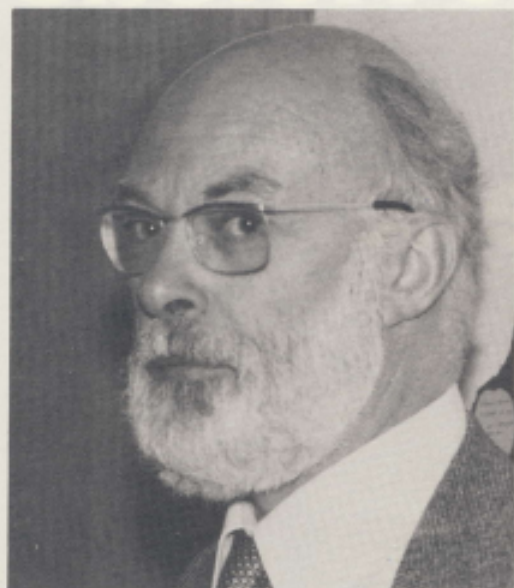


General practice in the Benelux

– René de Smet



Dr René de Smet
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Curriculum Vitae

PROF DR RENÉ DE SMET was born in Heverlee (Belgium). He qualified as a general practitioner at the University of Leuven and was in solo-, duo- and group practice from 1950 to 1980. From 1972 to 1980 he also lectured in General Practice at the University of Leuven. In 1980 he was the founder of a new chair in General Practice at the State University in Gent. He has been a member of the Flemish College of General Practice since its foundation in 1964, as a council member from 1969 to 1981 and as president from 1972 to 1976. He has also been a member of SIMG (International Society of General Practice) since 1973 and was a board member in 1974 and president from 1982 to 1985. In 1975 and 1984 he organized the SIMG congresses and has read papers at six of these congresses.

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At the 5th GP Congress the overseas speakers each told about the system of Health Care in their own countries. We place the contribution from Prof Dr René de Smet first.

Forty years ago Belgium, the Netherlands and Luxemburg – the three smallest countries in Europe – concluded a trade agreement, the Benelux. This, actually, was the start of the European Economic Community.

In comparison with its bigger neighbours, the Benelux is still a rather small country. It is one of the most densely populated areas and, consequently people are very industrious.

I've been asked to present General Practice in the Benelux.

Although Luxemburg is an independent region, with a Duke as the head of state, economically it is closely linked to Belgium and its health care system (HCS) is the same as ours. I'm not going to consider it separately.

On the other hand the Dutch HCS is quite different. In order to make my talk not too complicated, and also because I'm much more aware of the incentives and impediments of the system I'm working in, I'll give a more extensive report of the Belgian system. Consecutively I'll highlight, in contrast, some particularities of the Dutch system.

Health Care in Belgium

Some 100 years ago, at the beginning of the industrialization, help to underserved people was brought by the religious, i.e. Catholic community. Little by little a core of sick-insurance organizations was constituted. Later on this was taken over and expanded by the Christian political party. In a further stage all political parties have built their own health care systems.

Finally, from 1945 on, the Government has subsidized and coordinated all this multi-colored field but has left a certain degree of autonomy to each political column. That's the way our HCS went: from charity to political split-up.

In Belgium, nearly the whole of the population is insured against damage of sickness and injury. The whole system is basically hospital oriented. For many years the working conditions of the doctors

Belgium has 9 hospital beds for every 1 000 people.

and the program of the HCS were negotiated by specialists. Splendid and well equipped hospitals were built in great number. We have 9 hospital beds for every 1 000 inhabitants.

Hospital costs, at least up to 2 years ago, were reimbursed totally for most patients. In ambulatory care the patient has to pay a fee for service, but he is reimbursed to approximately 75 %.

It is worthwhile to mention that preventive care is not taken up in the insurance packet. Community oriented preventive care, as mother-child care, and mental health services resort to the Ministry of Welfare.

A basic character of the Belgian HCS is the freedom of choice. The patient has direct access to every doctor, a specialist or a GP, and as many times as he likes. He can prefer one hospital to another, and he can claim even the most complicated and expensive examinations.

A Belgian has free direct access to any GP or specialist.

Also the doctor has many liberties. The access to the Universities is open. There is no entrance examination and no limit on the number of students to be admitted. After qualification he can settle wherever he likes, he can ask for all investigations and actually there are but few limitations on his prescribing.

In such a free-market system doctors are competitive among themselves. As they have no registered patients, they can only maintain a good relationship with patients by improving their service: offering high quality care and being readily available. This can be considered as a positive aspect of our system but it brings many doctors under unbearable strain.

But I wouldn't disregard other problems inherent in our HCS. There is no long-term planning and nearly no limitations, the costs of the HCS are sky-rocketing and exceed the growth of the GNP. Only recently some restrictions have been imposed: a reduction in the number of hospital beds; regulations on the use of high technology; patients have to pay for their stay in hospital . . .

On different occasions the Minister of Health has expressed his willingness to pay more attention to Primary Health Care. This renewed motivation, perhaps, is more inspired by economic considerations than by being concerned about the quality of care.

Another problem we have to consider is the tremendous increase in the number of qualifying doctors. Presently we have one doctor for every 420 inhabitants, one of the highest figures in western Europe. Only recently the possibility of a selection at the end of the 1st university year has been discussed. Even if this rule is accepted, it will take another 6 years before it has any effect.

Belgium has 1 doctor for every 400 people.

