Health Policy, 13 (1989) 225–237
Elsevier

HPE 00303

Local housing scheme and political preference as conditions for the results of a health centre-stimulating policy in The Netherlands

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Accepted 8 October 1989

Summary

About two decades ago, changes in the demand for primary care in the Netherlands resulted in a need for more interprofessional collaboration. Health centres developed as a new supply of integrated care. The government was aware of the importance of this phenomenon in its policy to strengthen primary care. The encouragement of health centres was a crucial part of it. The development of this policy and the resulting growth in the number of health centres will be reviewed here. In general, this growth is lagging behind initial policy expectations, partly because of a lack of instruments to implement PHC policy. Examination of geographical distribution of health centres, however, shows a variation suggesting that local factors also affect the development of health centres.

Empirical findings show that the number of newly built houses in an area and the political 'colour' of the alderman for public health play a role in the development of health centres and thus co-determine the results of a central promotion policy to a certain extent.

Health centre; Primary care policy; Housing policy; Local politics

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Introduction

At the end of the sixties and the dawn of the seventies, consciousness grew in the Netherlands that the traditional single-handed general practice left much to be desired. The small scale of this setting is a poor basis for professional peer review and limits the possibilities of efficient purchase and use of diagnostic and treatment equipment.

In addition to this problem, general practitioners, being confronted with a shift in the complaints presented and changes in health care needs in the population, felt the shortcomings of the monodisciplinary approach. These insights led to two types of concentration: partnership and group general practice on the one hand and multidisciplinary health centres on the other*[1]. As will be outlined, the Dutch government recognized the importance of collaboration as a means to improve the problem-solving capacity of Primary Health Care*: it could counterbalance the unbridled extension of specialist and hospital care. In contrast with other countries such as the United Kingdom and Denmark, where the policy was aimed at increasing the number of group practices, in the Netherlands multiprofessional collaboration between GPs, district nurses, social workers, physiotherapists, home helps etc. was a focal policy issue. Especially the policy measures to promote health centres over the last 15 years can be viewed as unique.

The aim of this article is to outline the intentions and measures of the government policy in this field and to compare these with the resulting developments. Discrepancies between goals and actual development will point to the possible role of local factors in the establishment of health centres. We shall examine two of these in greater detail: the volume of newly built houses in the municipality, and the political colour of the alderman for Public Health.

For a clear understanding, however, we have to start with a brief overview of the instruments the Dutch government has in steering the health care system.

Scope for making health policy in the Netherlands

Because of the fragmented structure of the health care system, the government has limited means for an effective policy. It's true, there are statutory regulations on the aspects of quality in the provision of health care geographical accessibility and financial control. In the executing policy, however, several autonomous nongovernmental organizations are concerned. A major handicap is the separation of planning and financing in the health care system. Most of the health care

* In the Dutch health care system, a health centre is a formalized collaboration of at least GPs, district nurses and social workers in shared premises. Usually more professionals are involved, such as physiotherapists, home helps, midwives and pharmacists.

* The concept of Primary Health Care is used here in a narrower sense than its WHO meaning. In the Netherlands it refers (roughly speaking) to the directly accessible facilities of health care (the so-called first echelon). Most population-based prevention is excluded and provided in an autonomous structure without any great relation to curative care.

funding comes – apart from general taxation – from special premiums, partly from employers partly from employees, and is distributed to the providers of health care. For about 35% of the population health care costs are financed by private insurance companies: 65% is publicly insured by one of the so called 'sick funds' (health insurance funds).

The organization of primary health care is perhaps the most fragmented of all. Family medicine, physiotherapy, midwifery, dentistry and pharmacy are usually provided by independent contractors. District nurses, social workers, home helps, dieticians and maternity home nurses, on the other hand, are employed by local or regional nonprofit foundations.

Given this structure, the government has few instruments for controlling supply and demand, let alone that it is in a position to force providers to collaborate. The success of a restructuring policy is always dependent on the voluntary cooperation of the parties concerned. That is why a state policy on primary health care in general has the character of an extension policy in which grants and other attractive conditions are offered to achieve new aims.

