



NETHERLANDS

Transforming
primary health
care during
the pandemic

EXPANDING ACCESS FOR OLDER PEOPLE THROUGH OUT-OF-HOURS PRIMARY CARE

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MOTIVATION

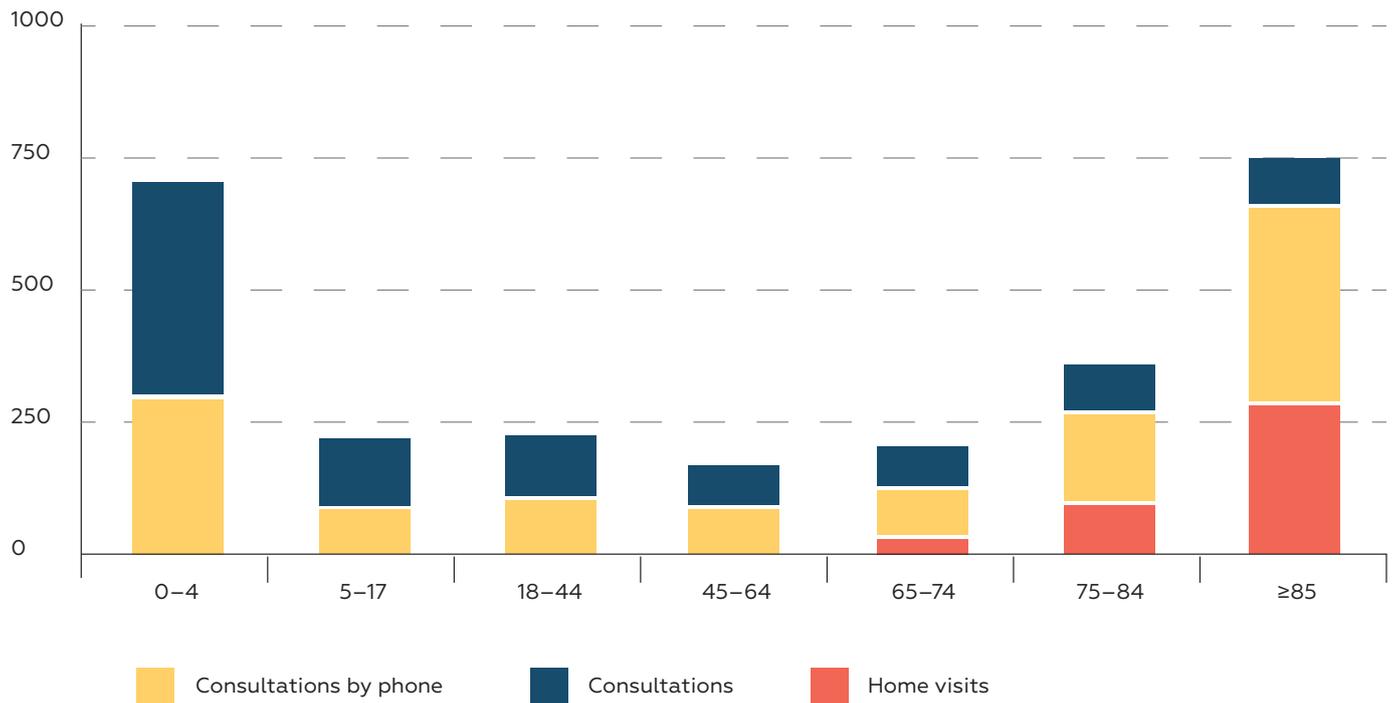
Across the WHO European Region, demographic change has required most countries to adapt primary health care to address the needs of an ageing population. Comprehensive and available out-of-hours primary care is one of the most important tools in the health system toolbox for older people. It supports older people in avoiding after-hours hospitalization, reducing the risk of their long-term dependence on institutionalized services by keeping them in their homes with an increased quality of life. Reducing avoidable hospitalizations also avoids costly interventions for the health system.

In 2017, about 20% of the population of the Netherlands was 65 years or older (3.2 million people). These out-of-hours services have been less integrated with social care services than daytime services and therefore risk not fully addressing the needs of older people. The pandemic changed this and accelerated the process of integrating social care services with out-of-hours services.

OUT-OF-HOURS PRIMARY CARE IN THE NETHERLANDS

Out-of-hours care is defined as services provided between 17:00 and 8:00 on weekdays and on weekends and holidays. Out-of-hours primary medical care in the Netherlands takes place in multidisciplinary networks run by general practitioner (GPs), referred to as Huisartsenposten (HAP). These networks are set up for urgent help requests that cannot wait until the regular consulting hours of the person's own GP. Box 1 lists the key features of HAPs. Each of the out-of-hours services by HAPs are run in shifts by – on average – 70 GPs in each region as a part of their regular responsibilities as a GP in their own practices. The HAP model is a nationally uniform model. In 2020, there were 113 HAPs, each serving 100 000 to 500 000 people. The HAP can refer people to hospitals and in very acute cases to emergency wards.

