The history of Dutch General Practice

or: how Primary Care saved the nation

Amsterdam
August 31, 2015, EFPC Conference

Chris van Weel

Emeritus Professor of General Practice RU Nijmegen

Professor of Primary Health Care Research ANU

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

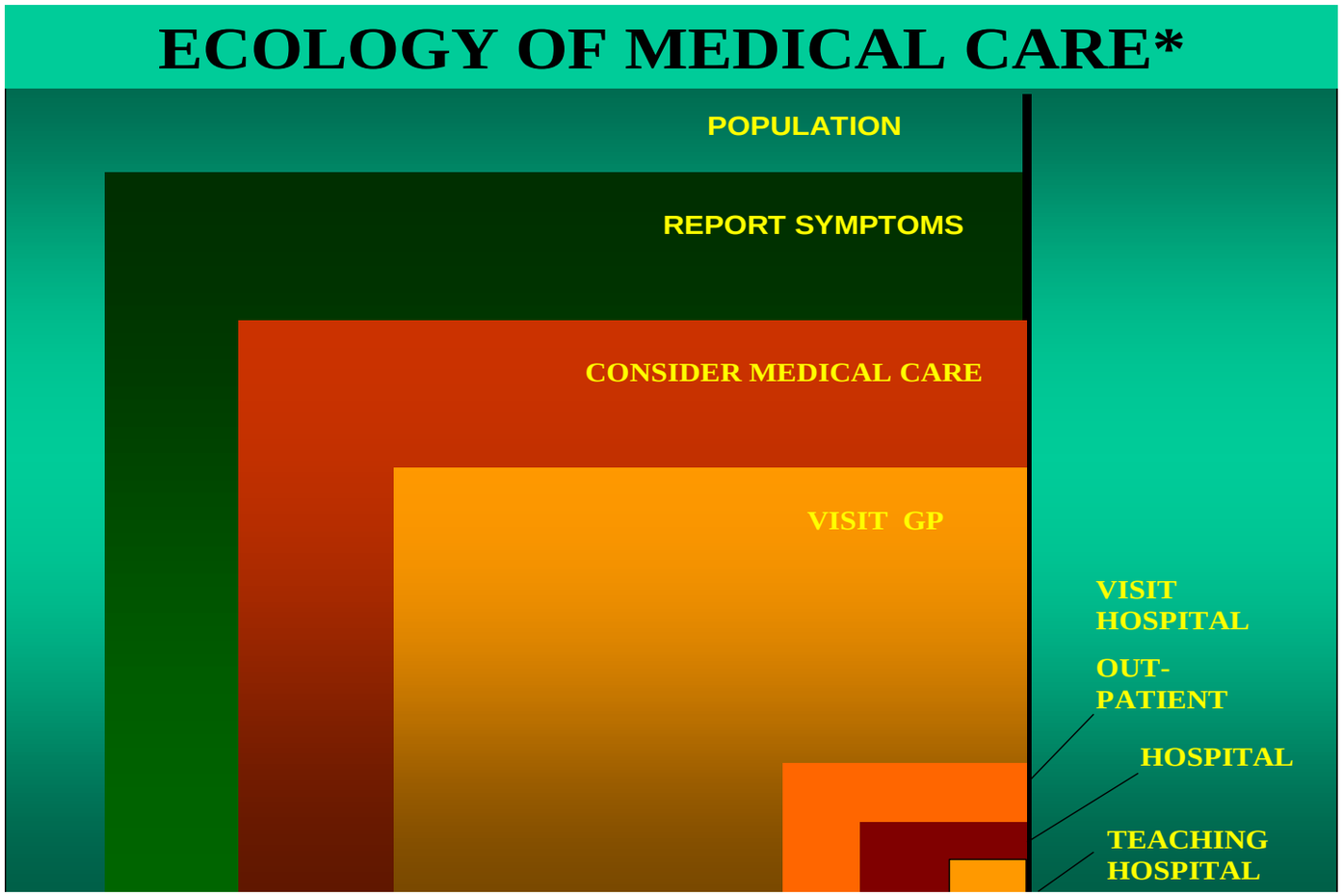
Background of my thinking

- 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

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The 2006 Dutch health care reform

