Challenges to prevention in Dutch general practice¹,²

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ABSTRACT In the Netherlands the general practitioner (GP) plays an important role in prevention. Every Dutch citizen has to be registered with one GP and GPs know their patients well. Face-to-face contact is a relatively effective means of influencing behavior; if preventive advice is related to a patient’s state of health, compliance may be stimulated. However, Dutch GPs have shown reluctance toward preventive work. Curing rather than preventing disease is emphasized in medical school. Many GPs doubt that they are entitled to interfere with a patient’s lifestyle unless asked. Some GPs are aware of their limited knowledge of nutrition. Preventive work requires some reorganization of medical practice and can lead to an increased workload, without financial compensation. Then there is the “prevention paradox”: preventive actions that have a demonstrable effect on the whole population bring only small benefits for individuals. Since 1989 the Dutch College of General Practitioners has published 60 standards for general practice. Several of these include advice on lifestyle and diet, eg, for non-insulin-dependent diabetes mellitus, hypertension, hypercholesterolemia, peptic ulcer, and heart failure. Prevention work in general practice must use only interventions proved to be effective and they must be feasible in the context of general practice. A trial collaboration of 118 GPs and 5 public health authorities between 1988 and 1990 for screening and lifestyle management of hypertension was a limited success. It brought to light the practical problems of this type of work in general practice. Present government priorities for GP–public health collaboration are influenza vaccination and cervical screening. Am J Clin Nutr 1997;65(suppl):1943S–5S.

KEY WORDS Prevention, general practice, screening, hypertension, general practice standards, Netherlands, lifestyle

INTRODUCTION

As for many Western countries, one of the main priorities of Dutch health policy is the reinforcement of disease prevention. One of the targets of the Ministry of Health is to stimulate prevention in primary care, especially in general practice. Some important noncommunicable diseases, for example, cancer and heart disease, are related to dietary factors. Therefore, healthy dietary habits are an important preventive measure to reduce the risk of chronic disease and increase life expectancy.

This presentation emphasizes the general practitioner’s (GP’s) role in disease prevention. On the basis of some Dutch experiences with prevention in general practice, I discuss the possibilities for and limitations of prevention in general practice. Finally, I present a long-term implementation plan that aims to involve GPs more in some preventive measures such as dietary interventions. But before I go into this subject, I consider the GP’s role in prevention in general.

PREVENTION IN DUTCH GENERAL PRACTICE

The Dutch GP has a central position in the health care system. There are four reasons that GPs play an important role in prevention (and in nutritional counseling). First, the GP has the best access to the individual at risk. Every Dutch citizen must be registered with a GP. Independent of the reason for consultation, the GP can easily recognize possible risk factors. Second, GPs know their patients well. Because GPs see ~70% of their patients annually and are aware of their patients’ lifestyles, they have the best access to the patients. Moreover, face-to-face-contact, one of the elements of the doctor-patient contact, is a relatively effective means of influencing a patient’s health behavior. Also, the GP has a certain authority. Finally, it is essential that prevention and cure are integrated. If there is a relation between disease prevention and the patient’s current state of health, the patient’s compliance with follow-up advice may be stimulated.

Therefore, we can conclude that there are some advantages to the Dutch GP playing an important role in prevention. But what do GPs really do in practice? In the mid-1980s Dutch GPs accepted prevention and counseling as obligatory tasks by entering them in the “Basic job description for the General Practitioner.” During consultation a GP should consider what preventive measures are suitable for the patient and see to it that these measures are carried out (1, 2).

LIMITATIONS AND PROBLEMS

Acceptance of these formal tasks unfortunately did not mean that prevention was automatically carried out in practice. A study by the Dutch Institute of Primary Care (NIVEL) showed a reluctant attitude of GPs concerning their role in prevention. Various studies were performed to get better insight into this reluctance. From these studies we can draw some conclusions about the problems with prevention in general practice (3):

1) The GP’s attitude and knowledge. During medical education, emphasis is mostly on curing disease. Prevention

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demands a different and more active attitude, with the possible danger of patient medicalization or placing patients in categories. Many GPs doubt whether they are entitled to interfere with a patient’s lifestyle unless asked. Some GPs are aware that they have too little knowledge about nutrition. Also, dietary advice is hard to fit into a 10-min consultation.

2) Some GPs question whether preventive interventions and measures are effective for individual patients. This “prevention paradox” means that preventive actions that benefit the population at large may bring only small benefits in individuals (4).

3) The organization of the medical practice. Prevention requires some modifications, such as a systematic administration and registration of patients and their medical records. Many GPs lack a good warning and systematic recording system, or a systematic registration of relevant risk factors.

4) Finally, prevention can lead to an increased workload, without any financial compensation.

These problems should be taken into account in the development of future preventive activities in general practice.