Fig. 1. Use of the HAP hubs by age in years (2019)

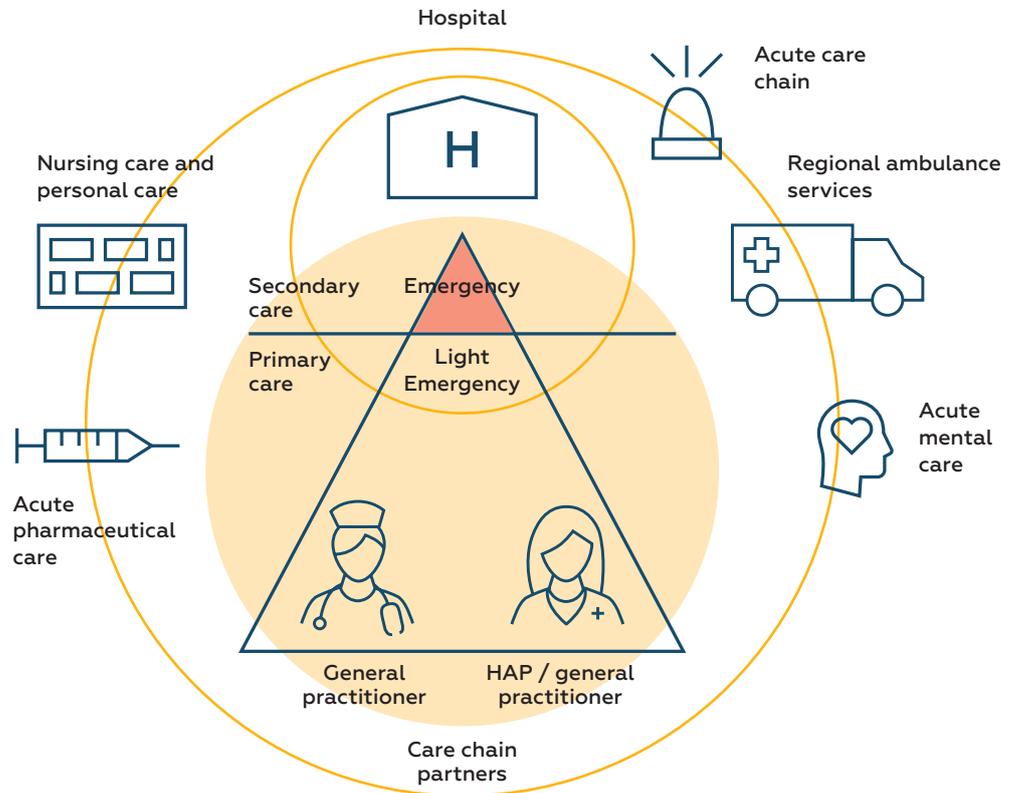


Source: Nivel Zorgregistraties Eerstelijin

Most of the 4.3 million annual contacts are early in the evenings and on Saturday mornings. Although the services do not explicitly target older people, most contacts are with or for older people 85 years and older and for young children. Home visits are primarily arranged for people 75 years and older or who are particularly frail (see Fig. 1). Fig. 2 shows how the HAPs relate to the various services.

“DURING THE PANDEMIC, INTERORGANIZATIONAL COLLABORATION WAS ARRANGED AT A MORE REGIONAL LEVEL, SINCE SCARCITY OF BEDS, STAFF AND EQUIPMENT CHALLENGED THE RESOURCES OF LOCAL COLLABORATION.”

Fig. 2 Overview of the collaboration between HAPs and emergency hospital care



Box 1. Key features of HAPs

General features

HAPs have been operating **since 2000**.

Every GP has to do a minimum number of shifts at the GP cooperative to maintain registration as a GP.

Participation of **50–250 GPs** per HAP with a mean of four hours on call per week with compensation of about €65 per hour.

There are about **120 HAPs** in the Netherlands.

Population of 100 000 to 500 000 patients with an average care consumption of **250 per 1000** inhabitants per year.

Patients are triaged upon arrival in urgency categories from high to low urgency (In 2014: U1: 2.1%; U2: 13.7%; U3: 35.3%; U4: 20.9%; and U5: 27.5%).

Paramedics and nurses visit patients as needed with GPs as back-ups for more complicated cases.

HAPs have access to “night pharmacies” set up for the sole purpose of serving the HAPs during out-of-hours service. These are often, but not always based in hospitals.

Location

HAPs are usually situated in or near a hospital.

Distance between patients and HAPs is maximally 30 km.

Accessibility

Access via a single regional telephone number, meaning the first contact mostly is with a triage nurse (only 5–10% walk in without a call in advance).

