

Primary health care in the Netherlands: current situation and trends

Prof. Peter P. Groenewegen

NIVEL – Netherlands Institute for Health
Services Research and Utrecht University



Contents of my presentation

- Problem definition
- Policy solutions
- From supply-centred to patient-centred health care
- Organization, manpower and regulation
- Trends and conclusions



Problem definition



Primary care is

- Generalist care, consisting of general medical, paramedical and pharmaceutical care, nursing and supportive care, and non-specialised mental and social healthcare, together with preventive and health educational activities linked to these forms of care.
- Problem: how to co-ordinate and integrate these diverse types of care?

Characteristics of strong primary care

- A generalist approach
- Point of first contact with health care
- Context-oriented
- Continuity
- Comprehensiveness
- Co-ordination

Problem: this applies to general practice, but not to most other primary care disciplines nor PC as a whole.



Effects of strong primary care

- Better health outcomes (in most studies)
- Good quality care
- Lower costs
- Better opportunities for cost containment and monitoring of health and utilisation.

But less responsive to patient demand

Demand side challenges to primary care

- Increasing and changing health care needs
- People live longer, stay longer at home, have multiple health problems
- Better educated, more demanding patients

Supply side challenges to primary care

- Organization: teams, networks and single practices
- Manpower: limited work force, more part-time work, undersupply and oversupply
- Incentives: regulation, payment, different sources of funding

Policy solutions

Policy of the Ministry of Health:

- Delegation of tasks
- (multidisciplinary) co-operation
- and integration of PC in health centres.
- Leading to increasing scale

Broad support, including from patient organisations

Addressing the challenges

- More prevention
- Cost-sharing to curb demand
- Neighbourhood teams
- Retaining older GPs
- Delegation of tasks within GP practice
- Shifting tasks to other providers (direct access to physiotherapy)
- Better organisation (e.g. out-of-hours care)

From supply-centred to patient-
centred health care

The Dutch health insurance reform

- Managed competition between health insurance organizations and between health care providers
- Comparative quality information to
 - inform patient choice
 - provide insurers with purchasing information
 - and providers with improvement information



Zoek en vergelijk ziekenhuizen

Hier vindt u informatie over ziekenhuizen in Nederland. U kunt nu ook [wachtlijden](#) van ziekenhuizen vergelijken!

Snel zoeken

Zoek via [zoek op plaats](#) welke ziekenhuizen er bij u in de buurt zijn en bekijk welke voorzieningen ze hebben.

Zoek uitgebreid

Geef via [zoek uitgebreid](#) uw zoekcriteria op en vergelijk ziekenhuizen die aan uw criteria voldoen.

U kunt hier gericht zoeken naar bijvoorbeeld ziekenhuizen met een bepaald specialisme (bijvoorbeeld cardiologie) of een bepaalde voorziening (bijvoorbeeld een mammapoli of internet op de kamers).

Ook kunt u ziekenhuizen vergelijken op kwaliteit (bijvoorbeeld het aantal patiënten met doorligwonden in een ziekenhuis). U kunt nu ook de [wachtlijden](#) van ziekenhuizen vergelijken!

Liever iemand spreken over zorg en gezondheid?

Bel of mail het [kiesBeter Informatiepunt](#), of ga naar een bibliotheek of Zorgbelangorganisatie [bij u in de buurt](#).

Measurement of patient experience with health plans and health care providers

- Based on QUOTE (developed by NIVEL) and CAHPS (developed in US)
- Consumer Quality Index or CQ Index

What patients find important in GP care:

Most important:

- GP must be competent
- Being taken seriously
- GP gives understandable information

Least important:

- GP prescribes drugs that are fully covered
- Not having to wait long in waiting room

Overall: organisational aspects less important than
substantial issues

Actual experience with GPs:

Positive

- Being taken seriously
- Having a say in treatment decisions

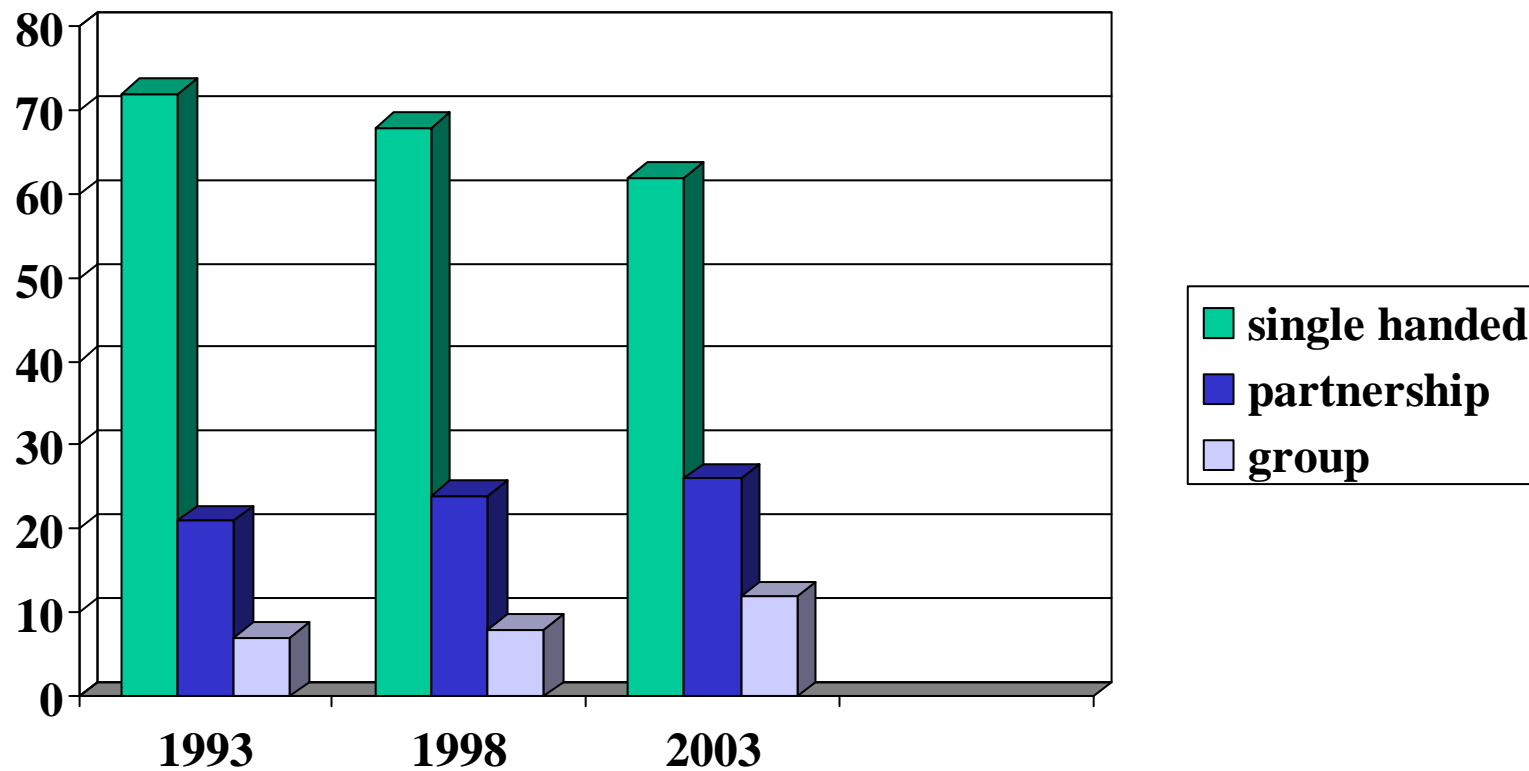
Negative:

- Physical problems too easily translated in psychological problems
- Not being referred

Overall: very positive experiences

Organization, manpower and regulation

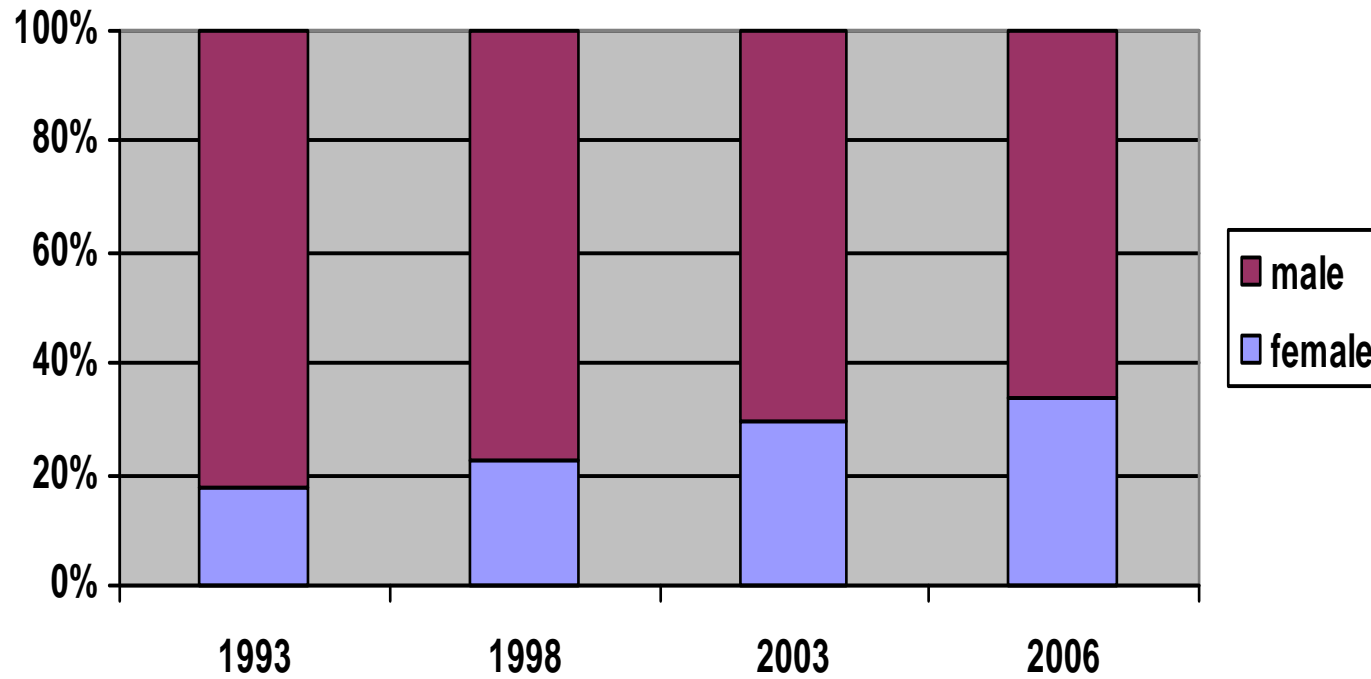
Decrease in share of single-handed practices



