Australian general practice. Whether the new GP contract will improve experiences and outcomes for patients, at a cost the NHS can afford, remains to be seen. On the downside, many GPs believe the wider healthcare service has not been able to accommodate the needs of patients in recent years; this may, despite the best efforts of individual primary care teams, lead to a demoralised workforce.

Towards the end of New Labour’s second term, the NHS is being pulled in several directions — involving performance management, quality payments, new contracts, and greater engagement with the private sector, including American managed care organisations. The competition and “constructive dissonance” of these changes is very reminiscent of the Thatcher reforms. How general

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

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

Over the years, Dutch GPs have been jealously protecting capitation payment and tried to exclude any financial biases that might affect their performance. Allowances in the actual money received have been made for the number of elderly and migrants on the practice list, compensating for the extra burden of illness and GP care needed. This has maintained relatively equal status among Dutch practices and helped to strengthen the corporate identity of GPs.

How general practice is funded in The Netherlands

Chris Van Weel

The Department of General Practice, University Medical Centre Nijmegen, Nijmegen, The Netherlands.

Chris Van Weel, PhD, FRCGP, Head.

Chris Van Weel is in charge of the Nijmegen research program on common chronic diseases in general practice (asthma, chronic obstructive pulmonary disease, diabetes mellitus, depression). This program seeks to improve the evidence base for general practice care. He is also a member of the executive of the World Organisation of Family Doctors (Wonca).

Reprints: Professor Chris Van Weel, Department of General Practice, University Medical Centre Nijmegen, PO Box 9101, Nijmegen, 6500 HB, The Netherlands. c.vanweel@hag.umcn.nl

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

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

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

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

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

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

References

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Family physicians (FPs) in Canada undergo specialised training, often in a Family Medicine Residency, and complete the College of Family Physicians of Canada (CFPC) national certification examination. Their payment is negotiated and administered separately by the 10 provincial governments and three territorial governments, using different funding arrangements in different settings. Under the Canada Health Act, provinces will be financially penalised if they permit private billing by physicians or copayments by provincially insured patients other than for certain services funded by third parties, such as insurance medical examinations, reports and travel services.

In 2001, FPs reported practising in private offices/clinics (73.1%), community health centres (7.1%), emergency departments (6.7%), hospital in-patient units (3.3%), walk-in clinics (3.1%), and family medicine teaching units (2.5%). National surveys confirm that fee-for-service continues to be the main form of remuneration for physician services (Box), with little apparent change between 1997 and 2001.

The drive towards alternative payment methods
Under the current healthcare system, 12% of Canadians (with considerable geographical variation) report having unmet healthcare needs. Millions do not have access to an FP, and emergency department waiting times are long. FPs have identified high levels of dissatisfaction with current workloads and working conditions. Governments appear to believe that alternative funding arrangements will address these problems and are the key to involving FPs in primary healthcare reforms. Alternative payment approaches combine fee-for-service, capitation (lump sum payment per patient managed over a given period), salary, sessional and other funding arrangements. Other, less common funding arrange-