

Conference

**Improving primary care in Europe and the US:
Towards patient-centered, proactive and coordinated systems of care**

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**Country Case Study:
Primary care in the Netherlands**

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1. Summary information

- the Netherlands has a private health care system, with primary care practices, hospitals, nursing homes, mental health providers, and other health care organizations negotiating contracts and budgets with various health insurers
- in January 2006 public health insurers have been privatized or have merged with private health insurers, resulting in a regulated market for health care insurance
- primary care is delivered by general practitioners, dentists, midwives, physiotherapists, pharmacists, psychotherapists, and various types of nurses. The latter play an increasing role due to the reshuffling of tasks from physicians to non-physicians
- main drivers for reform in primary care are the increasing number of elderly, the increasing number of chronic patients, the increasing complexity of the needs of patients (multi-morbidity), and the increasing costs of healthcare associated with these developments
- main barriers for primary care reform are fragmentation of primary care across several categories of caregivers, several disciplines, and several forms of organization; low level of professional development and negative attitudes regarding evidence-based practice in some primary care professions; limited use of computerized decision support tools and multidisciplinary electronic patient records; experimental status of self-management initiatives; lack of resources for and culture of innovation in delivering primary care
- in January 2008 four targets have been identified by the Ministry for further action: 1) improved coordination in care; 2) more innovation, more entrepreneurship and improved purchase of care; 3) more transparency, improved quality and self-evident safety; 4) improved organization of acute care

2. Macro level

2.1 *The health system*

In 2006 the Dutch health care system was reformed to address problems of offering little choice, uneven spread of the financial burden, and too little control of increasing health care expenditures. Under the new system public health insurers have been privatized or have merged with private health insurers and all citizens are required to purchase a basic package along with own-risk coverage. The basic insurance covers all primary and secondary care. Long-term institutional and nursing home care is covered by mandatory special insurance, with an income dependent premium. Insurers can not refuse coverage to any citizen, but can compete on price and quality and offer package with additional services.

In the past, sickness funds reimbursed primary care physicians through annual capitation payments, while private patients paid practices and were then reimbursed by insurers. The new payment system includes capitation per patient and a fee per consultation, plus a negotiable reimbursement for practice costs depending on services offered, staff employed, and quality and efficiency indicators.

The new system represents a regulated market: it aims to make citizens (more) aware of health care costs and to introduce a greater market orientation. As a result, the relationship among providers, insurers, and patients (or consumers) has changed. There is more competition among both insurers and providers, which is meant to enable consumers to make better choices. It is still too early to draw definitive conclusions about the effects of this reform. With the life expectancy of the Dutch population increasing more slowly than the European average, much is expected from better collaboration in health care and quicker uptake of effective treatments.¹

At the same time tension is recognized between competition and collaboration. To further strengthen primary care and to improve its level of integration 23 relevant partners signed a letter of intent* and agreed on an action program in 2004. This resulted in a national platform (LOVE) wherein activities and instruments are shaped in a dynamic way to foster improvement. These activities are aimed at finance (e.g. Diagnostic Treatment Combination for integrated diabetes care), transparency (e.g. structured assessment of patient needs), support (e.g. regional organizations for supportive services in primary care), accessibility and capacity (e.g. introduction of physician assistants (PAs) and nurse practitioners (NPs)), and stimulating processes of change (e.g. breakthrough series).² This action program has no end date.

Notwithstanding these activities, in January 2008 four themes for further action have been identified by the newly appointed Minister of Health: 1) improved coordination in care; 2) more innovation, more entrepreneurship and improved purchase of care; 3) more transparency, improved quality and self-evident safety; 4) improved organization of acute care. Roles and responsibilities in strengthening primary care on these themes have been appointed to patients, providers, health insurers, municipalities, and the national government, eventually as part of the existing national platform LOVE.²

Also, improving the uptake of effective treatments will receive more attention. Under the new system health care providers must now document the quality of care they provide, with reference to evidence-based guidelines and performance indicators.¹

* Nine national associations of primary caregivers (AVVV, KNGF, KNMP, KNOV, LVE, LVG, LVT, MO-group and VvOCM), national patient/consumer association, national association of health insurers, Ministry of Health, Welfare and Sport, and 10 other partners involved in primary care (ActiZ, IPO, LHV, NMT, NVD, NVE, NVH, NVLF, NVM, NVZ and VNG).

