The family physician in 1978 – „Dutch treat"

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My topic is the relation between primary care and the planning system. I would like to put up that in the present state of general practice the essential factor for development and growth is the general practitioner himself.
Several external factors favour the evolution of primary care and „invite the general practitioner out", so to say. The guest is pleased by the invitation and accepts. The surprise that he has to pay his own share – the „Dutch treat" – is considered unpleasant in more than one way, but should have been anticipated upon, as a lesson of history.

One of the less favourable aspects of our national character is described – of course by foreigners – as „Dutch treat". The meaning of the expression is that one invites somebody else to dinner or another recreational activity, and at the end of the evening let him or her pay his or her own share and not seldom the guest is left behind helpless.
This is hardly the place to consider all various cultural and transcultural aspects of this phenomenon, nor is it brought up to make a public confession of our national sin.As you all know we have many more and, though not being openly proud of them, we would not miss a chance to turn them into some kind of economic profit. Gaining profit from foreign national „défauts" has been one of the underlying motives to establish the Common Market. According to a recent report published by the Royal College of General Practitioners with the title „An opportunity to learn", this particular idea has spread beyond our national borders.
„Dutch treat" also relates appropriately to a Netherlands' angle on today's subject: the family physician in 1978. I would like to limit myself to some recent developments in general practice and the near future of primary care in the Netherlands.
You are all more or less familiar with the factors that determined the development of primary care in the postwar period. I will give some examples of two different, opposite trends.

In the first place the change in the morbidity and mortality patterns from infectious diseases and deficiencies towards accidents, ischemic heart disease, malignant diseases and the so called psychosocial problems. Although there is no hard evidence that the last category did increase in the course of the 20th century, general practitioners began to recognize them more frequently and consequently felt poorly equipped to solve these problems of life and the somatic signs and complaints they produced.
Secondly the influence of Government health care planning agencies increased more and more. A movement took place within the planning system to limit the expansion of specialist care, partly based on professional motives, but also on economic grounds. As a result of both, the profession, threatened with extinction went into a revival phase.
Visible results were the founding of the Dutch College of General Practitioners, the Nederlands Huisartsen Genootschap, and secondly the various eight university departments of general practice. Still later came the hesitant start of the badly needed research into general practice and the onset of the primary health care team movement, in Holland commonly known as the „first line". During these first years valuable progress was made, the public opinion was in favour and, of course the politicians became interested in the revived general practitioner.
The family doctor was soon recognized as a potential instrument, to economize especially in a country like ours with 70% of the population insured by a state insurance and where the general practitioner is the sole gatekeeper of the specialist' and hospital systems. Eventually, the family physician could be used in a health policy to stop the rising of the health care bill. The Netherlands has 4.600 general practitioners, who take care of 80% of the medical work for 20% of the total cost. The slogan became: „Reduce the volume of specialist and hospital services – it was calculated only four hospital beds per thousand people would be needed – and reinforce primary care by stimulating and supporting team work, research and diagnostic facilities and finally provide the necessary organisational framework".
A commotion took place within the specialist community and various economists of the new discipline of Health Economics oppose each other using complicated analytical models.
The traffic between the first and second line is also under close observation. Recently a team of Health Economists of Leyden university established firm evidence that a 10% increase in general practitioner density caused a 10% decrease in specialist referrals. Other factors turned up that had a negative effect on the expansion of primary care:
Attitudes of the public towards the medical profession went into a change and the medical system is under fire as the status and power gap between patients and doctors closes up. Health education and news media have removed a considerable part of the old magic and the citizens are sometimes told by their doctors or the press that the influence of all health care on their well being is marginal and that further expansion of the system will have no effect.
The patiens are told more and more that they are themselves responsible – in a large extent – for their own health and therefore should take part in the decision making on various aspects of the health care system. The traditional belief in the medical system, often misused, due to socio-economic wrongs, is changing, a change that first affects the general practitioner who was just on his way up.
With this new development taken into account the government planners slowed down and tried first of all to cut on specialist and hospital services while the announced reinforcement of the primary care sector kept the shape of an enormous amount of paper.
Simultaneously proposed regulations and future laws have been replaced by health economic growth models that are less openly threatening toward the profession. A fine example of this species, but with a dangerous filosofy, was recently produced

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in Holland by the Scientific Council that advised the Government.

Scheme 1 shows that in the sector of health care the population is divided into categories ,,of which each needs a different care system".

Scheme 1. Categories of people with health problems and the corresponding care system.

