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Group General Practice and Health Centres in the Netherlands

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Group General Practice and Health Centres are now an established part of the Dutch medical scene. Although there are no recent research results[1] to hand that show unambiguously that this particular form of health care is superior to the more traditional forms, most recent figures show that more than 1 million (out of the total of the 14 million inhabitants of the Netherlands) are involved in this form of health care. (July 1978)
The development has been rapid: the first group practices and health centres are scarcely ten years old and the number increases yearly. Before describing this phenomenon in detail it is worth making a few preliminary remarks.
We must first make clear what precisely we understand by the terms "group general practice" and "health centres".
Secondly one can only understand the developments (and the delays in development) when one has some knowledge of the peculiarities of the Dutch Health and Welfare System.
Thirdly we shall try to give a bird's eye view of the social circumstances in which the "health centre phenomenon" arises.
Finally we shall go over the same ground again and show some figures from the Registration-system for the group practices and health centres that have been kept by the Netherlands Institute for General Practice.

1. Attempts at research are generally unsuccessful because of the incomparability of the various forms of medical care. Health centre workers are "pioneers" and are thus not a representative sample of the population of the medical sector. Furthermore there is a tendency to compare health centres with one of the most traditional forms of medical care, namely the independant general practitioner. If one finds differences in this case it is impossible to discover to what aspect of the new form of medical care they may be attributed.

Group general practice and health centres: some terms, definitions and alternatives

To begin with the simplest definitions: a group general practice is an establishment of three of more physicians; you have a building with three or more name plates on the door. In general terms these physicians have a group practice: they share one or more assistants and share the complex diagnostic apparatus (an electro-cardiograph for example) and they consult one another when problems arise in the course of their practice.
The degree of cooperation can vary considerably; one can consider the above example as a "modal" example.
With health centres it is again a question of the communal establishment in one location of medical personnel, in this case in addition to the general practitioner several sorts of health care workers are available a minimal number of "district nurses" and "social workers". Furthermore in health centres one often encounters: physiotherapists, midwives, family care workers, chemists, pharmacists, dentists, psychologists and sometimes even an errant priest.
The most important features are then a common location and the presence of the three "central disciplines" in the form of the G.P., the district nurse and social worker.
The cooperation that obtains between these "disciplines" again can vary considerably in extent and intensity. There will at least be group conferences about shared patients or clients. There are often seperate meetings to discuss the problems of organisation and the development of a general policy in respect of the general services offered and the primary medical care.
As far as group general practice is concerned as well as the health centres it is a question of fairly carefully defined forms of medical care.
They are not though the only form of medical care. Out of approximately 5200 Dutch general practitioners (in the following paragraph we shall place these figures in a more general perspective)

two thirds practise independently. Of the rest approximately 25% have a joint practice, that is a two-man practice, (generally called an "association"), and the remaining general practitioners work partly in group practices and partly in health centres. Other professions in primary medical care (physiotherapists, dentists) can also operate on a group practice basis. However, we have little information on these professions. The same is true for the establishments of various other sorts of medical and paramedical practitioners; in so far as they don't belong to the trio of "general practitioner, district nurse and social worker". For example we don't know how many joint practices of G.P.'s and physiotherapists there are and there is no systematic record of this. The many forms of single- and multidisciplinary cooperation that take place _without_ a shared location, and there are a good many of them, are beyond the scope of this study. Home-teams, observation groups, and in-service training societies have not been systematically investigated by us. In this paper we are describing therefore a rather limited, but extremely important form of single- and multidisciplinary cooperation in the first echelon of Dutch medical practice.
In order to understand the place of group general practice and health centres within the framework of Dutch medical practice as a whole, it is worth summarizing the principal features of the Dutch medical scene.

The place of the G.P. in Dutch medical practice

As of January 1978, the Netherlands had 13.9 million inhabitants and almost 24,000 medical practitioners (17.2 per 10,000 inhabitants. Of these medical practitioners about 5,200 were general practitioners and 7,900 clinical specialists, the latter active principally within the hospitals.
The number of clinical specialists has grown faster in the last few years than the number of general practitioners. In 1961 there were 3,900 specialists and 4,400 G.P.'s - in 1978 the number of specialists had doubled (7,900), and the number of G.P.'s had increased by scarcely 20% (5,200); an increase that scarcely exceeds the increase in population (that is from 11.6 million to 13.9 million = 19.8%). The reason that the number of G.P.'s has not fallen despite the explosive rise in hospital sector, as has been the case in other countries, (the United States for example), has to do with the insurance system responsible for Dutch medical care.
The Netherlands do not have a National Health Service where physicians and nurses practice their professions as employees, but has an extensive system of compulsory insurance and fixed remuneration for medical practitioners. Approximately 70% of the Dutch population is insured in accordance with the Medical Insurance Act[1], for the greater part these are "compulsor insured people", from whose wages an insurance premium plus

1. In fact, here it is a question of 50% of the population, where the head of the family is salaried and where his income is below a certain yearly maximum. (This maximum is adjusted yearly), 7.5% Insured pensioners and 11.5% so-called "voluntarily insured", these are mostly self-employed people with a taxable income that is below the maximum.

an employers contribution is deducted. These premiums form a basis of a fund, from which the health insurance fund pays the cost of medical care. For the 70% of the Dutch population, who are insured under this system, there are no extra financial impediments to their medical care.

