Health care system innovation in the Netherlands - with a special focus on primary care

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N = 16,859,390
Outline

• Some history and background
• Dutch health care (insurance) reform 2006
• Implications for primary care
• Some examples
• Concluding remarks, learning points
Some history and background
• Since World War II: primary care cornerstone of Dutch health care system

• Essential characteristics:
  
  (1) full access to primary medical care
  • all citizens have a GP (60% > 10 years)
  • GP coordinates specialist referrals

  (2) all referred specialist & long-term-care covered by insurance

  (3) insurance coverage of population practically complete
Primary care morbidity
- Unique domain of illness & disease
- Frequency, prognosis, outcome
Patient perspective
- Needs, preferences, capabilities person central
- Person and context factors
System perspective
- Navigating resources
- 95% of presented problems, 4% of cost

(Chris van Weel)
Primary-care score vs outcome indicators (Starfield, Lancet 1994; 344: 1129 – 33)

Average rank for satisfaction, expenditures per head, 14 health indicators, and medications per head. N.B. 1 is best, high is worse
Ongoing improvements since 60s

- Structural collaboration between GPs and other primary care disciplines e.g., community nurses, pharmacists, physiotherapists → multidisciplinary health centers
- (3 years) post-MD vocational training of GPs
- Strong basis of academic primary care research
- Evidence-based clinical guidelines covering most problems presented to primary care
- Strong ICT/EMR-infrastructure
The Dutch health care (insurance) reform 2006
• From 2000 cost started to increase (1999-2009: 8.1 → 12.0 % of GDP (vs. 17.4% USA)(OECD)

• At the start of 20th century
  – system did too little to control increasing health care expenditures and
  – offered too little choice for consumers

• New health insurance system introduced (2006)
Important objectives of new system

• More effective cost containment by stimulating competition between insurers and among health care providers
• Promoting (regulated) market orientation
• More influence insurers and consumers on quality and cost
• Safeguarding good care quality for everyone
• Promoting health care innovation
System changes (1)

• Until 2006, two thirds of population insured by public insurance funds; one third - above predefined income threshold - privately insured.

• In 2006: mix of public and private elements
  – public insurers privatized or merged with private insurers
  – all citizens required to purchase a basic package of essential health care services (determined by MoH)
  – obligatory “own-risk coverage” currently €360/year (not for GP care)
System changes (2)

- Premium for basic package set by competition between insurers (and between care providers) as to price and quality
- Insurers must accept all without selecting risks
- Low incomes receive subsidy for basic insurance
- Option for additional package of non-vital extras
- Necessary long-term institutional and nursing home care covered by mandatory tax-based insurance; income-dependent premium
The new system and primary care
The new system and primary care (1)

• GPs:
  – previously: full capitation fee for publicly insured (70%)
  – from 2006: partial fee-for-service in addition to still relatively substantial capitation payment for all
• This enables GPs to keep fulfilling also non-consultation related preventive roles
• Extra allowances for:
  – caring for elderly and people with low-incomes
  – taking part in health care innovation, such as programmatic care for patients with chronic illness, substitution, and quality improvement initiatives
The new system and primary care (2)

• System’s incentives evoked facilitation and spread of primary care innovations
  – patient-centered and integrated approaches
  – collaboration of primary care and public health workers, patient/consumer groups, local communities
  – multidisciplinary regional ‘care groups’ for chronic care (e.g., diabetes, COPD) : 11 in 2006, 100 now, covering 75% of GPs
  – co-ordination of primary and clinical specialist care

• More attention for evaluation of effectiveness/efficiency of innovations
Some examples
Health center Thermion Nijmegen

- GPs, nurse practitioners, physiotherapists, psychologists, social care, dietary care, pharmacy, dentist, speech therapists, obstetricians, home care, local public health workers
- Collaboration University Medical Center (EBM)
- Analysis health care needs local community, e.g.,
  - Much alcoholism $\rightarrow$ priority programme
  - Many elderly with disabilities $\rightarrow$ telemedicine
  - Network development: more practices/topics (e.g., loneliness, mobility)
Integrated prevention of falls

• Collaboration: GPs, fysiotherapists, community nurses, pharmacists, a regional health care organization, organizations of the elderly, sports organizations, local public health
• Multimedia educational materials, risk checklists
• Preventive and fall training by certified professionals
• 7 other groups followed the initiative
Other examples

• Joint consultations GPs & specialists
  – Complex orthopedic, cardiological, dermatological problems
  → Less referrals and procedures, less costs, same quality

• Primary care follow-up after cancer treatment
• Reduction of antibiotics use: shared care initiatives

• Effectiveness evaluated and published
• Supported by research funds
Concluding remarks and learning points
* In 2013 almost no increase in percentage of GDP (15.0 to 15.1%). (NL National Statistics Institute)
Some concerns

• Public and political debate on tensions between public responsibilities and market opportunities intensified

• Points of attention e.g.,
  – Much competition on price, but too little on quality
  – Reduction of bureaucracy
Learning points

• Be practical, not ideological (e.g., mix public – private has advantages)

• Reward quality rather than quantity → measuring quality

• Primary care innovation
  – Frontrunners, infrastructure, incentives for quality
  – Evidence-based ambition
  – Support from insurers, research, and policy