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Commercial chains in general practice

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This report was written as country contribution on the Netherlands for a 'rapid response report', drafted by the European Observatory on Health Systems and Policies on corporate investment in primary and specialized outpatient care in Europe. The rapid response report was requested by the French national health insurance organisation CNAM.

Our contribution was written between 20 February and 2 March 2023. We have focused on chain organisations in general practice. In this short time it was impossible to do in-depth research and bring in the viewpoints of all actors involved. Our results show that there is no systematic information available; many important questions about the possible positive and negative consequences of chain formation in general practice are as yet unanswered. Given the importance of the phenomenon, systematic monitoring and research are recommended.

Introduction

Traditionally, Dutch GPs are self-employed professionals who run a general practice either alone or in cooperation with others (GPs or other health professionals). Transfer of ownership usually occurs when a GP retires and his or her successor would take over the practice. This traditional governance model of general practices has recently been supplemented with new models that involve private investors. It has become increasingly difficult for self-employed GPs who want to retire to find a successor to take over their practice, especially in certain regions. Several organisations, including commercial firms, have filled this gap by taking over practices or starting new practices in areas with a shortage. They have also been reported to compete with young GPs in bidding for existing practices (Stuijver, 2021). In doing so they have created chains of practices, with different ownership conditions, different relationships with the professionals and other staff working in the practices, and different earnings models. Some of these chains have had problems in staffing the practices they took over, with negative consequences for continuity and quality of care (Skipr, 2023). This has led to discussions in news media and discomfort among patients that were registered with these practices.
In the Dutch context, it is not easy to define what 'commercial' GP chains are. GPs in the Netherlands are independent contractors to the health insurance organisations and GP practices are usually owned by GPs (who may or may not employ other GPs) (see Box). They work for profit in the sense that they have to run the practice and pay the staff that is employed in the practice and earn their own 'salary' from their practice. As all Dutch inhabitants are obliged to take out health insurance and nearly all inhabitants are registered with a specific GP practice, there is no parallel circuit of private GP practices. With commercial GP chains – in the context of this contribution – we mean GP chains with non-GP shareholders/investors.
There is some experience with commercial investments – by private equity firms – in other parts of Dutch health care (e.g. in long-term care organisations). There are also some private specialist clinics, chains of dental practices and of pharmacies that are owned by investor firms.

Organisation of general practice

The Dutch health care system is based on social insurance. The insurance system is privately organised, but publicly guaranteed. Every citizen is obliged to take out health insurance with one of the competing insurance companies. Adult citizens pay a fixed, community rated premium and depending on their income, can receive compensation. GP care is covered by the basic health insurance. All insured pay a mandatory deductible, but GP care is exempted from this; however, the deductible applies to drugs prescribed by a GP, laboratory work, and to follow-up care by specialists after a referral (Kroneman et al., 2016).
Insurance companies are obliged to contract the necessary care to serve their insured. They can selectively contract providers based on price and quality of care. In practice, all insurance companies have contracts with all GPs and follow in most respects the insurer with the highest regional share of insured.
GPs are independent contractors. In 2022, 11,754 GPs were active, working in 4,874 practices. Taking part-time working into account, the GP-population ratio was 5.3 full-time equivalents (fte) GP per 10,000 inhabitants. General practices in the Netherlands are relatively small:

- 17% of the practices are single-handed (i.e. staffed by one GP);
- 44% of the practices are staffed by two GPs, and
- 39% of the practices are staffed by more than two GPs.

The largest category of GPs is self-employed, (65%) and owner of their practice; 45% works as an employee or locum in a health centre or practice (Batenburg et al., 2022).
All practices employ practice assistants who have administrative tasks but also conduct telephone triage and clinical support. Nearly all practices employ practice nurses for patients with a chronic disease, elderly care, and mental health care (Flinterman et al., 2018).
Nearly all Dutch citizens are listed with a specific practice they can choose freely within the area in which they live. Access to specialist care is only after a referral (gatekeeping). Consultations are relatively short; standard booking time is still ten minutes but increasing.
GPs are paid in a mixed system:

- Capitation with differentiation by patient age and patients living in deprived areas;
- Pay per consultation (including telephone, email and teleconsultations);
- Performance payment for some services to be negotiated with the insurance company in the area of referrals, prescribing, and service and accessibility, and for disease management for a number of chronic diseases.