Government policy on health centres since 1974

The year 1974 is a turning point in government involvement in the Dutch health care system. The appearance under a centre-left administration of the departmental Green Paper on the Structure of Health Care [2] marks the end of a period of laissez-faire. The Green Paper notes a need to curb ever growing costs and to increase coherence between facilities. There should be a shift in emphasis from institutional towards ambulatory care and prevention. The ideas of this Green Paper have been trend setting for at least a decade. The most important policy proposals as laid down in the Green Paper are:

- *decentralization*, i.e., cohesive planning and management in restricted geographical areas;
- *structuring of health care*, i.e., facilities with common features put together in one organizational frame, and separation of ambulatory general care (the directly accessible 1st echelon) and hospital and specialist care (2nd echelon);
- *strengthening the first echelon*; multiprofessional collaboration in integrated health centres was considered to be a major step towards improving primary care and achieving a substitution for specialist and hospital care.

Besides restrictive measures in secondary care, such as bed number reduction and a budget system for hospitals, an incentive policy on behalf of well-structured team work in primary care has been developed. For this purpose a development fund was created. Under these so-called 'Stimulation Regulations', formalized teams could qualify for a number of well-defined costs, such as costs for team counselling, for starting special projects or experiments, conference costs, administration and registration, costs of improving professional competence, costs

on behalf of involving the population and housing, and management costs.

Later on, in 1978, an additional financial provision on behalf of health centres came about to reimburse the extra costs of collaboration for which the Regulations mentioned were not sufficient. It was financed by a general fund and administered by the Public Health Insurance Board. The figure below shows the budgets on behalf of the two sources of subsidization of health centres.

The volume of the budgets is related to the policy measures taken. For instance, the amount of the Stimulation Regulations grows with the number of established health centres. The steep increase since 1983 is related to a decision to re-allocate means in order to promote collaboration. The budgets of the General Fund have been rising sharply since the new arrangement in 1978. After a few years budgets were decreased because there was a stricter financial supervision on starting health centres, and demands for financial support were less than expected.

Although the two subsidization sources are vital for health centres, they leave the unsuitable financing system unchanged. Moreover, their provisional status means an uncertain basis for those who intend to fund a health centre.

In the eighties, the policy on teamwork in primary care was continued and extended. This is evidenced by Green Papers in 1980 and 1983, both exclusively dedicated to Primary Care [3,4]. Here again the need for more coherence and integration in this part of the Health Care is stressed. It is established that implementation of the policy aims is lagging behind expectations. One is confronted with structural impediments for change (for instance a lack of planning power)

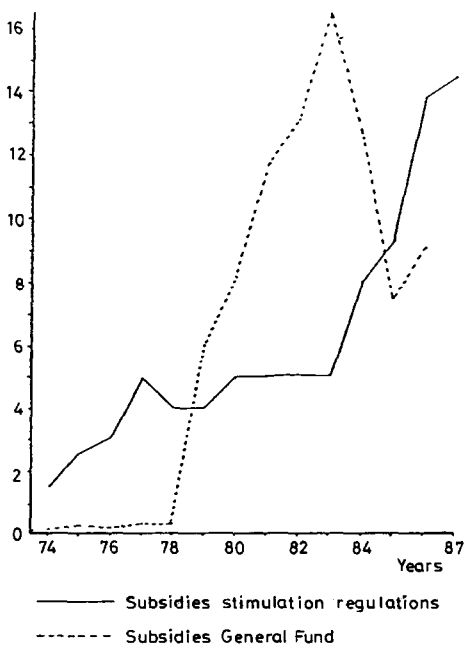

Fig. 1 Budgets of subsidization schemes on behalf of health centres 1974–1987.

and legislation remains behind*. Nevertheless, new actions and intentions have been announced. Budgets for the subsidization of health centres are being raised (see fig. 1). Home help is appointed as a so-called 'core discipline' beside GPs, district nursing and social work. The government will try to convince the parties to increase coherence in catchment areas and task packages. In addition, the regional support network, already realised since 1976, will be enlarged and there will be more scientific research, especially into the effects of multiprofessional collaboration in health centres. The need for this research arose from concern about the surplus value of health centres compared to the extra costs of subsidization. This need for information has been at least partly fulfilled by results of a research project in which GPs in health centres proved to have lower referral rates to specialist and hospital care than their colleagues working in other settings, even if intermediating variables are controlled for [5,6]. These differences result in savings that exceed the extra costs of subsidization more than threefold. This is an important argument to continue the current subsidization scheme. As years went by, however, the appeal to health centres to prove themselves has become stronger. No longer is good collaboration between providers of primary care sufficient; the centres will have to prove their claims more and more. The changed government policy on health care since 1986 may, in the long run, pose a threat to the existence of health centres.

