Building an Equitable Access to Care for a Healthier Workforce

The Netherlands stands at a crossroads. Not only is it facing a healthcare capacity shortage but also a workforce sustainability crisis. Sickness absence has risen to its highest levels in years, with mental health now accounting for roughly 40% of long-term absence cases. Employers are legally required to continue paying at least 70% of wages for up to two years during illness, placing sustained pressure on businesses particularly small and medium enterprises (SMEs). At the same time, public mental health institutions (ie, GGZ) face persistent waiting lists, and working adults often delay support until symptoms escalate.

This joint white paper by OW Care and Rypple explores how the Netherlands can make preventive care the path of least resistance by reimagining Employee Assistance Programs (EAPs), a corporate-level program for triage support commonly offered at large corporations. By reframing its purpose and scope, EAP is illustrated as a practice to enhance equitable access to care, reduce private spendings, and embed health responsibility within Corporate Sustainability Reporting Directive (CSRD) frameworks, especially for SMEs.

Disease prevention does not need new systems but smarter connections between the ones we already have. The Netherlands already operates an advanced network of employer health obligations and fiscal incentives under the Arbo-regeling and Werkkostenregeling (WKR), which often function in isolation. Employers pay for care benefits that go underused, and individuals turn to costly private spending with lack of awareness. By aligning them, disease prevention can become both affordable and measurable, benefiting people, business and society.

OW Care and Rypple share a belief that connected care is the next frontier of prevention. Connecting employees to local care providers, while helping SMEs integrate health responsibility into CSRD-aligned reporting, is a shared mission and vision of this partnership. OW Care, a digital care navigation, aims to strengthen access to care and local care circularity, while Rypple's mission-driven leadership in social wellbeing, preventative health, and moral ambition supports impact accounting for such implementation.

Subsequent chapters examine:

- The economic rationale for investing in preventive access through flexible EAPs;
- The opportunity to leverage CSRD for measurable health impact; and
- A pilot framework to operationalize care continuity for SMEs.

Prevention should not feel like an uphill climb. By uniting technology, responsible business, and people-centered design, the Netherlands can become a model for Europe, proving that continuity, not crisis, is the real measure of a healthy society. This white paper sets out a roadmap for policymakers, employers, and investors to co-create a care economy, where sustaining health or 'health-ing' becomes the easiest and the most economically sound decision.

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Prevention Fails by Fragmented Design

In a country with one of the most advanced insurance and healthcare systems in the world, Dutch workers face a prevention crisis. One in five employees (1.6 million people) reports burnout complaints, costing employers about €11,000 per affected worker and an estimated €3.3 billion annually (TNO, 2023). Stress-related absenteeism has risen by more than a third in five years, with burnout cases often resulting in an average 10 months away from work. Yet access to early, practical support remains fragmented.

The core issue is structural. Early, non-medical interventions, such as work-related mental health support, career coaching, financial advisory for debt stress, sit largely outside statutory coverage. Physiotherapy is only fully reimbursed for specific chronic conditions. Adults often need supplementary insurance or pay personally for early physical and mental health support, financing around 10–12% of health expenditure privately (OECD Country Health Profile 2025, Netherlands).

The problem is not a lack of goodwill or programs. It is the fragmentation in access by design. Employer schemes such as EAPs are narrowly defined or poorly known to employees, making them an underused asset. Among large employers in comparable markets, EAP availability is high, yet engagement usually sits in the low double digits annually (ie, ~10–12% of engagement per year, EAPA UK, 2023; McKinsey Health Institute, 2023). In the Dutch SME context, EAPs are even less visible, unaffordable, and are often configured as short-term counselling or financial advisory support.

What should be a straightforward search for care becomes a maze of portals, forms, eligibility rules, and unclear financial pathways. For employees, the lived sequence is simple:

Search for care → out-of-pocket barriers → delayed care → higher costs

For employers, benefits go underused while avoidable cases escalate. For municipalities and national payers, demand appears later at higher intensity and cost. Currently, no single actor owns the gap, which allows it to persist. The Netherlands already has the resources but lacks a visible shared access and governance that steer people to the right help at the right time.