G.P.'s and hospitals are availble without extra charges to the patient; and the cost of hospitals care is refunded in full (thougt lately there was a stormy political debate brought about by the suggestion that the patient pay a small personal contribution per day in hospital).

Consultation of a hospital or clinical specialist does not involve extra costs for the patient, but it is not however completely free.

A *clinical specialist* may only be consulted on *referral from a general practitioner*, thus after a *consultation with the general practitioner*. This condition gives the general practitioner an important place in Dutch medical practice or rather, the clinical specialist is not allowed to replace the general practitioners completely. It is true, however, that it has not prevented the number of patients referred to specialists per 1000 compulsorily insured patients rising from 330 (1960) to 500 (1976), but the doubling of the number of specialists must be taken into account in this case.

The Dutch general practitioner therefor has an important function as filter or selector in the medical case system. One cannot get round him. He is not compelled to refer patients to a specilist, though he would be reprimanded were he to be too late in his referral.

The remuneration of general practitioners and clinical specialists is quite different in principal (as far as the compulsorily insured are concerned). A.G.P. receives a fixed sum per insured patient per year, irrespective of the demand upon his services on the part of the patient in question. Specialists on the other hand are paid for treatments that they actually carry out. The first system, "subscription-system", has a braking effect on the phenomenon of multiple prescription, but is sometimes considered as unfair by those involved because there is no extra reward for extra effort.

A.G.P.'s practice is, however, not restricted to the compulsorily insured patients; the remaning 30% (we are here concerned with the

avarage - variations are considerable, depending on the prosperity of the community where the practice is established) pay the G.P. by consultation or treatment. In this case they are generally not insured, the so-called "private insurance" generally covers specialist and hospital care alone.
The G.P. is in general a private practitioner, is private practitioner in the sense that he is not in salaried service (scarcely 2% are in fact in salaried service). He is not, however, a private practitioner in the sense that he only accepts private patients, although this might infrequently be the case. This means that his income is for the greater part determined by the number of his patients, who are compulsorily insured[1] and by the number of treatments he carries out for private patients.
It is unusual for G.P.'s to be employed by one another.
The Royal Dutch Medical Association (KNMG) considers a maximum period of six months ethical; principally to give young doctors the opportunity to gain some practical experience.
In practice, however, one does find an increasing number of situations in which the six-month period is exceeded (a cautious estimate from the G.P.'s Registration Records at the Dutch Institute for General Practice comes up with a figure of 2% of the total number of G.P.'s).
Not all physicians may call themselves G.P.'s. Since about 1975, there has been a compulsory one-year post-graduate course to be taken after completing one's medical qualifying examination: the transitional period from the old system, in which the medical qualifying examination in itself was sufficient, has now come to an end. Virtually all G.P.'s who are at this moment establishing themselves in practice, have completed the post-graduate course in general practice. The demand for the course is considerable.

1. The health insurance fee is made up of a sum to cover costs, that is costs arising from the running cost of the practice, (in general these are refunded for the first 1800 patients) and a sum to cover the "subscription" itself - that is the fee. This latter sum is paid for all those insured.

Each year approximately 500 physicians graduate from the course, although there are no more than approximately 350 new G.P.'s establishing themselves in practic Further, because of the departure from practice of established physicians (40% retiring, 50% taking up another position, and 10% specialising) there are no more than 200 free places. The additional places must be created by G.P.'s deciding to share their practice with a new partner or by G.P.'s establishing themselves in new practices, that means that they will not be taking over patients from an already established G.P.

In most cases the establishment of a practice is accompanied by the take-over of patients for a fee of, for example, the health insurance fee for one year. For this sum, the "goodwill", there are certain maximum norms (90% of the gross yearly income according to the Royal Dutch Medical Association (KNMG) but in a period when many physicians wish to become general practitioners and when few practices are available this goodwill percentage cannot escape from the law of supply and demand and as a consequence the percentages are somewhat higher.

In addition to the sum for the goodwill, one also has to take over living accommodation and accommodation for practice and in order to set oneself up in general practice, the required investment is such that finance companies do not regard a practice of less than 2200 patients as financially viable.

