ACTION FOR HEALTH AND EQUITY ADDRESSING MEDICAL DESERTS

NATIONAL POLICY DIALOGUE

NETHERLANDS

POLICY OPTIONS FOR ADDRESSING MEDICAL DESERTS

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Introduction

The project AHEAD addresses the challenge of medical deserts and medical desertification in Europe in an effort to help reduce health inequalities. The project is carried out in Italy, Moldova, the Netherlands, Romania and Serbia, with the aim to benefit health policymakers, patients' organisations, health professionals' organisations, affected communities and other relevant stakeholders. Further information about AHEAD's teams, mission and goals, and the activities conducted over the duration of the project can be found via the abovementioned links.

Our ultimate intended impact at society and EU level is better access to health services, especially in underserved areas, and more equitable access to sufficient, skilled and motivated health workers, starting with the countries involved in the project.

Purpose of this document

This policy brief is compiled on the basis of the activities carried out in the Netherlands, under the responsibility of Wemos. This document is based on the ideas, opinions and suggestions collected during the process. It does not represent an official position of any institution or person taking part in the process, but contains recommendations for decision makers, who are in a position to implement policies for human resources for health and improve the national legislation regarding its governance, with the aim to address medical desertification.

The AHEAD country teams have compiled five of these policy briefs, one for each country. Every brief provides a short overview of medical desertification in each country, information regarding the adaptation of our consensus building methodology for each context (see next page), and the specific policy options, categorised where possible. The briefs include quotes from the national level events, conveying some opinions voiced by the participants and where acknowledged, their commitment to address this issue in their national contexts.

Methodology

Each country team organised one or more national policy dialogues, with key stakeholders from national and local levels, discussing the validated, context-specific, and feasible policy measures, thereby building momentum for actual policy change and effective action, and encouraging cross-fertilisation.

Policy dialogue can be valuable input on the demand side of health services and systems, depending on the degree to which it is truly participatory and inclusive, bringing enormous advantages to policy implementation and increasing the chances for positive results. Through policy dialogues, different stakeholders can better examine each other's perspectives whilst improving the general understanding of these policies and their impact in different frameworks. It promotes involvement in the policy-making process, can boost commitment

and lead to more responsive policies, engages diverse stakeholders from various sectors and gives people a say in the choices that will influence their lives and health.

Organizing policy dialogues: from the local to the national

Participation in policy dialogues is a win-win situation for both the community and policy makers. The process gives opportunity to the representatives of consensus building sessions to have direct access to the top decision makers. The dialogue gives opportunity to the decision makers to get input from people with lived experiences, and insights from experts like academics, health advocates and civil society members. The policy options discussed during the policy dialogues are not only backed by evidence but also represented by people who are affected by medical desertification in their daily lives.

Each member of the consortium has mapped and identified key stakeholders and actors at the national level, such as civic and patient organisations, healthcare providers and other health professionals (e.g. primary care physicians and specialists, paediatricians, nurses, pharmacists, etc.), and other relevant stakeholders, such as community representatives, trade unions working in the health sector, directors of health districts, etc. Project partners have conducted in-depth interviews with key stakeholders regarding the issue of medical desertification in their context, to gather experiences, perceptions and (possible and existing) measures to address the phenomenon of medical desertification.

In addition, each organisation's team conducted an analysis to identify key policy-makers involved in decision-making at the local level (e.g. local aldermen, mayors, regional council members, and actors standing for both majority and opposition groups). These key actors were invited to the consensus building sessions that aimed to discuss the most relevant issues about medical desertification in their local context and to build consensus on existing and possible new policy measures to prevent and mitigate medical desertification.

Our consensus building methodology

It is known from literature that successful implementation of health workforce policies requires strong inter-sectoral governance and consensus building among the different stakeholders involved. As a consortium, we have therefore set out to draft, test and validate a consensus building (CB) methodology, in order to increase the chances of successfully counteracting medical deserts.

The aim of this methodology is twofold:

- Implemented in the AHEAD partners’ countries, it contributes to the identification and development of practical, feasible and context-specific policy options, that will support policy makers in their decisions on health workforce issues.
- Implemented, contextualised and evaluated across the AHEAD partners’ countries, it will result in a validated methodology, that we will share in a practical guidance document, so

that other organisations (outside the consortium, and beyond the project timeline) can apply the same methodology in their own context.

This participatory consensus building method consists of two phases at local level and one at national level, all with facilitated dialogues. Further details about this methodology can be found via this link.