Global evidence reflects the same pattern. At system level, the OECD attributes up to a quarter of health spending to avoidable waste, often driven by delay, duplication, and mismatch between need and service (Health at a Glance EU report, 2023). Delaying early, low-intensity support predictably escalates to longer absences, more intensive care, and a loss of trust in the system's ability to help in time. The consequence is a predictable system-level drag: delayed help-seeking, higher downstream costs, and erosion of trust.

This joint white paper argues that prevention fails not only because of a lack of resources or intent, but because the system for accessing care is fragmented by design. The task is therefore architectural: treat prevention as a system function, not an add-on, and connect existing instruments and available resources at a local level so that early action becomes the default. The next chapter outlines how the Netherlands can turn this fragmentation into continuity using assets it already has.

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Turning Fragmentation into Continuity for Prevention

The Netherlands does not need a new system for prevention to take better place but rather a continuity across the one it already operates. The core building blocks are in place: employer-funded EAPs and other corporate wellbeing benefits. Upcoming regulatory tailwinds such as the EU Corporate Sustainability Reporting Directive (CSRD) and its European Sustainability Reporting Standards (ESRS) move employee wellbeing into the realm of accountability.

Dutch fiscal instruments such as the Arbo-regeling and WKR can facilitate prevention when structured in continuum and transparently across employees, SMEs, and the health system. The real challenge is in alignment between policy agreement and innovation stewardship.

> "The gap in prevention isn't one of resources but of continuity."
>
> - Hee Baek, Founder of OW Care

Global guidance from WHO, ILO and WEF is clear. Workplace prevention performs best when it combines individual support with organisational measures and when access to the right support is *simple and clear*. Re-designing EAPs as flexible prevention budgets can increase both utilisation and impact without requiring new categories of benefit.

An ideal climate is an ideal timing. CSRD and ESRS S1 (Own Workforce) require companies to disclose how they affect workers' health, safety, and wellbeing, embedding employee health within "double materiality" rather than treating it as a perk. For Dutch SMEs, many of which will be touched indirectly through value chains, finance conditions or voluntary alignment, this is both a risk and an opportunity. Organisations that cannot evidence how they manage employee health will face disclosure gaps. Those that can will operate with competitive advantage.

The underutilized EAP and changing regulatory landscape lowers the barrier to action today. The opportunity is to tie them together:

- A more flexible EAP offering that includes short, targeted interventions validated by evidence; and
- CSRD-aligned metrics that track time-to-first-appointment, shared responsibility for health, and work outcomes such as absence and retention. Report these under ESRS S1 as part of a coherent prevention narrative.

The next chapter explains why SMEs are the critical leverage point for making this opportunity real.

Why SMEs Need the Most

Small and medium-sized enterprises (SMEs) make up a significant backbone of the Dutch economy and employ most of the private-sector workforce. They are where many health and wellbeing challenges first surface: in small teams, tight margins, and roles where one

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person's absence affects the whole business. Meanwhile, the health burden faced by SMEs is significant. Data show high psychological distress among SME owner-managers, frequent presenteeism (working while unwell), and substantial costs associated with mental health-related absence, with average costs per sick day estimated at €250–€300 and mental health accounting for around 40% of long-term cases (TNO/NEA, 2024; EU-OSHA, 2014–2021).

Dutch law requires employers to pay at least 70% of wages for up to two years during sickness and to actively support reintegration. For a small company, a single long-term absence can disrupt operations and cash flow for months (Rijksoverheid, 2024). The incentive to prevent health problems is therefore strong, but the tools are not well tailored to SME realities.

Most prevention and employee assistance models like EAPs were built for large corporations with HR departments, procurement teams, and dedicated budgets. SMEs have limited capacities to contract such service, opting for vouchers or one-off group support instead. Unlike the traditional models of EAP with heavy architecture with HR overhead costs, inflexible contracts, and limited scope of care, SMEs need a simpler way to plug into prevention rather than designing and managing programmes themselves.

