faced by registries at the national level.

Some national registries may also lack diverse representation, with lower levels of data about women, older adults, people with multiple comorbidities and people of lower socioeconomic position.[14 38] This lack of diversity is primarily due to selection bias and creates significant data gaps, which in turn limit the accuracy and usefulness of registries,[14 38] affecting broader quality improvement and policy efforts, and making it difficult to identify and address inequalities.[38]

Heart failure practice in the Netherlands

Detection and diagnosis

Despite clear guidance, limited access to recommended tools prevents early diagnosis of HF in primary care

Current national guidance for the diagnosis and management of HF in primary care includes recommendations on the use of natriuretic peptide testing (NT-proBNP) and electrocardiography.[18] When HF is suspected based on these assessments, referral to specialist care is needed.[2,21] However, despite existing guidance, experts report that the use of NT-proBNP and electrocardiography in primary care remains limited, impeding rapid referrals and hampering the information available to cardiologists when people are admitted with suspected HF.[2,21]

GPs play a crucial role in detecting HF early, and referring people to specialist care and ongoing management as appropriate.[21] However, healthcare professionals are unlikely to recognise HF symptoms, which may contribute to many people being unaware of their condition, late diagnosis and delays to treatment.[4] Strengthening training and awareness in primary care, along with increasing the accessibility of diagnostic tools such as NT-proBNP and electrocardiography, remains essential to ensure equitable access.[4,7]

Low public awareness also contributes to delayed diagnosis; research suggests that up to four in five adults in the Netherlands are not familiar with the symptoms of HF.[4]

Delivery of best-practice care

HF is primarily managed by hospital cardiology departments, placing undue pressure on specialist services and underutilising primary and community care


Barriers to shared care remain

According to the Dutch General Practitioners' Association, cardiologists are responsible for initiating and stabilising treatment. After this, shared care with GPs may be considered – especially among people with HFpEF and among those whose conditions can be managed in a stable way.[2,7] However, outpatient HF care is typically managed by cardiologists and HF nurses, especially in the first year after diagnosis or hospitalisation.[2]

Experts have identified several barriers to shared care: unclear handover protocols; limited feedback loops between specialists and GPs; and challenges with reimbursement when care is delivered between primary and secondary settings.[7,21] For example, a GP is generally not eligible to have care provided for specific conditions reimbursed if the person is also under hospital care for that condition.[7] As a result, many people with HF remain under specialist care for longer than is necessary, with limited scope for GP input. This can strain hospital resources and affect continuity of care in the community.[7]

Recommended treatments and services for HF are largely available, with some gaps in access

All four key classes of medications for HF are available free of charge through national health insurance, but only 44% of people living with HF in the Netherlands are prescribed the full set of treatments, despite their proven benefits.[4,35] This treatment gap may reflect unclear guidance, inconsistent implementation of guidelines, or challenges in delivering comprehensive care, including the use of medications, devices and lifestyle support.[4] Additionally, there are persistent treatment gaps for people with HFpEF and right ventricular failure – specific conditions that have limited effective therapies.[4]

Less than half
of people living with HF in the Netherlands are prescribed the full set of treatments

In line with European guidelines, cardiac rehabilitation is available for people with HF and is generally covered by health insurance.[39] It is typically delivered in hospital or outpatient settings by a multidisciplinary team that includes physiotherapists, cardiologists, psychologists and, increasingly, HF nurses.[39] However, uptake remains low; it is estimated that only 11% of eligible people with HF participate.[40] This may be due to the gradual onset of HF symptoms and a clinical tendency to prioritise pharmacological management, leaving lower consideration for holistic care.[4,40]

Only 11%
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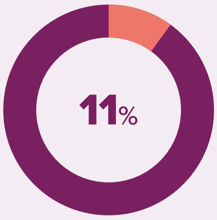

Palliative care for HF in the Netherlands is gaining recognition but remains underdeveloped compared with its established role in other diseases, such as cancer.[19] The Dutch Cardiovascular Agenda includes palliative care as part of its goals for HF management, aiming to ensure timely, meaningful conversations between carers and people with HF about care planning and quality of life.[4] Palliative care is increasingly being integrated into clinical practice through multidisciplinary HF teams, often led by specialised nurses who coordinate care across settings.[41] Additionally, the Foundation for Palliative Care Research in the Netherlands has placed HF on its knowledge agenda, with a focus on identifying the palliative phase and enhancing psychosocial interventions.[42] One of the foundation's key aims is to develop a Knowledge Hub for palliative care, which will centralise research and improve practice nationwide.[42]

