COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

QUALITY DEVELOPMENT IN HEALTH CARE IN THE NETHERLANDS

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ABSTRACT: The Dutch health care system's recent experiences with reform hold lessons for U.S. legislators and policymakers. In 2003, the Netherlands spent 9.8 percent of its gross domestic product on health care, below the spending levels in Germany, France, and Canada and more than one-third less than the United States. Even under the constraints of this budget, the Netherlands has implemented a number of health sector reforms that have led to important quality improvements. This report discusses several of these initiatives, including the central focus on primary care; reorganization of after-hours and emergency care; utilization of clinical guidelines, performance indicators, diagnostic treatment combinations; local collaboratives; and introduction of more stringent accreditation and evaluation procedures.

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INTRODUCTION

While no nation can be deemed "the best" in terms of its health care system, the United States is consistently outperformed in such areas as the prevention of medical errors, the provision of timely care for all citizens, and coordination of care.[1] The U.S., it would seem, could learn from models and best practices used in countries that have achieved these higher levels of performance. One such country is the Netherlands. In 2003, this nation of just over 16 million people spent 9.8 percent of its gross domestic product on health care, below the spending levels in Germany, France, and Canada and more than one-third less than the percentage spent in the United States (Table 1). Even under the constraints of this budget, the Netherlands has implemented a number of health sector reforms that have led to important quality improvements.

Table 1. Health Care Spending and Physician and Nurse Ratios, 2003

	Health Expenditure as Percent of GDP	Total Expenditure on Health Care per Capita (USD PPP)	Public Expenditure on Health Care per Capita (USD PPP)	Private Expenditure on Health Care per Capita (USD PPP)	Physicians per 1,000 Population	Nurses per 1,000 Population
Australia	9.3%[a]	$2,699[a]	$1,821[a]	$ 878[a]	2.5[a]	10.2
Canada	9.9[e]	3,001[e]	2,098[e]	903[e]	2.1	9.8
Finland	7.4	2,118	1,622	497	2.6	9.3
France	10.1[e]	2,903[e]	2,214[e]	689[e]	3.4	7.3
Germany	11.1	2,996	2,343	653	3.4	9.7
Netherlands	9.8	2,976	1,856	1,119	3.1	12.8[a]
Spain	7.7	1,835	1,306	529	3.2	7.5
Sweden	9.4	2,703	2,304	399	3.3	10.2[a]
United Kingdom	7.7[a]	2,231[a]	1,860[a]	371[a]	2.2	9.1
United States	15.0	5,635	2,503	3,131	2.3[a]	7.9[a]

Note: PPP = Purchasing power parity—an estimate of the exchange rate required to equalize the purchasing power of different currencies, given the prices of goods and services in the countries concerned.

[a] 2002 data.

[e] Estimate.

Source: Organization for Economic Cooperation and Development (OECD) Health Statistics 2005.

This report discusses several Dutch initiatives, including the establishment of a central focus on primary care; the reorganization of after-hours and emergency care; utilization of clinical guidelines, performance indicators, diagnostic treatment combinations; local collaboratives; and introduction of more stringent accreditation and

evaluation procedures. The report identifies lessons that may help the United States further its goal of enhancing the performance of its health system.

Features of the Dutch Health Care System

- Complete coverage of all residents
- Strong primary care focus: gatekeeping, all patients related to one specific practice
- Primary care by trained family medicine specialists
- All other medical specialists work in hospitals (private or salaried)
- Increasing role for nurses

