Waiting lists in The Netherlands: workers first?

Virtually all developed countries struggle with the perennial challenge of identifying an appropriate mix of public and private finance and delivery to ensure an efficient, equitable and affordable health care system. No country seems yet to have found the Holy Grail. To the extent that policies in the early nineties were successful in reducing rates of growth of health care costs by means of supply side constraints and by more effectively limiting spending, the rationing problem has been brought to the fore.

Several countries are facing rapidly increasing waiting lists and have adopted diverse strategies to tackle them. Some, like the UK, have always allowed those who are waiting – and can afford it – to bypass public queues by means of the private sector. In regions with longer than average waiting times, more people buy private insurance.[1] In other countries, such as The Netherlands, governments have tended to ban such private 'outlets' for pressures in the public sector. The main official reason for this policy stance is that those in equal need should be treated equally in health care. This equity principle, which has shaped many European countries' health systems, including those that do allow a private system alongside the public sector, is often used to veto any form of differential treatment of patients in equal need.[2] Therefore, government action and strict legislation have countered most private clinic initiatives in The Netherlands. Despite the long co-existence of a public health insurance scheme for about 60% of the Dutch population and a choice of private health insurance policies for higher income groups, there is no substantial evidence of any differential treatment between publicly and privately insured patients. Both groups receive similar treatment and face similar waiting times, and both sectors are subject to similar government regulation of delivery capacity.

Renewed interest in private remedies for public waiting times in The Netherlands arose from the privatization of workers' compensation insurance in 1994. In return for a reduction in social security contributions, the financial risk of providing compensation for work absence during the first two to six weeks was transferred from social insurance to individual firms. In 1996, this risk was extended to the full first year of absence. As a result, employers were suddenly confronted with the financial consequences of absences and productivity losses while their workers were waiting for diagnosis and treatment. Fairly soon, some companies discovered that they could gain substantially from getting their employees treated more quickly, even if they had to pay extra for it. They joined forces with insurers and providers to create so-called 'employee clinics'. Their aim was to provide quicker access to care for their own workers by exploiting 'unused' capacity in hospitals at weekends and in the evenings. Some large companies experimenting with such initiatives (e.g. AKZO Nobel Chemicals) reported significant net gains.

Proponents of these initiatives argue that it is only fair that employers be given instruments to manage their new financial responsibility. In an interview, Health Minister Els Borst admitted that the Dutch government had failed to anticipate that firms would react to the new financial incentives by seeking ways to have their employees treated more quickly. Privatization of workers' compensation insurance made the link between health care and social security expenditures much more visible, and has revealed an apparent imbalance between the allocation of resources to sickness and disability benefits on the one hand, and to health care on the other. Not only does the time spent waiting for treatment appear to be much more costly for employers than the treatment itself, but occupational physicians frequently claim that, the longer patients have to wait for initial treatment, the lower the chances that they will return to work. This seems to be true in particular for mental and orthopaedic problems, which account for approximately two-thirds of all work absences in The Netherlands. Recently, some firms have become liable for some of the costs related to disability pensions as well (i.e. for absence longer than one year), thereby further increasing the incentive to seek priority care for their employees.

The response of the Dutch Health Minister, Els Borst, has been ambivalent, varying over time from outright disapproval to genuine interest. However, the majority in Parliament has always condemned the experiments. The main argument against them is the risk of creating a two-tiered system and the violation of the principle of 'equal treatment for equal need'. These founding principles of the public system are to be applied to its private alternatives with equal vigour. Some have adopted a contrary view, however. For example, Brouwer and Schut have argued that priority care for employees can be justified on both equity and efficiency grounds if the waiting times of both those with and those without priority private treatment can be reduced by employee clinics, albeit to an unequal degree.[3] Nevertheless, official policy remains that all official experiments with priority care for employees of firms willing to pay extra should be banned in The Netherlands on egalitarian grounds. The fact that both employees and non-employees might gain from employee clinics were these to expand treatment capacity, cannot – at least in the current Dutch political arena – outweigh the fear that systematic differences in waiting times will be created between (some) employees and others.

In the meantime, to meet the demands of employers, the government has permitted the development of so-called 'centres for work-related health problems'. These are centres for the management of work-related stress, low-back pain and other occupational health problems. However, to emphasize once more how strictly the egalitarian principle is interpreted in Dutch health care, these expert centres for work-related problems are to be universally accessible to all Dutch citizens, irrespective of worker status! The centres will also have to be funded through public funds and not – as in the case of the proposed employee clinics – by private employers.

It is unlikely that the issue of priority care will die as long as long waiting lists remain. The most important new development in the debate is likely to come from the European Union. With interest in cross-border care delivery in countries with substantial waiting times, recent rulings of the European Court of Justice seem to have further increased the opportunities for patients to move across European borders for faster delivery of care.[4] Taken at face value, they seem to imply that publicly insured people who purchase care that is normally covered by public insurance across European borders, are entitled to reimbursement at domestic fee schedules. This would mean that it might be both easier and cheaper for Dutch employers to obtain priority care for their employees in Germany or in Belgium than in The Netherlands. Indeed, for cross-border care, they would only have to pick up the part of the bill that is not reimbursed by the public purse. More generally, it is hard to see how national health care policy-makers are going to be able to hold to strictly egalitarian principles if private priority care can be purchased freely across borders. It may turn out that cost-containment strategies based on rationing of health services become unsustainable as the borders between EU countries fade away. This makes a reconsideration of principles and systems in European health care urgent. Perhaps Dutch employers will get from the EU what the Dutch government does not want to give them – the right to buy additional services for their workers to get them back to work earlier than would otherwise be the case.

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Medical savings accounts: approach with caution

Medical savings accounts (MSAs) offer an enticing method for financing health care. MSA advocates promise cost control, more consumer choice, better access to many services, and an 'off-budget' way to finance the health care costs of an ageing baby-boom generation.[1,2] These prospects naturally command the attention of policy-makers in today's health care environment. However, MSA-based financing should be approached with caution.

All MSAs include two essential components: an individual (or household) account whose balance (which can accumulate over time) is normally earmarked for health care expenses; and a high-deductible, catastrophic insurance plan which covers expenses above the deductible. An individual uses MSA funds (and other personal resources, if the MSA funds are not adequate) to pay for health care expenses for which he or she is personally liable – i.e. all expenses below the deductible and partial costs above the deductible. The catastrophic policy pays for extraordinary, high-cost care. MSAs can be integrated into virtually any system of health care finance, with myriad variations of this two-part design, depending, for instance, on the source of the contributions (taxes, employers, individuals), the source of the catastrophic insurance (public or private), restrictions on how the balance can be spent (health care only; health care and other goods and services), the tax treatment of contributions, withdrawals and interest earned, and the range of insurance choices individuals have alongside their MSAs.

The attractions of MSAs are that they are intended to counter the moral hazard associated with comprehensive insurance by forcing individuals to purchase routine health care at full price (while reducing the inequities of standard user charges by providing resources to make such purchases) and to limit the role of insurance to low-probability, high-cost events (which economic theory tells us is its proper role). The accumulation of unspent balances over time allows individuals (and the system overall) to pay in advance for health care needs ('prefunding' in the jargon).