Australian National University

Innovative approaches to service and funding for primary health care development in the Netherlands and Europe

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

Contents of this presentation

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General information healthcare in Europe

General outline of successful systems

The Netherlands healthcare and history of PHC

Four Case Studies

- GPs out-of-hours care (NL)
- Emergency care in social context (NL)
- Comprehensive community care (B)
- Scaling-up working with migrants (EU)

Reflections, conclusions

Bottom line:

- PHC key function of any health care system
- Function can not be executed in isolation
- All incentives are at the end of the day perverse
- How to award the entire health care system to create health, not health care

European Healthcare Systems

- National States' responsibility
  - No EU Healthcare policy
- Diversity in history, culture and values
  - Common concerns of equity, sustainability, safety
- Area of increasing interest
  - European Forum of Primary Care
    - http://www.euprimarycare.org/
  - Comparative outcome studies
    - http://www.nivel.nl/sites/default/files/bestanden/Proefschrift-Dionne-Kringos-The-strength-of-primary-care.pdf (be aware: 336 pages!)
    - http://www.nivel.nl/en/qualicopc
    - http://www.nivel.nl/en

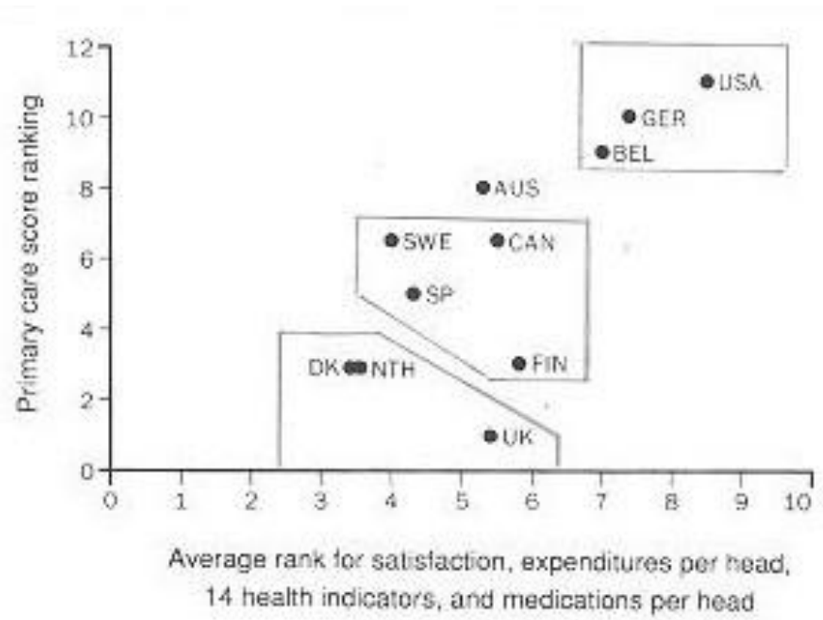
Where it all started for Europe

More primary care

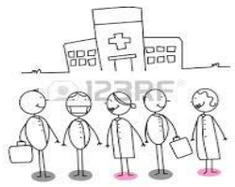
- Better health population, lower healthcare costs
- Higher life expectancy
- Better diagnosis, treatment diseases that matter

Illness - person with illness - population

Barbara Starfield
Is Primary Care Essential?
Lancet 1994



Three ‘Prototypes’



Free Access

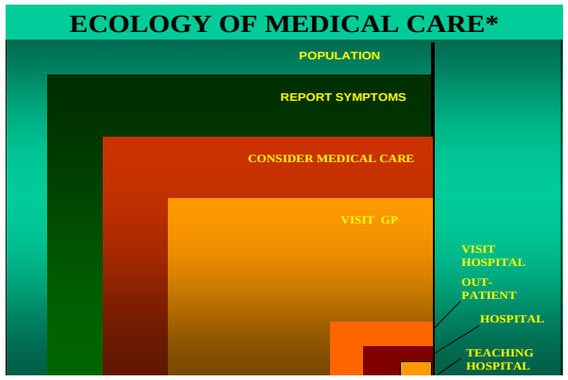
Gatekeeping through PHC

Gatekeeping through PHC
Personal GP

Two Facts of Real-life Health Care

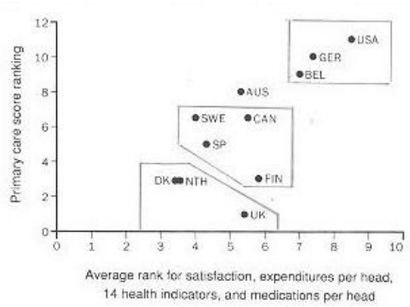
Disease - person with disease - population