Obligatory Private Health Insurance

market to regulate care and costing

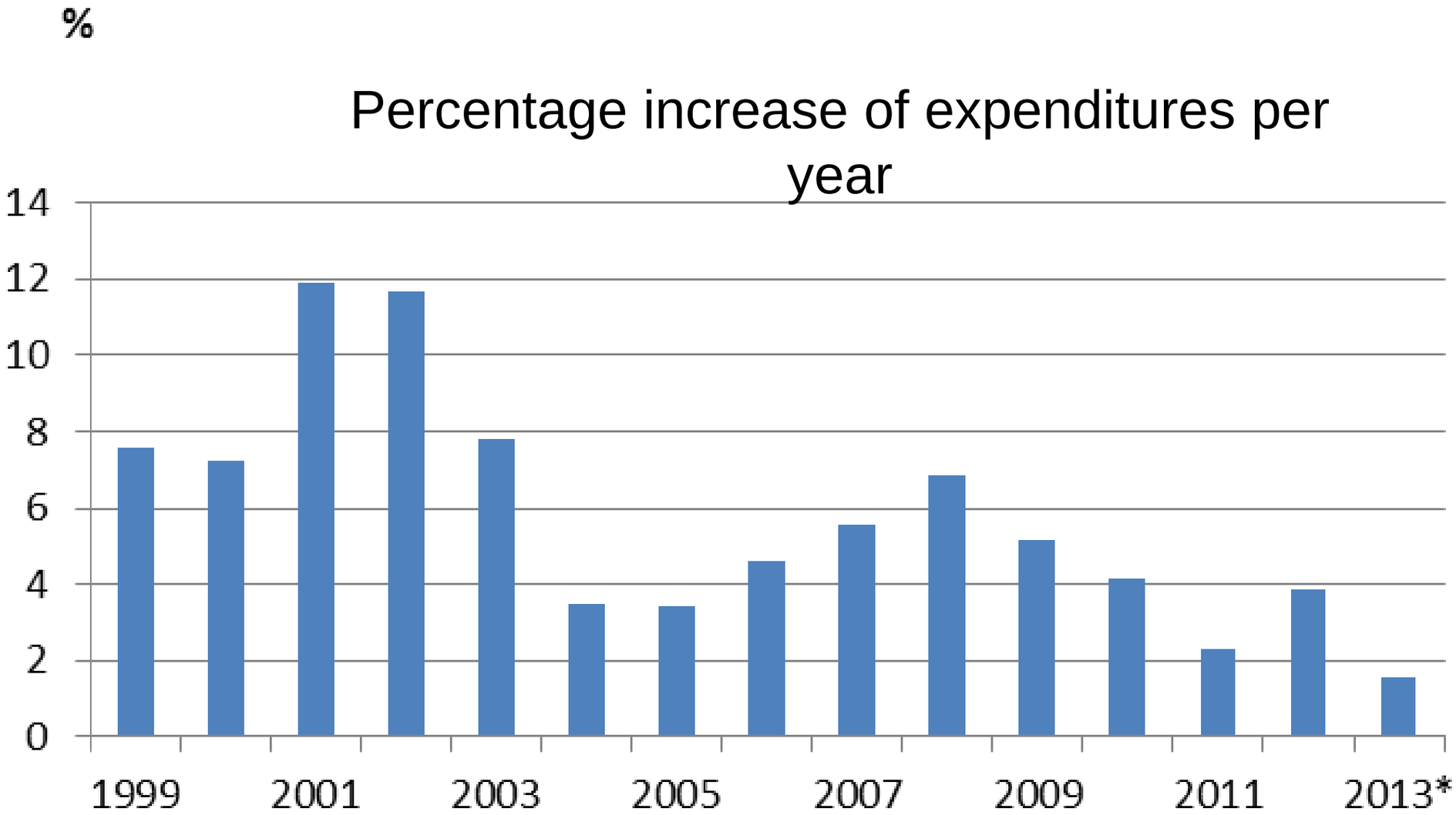
private insurers as advocates for their insurees/patients