In this contribution we will sketch the background of the emergence of this phenomenon of chains of general practices, give an overview of what is known about these chains and summarise the discussions about the positive and negative consequences.

Background

At the background of the emergence of chains of practices are a number of developments in the health care system which can be linked to different actors: young GPs who, for various reasons, may not want to work as a practice owner, practice owning GPs who want to transfer their practice to a new owner, health insurance organisations that are interested in stable care provision to comply with their obligation to provide sufficient care, and chain organisations that come in various forms and operate out of different motives.

The large majority of trainee GPs aspire to be self-employed practice owners, often after a period of working as a locum, according to a recent survey (Vis et al., 2021). However, young GPs are deterred from practice ownership by increasing regulatory demands, costs and/or workload that come with ownership of a practice . The combination of providing GP care and being an entrepreneur may give headaches. Young GPs may not be well prepared to the entrepreneurial side and being in charge of the practice brings responsibilities (Vis et al., 2021). The administrative workload is felt to be large and has increased over time. The health care system has become more complex in the course of time and shortages in other sectors, such as mental health care, make it difficult to refer patients to the care they need. The staff of GP practices has increased; even a single-handed practice may employ several practice assistants and practice nurses. The relatively small size of GP practices (see box) also makes human resource management difficult; a vacancy or long-term illness among staff may be disruptive and not easy to cope with by other staff. Demographic changes in the GP population may have added to the challenges. GPs increasingly work part-time to balance working life and private life. Female GPs work part-time more often and their share in the GP population has increased. Given personnel shortages, both of GPs and other staff, GPs have much more freedom in choosing the conditions and location of work. And if working as a locum GP or as an employee of a practice owner is more attractive than being a practice owner, and working in the centre of the country is more attractive than working in the periphery (with less job opportunities for one's partner), it is understandable that fewer young GPs choose for practice ownership.

However, apart from the preferences of young GPs, the emergence of GP chains is also dependent on other conditions. Practice owners who want to retire or shift careers, can sell their practice and the premises. When the price they ask is too high for a new GP to take over the practice, chain owners may step in and buy the practice. The characteristics of the payment system for GPs, where a large part of the renumeration is based on capitation, provides an attractive earnings model for chain owners. Patients who are registered with a practice they take over, may tend to stay with the practice as they usually don't have many alternatives close by. Hence, from the moment a chain organisation takes over a practice, there is a steady flow of income. Finally, insurance organisations have an interest in continuity of GP practices. They are obliged to contract enough care to serve their insured. This means that they have a problem if there is no successor in a practice and if there are no alternatives in the form of other practices that want to register the patients. In the past, at least one insurance company also tested the waters by trying to vertically integrate health insurance and care provision by buying general practices. For instance, in 2011 it was reported that Menzis, a large health insurance company, owned 28 general practices. It had obtained these practices through a joint ownership (together with investment firm Reggeborgh) of Zorgpunt, which had acquired these practices. This led to unease about the growing role of health insurance companies. Although a commission set up at the instigation of Parliament (Baarsma et al., 2009; see also Schut and Varkevisser, 2010) had previously argued against a legal restriction on health insurers taking over health care suppliers, the National Association of GPs (LHV; *Landelijke Huisartsen Vereniging*) was critical of this practice (Reijmer and van Uffelen, 2011). Their main fear was that the integration of

insurance and primary care provision would compromise the independence of GPs (*ibid*.). Parliament eventually changed the Healthcare Market Regulation Act in 2014 to outlaw the practice. However, given their obligation to contract sufficient care for their insurees, health insurance organisations are a potential driver of developments in this area.