Categories of people with health problems	Corresponding care system
The healthy	Health education
The "at-risk"	Prevention
The "pre-symptomatic ill"	Screening-intervention
The ill	Medicine
The "stress-susceptible"	Social-mental health care
The dependent	Nursing

Table 1. Estimations of the man power needed in the health caresystem 1975 – 1980.

	1975	1980
Number of general practitioners	4800	6000
Average list size	2800	2300
Number of para-medical- and auxilliary staff	8500	9200
Number of "social care"-giving professionals	7300	9000
Number of specialists	6650	7900
Average "list size"	2045	1770
Number of hospital beds (per 1000)	5.4	5

The futurologists predict a shift away from illness towards the other groups of health problems.

Table 1 presents the estimation of the manpower needed in the health care system, and the shift in the years 1975-1980. The general estimation of the authors is that with the growing integration within the sector of primary care, the general practitioner of the late 80-ies will have gone back to his purely medical work.

The medical profession on the other hand followed at a safe distance behind by stressing the quality of care as a starting point for careful planning, in the meantime not forgetting the position of its individual members. Recently several attempts have been made in Holland to define tasks and duties of the general practitioner in detail. Three purposes could be served by this:
– the profession could set standards and mark borders with the specialist sector;
– the university departments of general practice would get a better idea of what they had to teach. Also the existing gap between university departments and professional group could be filled up partly by a common ,,constitutional document";
– finally the negotiations with the state insurance agency could gain a firmer base.

Enterprises of this kind did not get past the first stage where the function of the general practitioner and his position within the primary care system was at stake, as seen in the light of an adequate definition of health and the goals of health care.

In 1975 a working party of the N.H.G. (the Dutch College) produced a report of the above mentioned type, called ,,How does the doctor help?". Originally intended as a compilation of tasks for the g.p., the paper gives a tentative description of the author's view on how a general practitioner should work, the various aspects of team work in primary care, the doctor as an instrument and finally the position of the general practitioners in the health care systems. Of principal value was the conviction that to do his work properly and be able to handle every type of health problem, the family doctor will have to cooperate with the other disciplines in primary care and use the team approach. The family doctor, as shown in scheme 2, stays at the intersection of the two systems: the vertical axis represents clinical and specialist medicine, the horizontal axis is called the first line and represents the multidisciplinary primary health care team.

It is doubtful if the general practitioner will ever lose his position as gatekeeper to the second and third line systems, but his – yet central – position in the first line as main ,,porte d'entree" for people with all sorts of health problems, could change.

One system is left out in *scheme 2* on purpose: the preventive one. Dutch doctors are still very ambivalent towards their role in prevention and they tend to the opinion that only aimed individual prevention and intervention should be a true element of primary care, but on the other hand they realize that this could lead to even more separate systems of care. The college report concentrated on the professional integrated approach of the request for help from the patient and evaluation of every question that is brought up before applying his specific medical skill.

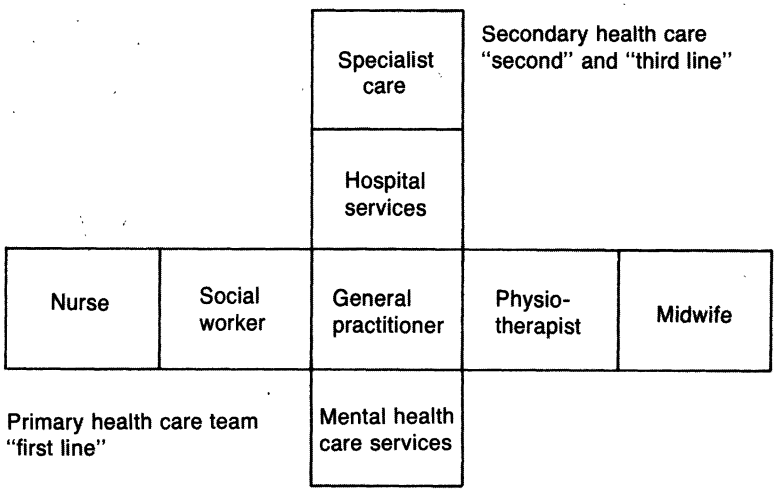
To establish a first line or primary care discipline, the general practitioner has to be aware of the frames of reference he uses in every day work. *Scheme 3* presents some frames of reference in general practice. Any a priori use of each of these frames excludes the integrated approach of requests for help in primary care.