Innovative and remote technologies

Innovative and remote strategies to monitor people with HF are inconsistently implemented

The Dutch government places particular emphasis on digital health applications that reduce hospital stays and facilitate outpatient treatment.[6 43] Since January 2022, eHealth applications for HF have been eligible for reimbursement by health insurers, marking a significant policy shift that aims to accelerate their wider adoption.[6] Innovative remote technologies can significantly enhance care for people living with HF,[9] but currently in the Netherlands there is no concrete policy drive to streamline or scale up their use.[6 16]

Existing telemonitoring tools for HF include platforms for daily symptom tracking and weight monitoring, and Bluetooth-enabled devices for blood pressure and heart rate measurements.[34] The majority of telemonitoring services in HF are non-invasive, though advanced implantable sensors, such as CardioMEMS, are available for a selected population.[44 45] These processes are designed to complement or sometimes even replace in-person care, allowing for remote monitoring of vital signs, symptoms and medication adherence,[4 44 46] improving care coordination and ultimately leading to better long-term outcomes.[4 45] In most cases, HF nurses monitor patient data and coordinate care, while cardiologists intervene when alerts are triggered or complex decisions are needed.[45] Non-invasive telemonitoring can provide reassurance and empower people living with HF by giving them better insights into their condition, encouraging active self-management and adherence to treatment.[4 44 45]

Non-invasive telemonitoring can provide reassurance

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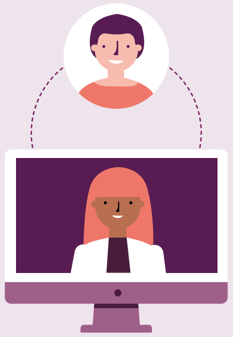

A conglomeration of seven large, non-academic hospitals in the Netherlands (known as the Santeon Group) has recently started an initiative to create a hybrid care pathway for HF, where non-invasive telemonitoring is being implemented on a large scale (*Case study 2*).[5 36 46] This initiative has been monitoring several thousand people with HF, and is funded by insurance companies and the Ministry of Health, Welfare and Sport to serve as a blueprint for future hybrid HF care.[5 36]

Case study 2. Empowering people living with HF through home monitoring

The Home Monitoring for Heart Failure (Thuismeten bij hartfalen) initiative by the Santeon Group is a leading example of hybrid care that empowers people while improving efficiency in HF management.[36 46 47]

Through a user-friendly app, people with HF regularly submit vital signs such as weight, blood pressure and heart rate from home, ranging from weekly for those with stable HF to daily for those recently discharged or undergoing medication adjustments.[46] These data are monitored by a national medical centre, which proactively contacts patients or care providers if abnormalities arise.[46]

This approach offers people living with HF peace of mind, greater insight into their condition and fewer hospital visits.[46] For healthcare providers, it enables more efficient care through faster medication titration, reduced routine check-ups and more streamlined collaboration, with the medical service centre handling monitoring while a care coordinator retains clinical oversight for each person with HF.[46] The system is secure and interoperable with electronic health records.[46]

While some initiatives are driving the implementation of telemedicine, these systems are not yet a widespread reality in the Netherlands.[1 6] Adoption remains limited due to lack of standardisation and variable integration into national care pathways.[28] Additionally, eHealth applications are not governed by a national framework and are typically offered locally by hospitals or individual healthcare professionals, so GPs' involvement in their integration is still limited.[7] This hinders scalability, interoperability and feedback loops between primary and secondary care.[6 7]

The way forward

HF poses a growing challenge to the sustainability of health systems in countries across Europe. While the impact of HF may vary, it is increasingly relevant to the Netherlands as the population ages and the demand for chronic disease management rises. Although HF can often be managed and – in some cases – prevented, it continues to affect the daily lives of a great number of people, placing a significant burden on the national health system and society. Although HF care in the Netherlands is typically of high quality, improvements are necessary to support the growing number of people with the condition.

SEVERAL ACTIONS ARE ESSENTIAL TO ADDRESS THE CHALLENGE OF HF:

1.

Increase awareness of HF among the public, healthcare professionals and decision-makers.

