Primary care in the Netherlands: current situation and trends
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Abstract

Background: Primary care in the Netherlands has a strong international reputation. However, this picture may be qualified in two respects. First of all, the Dutch primary care system is less cohesive than is sometimes suggested. Secondly, there are major challenges in the Dutch system (as is the case with other European health care systems), which have to be resolved in order to maintain and improve primary care.


Results: GPs have a strong position in the Netherlands. Their numbers are relatively low; they have a gatekeeping position, and there is no cost-sharing for GP care (unlike other forms of care). The primary care system as a whole, however, is characterised by weak coherence. Individual primary care disciplines have their own separate modes of funding. Challenges include a growing and changing demand for primary care services, and changes in manpower and organisation, that affect the balance between demand and supply regarding primary care services.

Conclusions: Among the threats to strong primary care are the risk of increasing fragmentation of care, negative side effects of a transformation process from cottage industry to service industry, and reluctance to invest in integrated primary care. An opportunity lies in the consensus among stakeholders that integrated primary care has a future. Technological developments support this, especially the development of electronic patient records.

Key words: primary care, general practice, the Netherlands
Recent trends in Dutch general practice are consequently a shift in the balance between both changing demand, a changing supply and, major challenges concerning increasing and international reputation of Dutch primary care and general practice is strong. However, there are also describes the current position of Dutch primary care while adapting to future needs is another. This paper ends with a discussion on whether the strong care and to countries where primary care is in the future. Challenges as well as trends are more general and in an international perspective two aspects might be highlighted.

Firstly, the number of inhabitants per GP, which is equivalent to average list size, is relatively high compared to other European countries. In most European countries the number of inhabitants per FTE GP does not reach 2000, while in the Netherlands there are over 2000 inhabitants per FTE GP [17]. The same goes for the number of inhabitants per community pharmacist. However, in community pharmacies there is a high rate of task.

Primary care in the Netherlands

The Dutch health care system can be characterized as a social security system. The distinction between private and public insurance has been abolished in the Netherlands since 2006. There is an obligation for each citizen to take out health insurance and for insurance companies to accept every citizen. The basic package is identical for everybody and there is a no-claim premium reimbursement (GP care is excepted from this). There is freedom of choice to take complementary insurance (for example for physiotherapy) and to opt for deductibles (up to € 500). The organizational structure of the health care system is tiered in a public health sector, a primary care sector, a secondary and a tertiary care sector. The public health sector consists of a system of regional health authorities governed by municipalities. Secondary care and (long term) tertiary care are mainly provided in private not-for profit institutions [18].

A range of professionals and organisations are active in primary care. In the Netherlands the most important of these are general practitioners - who are usually seen as the core providers of primary care – community pharmacists, physiotherapists, midwives, home care organisations, primary care psychologists and social workers. Midwives represent primary care obstetrics in the Netherlands, where a large percentage of births takes place at home under the care of a midwife [19, 20]. Primary care psychologists and ambulatory mental health care organizations represent community mental health care. Primary care psychologists work as independent practitioners in small-scale practices. Ambulatory mental health is also provided on referral by large integrated mental health care organisations. Probably due to their small scale - comparable to the size of general practices - primary care psychologists are increasingly seen as potential partners in primary care teams. Home care is provided by large-scale organisations that used to be monopolistic and regionally based, but they increasingly compete with each other over a larger geographical range. Small scale alternatives are not common. Home help and nursing care are both provided by these home care organizations.

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delegation to assistants who do the work at the counter. Traditionally, Dutch community pharmacists have a low-profile role in care provision to the public, compared, for example, to the UK [28]. They are currently reorienting their role in this area and they play an important part in local pharmacotherapy audit meetings with GPs [29].

Secondly, primary care does not constitute one clear and cohesive system. Organization and funding are mono-disciplinary which is not conducive to collaboration. General practitioners, physiotherapists, midwives and primary care psychologists work as independent practitioners in relatively small-scale practices, whereas social workers and home carers work for large organizations on a regional basis. This scale difference hampers cooperation between home care/home nursing and general practice. For pharmacists we see a trend from small-scale independent operations towards franchise formulas and chains, sometimes with salaried pharmacists working in businesses owned by pharmaceutical wholesale companies. Generally the scale of the primary care provision is small (as in most health care systems that are based on social insurance in contrast to tax based health care systems), but there are tendencies towards scale enlargement [30]. In 2007 22% of GPs worked in a single handed practice, compared to 40% in 1997 [21]. There are integrated, multidisciplinary health centres but despite receiving state subsidies these serve less than 10% of the Dutch population. Local arrangements may exist concerning the way primary care professionals co-operate regarding individual patients. However, we also see isolated providers with limited formal linkage to others. In general, primary care in the Netherlands can be characterized as mono-disciplinary small-scale enterprise.