POSSIBLE SOLUTIONS

An important condition for success is the development of national guidelines. Since 1989 the Dutch College of General Practitioners (NHG) has published 10 standards per year. Standards are based on the scientific literature and consensus procedures and are written by and for GPs (5, 6). A complete standard contains the standard as published in the NHG journal *Huisarts en Wetenschap*; a summary on a plastic card; a scientific review article, including references; and a teaching package.

Recent implementation studies show that the standards are well known and accepted by 80% of Dutch GPs (6). At this moment, there are 60 NHG standards. Several of these standards address nutrition. In many standards lifestyle and dietary advice (according to the “guidelines for good nutrition”) are the first step in treatment, for example, in the standards concerning non-insulin-dependent diabetes mellitus, hypertension, hypercholesterolemia, peptic diseases, and heart failure (7). Most standards are followed by a postgraduate teaching package.

We all know, however, that the formulation of guidelines does not mean that the guidelines are automatically implemented in practice because of other problems that must first be solved. For example, the doubt of many GPs concerning whether prevention is effective must be alleviated. Therefore, the NHG formulated three basic questions to guide every step in the decision-making process in prevention: 1) Is this preventive action or intervention known scientifically to be effective? Only if an intervention has proved its effectiveness can it be of possible interest. 2) Should this preventive action or intervention be executed by a GP? Some preventive interventions are more the task of public health authorities. Only if it is clear that the GP should carry out the intervention, should the actual implementation be considered. 3) How should this preventive action or intervention be implemented in practice? To be potentially successful, the implementation should be feasible.

FUTURE PLANS

In 1992 at the request of the Ministry of Health, the Dutch Association of GPs and the NHG formulated a long-range plan to stimulate prevention in general practice (8). In this plan a more systematic approach to prevention in general practice was proposed. The basic assumptions of this plan are as follows. First, individual prevention and cure must be integrated. Second, the preventive activities of GPs must be restricted to proven effective interventions. Third, systematic prevention requires better practice management. Facilitators (practice consultants), who support GPs in adapting the organization of their practices to enable prevention, can help meet this goal. This idea of facilitators was adopted from the Oxford Prevention of Stroke Project (9, 10). Last, individual prevention in general practice must be combined with general prevention in the public health care system. A combination of individual and population-directed preventive measures can be more effective.

There is some experience in the Netherlands with cooperation between GPs and public health services, which was not very successful. To investigate the possibilities of support for general practice by public health services, the government initiated the PreTension project in 1987. PreTension (a contraction of prevention and hypertension) was a relatively large-scale experimental project to determine which conditions should be fulfilled for GPs and public health services to implement a standardized and effective program for the prevention of cardiovascular disease (11, 12).

The basic concept of this project was the belief that combining individual prevention in general practice (high-risk approach) with a population-oriented strategy in public health services would be more effective than carrying out the individual and population strategies separately. If the project was successful, national implementation of the prevention program would be considered.

This project was carried out from 1988 to 1990 by 118 GPs in the area of five public health services. By way of case finding, GPs had to screen ≥70% of their 30- to 60-year-old patients for hypertension in 2 y. Persons with hypertension (systolic blood pressure ≥160 mm Hg or diastolic blood pressure ≥95 mm Hg or both) were also screened for hypercholesterolemia and overweight. Dietary and lifestyle guidelines were given to decrease the elevated risk factors. All smokers were advised to quit smoking. High-risk persons were encouraged to return for check-ups every 3 mo.

Facilitators, or practice consultants, employed by the participating public health services, assisted and supported the general practices in their area in implementing the program. Facilitators provided regular feedback on the follow-up of their at-risk patients (monitoring) and the results of intervention. The public health services also had the task of stimulating collective prevention of cardiovascular disease, for example, by health education about nutrition and by courses offered to help persons stop smoking.

It was concluded that most of the protocol had been feasible in the general practices. More than 70% of the target population in the general practices had been screened for hypertension within 2 y. A second conclusion was that the follow-up of patients with detected cardiovascular disease was a problem in many practices. Most GPs needed the support of the practice consultants to keep patients under surveillance. Furthermore,
the cooperation between GPs and public health services was of limited success. A better coordination between GPs and public health services would be necessary before the decision to implement this prevention program on a nationwide scale could be made. The theoretically effective combination of a high-risk approach in general practice and a population strategy did not work well in this 2-y project.

The implementation of prevention in general practice can only succeed if prevention can be introduced in gradual steps. Dutch GPs have chosen to start with rather simple subjects: influenza vaccination and cervical cancer screening. In 1995 the Ministry gave a grant to implement this plan, named Preventie: maatwerk (Prevention: tailor-made). Since September, > 70 facilitators are supporting GPs in the organization and implementation of influenza vaccination. In 1996 and 1997, the organization of cervical cancer screening will be added. If this approach is successful, a next possible subject will be secondary prevention of cardiovascular disease in high-risk groups, including the giving of lifestyle advice.

REFERENCES