The Numbers Behind the SMEs in the Netherlands:

- 70% salary obligation for up to 104 weeks of sickness (RVO)
- Average cost per sick day: €250–€300 (TNO/NEA, 2024)
- Mental health-related absence: 40% of long-term cases (TNO/NEA, 2024)
- Only 12% utilization of EAPs annually for large corporates (EAPA UK, 2023)
- Average ROI of psychosocial prevention: 2.5–4x (EU-OSHA, WHO/ILO)

The Netherlands already has the ingredients, such as employer allowances via Arbo-regeling and WKR, and CSRD/ESRS S1 reporting that elevates employee wellbeing from a perk to a reportable impact domain. What SMEs lack is a smoother access with flexibility that connects these mechanisms better. This is where OW Care's local care partnership aims to support: connecting SMEs to local care faster.

A conservative business arithmetic illustrates the point. For a 25-person SME, preventing 10 sick days across the team (all-in cost ≈ €250/day) avoids €2,500. A €1,000 annual flexible-EAP subscription (or an Arbo/WKR-co-financed package) pays for itself 2.5× before counting gains from reduced presenteeism and improved retention (illustrative).

In the Netherlands, TNO/NEA trends and the national Werkgeversaanpak Mentale Gezondheid document rising demand for simple toolkits and early-help that integrate occupational health with practical supports (TNO/NEA; Rijksoverheid, 2023), precisely the modular approach a shared infrastructure can supply like that of OW Care platform.

We invite insurers, municipalities, and employer networks to collaborate on pilot cohorts of SMEs to demonstrate measurable reductions in time-to-care, care utilized, and days lost. This approach makes prevention visible, financeable, and reportable and not as an add-on but an integrated system function, turning a fragmented landscape into a repeatable prevention model that makes care continuous in life to the workplace.

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The Financing Landscape

The central financing challenge in Dutch healthcare is not a lack of resources. It is a misalignment of incentives across dominant financing channels. Each actor pays at a different point in the pathway, while the benefits of early intervention are diffuse and often accrue to someone else. As long as reimbursement logic rewards activity after diagnosis rather than timely support before crisis, prevention will remain structurally underused.

International evidence is consistent. Systems that shift a modest share of spending toward early, low-intensity interventions achieve better outcomes and lower avoidable costs, particularly for mental health, musculoskeletal conditions, and stress-related problems (WHO/ILO, 2022; Chisholm et al., 2016; WEF, 2021). Across OECD countries, higher private spending burdens are associated with delayed care-seeking among younger workers, low-income groups, and the self-employed, especially for "discretionary" support such as early physiotherapy or short-term counselling (OECD, 2023).

This structural bias is reinforced by capacity constraints and contracting architecture. The debate around Article 13 of the Zorgverzekeringswet (Zvw) in 2023–2024, which proposed reducing reimbursement for non-contracted care, illustrates the tension: the intent was to improve access and encourage contracting, yet such measures risk increasing administrative burden, reducing autonomy for private practitioners, and further constraining already limited capacity in mental and physical healthcare. After significant stakeholder pressure, the proposal was withdrawn. This highlights that contracting incentives alone cannot solve access problems without the infrastructure to support providers sustainably.

At a glance:

Mechanism	Who Pays?	Limitations Today	Policy-Relevant Incentive Misalignment	Opportunity for Prevention
Private spending	Employee	High financial barriers; delayed care-seeking	Insurers bear high-cost claims triggered by late entry to care	Proactive introduction to free local resources like health checkups, buddy program, or company resources like EAP
Employee Assistance Program (EAP)	Employer	Narrow scope for available care; low utilization; SME exclusion	Employers pay for benefits with no measurable impact	Flexible and transparent prevention budgets; psychologically safe design; integration with CSRD reporting

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The CSRD Lens: Health as Corporate Responsibility

The Corporate Sustainability Reporting Directive (CSRD) brings a decisive shift for SMEs. Employee health is now treated as a material component of corporate performance, not a wellbeing perk. Under the ESRS S1 standard, companies must demonstrate how mental health, workload, and work conditions shape organisational risk. This places prevention at the centre of corporate governance.

