Dutch Healthcare Is a Dangerous ‘Anomaly in Europe’

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The Netherlands is often thought to have a system of public healthcare whose generosity and effectiveness approaches those of the Scandinavian countries. Such notions no longer reflect reality. The country once had a mixed, public-private system that guaranteed access to everyone, provided excellent service, and was financed by private policies and taxes. One’s source of coverage (private insurer or government schemes) depended on one’s income and employment situation. It worked reasonably well. I was proud to enter it when I left America to work in the Netherlands in 1972. I had attained an academic position in a society that was far more rationally and decently organized than was the USA.

Although there were forebodings my enthusiasm ended abruptly in 2007, when my Dutch wife became seriously ill. She was 72, I was 64. Misdiagnoses, 7 appointments cancelled without explanation or apology, and an outright lie straight in her face by the head specialist of a hospital division ruined her health for good. I was furious at what I thought were the failures of individuals: the usual story of uncaring personnel and inefficient bureaucracy familiar to users of the NHS.

I was wrong. In January of 2006 control over the Dutch medical system (except for a tax-funded system for difficultly insurable expenditures, the AWBZ) was transferred from the State to the private insurance firms by government decrees and legislation. Funding of facilities and staff was divided between tax revenues and premiums. The government guarantees everyone a ‘basic package’ provided by the insurers, but the latter determine the size, quality, and cost of the many remaining care provisions and facilities. State-supervised competition among insurers---called Regulated Competition in the USA---was the officially voiced mantra. Profit maximization, free market deregulation, and future privatization were and are the true motives. The public, whose inordinate respect for any authority has been ingrained in them since the 80 Years War by Calvin’s local henchmen, the Dutch Protestant priests, were easily fooled into thinking that this new system would work to their advantage. I am not of Dutch descent and was not deceived. My study of these changes since the onset of my wife’s illness led me to strongly suspect that her neglect was mandated by rules set by insurers and politicians acting in collusion. I decided that we were dealing with institutionalized age discrimination. I informed people but could do little except describe what had happened and voice my suspicions. Few Dutch persons believed me. My impression was and is that few wanted to believe me.

Last December I was diagnosed as having aggressive prostate cancer and

applied for treatment at the (Calvinist) Free University Medical Center in my city of residence, Amsterdam. The treatment offered seemed to be minimal, and my initial attempts to secure definite dates for tests were disregarded. A highly placed medical friend employed by a leading hospital in Manhattan confirmed the minimalism. I flew in secret to Sweden, for a second opinion and treatment plan at Uppsala Care, a division of the prestigious Academic Hospital (Akademiska Sjukhuset) of the great University of Uppsala. Two highly regarded specialists spoke with me and examined the tests results that I had brought with me. One decided that my condition was so serious that action within six weeks was necessary. They proposed a treatment plan that was far more extensive than the two proposed by 'my' Free University urologist, Dr R.J.A. van Moorselaar (I am now undergoing the first component of the plan's finalized version.)

I confronted Dr. van Moorselaar and asked him why his plans omitted a certain procedure that the Uppsala specialists said was an important part of their treatment. I did not tell him about my visit abroad. He gave me no medical reason but mentioned a Dutch 'directive' governing treatment. It is now official policy. I was shocked when I found that directive's PDF and saw that its archival name (here translated without abbreviations) was '65+ prostate carcinoma 2007.' Dr. van Moorselaar was one of its writers. (After I voiced my suspicions the archival name was changed. The '65+' is no longer mentioned.) I was 66 and suspected government-sanctioned age discrimination motivated by the cost-cutting superprofit plans of the insurers. I moved quickly to Uppsala, after fruitlessly attempting to publicize this in the Dutch press, and sought proof for my surmise. My fear was and is that such insurer-dominated deadly practices, if now active in the Netherlands, would be adopted by other EU countries. For their politicians could succumb to the influence of national and multinational insurance conglomerates such as AIG, whose corporate connections with my and other Dutch insurers ought to be more widely known and might be the source of the shabby options offered me by Dr van Moorselaar. The EU would lose a major component of its humanitarianism. (The state of Massachusetts has adopted a version of the Dutch system, and an influential American healthcare economist, Professor Alain Enthoven of Stanford University, has been urging its use throughout the USA.).

Late in March I obtained the needed proof. My source is a medical specialist employed by a hospital in the Netherlands (where most specialists work exclusively for public hospitals). This person is not of Dutch birth. This source told a reliable acquaintance of mine that a secret system of prioritization indeed exists in the Netherlands. It regulates the granting and withholding of treatment, or parts of internationally standard treatments. It is based on at least three factors: age, cost, and relevant statistics. Given my personal experience, research, and discovery of the PDF, I now maintain that this system was inspired by the

insurers, developed in secret by government committees set up to study these issues, and then adopted as official but unannounced policy whose ultimate aim is twofold: (1) cost-cutting that increases profits and saves the government money, and (2) consequent service inefficiencies, so that the possibly complicit directors of medical institutions will beg for privatization as an attractive alternative that will have the support of a public desperate for decent healthcare. Something like this has already occurred in one Amsterdam hospital, Slotervaart, which is now owned by big business.

I hold that this hitherto unknown arrangement was set in motion right after the transfer of power in January 2006. Whatever the details might be, in no other EU country do the insurance companies have such extensive decision-making freedom that national law prevents its government from interfering with most of their activities. (This differentiates the secretive Dutch system from the UK's, in which NICE [National Institute of Clinical Excellence] does the dirty work but can be publically called to account.) For this reason EU civil servants have called the Netherlands an 'anomaly in Europe.' Are elderly persons considered---even in the higher echelons of the EU---economically unproductive and hence financial burdens rather than sources of pride? And who bears these 'burdens' in the Netherlands? Not the taxpayer, but the government and insurers, who try to prevent any increase in their expenditures. Dutch citizens and legal residents pay their premiums and healthcare taxes every month, or are granted the basic package, in the expectation of receiving adequate and expert medical attention when necessary. Although many are vaguely aware that something is wrong, few know that and how they are being cruelly deceived. Does the reader want this dangerous anomaly to become the rule in the EU? The danger is real.