

How general practice is funded in The Netherlands

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The strength of Dutch healthcare is that the general practitioner's role is enshrined in the primary care structure and the personal listing of patients (Box).^{1,2} Primary care is delivered through a personal working relationship with the patient over time and the payment system reinforces this to some extent. Capitation fee payment encourages delivery of care that is tailored to individual needs, rewarding powerful primary care strategies such as “watchful waiting” and the follow-up of the natural course of signs and symptoms.³ It takes considerations of financial reward out of the consultation.

The profession of general practice considers the capitation fee payment as the prevailing frame of reference on which professional standards of care are based. Healthcare policymakers' attempts to change capitation payment are usually resisted by the profession. Although private insurance and fee-for-service might theoretically invoke different professional behaviour, in practice there are few differences in the care received by privately insured patients and that received by those who are Sickfund-insured. In general, GPs do not like fee-for-service payment, because it does not acknowledge strategies such as “masterly inactivity”.³

Over the years, Dutch GPs have been jealously protecting capitation payment and tried to exclude any financial biases that might affect their performance. Allowances in the actual money received have been made for the number of elderly and migrants

on the practice list, compensating for the extra burden of illness and GP care needed. This has maintained relatively equal status among Dutch practices and helped to strengthen the corporate identity of GPs.

How it works

- General practitioner payment is based on a two-tiered system depending on patients' income:
 - Capitation fee for Sickfund-insured patients (70% lowest income; in 2004, up to €32 600/year for people younger than 65 years. As the insurance includes the period after retirement (“pensioners”), the cut-off income for people 65 years and older is €20 750/year.
 - Fee-for-service payment by the 30% highest-income privately insured patients, who do not contribute to the Sickfund.
- Capitation fee is the payment a GP receives from the Sickfund for each patient on the practice list, regardless of whether the patient decides to consult the GP. Sickfunds pay the capitation fee out of the insurance contribution received from their insured members. This fee fully covers all GP services for that patient, including the GP's income and a proportionate contribution for practice costs.
 - The capitation fee is extended to family members who do not generate income of their own.
 - Employee and employer pay 8% of the income for Sickfund contribution (1.25% by the employee, 6.75% by the employer).
 - There is no direct government involvement.
- Key to access to general practice care is registration of the patient with the GP or practice, establishing continuity of care over time.
 - For Sickfund-insured patients, registration is obligatory for access to care.
 - For privately insured patients, registration is usually not required, but most patients do list with a practice and obtain care from the same GP or practice over time.
- Through registration with a GP, primary care remains the foundation of healthcare: patients receive their basic medical care through the GP and the primary care team, and specialist care is only available through referral by the GP.

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The most recent proposal by the Minister of Health to change healthcare financing aims to introduce a form of patient copayment for healthcare received, at 25% of GP costs for consultations, and more for secondary care. The objective is to encourage patients to take more responsibility for their own health and consult less often. This proposal is still in its early stage of political decision making, and it remains to be seen if it will be introduced. If it is, it will be interesting to see whether this financial approach rewards valued primary care approaches such as watchful waiting.

An alternative form of payment that has developed in recent years is GPs in the salaried service of colleague GPs. Although there has been a long tradition of locum services by young GPs before selecting a practice of their own, more GPs now seem to prefer salaried employment. This indicates dissatisfaction with the combined role of both practitioner and practice manager. As a consequence, practice has to be reorganised to make it more attractive for younger GPs, and salaried employment may become more prominent.

Disadvantages of the system

The trend towards salaried GPs highlights an obvious disadvantage of capitation fee payment, which covers practice costs and GPs' income at the same time, without conditions attached. For example, the fee covers a full-time-equivalent practice assistant for a standard practice, irrespective of actual hours of employment. Thus, general practice was poorly prepared for the rapid increase in female GPs, who prefer part-time, salaried positions to full-time, private contractor status. The need for general practice to accommodate this change, together with the additional resources needed to train more part-time GPs, is one of the factors leading to increased GP costs.

Another disadvantage is that new developments in medicine have to be included in the package covered by the capitation fee. As a consequence, there are few (financial) incentives for GPs and practices to innovate their care. This has particularly affected proactive aspects of care such as illness prevention and high risk

screening, and investment in practice support (such as practice assistants and nurses; providing technical equipment).

The package of care that the capitation fee should cover is critical. This should be based on the effectiveness of diagnostic and therapeutic interventions. In reality, the package has to flow with the political and economic tides. For a long time, the level of the capitation fee was fixed, irrespective of the patient's health status. In recent years, the fee has been increased for certain groups (eg, the elderly), becoming an indirect incentive to provide more proactive services (such as preventive home visits) for these groups. However, this is as far as the system has come in enhancing the capitation principle with financial stimuli.

Conclusion

Given the lack of financial incentives, it is surprising how strong general practice care is. For a long time, hospital specialists were paid on an item-for-service basis, in conjunction with GPs' capitation fee. Yet, although this payment system did reward the transfer of patients to secondary care, rates of GP prescribing and referral in The Netherlands were among the lowest internationally.^{1,4} Furthermore, more than 80% of Dutch practices are computerised in the absence of direct financial support.⁵ This may indicate that the payment system is not the sole determinant of GP performance, and that corporate identity and healthcare structure may also play a vital role.

References

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