THE DUTCH HEALTH CARE SYSTEM AND RECENT REFORMS

Unlike many other European nations, the Netherlands has a private health care system, with primary care physicians and practices, hospitals, nursing homes, mental health providers, and other health care organizations negotiating contracts and budgets with various health insurers. Health insurance coverage is nearly universal, with the population covered by a combination of private and public insurance. In each province, a single insurer covers 100 percent of the population for costs associated with long-term care, exceptionally expensive care, and care considered to be uninsurable, such as care for the disabled. Until 2005, acute and general health care expenses were covered by a second level of insurance, with 65 percent of the population qualifying for a publicly funded sickness fund because their incomes fall below a certain threshold and the rest purchasing private coverage. In 2006, this has changed due to the introduction of an obligatory national insurance with basic care for all citizens. Under the new regulations, insurers cannot refuse coverage to any citizen, but can compete on price and quality and offer packages with additional services. Citizens pay an annual fee of about $1,200 to $1,300 for the basic insurance, with a no-claim of about $275 (costs that will be reimbursed if not claimed by the insured person). Subsidies for the premiums are available for low-income citizens. The basic insurance covers all primary and secondary care; supplemental insurance is available to cover medical expenses for services not included (such as dental care and physical therapy).

Primary Care

Primary care, which has proven to be essential to achieving desired health outcomes and limiting costs, plays a central role in the health care system in the Netherlands.[2] The country has roughly 9,000 family physicians, most of whom have received two to three years of specialist training in family medicine. Dentists, midwives, physiotherapists, and pharmacists also deliver primary care services. Nearly all residents are linked to a regular

family physician and practice. Patients are able to choose their family physician but, beginning in 2006, must register with a specific primary care practice. Family physicians act as gatekeepers to the system and must give their approval before patients can access hospital and specialist care. As a result, 95 percent of problems presented in primary care are handled by the regular practices.[3] In surveys, patients have repeatedly expressed high levels of satisfaction with primary care and strong support for their longstanding relationships with family physicians.[4] In the United States, by contrast, 16 percent of adults with health problems report that they do not have a regular doctor.[5]

Nearly all practices use electronic medical records and an increasing number use computer software to identify and track patients who have chronic conditions or are at risk of developing them. Most patients with chronic diseases are treated and monitored within primary care practices, often in collaboration with hospital specialists. The country has launched a variety of local and regional initiatives aimed at improving care for patients with diabetes, lung diseases, depression, dementia, cancer, and other chronic conditions. Over 30 percent of practices now employ nurse practitioners to manage care for patients with chronic conditions and the number of such practices is growing rapidly. The role for nurses in the management of chronic conditions also has been expanding in the United States.[6] Other innovative practices for the management of chronic conditions include: using specific services or laboratories to monitor and track chronic patients; adopting evidence-based guidelines, critical pathways, and care protocols; instituting self-management and educational programs for patients; and developing collaborations among primary care and hospital facilities.[7]

Most family physicians and other primary care professionals currently work in private practices, with a majority working solo or in small group practices of two to three partners (88% of practices). However, capacity problems in family medicine and political pressures have been driving rapid change, and the number of large group practices is growing and new models for primary health care are being tested. In the near future, health care centers with four to six doctors, one or two nurses, and other professionals (such as physiotherapists or pharmacists) caring for about 10,000 to 15,000 patients and working in close collaboration with local hospitals will be the norm.

In the past, sickness funds reimbursed primary care physicians though annual capitation payments, while private patients paid practices and were then reimbursed by insurers. A new payment system has been introduced in 2006 which will include capitation per patient and a fee per consultation, plus a negotiable reimbursement for practice costs depending on services offered, staff employed, and quality and efficiency indicators.

Health Care Reform Slated for 2006

- Greater reliance on market forces and competition
- Compulsory national basic insurance for all residents
- Insurers competing on price and quality to attract clients
- Reimbursement of primary care: mix of capitation per patient, fee per service, and potential rewards based on indicators of quality and efficiency
- Increasingly, insurers contracting with primary care practices and hospitals based on price, quality, and levels of accreditation
- Move toward integrated, multidisciplinary primary care centers