2.2 Delivery system design

Within primary care it is especially the GP as gatekeeper who plays an important role in the efficiency of Dutch health care. GPs “specialize” in common and minor diseases, in care for patients with chronic illnesses and in addressing the psychosocial problems related to these complaints. The top five of health care problems treated by GPs are: complaints of neck and back (10.0%), hypertension (6.4%), acute infections of upper airways (5.6%), infection of the skin (5.4%), and coughing (4.7%).³

Primary care, which has proven to be essential to achieving desired health outcomes and limiting costs, plays a central role in the health care system in the Netherlands. There are roughly 9,000 GPs, most of whom have received two to three years of specialist training in family medicine. Dentists, midwives, physiotherapists, psychotherapists, and pharmacists also deliver primary care services. Nearly all residents are linked to a regular GP and practice. Patients are able to choose their GP but must register with a specific primary care practice. As gatekeepers to the system GPs must give their approval before patients can access hospital and specialist care (with some exceptions). As a result, 95% of problems presented in primary care are handled by the regular practices. In surveys, patients have repeatedly expressed high levels of satisfaction with primary care and strong support for their longstanding relationships with family physicians.⁴

Most family physicians and other primary care professionals currently work in private practices, with a majority working solo or in small group practices of two to three partners (88% of practices). With the exception of home care, practices are typified as mono-disciplinary small business. The growing desire for normalization of working hours and part-time work has consequences not only for the capacity required in primary care, but also for the organization because part-timers prefer to work in larger-scale organizations. Currently, a tendency toward an increase in scale exists. In the near future, health care centers with four to six doctors, one or two nurses, and other professionals (such as physiotherapists or pharmacists) caring for about 10,000 to 15,000 patients and working in close collaboration with local hospitals will be the norm. Within general practice, the delegation and reshuffling of tasks to non-physicians (i.e. nurses) is regarded as an important contribution to a more efficient provision of care.³⁻⁵

There is a looming prospect of fragmentation of primary care across several categories of caregivers, several disciplines, and several forms of organization. This creates a risk of a lack of coordination and continuity in primary care provision.³

All primary care professions have programs of guideline development – guidelines give recommendations on healthcare delivery and thus can have major impact on healthcare. But the size and impact of the programs varies substantially. GPs have a long-standing program of guideline development and implementation (since 1989), led by the Dutch College of GPs (NHG). Besides educational materials for patients and doctors, a crucially important mechanism for quality improvement is the national system of practice accreditation, developed by the College in collaboration with the Centre for Quality of Care Research (WOK). This system comprises a broad assessment of the practice management, focusing particularly on organizational and clinical indicators of chronic care. Between 2007 and now 100 practices have been accredited successfully, 400 practices are in the middle of the accreditation procedure and 90% of practices still need to start this procedure.

In 2008 other primary care professions have similar programs, but they tend to be smaller and have less impact. Primary care midwives have published three practice

guidelines and they have tested a small group educational program. Physiotherapists have developed a number of guidelines, but dentists do not have a national guideline development program, but recently a regional protocol for regular oral examination was developed and implemented. Psychotherapists do not have a strong tradition of evidence-based practice, with the exception of cognitive behaviour therapists. Pharmacists are currently exploring their role in delivering pharmaceutical patient care. In addition to these mono-disciplinary guidelines, all professions participate in multidisciplinary guidelines developed nationally (e.g. for diabetes, depression, and cardiovascular risk management).

The infrastructure for public health research in the Netherlands is rather fragmented. Public health policy in the Netherlands is guided by advisory councils such as the Health Council (GR), a Council for Public Health and Health Care (RVZ) and the Advisory Council on Health Research (RGO) and the Social Cultural Planning Office (SCP). Moreover, specific research programs are funded by the government and managed by the Netherlands Organisation for Health Research and Development (ZON-MW). The budget for health service research is approximately €60m, which is equivalent to 7% of total public budget for health research and 1.2% of total health care costs. Under the current Minister of Health the role of public health research in the Netherlands has changed from active integration to stand-back system responsibility and from public information to strategic business information. The research on improving healthcare suffers from a lack of status and in open competitions success rates for health science research has fallen from 16 to 8%.^{6,7}

3. Meso level

3.1 The community

The development and management of Dutch public health policy used to be rather centralized in the past, but currently the responsibility for the implementation of prevention and health promotion is shifted more and more towards the municipalities. Some controversy has arisen in the public health field, however, as to the potential lack of coordination and inspiration that this approach may coincide with. The Netherlands has a regional network of municipal public health services, which take care of child health examination, vaccinations, environmental health, health protection and health promotion activities.⁸

Collaboration within primary care is currently intensified around specific needs: chronic care, prevention, youth care, and care for addicts.² New legislations facilitate municipalities to take on their role and responsibilities to connect health, work, living environment, and safety.

However, for many primary care providers the meso level is probably not very important, because the major drivers are at either macro or at micro level.

4. Micro level

4.1 *Self-management support*

Under the new health care system consumer organizations seem to have embraced their more active role. Consumer organizations are participating in negotiations with providers, insurers and policymakers and are represented on task forces that prepare professional guidelines and performance indicators.¹ Nevertheless, initiatives are planned to further improve the information for decision making by consumers.² To improve self-management, initiatives are being undertaken to improve the accessibility to health information for people (healthy, elderly, patients). Examples are internet websites about self-management and services people can contact by phone for free advice.³ Furthermore, on local or regional level many initiatives exist for specific groups (e.g. chronically ill), whilst most of these initiatives are still experimental and small sized. Finally, in a number of research projects and innovative educational programs for health professionals specific examples of self-management support are tested. A similar situation exists for initiatives to foster prevention.