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



* 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
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- 2006 New Health Insurance Law

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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
- 1975 White Paper ‘Primary Health Care’ <= WHO, Alma Ata, PHC (1978)
  - Support multidisciplinary health centres
- 1986 GP Research Program <= EBM, Cochrane Collaboration (1993)
  - Research for practice
- 1989 DCGP Quality Initiative
  - Guideline program
  - Individual and practice audit & accreditation
- 2006 New Health Insurance Law <= cost-effectiveness health care

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International development and collaboration

Driven by prevailing local conditions

Interaction ‘stakeholders’

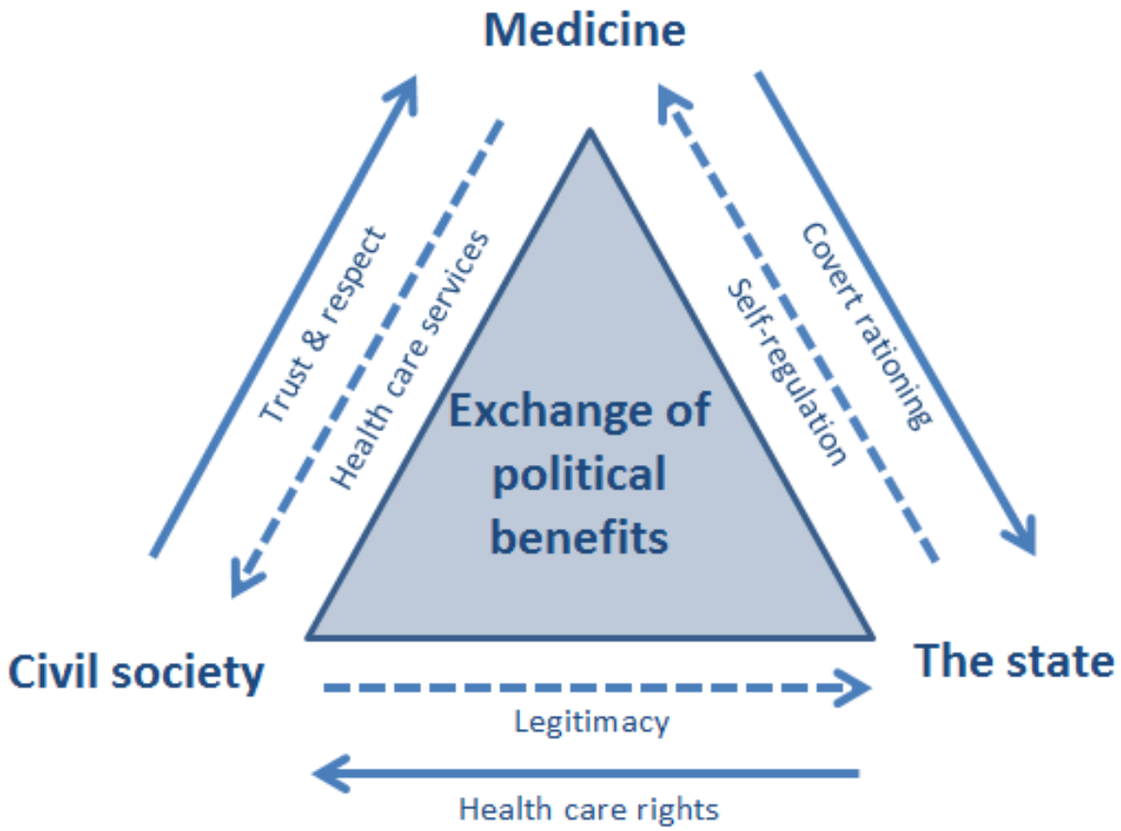
Role profession, patients and academia

Landmarks Dutch General Practice Development

Government	Professional	Academic