Greater public and professional awareness is essential to effectively address HF in the Netherlands. National public campaigns to improve people's understanding of symptoms can prompt earlier medical consultations. To improve quality of life for people living with HF, policymakers should support education on person-centred care and initiatives that empower people to manage their condition effectively.

2.

Establish a centralised HF strategy, as part of a national cardiovascular disease strategy.

The growing prevalence of HF demands a coordinated national response. Led by the Ministry of Health, Welfare and Sport, a centralised HF strategy should set clear targets for early detection, treatment quality and outcomes. This strategy must align stakeholders across the health system, ensure sustainable funding for initiatives to coordinate and improve HF care, and integrate HF into broader chronic disease and ageing population policies. The national HF strategy must actively address health inequalities and promote clear communication, culturally sensitive care and accessible education.

3.

Enable coordination of HF care, with stronger primary care involvement.

Primary care providers play a crucial role in the early detection and long-term management of HF. Integrating HF care into the management of any existing comorbidities can make care more efficient and reduce pressure on specialist services. National and regional agreements provide a strong basis for integrated HF care, and initiatives such as NVVC Connect support improved collaboration and regional pathways. To support consistent identification and monitor progress, access to diagnostic tools (such as NT-proBNP and electrocardiography) should be standardised. Further national coordination is needed to ensure long-term sustainability and reduce variation in care delivery.

4.

Prepare the health system for future challenges through remote technologies and hybrid care.

To ensure HF care is equitable, sustainable and person-centred, decision-makers must place greater emphasis on hybrid and digital care models, particularly in primary care settings. While secondary care has made strides in telemonitoring and digital innovation, GPs require better access to digital tools, training and specialist support. Integrating hybrid models into primary care will enhance early detection, improve care continuity and reduce unnecessary hospitalisations for people living with HF.

5.

Prioritise reimbursement of HF care in line with other chronic conditions.

Health insurers in the Netherlands play a pivotal role in shaping care. While they have a demonstrable interest in cardiovascular risk management, HF care is not always given the same priority. The impact and cost of HF should be recognised by including HF in chronic disease management programmes in primary care and incentivising the use of guideline-recommended treatment. Funding models should not be siloed, but should support collaborative, multidisciplinary care across settings, and outcome monitoring (through registries) should be used to improve quality and efficiency.

6.

Plan and invest in a future-ready and multidisciplinary HF workforce.

The Netherlands has a strong foundation in HF workforce development, with integration of specialist HF nurses recognised as best practice. HF is already integrated into cardiology training, and continuing professional development is supported by programmes. However, the growing burden of HF requires a broader and more future-orientated strategy. This includes investing in upskilling GPs and practice nurses by integrating HF into existing chronic disease education pathways, and developing multidisciplinary training aligned with real-world care models. Training should also ensure that care is inclusive and person-centred to meet the needs of diverse populations. Finally, targeted efforts must be made to engage and inspire the next generation of professionals – including students, residents and early-career nurses – through curriculum development, clinical exposure and mentorship. A national HF strategy must provide a centralised vision for HF workforce planning, supported by funding for reimbursement of education and team-based care models.

Focusing on these priority areas will likely offer a cost-effective opportunity to improve care for people with HF, reduce hospitalisations and mitigate future pressures on the health system.

Addressing these gaps is an investment in a more resilient and prepared health system for the Netherlands, not just for HF but for chronic diseases more generally

There are many strengths and existing resources within the Dutch health system on which to build. But without continued attention to the actions recommended in this report, HF will increasingly strain the health system in the Netherlands, challenging its long-term resilience. Lasting success will require effective central oversight of inequalities and unacceptable disparities in care, as well as long-term collaboration and commitment from decision-makers, patient representatives, healthcare professionals and healthcare insurers.

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The Heart Failure Policy Network

About the Heart Failure Policy Network

The Heart Failure Policy Network (HFPN) is an independent, multidisciplinary network of healthcare professionals, advocacy groups, policymakers and other stakeholders from across Europe. It was established in 2015 with the goal of raising awareness of unmet needs and seeking meaningful improvements in heart failure policy and care. Our aim is to help reduce the burden of heart failure – on people living with it, those supporting them, health systems and society at large.

HFPN is made possible with financial support from AstraZeneca, Bayer and Roche Diagnostics. The content produced by HFPN is not biased toward any specific treatment or therapy. All outputs are guided and endorsed by HFPN's members. All members provide their time for free. Secretariat is provided by The Health Policy Partnership, an independent health policy consultancy based in London, UK.

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