Most health problems community based



White et all, NEJM 1961
Green et all, NEJM 2001

Primary health care matters:

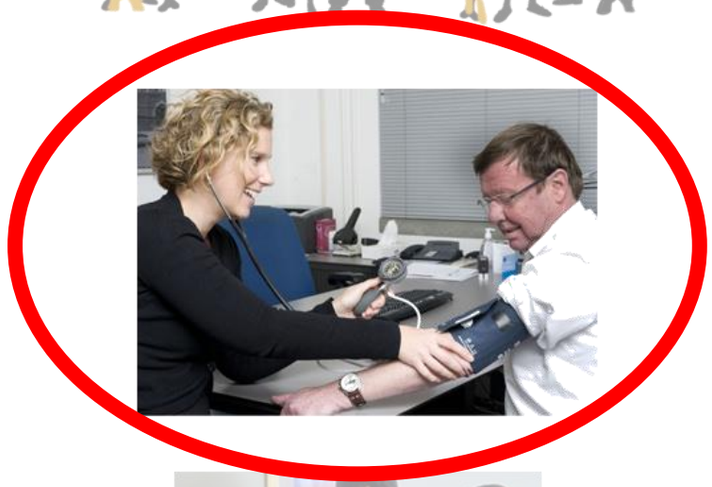


More primary care:

Better population health

Higher life expectancy

Lower healthcare costs



Clash of Concepts:

- PHC
  - Individuals and Populations
  - Social Context
  - Co-morbidity - Multimorbidity
- Evidence-based Health Policy
- Health Systems, Education, Research
  - Disease-specificity in diagnosis and management

Dutch health care system

- Access to health care through general practice
- Primary care the link community - health care 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

Landmarks Dutch Health Care

- 1941 Sick Fund Decree
  - universal coverage, primary care lead, patients' lists and capitation payment
- 1956 Founding Dutch College of General Practitioners (DCGP)
  - start of academic development
  - university departments, teaching, training, research
- 1973 Introduction residency training
  - GP Specialist register, re-accreditation since 1975
- 1989 DCGP Quality initiative
  - Development, implementation guidelines most common health problems
- 2006 Individual health care based private insurance

Experiences before 2006

- Since 1941 ‘PHC-led health system’ based on lists, capitation fee
- Long tradition reasonably good access and care, decent price
- Protection against ‘dehumanization’ of medicine
  - Listing encouraged the bonding and trust between patients and GPs
  - Capitation payment encouraged GPs to act in best interest of patients
- There was a ‘structure’ to stimulate
  - Teaching, training, education since 1973
  - Research, quality assurance since 1986

Pay Back:
Evidence based clinical practice through PHC 1989
PHC main function for health problems (> 90% => > 96%)

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The 2006 Dutch health care reform

limited financial resources – struggle to contain costs
limited health returns on care investment

(initial) political solution:

Private insurance system

market to regulate care and costing
private insurers as advocates for their insurees/patients

The 2006 health care reform: from design to implementation

Policy intentions

- •Market: best care, lowest price
- • Patients', insurers' choice
- • Active role insurers contract care
- • All rules off the table
- •Primary care to earn its position
- • Market promote prevention

System implementation

- • Health policy to contain 'market'
- • Return to 'relevant' care
- • Passive role insurers
- • Market regulation
- • Primary care: keep system operational
- • Market ignores prevention

Positive: possibility of money following innovative initiatives
health promotion, high risk groups
community based planning health and wellbeing

Problematic: restrict trivial hospital care
emergency department as revolving door of care
fancy outpatient departments