In order to give an impression of the workload of Dutch general practitioners one can, as a rule of thumb, assume that for 2500 patients there are approximately 10,000 contacts per year (approximately 40 per working-day - of which 30-35 take place during surgery hours). The average duration of treatment during surgery hours is between 4 and 6 minutes. One should also realize that the patient population in a G.P.'s practice is not strictly local. Except in places where there is only one G.P., patients belonging to different practices are all jumbled up together. This is not an unimportant detail when the question of cooperation with other medical practitioners arises.

Thus far then this statistical portrait of the general practitioner. An important man (and in fact 95% of Dutch G.P.'s are men) in the world of medical practice; access to specialised clinical care is via him. He has on average the care of approximately 2700 patients. That means that he has approximately 40 contacts per day which last from 4 to 6 minutes. He is self-employed, and in almost two-thirds of his time he works alone and only exceptionally in salaried service. His income is for a great part determined by the extent of his health insurance practice, and for the care of these patients he receives a fixed amount from the health insurance fund and for the rest (and so far as one does not take into account subsidary activities - that is income from his private dispensary for the 1300 country G.P.'s, and confinements and deliveries) from the treatments which he gives to his private patients.

The general practitioner has a place in the front line of medical health care, this means that he is accessible, there are no barriers between him and the patient. In addition to the general practitioner there are a number of other practitioners who belong to this front line of medical health care and we shall try to describe the characteristics of these practitioners below.

Further practitioners in first line of medical health care

The description of the other medical health care practitioners in Dutch first line medical health care will be somewhat less extensive than that of the G.P. and in addition to a short description of the tasks and number of practitioners we will just deal with those characteristics which are important for our cooperation.
A useful characterization of first line health care practitioners is in terms of their economic status. There are therefore the independent professionals and those health care workers who are in the employment of institutions of one sort or another. As far as the prefessionals are concerned they are all paid by treatment. Chemists/pharmacists, dentists, physiotherapists and midwives are paid by the health insurance fund or (occasionally) by private insurance for the number and type of treatment which they carry out (for example physiotherapists and dentists) or for their turn-over (as is the case with chemists).
District nurses on the other hand receive a fixed income; and the same is true for that area of medical care that is perhaps not strictly a part of medical care proper, but does in fact work very closely with medical practitioners, and that is the social worker.
In the following chart the most relevant characteristics are schematically represented.

1. a very rough estimate; it is not known how a great number of physiotherapists are in fact employed.
2. including nurses among the district and health care workers.
3. calculated according to fully occupied jobs.
4. excluding teamleaders in health care and students; averaged over the year 1975.

For the charts see page 9a.

	Generally private practitioners					Generally in salaried service		
	General Practitioner	Physio- therapist[1]	Dentist	Chemist/ Pharmacist	Midwife	District nurses [2]	Social Work	Family Care
number 1-1-1978	5200	± 3300	4800	1100	800	4400	1800	35000
function	general med. care with no restriction of access	rehabilitation, of motor and muscular systems	dental care	distribution of medication	non-pathological deliveries	nursing for the chronicly sick, mother and child care	solution of social problems	family care and care for the aged
source of income	regular subscription payments for health fund patients. by treatment for private patients	for the independent practitioner by treatment - remainder on hourly basis.	limited treatment for health fund patients, extensive for private patients	profit % of turnover	by delivery + ante- and post-natal care	salaried	salaried	salaried
setting up in practice	by taking over pats. independent establishment in princ. possible	mostly in service of an independently established therapist	generally independent establishments except in areas with many dentists	controlled by Soc.of the Promotion of Pharmacy; independent establish ment sometimes possible	see general practitioner	employment based on national norms	see district nurses	see district nurses
territory	practices in general not strictly territorial	non-territorial	see G.P.	strictly related to municipal boundaries	by district	strictly limited to district or municipality	mostly strictly limited to district or municipality	see social work
peculiarities	in country districts, G.P. has private dispensary, attends confinements and deliveries.	two types of physiotherapists: 1.independent practitioner 2.in the service of one.		pharmacists gradually taking over distribution in country areas.			no new opening since 1977	quite different serv. "intake" taken care of by team-leaders

There are great differences in the manner in which practitioners of the various branches of the medical profession establish themselves in practice; the differences extend themselves to the number of patients/clients that one can take care of and the degree to which one has to do with the G.P. Contact between G.P. and dentist is minimal; they have both in theory and in practice practically nothing to do with one another. Physiotherapists on the other hand receive a good many of their clients on referral from the G.P. Furthermore in respect of physiotherapists, although in principal they form an indepent professional group, in practice one is confronted with the phenomenon that only a part (25%) is independently established and paid by treatment from the health insurance fund. The so-called "independently established physio-therapists" employ an unknown (but in practice not limited) number of physiotherapists who are either in their salaried service, or work for them on a contract basis. The chemist/pharmacist and midwife assume an intermediate position here. The work of the chemist/pharmacist has a great deal to do with that of the G.P. (the price of the prescribed medicaments make up a part of the chemist's/pharmacist's income; the pharmacist is responsible for the prescription in that he must spot (dangerous) mistakes) and furthermore those G.P.'s who have their own dispensaries, and are responsible for the distribution of medicaments in the country, have a somewhat tense relationship with the pharmacist, but both are able to do their jobs perfectly well when only strictly necessary contacts take place.