CSRD moves prevention into mandatory reporting:

- Health and wellbeing sit clearly under the "Social" pillar.
- Companies must report risks linked to mental strain, psychosocial hazards, and unsafe work design.
- Early support to counselling, coaching, early physiotherapy, financial guidance can be counted as evidence of responsible workforce management.

For health systems, this represents an overdue alignment. Prevention is now *on the balance sheet*, influencing risk ratings, employer reputation, and long-term productivity. Despite this shift, most Dutch organisations, particularly SMEs, cannot yet report what matters for prevention due to the absence of consistent employee support programs in place. This gap weakens reporting credibility and perpetuates late intervention.

Individually manageable but operational complexity keeps systemic consequences to play out unsustainably. National authorities can introduce standardised CSRD-aligned templates for health and wellbeing indicators, giving employers a ready-to-use framework instead of requiring them to interpret complex sustainability standards on their own.

Municipal stakeholders can reinforce this by supporting SMEs to join low-threshold prevention platforms like OW Care that consolidate early-support options for their workforce. Through a local joint pilot, a shared civic duty to carry out greater societal health and wellbeing can lead to proactive discussions on tax-advantages for preventative programs and deployment practice, where innovation does not outpace inclusion for greater public trust.

Workforce Health as Infrastructure: Measuring and Steering Prevention as Capital

Prevention is widely accepted as desirable. Yet in the context of most Dutch SMEs, it is not governed as a disciplined investment decision. SMEs already invest in workforce health: ergonomic equipment, occupational health services, mental health support, flexible work arrangements, and increasingly, Employee Assistance Programs (EAPs). These investments are necessary and often well-intentioned. In practice, however, they are typically classified as operational costs or compliance measures rather than as structured drivers of business stability and performance.

EAPs illustrate this gap clearly. They are designed to provide early care benefits, yet are often governed as passive, late triage support. Low utilization is interpreted as success. Speed of

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access is rarely monitored, and impact is assessed retrospectively, if at all. As a result, the most time-sensitive component of prevention — early intervention or time-to-care — is not actively managed as a business variable. The result is fragmentation. Workforce health remains a cost centre, even though it directly influences productivity, retention, resilience, and long-term continuity.

The challenge for SMEs, and for insurers and policymakers operating within the same ecosystem, is not whether prevention matters. It is whether prevention can be measured with credibility, compared across intervention choices, and steered over time as an active business lever rather than absorbed as overhead.

From Benefit to Decision System

The Health-ing Impact Framework addresses this gap. It reframes prevention from a retrospective wellbeing initiative into a structured, time-sensitive decision system—governing workforce health as capital infrastructure rather than an operational line item. Instead of asking, "Did this programme work?", leaders can ask:

- Where is structural health risk accumulating?
- Which interventions shift risk trajectories most effectively?
- How does early action influence future cost exposure?
- What value is being protected across productivity, resilience, and governance?

For SMEs operating in tight-margin environments, workforce health volatility is operational volatility. A small number of stress-related absences can materially affect output, team capacity, and customer commitments. Prevention therefore behaves less like a discretionary benefit and more like stabilizing infrastructure. The Health-ing Impact Framework provides the measurement architecture to govern it accordingly.

The System Logic: Prevention as a Steerable Cycle

The Framework is not a one-time audit. It operates as a continuous six-step governing cycle, connecting risk identification to measurable impact evidence. Each step builds on the last, ensuring that prevention decisions are data-led, mid-flight adjustable, and CSRD-reportable from day one.

#	Action	What Happens	Pillar
01	**Identify**	Map health risks to business exposure	Risk Translation
02	**Simulate**	Model intervention scenarios before spend	Risk Translation
03	**Act**	Deploy targeted prevention with OW Care pathways	Prevention as Capital Allocation
04	**Measure**	Track leading & lagging KPIs in real time	Prevention as Capital Allocation
05	**Adapt**	Adjust mid-flight as data flows	Prevention as Capital Allocation
06	**Showcase**	Auto-generate CSRD-aligned evidence	Value-Based Accounting

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Prevention becomes a steerable system, not a reportable benefit. The impact trajectory runs from leading indicators through lagging indicators to compounding business value over time.

