The history of Dutch General Practice

or: how Primary Care saved the nation

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The community is the laboratory of primary care – every community and at all times
Background and objective presentation

Dutch General Practice

• Success Story
  – Commonwealth Fund / Our minister (when in DC) / ‘We ourselves

• International beacon
  – Experience others can learn from

But

• Developed over a long period of time
  – Not just a rosy journey – many episodes of concern, doubt

• Understanding the journey is to understand what primary care is

• Strengthen international primary care collaboration
This presentation

Content:
Presentation of main landmarks of development
Relation to societal and health (care) issues
Relation to international PHC developments
Role of the profession and academia

Context of analysis:
PHC is an international concept
Developed in national historical, socio-economic, values setting

Frame of analysis:
Drivers and barriers of success
Role of professionals, patients, academia, policy makers
Background of my thinking

• 2006 Health Care Reform
  – ‘Introduction’ the market
  – Selling products vs creating values

• Australian experience
  – Comparable health systems and role for GPs
  – Comparable international status
  – Yet substantial differences in development
  – In progress: a comparative historical analysis
Dutch health care system

- Access to health care through general practice
- Primary care the link community - health system
- Gate keeper, navigator function
- Specialists, hospital, after GP referral only
- Personal listing with a practice, GP
- Practice population defined, and ‘known’
- Primary care the link to society: governance, societal impact
Dutch health care ‘primary care based’
Organised ecology

* White et all, NEJM 1961
Green et all, NEJM 2001
The 2006 Dutch health care reform

Obligatory Private Health Insurance
market to regulate care and costing
private insurers as advocates for their insurees/patients
Motives for health care reform 2006

• Political:
  – Era of privatization (Dutch Rail, Dutch Mail)
  – Belief of the Market solving problems, the public sector could not

• Financial:
  – Increase in health care costs (‘Dutch health care the best, most expensive’)

• Public Health:
  – Decreasing returns on investment (life expectancy, in particular men)
  – Under-utilization of prevention

Notion of Putting Health Care Back on Track
Look of innovative solutions – ‘All rules off the table’
Including, initially, the primary care structure
Development health care costs

Percentage increase of expenditures per year

* In 2013 almost no increase (0.1%) in percentage of GDP (NL National Statistics Institute)
Evolving governance

– Initially: making sure that the market would govern
  • Expected: lower costs, higher quality, more focus prevention, active insurers
  • Actual: higher costs, same care, passive role insurers

– During implementation: equity and access
  • Strict regulation obligatory insurance, unrestricted eligibility
  • Retained: role of PHC/GP with patients lists, gate keeping, capitation
  • Restrictions on access to secondary care (ED)
  • Example: undocumented migrants access to high quality care through PHC

– On reflection: building on general practice developed 1941- 2006
  • Population values of a personal GP
  • Importance of community, social determinants
  • (Re)defining PHC function in the ‘new’ structure
  • Entrepreneurship in context
Landmarks of Dutch General Practice

- 1941 Sick Fund Decree
  - ‘Primary health care structure’, with patients listed with a GP, capitation payment
- 1956 Founding Dutch College of General Practitioners (DCGP)
  - Start of academic development
- 1968 Founding University Departments, chairs general practice, all schools
  - Teaching, Specialty Training, Research
- 1973 Residency program
  - Compulsory for entry in the field, profession
  - Register, re-registration
- 1975 White Paper ‘Primary Health Care’
  - Support multidisciplinary health centres
- 1986 General Practice Research Capacity Program MRC
  - Research for practice
- 1989 DCGP Quality Initiative
  - Guideline program
  - Individual and practice audit & accreditation
- 2006 New Health Insurance Law
Societal and health (care) issues

- 1941 Sick Fund Decree <= Affordable health care, population needs, equity
  • ‘Primary health care structure’, with patients listed with a GP, capitation payment
- 1956 DCGP <= Person centeredness of health care
  • Start of academic development
- 1968 Founding University Departments, chairs general practice, all schools
  • Teaching, Specialty Training, Research
- 1973 Residency program
  • Compulsory for entry in the field, profession
  • Register, re-registration
- 1975 White Paper ‘Primary Health Care’ <= Population/community centeredness
  • Support multidisciplinary health centres
- 1986 GP Research Program <= Evidence-based medicine, quality, safety
  • Research for practice
- 1989 DCGP Quality Initiative
  • Guideline program
  • Individual and practice audit & accreditation
- 2006 New Health Insurance Law
Health (care) related ‘crices’:
PHC, general practice ‘re-invented’
Adaptation of PHC values towards societal challenges
Importance of the profession/field to adept
Relation to international developments