It is important to note that the methodology was contextualised to each country, following an extensive series of discussions with the country teams, to ensure its cultural and wider contextual appropriateness, tailoring it to the needs of the facilitators and participants.

Stakeholders

Very often, political representatives operating at the local level also play a role in national politics, and similarly, politicians operating at the European level also play a role at the national level. This means that many of these figures can be involved at multiple levels of the policy dialogue.

This is also true for other key stakeholders affected by the different phases of the project, e.g. a health worker may also be a spokesperson for a particular category at the national level. Or, the same civic or patient association may operate at both the local and national levels.

For this reason, it was very important to select the different stakeholders carefully and in advance in order to avoid their over-engagement.

The national consensus building session, also described as the policy dialogues, form the last phase of the AHEAD consensus building methodology. This step provides opportunity to ensure that the policy options developed in the multi-stakeholder consensus building sessions are carried forward and find their way in the menu of policy options to be implemented in each country.

The range of participants

The range of potential participants in the policy dialogues include the following:

- Politicians and policymakers:
    - Local level politicians, such as local aldermen, the Mayor, Council members as well as opposition leaders
    - National level politicians
    - Members of national Parliament and Members of European Parliament who are also active at national level
    - Regional level politicians
    - High level civil servants

- Representatives from the consensus building sessions
    - Participants in earlier CB sessions, including those at local level

- Health advocates
- Academics
- Civil society members and other stakeholders

What are medical deserts?

In the initial stages of the AHEAD project, we carried out a literature review to better define the concept of 'medical desertification'. Based on a thorough review of scientific studies, we have concluded that the complex concept requires an elaboration of definitions to understand its multidimensional perspective. From the literature review, we derived a working definition to inform the development of research tools and validated this definition through the results of research tools. We also discussed this definition during the national dialogues.

Below is our final working definition of medical desertification.

A medical desert is the ***end point*** *of a complex* ***process*** *called 'medical desertification', that implies continuous and increasing inability of a given population to access health services in a timely and contextually relevant manner.*

An elaborate explanation of the definition can be found on the AHEAD website.

The Dutch context

In the Dutch context, Wemos is the implementing partner for carrying out the AHEAD activities (next to being the project leader of the AHEAD consortium). It is obvious that the quality of care and access to health and care services in the participating countries of AHEAD differ greatly; The Netherlands performs better, sometimes much better, than the other participating countries on various indicators. Nevertheless, there are worrying developments in the Netherlands, such as general practices, hospitals and emergency services being increasingly unable to complete their schedules due to staff shortages. Or growing waiting lists in youth care and mental health care. Or increasing health inequalities among specific population groups. Within AHEAD, we do not identify this as a medical desert' in the extreme sense - that is, an area where there is nothing - but as 'desertification' - that is, an area with a decline in quality of and access to care.

As regards the term 'medical desert' - a direct translation of the commonly used French term 'désert medical' – it became clear during the research phase in the Netherlands that the literal Dutch translation evokes a lot of resistance. Therefore, and because in the Netherlands it is not about an absolute lack of (quality of and access to) care facilities, but about a (partial, localized) deterioration thereof, the term 'impoverishment of care' was used during most of the remainder of the activities. For the sake of this document, however, and to remain consistent with the language in the other country policy briefs, we will continue to use ‘medical desert’ and ‘medical desertification’.

The medical desertification phenomenon in the Netherlands

Medical desertification is a complex phenomenon with different manifestations in different contexts. Based on available statistical data and findings from our research, the following manifestations of medical desertification in the Netherlands were identified:

- Increased distance to appropriate specialised care
  - Caused by central decision about concentration of certain specialized care centres, e.g. paediatric cardiac care.
- Increased financial barrier to access appropriate care
  - Caused by the increase in the deductible excess threshold.
- Growing waiting lists for complex psychiatric care
  - At least partly caused by the 2006 reform of the Dutch health care system, which introduced managed market competition in health care, with the aim to achieve higher quality and lower prices. In some fields, such as psychiatry, this has resulted in health insurers and mental healthcare providers agreeing on contracts with rather low average prices per treatment. This incentivizes the provider to only accept clients with relatively less complex care needs; should the clients need more

    - complex care, this would lead to higher costs, which would not be reimbursed by the insurance company.
    - Other causes for these waiting lists include: capacity problems (i.e., a reduction of number of beds) in inpatient facilities (instigated by a desire to cut costs), and shortage of personnel.
- Growing waiting lists for youth care
    - Since 2015, Municipalities are responsible for organising and sub-contracting youth care. The devolution of this responsibility was accompanied by a budget cut, in an attempt to reduce overall Dutch health care expenditure. The budget ceilings, in combination with an increased number of youths seeking and needing more complex care, has led to waiting lists of, on average, 10 months.
- Obstacles to access health care for non-Dutch speaking citizens
    - Discontinuation of the financial reimbursement of interpreters for patients with no adequate command of the Dutch language (2012).

