World Health Organization-Regional Office for Europe

Assessment of primary health care development in the European region after the Bordeaux-conference 1983 Country contribution: The Netherlands

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1. STUDY OBJECTIVES

Overall study objectives:

1.1 To review the development of primary health care in respective countries of the European Region, with special emphasis on the period 1983 to the present;

1.2 To identify general features of the development process for primary health care, with emphasis on main obstacles for development; and

1.3 To define common general and specific activities for further development of PHC in the Region;

Supplementary study objectives:

1.4 To exchange information on selected PHC components and to contribute to their understanding in different circumstances;

1.5 To create a European core network for PHC monitoring, development and evaluation;

1.6 To develop methodological material and experiences for international comparative studies in broad subjects; and

1.7 To test possibilities of collaborative and national centres for the collection and handling of information on PHC.

2. STUDY DESIGN

2.1. Background information

2.1.1 Country/State: The Netherlands

2.1.1.1 If available, attach a copy of a map.

2.1.1.2 Geography:

Area and land use, January 1st

	1983
	square kilometers
Total area of the Netherlands	41,473
Not municipally classified	4,181
Municipally classified[1]	37,291
	%
Traffic grounds	3.5
Recreational grounds	2.0
Industrial and commercial grounds	1.3
Residential grounds	5.4
Other built-up area	1.0
Building sites	0.8
Woodland	8.0
Agrarian use	64.5
Natural grounds	4.2
Other grounds	0.5
Water	9.0
Total municipally classified[1]	100.0

[1] Incl. Z.IJ.Polders (Southern IJssellake polders)

The northernmost point of the Netherlands territory is situated in 53°52'5"" north latitude, the southernmost in 50°45'5" N., the westernmost in 3°21'31" E. and the easternmost point in 7°13'14" E. To the west and the north the Netherlands is bounded by the North Sea over a length of 1,313,5 km (flood mark), to the east by the Federal Republic of Germany over 583,9 km and to the south by Belgium over a length of 495,9 km. The Netherlands is a rather flat country: only in the south and east are there some hills. The lowest point, 6.1 meters below sea level, is situated between Rotterdam and Gouda. The highest point, 321 meters above sea level, coincides with the point where the borders of the Federal Republic of Germany, Belgium and the Netherlands meet. About 27% of the land surface of the Netherlands is below sea level; a considerable part of the population lives here.

On January 1st 1985 the territory of the Netherlands was divided into 11 provinces. On january 1st, 1986 the newly reclaimed polders were transformed into the 12th Dutch province Flevoland. Each province is sub-divided into a number of municipalities, varying from 30 (Province of Zeeland) to 131 (Province of Noord-Brabant) on January 1st, 1985. On the same date the total number of municipalities was 741 (incl. 4 in the "Zuidelijke IJsselmeerpolders".)

2.1.1.3 Climate:

The Netherlands has an oceanic climate - marked bij cool summers and mild winters. In summer the average temperature is about 16°C on the coast and about 17°C in inland areas; in winter about 3°C and about 2°C respectively. Partly owing to the influence of the Gulf-stream, the Netherlands seaports are permanently accessible to navigation.

2.1.1.4 Population (include nationalities, languages, cults, urban/rural, etc.).

a. demographic key-figures, 1985, January 1st:

. total population	14,453,800
- males	7,149,600
- females	7,304,200
. population per square km land area	426
. average annual growth (percentage)	0.41
. aliens as a percentage of the total population	3.8
- aliens by country of nationality	
Morocco	111,300
Turkey	155,600
other countries	291,800
. average size of households	2.59 (% of one-person households in total : 25.5)

b. population by religion, 1984 (percentage of total population)

Roman Catholic	36.2
various protestant denominations (both calvinistic protestantism):	
"Nederlands Hervormd"	18.1
"Gereformeerd" (radical calvinistic)	8.3
Other religious denominations, total:	4.3
of which :Muslims	2.3
Hindus/Buddhists	0.5
No religious denomination	34.7

c. population by group of municipalities, 1985, January 1st

Municipalities with:	Percentage of total population
to 5,000 inhabitants	3.8
5,000 to 10,000 inhabitants	9.8
10,000 to 20,000 inhabitants	18.9
20,000 to 50,000 inhabitants	25.3
50,000 to 100,000 inhabitants	16.4
100,000 inhabitants and over	25.8

d. population per group of municipalities according to degree of urbanization of the municipalities, 1985, January 1st

degree of urbanization	% of the total population
Rural municipalities[1]	11.5
Urbanized countryside	37.4
of which	
- industrialized rural municipalities	22.9
- specific resident municipalities of commuters	14.5
Urban municipalities	51.1

[1]over 20% of the total economically active (male) population employed in agriculture on 28th of February 1971. The number of inhabitants of the largest population cluster in these municipalities is as a rule less than 5.000.

2.1.1.5 Major population centres.

Population and area of urban agglomerations, 100.000 inhabitants or more, January 1st 1985.

	no	pop.	area in sq.km		no	pop.	area in sq.km
Amsterdam(West)	2	998,130	635.98	's-Hertogenbosch (South)	14	188,001	238.45
Arnhem (East)	6	292,802	374.76	Hilversum(West)	21	104,372	81.20
Breda (South)	18	154,089	174.96	Leiden(West)	15	177,438	82.95
Dordrecht/(West) Zwijndrecht	13	199,714	131.26	Maastricht(South)	17	158,145	161.51
Eindhoven(South)	5	374,974	449.95	Nijmegen(East)	9	235,739	273.45
Enschede/(East) Hengelo	8	247,939	251.74	Rotterdam(West)	1	1021,141	422.02
Geleen/Sittard (South)	16	177,010	245.64	Tilburg(South)	10	222,397	274.91
's-Gravenhage (West)	3	671,830	210.09	Utrecht(Centre)	4	504,310	417.54
Groningen(North)	12	206,978	195.55	Velsen/Beverwijk (West)	20	124,324	90.71
Haarlem (West)	11	215,309	110.84	Zaanstreek(West)	19	140,179	95.50
Heerlen/(South) Kerkrade	7	266,608	211.33				

2.1.1.6 Transport.

The position of the Netherlands as a transport link is determined to an important degree by its situation on the open sea at the mouth of easily navigable Western European rivers as the Rhine, the Meuse and the Scheldt, which establish a natural communication with a number of densely populated and highly industrialized regions of the European continent.
On account of this position the Netherlands seaports have an important function as a European centre for transport and transshipment. About 45 per cent of the arrivals and removals of goods by sea are direct Netherlands imports and exports, the remaining 55 per cent being international transshipments and distribution.
This international character and its significance for the Netherlands transport apparatus also manifests itself in the other branches of transport. More than 80 per cent of the ton-km performance of inland vessels on the extensive network of the Netherlands rivers and canals represents international transport; the volume of international goods transport of the Netherlands Railway is twice as large as internal railway transport, and ca. 60% of the international road-transport between the Netherlands and the surrounding countries is carried out by Dutch lorries.

2.1.1.7 Other specific characteristics of the country.

Open to foreign influences - commercial tradition - Rotterdam is the world's largest port. Culture: many institutions have religious roots (the Dutch republic arose in the 16th century as a protestant revolt against the Habsburg Catholic rule). Calvinism caused some characteristics of the Dutch, a certain independence (or stubborness), lack of subtlety and a dislike of the theatrical behaviour. The Dutch attach more value to be able to express their views (to be right) than to be proved right. The historic division of a protestant (and dominant) North and a Catholic South still can still be found today.

The Netherlands is a constitutional and hereditary monarchy. The reigning queen is Beatrix Wilhelmina Armgard, born January 31st 1938.
Political system: Democracy with proportional representation and no threshold for the number of seats te be required to be admitted to parliament. Since the last election (1986) 9 parties are being represented in the Second Chamber of Parliament. The government has a centre-right composition with a Christian Democratic majority and a Liberal (conservative) minoraty. The Prime minister is mr. Ruud Lubbers.

2.1.2 Population by age, January 1th (Source: Netherlands Central Bureau of Statistics (CBS)

	Number (x 1000)		% of total population	
	1975	1985	1975	1985
No. under one year	184.6	173.7	1.4	1.2
No. 1-4 years	871.3	700.4	6.4	4.8
No. 0-19 years	4,646.2	4,084.5	34.2	28.3
No. 20-64 years	7,493.4	8,639.6	55.1	59.8
No. 65+ years[1]	1,459.4	1,729.7	10.7	12.0
No. 75+ years[2]	539.1	725.2	4.0	5.0
No. of women 15-44 years	2,897.5	3,387.9	21.3	23.4

1) age 65 or over
2) age 75 or over

1.3 Population by status, January 1th (Source: CBS)

% of total population (national average and extreme values of provinces).

Population	Number (x 1000)		1975			1985		
	1975	1985	-	0	+	-	0	+
Total employed[1]								
- male	3,445.1	3,414.3	47	51	53	44	48	50
- female	1,241.1	1,730.1	15	18	21	19	24	27
Total unemployed[2]								
- male	153.0	498.0	1.2	2.3	4.3	5.4	7.6	9.9
- female	42.3	263.0	0.3	0.5	1.0	2.7	3.6	4.4
Total migrants[3]	350.5[4]	558.7	.	2.6[4]	.	0.9	3.9	5.9
Total underprivi-ledged[5]	222.1	572.3	.	.	.	.	.	.
Total urban[6]	7,119	7,385	-	27.2	46.6	-	24.3	41.3
Total illiterate	see explanation							
- male								
- female								

= nil
= data not available

Employed persons:
a. Persons who carry out work in exchange for a wage or salary (employees): these include relief workers, trainees who receive a wage or salary and conscripts;
b. Persons who receive no wage or salary but who:
   - carry out a profession or run a company on their own account and/or at their own risk by one or more members of their family.
   - work in a profession or company carried out or run on their own account and/or their own risk by one or more members of their family.