Regulation, funding and payment
Specialty training for general practice is obligatory and takes three years. Practising GPs require re-accreditation every five years. Re-accreditation is conditional on how much of the five-year period they have worked as a GP. It is also contingent on having followed an average of 40 hours of accredited continuous medical education per year.

GPs in the Netherlands are gatekeepers for specialised care. Self-referral is not common, except for visits to an ophthalmologist and emergency departments of hospitals [31].

The relationship between providers (GPs, physiotherapists) and insurance organisations is governed by contracts. Until recently the contents of these contracts were mainly governed by negotiations at national level between government, umbrella organizations of insurers and providers. Gradually, insurers are being given more freedom in negotiations. Since 2005 tariffs for physiotherapy are freely negotiable, and with respect to GP care since 2006 a specific list of diagnostic and therapeutic interventions is negotiable. With respect to
to multidisciplinary health centres, national subsidies have been replaced by negotiations between insurers and providers offering ‘integrated primary care’.

Typical for the Dutch system is self-governance of professionals. Dutch GPs were, for example, early initiators in the development of professional guidelines. The first were developed in 1990 and currently there are over 70 guidelines, developed by the Dutch College of General Practice (NHG). The guidelines have no formal status, but deviating from the guidelines without a good reason can have legal consequences if adverse events lead to cases before the disciplinary tribunal.

The Dutch insurance system changed in January 2006. Since that date, the entire population is insured in the same way. GP services are part of the basic insurance package for the whole population as are services from midwives, pharmacists and primary care psychologists. Physiotherapist care is only part of the basic package for chronic patients (when they receive more than nine sessions). For all other people physiotherapy is not part of the basic package, but a large part of the rest of the population is additionally insured for physiotherapy. Illustrative for the strong position of general practice is that cost sharing does not apply to general practice (although it does for drugs prescribed by GPs). Table 2 summarizes the insurance reform [32].

Payments for independently working professionals (pharmacists, physiotherapists, midwives, psychologists) are mainly on a fee-for-service basis, whereas social and home care workers are salaried. For GPs the payment system is a mix of capitation and a fee for each consultation.

**Future challenges for primary care**

Meeting growing and changing demand

Demand will increase as a consequence of demographic changes (population growth and ageing of the population) and epidemiological developments (changing patterns of disease). Ageing of the population will lead to more chronically ill people and greater co-morbidity. Apart from that, epidemiological trend analyses show increases in prevalence of such chronic diseases as diabetes, asthma, COPD and osteoporosis but decreases in neck and back problems [33,34]. The differential effects of these trends on demand for primary care disciplines were computed. Demand for general practice care, pharmaceutical care and home care is growing strongly whereas demand for physiotherapists grows at a lesser rate and care for midwives at a much lesser rate. In more general terms demand from chronically ill people requiring

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**Table 2. The Dutch health insurance system after the insurance reform of 1 January 2006.**

<table>
<thead>
<tr>
<th>Health care insurance law</th>
<th>Introduced on 1 January 2006</th>
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<tr>
<td>Abolition of distinction between private and public insurance</td>
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<td>Insurance under private law with public limiting conditions</td>
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<tr>
<td>Obligation for every citizen to take health insurance</td>
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<td>Risk Adjustment</td>
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**Insurance policy**

Free choice between insurance organizations

Basic package (identical for everybody)

Choice between in-kind and restitution policy

Additional insurance (no obligation to accept, not necessarily with same insurer as basic package)

Deductible € 150 per year (freedom to choose a higher deductible up to € 500)

Collectives (via work or other) get premium reduction up to 10%

**Primary care**

Deductible does not apply to GP care and midwifery care

Whole population on the list of GP/practice

Mixed remuneration of capitation (€50 per year) and fee-for-consultation (€9 per consultation; higher amounts for long consultations and home visits)
Changing supply

On the supply side we see, especially among general practitioners and pharmacists, a trend towards greater numbers of female professionals. The percentage of female GPs grew from 18% in 1993 to 35% in 2007 and, considering the gender profile of medical students, will continue to grow to almost 60% in 2020. Female GPs work on average fewer hours per week than male GPs, but also among males there is a trend towards part-time work status. Partly for this reason, but also to steer clear of management concerns, young GPs prefer to work as salaried employees in a group practice [34,35].