The professional attitude can be summarized as the integrated approach of health problems in primary care and this can best be realized in multi-disciplinary primary health care teams. Practice experience and research in this field, however, is scarce until now, since no more than 8% of Dutch general practitioners work in some sort of team. Compared to the U.K. figures this is a small number. Professional development is – though favoured by many

Scheme 3. Frames of reference in general practice

1. Clinical medicine
2. Social context of the patient
3. The patient's phase of life
4. Selection and ordening of help providing-systems or -institutions

Scheme 2. The g.p. at the intersection of clinical medicine and first line.



Dutch family doctors – still in an early embryonic stage.
I have presented in very general terms two examples of divergent tracks and there are pitfalls: the planners and the government managers who want to support primary care by way of producing calculations and on a categorical basis quite opposite in itself to the integrated approach favoured by the profession, and moreover, still based on a outdated definition of health. The medical profession of primary care is still at the early stage of the ideological movement and the idea is ahead of reality. The planning and managing system is moving in a direction that is quite different and both groups speak a different language.
A fast covering of the distance between the two will have to be made by the emerging profession of primary health care. In other words the profession has to pay and invest.There is only one possible currency: research in and into primary care. In the meantime enough opportunity to change has to be offered by the planning and managing system of health care policy.
A lot of these developments and stated comments are far from new for you all and I think we should be aware of the inflatory nature of this kind of rhetoric. I remind you of the less pleasant effects of the current monetary situation. I hope that this conference will help to beat professional inflation in primary care and speed up the necessary development, not only in the Netherlands. For only the general practitioner himself can produce the needed professional elements for all well balanced primary health care system.

Engelse teksten

Tijdens het in mei 1978 te Montreux gehouden achtste WONCA-congres werden door enkele Nederlandse deelnemers voordrachten gehouden. Van de ons op ons verzoek toegezonden teksten waren er twee in het Engels, de taal waarin de voordrachten waren gehouden: Assessing the doctor, door P.V.M. Cromme en The family physician in 1978 – Dutch treat, door F.E Riphagen. De redactiecommissie vertrouwt dat haar beslissing deze teksten onvertaald af te drukken voor de lezer aanvaardbaar is.

Assessing the doctor

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Assessing the doctor could be misleading and perhaps it is wiser to explain a more logic aproach towards auditing, that is when our goal is a possitive and stimulating one. Assessing bears in it comparing and judging an observed value against a known and accepted standard. Assessing the doctor could mean that not only the professional part is looked upon but also a certain part of the person delivering this service, what seems to be logic, because the results of the health care delivering system depend partly on the relationship between recipient and provider of care. That second part also means that it is getting very personal and no one likes to be judged and rejected afterwards, so it is perhaps at this point that the fear for auditing starts and also a trace of restraint or perhaps even a passive resistance.

The fact that a medical audit system is not received as a heaven send gift can perhaps partly be explained by this existential fear and we can only try to convince those non believers with promises and some facts hope this feeling of fear will vanish.
It could be worthwhile to try a more positive attitude to auditing and develop the thesis that medical audit serves to find gaps in the health care providing system that can be filled by advises for postgraduate training and university teaching and organisation.

Goals of medical auditing

Medical audit on itself does have no value what ever, it is only in relation with postgraduate training and university teaching that its value exists. Medical audit serves to obtain better results from the health care providing system. These better results can be viewed upon from two different points:

firstly: a better result for the receiver, seen in the scope of ideal results as found in the patient expectation design from the health care providing system;

secondly: a better result in view of the satisfaction found in his work by the doctor.

What the user of the health care providing system does expect from this system is part of the ideas produced by cultural opinions. This again is an important point in the design for a medical audit system especially in search for standards. In this context culture is a group's design for living with a shared set of socially transmitted assumptions about goals of life and the appropriate means of achieving them. Such assumptions also relate to well-being and the human body.
Ideas about this well-being and the human body are reflected in the opinions about disease, health, death etc. It is partly by this mechanism that opinions about, tolerance for non well-being are formed, these opinions can form a possible problem when they differ to much from the task ideas of the doctor. Mentally, bodilly and socially well-being may be out ideal but the health care providing system has only influence on some of the conditions for this. In this system the general practitioner has a certain role, and some influence.

Litterature

Most of the litterature about medical audit consists of hospital auditing system or second line medical systems and it would be wrong to use the same standards for treatment in general practice as in hospital practice. It is only in the last ten to twenty years that general practice starts to identify itself in relation to hospital practice and starts to be science of its own. This lack of facts and figures about general practice

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