1941 Sick Fund Law	1953 Integrated Care (Querido) 1956 College GPs 1959 Woudschoten Declaration	1949 Buma: PhD *GPs and their patients*
1968 Law on medical qualification	1968 Health Centres	1968 University Departments, chairs GP (including Specialty Training GPs)
1975 White Paper PHC 1983 Neth. Institute Health Research NIVEL	1973 GP Registrar Program (compulsory for entering practice) Professional Registration	1986 GP Research Capacity Building
1989 1st National Study GPs	1989 Guideline program DCGP 1990 Professional audit & accreditation	1991 Royal Academy recognises PHC field science 1995 Netherlands School Primary Care Research
2002 2nd Second National Study GPs/PHC 2006 Compulsory private health Law	2005 Practice audit & accreditation	2002 Netherlands Organization of Health Research & Development (Zon/Mw)

Framework of health care development

(Salter, 2004)



Salter, B. 2004. *The new politics of medicine,* Basingstoke, Palgrave Macmillan

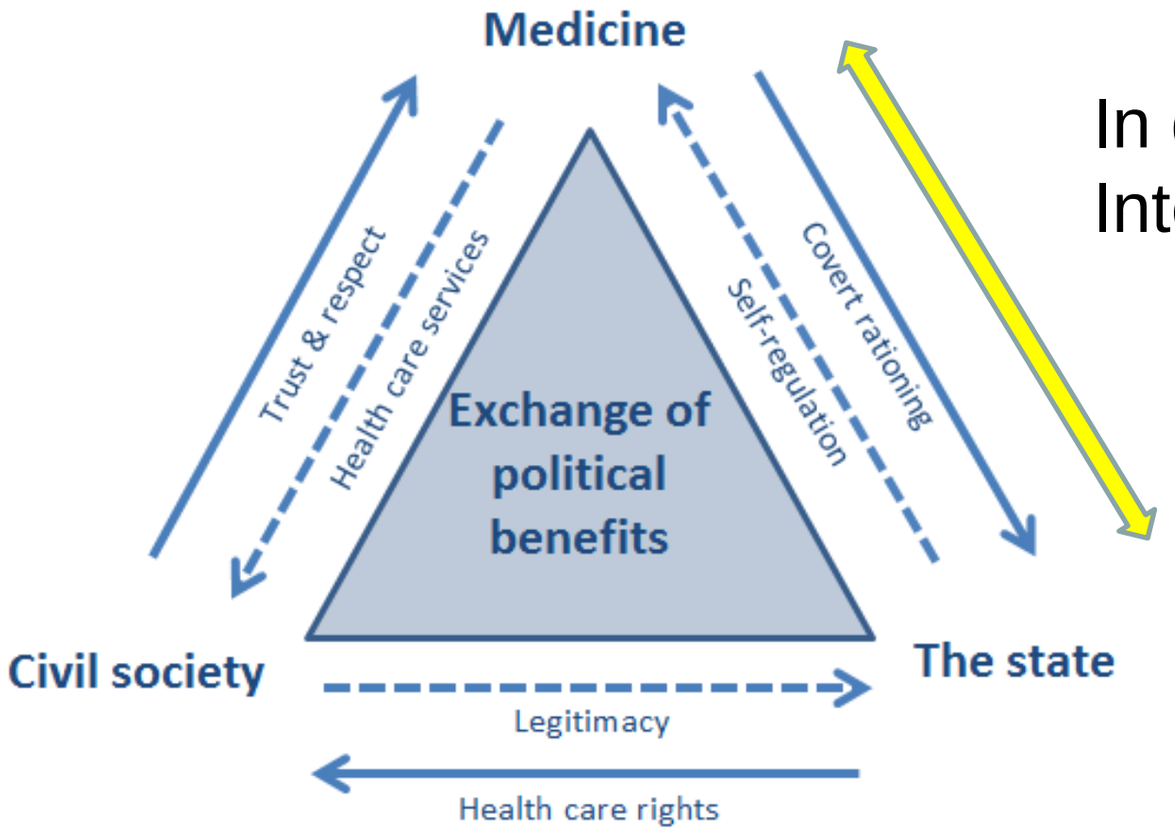
Legislation, Empirism and Evidence

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)