Registered unemployed persons.
Because of changes in definition the 1975 and 1985 figures are not entirely comparable. From 1983 onwards, figures on registered unemployment are drawn up acording to the definition of the Labour Force laid down in 1981. Here, registered unemployment in a strict sense is meant, i.e. persons without employment who are looking for a job of at least 20 hours a week or more and to this end are registered at a Labour Exchange. Until 1983, registered unemployment was computed stressing 'suitability' and 'placeability'. According to the new definition 'whishes' and 'capability' are now taken into account. This implies that a number of extra categories of registered

persons are included. The number of hours has also been lowered from 25 to 20 hours (until 1978, the lower limit for full-time employment was 30 hours).

3) Aliens residing in the Netherlands

4) January 1st 1976

5) Number of households receiving assistance on account of the General Assistance Act. Persons not living at home (but mostly in homes for the aged) are excluded. Only those groups of people (under the 'Rijksgroepsregelingen') are included that received assistance at the end of 1984. Because of differences in the definition of household it is not possible to relate these figures to general household and population figures (per province).

6) Population living in large towns (100,000 inhabitants or more in built-up area).

Illiteracy

There are no official statistics on illiteracy in the Netherlands. Since the 1981 Population census has not been held in this country the Unesco recommendations with regard to questions on (il)literacy could not be met. Illiteracy, taken absolutely, is regarded as practically non-existent in the Netherlands (apart, of course, form mentally deficients), but functional illiteracy might amount to some 400,000 or 500,000.

2.1.4 Health statistics (average and extreme values) (Source: CBS)

VALUE	Crude birth rate[1]		Crude death rate[1]		Natural growth rate[1]		Infant mortality rate[2]	
	75	85	75	85	75	85	75	85
Avarage value (for whole country)	13.1	12.4	8.3	8.5	4.7	3.8	10.6	8.0
Lowest value	11.9	11.4	6.8	7.1	2.9	2.0	8.8	6.1
Highest value	14.6	13.9	9.9	9.7	6.9	5.1	12.9	9.9

VALUE	Neonatal mortality rate[2]		Life expectancy at birth				% of death over 65[3] in all deaths	
	75	85	75		85		75	85
			M	F	M	F		
Avarage value (for whole country)	7.6	5.0	71.4	77.7	73.1	79.7	73.6	77.1
Lowest value	6.0	3.4	.	.	.	.	68.3	73.2
Highest value	10.1	6.5	.	.	.	.	78.4	80.4

1 per 1,000 inhabitants
2 per 1,000 live births
3 over 64 years of age
. = data not available

2.1.5 Morbidity and mortality (Source: CBS)

2.1.5.1 Most common causes of death in children (age 0-4 years)

Priority Rank	Cause of death*	No. of deaths		Mortality rate[1]	
		1975	1985[2]	1975	1985[2]
1.	Congenital anomalies	584	526	56.8	60.2
	Conditions originating in the perinatal period	908	517	88.3	59.2
	of which				
3.	- birth trauma	.	59	.	6.8
2.	Signs, symptoms and ill defined conditions	204	242	19.8	27.7
	Malignant neoplasms	63	47	6.1	5.4
	of which				
5.	- leukaemia	.	17	.	1.9
4.	Pneumonia	35	30	3.4	3.4
	Diseases of the circulatory system	18	27	1.8	3.1
	of which				
7.	- cerebrovascular disease	6	8	0.6	0.9
6.	Motor vehicle traffic incidents	80	16	7.8	1.8

*based on the grouping of causes of death in the "Adapted Mortality-List"
1 per 100,000 of the mean population.
2 provisional figures.
. = data not availiable

remark: other causes of death (8-10) in conditions originating in the perinatal period, malignant neoplasms and diseases of the circulatory system, but are not specified.

2.1.5.2 Ten most common causes of death in adults (age 20+)

Priority Rank	Cause of death*	No. of deaths		Mortality rate[1]	
		1975[2]	1985[3]	1975	1985[3]
	Diseases of the circulatory system	47,324	54,100	524.0	516.8
	of which				
1.	- ischaemic heart disease	24,940	25,529	276.2	243.9
2.	- cerebrovascular disease	12,657	11,718	140.1	111.9
	Malignant neoplasms[4]	28,297	32,768	313.3	313.0
	of which				
3.	- mal. n. of trachea, bronchus, lung	.	8,116	.	77.5
6.	- mal. n. of female breast	.	3,025	.	28.9
8.	- mal. n. of colon	.	2,796	.	26.7
9.	- mal. n. of stomach	.	2,367	.	22.6
4.	Signs, symptoms and ill defined conditions	5,166	4,208	57.2	40.2
5.	Pneumonia	2,117	3,322	23.4	31.7
7.	Bronchitis, emphysema and asthma	3,751	2,829	41.5	27.0
10.	Diabetes mellitus	1,575	2,321	17.4	22.2

*based on the grouping of causes of death in the "Adapted Mortality-List".
1 per 100.000 of the mean population
2 extra for 1975: motor vehicle accidents: 2.232 (1985: 1.415)
3 provisional figures
4 Figures for the various melignant neoplasms over 1975 have been published in "Overledenen naar doodsoorzaak, leeftijd en geslacht Serie A." (CBS).
. = data not available

2.2 Activities and approaches undertaken at the national level to strengthen PHC development.

2.2.1 Policy and legislation.

2.2.1.1 In what way, and to what extent are human rights to health and health care included in national health legislation, and how are these formulated (citation).

The Dutch Constitution contains four sections that relate directly or indirectly to human rights regarding to health.
Section 1. 19-2 The promotion of sufficient employment is object of governmental care.
1. 20-1 The social security of the people and the spreading of prosperity is object of governmental care.
-2 The law sets rules with regard to the title of social security.
-3 Citizens and residents of the Netherlands, who cannot subsistence, have a right to governmental assistance to be regulated by law. (see table 2.1.3.).

1. 21 The care of the government is directed to the habitability of the land and the protection and improvement of the environment.

Section 1. 22-1 The government takes measures for the promotion of the health of the people.

1. 22-2 The promotion of sufficient housing is object of government care.

1. 22-3 The government creates conditions for social and cultural development and for recreation.

Section 1. 23 Is about education.

Forced admission in psychiatric institutions is regulated in the 'Mental Illness Act', dating from 1884. The replacement of this outdated Act by a new one ('Exceptional Admission in Psychiatric Institutions Act') is still in process.

2.2.1.2 Which national law(s) support(s) PHC development in the country and in which way.

There is no comprehensive Primary Health Care Act in the Netherlands.
Elements of PHC development are to be found in:

- 'General Exceptional Medical Expenses Act' (1967) (covers expenses for hospital and psychiatric care after the first year, all exceptional institutional care (for the mentally retarded e.g.) from the first day, and the following elements of primary health care:
  - the well baby and child care, including immunization (1967)
  - home nursing (1980). Both by the Cross organization.
  - ambulatory mental health care (1977)
  - extra costs of integrated (i.e. multidisciplinary) health centres

  All residents of the Netherlands are liable to the provisions of this Act. The premiums are paid by employers. There is a varying State contribution to the total cost (+ 28% of the total health care costs are included in this Act) (1985).

- The Sick Fund Act. For the + 65% of the Dutch population that is publicly insured against the costs of illness (all employees with an income below a certain ceiling, most of the old age pensioners, unemployed and disabled) practically all health care is provided in kind (a small payment per prescription excluded). Specialistic medical care (in- and out patient) and paramedical care is delivered in kind on referral by a general practitioner only. Non-pathological obstetric care is delivered in kind by a midwife only. (that is - the costs of a midwife are being reimbursed only). The latter limitations (specialistic care by referral only) form an important stimulus to PHC-development.

- Although no more than 10% of the total health care financing goes via the budget of the Ministery of Health, some articles of the budget promote primary health care specificly:
  Among these major budget-articles are (budget 1985)

1. total costs of general social work and home helps
   DFL 1.200 million
   approx.
2. a grant for the doctors that follow the obligatory one year vocational training for general practioners
   DFL 12 million
3. early detection of cervical cancer and retarded development of children
   DFL 8.5 million
4. promotion of PHC DFL 26 million
5. restructuring PHC DFL 33.5 million
6. health promotion and patient-organization DFL 12 million
7. PHC-research (NIVEL) DFL 5 million

2.2.1.3 Is there a clearly defined health policy on PHC in the country?

Yes.

If yes, what type of document (developmental - not regular) includes these policy issues.

Primary health policy has been stated in the following documents:
- 'Structuurnota Gezondheidszorg': White paper on the structure of health care (1974).
  The basic principles are:
  - a strict hierarchic division into levels of care
  - an emphasis on local decisions
  - substitution of secondary (in- and out patient hospital care) to primary care
  - 'Schets eerstelijns gezondheidszorg'. Outline of primary health care (1980). The first comprehensive discription of Dutch primary health care.
  - 'Nota volksgezondheidsbeleid bij beperkte middelen': White paper on public health policy with restricted means (1986). This paper stresses substitution of institutional care to primary
    care out of budgetary necessity.
  - 'Nota Eerstelijnszorg': White paper on primary care (1983). Note that the term is: primary care and not primary health care. This paper is based on 4 so called "core-professions" in primary care: the general practioner, the district nurse, the social worker, and the home-help. Close cooperation between health care and the social services is a major policy target.

2.2.1.4 Are there any policy documents (explicit and implicit) that specify health priorities, targets and strategies from the present to the year 2000 in line with the HFA 2000 Strategy and Target Document of WHO's Regional Office for Europe?