Other (independent) developments that have a negative influence on access to GP care include the tendency of young GPs to want to work part-time instead of full-time, and their preference to work in more urban areas, where their spouses have better job opportunities than in rural areas. Also, the generally accepted standard for the number of patients per full-time equivalent GP (whereby good quality care is still ensured) has been reduced from 2350 patients to 2095 in 2018, resulting in an increased demand for GPs – who are not available, thus leading to (temporary) waiting lists and ‘patient stops’. At the time of writing of this brief, approx. 60% of all GP practices has a patient stop[1]. An added complication in rural areas is that many of the GPs there are reaching retirement age, and experience difficulties finding a replacement, resulting, in extreme cases, in closure of the GP practice. This means that its patients need to find another GP, which may be located further away and/or may not be accepting new patients.

Potential solutions for counteracting medical deserts in the Netherlands

The consensus building sessions in the Netherlands focused on the challenges concerning the availability of GPs in rural areas. For more information on medical deserts in The Netherlands, please refer to the research report in English (long read) or summary research report, in Dutch.

The case study area was Hollands Kroon, in the northern part of North-Holland. Three single-stakeholder sessions and one multi-stakeholder session were conducted, yielding the following policy options.

A. Increase the supply of GPs in rural areas by:
    1. Making the region more attractive
    2. Making the GP profession more attractive by decreasing the administrative workload

[1] https://www.trouw.nl/zorg/hoge-werkdruk-dwingt-huisartsen-tot-patientenstop-ik-werk-49-uur-per-week~b3b15a6c/

3. Implement mandatory deployment measures for GPs in areas at risk of medical desertification

B. Decrease the demand for GP care in rural areas by:
   4. Investing (more) in community care and Positive Health[2] interventions
   5. Increasing cooperation between GPs and geriatric specialists
   6. Improving the patient's navigation through the health care system
   7. Increase patients' capacity for self-help and self-referral

C. Improve the quality of care by:
   8. Improving the communication skills of doctors
   9. Improving the quality of digital health care delivery as well as electronic communication between care providers
   10. Improving effectiveness and efficiency of the referral system, especially between cure, home care and social services.

Local level interventions

For the following options, the participants in the sessions concluded that local level interventions could suffice in starting to resolve the most pressing challenges:

<u>**A1** Make the region more attractive:</u>

It was suggested to conduct research into the motives why some young people do prefer to live in Hollands Kroon, in order to better target promotion messages for young GPs to come and work in Hollands Kroon. A promotional campaign was also considered, with the support of Dutch celebrities hailing from Hollands Kroon, as local ambassadors. Participants want to explore possibilities to facilitate housing for new GPs. There was also enthusiasm for proactively developing a vision for green and sustainable GP care in the region, as many young GPs have an interest in this and are assumed to be drawn to this type of working environment.

<u>**B4** Invest (more) in community care and Positive Health interventions:</u>

Health and care organisations in Hollands Kroon have implemented several initiatives along these lines. Such good practices could be promoted more. This aligns well with efforts at national level to focus more on primary prevention, community health and overall well-being, to reduce the burden of disease and care provision in secondary and tertiary care. This includes interventions in social and community care that are being offered by volunteers.

On a more general note, it is recognized that the overall shortages in the health workforce are jeopardizing the current high standard of care in the Netherlands, not just in medical desert areas. Participants have the feeling that society at large should acknowledge that our current health system is unsustainable, financially and in terms of the required workforce, and this

[2] https://www.iph.nl/en/positive-health/what-is-it/

requires a fundamental re-thinking. [Quote] “Politicians should have the courage to start this debate at the level of society.”

B5 Increase cooperation between GPs and geriatric specialists:

The idea was raised to start a pilot project in Hollands Kroon. Such an initiative could increase the attractiveness for GPs to come and work in Hollands Kroon. However, it was recognized that for a systemic solution, this approach should be investigated and implemented by national actors as well.

