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Guest editorial

New Dutch government: strong primary care close to the people

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After unusually short negotiations – within two months after the general elections on 12 September 2012 – the Netherlands has a new coalition government. Two parties, the Labour party on the left and the Liberal party on the right, agreed a government programme under the motto 'Building bridges'.[1] Although huge budget cuts are the most eye-catching elements of the programme, it is not only fiscal austerity; in the area of health care there are also interesting policy developments that are relevant for primary care.

The three central aims of the chapter on care (it is not only about *health* care, but also social care and participation in society) are improving quality, reducing costs and facilitating cooperation. In the areas of health and health care there is much continuity (the minister of health is unchanged, but with a different secretary of state), but also some interesting new emphases.

First, the continuity. The policy of the previous government to strengthen care close to people's homes is going to be continued. Primary care and general practice remain the core of the healthcare system. Primary care has to be organised close to people's homes, be easily accessible and of high quality. An important change is that there is more emphasis on cooperation rather than competition in the new government's programme.

The extent to which health care can be a (regulated) market has been debated ever since the insurance reforms of 2006, but intensified in the period before the elections, with several political parties in favour of fewer market elements in health care. The outcome of the debate as reflected in the government programme is that the Dutch 'experiment' of regulated competition will see a move towards more regulation and less competition. Expensive, complex care (e.g. in the area of oncology) and emergency care departments will be concentrated in specialist centres, while less complex care has to be organised as close as possible to people's homes.

Prevention and lifestyle are back on the policy agenda. As the programme states: of course a healthy lifestyle is a person's own responsibility (the Liberal part), but we will support it (the Labour part of the same sentence). Although the previous government's emphasis on individual responsibility nourished debates on the effectiveness of universal prevention in the form of mass media educational campaigns, it contrasted the evidence on social determinants of lifestyle and health.

It is unclear what will happen with the bundled payments for specific chronic diseases. The evaluation earlier this year pointed towards a population-based system of payment as a next step.[2,3] The new government programme does not mention the current bundled payments, but explicitly mentions population-based funding as an instrument to advance substitution of care from secondary to primary care, to discourage unnecessary referrals and to promote care for the chronically ill in primary care.

The new government wants to invest in district nurses. Over the past decades, this professional group has more or less disappeared from primary care. Policy is now to support district nurses again. This must be seen against the background of increasing numbers of elderly people with complex care needs that stay in their own homes. The biggest change that will be implemented is a thorough reorganisation of long-term care. The responsibility for long-term care will be devolved to the municipalities (again: care close to people's homes). As a consequence, fewer elderly people will be living in nursing homes and elderly people with moderately severe dementia will have to stay living in their own homes with care and support from primary care and municipal social services. Residential care will be a last resort. This requires much more cooperation within primary care and between primary care and social services.

Very timely, the two organisations of general practitioners (GPs) in the Netherlands, the Dutch Association of GPs and the Dutch College of GPs, launched

their new vision document on the future of GP care: 'Modernisation on a human scale'.[4] This vision states that 'GP care is generalist medical care, easily accessible for all people close to their homes. GP care is the key to sustainable, effective health care of high quality', thus connecting key values of GP care to health system goals.[5] The vision document describes the ambitions for 2022 and although this sounds far in the future there are only 10 years to realise these plans. Just as in the new government programme, continuity of ideas prevails but also has some interesting nuances.

Although Dutch GP care is still organised on a small scale, there is clear trend towards larger practices and greater numbers of different professionals per practice as a consequence of more GPs working part-time. To maintain a 'human scale', the vision document proposes that all patients will have their own personal GP and one specific second GP within the same practice as back up. GPs should be available for patient consultations on at least three days a week and within the practice, patients should not see more than two GPs: their own GP and the second GP in case their own GP is not available.

GP practices should be organised as teams with GPs, practice secretaries, practice nurses (generalist and mental healthcare practice nurses) and if necessary nurse specialists (nurse specialists are equivalent to nurse practitioners, work more autonomously and can prescribe drugs[6]). GP practices should cooperate locally with other primary care providers within specific organisations such as health centres or in local networks. On a regional level they should cooperate, for example, by pooling specialised GPs and nurses. Prevention is seen as an important part of GPs' work. Care-related and indicated prevention is a core part of GP work and GPs should work together with public health professionals and organisations in providing community based prevention.

The GP organisations' vision of the future concentrates on primary health care. However, given the big changes that are foreseen in the area of long-term care there is a need for more attention on the organisation of primary care as a whole and local cooperation with social and municipal services. This requires a vision of community based primary care.

Both the GP organisations and the government at different levels will have to design concrete policies regarding the capacity of GPs and primary care in general to serve an ageing population with increasing multi-morbidity, including cognitive impairment as a result of dementia. A high-quality and sustainable organisation of long-term care is one of the biggest challenges. In particular, the government programme does not address one of the pressing problems of the future: the human resources for health care.

Internationally, the strong emphasis on primary care reflects common policy approaches in Europe. The challenge of caring for a population with complex health and social care problems is shared with other countries. However, the Netherlands currently has among Europe's largest GP practices. This calls for innovative human resources policies. The idea of moving towards population-based funding fits in with international trends.[7]

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PEER REVIEW

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CONFLICTS OF INTEREST

None declared.

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