General practice chain organisations and estimated number of practices

Another way in which commercialization can enter primary care is through General Practice Chain Organisations (GPCOs). These come in a number of forms, only some of which can be designated as commercial (for-profit) organisations. Table 1 depicts, to the best of our knowledge, the current situation in the Netherlands.

Table 1 Overview of 24 General Practice Chain Organisations (GPCOs) in the Netherlands (situation end of February 2023).

Category	Description	Example(s)	Estimated number of practices	Key activities
1	Companies owning general practices (for-profit) (n=6)	Arts & Zorg, Co-Med, Centric	45	Take-over and ownership of general practices
2	Forms of cooperation between GPs (not-for-profit) (n=8-11)	Flexdokters, Fonkelzorg, Buurtdokters	44	Cooperation between independent GPs to share costs, workload etc.
3	Facilitators of take overs, succession etc. (for-profit) (n=1)	Familiedokters	Unknown	Legal and financial help with selling/buying practices
4	Companies offering online services, apps etc. (for-profit) (n=6-7)	Huisartsen van Nederland, Artsonline	Unknown	Offering online solutions for GPs, including apps, AI solutions and platforms that also offer care capacity for GPs (locums)

This table is based on a preliminary analysis of websites, news sources and the Orbis- and Chamber of Commerce databases, as well as on an analysis of the Nivel Registration of General Practitioners and General Practices data by Benno Duijkers and Jelmer Wedholm (Nivel). For some organisations (in categories 2 and 4) we were unable to definitively assign them to a category based on the information available.

Since our focus in this overview is on GPCOs, we will not discuss the third and fourth categories further at this point. We do note, however, that these organisations are potential sources of further commercialization of primary care. Especially the development of online services for general practices and apps for communication with patients have gained attention from investors (like private equity), who see business opportunities in a growth market linked to the increasing emphasis put on e-health as a strategy to control healthcare costs.

The first category holds companies that own a share in GPs as investors with a for-profit motive. An example is Arts & Zorg, a company owning some 23 practices in the Netherlands, and which itself is owned by NPM Capital, a private equity group. Interestingly, the company took over the aforementioned Zorgpunt from Menzis and Reggeborgh in 2012.

The second category holds a diverse group of companies that are cooperations between GPs. The aim often is to reduce overhead costs (like administrative costs by sharing a back office), workload or procurement costs (e.g., in the case of GPs also owning a pharmacy). Our exploratory analysis indicates that by our definition most are not-for-profit, although in two cases this is not entirely clear. In those cases, a general practice seems to be in the lead, offering services to the others in the group. Although we could not identify an outside (i.e., non-GP) investor, the underlying motive of the lead GP might still be a for-profit motive.

The total number of practices that are part of a commercial provider is highly uncertain. As indicated in Table 1, our estimate on the basis of the available data is 45 practices. However, this must be regarded as the minimum number. Based on the analysis of the Nivel registration of general practitioners and general practices data, 120 practices were identified which were staffed with locums only. These could potentially be part of for-profit chains. However, it is likely that this also includes different forms of not-for-profit cooperations between GPs. Moreover, we found 108 practices which employed practice holders as salaried employees and were not registered as (non-profit) foundations. These 108 practices could potentially also be for-profit. Summing up, our best estimate would be that the number of commercially run practices in the Netherlands is somewhere in the range between 45 and approximately 230 practices (out of the 4,874 practices registered in 2022).

Effects of practice chains on care provision

There is no research in the Netherlands on the consequences of the emergence of practice chains for service provision. We have scanned the discussions in health care periodicals to assess the possible consequences of the activities of these chains.
Consequences can be both positive and negative. To start with potential positive consequences, the urgency of the capacity problem in primary care has been stressed. In the situation where practice owners cannot find a successor and patients run the risk of not having access to GP care, practice chains can provide a solution (Lambregtse, 2021). Chains of practices may provide better support in administration, management of the property and human resource management (Schers, 2023). For GPs it may be attractive to work in a chain practice, if that means shorter working times, less administrative burden and the possibility to work as employee of the chain (Schers, 2023). Finally, the focus of a number of practice chains on digital care may lead to innovations that can improve GP care in general.