G.P. and midwife are in a certain sense competitors in those areas where the G.P. attends to his own confinements and deliveries. The compulsorily insured are only covered for the services of the midwife, in a, non-clinical, normal delivery when there is a midwife in the area. If there is no midwife (or should there be insufficient midwives) in the area, then the delivery by the G.P. will be covered. In addition the "private" patient is free to seek the service of the G.P. or midwife. Independent medical practitioners have a certain amount of freedom to choose the form

of organisation and manner of practice that suits them best. They are restricted by their social and material circumstances and by the (in most cases not binding) guidelines of their professional organisations, they are able to escape the pressure excercised by these organisations and in an extreme case can escape by giving up their membership (the Netherlands is not familiar, in medical circles at least, with the compulsory membership of a professional organisation). Recently The Society for the Promotion of Pharmacy (the professional organisation of pharmacists) had strong objections to the situation in which extra-murally employed pharmacists were to be in salaried service. However, an exception has been made for the foundations which operate health centres.

Those practitioners who, as a rule, work in the salaried service of institutions are much less free to choose the circumstances in which they work. The district nursing service has a fairly tightly controlled territorial organisation which obtains at national, privincial and local level.

The organisation of social work is less streamlined and has still the character of the local organisations for the alleviating of the social problems of the weaker members of the community; but, here too, one finds that the 200 local organisations are not in the position to counter the centrally established guidelines.

For the practitioners in the service of this organisation, their work is somewhat different from the practitioners of the independent medical professions. They are confronted with the problem of deciding to whom they must acknowledge responsibility for their services when they start to work with other people.

In summary one can say that independent medical of paramedical practitioners, who have overcome the resistance in their profession organisations, do have a great deal of freedom to experiment, which practitióners in the service of institutions do not have.

This is of very great importance to the experimental phase before the development of cooperation.
There is of course another side to this freedom: a certain laxness of approach which can seriously frustrate a systematic and planned approach. When the development is in its post-experimental phase and the decision to adopt a planned approach is taken, then there are considerable problems.

Problems in cooperation between practitioners

With the above remark we have already passed on to the following topic: a summary of the problems that one encounters in single- or multidisciplinary cooperation.
One can divide these roughly into two groups:

a) problems that have to do with the contents, as it were, of the service,
b) problems that have to do with the framework within which the service takes place.

It is easy enough to imagine the problems that arise in consequence of the contents of service. Every sort of service consists in a more or less worked out totality of ideas about the reasons why people need help and contain a number of practical guidelines in respect of how one should deal with these problems.
The degree to which these ideas are worked out, differs in accordance with the type of practitioner (this is more the case in medical science than in physiotherapy or nursing) and, furthermore, the most generally used explanatory principals differ (compare medical science with psychology or sociology).
Cooperation takes for its point of departure the view that the differing ideas about the origin and solution of problems should complement one another and that out of the Babel of linguistic confusion a new practitioner's experanto should spontaneously arise. In practice, however, there is a very difficult process of searching for points of agreement and accepting differences.
The problems concerned with the framework within which medical service takes place, are of a more concrete sort and easier to summarize.
Actually it arises from the features summarized in the previous section: on the one hand it is a question of the problems that arise when independent medical practitioners work closely together

with salaried personnel, on the other hand problems have to do with the difference in social status of the various practitioners. Finally, cooperation within the group as a whole makes certain demands in the area of setting up practice, consultation and support. When, for example, The G.P., district nurses, social workers and physiotherapists start to work more closely together and choose a communal establishment, the following practical problems can arise:

1. the total of clients/patients of the practitioners overlap, but only partly (as of 1.7.1978 this was only true in 25% of the cases for the four disciplines).
2. There is no communal employer. Even where a health centre is administered by a legally constituted body, which employs the independent medical practitioners, the district nurses and social workers are only "secounded" by their employers. In the case of conflicts, this is a handicap.
3. In a typical situation there is a hotchpotch of working and material relations. The G.P.'s may practice independently and personally employ the assistants in the practice. The independent physiotherapist has colleagues in salaried service and working on a contract basis. Practitioners in salaried service are in the service of their respective organisations. One of the organisations is, for example, the owner of the building, the others hire space. A foundation may have been instituted to promote coöperation and might be the employer without owning the building or exercising control.
4. The differences in income and remuneration that arise from this situation can be very considerable. The closer one gets to an integration of the various services and the more equal the contributions of the various practitioners become, the trickier the problem itself becomes.
5. Cooperation costs money. A part of the time is spent on consultation and verbal agreement about the services to be

rendered. The chances of resolving a series of knotty problems at top speed, are extremely limited. A good part of the extra cost is caused by the high level of investment necessary for adequate housing.