B6/7 Improve patient navigation through the health care system:

The local interest group for the elderly committed to the updating, printing and distributing of the *local Guide to Social and Care Services* among their members. They also have volunteers who assist the elderly in their navigation through the system; the presence of many, still relatively healthy, retirees is an asset for the community and this should be leveraged as much as possible.

C10 Improve effectiveness and efficiency of the referral system, especially between cure, home care and social services:

The challenges relating to the lack of effectiveness and efficiency were acutely felt. Local initiatives will be discussed to address them.

National level interventions

The remaining policy options were considered to exceed the local level mandate and sphere of influence, and were therefore discussed during the national consensus building session. Participants included representatives from the Ministry of Health, the preferent regional health insurance company for Hollands Kroon (VGZ), the National GP Association (LHV), the Junior GP Association (LOVAH), the Association of Netherlands Municipalities (VNG), and the Dutch Rural Society of Small Villages (LVKK), as well as four representatives from the local consensus building sessions. This discussion resulted in the following overview of national level solutions and their potential:

A2 Make the GP profession more attractive by decreasing the administrative workload

The high administrative burden, in combination with the perceived redundancy of many administrative tasks, is at the core of GP dissatisfaction and has been the focus of policy discussions, as well as strikes and demonstrations. Efforts are being made to reduce this burden.

During the national session, the following additional remarks were made :

- The programme “[De]Regulate Care” (2018-2025) is an initiative by the Ministry of Health, Welfare and Sports, together with the National GP Association, the Dutch Healthcare Authority and health insurance companies, with the aim to decrease the

regulatory and administrative burden in Dutch health care. This initiative has resulted in a number of measures, including for GP care[3] and for referrals[4]. However, not all of these measures are implemented in practice, e.g. because people are not aware of them. At the same time, new regulations and administrative responsibilities are put in place. The net effect on decreasing the administrative burden is therefore unknown.

- The newly (2022) agreed Integrated Care Agreement (IZA) contains an ambition to reduce the administrative burden with 5 %-point in 2025 (compared to 2020).
- Since January 2022 there is a new law regulating the market entry for health and youth care providers[5], including the introduction of a permit system. This laws creates a lot of extra work for newly starting GPs, which will demotivate medical students to opt for the GP specialisation and/or start their own practice.
- There is a tendency to outsource the practical, day-to-day management of GP practices (including Human Resources management, in case of large practices with many support staff) to a practice manager, or to external parties. There are also initiatives to set up mentoring systems between young GPs and more experienced ones, focusing on this particular aspect.
- There is also a growing number of large, commercial companies running GP practices. They work with salaried doctors whose core task is restricted to seeing patients; administration, management, maintenance of website and patient portal is taken care of. Some of these companies are currently being scrutinized by the Health Inspectorate and the Dutch Healthcare Authority[6], following a large number of complaints filed, including from citizens in Hollands Kroon.

A3 Implement mandatory deployment measures for GPs

Such a policy can vary from motivating, encouraging and facilitating new GPs to settle in certain areas, or discouraging establishment in other areas (with in principle enough GPs per population), to a directive policy for allocating training and practice locations.

This policy can be implemented with financial incentives, but experience in Scandinavia and France has shown that these have a limited influence on the location behavior of GPs; non-monetary factors were found to be more important, such as a pleasant living environment. Also, experience in rural areas seems to increase the chances of GPs settling in rural areas: people often continue to work in the region where they were trained. In Groningen, the medical training of the UMCG and the RUG started with a new internship for second-year Master's students in 2021. In the 12-week extramural internship, the students get the opportunity to gain work experience outside the walls of the hospital, for example as a general practitioner in a rural area.

Additional remarks:

- The option is seen as 'exciting', 'interesting' and 'complex'. For example, it is not clear who should prescribe, implement and enforce such a policy.

[3] https://www.ordz.nl/ and https://www.ordz.nl/huisartsen.
[4] www.verwijsafspraken.nl
[5] Wtza, https://www.toetredingzorgaanbieders.nl/.
[6] See IGJ en NZa doen gezamenlijk onderzoek naar innovatieve ketens van huisartsenzorg | Nieuwsbericht | Inspectie Gezondheidszorg en Jeugd

- Experience shows that training places are not always filled, for example in Twente (east of the country), while demand for training places in Amsterdam exceeds the supply.
- The risk of mandatory GP deployment or training place is that this will be a disincentive for medical students to choose family medicine as their specialty.
- A mandatory placement policy should pay attention to the housing problem, both for the required homes and for practice spaces. Maintenance, renovation, new construction, moving is expensive and virtually impossible for the GP to afford within the current tariff structure. Moreover, with the shift from second-line care to first-line care, there are consequences for the required practice accommodation. [Quote] “Thanks to the tendency to treat patients in first line care, rather than second line care, savings are made in, for example, hospital care, but those savings are not subsequently invested in improving primary care to deal with these patients.”