The policy has shifted from 'structure' to health and demand for care [7]. Although current stimulation measures have been left intact, health centres have been accorded, in contrast to former Green Papers, only a modest position in the new policy. The government expresses some disappointment about the possibilities to convert principles in concrete policy. Another trend has been set by the proposals of an expert Committee on the Structure and Financing of the Health Care System in 1987 [8]. In its report, a market orientation is introduced in which financial incentives have to improve the efficiency and quality of care. A strong cost-consciousness and competition have to provoke co-operation aimed at providing the best care at the least cost. Combined with a retreat of the government, also from regulating health care, these developments may be a challenge as well as a danger to the survival of health centres.

* The Health Care Provision Act provided for planning procedures and responsibility at a decentralized level (provinces and municipalities). This act was to contain health facilities licensing requirements to implement coherence and joint working among other things. Being a Skeleton law it had to be filled in later by measures of the Minister of Health. Three reasons for its withdrawal can be mentioned: (1) growing insight that planning without funding competence makes little sense; and (2) a more general policy of government withdrawal and less bureaucracy; (3) the impossibility to create an appropriate level of decentralization between the 12 provinces and the 700 municipalities.

Development of health centres in the Netherlands

Now we come to look at some results of the above-outlined policy. The earliest health centres came about by the end of the sixties. In 1974, the year we started our description of health centres policy, their number was 21. And nowadays a number of 153 can be viewed as the result of this policy in the Netherlands [9]. Table 1 shows the relative number of workers of four disciplines integrated in health centres, and the percentage of the Dutch population registered with a GP in a health centre.

Table 1
Percentage of professionals working in health centres and percentage of the Dutch population registered with a GP in a health centre [9,10]

Professional population	% involved in health centres
GPs	7.5
District nurses	7.6
Social workers	11.1
Team leaders home help	2.3
Dutch population	6.7

Health centres appear to have a limited significance in a quantitative sense in primary care in the Netherlands. (Qualitatively speaking they may play a more important role in professional innovation.) Only a modest proportion of the ambulatory health professionals is working in this setting and less than 7% of the 14.7 million Dutch is on the list of a GP in a health centre. Apparently it is difficult to integrate home help in health centres, although this discipline often is indispensible in home care.

We will consider now in more detail the annual increase of the number of health centres since 1972. Being interested here in establishment factors, we will view gross increase numbers*. The graph below shows the yearly number of newly established health centres. A distinction is made in the kind of places they were erected in.

Although it is difficult to relate policy measures to the time-consuming erection of health centres, it is likely that the peak of 1976 and 1977 at least partly results from the 1974 subsidization measures. After these years the trend is downward, and nowadays the annual increase seems to have stabilized at 5 or 6 new centres. Considering the places of establishment, health centres show a very

* In this context we leave aside the former health centres. Since 1972, 11 health centres have no longer met with the criteria to be regarded as such. Two of them have never been vital teams. In three cases, Cross Association or Social Work Association decided no longer to use the shared premises; however, without stopping the collaboration. In four cases, one or more of the participating parties terminated the collaboration, and in two cases there were financial or economic reasons for closing.

