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 practice is funded in The Netherlands

Chris Van Weel

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

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

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

How it works

• General practitioner payment is based on a two-tiered system depending on patients’ income:
  • Capitation fee for Sickfund-insured patients (70% lowest income; in 2004, up to €32,600/year for people younger than 65 years. As the insurance includes the period after retirement (“pensioners”), the cut-off income for people 65 years and older is €20,750/year.
  • Fee-for-service payment by the 30% highest-income privately insured patients, who do not contribute to the Sickfund.

• Capitation fee is the payment a GP receives from the Sickfund for each patient on the practice list, regardless of whether the patient decides to consult the GP. Sickfunds pay the capitation fee out of the insurance contribution received from their insured members. This fee fully covers all GP services for that patient, including the GP’s income and a proportionate contribution for practice costs.
  • The capitation fee is extended to family members who do not generate income of their own.
  • Employee and employer pay 8% of the income for Sickfund contribution (1.25% by the employee, 6.75% by the employer).
  • There is no direct government involvement.

• Key to access to general practice care is registration of the patient with the GP or practice, establishing continuity of care over time.
  • For Sickfund-insured patients, registration is obligatory for access to care.
  • For privately insured patients, registration is usually not required, but most patients do list with a practice and obtain care from the same GP or practice over time.

• Through registration with a GP, primary care remains the foundation of healthcare: patients receive their basic medical care through the GP and the primary care team, and specialist care is only available through referral by the GP.

References

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GP FUNDING – VIEWPOINTS

How general practice is funded in The Netherlands

Chris Van Weel

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
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-