6. Furthermore, existing housing is seldom suitable for other than a strictly temporary solution. New buildings are required. This is an investment that is scarcely possible without additional financial support (the present price per square meter is about 2000 guilders - this would mean a total of 1,5 million guilders in foundation costs for a relatively modest centre with four G.P.'s, four district nurses, two social workers and two physiotherapists).
7. Cooperation under the above conditions often brings about tension between the members of the team, one has to seek the help of experts in small-group-communcations to solve such problems and this help in turn has to be paid for.

SOLUTIONS

A good many of the problems are not relevant when the team is employed by a legally constituted body or individual, who employs the practitioners and owns the building. Furthermore, when the establishment of the practice takes place in a new estate, then the chance that one will damage the established interest of local practitioners is as small as possible.
One cannot prevent other G.P.'s from establishing themselves in this estate (as has recently happened in a number of cases), nor cane one prevent those people, who have moved from the city to a new estate, from staying with their old G.P.
The extra costs of cooperation (for example, in combatting the problems of cooperation) can by means of goverment subsidy (the so-called act for the encouragement of district health centres) be kept in check for a number of years and for those teams, who employ independent practitioners, a regulation to cover the refund of their costs has recently been made available from

social service payments (under the law for special medical costs). There is only very occasionally a chance of investment subsidies from local governments, health insurance, investment regulations and unemployment measures. There is a general preference to defray the running costs, rather than assist with initial investment.

Why cooperation then?

One may well ask oneself how there comes to be any cooperation between practitioners when there are so many problems involved. What are the forces that are stronger than the unfavourable circumstances? The basis of the multidisciplinary cooperation between G.P.'s and other practitioners lies in the increasing doubt on the part of the G.P.'s about the value of the classical medical approach to many of the problems that the G.P. encounters. This train of thought, which developed within the framework of the Dutch Society for General Practice in the sixties, and was, paradoxically enough, the basis for a revival of medicine for general practice, as can be seen in the establishment of University chairs of general practice, can best be illustrated by following the development of ideas about "the general practition and sickness". The Dutch general practitioner began to realize that a great many of the cases awaiting him in his consulting room each morning (colds, sore throats, headaches, pains in the lower back, tiredness/wakness and general listlessness), were from the viewpoint of classical medicine so trivial, or at any rate so difficult to place within a medical framework, that the physician had to ask himself not so much "what is the diagnosis, or what is wrong with this patient", but "why has he come to see me with this complaint at this time". One also began to realize (particularly after the pioneering work of Huygen and his team) that the watchword, that had obtained up to that time "if it does not do any good, at least it does not do any harm", on the basis of which a good many vague complaints had been passed on for specialist examination to exclude potential dangers, in a number of cases did in fact damage the patient, even if it was just the case of some-

one with undifferentiated complaints being confirmed in his belief that he was sick by virtue of his visit to the specialist and hospital and therefore requiring extra attention from his immediate social environment.

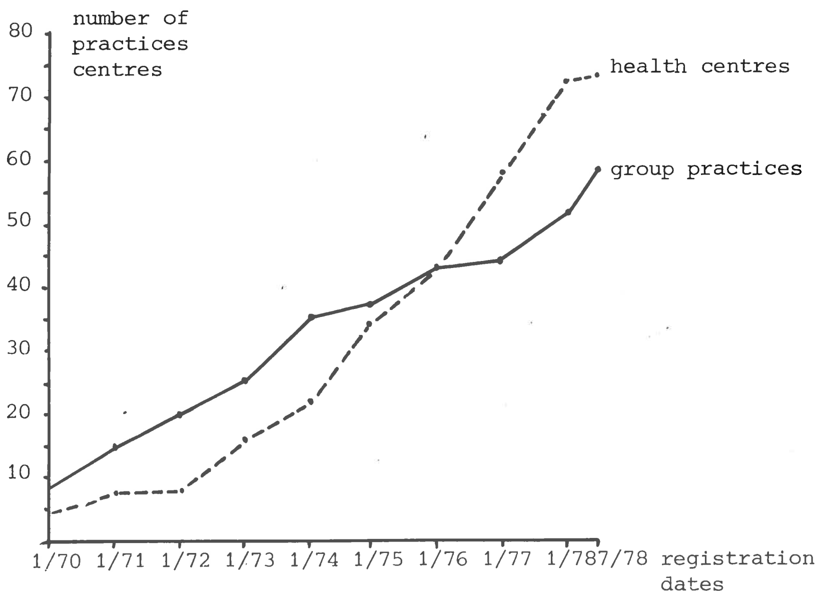
When G.P.'s (of whom it can justifiably be said that they have been the motive force behind the developments in the area of cooperation, as sketched above) come to these conclusions, then it is not so surprising that they seek support among colleagues who have undergone a different sort of training. The feeling is that the sort of classical medical knowledge that was served up to one as a student, is inadequate, but there is no clear idea as to how one should confront the many problems that one faces in general practice. (This is not to say that other practitioners have a ready answer for these problems, on the contrary, but as the proverb has it "many hands make light work" and the thought is that a cooperative approach can well lead to some solutions).