After-Hours and Emergency Care

In 2005, 61 percent of American adults with health problems surveyed by The Commonwealth Fund reported it was "very difficult" or "somewhat difficult" to get care on nights, weekends, and holidays without going to the emergency room.[8] The Netherlands has taken important steps to improve access to after-hours care in a manner that is acceptable to health care professionals. Historically, groups of collaborating family physicians provided after-hours and emergency care, but these responsibilities have been assumed by large-scale, after-hours organizations, called primary care cooperatives, some years ago (2000-2002). In almost all regions, approximately 100,000 to 400,000 patients are assigned to a cooperative, making access to care on the nights and weekends easy for nearly all citizens. In emergency situations that happen outside office hours, patients can call their assigned cooperative for triage advice or visit the emergency room of a hospital. Roughly 85 percent choose the former option. At the cooperatives, trained nurses are the first point of contact, performing triage and giving advice. Evaluations show that about half of all contacts are handled solely by nurses.[9] After triage, family physicians provide consultations by telephone, at walk-in centers, or, when necessary, at patients' homes. Physicians are very positive about the reduced workload and privacy the new system affords. Seventy-five to 80 percent of the patients contacting the cooperatives have had a positive response to them, with some criticism focused around the triage and advice provided by nurses over the telephone. About 25 percent of the patients were negative about the advice and reassurance the nurses provided (data not published).

Hospital Care

The majority of the more than 100 acute care hospitals in the Netherlands are private and nonprofit. When they are referred to medical specialists by their family physicians, patients see specialists who work either in private practice within hospitals or on a salaried basis for

the hospitals. Historically, hospitals have negotiated annual budgets for patient care and other costs. A new system of diagnostic treatment combinations (DBCs), which assign a price to each product or service, is now being used; 10 percent of these DBCs are now freely negotiable with the insurer, and this proportion will gradually be increased in the future. Medical specialists' salaries or fees are included in the DBCs, as well as all hospital costs involved. (In the United States, the comparable diagnostic-related group payments are used to reimburse hospitals, but they do not include specialists' salaries.) This new system enables insurers to purchase care based on price and, potentially, on quality—forcing hospitals to make prices transparent and increasing competition among them.

DUTCH QUALITY DEVELOPMENT

Traditionally, Dutch quality development among health care providers was largely self-regulated. This began to change with the Quality in Institutions Act of 1995, which offered a simple framework for quality assurance and improvement. Although it did not dictate decisions regarding specific tools and procedures, the Act mandated that every profession or organization in health care set standards for optimal care; develop strategies for monitoring and improving care; and create systems to enable public reporting to the health care inspectorate, through an annual quality report, and to patient organizations. A 1995–2000 study evaluated progress on 46 distinct quality management activities in 474 health care organizations in the Netherlands and found an increase of an average of 20 activities per institution in 1995 to on average 25 in 2000; the increase was, specifically in the areas of quality reporting, policy development, use of patient satisfaction surveys, and creation of client counsels.[10] Nevertheless, key stakeholders—government, inspectorate, payers, and patient organizations—were not satisfied by the level of progress, particularly in the areas of hospital care and patient participation. Consequently, these stakeholders have become more intensively involved in improvement initiatives. The different parties' initiatives often overlap and compete with each other and have resulted in some confusion within the target groups. For instance, different sets of performance indicators are now being developed by the inspectorate for health care, insurers, professional bodies of physicians, and patient organizations, creating confusion among those responsible for collecting the data.

Quality Improvement Initiatives	
Primary Care	• clinical guidelines, education for professionals • practice-level performance indicators • local collaboratives or "quality circles" • accreditation and improvement models • outreach visits, practice support
Hospital/Specialist Care	• disease management programs • clinical guidelines • hospital-level performance indicators • specialist team appraisals by peer visits • individual specialist appraisals • national collaboratives and business process redesign programs