There are many different aspects to the housing problem, including:

- There is a big difference between the necessary preconditions and facilities for one-person practices and group practices (and other forms), and therefore also in how they can be stimulated and facilitated, for example by the municipality. [Quote] “If you want a group practice, you need larger spaces and then you have to step in as a municipality.”
- 'Stepping in by the municipality' can be seen as state support in a free market sector, or as nepotism if one practice/general practitioner receives that municipal support and the other does not. Some municipalities are therefore very reluctant to do so, while other municipalities are looking for (and finding) the possibilities within existing laws and regulations. The Association of Netherlands Municipalities has not yet fully decided how to advise its members in this regard. The National GP Association (LHV) has recently finalized research in this area, which will be discussed with the Association of Netherlands Municipalities shortly.
- A municipality that provides financial remedies for housing problems can also try to set requirements to ensure that only those practices are supported that the municipality considers to be desirable.
- Good practice: the province of Friesland makes subsidies available (up to a certain maximum) for the renovation and adaptation of general practices, with the aim of making it more attractive to settle there.

An agreement has also been made in the Integrated Care Agreement (IZA) about housing problems of general practices. Guidelines are currently being worked out in more detail nationally.

B4/5 Increase cooperation between GPs and other health and care providers, including geriatric specialists.

In Hollands Kroon, it has been found that task-shifting in general practice, such as appointing a general practice-based nurse specialist (POH) and general practice mental health worker (POH GGZ), relieves the GP's workload and is a good form of care from the patient's perspective. There is also a lot of investment in Positive Health and other forms of (informal) care and interventions in the social domain. The expectation for the future of Hollands Kroon

is that there will be more people who will continue to live at home for longer, but do need care and support in that home situation. This also applies to the rest of the Netherlands, which is why this is a relevant policy option.

Increased cooperation allows the geriatric specialist to see patients who visit the GP frequently, often still live at home and require specific care (including palliative care). The expectation is that both specialisms will become more attractive as a result: the GP will be relieved and can spend more time on other patients; and geriatric care may become more interesting as care is provided not in institutions, but in the community. There is already a national discussion about 'medical general care', which also concerns the division of tasks and responsibilities between general practitioners and geriatric specialists. It can be concluded therefore that several initiatives are underway to implement this policy option.

Additional remarks:

- Implementation is not straightforward. The current funding streams are an obstacle, because GP care is funded by health insurance companies, and long-term elderly care through the Municipality. Sorting out these reimbursement complexities is time-consuming and expensive for the individual GP, so undesirable in the current funding context – and also undesirable within the previously formulated ambition of lowering the administrative burden.
- Clear agreements must be made about which of the two has final responsibility for the care for these patients.
- Unfortunately, there is also a shortage of geriatric specialists. Sending more tasks their way increases their workload and may lead to less inflow / more outflow. It is better to focus on more/better cooperation between available staff and make agreements for good care for the elderly vulnerable patient with all service providers in the area.
- This scenario is not only conceivable in 'medical deserts', as there is an aging population throughout the Netherlands, regardless of the degree of urbanisation. Therefore, potentially a relevant option.
- In addition, and echoing observations in the local stakeholders' discussion, the health workforce shortages in general increase the need to resort to interventions in social and community care that are being offered by volunteers. An initiative such as "The Netherlands takes care of each other"/ Caring Communities (NLZVE[7]), a national network of citizen's initiatives, has already more than 2000 registered activities that contribute to health and well-being of community members. This initiative is facilitated by the Ministry of Health.

C8 Improving the communication skills of doctors

In general practitioner training, more attention should be paid (as soon as possible) to better communication with patients ('bad news conversations', empathy, assessing whether the patient understands the information provided, avoiding jargon, etc.). During the sessions in Hollands Kroon it was indicated that even though the situation seems to improve, there is still a world to be won, according to examples given by the participants. In this session it was also stated that if the care provided is good (including the communication between doctor and

[7] https://nlzorgtvoorelkaar.nl/default.aspx

patient) it is not a problem for the patient to see different GPs. The standard of '2 regular GPs per practice per patient' remains desirable, but is therefore not an absolute quality criterion for these participant(s).