This is a synopsis of what in our view are the most important background features of the phenomenon of intensive multi-disciplinary cooperation in first line medical care, which is prospering in spite of opposition. We shall now give some statistical information.

Some statistical information on the progress of group general practice and health centres in the Netherlands

If one forgets for the moment that the Philips Electronics Concern set up a health centre for its workers as early as 1920, one can say that the first group practices and health centres appeared in the Netherlands at the end of the sixties.
Our overview begins in 1970 with 8 group practices and 4 health centres. Since then the number has systematically increased, the health centres growing faster than group practices. A number of the group practices have developed into health centres, and this is probably part of the reason for the slowing growth of the group practices.
In the graph below the development, starting in 1970, is sketched our

Graph 1 : the number of group practices and health centres in the Netherlands for the period 1.1.1970 to 1.7.1978.



As of 1979, there have been more health centres than group practices. Despite the sombre prognosis on the viability of this new form of health care, only one health centre has failed. The number of group practices which have failed is also no more than three. We do not know how many plans have come to nought in an early stage because of the pressure of circumstances.

DISTRIBUTION IN THE NETHERLANDS

Generally speaking group practices and health centres are situated in the more heavily populated areas of our country. An exception to this is formed by the health centres which have been set up according to plan in newly reclaimed areas (polders) namely the IJsselmeerpolders where all G.P.'s are employed in health centres.

In Table 1 the total number of G.P.'s working in group practices and health centres per area. Furthermore, this number is related to the total number of G.P.'s.

Table 1: number of G.P.'s as of January 1978 in group practices and health centres per area.

	number grp. practices	number health centres	number G.P.'s Grp.Pr.	number G.P.'s H.Centr.	total number G.P.'s	% G.P.'s in Gr.Pr.	% G.P.'s in H.Centres
North Gron.Friesl. Drente	6	6	23	21	634	3.6%	3.3%
East/middle Overijs. Geld. Utr.	20	17	63	51	1306	4.8%	3.9%
West N.H., Z.H., Zeeland	12	32	32	116	2148	1.5%	5.4%
South N.Brabant Limburg	19	13	58	36	1056	5.5%	3.4%
IJsselm. polders	0	6	0	19	19	0	100%
the Nether-lands total	57	73	176	243	5163	3.4%	4.7%

One encounters proportionally fewer group practices in the west and more in the south. Health centres, except for the example already given of the polder areas, are more common in the heavily populated west of the country.

THE COMPOSITION OF GROUP PRACTICES AND HEALTH CENTRES

Answers to questions as to the composition of groups practices and health centres vary considerably. As far as group practices are concerned, it is only a question of the number of doctors and assistants in the practice. For health centres it is much more a question of composition in terms of the type of medical/para-medical practitioner.

GROUP PRACTICES

On July 1, 1978 (the most recent date for which we have figures in the registration system of group practices and health centres at the Dutch Institute for General Practice) 39 (68%) of the 57 group practices comprised no more than three physicians and scarcely 4 (7%) comprised five or more physicians. A group general practice in the Netherlands is therefore a comparatively small scale phenomenon the average number of G.P.'s is between 3 and 4.
The average number of assistants per group practice is 2.9
The average number of total personnel is 4.3
The entire practice generally comprises no more than 7 persons.

HEALTH CENTRES

With health centres the situation is somewhat more complex. We shall first consider the development in terms of the number of medical/paramedical disciplines represented and then we shall consider the number of practitioners per discipline.

NUMBER OF DISCIPLINES

In table 2 is the distribution according to frequency of the number of discplines for a number of years between 1970 and 1978.