Yes.
If yes, cite the document. If not, are there any other documents (and which) that define national targets and strategies for extended periods of time.

There are several explicit policy documents in line with HFA 2000 strategy.
- The Ministry of Health published a country report in 1985 (a cooperation between the Central Bureau of Statistics and the information-department of the Ministry of Health) (a.).
- In 1986 the Secretary of State for Public Health offered a substantial report to the Dutch parliament: The 'Nota 2000' in which a national strategy to reach HFA in 2000 has been outlined (b.).

a. 'Health for all by the year 2000', country report, ministry of Welfare, Public Health and Culture, 1985 (106 pages).
b. 'Nota 2000', 's Gravenhage, Staatsuitgeverij, 1986 (381 pages).

2.2.1.5 What national policies have been established in the last five years for strengthening PHC in the fields of:

2.2.1.5.1 Health promotion and disease prevention.

In 1983 a national plan for health promotion and education has been presented to the Dutch parliament. In this national plan regional offices and plans for health promotion were proposed. A general campaign, organised by the Sick Fund Association made the Dutch more conscious about health hazards, while the most recent White Paper ('Nota 2000') is predominantly devoted to health promotion and disease prevention.

2.2.1.5.2 Food, nutrition, alcohol, tobacco.

Recent developments in the domain of prevention of health hazards are:
- A recent 'White Paper on Alcohol and Society' (1985) proposes a general discouraging policy of alcohol consumption by increasing excises, decreasing advertising and reducing the number of selling points.
- A Bill on tobacco-use and protection of non-smokers has been proposed to Parliament (1983), but has not been accepted yet, although the policy paper on "smoking" has been accepted in 1977.
- Sport and physical exercise. In 1984 a policy paper on "sport-policy" has been presented to the Parliament.
- Nutrition. A parliamentary debate on the White Paper on Nutrition Policy has led to a national campaign for balanced nutrition. A national database on nutritional value of foodstuff has been established (1984). Stricter rules about consumer information regarding additives and nutritional values of food have been accepted.

- Accidents. A paper on "Safety around the house" has been accepted by Parliament (1985). Campaigns about "firework", "sport accidents", "dog-bites", etc. have been launched since.

2.2.1.5.3 High risk, underserved and disadvantaged groups.

- A Bill on coherent youth-help has been presented to the Parliament, but consultation between the Ministry of Health and the Ministry of Justice about the place of the "child protection" has delayed final acceptance.
- A policy paper about the "handicapped" has been presented to Parliament, but was not followed by legal proposals.
- A trend-report on health problems of ethnic minorities has been presented recently (1986).
- For the elderly: most activities have been directed towards the integration of medical and non-medical care (policy paper on "Care for the elderly" 1986), both institutional (nursing homes and homes for the elderly) and ambulatory (especially the integration of home nursing and home help).
  No definite action has been undertaken to realise these proposals yet.

2.2.1.5.4 Health service coverage (comprehensiveness).

The only recent activity in the field of health service coverage has been a reduction of the coverage by public insurance in the Access to health insurance Act (1986), where the so-called "voluntary public health insurance" was abolished and (partly) shifted to private insurance. The coverage by public health insurance decreased from 69% of the population to 62%.

2.2.1.5.5 Accessability, acceptability, equity.

see 2.2.1.5.4.

2.2.1.5.6 Resource allocation (financial, manpower, facilities).

One should bear in mind that approx 90% of the health care costs in the Netherlands do not go via the budget of the M.O.H., although this ministry is politically responsable for health care policy and expenses. To create an overview of total health care expenditures and financing a yearly financial survey has been produced since 1977. This yearly 'Financial survey of health care costs' has proved to be a most effective instrument of resource allocation. Although it's legal status is rather misty, this Financial Survey both succeeds in showing the total picture of health care finance and expenses and in setting limits to health care spending.
Budgetting institutional care and stimulating ambulatory care is undertaken guided by this Financial Survey.

Although direct reallocation is rare, more funds have been devoted to PHC. Examples of this: the continuous growth of the Cross Organization; a policy to reduce list size of general practitioners from 2400 to 2000 in four years time; stimulating financially integrated health centres.

2.2.1.5.7 Continuity, referral, integration of services.

- Continuity of care has been promoted by creating a "continuity-nurse" within the Cross Organizations, especially in charge of organizing and smoothing care after hospitalization. This care is (in contrast with the United Kingdom or France) not organized by the hospitals, but by the district nurses. Since 1981 there is a formal 7 x 24 hours accessability of district nurses and home helps.
- The referral system has been unchanged. Access to ambulatory mental health care has been formalized via referral of a general practioner only.
- Integration of services. It has been stated that the existence of separate organizations for home nursing and home help is not functional, but formal integration did not take place yet.

2.2.1.5.8 Community participation.

An extra financial incentive is presented to integrated health centres if they operate with a "patient council"; the extra costs of meetings and communication are rewarded.
A bill to regulate 'patients rights' has been presented to Parliament in februari 1987.
For the rest no specific actions in community participation have been undertaken.

2.2.1.5.9 Intersectoral collaboration.

- A well developed form of integrated collaboration is the cooperation between health care professionals (general practitioners, district nurse) and social workers.
- Standard cases of intersectoral collaboration are:
  . environmental protection (air, water and pollution) with the Ministry of Housing and Environmental Planning and Protection.
  . Traffic safety (with the Ministry of Transport).
  . Nutrition (Ministeries of Agriculture and Economic Affairs).
  . Youth protection (Ministery of Justice).

2.2.1.5.10 Controlling the balance of levels of care (PHC/hospitals) especially with regard to restricting the expansion of the hospital sector.

The main emphasis has been on the reduction of secondary health care during the last decade. After a failure to close the surplus of hospital-beds directly (too much social protest and lobbying), the introduction of budget control of institutions was rather successful in cost containment. The reinforcement of primary

health care has not been a complete success. The number of primary health care providers continued to grow (despite a strong policy of reduction of health care expenditure), but the balance still is heavily tilted towards secondary health care.

2.2.1.5.11 Technology and drugs.

A general policy to test first and pay later advanced health care technology has been adopted in the past five years. Examples of this are: In vitro fertilization, kidney-stone pulverization, heart transplantations.
There is an continuous action to reduce the costs of prescribed drugs (the prices of these are highest in Europe!). A measure to introduce a copayment of Dfl 2,50 (1 ECU) per prescription has not reduced the amount of drugs prescribed.
Now action is undertaken to prohibit extra profits of pharmacists who collect bonuses from drug manufacturers.
Changes have been proposed in the 'Drug Distribution Act' (1985) and the 'Medical Devices Act' (1984).

2.2.1.5.12 Other relevant health aspects of the country (specify).

A phenomenon casting it's shadow before is the discovery since 1982 of Aids-victims. Alarming epidemiological information about an ever increasing number of infected persons and a consistent upward adaptation of the relative risk of dying, spreads panic around specific parts of Dutch society.
The influence of this new epidemy in sexual policy and tolerance should not be underestimated the next few years.

2.2.1.6 Describe the mechanism through which policy and legislation is applied at the regional and district levels.

The Netherlands is subdivided administratively into 12 provinces and 741 municipalities. In some Health (care) Acts either provinces or/and municipalities have an explicit task; the legislation about financing health care, however, does not use the administrative subdivision of the country, but has a regional subdivision of its own (the Sick-Fund areas), that do not coincide at all with the general administrative subdivisions. In the Dutch health care the financial and the administrative subsystems do not match at all. This is the main reason behind many peculiar features of the Dutch health care "system".

2.2.2 Planning and management

2.2.2.1 What system of planning exists as far as levels of centralization and decentralization are concerned.

There are several planning "systems". One system goes via the yearly preparation of the budgets. Although, as has been stated, the Ministry of Health covers a minor part of the health care

costs, it edits since 1977 a Financial Survey of health care and social services as an appendix to the annual budget. This Financial Survey, although it's legal status is doubtful, becomes increasingly a policy instrument for the Minister of Health, because it sets limits to the total amount of public spending; both the direct spending of the Minister of Health and the spending of the social security councils.
Since the introduction of a budget-system for health care contributions (in 1983) for the first time the growth of health care costs stagnated. All this financial planning is central planning. The 12 provinces have a say in the planning of hospital facilities and since 1985 for general practioners a permission is necessary to establish themself and a permission for physiotherapists is in preparation. Planning of home nursing facilities is central, with some margin for the provincial associations of homenursing, (non) governmental but publicly funded charities and of the AWBZ ('General Exceptional Medical Expences Act') For most of the other professionals no planning exists at all. For most of the specific health acts (like the 'Hospital Facilities Act') there are planning procedures.

2.2.2.2 For what length of time are plans made.

The budgetary planning is formally an annual planning, but there are "estimates" for more than one year, for 4 years for the budget of the Ministry of Health.
There is a nominal planning-system in the 'Health Care Provisions Act' (4 year planning periode) that stems from 1982, but this Act is not in force in fact. It is a so-called "Framework-Act", the general principles only have been accepted, but the government hesitates to fill in the detailed measures, because of an increased tendency not to overregulate.
The Act has been implemented in three regions only, as a sort of experiment. After evaluation of these regional experiments, further decisions about either abolishing or intensifying the Act will be taken.

2.2.2.3 How comprehensive are the plans as far as coverage of the system is concerned?

In the Netherlands planning is never comprehensive, because of the existence of two seprarate decision-circles: one financial and one about the other aspects of health care.
The planning-methodology as described in the 'Health Care Provisions Act' is only valid for three regions in the Netherlands (the province of Limburg and the regions around Eindhoven and Haarlem), while in the 'Hospital Facilities Act' (formally the legal predecessor of the 'Health Care Provisions Act', but due to delays in the implementation of the new Act still in force), the concept of central planning has been abandoned in favour of a planning by provinces within the centrally drafted guidelines. New facilities cannot be built or installed without a permit, while existing facilities can be closed for reasons of overcapacity.