Clinical Practice Guideline Development

The first major movement to improve quality in the Netherlands focused on the development of national clinical practice guidelines. The initiative was spearheaded by the Dutch Institute for Health Care Improvement (CBO), which began development of multidisciplinary guidelines in 1983, and the Dutch College of Family Physicians, which began development of primary care guidelines in 1987. Organizations of medical specialists, nurses, allied health workers, and mental health professionals began to develop their own guidelines in the mid-1990s. A large body of guidelines has since been developed and is regularly updated, mainly through systematic and rigorous evidence-based procedures.[11] More than 80 clinical guidelines have been developed for primary care alone, covering most of the health problems seen by family physicians. Educational materials and tools have been developed to supplement these guidelines, including packages used in local collaboratives and continuing medical education (CME) courses; leaflets and letters for patients; and triage recommendations for receptionists, practice assistants, and practice nurses. Furthermore, specific indicators to monitor adherence to the primary care guideline recommendations have been developed and rigorously tested. The impact of the guidelines is now continuously monitored in a representative sample of about 80 primary care practices representing roughly 400,000 patients throughout the Netherlands (Table 2).[12] Data show that adherence to guidelines is better than in the United Kingdom or United States, probably because the country has had a longer history with practice guidelines in primary care.[13]

Table 2. Clinical Performance in 80 Primary Care Practices in Line with Guideline Recommendations (% adherence) in 2003

	Number of Indicators	Mean%	Range%
All actions and decisions	45	75	27–99
Decisions on:			
prescribing medication	25	62	32–96
referral to hospital (specialists)	12	87	63–99
test ordering	6	75	27–99
prevention (influenza/Pap smears)	2	76	76–76

Source: Braspenning, Schellevis, and Grol, eds., Kwaliteit van Zorg belicht (Quality of Care in the Spotlight), 2004.

Evaluation and Quality Improvement in Primary Care

Prior to the mid-1990s, evaluation in primary care was restricted to licensing doctors on the basis of continuing medical education credit points. In the last 15 years, however, there has been an effort to develop, test, and validate indicators, assessment tools, and instruments used in measuring clinical performance, prevention, management of the services, and patient experiences with the care provided.[14] Many of the evaluation tools have been integrated within a new system of voluntary accreditation, established in 2005 and run by the Dutch College of Family Physicians (in which 90 percent of the family physicians in the Netherlands are members) and the independent Centre for Quality of Care Research (WOK). Practices are now encouraged to compile data from patient records, surveys, and staff questionnaires as well as input from trained observers into feedback reports that guide team discussion and result in specific targets for improvement. Trained auditors follow up to see if practices are working to achieve these targets. A support program is offered by the Dutch College of Family Physicians; reaccredidation takes place after three years. This system will gradually be transformed into a more formal system of obligatory recertification, with an independent body responsible for the process. The accreditation increasingly will be used as the basis for contracting and licensing of practices. An initial experiment has been conducted, during which two major insurers worked with a group of primary care practices using pay-for-performance quality indicators that allowed the practices to earn extra income of €10,000 to €15,000 (approximately $12,000 to $18,000); in all, about 10 percent of practice income was related to quality indicators.

Local collaboratives, or "quality circles," were developed in the Netherlands in the mid-1980s and continue to be one of the preferred and most widely used methods of continuous quality improvement in primary care across Europe.[15] Each collaborative is comprised of eight to 12 professionals—multidisciplinary teams of physicians, dentists, midwives, community nurses, and others who meet regularly to discuss clinical guidelines

and performance, establish local consensus, exchange best practices, and make plans for change.[16] Research on the effectiveness of local collaboratives has repeatedly shown positive results.[17]

Another quality improvement strategy relies on peer visits to practices by trained providers, such as nurses and physicians. The providers offer training, feedback, materials, and other support to ensure that guidelines are implemented and care is improved.[18] They also teach the staff the skills needed to carry out continuous quality improvement.[19] This approach was used successfully by a national prevention program, focused on the provision of flu vaccinations and cervical smears for people at risk and on the prevention of cardiovascular risk conditions. The program staff developed a multilevel intervention, which included three to four outreach visits in total by trained nurses, education, and support. Prior to the intervention, 10 percent of patients were vaccinated. Within two years, the percentage rose to 16 percent, with about 80 percent of those at risk receiving vaccinations. Over the same period, the percentage of at-risk women getting Pap smears rose from about 45 percent to nearly 70 percent. Similar improvements were seen for the cardiovascular risk program. These results have been attributed largely to the peer visits, along with the computer-support software developed to identify at-risk patients and financial incentives for the extra work.