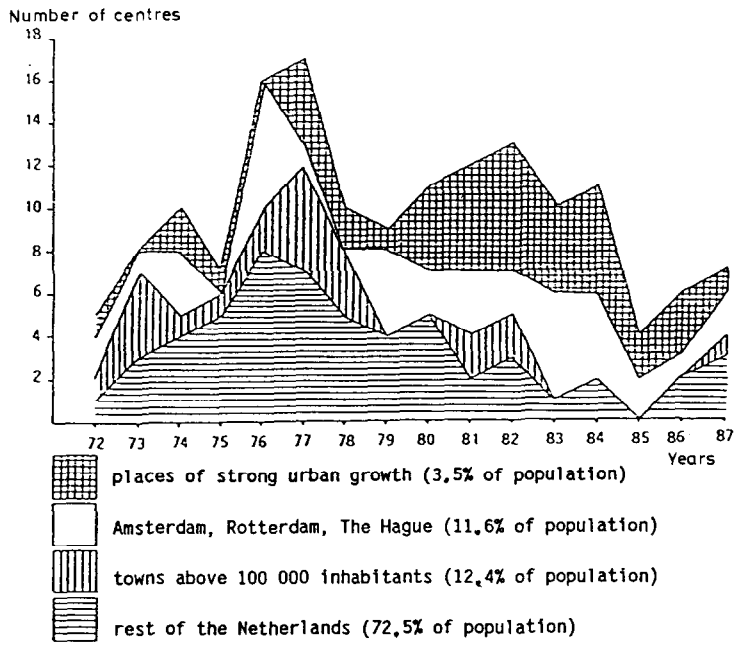

Fig. 2 Annual (gross) increase of health centres in different types of places of establishment 1972–1987 [9].

uneven geographical distribution. In places of strong urban growth, for instance, where only 3.5% of the Dutch population is living, well over 20% of the health centres is situated. To give insight into this location factor, the annual increase as represented in Fig. 2 is broken down into four location categories: (1) those of strong urban growth; the three largest cities, Amsterdam, Rotterdam and The Hague; towns above 100000 inhabitants and other parts of the Netherlands. It is interesting to see that the increase in the years up to 1980 has taken place to a large extent in the unspecified 'rest of the Netherlands'. The new centres in places of strong urban growth (among which new towns such as Almere) and to a lesser extent the three biggest towns are responsible for most of the increase in the years 1980–1985. It is also clear that in the eighties, only a small number of new centres developed in other towns with a population of over 100000 inhabitants. From this we may cautiously conclude that, except in the three cities mentioned and in places of strong urban growth, the potential for the establishment of health centres has obviously been low in the Netherlands and that most of this potential was already fulfilled by 1980. Policy has not been able to make already established GPs join a health centre.

Local factors in creating health centres

The uneven distribution of health centres over the country points to local conditions favouring or impeding the creation of health centres. From the polls we conduct in the field of existing and coming centres*, we know it takes several years to establish a health centre. By definition at least three disciplines are involved. Besides GPs, one or more Cross Associations and institutions of Social Work have to participate by posting workers in the centre. We know this is not always possible due to other priorities or understaffing. If colleague-GPs in town do not tolerate the new centre because they think there is no room for more GPs it will be much harder for the centre to function (for instance because colleagues are not available for locum tenancy). Due to Local Establishment Regulations, GPs can only settle if a certain population ratio is not exceeded. Practically speaking, this means that health centres have been (and will be) erected in new housing estates or in underserved redevelopment areas. It will be clear that the active cooperation of local authorities – among other things, in adapting area plans – can be of significance. Last but not least, the local Public Health Insurance can facilitate the foundation of a health centre. In Fig. 3 we summarize these local determinants.

As can be derived from the diagram, the factor 'room for new establishment' is considered to be a prerequisite. Only if this condition is met, can an initiative

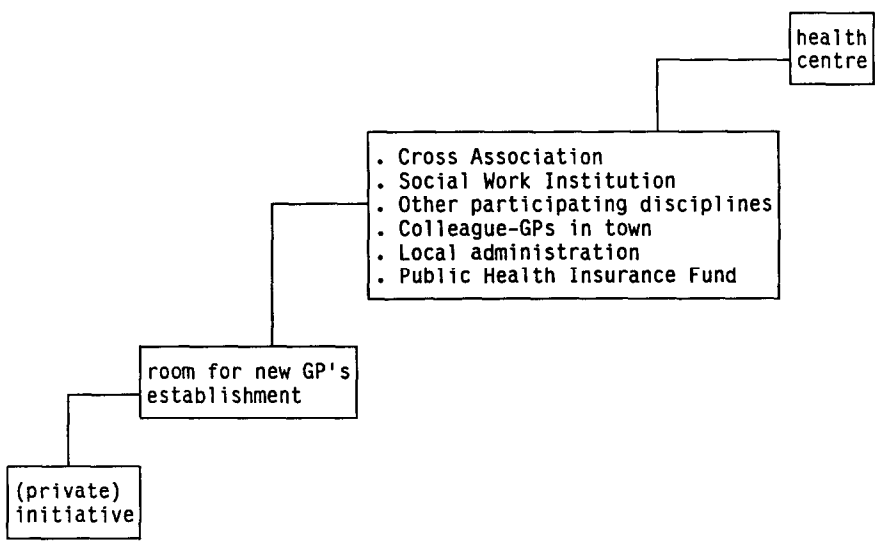

Fig. 3 Diagram of local factors determining the establishment of health centres.

