

“Measuring Up”

Improving Health Systems Performance in OECD Countries



Can a tulip become a rose?

The Dutch route of guided self-regulation towards a community based integrated health care system.

**Niek Klazinga, Diana Delnoij, Isik Kulu-Glasgow
Department of Social Medicine
Academic Medical Centre - University of Amsterdam**



Health
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Canada

- Concepts
- The Dutch Health Care System
- Quality Policies and Quality Systems
- Strength and Weakness of a System based on Selfregulation
- Comparison with other OECD Countries
- Conclusions

Concepts

- Health System
- Performance
- Improvement
- Measurement

Characteristics of the Dutch Health Care System

- Mixed public/private system with self-regulation
- Mainly private not-for-profit providers
- Financing through a mix of private/public insurance schemes
- Separate insurance schemes cure and care
- GP as gatekeeper
- Municipal Public Health Offices

Problems in the Dutch Health Care System

- Focus on cost control
- Labour shortages
- Waiting lists
- Quality problems
- Future financing schemes
- EU and public/private mix
- Difficulties in addressing prevention
- Separation cure, care, social care, public health, health policies
- Separation steering mechanisms

Table 1. Examples of information in the Dutch health system (1)

Parameter	Types of indicators	Frequency of data collection, type of data	Registration name, collecting institute
Demography	<ul style="list-style-type: none"> • Age-sex distribution of the population • Birth rate, death rate • Life expectancy etc. 	Continuously, census data	Population statistics, CBS (Central Bureau of Statistics)
Population health	<ul style="list-style-type: none"> • Incidence and prevalence of diseases in the population • Incidence and prevalence of diseases in general practice • Socio-economic differences in health status, etc. 	Every 4 years, registrations in nationally representative samples	Health (care) forecasts, RIVM
Utilization of health services	<ul style="list-style-type: none"> • Number of visits to GPs, specialists, physiotherapists per non-institutionalised inhabitant per year 	Every year, survey of a nationally representative sample	Health questionnaire, CBS (Central Bureau of Statistics)

Table 1. Examples of information in the Dutch health system (2)

Parameter	Types of indicators	Frequency of data collection, type of data	Registration name, collecting institute
Production of health services	<ul style="list-style-type: none"> • Number of GP contacts • Number of referrals by GPs to specialists per diagnosis per 1,000 enlisted patients • Number of prescriptions per 1,000 enlisted patients 	Continuously, registration in a nationally representative sample	National Information Network GP-care (national GP information network) (LINH), Nivel/NHG/LHV/WOK
	<ul style="list-style-type: none"> • Number of hospital admissions per diagnosis • Length of stay in hospital per diagnosis • Number of procedures conducted in hospitals, etc 	Continuously, registration in hospitals	National medical registration (LMR), Prismant
	<ul style="list-style-type: none"> • Number of visits to hospital outpatient department by speciality 	Yearly, survey of all hospitals	National ambulatory care registration (LAZR), Prismant
	<ul style="list-style-type: none"> • Number of admissions to nursing homes per diagnosis • Length of stay in nursing homes per diagnosis, etc. 	Continuously, registration in all nursing homes	Nursing home registration (SIVIS), Prismant

Table 1. Examples of information in the Dutch health system (3)

Parameter	Types of indicators	Frequency of data collection, type of data	Registration name, collecting institute
Production of health services	<ul style="list-style-type: none"> • Number of clients receiving home care • Number of hours home care provided 	Yearly (in principle; though absent in recent years), surveys of non-profit home care organisations	Home care registration, Prismant
Supply of health services	<ul style="list-style-type: none"> • Number of doctors, nurses, physiotherapists, speech therapists, occupational therapists, midwives, etc. 	Yearly, combination of registration and survey data	Health manpower report (RAZ), Nivel/Prismant /OSA, commissioned by the MoH
	<ul style="list-style-type: none"> • Number of hospitals, nursing homes, homes for the elderly, home care organisations, etc. • Number of hospital beds, nursing home beds, etc. 	Yearly, different surveys	Various statistics collected by the Central Bureau of Statistics (CBS)
Health care costs	<ul style="list-style-type: none"> • Costs per sector specified by category (e.g. personnel vs. material) and by source of financing (public/private) 	Yearly, surveys and accounts	Financial statistics, CBS (Central Bureau of Statistics)

Quality Policies since 1989

- Professions and institutions develop quality systems
- Internal quality improvement as well as external accountability
- Involvement patient organizations and financiers
- Enforcement by government (legislation) and Inspectorate of Health

Quality system development amongst professionals (1)

- Further formalisation of training programmes
- Further formalisation of practice profiles of various professions
- Further formalisation of continuous education (i.e. accreditation of courses)
- Introduction of national practice guideline programmes for medical specialists (> 1982), general practitioners (> 1987), allied health professions and nursing professions

Quality system development amongst professionals (2)