Table 2: frequency distribution of the number of disciplines in health centres 1970 - 1978.

number of disciplines	1970	1972	1974	1976	1978
3		1	3	8	11
4			7	6	20
5	1	2	4	12	18
6	1	2	5	5	13
7	1	1	2	9	5
8	1	1	1	1	4
9					
10					
11				1	
12					1
averaged number	4.5%	5.7%	5.0%	5.2%	5.0%
number of health centres	4	7	22	42	72

Scarcely 11 of the 72 (15%) of the health centres were staffed by personnel from the three central medical disciplines. On average about five disciplines are represented, together with their assistants, which all goes to make a health centre a somewhat complicated whole.

NATURE OF THE DISCIPLINES REPRESENTED

What sort of medical/paramedical practitioners are to be found in a health centre now?
In addition to the G.P., social workers and district nurses, one often encounters physiotherapists, midwives and family care workers. In table 3, we give an overview of the total from 1970. We give figures for those centres with more than three disciplines represented.

Table 3: distribution of the disciplines among health centres with 4 or more disciplines 1970 - 1978.

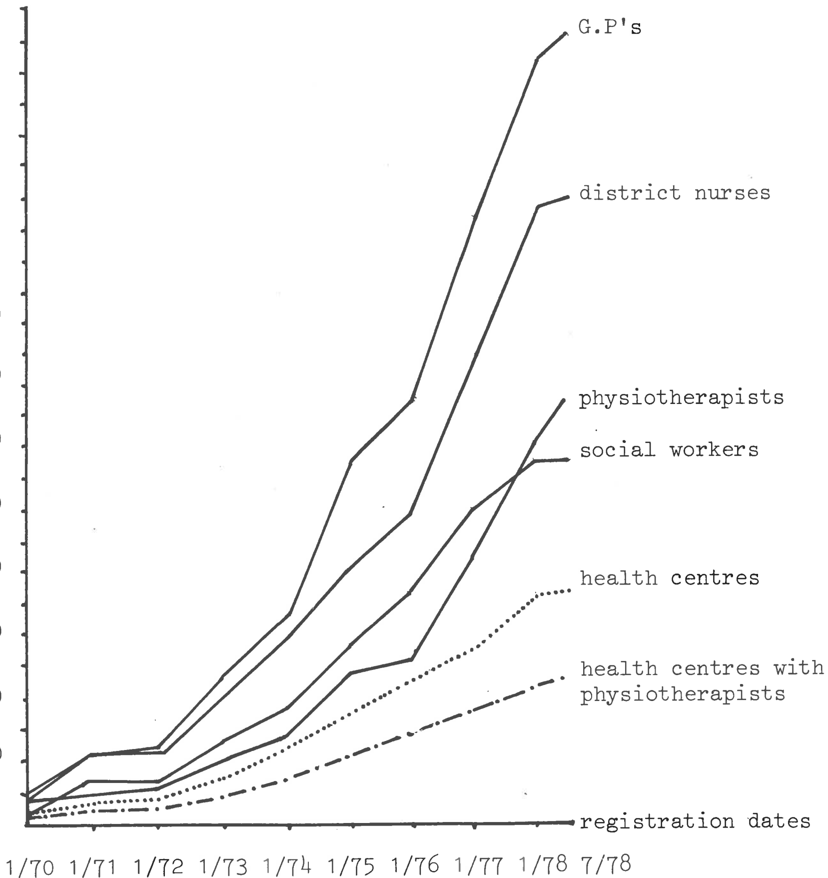
year / discipline:	1970	1972	1974	1976	1978
physiotherapy	3	4	12 (63%)	24 (71%)	42 (69%)
midwifery	1	2	5 (26%)	13 (38%)	17 (28%)
family care	2	3	5 (26%)	10 (29%)	18 (30%)
dietetics	2	2	2 (11%)	10 (29%)	10 (16%)
dentistry	2	2	5 (26%)	9 (26%)	12 (20%)
care for the sick	1	2	6 (32%)	7 (20%)	13 (21%)
care for the aged	-	1	2 (11%)	6 (17%)	7 (11%)
pharmacy	2	2	4 (21%)	7 (20%)	12 (20%)
psychology	-	-	1 (5%)	4 (11%)	4 (7%)
remedial education	-	-	-	1 (3%)	2 (3%)
maternity care	1	1	1 (5%)	1 (3%)	1 (2%)
social wel-fare work	-	-	-	-	1 (2%)
practical nursing	-	-	1 (5%)	1 (3%)	1 (2%)
pastoral care	-	-	-	1 (3%)	2 (3%)
development work	-	-	-	-	1 (2%)
number of centres with 4 or more disciplines	4	6	19	34	61

Over the years a number of trends become clear: the share of physiotherapy stays at about 70%, the other disciplines fluctuate slightly, but there are no great changes in composition.