Telephone triage by nurses supervised by GPs: contacts are divided into telephone advice (40%), centre consult (50%) or GP home visit (10%).

Facilities

Home visits are supported by trained drivers with basic paramedic skills in identifiable fully equipped cars (such as oxygen, intravenous drip equipment, automated external defibrillator and medication for acute treatment).

Information and communication technology support, including electronic patient files, online connection to the car and sometimes connection with the electronic medical record to the daytime primary care service.

Access to the HAPs follows a triage system by qualified triagists (see Box 2). GPs perform telephone consultations only for those with complicated or urgent issues that cannot be dealt with by the triagist.

Triagists are either qualified nurses or doctors' assistants with a number of years of practical experience. For the triagist post, they receive additional training from an accredited HAP. They can conduct assessments over the phone or on site. Triagists can see patients at the regional centre and perform home visits if needed (2). GPs provide supervision of the triagists, when needed.

Triagists are supported by the Dutch Triage Standard. This standard is a computerized and standardized protocol with questions to assess the medical condition of the patient. It is also used by nurses at the emergency wards and the centralists of the ambulance posts and is based on the ABCDE method. After assessing the urgency of the patient's health problem, triagists decide the appropriate action to be taken. Options include referring the patient to the emergency department or ambulance service, making an appointment for GP consultation or home visit, giving the patient self-care advice by telephone or advising them to visit their own GP the next working day. Triagists can also provide medical assistance and document the care provided.

REGIONAL AUTHORITIES ACT TO ACCELERATE THE INTEGRATION OF HEALTH AND SOCIAL CARE DURING THE COVID-19 PANDEMIC

Primary care, home care and social care for older people living independently are provided by separate and independent organizations and professionals. In practice, they often collaborate at neighbourhood level, since they know each other. However, if there are many home care and social care providers, collaboration can be complex. Out-of-hours, home care organizations often collaborate and share shifts but not working alongside primary care. During these shifts, home care professionals are on call for their patients and can make a home visit in case of an urgent situation. Out of hours, both GPs and home care services only scale up for emergencies and for short-term solutions.

The pandemic has accelerated the coordination of various services. During the onset of the COVID-19 crisis, the existing structures for crisis and disaster management, acute care and public health structures for combatting epidemics were activated according to the tasks assigned by existing legislation and by the national government. The measures to respond to the COVID-19 epidemic were coordinated by the 25 safety regions. These are collaborative networks that exist for crisis and disaster management, medical assistance in times of crisis and regional public health authorities. Mayors of municipalities and directors of public health govern these networks. Operational governance of the medical services during the pandemic was attributed to regional coordination networks for acute care chains. These decided how the hospitals and other services in the region accommodate the needed capacity and how protective means, equipment and infrastructure could best be distributed.

Collaboration between secondary and primary care and between acute, long-term care and public health was rapidly intensified across the country. Where and how people could be admitted, cared for, treated and rehabilitated after initial treatment was coordinated at the local level. For older people, care homes were appointed for those with COVID-19, home care services were coordinated for COVID-19 and non-COVID-19 clients and GPs arranged their services accordingly. These arrangements were around the clock and over the entire week, given that night and weekend care delivery is less frequent and intense and that usual out-of-hours agreements and structures were leading.

Various stakeholder groups helped the national government clearly communicate the new measures, including the national public health institute, general practices, the national umbrella organizations, knowledge institutes such as Vilans, social media and various other sources. Most of the communication was over the Internet. As a consequence, some groups in society were poorly reached by these means. GP practices and home care organizations therefore also proactively approached clients who might miss the information.

SERVICES ADJUSTED DURING THE PANDEMIC

Giving priority to the needs of older people led to adjustments in several types of services, in particular, in delivering COVID-19 services in the community, integrating the out-of-hours primary care services with out-of-hours home care and delivering advanced care planning in the community.

HAPs expanded to include COVID-19 care and primary care beds. Most of the HAPs in the Netherlands are situated within or very close to a hospital. During the pandemic, it was vital to keep all patients with COVID-19 symptoms out of the non-COVID-19 wards of the hospital. Therefore, many hospitals were able to physically organize the HAPs outside the hospitals in emergency buildings or large tents. COVID-19 teams were put in place to organize care for people with COVID-19 with the HAPs. For some older people with COVID-19 who did not want to be treated in the hospital or at an intensive care unit or who had to be discharged despite still needing close monitoring and support, a system of primary care beds was established. These primary care beds were managed through close collaboration between hospitals, home care, GPs and HAPs during out of hours. In 2019, oxygen supply at home and monitoring of oxygen saturation levels, blood pressure, heart rate, temperature and glucose by means of a health dot supervised at distance by the hospital monitoring centre was still relatively new for the Netherlands, but this development received a great boost during the pandemic. It proved to be a valuable service for patients to recover in their own environment, at lower costs and relieving the pressure on hospitals.