At the same time we see a trend towards medicine (or nursing for that matter) as an occupation like any other, and no longer as a vocation. This has partly to do with the growing numbers of female practitioners seeking to strike a balance between private life and professional life. And it has partly to do with market effects penetrating the health care domain, whereby health care is marketed as a product. At the same time, GP care is evolving from being provided by individual doctors to being provided by institutions.

Changing balance between demand and supply

Growing and changing demand combined with professionals working less hours, poses challenges to the primary health care system. These challenges have to be met within the context of a shift from supply-side policy to demand-side policy. This trend is related to increased patient choice and better informed patients. The gate-keeping system, although functioning well [36], may not be a sustainable in the long run in Europe, where consumer orientation becomes more important. EU rulings and policies emphasize consumer sovereignty and this may contradict the restrictions inherent to gate-keeping.

A second trend is a shift from the typical Dutch self-governance by professionals to management by both third parties and primary care professionals. The role of third parties in Dutch health care is changing. Insurance companies are increasingly important in the new insurance system. Both the Ministry of Health and the Health Care Inspectorate introduced performance indicators. Performance indicators are a way of governing health care that shifts autonomy and power from professionals to management. We see this especially in home care where care provision is left to the market after needs assessment by independent agencies [37].

The increasing scale of organisation of primary care also affects self-governance. With increasing scale of practices there will be differentiation of professional work and practice management.

Worries about shortages of GPs in the future have set the agenda in the last couple of years. The intake of trainees has been increased in recent years after forecasts with significant shortages were made, and indications emerged of increasing numbers of people not listed with a GP. Recent studies show that the number of people without GP is very low, but up to 2020 shortages can be foreseen varying in magnitude between 2% and 8% [34].

Trends in primary care

We can analyse trends in demand because in 1987 and 2001 comprehensive surveys were held in general practice (the First and Second National Surveys of General Practice [8,33]). Growing demand is reflected in bigger patient lists and higher consultation rates. Between 1987 and 2001 the number of patients listed per GP increased by 10% to 2,500 per full-time working GP. In the same period the consultation rate increased by 10% to 3.9 per patient per year in 2001 [38].

GPs were able to achieve this by changing their working pattern. The percentage of home visits of the total number of consultations almost halved to 9% [39], while at the same the percentage of telephone consultations almost tripled to 11% in 2001. The percentage of GPs with a walk-in consultation hour decreased from 48% to 13%.

Moreover considerable delegation of tasks to practice secretaries took place. Per full-time working GP there is on average 0.84 FTE (Full time equivalent, part-timers are counted on the basis of the fraction of a full-time working week they are working) qualified practice assistant. Apart from management and administrative tasks the practice assistants perform medical tasks, such as taking cervical smears, conducting hypertension checkups, removing stitches and treating warts [40]. Besides task delegation, task reshuffling has been proposed to solve capacity problems in general practice. Task reshuffling to existing as well as new professions and services is suggested. There are several initiatives we will summarize below.

From 1998 onwards practice nurses were introduced in general practice. In 2006 in almost 60% of general practices had a practice nurse doing checkups of diabetes patients and to a lesser degree hypertension and COPD-patients. Evaluations show that the introduction of practice nurses improved the quality of care and patient satisfaction and led to some reduction of GPs’ workload [41]. Recently specialised master-level training courses were launched for nurse practitioners and physician
assistants. Numbers working in general practice are limited up to now but expected to increase in the future [42]. They are mainly working in the care for chronically ill.

Within the field of psychosocial care we see that GPs consider treating patients with psychological problems to be less their task than was the case fifteen years ago. The possibility to refer these patients to psychologists working in primary care has increased, both because the number of psychologists rose considerably and because psychology in primary care is now (since 2008) covered by basic insurance. In addition, psychiatric nurses are available for consultations in general practice; thus providing a link between primary and secondary mental health care. One third of general practices use this possibility [43]. The attention GPs pay to their patients’ mental health problems does not add to their overall workload [44].

A major development since the end of the 1990s is the rise of independent organizations providing out-of-hours GP care. Until recently out-of-hours care was provided by small locum groups of between 8 and 12 GPs. Now almost 90% is provided by large scale GP cooperatives on a regional basis. In these GP coops telephone triage is standard procedure. For GPs the introduction of the coops meant on average five times less out-of-hours-services and more work satisfaction [45]. These coops limit themselves until now to out-of-hours care. One experiment with a call centre that conducted daytime telephone triage was stopped. The participating GPs did not notice any workload reduction [34].