NUMBERS OF PRACTITIONERS IN HEALTH CENTRES

In addition to the number of health centres an overview of the number of medical/paramedical practitioners per discipline is of importance. We shall show these numbers in the form of a graph. In this graph we show the total number of practitioners. For illustration we give the total number of health centres and for the physiotherapists the total number of centres which employ physiotherapists.

Graph 2 : numbers of G.P.'s, social workers, district nurses, physiotherapists employed in health centres between 1970 and 1978.



Two things immediately meet the eye. The contribution of the social workers has remained unchanged since 1977. This has to do with the fact that no positions are being filled in general social work, it means that as vacancies occur they will not be filled. This has not only consequences for the figures on the graph, but if a vacancy is not filled, then the workload has to be redistributed among the remaining social workers. In consequence the effect of this halt in the employment of social workers is stronger for the figures that have been corrected in terms of full-time or part-time employment.
Physiotherapists, on the other hand, are increasing in number. The number of health centres, in which physiotherapy is represented, is climbing steeply, but this is not out of proportion with the general increase in number of centres. The total number of physiotherapists per centre is increasing more quickly. In the introduction we have already spoken of the flexability with which physiotherapists are able to expand their activities (a so-called independent therapist can employ a considerable number of colleagues on a contract basis). This added to a rapid increase in the number of therapists (the schools of physiotherapy produce about 1000 - 1100 new physiotherapists each year, this is on top of a total of 10,000 physiotherapists already registered, they are not, however, all employed in first line medical care) and a fee structure based on treatment leaves one to expect a further rapid increase in their numbers. The number of district nurses keeps pace with the number of health centres; there is no question of stagnation nor is there a question of an explosive increase in their numbers.

PATIENT/CLIENT TOTALS

Finally we shall shed some light on one of the most important practical problems in cooperation between practitioners from differing organisational backgrounds. This is the problem of territory in respect of the compass of one's activities. The

Dutch Health and Welfare System offers practically no possibility of agreement on territories other than on the basis of free choice by a great many individuals and institutions.
Choice of doctor is free and the establishment of a practice is also in principal free; even when all parties are agreed that a health centre is to be set up in a particular area, it is still impossible to prevent an indivudal from setting up a practice in that area.
For those practitioners, who are organised on a territorial basis, such as district nurses and social workers, it is not impossible for them to adapt themselves to the patient population of the G.P.'s. But it does have a very disturbing effect on the organisation. Take, for example, a new estate in town A., where the local government together with medical and paramedical practitioners has established a health centre.
Of the 15,000 inhabitants 10,000 are the patients of the 4 G.P.'s belonging to the centre. The addition of a fifth G.P. to the total at the centre is endangered by a recently established new G.P., who in the space of one year has been able to acquire a 1000 patients. Furthermore, there are 3,000 patients who are not prepared to leave their 'old doctor' in the part of the town where they originally came from. And of the 1000 remaining patients (private patients in this case, because they are not registered with the health insurance fund), no one knows whose patients they are. In any case they make no claim on the centre.
The district nurse and the social worker are responsible for the whole district, and they cannot discuss the problems of a third of their clients in the team conferences and so have to create another forum for discussion not only with the independent G.P., but also with twenty different G.P.'s from the old part of the town, as these people have the care of 3000 of their patients.
This is just an example. The situation can be even more complicated when te G.P.'s have not restricted their intake of patients to a certain area. If one tries to get a complete overview then, as of July 1, 1978, the following picture emerges (73 health centres).

Table 4

Comparison of patient/client totals in health centres per G.P., district nurse and social worker as of July 1, 1978.

	numbers of centres:
1. G.P.=D.N.=S.W.	32
2. G.P.=(D.N.=S.W.)	18
3.(G.P.=D.N.)=S.W.	6
4.(G.P.=S.W.)=D.N.	9
5. G.P.=D.N.=S.W.	8
	73

The situations under 1) and 5) are clear enough. In the one case the totals are calibrated with one another (albeit at the cost of organisational problems in respect of the district nurse and social worker), in the last case all of the total differ from one another which causes problems within the team.
The second case, in which district nurse and social worker have the same total of patients, the G.P.'s differ. This is the case that one often finds in new estates. In the third and fourth cases there is a calibration between the G.P.'s total and one of the two other practitioners, but not with both.
In other words this problem of the calibration of areas of activity brings a good many problems in its train.

IN CONCLUSION

We have given a bird's eye view of some aspects of group practice and health centres in the Netherlands. A great deal of attention (more actually than on the centres themselves) has been paid to the situation within which the developments of group practices and health centres have to be placed.
The Dutch Health and Welfare System has certain characteristic features, which have assisted the rise of health centres and multi-disciplinary cooperation. We hope that we have given some insight into these factors.

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