Three Value Layers of Workforce Health

The Framework integrates three interconnected value layers that together cover the full impact chain from individual employee to societal system:

1. Employee Outcomes: Individual stabilization through early intervention
2. Employer Outcomes: Enterprise performance protection through reduced absence, presenteeism, and turnover
3. System-Level Impact: Cost avoidance and strain reduction aligned with insurers and public health actors

Together, these dimensions enable Dutch SMEs to govern prevention as a structured investment discipline, align with CSRD reporting expectations, demonstrate measurable value protection, and actively steer outcomes over time. Without adding new budget lines, it is about optimizing existing health investments so prevention becomes embedded in how the business operates rather than as an afterthought in annual reporting.

The Health-ing Impact Framework: Measurement Architecture

1. Employee Outcomes: Early Intervention & Access

The first and most critical question of prevention is not how many employees accessed support, but whether they accessed support early enough to prevent escalation. This shifts measurement from utilization volume to timing sensitivity.

Metric: Time-to-First-Appointment

Early intervention materially reduces escalation risk.

Employees who access mental health support within two weeks of recognizing sustained stress are significantly less likely to progress to clinical burnout. Delayed access substantially increases the probability of long-term absence and prolonged recovery.

Time-to-first-appointment therefore functions as a leading indicator of future absence and productivity exposure, not simply a service metric. For SMEs relying on EAPs as an access gateway, this transforms the EAP from a passive benefit into an early-warning stabilization mechanism.

How to measure

- Track EAP referral date and first appointment date
- Collect optional post-appointment input:
  “When did you first notice this issue?”
- Cross-reference recognition date with appointment date

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Baseline (Dutch Context)	Target
Standard healthcare pathways: 4–6 weeks	Less than 10 business days from issue recognition to first appointment
EAP-only pathways: 7–10 days	Out-of-pocket burden below 20%
Utilization typically 10–12% annually	Measurable change within 3 months; full impact visible within 6–12 months

Scenario Lens: Timing Sensitivity

Employees naturally fall into access timing bands (early, delayed, late). Each band corresponds to a distinct future risk trajectory, with materially different probabilities of escalation, recovery duration, and functional impairment. The Framework makes these timing differences visible before clinical outcomes deteriorate.

2. Employer Outcomes: Cost Reduction & Productivity Protection

Employer outcomes translate prevention into business language. The Framework focuses on value protected, not abstract wellbeing scores. Three cost pathways are central: absenteeism, presenteeism, and retention.

Metric A: Absenteeism Reduction (Days & Costs)

Stress-related absence costs Dutch employers approximately €11,000 per employee per year. In SMEs, even a small reduction in stress-related absence has disproportionate operational impact.

How to measure: compare stress-related absence year-on-year via HR systems or occupational health providers, coding illness reasons as "stress," "burnout," or "mental health." Baseline figures are an overall SME absenteeism rate of 4.8%, with stress-related share at approximately 1.2%. The target is a 15–20% reduction within 12 months through early intervention.

Scenario Lens: Absence Risk Trajectories

Absence is not binary. It reflects accumulated strain. Early intervention flattens escalation curves; delayed access compounds exposure.

Metric B: Presenteeism Reduction (Productivity Loss)

Employees working while unwell may operate at significantly reduced capacity. In small teams, presenteeism often equals or exceeds the cost of absence. The target is a 25–30% reduction in productivity loss among early-access users.

Scenario Lens: Productivity Trajectories

Productivity trajectories diverge depending on how quickly stress cycles are interrupted. Early access stabilizes output; delayed access prolongs partial capacity.

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Metric C: Retention & Recruitment Impact

Stress and burnout are major drivers of voluntary turnover. Replacing an employee typically costs 50–150% of annual salary. The target is 10–15% lower turnover among prevention users.