2.2.2.4 What is the predominant planning "style" in the country?

- formal or nonformal problem-solving incrementation
- laissez-faire
- scenario
- through norms and normatives
- other (combination)

"Problem solving" could be the right catchword for health care planning in the Netherlands, although many problems do not cease to exist.

2.2.2.5 Give examples of national plans and programmes which have been developed and implemented in the last five years or which are in the process of being developed or implemented, for the areas of:

- Resource allocation for PHC:

  Although the financial means for primary health care have been expanded and the costs of the hospital sector stopped increasing since the introduction of budget measures; strictly spoken there is no re-allocation of means. The most recent long term White Paper (Nota 2000) states clearly that the reallocation policy failed.

- Acessibility of basic health services, especially for disadvantaged groups:

  As the Dutch general practioners have a fixed list and health services are being provided in kind for 62% of the population that are publicly insured practically without copayment (the 35% with the highest incomes have private insurance) and as the country is densely populated and has no isolated rural areas, there is no such thing as an underserviced area in the Netherlands.

- Full coverage by health services:

  There is a tendency in the Netherlands to shift from public to private financing of the health care system. The number of publicly insured persons was reduced from approx. 70% till 62% in april 1986, when the self employed with an income below the wage-ceiling that decides the mandatory partcipation in the public health insurance for the employed, was abolished. They had to shift to private insurance.

- Integration of health services:

  Integration of health services is a thorny problem in the Netherlands. A good example however, is the creation of multidisciplinary primary health centres, that cover approx. 7% of the Dutch population nowadays. In these centres general practitioners, district nurses and social workers coöperate closely, often accompanied by fysiotherapists and home helps.

  Another interesting example of integrated health care can be found in the new town of Almere (45,000 inhabitants (1985) 75-80.000 expected in 1990), where PHC is delivered in multidisciplinary health centres (with salaried providers) and the planned hospital is of limited size, fulfilling a secundary role only.

- Manpower and facility distribution in underserved areas:

  As was shown above, there are no real underserved areas in the Netherlands.

2.2.2.6 How centralized/decentralized are the following:

Level of centralization	Planning and programming	PHC services delivery	Personnel admin. transfer of staff	Financial resource allocation	Setting guidelines and standards	Organization and implementation of education	Others (specify)
			?				

2.2.2.7 Give example(s) where regional/district bodies have been involved in national planning and programming.

Povinces are increasingly being involved in planning; the same goes for municipalities, that are in charge of providing permits for the establishment of general practioners since February 1986.
There is one "snag", however, the planning laws have been accepted by Parliament, but, as they are "framework-laws" that have to be filled in by governmental decrees and as there is a strong tendency to refrain from over-interference by this government, the involvement of lower administrative levels in health care planning is merely theoretical.

2.2.2.8 Has there been an evaluation of PHC or its components in the past 5 years?

Yes. In the several White Papers on primary health care (the last one stems from 1983, 'White Paper on Primary Care'), there is continuous evaluation of PHC.

The same goes for the HFA-country reports in which the development of PHC is reported regularly to WHO.
Many different aspects of PHC are being evaluated within the research activities of NIVEL.

2.2.2.9 Indicate which actions have been taken on results and which recommendations have been implemented?

A mixture of positive and negative measures has been taken as a result of the evalutation.

- A policy to reduce the list size of g.p's (or rather to maintain the same income with fewer patients) started in 1985 with a reduction from 2500 - 2100 in 4 years.
- Selling and buying of clients of general practitioners (a common practice in the Netherlands) has been abolished.
- The Cross Organization (home nursing) has been allowed an annual budget growth of 4%, as most other public services had to reduce their activities.
- Funds for research of PHC have been increased considerably, one of the targets is to improve the scientific quality of the work of university departments in family medicine.
- Negatively, as a result of assessment-studies, the psychologist has not been admitted as a directly accessible primary care provider.
- Experiments with diagnostic centres, attached to hospitals but open to PHC-providers (like the g.p.) have been stopped after evaluating the results.

A real bottle-neck in PHC-provision is the organizational division of PHC, general practitioners being independently established private practitioners; while district nurses, social workers and home helps each belong to different organizations. Although it has been said for years, not much progress can be reported regarding the necessary integration of PHC-services.

2.3 Concept, content and administrative structure of PHC at the national level.

2.3.1 Conceptual and content component of PHC.

2.3.1.1 Definition of PHC used by the country.

- The White Paper on PHC (1983) describes professional home-care as follows:
  Professional primary care, also called home-care, is described as a subsystem of care, wherein the professionals take joint responsibility for a continuous, complete and personal care in the natural environment of the people to whom the care is being delivered (p. 8).

- In the Netherlands primary care is predominantly curative, includes social services and home-help and is, generally spoken, directly (without referral or prescription) accessible ambulatory care that is the least specialized of it's kind.

2.3.1.2. What is the understanding of essential care?

Practically all health care is included in the public health insurance 'package'. A major ecxeption is advanced dental care for persons over 8 years of age (more complicated procedures than extractions and fillings).

2.3.1.3 What is the degree of relevance of PHC according to the Alma Ata declaration?

In the Netherlands the term "Primary Care" in fact refers mostly to curative care although (mostly individually based) prevention is an essential part of the task descriptions of PMC-provinders. The other aspect of primary care, according to the Alma Ata definition is named "public health care" or "basic health care", that surveys the whole population and not only the part of the population that calls on health care providers.
This does not mean that the "public" and "positive" aspect is absent in the Netherlands; it just has got another name.

2.3.1.4 What is the degree of Government commitment to PHC?

Formally the Government committed itself to PHC in the White Paper about the structure of health care of 1974. The principle of creating "echelons" and promote a shift from residental and/or specialistic care to ambulatory or/and general care was stated firmly in this paper.
In the most recent White Paper (Nota 2000), however, the Ministry seems to retrace it's steps. In this Paper it is observed that the reduction of secondary health care has, firstly, not been a complete success, and secondly the benefits of this reduction have not been transferred to primary health care.
The Paper puts question marks at the effectivity of the policy of the last decade and wonders whether more flexibility should be applied in the relation between secondary and primary health care.

2.3.1.5 What is the understanding of community involvement in health care?

Community involvement in health care consists of three elements:
- The first element is the "normal" democratic involvement in local government. Municipalities and provinces have responsibilities regarding the organization and functioning of health care. The local government with representatives of the political groups forms the standard community involvement of the population. Municipalities might choose for an active local health care policy, although their formal possibilities are limited. An interesting example is the health care policy of the local

government and the local sickfund in Amsterdam, where a chain of integrated health centres have been created, and the already mentioned primary health care experiment in the new town of Almere.

- The second "involvement" has to do with "patient-rights". The set of rights and obligations of a client vis à vis the health care professional that provides his services.
  There is a government White Paper "Patient-policy", that formulates a set of rights (especially the right to be informed) that should form the formal base of the client/provider relationship in health care. The Dutch consumer-organization has been involved actively in formulating and proposing a common-standard set of rights. (A bill has been proposed to parliament in februari 1987.)
  This is not literally "community-involvement", because the set of rights refers to individual persons. Based on these rights, however, community action could (and does) easily take place.

- The third section is real "community participation": specificly directed to (primary) health care.
  The first form of participation is the "home-nursing" association. These have the legal form of "associations" of which the users of care are members. They have the right to participate and to be elected in the board of the local "cross-" organization. The factual participation is not overwhelming. There are in fact few people interested to participate, but the possibility is present.
  Secondly, most integrated health centres either have the legal form of charities with an elected board or have a patient-council in which interested clients can participate. These health centres, however, cover a limited part of the population only (no more than 7%).

2.3.1.6 Which components are considered as important activities in the PHC delivery services?

1. Nutrition, lifestyle.
   Well- baby and child care is provided by Cross Organizations and district nurses for the whole population. These pay much attention to nutrition.
   Attention to lifestyle is part of the preventive behaviour of nurses and general practitioners, but only as a reaction upon a request for help.

2. The same goes for health education; mostly part of the curative actions of general practitioners, nurses, physiotherapists, dentists, although there is a national bureau for information about food and the local "Cross Organization" usually have special health-promotion officers.

3. Monitoring health status, with the exeption of well- baby and child care, (that forms part of PHC, because the district nurse is part of PHC), systematic monitoring of the health status of the whole population is no part of Dutch PHC.
This monitoring is done systematically in school health care and some industries, where occupational health care is part of the routine.

4. Check-ups, screening and early detection.
See 3. There are some schemes for screening women of 35-50 years for cervical and breast cancer. The first task has, however, been delegated to general practitioners and second is experimental only. Population screening on TBC has been replaced by general lung screening to detect malignancies. These are organized outside PHC by special agencies, part of the public health care. All newborn babies are screened for phenylketonuria while infants are being screened on hearing and sight deficiencies.

5. Immunization.
Formally part of PHC, because well baby and child care forms part of it. Immunization is provided by well baby and child care for the whole population (participation over 95%).

6. Control and treatment of communicable diseases.
Here both general practitioners and public health care have a task. Communicable diseases are divided into three groups: for two of them reporting is mandatory; the third voluntary. The detection of diseases has to be reported to the public health care services, who are entitled to take measures to protect the population (immunization, isolation).