Increased collaboration between HAPs and overnight home care. Before the COVID-19 outbreak, many home care organizations were already starting to restructure their overnight home care delivery to improve efficiency. Instead of working separately from HAPs and according to the different home care providers, staff were starting to work closer with HAPs and in the pandemic urged the various home care organizations to intensify and speed up their coordination on their night routes. As such, it accelerated the already ongoing processes of intensifying local and regional collaboration to a speed that was unprecedented.

Ensuring dignity for older people through careful advanced care planning. During the pandemic, HAPs were asked to pay extra attention to advanced care planning for older people to prevent referrals to hospitals for people who want to stay at home in case of emergency with good palliative care instead of hospital treatment and/or treatment at intensive care units. Further, extra capacity was created in long-term care facilities to care for people after hospital admission or for people for whom residential care was sufficient to recover during COVID-19 illness.



EARLY ACHIEVEMENTS AND SUSTAINABILITY PROSPECTS

Out-of-hours care for older people in the Netherlands is well organized. How it has been used and engaged to support the pandemic response revealed that there is room for improvement to ensure person-centred service delivery for older people. The COVID-19 pandemic triggered the acceleration of existing developments in the Netherlands that will be necessary to face the challenges of an ageing society lying ahead.

During the pandemic, the connections and collaboration between public health, acute care and long-term care (especially care homes) intensified. Acute and non-acute care networks took charge of the distribution of patients, infrastructure, equipment and professionals across all available care facilities at the regional level. Nevertheless, the strong primary care structure at the neighbourhood level remained functioning and proved to be effective during office hours. Scaling up appears to be relevant in times of scarcity of resources and when specialized secondary care is needed that cannot be organized at the local level.

Regional authorities turned out to be very supportive to the local jurisdiction. As debates ensue on how to prepare for future emergencies and manage surge capacity, this example from the Netherlands demonstrates how networks at the regional level can serve as the right level to organize the surplus resources needed during emergencies.

This scaled-up regional collaboration has been key for several reasons. First, this collaboration has helped to respond to the preferences of older people who preferred to stay at home or nearby in a care home while still receiving 24/7 care. Second, the care delivered to older people in their community could more comprehensively meet their health and social needs. Third, this alleviated the already great strain on hospitals. At the peak of the first wave, many patients had to be transferred to Germany. These capacity problems, combined with the fact that the hospital is not always the right place for older people, ensured vital care for everyone who urgently needed it.

LESSONS LEARNED

- 1. Out-of-hours care is well organized in the Netherlands and accessible for older people.** The structure proved to be well suited to serve in regular times and during the pandemic, in particular for older people. The use of out-of-hours primary care services (HAPs) for regular care demonstrated more or less the same pattern for older non-COVID-19 patients as before.
- 2. The existing collaboration between HAPs and home help organizations provided a basis for effectively scaling up the COVID-19 response.** In the pre-COVID-19 era, most interorganizational collaboration focused on daytime practices, often at the local level. During the pandemic, interorganizational collaboration was arranged at a more regional level, since scarcity of beds, staff and equipment challenged the resources of local collaboration. Out-of-hours primary care services became an important resource for people with COVID-19 who wanted to be cared for in the community.
- 3. Networking services at the regional level overall are an important tool for rapidly adjusting services during an emergency.** The existing structures of acute care networks, the networks for crisis and disaster management and public health structures for combatting epidemics were rapidly activated and upgraded with actors from adjacent fields, such as long-term care and home care. Regional-level networks were able to manage and arrange patients' logistics (or placements) and the distribution of personal protective equipment and infrastructure. Although the reasons for intensifying this integration were dramatic, the COVID-19 pandemic accelerated the collaboration and coordination in the care for older people living at home and in residential settings. This proved to improve older people's quality of life, mitigate the strain on hospitals and keep older people safe for as much as possible..
- 4. Multidisciplinary, collaborative planning and decision-making can help achieve greater efficiency and better round-the-clock service delivery.** In the Netherlands, regional coordination networks for acute care chains include a wide range of stakeholders representing different professions, organization types and sectors. If countries are to consider an integrated approach to crisis response (and to service delivery more generally), all perspectives should be represented around the decision-making table in a way that recognizes the importance of all professionals and their contributions in delivering services.



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REFERENCES

1. Giesen P, Smits M, Huibers L, Grol R, Wensing M. Quality of after-hours primary care in the Netherlands: a narrative review. *Ann Intern Med.* 2011;155:108–13.
2. Smits M, Rutten M, Keizer E, Wensing M, Westert G, Giesen P. The development and performance of after-hours primary care in the Netherlands: a narrative review. *Ann Intern Med.* 2017;166:737–42.