> **Scenario Lens: Retention Trajectories**
> *Retention reflects cumulative exposure. Early stabilization reduces long-term attrition risk even when short-term indicators appear stable.*

3. System-Level Impact: Healthcare & Population Health

System-level metrics capture societal return and support CSRD alignment. These effects lag behavior change but are essential for long-term sustainability.

Metric: Healthcare Cost Avoidance

Early intervention reduces GP visits, specialist referrals, and rehabilitation costs. The target is a 30–40% reduction in downstream treatment costs.

Metric: Work-Directed Outcomes

Aligned with WHO and WEF emphasis on functional participation, these metrics track the ability to perform the job at full capacity, employee engagement levels, and weekly productivity loss. Together they capture the degree to which prevention translates into genuine workforce participation rather than managed absence.

Operationalizing Measurement: From Data to Decisions

Prevention as Capital Allocation: The Dashboard & Predictive Engine

The three value layers are governed through a unified dashboard and predictive simulation engine, the operational heart of the Framework. Rather than reviewing outcomes quarterly, SME leaders and HR teams gain a real-time prevention command centre that enables scenario modelling before spend decisions are made.

For SME leaders and HR teams, the dashboard delivers a one-screen view of prevention ROI:

> **Prevention ROI Snapshot (Illustrative)**
> *"We invested €1,000 in prevention. Here's what we got: 8 employees accessed early support; 2 prevented from burnout-related leave; €3,500 in absence costs avoided; presenteeism improved 20%; 1 valuable employee retained."*

The dashboard further enables:

- Benchmarking: compare your SME's outcomes against an anonymized peer group (similar size, sector, geography)
- Simulation: model the likely impact of different intervention timelines and EAP configurations before committing spend
- CSRD export: auto-generate report-ready metrics on time-to-care, EAP-covered vs. out-of-pocket ratios, and absence and retention trends for mandatory disclosure

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Value-Based Accounting: For Occupational Health & Insurance Partners

At population level, the Framework aggregates anonymized data across participating SMEs to enable system-wide insight:

- Population trends: identify sectors, demographics, or risk profiles where prevention is generating strongest returns
- Policy input: data informs national prevention strategies and insurance reimbursement design
- Credible benchmarks: illustrative system output might show that across 100 participating SMEs, 18% of the workforce accessed prevention services, 35% of those were early interventions, and average time-to-care was 9 days

Closing Perspective

The value of prevention is not binary. It compounds or deteriorates based on timing.

The Health-ing Impact Framework preserves rigorous measurement while enabling organizations to compare alternative futures under different intervention choices. By integrating risk translation, capital allocation, and value-based accounting into a single governing cycle, it transforms prevention from a reportable benefit into a steerable system.

For Dutch SMEs, this means workforce health is no longer an overhead to be managed but infrastructure to be governed, with the same discipline, visibility, and accountability as any other strategic investment.

> **The Core Shift**
> *From: 'Did our prevention programme work?' To: 'Where is health risk accumulating, which interventions change the trajectory, and what value are we protecting?'*

Piloting & Validation

To establish credibility for these metrics, OW Care and Rypple propose a structured pilot phase:

Phase 1 (Months 1-3): Baseline & Infrastructure

- Partner with 3-5 Dutch SMEs (different sectors, 20-50 employees each)
- Establish measurement baseline (current absenteeism, presenteeism, OOP burden, turnover)
- Collect initial participation data

Phase 2 (Months 4-12): Active Measurement

- Track all metrics weekly/monthly
- Gather qualitative feedback: "What made it easy to access? What barriers remained?"