7. Control and treatment of chronic diseases.
There is a dispute about the share of primary health care (the general practitioners in this case) and specialistic health care. In the Dutch health care system the predominant remuneration of general practitioners is the capitation fee, while medical specialists receive a fee per item of service. This gives the wrong incentives when a topic like the control of chronic illness is concerned. In the (officially recognized) "task description" of general practitioners, the control of many chronic diseases is considered as part of the general practitioner's task. In fact there are, however, considerable exceptions to this principle.

8 Mental health, alcohol abuse, smoking.
The latter two topics have been discussed with the item "lifestyle". The first one is an interesting subject. In the Netherlands there is an elaborate structure of ambulatory mental health care, organized in 25 regional institutions covering the country as a whole. These regional institutions were formed out of a merge between all sorts of agencies in the

field of mental health care (marriage counseling, school-children's problems, care after psychiatric hospitalization).
These regional institutes (RIAGG, Regional Institute of Ambulatory Mental Health Care) provide psychological and psychiatric care.
On the other hand, psychiatricians (independently established) provide psychiatric care after referral by general practitioners, as do outpatient clinics of mental health institutions and psychiatric departments of general hospitals.
The guidance (voluntary or legally forced) of alcohol-problems is outside these regional institutes.
Although there is a well-organized and publicly financed network of ambulatory mental health care, this care is not considered as primary health care, because a referral from general practice or social work is necessary.
The number of referrals from general practice to these regional institutes is remarkably low (0.3 per 100 patients per year).
It is contended that the bulk of psychosocial problems is treated in one way or another in general practice itself. It also is a well known fact that there is a substantial turnover in the course of psychosocial problems ($^3/4$ is no problem-patient anymore after one year). In primary care the social worker is considered to provide additional care for psychosocial problems. In integrated health care centres this has been formalized, but also in less formalized structures like the home-team (where all providers have their own premises but have regular meetings) the social worker represents the psychosocial help.

9. Mother and child care.
   - maternal care depends on the health care provider that does the delivery. This is either an independently established midwife (does approx. 40% of the deliveries, the non-pathological ones), the general practitioners (15-20%) or the gynaecologist (the more complicated cases, + 40%). Costs for a midwife only are being reinbursed for the publicly insured, if it seems to be a non-pathological ("normal") delivery. About 35% of the deliveries are home-deliveries in the Netherlands.
     Ante-natal care is shared between midwife and general practitioner. Well-baby clinics are organized by the Cross Organizations and the district nurses deliver the care in + 60% of the cases in combination with a "child-doctor" (not a pediatrician), including immunization. In the other 40% general practitioners take part in these well baby clinics. Normal curative care is provided by the general practitioners. A pediatrician is only accessible after referral.
   - Family planning is considered to be part of the general practitioners task, who prescribes oral or other types of anticonception.

10. Elderly.
There is no specific branch of medicine that it in fact occupies itself exclusively with the elderly; general care is provided by general practitioners and specialists (on referral). Doctors employed by nursing homes, of course, have extended geriatric know-how.
Nursing care by district nurses and assistant nurses, while home helps assist in the household.

11. Environmental health.
This is no part of primary health care in the Netherlands. One of the three chief directorates of the M.O.H. is the Chief Directorate of Health protection; control of commodities and food stuffs is part of their task. Environmental protection, however is part of the Ministry of Housing and Environmental Planning. There is a Chief Directorate of Environmental Protection, that even contains a branch of the Chief Inspection of Public Health. The Inspectorate of Environmental Protection reports to the director-general of environmental protection - while the other branches of the Chief-Inspectorate (especially the inspection of foodstuffs) report to the director-general of public health (MOH).

12. Rehabilitation.
In rehabilitation in primary (ambulatory) health care physiotherapists (or for diseases like afasia the speech therapist) play an important role. Institutional rehabilitation is provided by a few specialized rehabilitation centres.

13. Home-care.
District nurses have both a task in well-babycare and in home-nursing. For the simpler tasks they have assistants, while home helps (from another organization) are involved in maintaining the household. Medical care is provided by the general practitioners, the only medical professional that makes house-calls. District nurses and home helps have a 7x24 hours deputising service.

14. Emergency-services.
First-aid clinics, are as a rule part of general hospitals, they provide emergency-services. In rural areas the general practitioners usually have an active role in this, but in urban areas this is much more limited.
Acutete psychiatric care is offered in some "crises-centres" or in outpatient-departments of the (very unequally distributed) psychiatric institutions.

15. Drug prescriptions.
The prescription of drugs is a task of the physicians (general practitioners and specialists). The provision of drugs in urban areas is by pharmacies, in rural areas by dispensing general practitioners.

16. Sick-leave certification.
    Explicitly no task of the general practitioners. There is a special branch of social medicine, that controls sick-leaves.

2.3.1.7 What formal structure/mechanisms for community involvement in health exist (according to regulations)?

As has been said in question 2.3.1.5 , there are 2 formal structures: the regular democratic process of local elections and the "association-structure" of the Cross Organization in which members decide (in theory that is) the policy.

2.3.1.8 Give examples of how community demands at the local level have been satisfied through the national health programme?

?

2.3.1.9 What formal and nonformal organizations have been recognized as the most effective "channels" for community involvement in health?

Voluntary associations of "patients" (persons with specific, mostly chronic, illness or handicaps) are being considered as rather effective (lobbies for open-heart surgery, removing thresholds from official buildings, pedestrian traffic-lights that "talk", etc.). On a national level the Dutch Consumers Organization is very critical about health services and has a certain watchdog-function.

2.3.1.10 What are the main obstacles for a more effective involvement of the community in health?

The organizational fragmentation on the one hand is a major obstacle, because there is no unified PHC-organization to be influenced, on the other hand there is no formal participation structure (unlike the education sector, where parents form school-boards), the already mentioned examples excepted.

2.3.1.11 Does a national intersectoral body exist?

No

2.3.1.12 Who are the members of that body?

Does not apply.

2.3.1.13 Which other sectors are involved in:

1. Health education: the Ministry of Education (the large academic hospitals are part of the Ministry of Education).
2. Water, air and sanitation: Ministry of Housing, Environmental Planning and Protection.
3. Nutrition and food: Ministry of Agriculture.
4. Others (specify): traffic safety: Ministry of Transport.

2.3.1.14 Which other governmental and nongovernmental organizations and sectors are involved in the formulation, planning, implementation and evaluation of health programmes (and plans)?

There are some national nongovernmental sectoral bodies:
1. National Council of Public Health (policy advice).
2. Health Council (scientific advice).
3. Sick Fund Council (controlling the public health insurance).
4. Central Organ for Tariffs in Health Care (financial and tariff advice).
5. College of Hospital Facilities (part of 1)
6. College for the Assessment of drugs.
7. Council for Environmental Protection.
8. Socio-cultural Planning Office.
9. Harmonizing Council of Welfare Policy.
10. Central Bureau of Statistics.
11. Policy Council for the elderly.
12. Communication Organ for health care of minorities.
13. Council for the Handicapped.

All these "Quango's" (Quasi Autonomous Non Governmental Organizations) are strongly interconnected. There are plans to reduce their number considerably.

Intersectoral bodies:
- Food Council (together with the Ministry of Agriculture).
- Medical Defense Council (together with the Ministry of Defence).

The Ministry of Education is in charge of the 8 university-hospitals (large and powerful) and of the medical faculties and other training institutes.

2.3.1.15 What are the main obstacles to better intersectoral collaboration in health?

The main obstacles are: departemental warfare. Environmental protection is part of the Ministry of Housing and Environmental Planning; the Ministry of Transport is in charge of traffic safety, etc.

2.3.1.16 Do national standards exist for technical equipment in PHC settings?

In the 'Medical Devices Act' (a frame work Act) a procedure for quality assurance of medical devices has been described. However, for two devices only i.e. condoms (protective contraceptives) and sterilization equipments) the full procedure has been carried out. This possibly useful Frame-work Act has in fact been left 'empty'.

2.3.2 The administrative structure of PHC components.

2.3.2.1 Organization chart of the Ministry of Health (or equivalent) clearly specifying the units responsible for PHC components. (See appendix I)

The units responsible for primary (health) care are in two separate directorates-general of the Ministry of Welfare, Public Health and Culture.
Directorate-general of Welfare:
Social workers/home helps.
Directorate-general of Public Health:
Nurses, doctors, etc.

The chief-department of PHC is part of the Directorate of General Health Care and the Chief-directorate of Health Care (one of the three chief-directorates, the others are about financing and planning, that is planning of institutional care) and about health-protection (environmental protection excluded).
The Chief-inspectorates of health, mental health, drug-provision and food control are accountable to the Director-general of Public Health, but do not form part of the departmental organization, they coordinate the regional inspections, that have a major task in controlling the quality of professional care.

2.3.2.2 Describe the coordination mechanisms of the PHC components within the Ministry (i.e. MCH, immunization, sanitation, drugs, etc).

There is a regular meeting of all the directors and chiefs of departments with the Director-general of Public Health, who is also in charge of the coordination between Chief inspectorate of Health and Environmental Protection.

2.3.2.3 Describe the relationship between the Ministry of Health and the regional and peripheral health organizations.

The most direct link of the Ministry of Health with regional health organizations is the Chief Medical Office (health, mental health, drug-provision, quality of food and commodities). The Ministry of Health also issues regulations for regional and local use.

2.3.2.4 What are the sources of PHC delivery?

Part of PHC is by independent "contractors" (the general practitioner, dentist, physiotherapist, midwife, pharmacist, speech-therapist and other paramedical professionals.)
District nurses, home-helps and social workers belong to three different organizations. These organizations are private foundations or associations, financed by public funds.
Emergency-aid is by first-aid departments of hospitals, ambulatory, mental health care by regional institutes of mental health, by outpatient departments of psychiatric hospitals and independently established psychiatrists and psychologists.