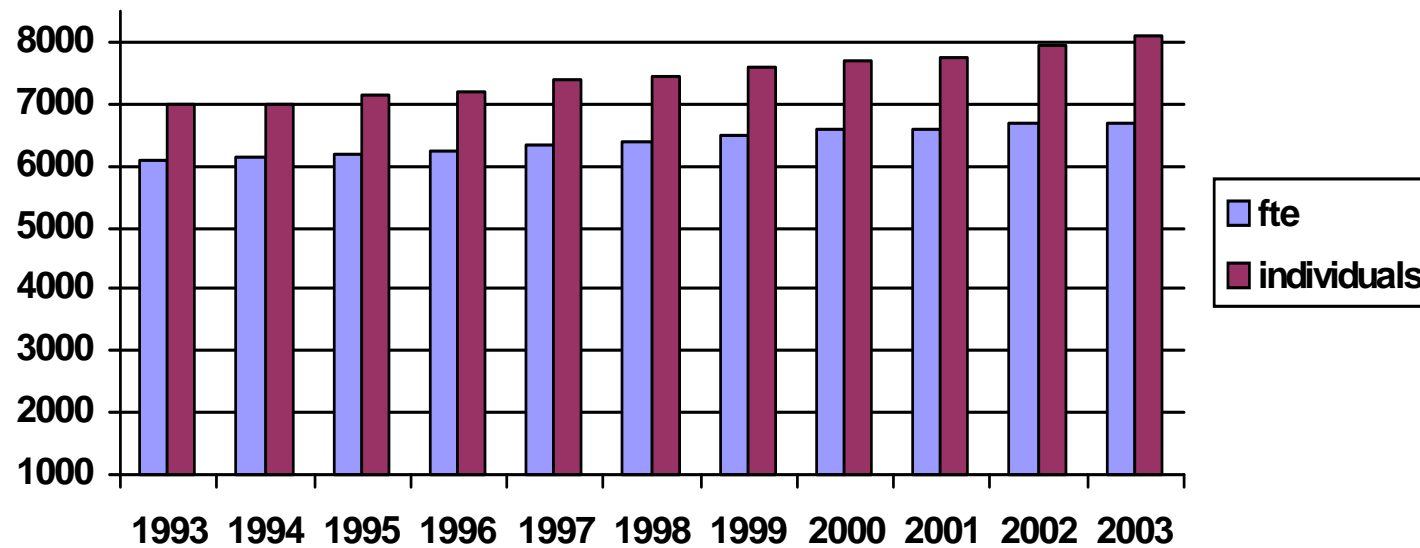
Primary care manpower 2003

	Number (absolute)	Inhabitants per FTE provider
General practitioners	8,110	2,400
Pharmacists	2,650	6,100
Physical therapists	13,250	1,320
Midwives	1,500	2,280 (WFA)
PC Psychologists	1,285	16,000
Social workers	3,370	7,600

Increasing share of female GPs



Increase in numbers and in full time equivalents GPs



Changing occupational structure in primary care

Specialisation in nursing

- Practice nurses
- Specialised clinics between hospital and primary care (DMP)

In-between professions

- Nurse practitioners
- Physician assistants

Quick diffusion of nursing into general practice

Response to workload increase

- At first task delegation to practice secretaries
- Then, introduction of practice nurses

