Summary

The general practitioner (GP) is in the Netherlands the gatekeeper of the healthcare system. The focus of the GP in the Netherlands lies on providing general, accessible, personalized en continues care. In the past GP's used to work solo in his practice. He had his own practice and therefore was fully responsible for all the patient care. A number of developments caused the care delivered by GP's to change. Because of the increasing work pressure new disciplines were found and task delegation became a common good. The most important development however is that GP's more and more tend to collaborate intensively. This development is also stimulated by the government and insurance companies. More and more group-practices were found and between 1995 and 2005 the number of solo-practices decreased with 50 percent, while the number of group-practices doubled.

Group-practices were found because the advantages gained out of it are significant. For example, there are advantages in consultation, specialization, automation, availability and management. A number of these intended benefits has to do with the quality of care that is being given. Unknown is whether there are differences to be found in the way solo- and group-practices handle quality care. Therefore the problem definition in this thesis is:

To what extend differs the way that group- and solo-practices handle their quality care?

To measure quality care in healthcare is not easy. However there are a number of points that good quality care should match up to. The care provided should be adapted to the patient-needs and the provided care should be of high level, it should be provided efficiently and patient-oriented. There are several instruments to improve quality. These instruments are; standardizing and protocolization, advanced training, cyclic quality improvement, involve patients and certification (Harteloh en Casparie, 1998). This research deals with the way that GP's handle quality and the instruments they use in that process.

Six GP's were interviewed for this thesis. Three of them are solo and three work in a group-practice. A description of all the activities that the interviewed GP's perform on quality can be found in chapter 5. Remarkable differences and similarities are:

- All the GP's use the same instruments to improve quality. Certification is the only thing that group-practices are more active in than solo-practices.

- Both solo- and group-practices have all the delegated task protocolized.
- Group-practices spend more attention to revising and authorization of protocols.
- GP's in group-practices spend more time on advanced training of practice assistants.
- In group-practices assistants are better trained on triage.
- GP's in group-practices delegated more tasks to practice-support assistants; therefore they gave them more advanced training.
- GP's in solo-practices try to improve telephone availability, while GP's in group-practices try to 'steer' the patient.
- GP's in group-practices tend to cooperate more on large innovative projects to improve he quality and efficiency of the care provided.

From these differences and similarities can be concluded that group-practices are more active in improving the quality care. However in solo-practices there are advantages to be gained with collaboration. But these collaborations will cost more effort. Up until now GP's in group-practices spend more effort on quality care then there solo colleagues.