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

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Outline

- Some history and background
- Dutch health care (insurance) reform 2006
- Implications for primary care
- Some examples
- Concluding remarks, learning points

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Some history and background

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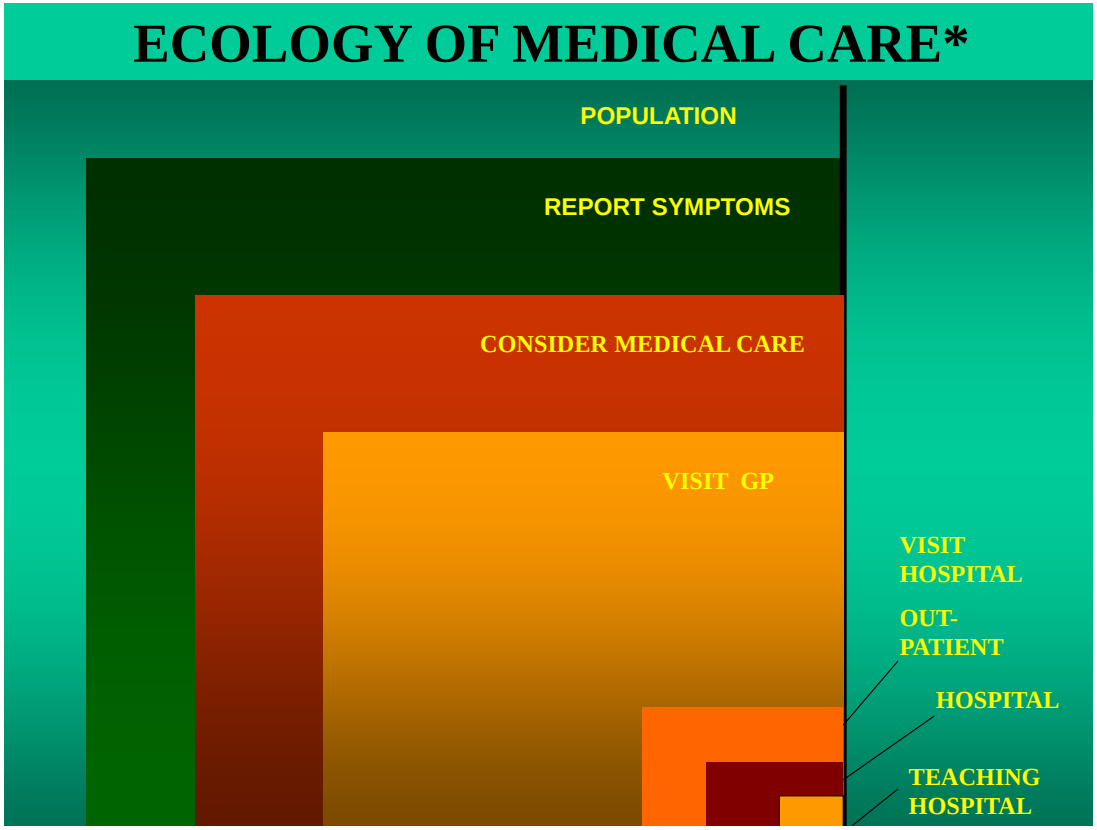
- Since World War II: primary care cornerstone of Dutch health care system
- Essential characteristics:

  (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



(Chris van Weel)

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

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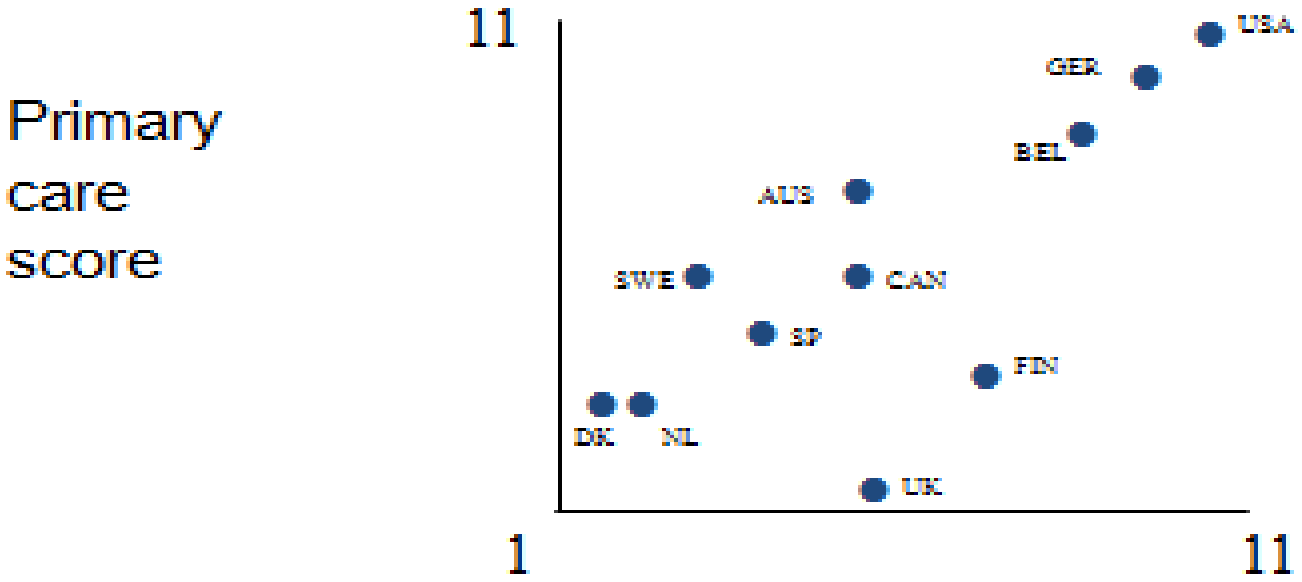
Primary-care score vs outcome indicators (Starfield, Lancet 1994; 344: 1129 – 33)