On the negative side, a number of considerations relating to quality and accessibility of care have been mentioned. Chain practices often ‘man’ the practices with locum GPs. As a consequence, patients do not have their own GP (Lambregtse, 2021). This hampers one of the core values of Dutch general practice (Van der Horst, Dijkstra, 2019). The earnings model of some of the chains is based on digital care (De Wildt, 2021). There is a risk of using distance care to much (Lambregtse, 2021). The reliance on distance care implicitly selects longer educated patients, with digital literacy, and single health problems (De Wildt, 2021). This may lead commercial providers to willingly or unwillingly select patients, a practice known as cream skimming. This is a general risk of capitation systems; however, until recently there have been no signs of GPs selecting the less laborious patients. This has been attributed to the moral commitment of GPs to provide the best possible care and a strong tradition of working according to guidelines, developed by the GP profession itself (Van

Dijk, 2012). If the emergence of commercial chains are a tipping point in this respect, the question is how to redress this.
There is also a risk that patients with more complex problems that in principle can be treated in general practice will be referred to secondary care instead (Schers, 2023). Again, there have been no signs that GPs do this under the current capitation system, but the system does hold an incentive to do this that can be exploited by more commercially orientated actors.
It has also been mentioned that regional cooperation in primary care and between primary and secondary care may be more difficult with chains of practices that are not attached to a specific region (Schers, 2023). Finally, general practice generates many data about patients and the question has been asked whether chains would use these data for commercial ends (e.g., by selling them; see Schers, 2023).
The *Inspectie Gezondheidszorg en Jeugd* (IGJ; Inspectorate Health Care and Youth) has investigated some of chains of practices (i.c. Quin Dokters, CoMed, Centric Health), following complaints by patients and other health care providers (several news items in Medisch Contact). Recently, an investigation started by the ICJ and the *Nederlandse Zorgautoriteit* (NZa; Dutch Health Care Authority) into what they call innovative chains of GP care. This investigation is more general, because it is not exclusively focused on separate chains; it also investigates whether the IGJ and NZa have to adapt their way of supervision to the emergence of chains of GP practices (NZa, 2023).

Conclusions

There is a number of chains of GP practices active in the Netherlands. Their background and the way they organise the practices in the chain differ. There are positive and negative sides in the emergence of GP chains. The risks of decreased accessibility and continuity of care have induced investigations of the Inspectorate. It is as yet not clear what the consequences of these investigations will be.

In general there is not much information or research on this important development of GP practice chains. There are more questions than answers. There is a need for monitoring the numbers and research into organisational forms, the position of GPs and other professionals working in the practices, the effects on regional cooperation, and the consequences for patients.

Various observers note that the Dutch healthcare system is standing on the threshold of an increasing commercialization, fueled by private investors. Last year, Gilde Health Care, a Dutch private equity firm that specializes in health care, raised € 517 mln. for a new fund designated for take overs in the healthcare sector (FD, 16 March 2022). It is difficult, however, to foresee the development for primary care in the near future. As the situation on the labour market for GPs and support staff will not improve in the coming years, it may be expected that new forms of organisation of GP care will grow in importance. However, whether these will take the form of commercial chains or self-organised, cooperative chains of GPs themselves is not to say. The current policy focus on regional cooperation may lead to the balance swinging towards cooperative chains.

About the research

At the request of the European Observatory on Health Systems and Policies, researchers from the Nivel contributed to a "rapid response report" for the French National Health Service through an exploratory study of commercial general practitioner chains. By means of a scan of the literature and an analysis of the Nivel registration of general practitioners and general practices, a first inventory was made on what is known about these chains, and what are the possible advantages and disadvantages of commercialization of general practitioner care.

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