As a negative result of the competition between doctors, everyone is cultivating his own parcel. Cooperation between colleagues and other primary care workers is becoming more and more difficult.

Health Care System in the Netherlands

The major part of the Dutch population is insured by law against the damage of sickness. Those belonging to the upper class – roughly 25 % of the population – do not. They can conclude a private insurance, if they wish. Actually, they are in a free-market system.

The care for insured citizens is organized as a tier system with a level for primary care and one for secondary care. These citizens have to register with a GP. The GP is paid on the basis of a capitation fee. Above a certain number of registered patients, the capitation fee is reduced.

Dutch patients need a referral letter from their GP to a specialist.

Registered patients cannot consult the specialist freely; they have to get a referral letter from their GP. Access to the university is assigned by lot, and the number admitted by each university, depends on the teaching capacity. After qualification the doctor needs a licence to settle down in a particular area.

At the secondary care level, specialists are paid on the basis of a fee per item.

Education in Belgium

Medical studies last for seven years. Only 4 of the 7 universities have a Department of General Practice.

These Departments are rather small, they are not well paid and their possibilities of doing research are poor.

After qualification the Belgian doctor can settle down, but if he has followed a 2-year vocational program, he is entitled to ask a higher fee. He has to be full-time in practice for 2 years, either in his own practice or in a teaching practice. Some hospital departments are also acceptable, albeit only for periods of 3 months.

Medical schools in Belgian universities allow anybody without any entrance examinations.

During these 2 years in practice the young doctor has to participate in day release courses. There he will meet other young colleagues to discuss problems they have been confronted with in their practices. These group discussions are accompanied by a senior GP who has been trained for this job by the Department of General Practice.

Education in the Netherlands

Dutch medical students have a 6-year curriculum.

Departments of General Practice are attached to all 7 universities. Their staff is large and composed of

Access to a Dutch university is decided by lot.

doctors, educationalists and psychologists. Their financial resources are remarkable (certainly in comparison with the Belgian situation), and they are able to carry out research.

After their 6th year, Dutch students are bound to work for 1 year as an assistant in a teaching practice. He will be supervised by the senior doctor of the practice and in the meantime he has to participate in day release courses.

After qualification he has to buy a practice. Very often he has to wait several months, even years, for a suitable offer and the price to pay is always high.

General Practice

Differences in education and in the HCS inevitably must lead to distinctive ways of practice management.

In Belgium more than 90 % of all GPs are working

in solo practices. Nearly all of them have their surgery in their home. Administrative help is very exceptional. This task is to be carried out by a family person. In these circumstances intrusion of professional activities in the private life is inevitable.

More than 50 % of Belgian patients are seen in their own homes.

A well-settled GP cares for 20-30 patients a day. Younger GPs do less, and we have reached the point, where seeing so few patients would lead to lack of experience. These doctors could constitute a threat to the public health.

Peculiar to the Belgian situation is the fact that half of all patients, or even more, are visited in their own home. I don't see any reason to justify this behaviour.

As already mentioned, most Belgian doctors are not inclined to share their duties with others. Exception has to be made for members of group practices, who try very hard to promote multidisciplinary cooperation.

More than 90 % of GPs in Belgium are in solo-practices, working from their own home; for only 50 % of Dutch doctors this is the case.

In the Netherlands 50 % of the GPs do work in cooperation, duo practices or group practices. There are a few Health Centres, but their number does not increase any more.

The mean time for contact with the patient is 6 minutes, but repeat prescriptions, follow-up consultations and requests for referral are included in these figures.

The Dutch situation is characterized by the relatively high number of home deliveries. These are supervised by the midwives who call for the GP in

Doctors in Belgium are competitive among themselves, causing much stress and poor cooperation between them.

case of emergency. A large number of GPs also work in a home team where multi-disciplinary programs for patients at home are agreed upon.

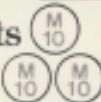
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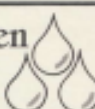
Motilium TRADEMARK
domperidone
JANSSEN

Indications



Dosage

adults  One tablet (or 1ml suspension) 3 times per day, 15 - 30 minutes before meals and, if necessary, before retiring.
In acute cases, e.g. nausea, vomiting and hiccups, two tablets (or 2ml suspension) taken as above.

children  Suspension: One drop (0.5mg) per kg body mass, taken 3 times per day before meals and, if necessary, before retiring.
In acute cases, e.g. nausea, vomiting and hiccups, two drops (0.5mg) per kg body mass taken as above.

Motilium TRADEMARK
gets the lazy stomach
moving again

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General practice in the Benelux

Continuing Education

Continuing education in Belgium is still old-fashioned. The local circle of GPs invites a specialist to speak about new trends in investigation or treatment. Questions can be put. Continuing education is not mandatory, as yet.

Little by little GPs are becoming aware that this formula is not ideal. The College of GP is really

Almost half the babies in Holland are delivered at home.

concerned in stimulating new, more valuable formulae of continuing education. As yet, active learning in small groups and medical audit are performed by only a few.

In the Netherlands continuing education is better structured. Active learning is widely accepted and in each region a steering committee of GPs is working out a yearly program. Specialists are invited when necessary and they are only allowed to answer questions.

Conclusions

Although Belgium and the Netherlands have the same cultural background and are close to each other in many respects, their HCS and their management are very different.

I've tried to illustrate the most important aspects of each system. I've not spoken about the quality of each system of care. I think it is not so important to compare, for it is not the system but the persons who are working within it, that influence the value of a system. And on both sides there are many, many good doctors.