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

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- 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

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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 inititiatives

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

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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 → priority programme
  - Many elderly with disabilities → telemedicine
  - Network development: more practices/topics (e.g., loneliness, mobility)

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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

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Other examples

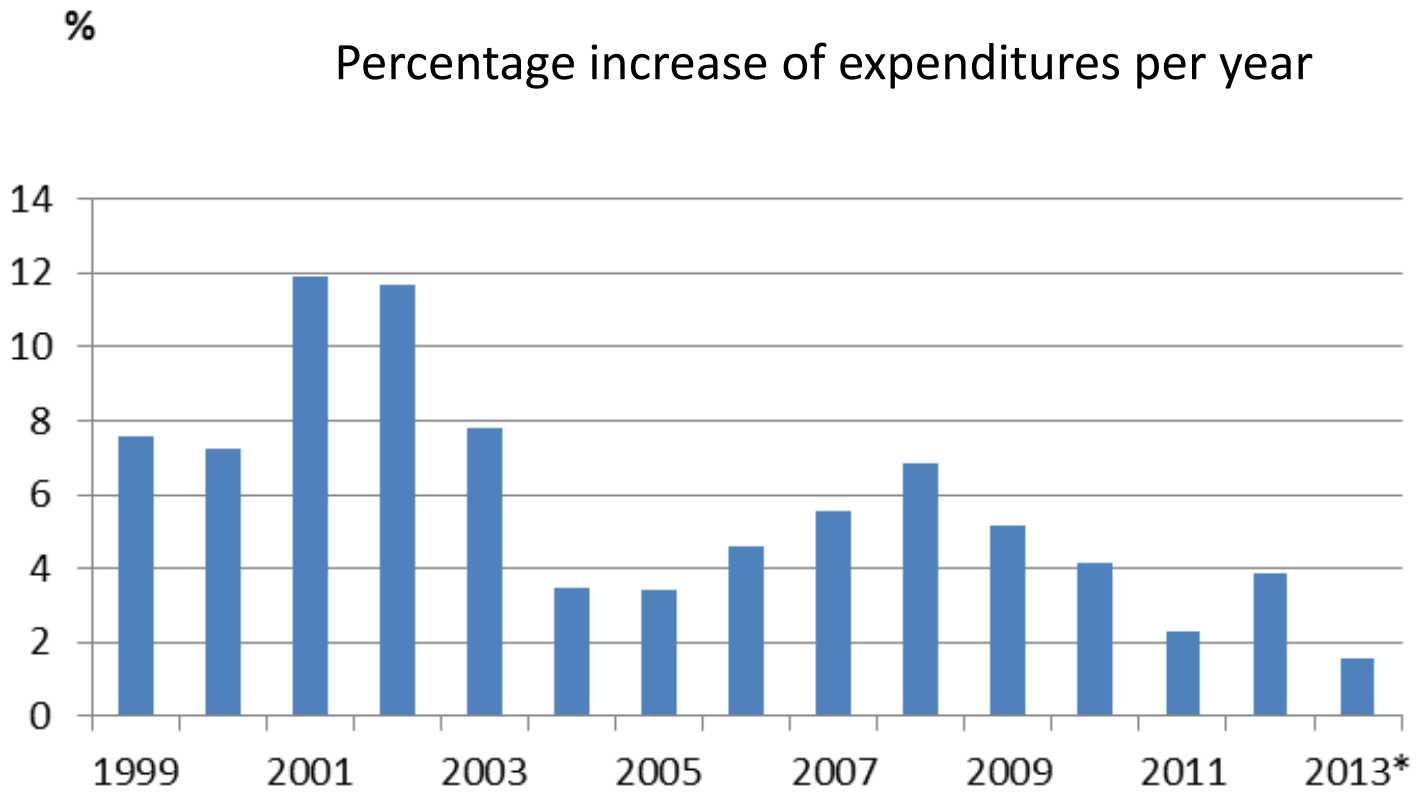
- Joint consultations GPs & specialists
  - Complex orthopedic, cardiological, dermatological problems

  →Less referrals and procedures, less costs, same quality
- Primary care follow-up after cancer treatment
- Reduction of antibiotics use: shared care inititatives

- Effectiveness evaluated and published
- Supported by research funds

Concluding remarks and learning points

Development health care costs



* In 2013 almost no increase in percentage of GDP (15.0 to 15.1%). (NL National Statistics Institute)

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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 litte on quality
  - Reduction of burocracy

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

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