Case Study I:

out of hours care, GPs and hospital emergency departments

- **Objective:**
  - Secure access to health care 24/7, guarantee access, retain PHC structure
- **Local consortia of general practices:**
  - *Shared* care for community, GPs and receptionists/practice nurses out-of hours
  - Advice, GP-consultations and -home visits which can not wait till regular hours
  - Triage function, access to patients' EMR
- **Outcome:**
  - Retaining older GPs in system; satisfaction patients; professionalization out-of-hours
- **Development since 2006:**
  - Initially ' dual system' with hospitals' ED ('market share of the hospital')
  - Costs generating effects of ED did lead to cap on payment, which forced PHC-hospital alignment for out-of-hours care

Determinants of success:
PHC investments before 2006; Insurer money as seeding money, reallocation available resources

Case Study II:
emergency care intimate partner violence

- **Objective:**
  - Comprehensive approach intervention, prevention and legal protection victims of intimate partner violence
- **Projected outcome:**
  - Prevention of repeat-episodes; promotion self-efficacy; lower ED use/costs
- **Local consortium stakeholders:**
  - Patients and their ‘advocates’, Emergency department, PHC, Police
- **Procedure:**
  - PHC consultant in ED; victims provided with treatment, planning follow-up, legal protection within
- **Funding:**
  - Insurer (additional costs ED), Reallocation regular costs PHC, police

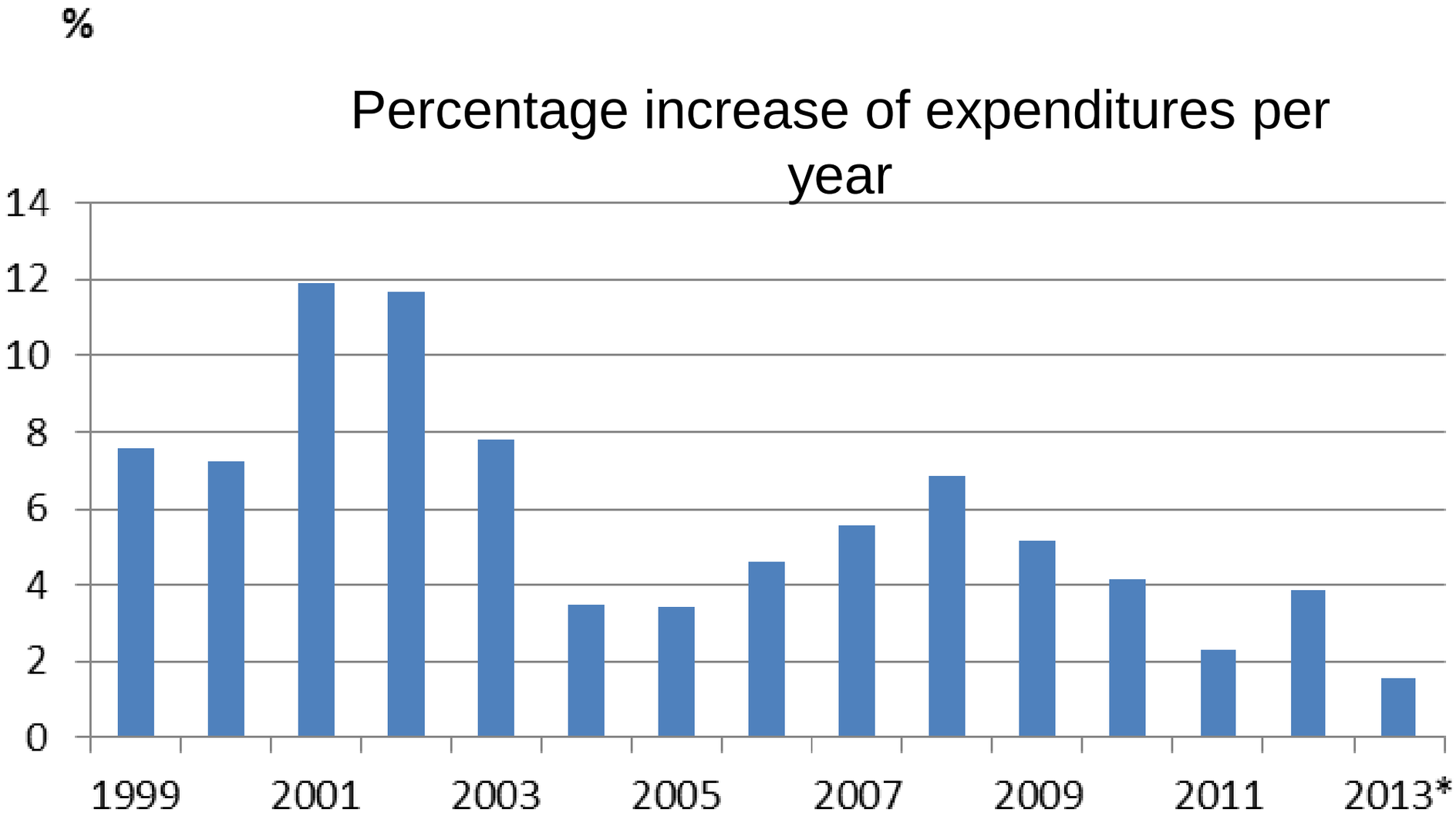
Determinants of success:
PHC investments before 2006; Insurer money as seeding money, reallocation available resources