Evaluation and Quality Improvement in Hospital and Medical Specialist Care

Certain evaluation and improvement initiatives focus specifically on hospitals, medical specialists, and other hospital professionals. Regular and compulsory appraisals of specialist teams, with well-developed and validated procedures and criteria, are run by specialist societies. A similar program, aimed at appraisal of individual physician performance, is in development. The appraisals will be performed by peers using validated instruments to collect data and also will draw on evaluations by colleagues and possibly patients. The aim is to focus on the personal development of all physicians and the identification and revalidation of underperforming doctors.

Previously, evaluation of hospital performance was voluntary and consisted of extensive accreditation procedures based on existing models, such as the International Organization of Standardization (ISO) or the Baldridge model. Recently, the inspectorate for health care launched a program mandating that hospitals collect data on 20 performance indicators, including mortality after myocardial infarction or stroke, wound infection, pressure ulcer incidence, and medication errors. The results are publicly reported on a freely accessible Web site. Hospitals are obliged to participate in this program. If they do not provide appropriate and timely information, they run the risk of a

sanction by the inspectorate. Indicators were developed in collaboration with the associations for hospitals and medical specialists. While many hospitals have had complaints about the difficulty of collecting appropriate data and about the validity of the indicators, the initiative demonstrably identifies gaps in quality, stimulates hospitals to improve monitoring of care, and encourages specialists to develop better indicators.

For many years, the focus of quality improvement in hospitals has been on developing and disseminating guidelines and on continuing medical education for physicians, nurses, and others. In recent years, however, breakthrough collaborative and business process redesign (BPR) programs have been organized by government, associations of medical specialists, and independent organizations around intensive care, emergency care, medication safety, stroke, diabetes, and breast cancer. Some of these efforts have had success, mainly in improving intensive and emergency care, while others have been found to be less effective. The collaborative method is now used in mental health care, mainly in the treatment of depression, and in the partnership between family physicians and hospitals for care of asthma patients. The most recent national programs to use the collaborative and BPR methodologies have broad aims, such as using indicators to increase the transparency of care and reduce waiting times.

Many quality improvement initiatives in the Netherlands have shown positive results. Future efforts must focus on integrating the various quality improvement initiatives into a single and coherent system.

CONCLUSIONS: LESSONS FOR POLICYMAKERS

The Dutch health care system's recent experiences with reform, including the use of quality development initiatives, hold lessons for policymakers in other countries:

- A health care system with accessible primary care as a first point of entry for all citizens, delivered in small- to mid-sized centers that are fully integrated into the wider health care system, may offer the best guarantee for cost-effective patient care.
- It is important to strike a balance between external, authority-driven systems for quality development and internal, professionally led systems.[20] The primary care sector demonstrates that a degree of self-regulation by care providers is possible and can be effective. At the same time, there is often a tendency to maintain the status quo in the absence of pressure or sanctions. Therefore, a balance between external and internal quality improvement must be established in consensus among all stakeholders.[21]

- Separate, unrelated initiatives by different stakeholders can contribute to confusion and resistance among the target groups and waste time and money. Integrating initiatives within a single, widely accepted quality improvement system is crucial for success. Policymakers must take the lead in this integration.[22]
- While policymakers often seek immediate, revolutionary change, sustained change demands long-term strategies, policies, and support.[23] The primary care quality program in the Netherlands has been in existence for more than 15 years, and its success can be partly attributed to the consistency of its approach.
- Evaluation and quality improvement are new to many people, and some may find the experiences difficult or threatening. Education and support to help professionals, teams, and practices understand the field and become receptive to innovation are crucial to participation and success. Training programs for undergraduate and graduate students, as well as continuing medical education for professionals, must teach evaluation and quality improvement skills.
- Quality improvement research is limited. Models and innovations that do not work are a waste of money. To ensure efficiency and effectiveness, countries must invest in health services research and research capacity building focusing specifically on quality improvement.

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