- Introduction of visitatie programmes (site visits by peers) by scientific societies of the various medical specialities (> 1985 covering all specialities by 1998)
- Peer review and audit programmes for specialists, general practitioners, nursing home physicians, specialists in social medicine, allied health professions and nursing professions (> 1976)
- Development of clinical registries by scientific societies
- Development of clinical indicators (> 1998)

Quality system development amongst health care institutes

Models: EFQM and ISO

Many quality improvement projects

Quality improvement coordinators

In 2000:

majority project based, one third quality system under development, 5 % quality system in place (Nivel 2000)

Accreditation / certification

Table 2. Percentage of institutions in different sectors using indicators in order to monitor quality of care

Sector	Percentages of institutions
Municipal public health departments	80 %
Primary health care centres	75 %
Hospitals	91 %
Home care non-profit organisations	93 %
Home care for-profit organisations	95 %
Home for the elderly	86 %
Nursing homes	85 %
Social services	86 %
Social-paediatric services	82 %
Mental health care institutes	76 %
Care for the handicapped	84 %

Source: Sluijs EM, C Wagner. Kwaliteitssystemen in zorginstellingen. Stand van zaken in 2000. Utrecht: Nivel, 2000

Table 3. The top-3 indicators used by health care institutions in different sectors and the % of institutions using them (1)

Sector	Top-3 indicators	% of institutions
Municipal public health departments	Production data	72 %
	Formal complaints	65 %
	Sickness absence/% of personnel quitting jobs	52 %
Primary health care centres	Formal complaints	61 %
	Production data	58 %
	Sickness absence/% of personnel quitting jobs	46 %
Hospitals	Production data	91 %
	Formal complaints	91 %
	Sickness absence/% of personnel quitting jobs	90 %
Home care non-profit organisations	Formal complaints	90 %
	Sickness absence/% of personnel quitting jobs	82 %
	Waiting lists/waiting times	70 %
Home care for-profit organisations	Formal complaints	75 %
	Evaluations of care plans	75 %
	Incidents	65 %
Home for the elderly	Data on case mix	74 %
	Sickness absence/% of personnel quitting	74 %
	Registration of incidents	62 %

Table 3. The top-3 indicators used by health care institutions in different sectors and the % of institutions using them (2)

Sector	Top-3 indicators	% of institutions
Nursing homes	Sickness absence/% of personnel quitting jobs	76 %
	Formal complaints	75 %
	Incidents	72 %
Social services	Production data	85 %
	Waiting lists/waiting times	64 %
	Sickness absence/% of personnel quitting jobs	59 %
Social-pediatric services	Waiting lists/waiting times	79 %
	Sickness absence/% of personnel quitting jobs	61 %
	Formal complaints	61 %
Mental health care	Waiting times	55 %
	Case mix	50 %
	Formal complaints	47 %
Care for the handicapped	Formal complaints	79 %
	Sickness absence/% of personnel quitting jobs	74 %
	FONA	74 %

Source: Sluijs EM, C Wagner. Kwaliteitssystemen in zorginstellingen. Stand van zaken in 2000. Utrecht: Nivel, 2000

Strength

- Many profession and institution based initiatives
- Involvement patients/financiers
- Consensus/mutual dependencies

Weakness

Slow working towards integrated care

Freezing existing providers

Seperate management frameworks with seperate data collection and indicator development

Table 4. Performance of the Dutch health care system on various indicators compared to other countries in the EU and the OECD, as described by the WHO, the OECD, the Ministry of Social Affairs and Labour (SZW), and the Social Cultural Planning Bureau (SCP)

Netherlands perform worse than average on the indicators:	Netherlands perform more or less average on the indicators:	Netherlands perform better than average on the indicators:
<ul style="list-style-type: none"> • Development of life expectancy (SCP) • Development of infant mortality behaviour (SCP) • (Development of) smoking behaviour (SCP) • Physician density, number of medical students (OECD) • Waiting lists (OECD) • Percentage of health personnel in direct patient care (SZW) • Development of drug expenditures 	<ul style="list-style-type: none"> • Level of life expectancy (all reports) • Level of infant mortality (all reports) • Healthy life expectancy (SCP) • Disability adjusted life expectancy (WHO) • Premature death in women (SCP) • Level of responsiveness (WHO) • Fairness of financial contribution (WHO) • Number of consultations of ambulatory care physicians per capita (OECD) • (Development of) health expenditures (all reports) • Level of drug expenditures (OECD) 	<ul style="list-style-type: none"> • Premature death in men (SCP) • Subjective health status (OECD) • Patient satisfaction (OECD) • Medical consumption (OECD)

(translation of table in Kramers et al, 2001)

Conclusions

- Indicators should be part of quality systems
- A national performance framework should be based on a balanced set of indicators
- Public health data can be used more productively for performance frameworks on sector, regional and institutional level
- Indicator development itself is a political process
- Self-regulation enforces professional and institutional quality system development
- A clear vision on system goals and system design is necessary to promote integrated care