Reflections health system reform in the Netherlands: what changed and what remained the same

- The initial concept challenged all roles and functions (‘the market’)
  - Empirical wisdom reconfirmed critical role of the PHC function
- Insight in costs and money flows has pointed to critical problems
  - Hospital, (sub)specialist sector under financial pressure (market management)
  - Reduce waste and combine, better use available resources
- Health reform is integral approach, not restricted to single functions
  - Failure of the 1990, need of better interactions (in PHC, with hospital, public health sector and inter-sectorial)
- Rethinking values and ways to award performance
  - Societies need less hospital, more PHC – yet importance of specialist expertise

Key question in payment:
How to award professionals to make patients, populations healthy?

Development health care costs



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

Case Study III

Community health centre ‘Botermarkt’ Ghent, Belgium

http://www.wgcbotermarkt.be/eng/?q=node/1
http://www.who.int/social_determinants/resources/isa_multilevel_contribution_bel.pdf

- Multidisciplinary centre in a socially disadvantaged area
- Private non-for-profit initiative professionals, University
- Intersectorial action, directed social determinants health
- **An example**: Childhood obesity
- **Problem analysis**: lack of physical activity

- **Problem reflection**: lack of *safe* facilities play, recreation
- Societal action to build and community-govern facilities
- **Outcome**: where was the first effect spotted?

http://www.euprimarycare.org/sites/default/files/2013%20Alma%20Ata%20-%20EngelsJDM.pdf

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- Societal action to build and community-govern facilities