- 1941 Sick Fund Decree <= WHO, concept, definition health (1948)
  - ‘Primary health care structure’, with patients listed with a GP, capitation payment
- 1956 DCGP <= founding of national Colleges, WONCA (1952 – 1972)
  - Start of academic development
- 1968 Founding University Departments, chairs general practice, all schools
  - Teaching, Specialty Training, Research
- 1973 Residency program
  - Compulsory for entry in the field, profession
  - Register, re-registration
  - Support multidisciplinary health centres
  - Research for practice
- 1989 DCGP Quality Initiative
  - Guideline program
  - Individual and practice audit & accreditation
- 2006 New Health Insurance Law <= cost-effectiveness health care
International development and collaboration
Driven by prevailing local conditions
Interaction ‘stakeholders’
Role profession, patients and academia
## Landmarks Dutch General Practice Development

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<thead>
<tr>
<th>Year</th>
<th>Government</th>
<th>Professional</th>
<th>Academic</th>
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<tbody>
<tr>
<td>1941</td>
<td>Sick Fund Law</td>
<td>1953 Integrated Care (Querido)</td>
<td>1949 Buma: PhD GPs and their patients</td>
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<td>1956 College GPs</td>
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<td>1959 Woudschoten Declaration</td>
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<td>1968</td>
<td>Law on medical qualification</td>
<td>1968 Health Centres</td>
<td>1968 University Departments, chairs GP</td>
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<td></td>
<td></td>
<td></td>
<td>(including Specialty Training GPs)</td>
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<td>1983 Neth. Institute Health Research NIVEL</td>
<td>Professional Registration</td>
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<td>1989</td>
<td>1st National Study GPs</td>
<td>1989 Guideline program DCGP</td>
<td>1991 Royal Academy recognises PHC field science</td>
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<td>1990 Professional audit &amp; accreditation</td>
<td>1995 Netherlands School Primary Care Research</td>
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<td>2002</td>
<td>2nd Second National Study GPs/PHC Compulsory private health Law</td>
<td>2005 Practice audit &amp; accreditation</td>
<td>2002 Netherlands Organization of Health Research &amp; Development (Zon/Mw)</td>
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Framework of health care development
(Salter, 2004)

Salter, B. 2004. The new politics of medicine, Basingstoke, Palgrave Macmillan
Legislation, Empirism and Evidence
role of policy, profession, academia

- Patients as (often silent) partners in crime
  - Sick Fund Decree 1941 reflected patient advocacy for access to care
  - Human face of medicine 1950/60
  - ‘Voice of patients’ in the 2006 reform to retain practice lists, capitation
  - Throughout: societal value personal GP/PHC

- Academia
  - Inclusion in universities
  - Research capacity building (MRC), assessment (Royal Academy), funding (ZonMw)

- Profession
  - Support (social) psychiatry 1950, paradigm
  - Collaborative approach EBM and professional guidelines

- Policy discrete support over time
  - Responsive support (1941; 1968; 1975)
  - Exception 2006 health reform
Framework of health care development
(Salter, 2004)

Framework of health care development
(Salter, 2004)

For the Netherlands:
• Role society, patients
• Importance academia
• Within profession

Role of academia and research:
High Societal Impact
and
High Scientific Impact
Fig 2  Number of research publications (15% sample) by authors from primary care in journals with ISI impact factor per billion dollar gross domestic product spent on research (GERD).

Glanville J et al. BMJ 2011;342:bmj.d1028
Fig 3 Mean number of research publications by authors from primary care (2001-6, 15% sample) per billion dollars gross expenditure on research and development (GERD) and by journal impact factor.

Glanville J et al. BMJ 2011;342:bmj.d1028
Fig 2 Comparison across six countries of average number of citations per publication indexed by journals in the Web of Science “medicine—general and internal” category.
Conclusions:

– General practice, PHC international movement
  • Learning from each other’s experiences, inspiration
  • Creating values for society
– Work in, apply for and adept, re-adept to local context
  • No copy-paste implementation
  • Local conditions have their history, barriers and facilitators
  • Local conditions present stakeholders to work with
– Dutch local conditions to cope with
  • Silent support of patients, population
  • Supportive role of academia, restrained role of politics
– Long-term perspective
  • 1941 sick fund structure => 2006 health care reform
  • 1959 values, principles, 1975 white paper => current community outreach
  • 1986 research capacity building => 2004-2010 research output
– GP, PHC ‘is’ not so much, but has to be constantly re-created
Last thoughts

In crises:
General practice, PHC re-discovered, reinvented

Culture:
Collaborative approach with other stakeholders

Intrinsic strength as discipline:
1986 Research capacity building, but:
1949 PhD JT Buma ‘the GP and his patient’
➢ basis of the paradigm of GP/PHC
Between 1895 – 1940 > 130 GPs
➢ Important health challenges (fe TB, malnutrition, heredity)

Collaboration can only be as good as its partners