4.2 *Decision support*

As described above, for many diseases evidence-based guidelines exist, which have been developed by one discipline and increasingly by multiple disciplines. Moreover, patients and insurers participate in the development of guidelines. In many cases the guidelines are part of a quality improvement system, currently being implemented, to enable continuous assessment and improvement of quality of care. Guidelines also exist in patient versions (leaflets). The GPs have developed over 80 guidelines and these are on average followed up for 75%.^{3,9}

However, guidelines developed at a national level need to be translated into decision support tools at meso and micro level. Together with scientific organizations for medical specialists, the Dutch College of GPs (NHG) formulates National Interdisciplinary Agreements. Based on the guidelines of GPs and medical specialists, these interdisciplinary agreements form the basis for regional working agreements. Together with the scientific organizations of other primary care disciplines (midwives, occupational physicians, district nurses and paramedics) the NHG develops National Primary Care Working Agreements. Pharmacotherapeutic reports are developed for subjects not directly related to NHG Practice Guidelines. These mostly concern 'minor ailments' in general practice. Just like the Practice Guidelines, these reports provide the scientific basis of the pharmacological recommendations in the NHG Electronic Prescription Support Program. The content of this is regularly revised on the basis of new data. The Electronic Prescription Support Program has recently been integrated in most of the current electronic patient files available for GP practices, although it has been available for several years already as a stand-alone programme.⁹

New is the development of 'care standards'. These documents exist for diabetes, COPD, depression, anxiety disorders, and vascular risk management and describe the integrated setting wherein care needs to be provided. These standards are defined by multiple stakeholders and include quality indicators for the organization of care. As such, these standards are an important document for the negotiations between providers, insurers and patients.²

Within primary care programs for distance learning and additional modules for continuing medical education in groups provide the basis for professional development.⁹

4.3 Clinical information systems

ICT has become an integral part of general practice in the Netherlands, although not all practices use all its tools. Since the 1980s the NHG has formulated reference models which describe the minimum requirements for a GP information system. The NHG is now closely cooperating with other parties to develop guidelines and standardization activities to facilitate the communication between GP information systems. The NHG also produces facilities which support consultations such as the Electronic Prescription Support Program which is used by the majority of GPs.⁹ Today, nearly all practices use electronic medical records and an increasing number use computer software to identify and track patients who have chronic conditions or are at risk of developing them.⁴ Currently, the supply of data still has prominent gaps.³ Implementation of multidisciplinary electronic patients records is believed to be the ultimate step in sharing information. Except some regional initiatives, on national level first steps towards implementation have only been made very recently.^{2,10}

5. Further aspects

Traditionally, Dutch quality development among health care providers was largely self-regulated. This began to change with the Quality in Institutions Act (1995), which offered a simple framework for quality assurance and improvement. Although it did not dictate decisions regarding specific tools and procedures, the Act mandated that every profession or organization in health care set standards for optimal care, develop strategies for monitoring and improving care, and create systems to enable public reporting to the health care inspectorate, through an annual quality report, and to patient organizations. Consequently, these stakeholders have become more intensively involved in improvement initiatives.

The different parties' initiatives often overlap and compete with each other and have resulted in some confusion within the target groups. A challenge is also to maintain and foster the health professionals' motivation to continuously improve the quality of their work, because external quality control and transparency of performance might threaten this. Future efforts must focus on integrating the various quality improvement initiatives into a single and coherent system.⁴

Major developments have occurred in acute care, including the establishment of GP out of hours services in almost all regions and (more recently) the integration or collaboration of these services with hospital emergency departments. The need for integration also counts for the management of chronic diseases, since this is being implemented as a set of different innovative practices. These include: using specific services or laboratories to monitor and track chronic patients; adopting evidence-based guidelines, critical pathways, and care protocols; instituting self-management and educational programs for patients; and developing collaborations among primary care and hospital facilities.⁴

6. Key findings from case study

Following the description of the components above, the following key findings from the Netherlands are found:

Main barriers:

- the looming prospect of fragmentation of primary care across several categories of caregivers, several disciplines, and several forms of organization causes a risk of a lack of coordination and continuity in primary care provision

- the increase in scale of insurers and care providers conflicts with the objective of competition in health care
- professional development and acceptance of evidence-based practice are suboptimal in some primary care professions
- the use of clinical information systems (i.e. electronic patient record) is limited
- self-management initiatives are still experimental and accessible for only a limited number of patients
- fragmented and limited resources exist for health services research

Main success factors:

- primary care, at the centre of the Dutch health care system, provides high quality care at relatively low cost
- a long history of practice guidelines in general practice facilitates a continuous delivery of high quality care
- the regulated market orientation, as a result of the system reform, affects relationships between providers, insurers and patients and facilitates a sphere of innovation
- the increase in scale of insurers and care providers results in better collaboration, multidisciplinary care (incl. role of nurses) and, as is expected, in higher quality of care

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