- **Outcome**: drop in crime rate, improved safety street

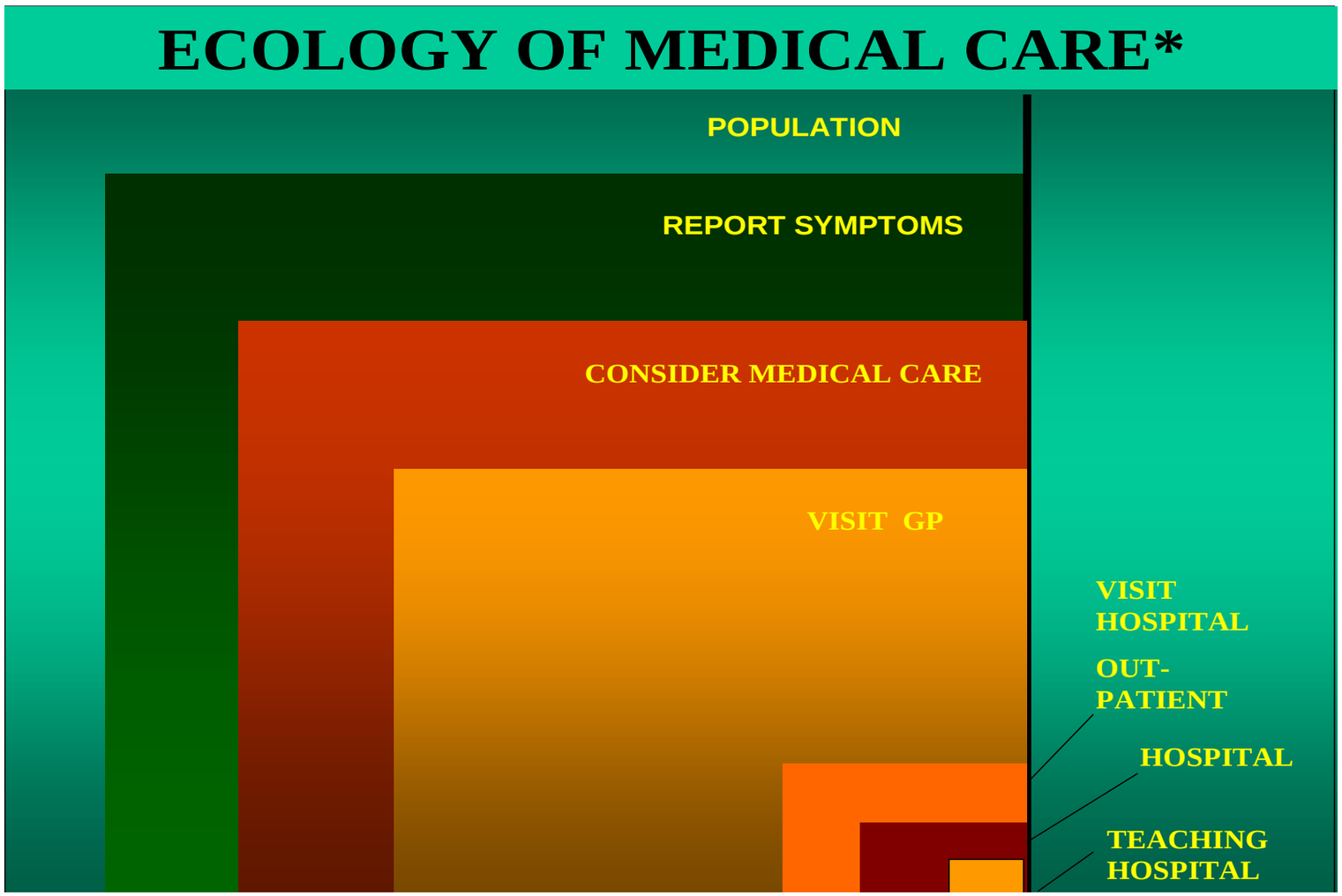
Case Study IV

Implementing PHC through Europe: RESTORE program

- Background and aim:
  - Migrants form a substantial part ‘European PHC population’
  - Communication key determinant of outcome of care, some professional guidelines
  - Poor uptake, developed for, but not with migrant service users
- Approach:
  - Built upon successful study in Ireland to engage difficult-to-reach migrants
  - Use of migrants as co-designers, to plan service design with difficult-to-reach migrants
  - Application state-of-the-art methods (NPT/PLA)
- Context:
  - Example of a ‘Scaling-up’ approach
  - Priority setting national scale: heterogeneity of health systems, migrant populations
- First experiences:
  - Availability of resources, but a need to test these in different settings
  - Methods to engage the hardest-to-reach migrants works throughout the EU region
  - Importance of flexibility to fit the system (for example professional translators in NL)

RESTORE: Research into implementationSTrategies to support patients of different Origins and language background in a variety of European primary care settings
MacFarlane et al. Implementation Science 2012, 7:111
http://www.implementationscience.com/content/7/1/111ropean Study

From ecology to a system of health care: organising the transitions



* White et all, NEJM 1961
Green et all, NEJM 2001

Reflections, conclusions

Best outcomes in systems with PHC structure

Relation of trust between GP practice – patient critical

Registration – practice lists – rostering

Leadership of professionals critical driver of success

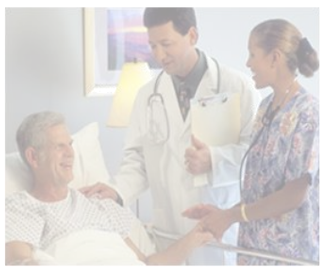
All PHC professionals,

Payment be directed at care for the patient with the health problem, rather than at the health problem the patient has

Value of capitation payment

Challenges remain in the further integration of PHC with

Social welfare and public health

Hospital care and specialists

Impact of PHC is broader than health and health care