* In the Netherlands Institute of Primary Health Care (NIVEL) a registration is kept of health centres and other forms of teamwork in primary care. The basic data on health centres are available from 1970 onwards. The system is updated by annual polls conducted by telephone.

ever be successful. We will later return to this point. Now we turn our attention to the possible role of local authorities in supporting health centres.

As a result of the withdrawal of the newly made Health Care Provision Act (see footnote on p. 229) there will be no change in the very modest role municipalities play with respect to primary care. They have only a few tasks and powers in this field. Therefore, local policy on health care is mainly the result of priority choices and that is why there is variation between municipalities in their activity towards interprofessional collaboration in health centres. A striking example is the difference between Amsterdam (690000 inhabitants, 17 health centres) and the Hague (440000 inhabitants, 3 health centres). The greater number of health centres in the nation's capital cannot just be traced back to its size and the fact that a greater part of its extension took place within its boundaries when compared to the Hague. A study devoted to this matter points to clear differences in health care policy between these two cities. Amsterdam has been earlier and more active in developing health centres than the Hague [11]. In cooperation with the local Sick Fund, the Amsterdam administration even in the early seventies developed an additional subsidization scheme and a support structure. In the Hague, it was not until the eighties that priorities were directed more towards health centres; however, without the measures as mentioned in relation to Amsterdam.

Another broader survey points out the effects of an active local policy on the presence of health centres (although this effect may also be the other way round) [12]. Most municipalities appear to subscribe to the government policy and think they have to play a role in supporting collaboration in primary care (not necessarily in health centres). Viewing their actions, however, municipalities as a rule do not turn out to be very actively sustaining. The study mentioned showed that differences in attitude between local administrations are independently related to political factors. The composition of the town council and the political colour of the alderman for public health determine to a certain extent to position in this area. In the Netherlands in general, left wing parties are more inclined to an active stimulating role of the authorities. Although health centres are not a hot political issue (the government policy outlined earlier which was initiated during centre-left administration has not been reversed by the centre-right cabinets that followed) social democrats and other left-wing parties are more dedicated to the creation of health centres than are christian democrats and liberals who tend to stress pluriformity and adapt a more laissez-faire position. In the last part of this article we will describe some results of an investigation into the relationship between the geographical distribution of health centres and two local factors out of the diagram shown in Fig. 3: room for new establishment and the alderman for public health as a key representative of the local administration with respect to these affairs.

Political colour of administrators, number of newly built houses and the development of health centres: empirical results

We wanted to test the hypothesis as to whether and how far room for new establishment and local political factors affect the creation of health centres. As an indicator of room for new establishment we have taken the absolute number of newly built houses in the municipality between 1974 and 1986 [13]. The indicator of the local politics is the political party to which the alderman for public health belongs [14,15]. We again considered the period 1974–1986 as being three formal terms of four years each. In distinguishing the political signature, we labelled the categories left/centre-left wing and right/centre-right wing. Given the three terms, each municipality got one out of four possible scores from three times 'left wing' to three times 'right wing'.

The analysis has been conducted for the 103 municipalities of at least 30000 inhabitants. We made this selection because possible locations of new health centres appear to need a certain scale. The results are shown in Table 2.

Table 2
Newly built houses and political persuasion of the alderman for public health as local determinants of the establishment of health centres 1974–1986 [12–14].

Percentages of municipalities with one or more health centres

Political colour alderman PH	newly built houses 1974-1986			total municipalities
	up to 4000 (%)	4000-8000 (%)	more than 8000 (%)	(%)
Mainly Right-wing*	17	35	71	100 (*N*=66)
Mainly Left-wing*	10	57	85	100 (*N*=37)
Total	15 (*N*=39)	41 (*N*=30)	79 (*N*=34)	100 (*N*=103)

* mainly right wing = christian democrats, liberals, small right-wing parties and local parties in two or all three periods between 1974 and 1986.
mainly left wing = social democrats, left-wing liberals and small left-wing parties in two or all three periods between 1974 and 1986.