In general focus
Interaction with politics

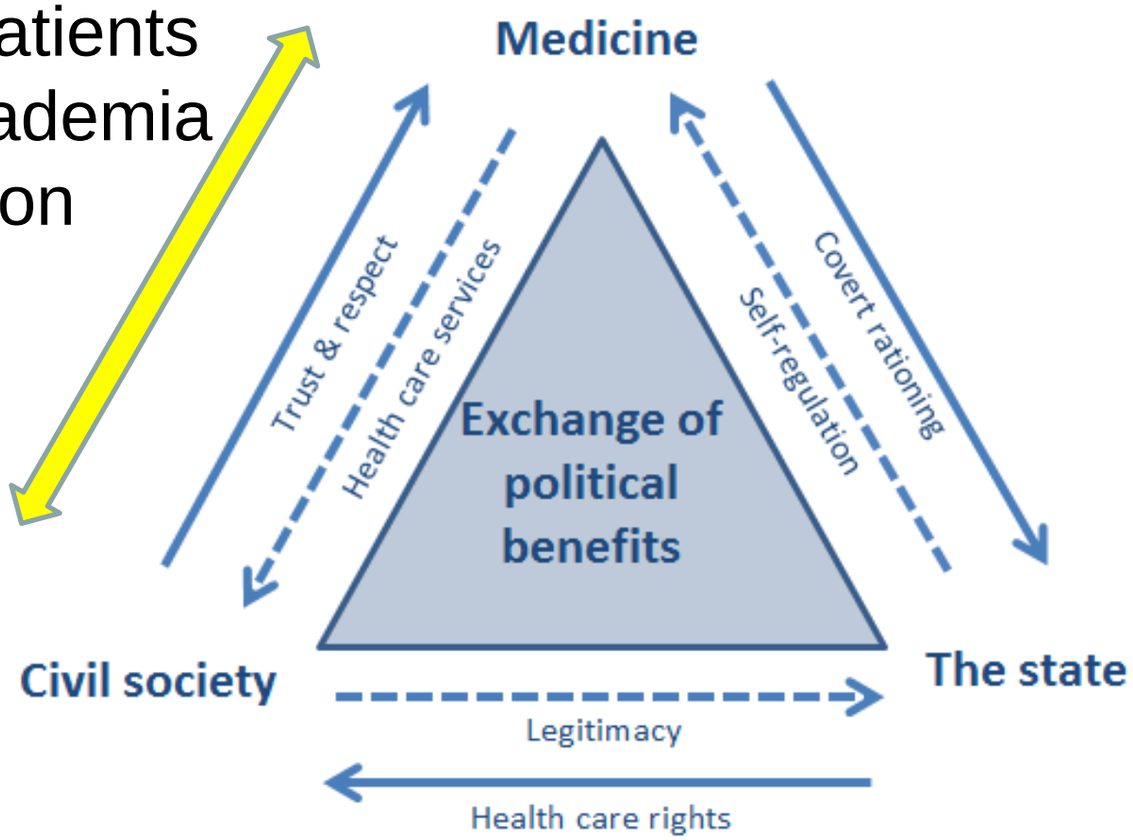
Salter, B. 2004. *The new politics of medicine,* Basingstoke, Palgrave Macmillan

Framework of health care development

(Salter, 2004)

For the Netherlands:

- Role society, patients
- Importance academia
- Within profession



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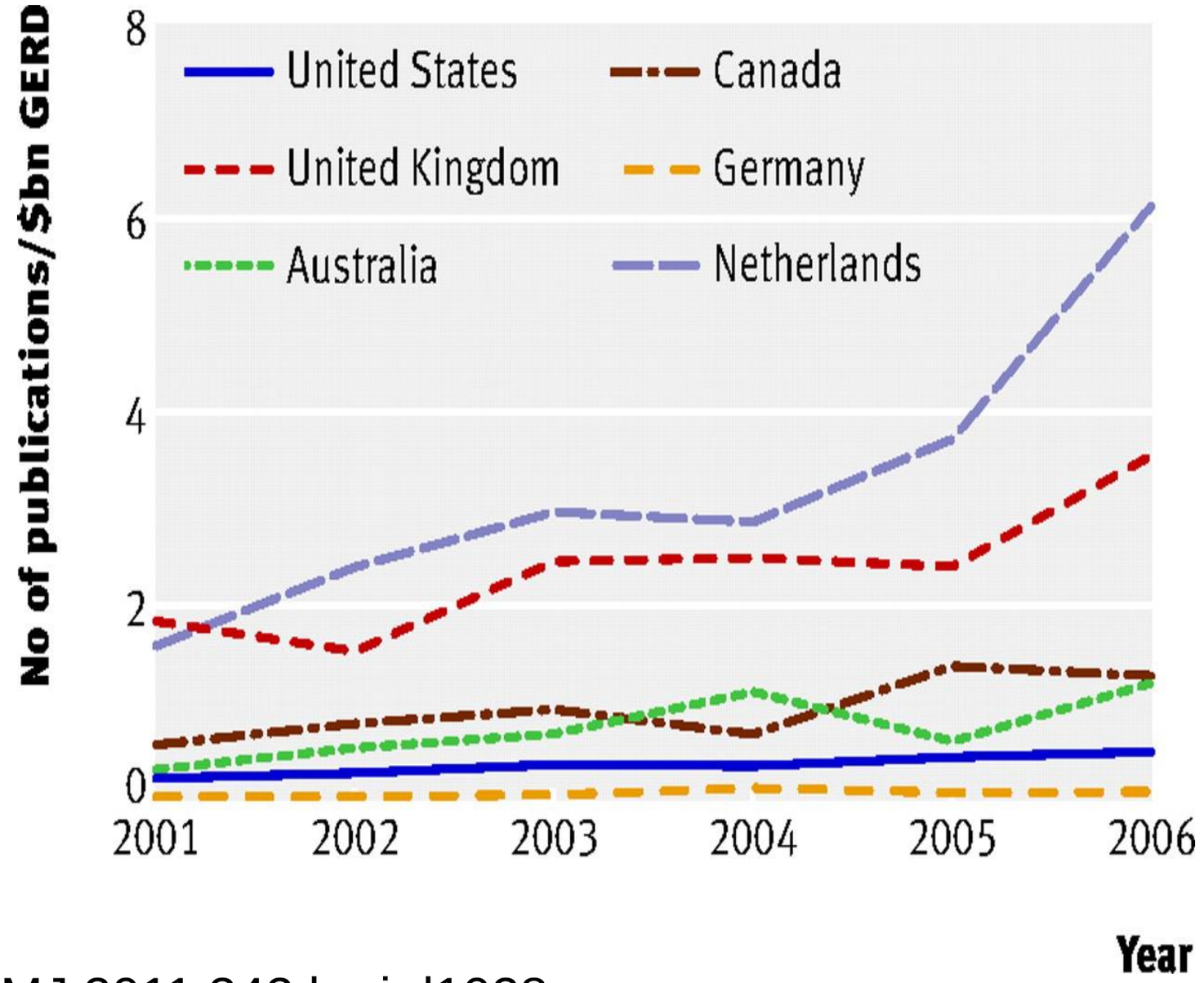
Role of academia and research:

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

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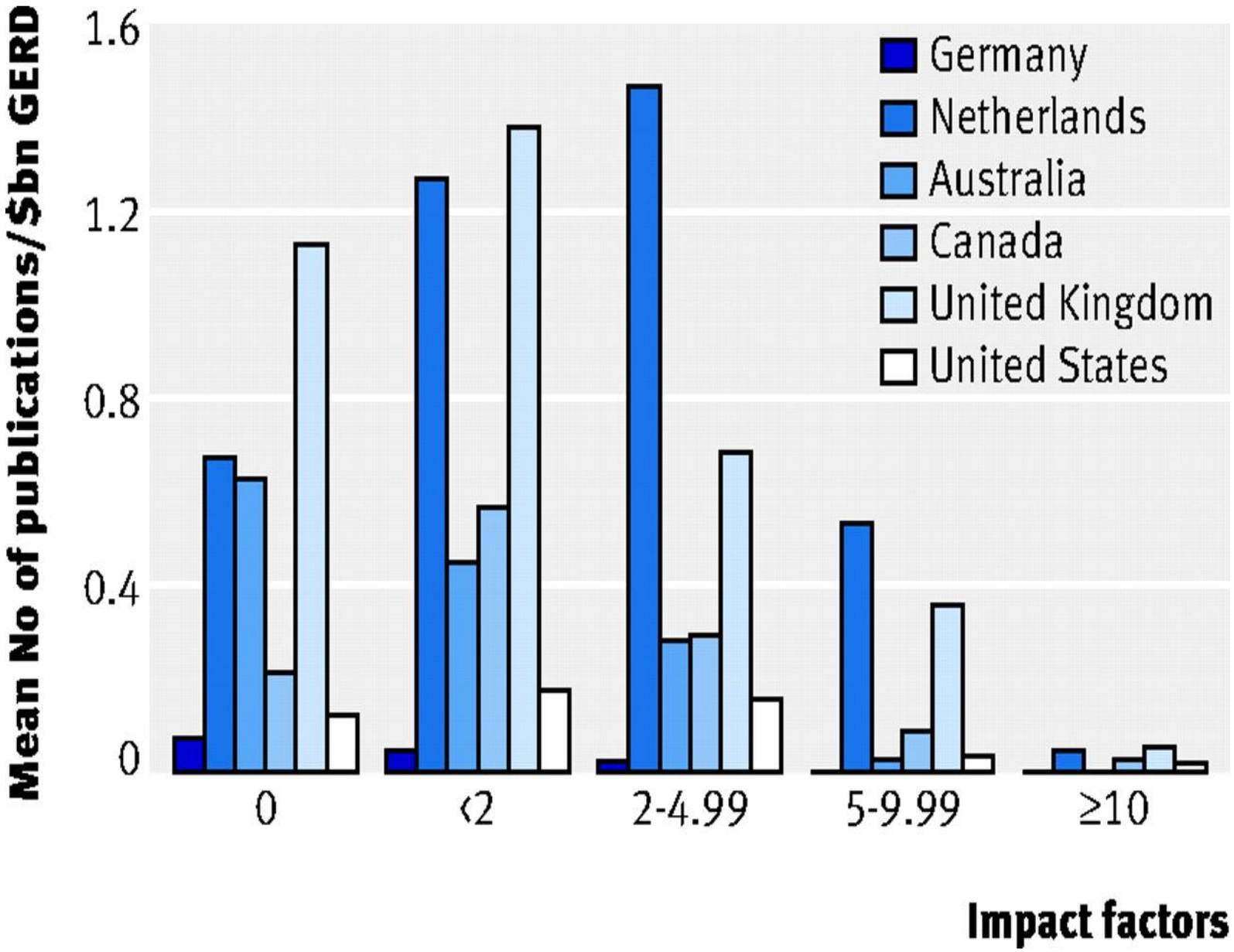
Fig 3 Mean number of research publications by authors from primary care (2001-6, 15% sample) per billion dollars gross expenditure on research and development (GERD) and by journal impact factor.