2.3.2.5 What is (according to policy and legislation) the profile of the main PHC delivery organization responsible for primary health care (describe)?

There are two main organizations:
- The Dutch Medical Association and its subdivision the National Association of General Practitioners.
- The Cross Organization.

2.3.2.6 What is the relationship between the main PHC delivery organizations and other support health organizations (e.g. hospitals and other specific organizations).

Within the Dutch Medical Association both the Association of General Practitioners and the Association of Specialists are represented.
In the National Council of Public Health, the Sick Fund Council, and the Central Organ for Tariffs in Health Care, representatives of all health care sectors meet regularly.
In the provincial councils of public health all participants are represented too.
There also is a regular consultation between all PHC organizations (NOBEL-National Consultation PHC Policy).

2.3.2.7 What are the main problems/obstacles for a better organization of PHC at the national level?

The main obstacle is the fragmentation of primary health care organizations. Each profession has its own union and organization, sometimes a professional association, sometimes an organization of charities, like the Cross Organization.
There is no formal connection between PHC and most other sectors (hospitals, mental health, public health).
The separation of health care financing and health care planning and organization is a second major obstacle.

2.4 Resource allocation.

2.4.1. Financing.

2.4.1.1 Finance preparation and delegation.

2.4.1.1.1 Are finances prepared at the:

- central level
- medium level
- local level

Most finances are prepared centrally by negotiations between professional organizations, the Association of Public Health Insurance Funds (Sick Funds) and private health insurance firms.
Tariffs have to be approved by a semi-autonomous organization: The Central Organ for Health Care Tariffs and by the Secretary of State for Public Health.

2.4.1.1.2 Who is involved in the financing of health care at any level?

Financing of health care goes via:
1. Premium for the 'Sick Fund Act': ± 35% (employers and employees below a certain income-ceiling.)
2. Premium for the 'General Exceptional Medical Expenses Act': + 20% (employers only.)
3. Government subsidies to 1. and 2.: in 1980 7 and 6% respectively.
4. Direct government funds: 5%

1.-4. Total public financing: 73%.
5. Private insurance: 23%.
6. Direct out of pocket expenditures: 3%, other (1%).

2.4.1.1.3 Are the regional/district authorities given a finance planning limit to work within by the central level?

In the Netherlands provincial authorities have a very small involvement in financing health care.

2.4.1.1.4 How much flexibility do the regional/district authorities have to change the annual budgets for the different programmes and activities?

Does not apply. Only institutions have a fixed budget (general hospitals since 1983, others since 1985).

2.4.1.1.5 Can the regional/district authorities transfer savings from one year to use in the next budgetary period?

Hospitals are allowed to "save" in the new budget-structure.

2.4.1.1.6 If the regional/district authorities do not prepare the budget, who decides the available budget for the region/district?

Tariffs are being negotiated centrally, the same goes for institutional budgets.

2.4.1.1.7 Do the regional/district authorities have the possibility of transferring funds from one line of item to another?

There are no "regional authorities" with financial responsability for health care, provinces and municipalities only have marginal tasks for public health: regional Sick Funds do, as a rule, execute centrally agreed negotiations, although they have some degrees of freedom in their so called "additional insurance"

2.4.1.1.8 Is it policy to collect fees for services rendered?

If yes, describe in detail (including details on what level establishes the fees).

For the private sector (35% of the population, 25% of the health care costs) there is a common policy to collect fees for services rendered. The same goes for large parts of the public sector; medical specialists, physiotherapists, dentists etc. receive a fee per item of service.
Fees are negotiated between professional organizations and financing organizations (public and private health insurance funds). The results of these negotiations are presented to the Central Organ for Health Care Tariffs, that has to give its consent. Before that the tariff has been tested against the criteria of the 'Temporary Act for Standard Incomes' for the self-employed profession. An agreed tariff may not cause average incomes that exceed the levels agreed according to the temporary Act.
For specialistic care, degressive tariffs are in force. The Minister of Health has the power to veto the agreed tariffs, but, as a rule, does not use it.

2.4.1.2 Finance allocation.

2.4.1.2.1 Finance allocation by sources.

Capital	Year	GNP per capita (US $)	% alloc. for health	Total Govt. alloc.	Health insur. Funds	Public parti- cip.	Priv. alloc.	Fee for Ser- vice	Ext. supp. (other sect./ count.	Others
					See appendix II					

2.4.1.2.2 Distribution of budget by region/equivalent:

Region/equivalent	no. of pop.	GNP per capita			Expenditure per capita			Budget per capita
		75	80	85	75	80	85	
with highest GNP per capita								
with average GNP per capita								
with lowest GNP per capita								
Total								

Level of care	1975			1980			1985		
	public	priv.	total	public	priv.	total	public	priv.	total
university and other specialized referral hospitals									
general regional hospitals									
district hospitals									
PHC health centres and other PHC facilities									
Public health institutions									
others (specify)									

There are no specific figures about finance allocation by region in the Netherlands.
The Gross Regional Product can be computed for the 12 (11) provinces and for 40 so-called COROP regions (no administrative but statistical subdivision of the 12 (11) provinces), but no budget allocation can be computed, because there is no such thing as budget-allocation from central to local levels.

2.4.1.3.3 What are the main problems/obstacles for budget distribution with regard to health needs, concerning:

- health policy and legislation
- health management (centralized/decentralized)
- health planning and programming
- existing structure and organization of the health service
- social (pressure) groups
- others (specify)

Budget distribution is only indirectly related to health needs.

2.4.1.3.4 What are the current predominant cost-containment policies with regard to:

1. Decreasing accessibility to health services (through user payment participation):
   decreasing accessablity (copayment rates):
   In 1983 a copayment of DFL 2.50 per prescription has been introduced in the public health insurance.
   There is a proportional (according to income) contribution for the costs of home helps, while a compulsory membership of the Cross Organization (home nursing) is necessary when it's services are being used. Copayment rates for transport per ambulance have been introduced too.
   All other services are being delivered in kind in the public health insurance, while copayment rates in private insurance vary greatly, depending on consumer's preferences.

2. Decreasing benefits:
   ?

3. Establishing budget ceilings:
   The establishment of budgets for hospitals and other health care institutions has been a major success in reducing health care costs, although hospitals (and especially the nurse's associations) complain about the increased burden for the remaining staff. Bear in mind that in the Netherlands specialists usually are not employed by hospitals and, although their decisions generate a major part of hospital costs, their activities are not included in the hospital budgets.

4. Establishing provider incentives for cost containment:
   With a capitation fee remuneration system for the general practitioners and a fee for service system for specialists, physiotherapists and dentists the financial incentives for cost-containment are in the wrong direction. A central 'equalization' of costs and benefits of the regional Sick-funds does not stimulate cost-effectiveness in public health insurance either.

5. Implementing educational programmes for cost containment:
   Local Sick funds (and private health insurance companies) try (by their medical officers) to monitor health care costs per provider and try to influence their behaviour, although they have no formal means to refuse cooperation, for instance.

6. Implementing more direct community financing and participation in development and management of health services:
   Since budgets have been introduced, hospital management did not become easier. Symposiums and courses 'how to survive in a budget-economy' have been introduced to help managers solve the new problems.

2.4.2 Manpower and facilities.

2.4.2.1 Country health manpower by employer, by site and profile in last five years (1980 - 1985 or 1978 - 1983), Januari 1th.

Type (profile) of health worker	total no. working		employer(s)		% of total no. working by site (hospital, PHC, etc.)	
	1980	1985	% on pay roll[1]	% self-employed	intramural health-care	extramural and other health-care
All health workers[2]	325,346	353,623	90[16]	10[16]	71[16]	29[16]
All physicians[3]	25,947	31,185	.	.	.	.
all specialists (physicians)	8,939	10,796	35	65	81	19
pediatrician	617	735	.	.	78	22
gynaecologist/ obstetrician	545	673	.	.	89	11
rehabilitation specialist	165	213	.	.	89	11
occupational[4] medicine specialist	429	664	.	.	< 10	> 90
psychiatrist[17]	1,056	1,412	.	.	77	23
ophtalmologist	404	462	.	.	85	15
ORL specialist	377	414	.	.	89	11
radiologist[18]	615	764	.	.	39	61
biochemist[6]	13	11	.	.	.	.
surgeons	794	925	.	.	86	14

(continued)

Type (profile) of health worker	total no. working		employer(s)		% of total no. working by site (hospital, PHC, etc.)	
	1980	1985	% on pay roll[1]	% self-employed	intramural health-care	extramural and other health-care
other physician specialists	4,353	5,187	.	.	80	20
GP's	5,468	5,900	< 5	> 95	< 5	> 95
dentists (specialists)	259	339	< 5	> 95	< 5	> 95
dentists[19]	5,346	6,865	< 5	> 95	< 5	> 95
pharmacists[7]	1,463	1,800	30	70	12	88
psychologists	1,500-2,500[8]		> 95	< 5	.	.
social workers	7,000-8,000[9]		> 95	< 5	20[16]	80[16]
nurses	54,100	77,700[10]	> 95	< 5	80	20
home visiting nurses[11]	4,853	6,287	> 95	< 5	-	100
midwives	898	950	30	70	17	83
pharmacological technicians	does not apply					
radiological technitians	2,190	3,541[12]	> 95	< 5	100	-
dental assistants	.	.	.	.	.	.
assistant nurses	19,800	24,100[13]	100	-	78	22[14]
sanitarians	.	200[16]	100	-	100	-
health assistants	does not apply					
TOTAL[15]						