Accessibility of primary care physiotherapists has been improved with the provision of direct access since 2006. In the past they were only accessible with a referral from a GP or a specialist. Preliminary analyses show that 25% of new patients of physiotherapists came without a referral [46]. To improve reintegration after sick leave, Occupational Physicians have been authorized since 2004 to refer chronically ill patients to psychologists working in primary care [47]. The participating GPs did not notice any workload reduction [34].

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Pharmacists claim an increasing role as providers of pharmaceutical care, which could diminish workload in general practice. Examples are the management of repeat prescriptions, check-ups for diabetic patients and improving compliance. The first of these examples has been trialled in several local experiments but up to now, systematic evaluation has not taken place [34]. The second example was developed in a national programme called the Diabetes Check. Pharmacies taking part in this programme provide more (written) information to patients; however patients claim to need more oral information [48].

A pharmacy-led intervention showed that medication compliance in patients with moderate to severe heart failure can be improved, even in those with relatively high compliance [49]. Despite all the changes that have taken place, trust in the health care system in general and primary care in particular is consistently high [50].

Discussion

To start with, the good news is that general practice-based primary care still holds a strong position in the Netherlands, despite the major changes that have taken place during the last few years. The capitation fee for general practice is maintained under the health insurance reforms, which is important because this underlines the responsibility of general practitioners for their practice population. Moreover a fee-for-service system would have put GPs in a position where others could compete for parts of services provided by GPs. A further striking point is that GP care is the only health care service that has been kept outside of cost-sharing measures. Stakeholders in the Dutch health care system seem to be well aware of the advantages of a strong primary health care system. The stakeholders committed themselves in a ‘declaration of intent’ to a community-based primary health care system with structural collaboration between primary care providers [51].

But is this enough to guarantee a properly functioning primary health care system for the future? We have seen that future demand with its growing numbers of chronically ill people requires a cohesive, collaborative system. Coherence is traditionally a weak point of Dutch primary health care. As in other countries primary care can be characterized as a ‘cottage industry’, dominated by mono-disciplinary, small-scale enterprise [52]. In the past, there was the GP as a personal and a family doctor who was supposed to keep an overview and provide comprehensive and integral care. Looking at the trends described in this article, this will be increasingly difficult. Within general practices, part-time working tends to fragment care over a greater number of providers. The introduction of GP cooperatives for out-of-hours work brought parts of general practice care into new organizations. Task delegation and task reshuffling to new and existing professions harbours the danger of further fragmentation. The scale increase and introduction of market forces in home care makes collaboration with locally working primary care providers
practically impossible. Similar worries about fragmentation are seen in the UK [53].

In conclusion, a number of forces work against the direction of integration and in the direction of fragmentation. In such a case strong policy instruments are needed to reach the intended situation of integrated primary health care. The actual implementation of cohesive primary care is, however, left to the interplay between health care providers and insurers. It is potentially attractive for insurers that they can contract integrated primary care as a whole, e.g. in the form of community health centres.

Furthermore, strong, integrated primary care can potentially save costs in secondary care, as is indicated by international evidence at system level. Some insurance organisations are taking concrete steps to support community health centres. However, at first this increases costs, and benefits will only show in the longer run. For insurers, it is still technically difficult to use savings in secondary care to invest in primary care. Moreover the existing fragmentation of primary care has the potential advantage for insurers to purchase care in a more competitive market. Add to this the general distrust between insurers and providers [54] and the prospects for integrated primary health care are not unequivocally positive.

An important condition for providing integrated primary care in a situation where more and more professionals are involved in the care for a single person, is the development of electronic patient records. Electronic medical record keeping is relatively well developed in the Netherlands (94% of GPs work with computerized patient records for example, [55]) but every discipline within primary care has its own software. The first steps will be the linking of records from GPs and GP-coops and by linking the medication records between relevant providers. Developing this further to a fully integrated Electronic Patient Record system is very important, but cannot replace a personal doctor guiding patients and their family through an increasingly complex health care system. Therefore, the main stakeholders in Dutch health care have spoken in favour of maintaining the situation in which patients are listed with a single GP or practice. Ideally, these GPs are members of a primary health care team or network and are supported by fully-linked patient records to keep an overview, in order to provide integral, comprehensive and continuous care.

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References