Glanville J et al. BMJ 2011;342:bmj.d1028

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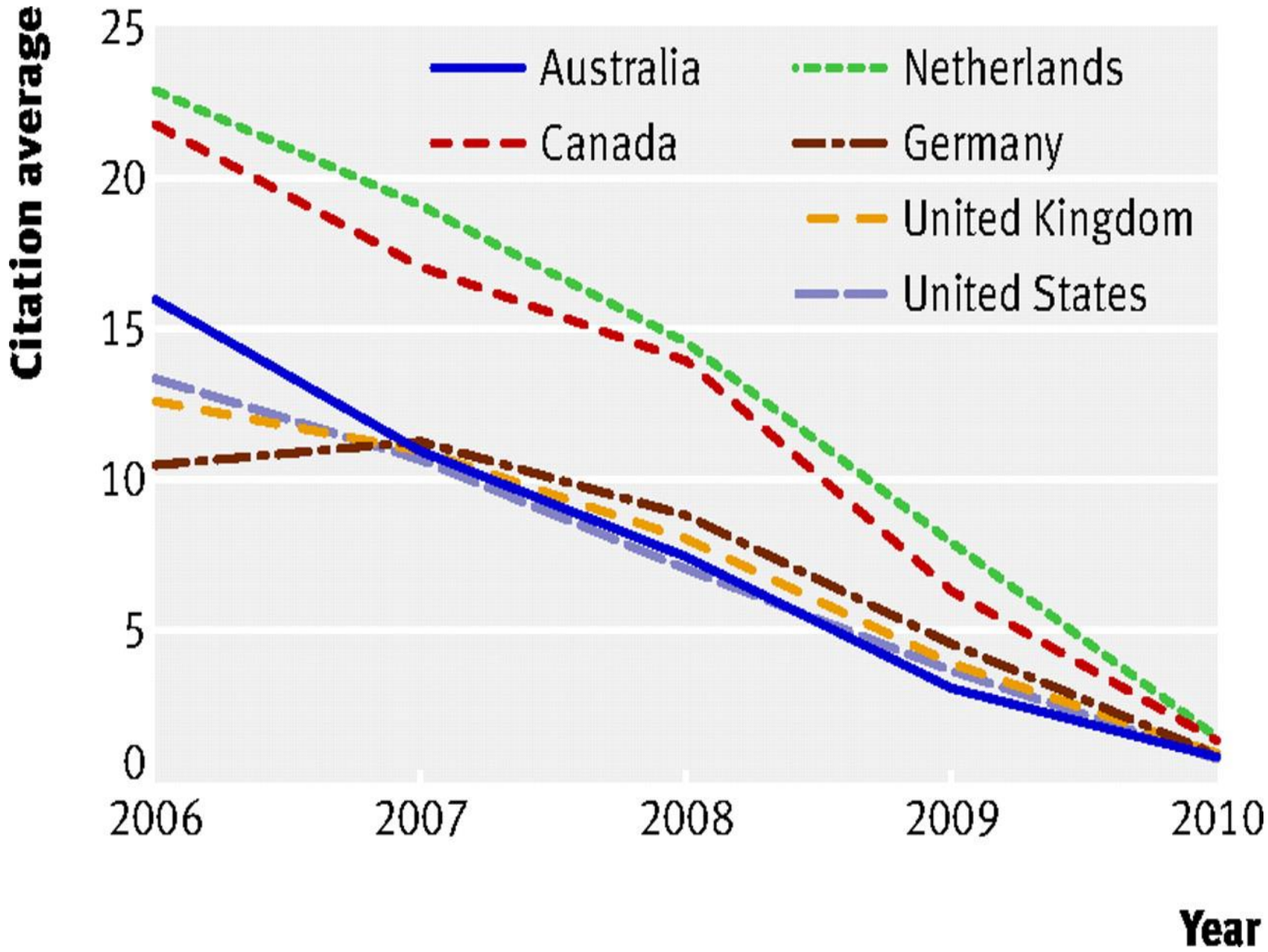
Fig 2 Comparison across six countries of average number of citations per publication indexed by journals in the Web of Science "medicine—general and internal" category.



Weightman A L , Butler C C BMJ 2011;342:bmj.d1083

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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