1 Minor role for central or regional government in employing health workers.
2 In fulltime equivalents. 1985: provisional figure
3 Registered physicians, active, in training and unemployed, excluding retired physicians.
4 Not a medical specialist but public health physician (labour and industrial medicine). Mainly working for occupational health services
6 Type of care mainly provided by non-physicians,viz chemists.
7 Number of pharmacists working in ordinary pharmacies or in hospital pharmacies; excluded are pharmacists working in the armed forces, in industry or wholesale trade, at universities or as civil servants. Excluded are also general practitioners running a small pharmacy along with their practice.
8 Exact no. depends on definition of profession (considerable amount of psychologists, especially those employed by planning and research institutes, cannot be regarded health workers) No. working in Institutions for Ambulatory Mental Health Care: 1206
9 of which: working in Institutions for Ambulantory Mental Health care: 1440, in Institutions for General Social work 2,583 (1984).
10 1984, January 1th (nursing-aids excluded).
11 (Chief) district nurses included.
12 Those in training included (597), 1984, full time equivalents.
13 1984, January 1 st.
14 of which in elderly homes: 5.100 (1984).
15 Summing up of table 2.4.2.1. is not possible because of overlap in figures.
16 rough estimate.
17 In 1971 the post-graduate course "neuropathology and psychopathology" was divided into two new courses: "neurology" and "psychiatry". The (corrected) figures on psychiatrists in 1980 and 1985 are estimates, consisting of the number of psychiatrists with the new diploma and the proportion of those specialists with the old diploma "neuropathology and psychopathology" who, according to a 1983 study by the National Hospital Institute, were working psychiatrists.
18 Specialists in radiognostics, radiology and radiotherapy. The post-graduate training for radiology has been divided into two new training courses for radiodiagnostics and for radiotherapy.
19 Dentists: including dental specialists, unemployed dentists and other dentists not working in primary health care, e.g. as civil servants.
. = data not available
- = nil.

Sources:
Netherlands Central Bureau of Statistics (CBS)
Netherlands Institute of PHC (NIVEL)
Director-general of Public Health
Ministry of Welfare, Public Health and Culture.
National Hospital Institute (NZI)

2.4.2.2 Rate per 1.000 population* by region/district** (1980, 1985), Jan 1th

Type of health worker	average rate by country 80	85	Regions/equivalent with highest rate 80	85	with lowest rate 80	85
All health workers	23.1	24.1		?		
all physicians	1.84	2.16	2.71	3.11	1.13	1.36
all specialists	0.63	0.75	0.98	1.1	0.38	0.44
pediatrician	0.14	0.19				
gynaecologist/ obstetrician	0.17	0.20				
rehabilitation specialist	0.01	0.01				
occupational medicine specialist	0.09	0.13	registration of specialists by hometown, not working place. regional dispersion figures therefore do not necessarily reflect differences in care provided by specialists.			
psychiatrist	0.07	0.10				
ophtalmologist	0.03	0.03				
ORL specialist	0.03	0.03				
radiologist	0.04	0.05				
biochemist	< 0.01	< 0.01				
Surgeons	0.06	0.06				
other physician specialists	0.31	0.36	idem			
GP's[1]	0.39	0.41	0.42	0.44	0.35	0.37
dentists (specialists)	0.02	0.02	.	.	.	.
dentists	0.38	0.47	0.71	0.81	0.21	0.32
pharmacists	0.10	0.12	0.14	0.15	0.05	0.08
psychologists	0.10	0.18	.	.	.	.

(continued)

Type of health worker	average rate by country 80	85	Regions/equivalent with highest rate 80	85	with lowest rate 80	85
social workers	0.50	0.57	.	.	.	.
nurses	3.84	5.40	.	.	.	.
home visiting nurses	0.34	0.43	.	.	.	.
midwives	0.06	0.07	0.09	0.09	0.01	0.02
pharmcological technicians	does not apply					
radiological technicians	0.16	0.24	.	.	.	.
dental assistant	.	.	.	.	.	.
assistent nurses	1.41	1.67	.	.	.	.
sanitarians	.	0.01	.	.	.	.
health assistants	does not apply					
Total[2]						

* For pediatricians: per 1000: 1-19 years
For gynaecologists per 1000: women 15-45 years
For occupational health specialists per 1000: workers in commercial sectors (Note: 1985: workers included with jobs of less than 15 hours a week)
For GP's per 1000: 20+ years of age if pediatrician in charge

**= province

. = data not available

1 per 1,000 of total population (for occupational medicine specialist: per 1,000 employed persons)

2 see explanatory notes to table 2.4.2.1.

2.4.2.3 Are there explicit quantitative staffing norms for different profiles/types of health workers for different facilities, i.e.

1. health centres. Yes. For the Dutch health centers (that are, as has to be remembered, not the common form of primary health care providors) staffing norms are lower than for other facilities:
   - general practitioners 1 per 2,000 inhabitants instead of 1 per 2,350
   - district nurses 1 per 3,000 inhabitants instead of 1 per 3,450
   - physiotherapists and midwives 15% lower gross standard revenues.
2. district and regional hospitals form no part of primary health care in the Netherlands: staffing norms are these of the institutional setting.

2.4.2.4 What are the main obstacles during the last five years and what progress has been made in the distribution of various profiles of health personnel according to needs, regarding:

- health policy and legislation
  A major obstacle in lowering the staffing norms for multidisciplinary health centres has been a policy to avoid 'discrimination' of other primary health care provisions. So, for this specific and experimental facility, norms are approx. 15% lower, but they have not been adapted - in part- to the general agreement to lower the g.p.'s list size from 2,400-2,000 patients in four years time.

- health management and administration
  Although the need for professional management has been recognized from the beginning, the financial possibilities for management staff have never been created in these health centres (some exceptions excluded). Usually management tasks have been devided between health care professionals. Some administrative support has been delivered by, for instance, the Cross organization, on a voluntary base.

- planning, programming and financing
  The sad history of the major planning Act - 'The Health Care Provisions Act' - is a striking example of the difficulties that arise in restructuring planning mechanisms.

- health service structure and organization
  For primary health care the existence of four separate professional organizations is a major obstacle in health planning.

- shortage and overproduction of personnel
  In spite of a 'numerus fixus' for medical students, unemployment under docters is growing fast. The formal establishment policy since 1986 favours the position of the already established professionals. The agreement to decrease the g.p.'s list size

from 2,400-2,000 provides some new positions for young g.p.'s. The extension of the vocational training from 1 to 2 years, might cause some temporary delay in the growth of medical unemployment.

- professional status, prestige and career
  A general practitioner is a well respected medical professional in the Netherlands; of course some specialisms have more 'glamour', but there is more than enough demand for the profession. There centainly is no shortage either of applicants for district nurses jobs.

- advanced training
  The post graduate vocational training of general practitioners (1 year) is hunted, compared to many other countries. It has been acchieved to extend the training to two years, although a three year-education has been favored by most of the medical schools. Financial problems (who is going to pay the doctor in spe) delay execution of the new two-years education.

2.4.2.5 Distribution of health facilities.

Type of setting (describe)	1975 No. of facilities	1975 Rate* per 1000 population	1985 No. of facilities	1985 Rate per 1000 population
a.intramural health care:				
Hospitals	256	5.4	208	4.7
Mental hospitals	72	1.9	82	1.7
Institutions for mental-deficients	129	1.9	121	2.1
Nursing homes	298	2.9	331	3.4
Children's nursing homes	27	0.11	12	0.05
Institutions for sensorily handicaped	.	.	12	0.11
Nurseries for toddlers under medical supervision	13	0.08[7]	29	0.12[7]
b.extramural health care[8]:				
Health centers[2]	34	.	140[1]	.
maternal care centers (ambulantory)	81	.	78[1]	.
Institutions for ambulatory mental health care	116[9]	.	90[1]	.
Ambulance service	242[9]	.	230[1]	.
Public health services	58[9]	.	65[1]	.
School health service	127	.	101[1]	.
Occupational health service	162[9]	.	152	.
Thromboses services	65[9]	.	70[1]	.
Blood banks	.	.	22[1]	.
Cross organizations	± 1,470	.	± 200	.
Self employed PHC providers (no. of practices):				
- G.P.'s[3]	4,060	.	4,400	.
- Midwives[4]	580	.	490	.
- Fysiotherapists[5]	.	.	2,889	.
- Dentists	3,688	.	6,161	.
- Dieticians[6]	.	.	154	.

* for hospitals: no. of beds per 1000 population.
for PHC settings: no. of sq. metres per 1000 population.(note: no statistics available on this standard in the Netherlands.)

. = data not available.

1 1984

2 1984, some 400 g.p.'s were working in health centre on self employment basis.

3 duo/groupppractices included, January 1th.

4 January 1th.

5 remedial gymnastic professionals and massagists included.

6 1983

7 places (not beds)

8 given are the numbers of institutions (organizations), not of facilities

9 in 1976

2.4.2.6 Distribution of outpatient PHC setting by region/equivalent.

Type of setting	Average value for country		Highest value for Region in country		Lowest value for Region in country	
	Rate per** 1000 pop.		Rate per 1000 pop.		Rate per 1000 pop.	
	1975	1985	1975	1985	1975	1985
			?			

no. of sq. metres per 1,000 population: standard not used in statistics on health care.

2.5 Population coverage with PHC services, accessibility and utilization of health services.

2.5.1 Accessibility of PHC services to the population, January 1th.

Indications		Average values for country		Regions/equivalent With highest value		With lowest value	
		1980	1985	1980	1985	1980	1985
number of population per GP in PHC	rural[1]	2,577	2,450	2,837	2,707	2,364	2,284
	urban						
number of population per nurse in PHC	rural	2,904	2,229	.	.	.	.
	urban						
distance from health unit centre having a GP		GP in dwelling-place: 96% of the population % of population living more than 10 km from GP-practice is neglegible (no statistics on provincial dispersion.)					
% of population living less than 10 km. from the health centre[2]							
% of health centres organizing inform. sessions for groups outside (schools, factories, commun. centres, etc.)		.	.	.	.	.	.