First of all, the marginal values of Table 2 show the prominent role of building capacity: of the 39 towns with less than 4000 newly built houses, only 15% has one or more health centres. With the increase of this capacity, the percentage of towns with health centres rises as well, so that in 79% of the places with more than 8000 newly built houses at least one centre is established. The overall effect of the political colour of the alderman for public health is not valid for all three building conditions. In the two highest building-capacity categories, towns with left-wing aldermen show higher percentages of health centre establishment. In the

Table 3
Analysis of variance between towns with more than 30 000 inhabitants of the effect of political colour on the percentage of GPs in health centres

	Sum of squares	*df*	*F*	sign. of *F*
Main effect				
political colour	2579.1	3	4.8	0.004
Covariate				
housing scheme	4579.5	1	25.7	0.000
Explained variance	7158.7			
Total variance	24600.6			
% explained	29.1			

Table 4
Deviations from the grand mean of the percentage of GPs in health centres for political colour categories before and after adjustment for the effect of housing schemes

grand mean: 9.31

Number of 'left-wing terms' (out of 3)	Before	After	*N*
none	−5.61	−4.00	36
1	−0.52	0.93	30
2	9.71	8.59	22
3	0.25	−4.86	15

lowest category this relationship is absent; in these places 'left-wing' aldermen are even related to a lower percentage than their 'right-wing' colleagues.

We made yet another analysis in which we used the percentage of GPs in the municipality established between 1974 and 1986 in a health centre as the dependent variable [1,9]. The effect of the political colour of the alderman for public health is examined while controlling for the factor 'housing scheme'. Tables 3 and 4 show the results of the analysis of variance procedure.

From Table 3 we conclude a significantly independent effect of both political colour and housing scheme, although the weight of the latter exceeds the former by far. Together these two variables explain 29% of the variance of the dependent one. Table 4 shows a rather consistent picture before adjustment for the number of houses built: municipalities without a left-wing alderman for public health in all three terms score mostly below the mean percentage of 9.31 and the category with one left period also show a negative deviation from the grand mean. Both other categories of towns are situated above the mean, although the last one only slightly.

After adjustment, this last category with left-wing aldermen in all three terms shows a dramatic change; they appear to have an even more negative deviation than the first category. This means that their initial positive score has to be attributed to the high volume of houses built. In the three other categories the relationship remains linear.

From these results we conclude that there is a clear relationship between the number of houses built in a certain municipality, and the creation of health

centres. In this respect, the political colour of the alderman for public health is also relevant, although of much less importance, and this relationship appears to be nonlinear. Instead of the highest expected percentage of GPs established in health centres in the three-terms category, these municipalities score low. The other categories show results conforming to the expectations. The deviant position of the municipalities with a left-wing alderman in all three terms remains somewhat puzzling. A possible explanation for this finding is that in these 'stable left-wing' conditions there is less need to stress one's distinctive features, for instance by promoting health centres.

Conclusion

Despite an active stimulating government policy over the past 15 years, only a modest part of the primary care in the Netherlands is concentrated in health centres. This somewhat disappointing result can be partly attributed to the powerlessness of government (rooted in the structure of the health care) in implementing policy intentions. Autonomy of the professional groups is a major obstacle in realizing policy aims. Especially the weak degree of organization of the GPs means that the core of primary care consists of some 6000 independent entrepreneurs who cannot be forced or tempted to enter a multidisciplinary organization like a health centre. The redistribution of scattered practice populations of GPs, for instance, appears to be impossible, which is an obstruction for interprofessional collaboration in general. It is doubtful whether this situation can be changed in the near future when the government will be less involved and things will be more determined by factors of demand and supply. Insurers will be more free (not) to contract professionals and facilities. If health centres appear to work better or more efficiently, insurers can show preference for teamwork in primary care and stimulate its creation. If there is no active incentive policy on the promotion of health centres, we expect on the basis of our findings, the growth of their number to remain very modest, and that they will only be erected in certain restricted areas. Local authorities may play an additional role in structuring health care, especially in new suburbs and in redevelopmental areas. Increasing market orientation may lead to gaps in the provision of health care, especially to high-risk population categories such as the elderly, allochtonous people and the socially vulnerable. Under these circumstances the local authorities may have to play a more active role in developing ambulatory care facilities, for instance by promoting health centres.

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