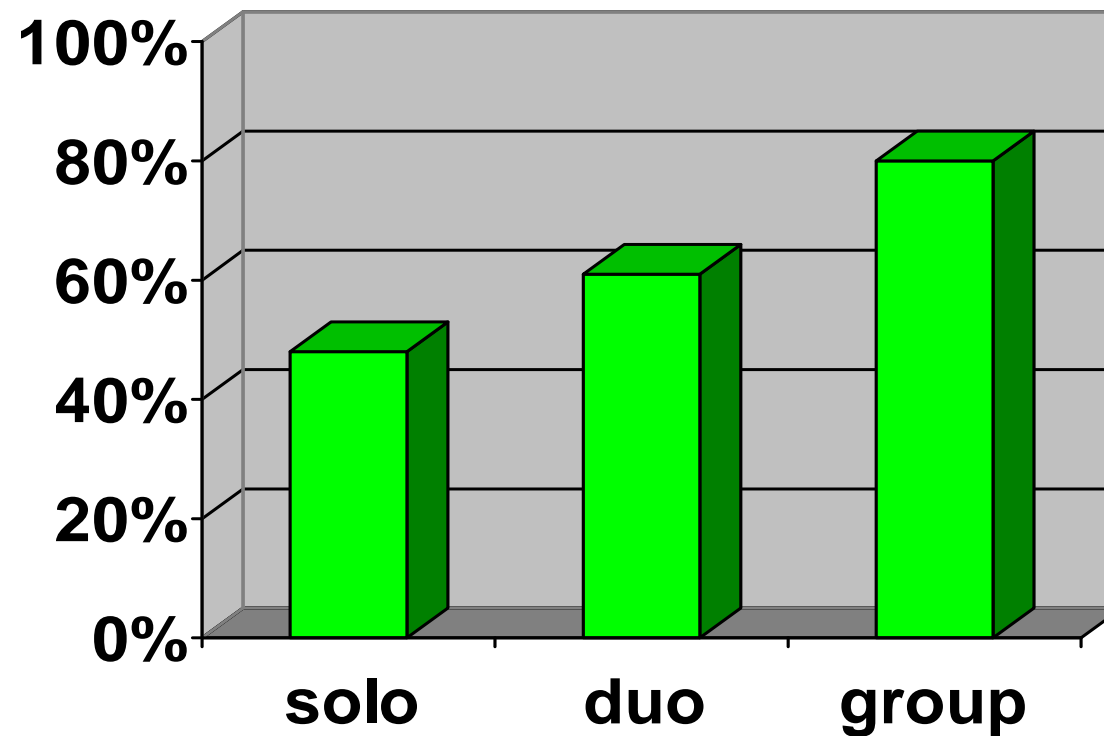
Response to changing interpretation of GP role

- Co-operation with secondary mental health care, introducing mental health nurses in primary care

Practice Nurses in the Netherlands

- Increase of general practices with a practice nurse from 6% to 60%
- No reduction of workload for GP's, but increase in quality (more and longer consultations, mostly with chronically ill patients)

Share of general practices with Practice Nurses by type of practice



Source: NIVEL 2007

Ambulatory mental health nurses in the Netherlands

- Subsidy arrangement in 1999 to provide support in primary care for mental health problems
- Introduction of mental health nurses from secondary to primary care
- In 2006: mental health nursing available in 25% of all general practices

Regulation of general practice

- Three years of specialty training
- Re-accreditation every five years, conditional on an average of 40 hours CME
- Gate keeping
- Contracts between GPs and insurance organizations
- Professional guidelines



Funding and payment

Old situation

- Publicly insured patients (60%): capitation
- Privately insured (40%): fee per consultation

From January 2006

- Uniform insurance system
- Fee per consultation (€9)
- Capitation (€52)
- Fees for specific services (e.g. surgical interventions)

Effects on services

- Increased number of consultations
 - more long consultations (double consultation fee)
 - gatekeeper for former privately insured patients
 - incomplete administration for former publicly insured patients
- Specific services
 - large variation between practices
 - no apparent substitution with referrals

Trends and conclusions

From supply-side policy to demand side policy

- Increased patient choice
- Better informed patients
- Is gate keeping a sustainable system?

From self-governance to management

Changing role of third parties:

- Insurance companies
- Performance indicators

Increasing scale of organisation

- Differentiation of professional work and practice management

From calling to occupation

- Health care as product that can be sold in a market
- From GPs as personal doctors to institutions that provide care
- Outside demands on practitioners (the balance between private life and professional life)



Conclusions

- How strong is primary care in the Netherlands?
- Is primary care sustainable in a demand driven system?
- Will GPs regain their professional pride and vanguard role?

www.nivel.eu

www.euprimarycare.org