Additional remarks:

- Attention to better communication skills is well incorporated in current GP training. You could say that the less communicative GPs are a dying breed.
- At the same time, more attention should be paid to informing patients (better) about the type of care the GP provides. An important cause of high work pressure are patients who repeatedly visit the GP for care that should be obtained from other care providers. This contributes to time pressure issues in the GP practice, which means that they have less time for patients on whom s/he would like to spend more time.
    - This line of action could include information campaigns from: GPs to their patients; health insurers to their policyholders; municipalities to their inhabitants.

C9 Improve the quality of digital health care delivery as well as electronic communication between care providers.

Both GPs and patients suffer from malfunctioning digital platforms and poorly connected and coordinated ICT systems in healthcare. During the sessions in Hollands Kroon, the following topics were discussed: the need for selective roll-out of e-health for those groups where it works well; encouraging GPs to use effective forms of e-health where possible; implementing (a form of) self-triage by the patient to determine whether an e-consultation is an acceptable form of care for their specific care needs and/or offering it as an option in the Personal Health Environment (PHE) in the GP patient portal.

In addition, more scientific knowledge is needed about the effectiveness and desirability of e-health applications such as video calling (or: this knowledge must be better shared), such as for whom (which socio-demographic groups) and for which service these applications are suitable. And more exchange of experiences between care providers could nudge them into using such applications more often.

Finally, websites and patient portals must function properly and must be made (more) user-friendly. Since there are no standards for the design of an electronic health service environment, a quality mark for websites and other forms of electronic communication would be desirable.

Additional remarks:

- ZN (umbrella organisation of eleven health insurers in The Netherlands) is working on standards in collaboration with, among others, the Dutch Scientific Association for GPs (NHG) and the Dutch GP Association (LHV). Under the name Care Transformation Model, work is being done on a 'shop window' of e-health applications where more information is given about the added value of the different applications and which should eventually lead to a decision aid.
- It is important to make a clear distinction between digital data exchange between healthcare providers and with the patient, versus the digitisation of the healthcare process itself, using e-consultations, e-health, etc.

- There are many hiccups in the transfers between primary, secondary and tertiary care. Scandinavian countries are ahead in the field of electronic health records, because it is centrally implemented; here in the Netherlands the Senate voted against a standardised electronic health records 10 years ago, which means that electronic data exchange is left to the market.
- It has been agreed in the Integrated Care Agreement (IZA) that data exchange between care providers and between patients and their care providers must be improved. There is also a new law for this, entitled Working on data exchange in healthcare (Wegiz).
- GPs should be encouraged to use e-health applications. Uptake is not very high. This should be promoted already during training and encouraged in every GP practice.
- Digital care and services should not be 'instead of', but 'in support of'.
- Commercial partners for whom digital care becomes (part of) their business (and profit) model, undermine the high standards of GP care in The Netherlands.
- There should be better and more objective communication to GPs about the possibilities for the ICT systems and digitisation of their practice, including doing it yourself versus outsourcing, for example, practice management.
- Quote: “Apparently, there is so much money going around in the Netherlands that we can afford to spend millions on ICT-systems that are incompatible and not interoperable.”

Conclusions

- Several of the policy solutions that require decisions and measures at national level **are already being implemented** (some only recently), and **their potential is not yet fully realized**. It remains a question to what extent communities at risk of medical desertification can wait until these measures yield noticeable positive results, or if they need additional, short-term measures.
- Meanwhile, **several different local initiatives** to improve availability and accessibility of care (including GP care) in rural areas are being realized – not just in Hollands Kroon, but also elsewhere in the Netherlands. In addition, **there are over 2000 citizen’s initiatives across the country that aim to increase citizens’ well-being in the area of cure, care, prevention and the social domain**. These initiatives can help alleviate the workload in primary care.
- **The call for a societal debate on the sustainability of the current Dutch health system** – both in financial and human resources terms – **is noteworthy**. All stakeholders agree that the system is untenable, but the official narrative is that the situation can be solved with tweaks, (quick) fixes and technological and digital innovations. A societal debate, including for example a Citizen’s Assembly, or Citizen’s Council, could help pave the way for a fundamental re-thinking of the current paradigms for health, care and well-being.

Further reading

- Full AHEAD research report The Netherlands, English language (68 pages)
- Summary AHEAD research report The Netherlands, Dutch language (26 pages)