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- Adjust EAP scope, access, or communication based on early data
- Compare early intervention adopters vs. control groups within same SMEs

Phase 3 (Months 13-18): Analysis & Reporting

- Final outcome report: absenteeism change, ROI, retention impact
- Third-party validation: Partner with TNO or occupational health service for credibility
- Publish case studies (anonymized but sector-specific)
- Generate CSRD-compliant metrics template for scaling

Expected Output:

- Proof that integrated prevention reduces absenteeism by 15-25% within 12 months
- Clear ROI model SMEs can use to justify investment
- CSRD-ready metrics and reporting template
- Benchmark data for policymakers and insurers

Linking to CSRD Compliance

All Health-ing metrics align with ESRS S1 (Own Workforce) reporting requirements:

ESRS S1 Requirement	Health-ing Metric	Data Source
S1-14: Health & Safety coverage	% of employees with access to preventive care	EAP enrollment via OW Care
S1-14: Work-related ill-health incidents	Stress-related absenteeism rates	HR/occupational health data
Work-life balance / wellbeing	Presenteeism, job satisfaction post-support	Post-appointment surveys
Materiality of health risks to business	Absence cost, turnover cost, productivity impact	Financial modeling
Actions taken to manage impacts	Description of integrated pathway and prevention scope	Narrative and metrics

With Rypple's support:

- Model potential ROI of EAP adoption for SMEs.
- Measure impact across:
  - Reduced absenteeism and presenteeism
  - Improved wellbeing indicators
  - Lower healthcare costs in the local area

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Indicators:

- % of employees using EAP services within 3 months of issue onset
- Average OOP savings per user
- Employer savings on absenteeism

Policy & Practice Recommendations

For Employers:

- Integrate EAPs into HR and CSR strategies.
- Use tax-deductible health benefits under *WKR* or *Arbo*.
- Track wellbeing KPIs in sustainability reports.

For Policymakers:

- Provide fiscal incentives for SME-level EAP adoption.
- Broaden insurance definitions of prevention to include early mental and physical health care.
- Recognize EAPs as formal preventive care channels in national health planning.

For the Private Sector:

- Embed prevention into ESG/CSRD disclosure standards.
- Partner with digital health platforms like OW Care to provide aggregated, equitable access.

Conclusion

From 2026 onwards, the Corporate Sustainability Reporting Directive will require Dutch companies to report on employee health outcomes. Hundreds of SMEs will face a choice: embed prevention strategically and score well on CSRD compliance, or disclose gaps and face investor pressure. Meanwhile, one in five Dutch workers suffers from burnout. Stress-related absence costs employers €3.3 billion annually. Yet prevention mechanisms remain fragmented, expensive for employees, and complex for SMEs.

The building blocks to solve this are already in place. EAPs exist. Tax incentives exist for SMEs, as well as CSRD reporting frameworks. What the Netherlands needs is a smoother, connected path towards a system that nurtures preventative acts to thrive.

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APPENDIX: GLOSSARY

- EAP (Employee Assistance Programme): An employer-funded support service providing confidential counselling, coaching, or advisory services to employees, typically focused on mental health, psychosocial support, or practical life challenges.
- OOP (Out-of-Pocket Expenditure): Direct payments made by individuals for healthcare services not reimbursed by insurance, including deductibles, co-payments, and uncovered services.
- CSRD (Corporate Sustainability Reporting Directive): EU legislation requiring companies to disclose environmental, social, and governance (ESG) information, including workforce-related risks and impacts.
- Arbo-regeling: Dutch occupational health framework requiring employers to ensure safe and healthy working conditions. Certain occupational health provisions may qualify for tax exemptions under specific conditions.

ACKNOWLEDGMENTS

Rypple is a purpose-led business that empowers the global ecosystem, by building bridges across sectors and uplifting society into shared ownership and responsibility, towards a proactive, health-ing mindset. Our economic modelling and scenario analysis help leaders turn prevention into evidence-based policy and investment decisions.

OW Care is an AI-assisted care navigation platform that connects people to local care providers and resources, starting in the Hague, The Netherlands. It aims to connect local SMEs and care providers for more accessible care through local care partnership.

DISCLAIMER

This white paper is a collaborative exploration between OW Care and Rypple. Rypple was not involved in the development of OW Care's platform, technology, or proprietary methods. All intellectual property and data referenced remain the exclusive property of OW Care and are not disclosed in this document. No personal data was shared or processed for this publication. Content is illustrative only and intended to support dialogue, not to describe technical implementation.

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