(continued)

Indications	Average values for country 1980	1985	Regions/equivalent With highest value 1980	1985	With lowest value 1980	1985
waiting time for appointment with:						
- GP	17,4 min.	.	.	.	.	.
- specialist						
- X-ray			?			
- laboratory						
% of population attending PHC centre with respect to total popul. assigned to that area			?			
% of population using PHC services free of charge	For the +66% (1985) of the Dutch population that are publicly insured, PHC services in principle are being provided without co payment. Exceptions exist in the field of medicine supply, maternity care and home care. (see 2.2.2.5.)					
% of population covered by health insurance funds	68.2	66.4	72.5	71.5	60.8	60.7
% of users[3] financial particip. of total cost for:						
- drug prescription	-		all (Dfl 2.50/prescription)			
- physicians exam.	-		- Sick funds insured pay no contri-			
- X-ray exam.	-		- bution for hospital and specialist			
- lab. exam.	-		- care. Other conditions for privatly			
- hospitals	-		- insured patients (32% of total popu-			
			lation.			
no. of visits[4] per person per annum to the GP	3.5[5]	3.4[6]	?			
no. of visits per person per annum to other PHC personnel						
dentist	1.3[7]	2.1[9]	?			
maternity care	6.0[8]					
infant welfare	9.5[10]					
toddler welfare	1.2[11]					

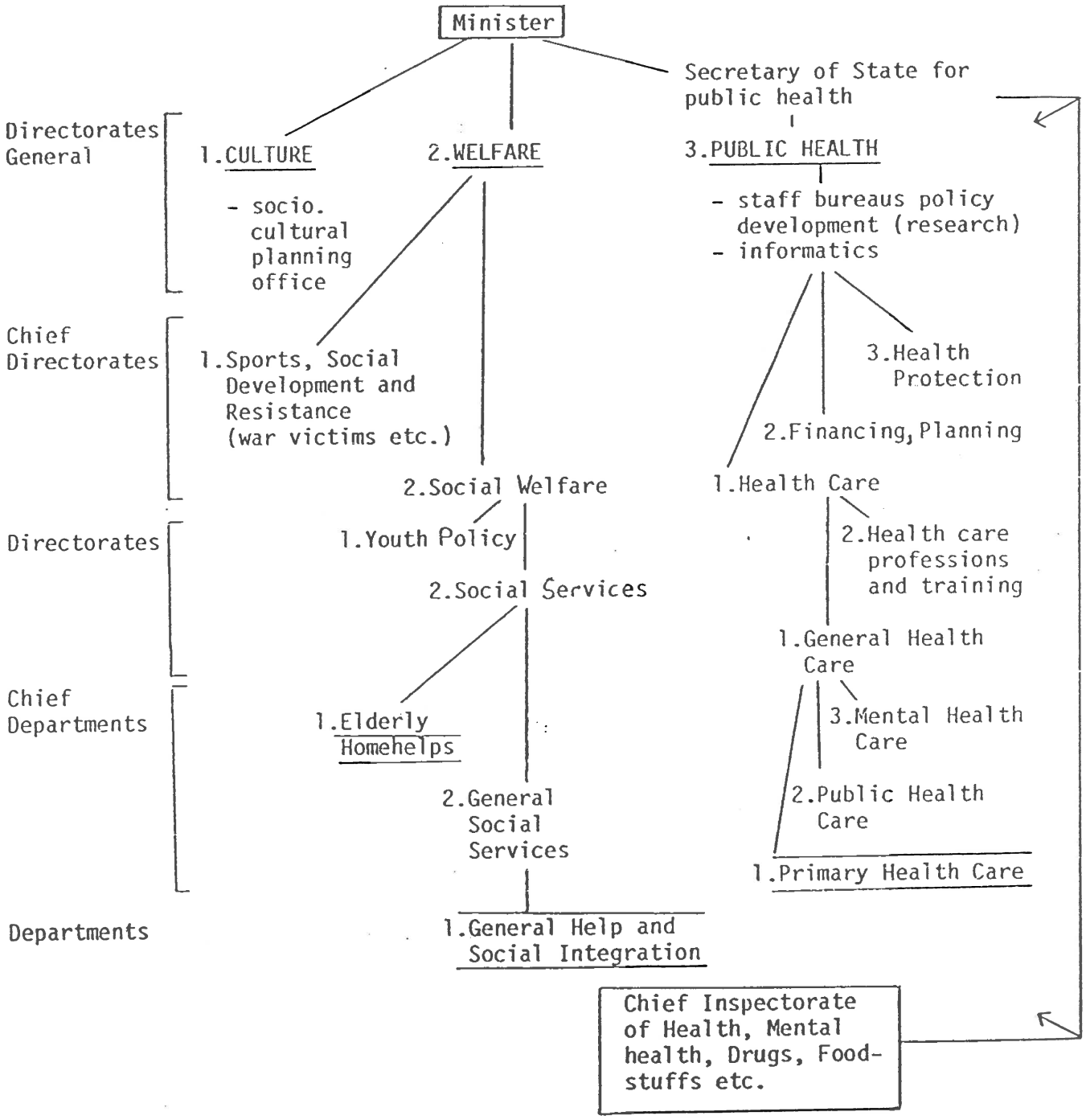
(continued)

Indications	Average values for country 1980	1985	Regions/equivalent With highest value 1980	1985	With lowest value 1980	1985
no. of drug prescrip.[12] per person per annum	14.4		15.3		12.8	
no. of drug prescrip. per GP visit	.	.	.	.	.	.
no. of X-ray exam. per GP visit	.	.	.	.	.	.
no. of lab. referrals per person per annum	.	.	.	.	.	.
no. of lab. tests per GP visit	.	.	.	.	.	.
% of school children prev.[13] examined per year	49.0	50.3[14]	56.5	54.4[14]	39.1	45.3[14]
% of women examined for PVU Ca (35+)[15]	5.7	6.4	6.0	6.5	2.7	4.7
no. of antenatal visits per pregnancy	.	.	.	.	.	.
% of check-up exam. in total exam. of workers in commercial sector	.	.	.	.	.	.
% of children vaccinated according to Min. Health recommendations	measles: 90-95 DKTP: > 95 (I-IV)		no significant differences			
% of home visits of all visits per patient	GP: 20 > midwife: > 90 nurse in PHC: > 95 maternity aid : > 90					
% of women visited by midwife (at home) after the birth to inform about child rearing and family planning	.	.	.	.	.	.
CEF index* per person	?					

CEF index: Ratio between no. of - caries; extractions; fillings.
1 rural/urban: no significant classification in the Netherlands (absence of underserved areas.)
2 'health centre': GP
3 Those insured by health insurance funds.
4 no. of consultations ("contacts").
5 1981/1982
6 1983/1984
7 1980/1982
8 per 1,000 population.
9 1983/1984
10 per 1 live birth.
11 per 1 toddler (1-4 years)
12 % of population who had medicines prescribed in 14 days, 1981-1984.
13 total no. of examined children as a % of all children under supervision.
14 1982
15 no. of cervical smears, rough estimates.
Values for region/equivalents:no. of cervical smears in all age groups (35- included), in 4 regions (North,East etc.)

Appendix I

Organizational Chart of the Ministry of Welfare, Public Health and Culture.



Appendix II

Cost and proceeds of health care

	1975	1980	1984*
	min hfl		
Cost of intramural health care			
hospitals	5,585	9,338	10,847
mental hospitals	1,082	1,651	1,976
institutions for mentally deficients	941	1,647	2,071
nursing homes	1,627	2,864	3,457
other institutions[1]	483	890	1,145
Total	9,718	16,417	19,496
Cost of extramural health care			
specialist practices[2]	1,135	1,638	1,909
general practices	889	1,242	1,444
institutions and practices for dental treatment	927	1,456	1,633
practices of midwives and other allied health professions	379	957	1,137
supply of medicines, dressings, etc.	1,855	2,634	3,518
institutions of public health care[3]	916	1,651	2,031
other institutions[4]	371	587	668
Total	6,472	10,165	12,340
Cost of other health care			
food and water inspection	80	123	142
policy, administration and management	699	1,116	1,772
Total	779	1,239	1,864
Total cost	16,969	27,821	33,700
Exploitation balances	-83	-185	125
Total proceeds	16,886	27,636	33,825
Directly financed by			
enterprises	162	242	266
central government	912	1,197	1,239
provinces	13	14	17
municipalities	308	351	328
health insurance funds	7,261	11,942	14,620
Exeptional Medical Expenses Act	3,946	7,331	9,225
other sources[5]	4,284	6,559	8,130

(continued)

Cost and proceeds of health care

	1975	1980	1984*
	min hfl		
Ultimately financed by:			
enterprises	172	315	287
government	2,674	5,130	3,578
private households	14,040	22,191	29,960

1 Children's nursing homes, nurseries for toddlers under medical supervision, institutions for sensorily handicapped, day rooms for handicapped persons, etc.
2 Meant are the costs of specialist treatment not included elsewhere.
3 Cross organizations, maternity centres, school health services, public health services, institutions for ambulatory mental health care, etc.
4 Ambulance services, bureaus for medical sport's examination, medical care for the armed forces, associations for tuberculosis control, etc.
5 Includes private health insurance companies, public arrangements for cost of sickness, and private households.

Source: CBS, Statistical Yearbook of the Netherlands, 1986