Health care performance in the Netherlands:

Easy access, varying quality, rising costs

Michael van den Berg, Richard Heijink, Laurens Zwakhals, Harry Verkleij and Gert Westert

Summary: To monitor trends in health care performance, the Dutch Ministry of Health has commissioned the Dutch National Institute for Public Health and the Environment (RIVM) to produce the Dutch Health Care Performance Report (DHCPR) every two years. Using a set of 125 indicators, the DHCPR 2010 assessed the quality, accessibility and costs of the Dutch health care system by comparing performance with standards, with previous years and with other countries. The report confirms many of the Dutch achievements reported in international comparisons, but also reveals some urgent challenges for Dutch health care.

Keywords: performance assessment, the Netherlands

The Dutch health care system tends to do very well in international comparisons; patient organisations have a strong position, and health services are just around the corner and easily accessible for all. The Netherlands is, without doubt, a relatively wealthy and healthy nation, but is it really a patients' paradise? The *Dutch Health Care Performance Report* 2010[1] confirms many of the Dutch achievements, but it also reveals some urgent challenges for Dutch health care.

To monitor trends in health care performance, the Dutch Ministry of Health has commissioned RIVM to produce the *Dutch Health Care Performance Report* (DHCPR) every two years. Using a set of 125 indicators, the DHCPR 2010, published in English in November 2010, assessed the quality, accessibility and costs of the Dutch health care system by comparing performance with standards, with previous years and with other countries.

The conceptual framework used for the DHCPR is based on an extensive international literature review.[2,3] In the applied framework, health care is divided into four specific health care needs: staying healthy (prevention), getting better (cure), living independently with a chronic illness or disability (long-term care), and end-of-life care. The indicator framework used is well accepted internationally. The Organisation for Economic Co-operation and Development (OECD) has adopted this framework for the further development of international comparisons of health care system performance.[4] Results of the previous DHCPRs were also used in the recently published Health System Review of the Netherlands.[5] To fill the indicators, RIVM used 68 different national and international data sources from 30 different organisations.

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How is the Dutch health care system performing?

What does the DHCPR 2010 teach us about the Dutch health care system? We will discuss some of the major challenges and the successes of Dutch health care that stand out in the report.

Easy access; health care for all

Overall, we concluded that the Netherlands provides excellent access to health services. Following the definition of Smits and colleagues,[6] accessible care implies that 'people, who need care, can access care in a timely manner and without great barriers'. The Netherlands has a very intricate network of health services. Geographical analyses show that the average driving time from home to the nearest general practitioner (GP), physiotherapist or pharmacy is 1.3 minutes. For hospitals this is 7.7 minutes. Hardly anyone has to drive more than fifteen minutes to reach any of these services.

Costs of care seldom pose a problem. Under a mandatory health insurance scheme practically all residents are insured for curative health care costs. Most long-term care services are paid for by a social insurance scheme that covers all Dutch residents. Co-payments are amongst the

lowest in the OECD countries. In comparison with six other affluent countries, the Netherlands reported the smallest percentage of residents (1%) and people with chronic illnesses (3%) who forego visits to the doctor for financial reasons.

Still, it appears that this easy access might be under threat in some areas. Waiting times for certain health services have been a persistent problem in the Netherlands. For 25% to 33% of clients receiving mental health care, waiting times for treatment were longer than the agreed standard. Likewise, waiting times in outpatient clinics and long-term care often exceeded the standard. Poor telephone access to GP practices during office hours was reported as a problem by many people and one third of emergency calls to GP practices were not answered within the thirty-second standard.

Quality of care stands out in many ways, but varies between providers

Nine out of ten citizens evaluated health care positively. More than 90% were satisfied with the interaction between themselves and their health care providers. Moreover, outcome indicators show positive figures and trends: hospital mortality rates have been decreasing for five years in a row, while infant mortality has decreased by some 20% since 2005. Survival rates for cancer are high by international comparison and there are only a few avoidable hospital admissions compared with other countries. The latter is due to a strong developed primary care system and outpatient clinical care.

A typical characteristic of Dutch health care is a somewhat reserved approach towards medical interventions. This results, for example, in low referral and admission rates, low prescription of antibiotics, and low numbers of revascularisations and caesarean sections compared to most other countries.

Although the overall level of curative care is acceptable for many treatments, it makes quite a difference where the treatment takes place. A number of indicators show wide variations between health care providers:

- the percentage of prescriptions by GPs in accordance with guidelines varied from 49% to 77%;
- the percentage of hip fracture patients operated on within 24 hours ranged from 67.5% to 100% across hospitals;
- the percentage of caesarean sections in low risk pregnant women varied widely between hospitals, ranging from 7% to 30%;
- for a number of conditions treated in mental health care, drop-out rates ranged from less than 5% to 28%.

These findings appear to confirm the importance of a best practice approach and of the use of benchmark or reflective information for health care providers. Moreover, patients and health insurers need such information to make informed choices on the health care market. However, suitable information about quality of care, and patient outcomes in particular, is still lacking.

Long-term care is under pressure. The demand for care is growing and intensifying and becoming increasingly complex. Meanwhile, qualified staff are hard to find. There is also criticism about the quality of care, from both the consumers and providers of long-term care. Just one third of the representatives of psychogeriatric patients state that physical care is always of good quality. Nurses and carers in nursing homes are not always positive about the quality of care; a significant number consider that it is below standard.

The problems in long-term care are taken seriously in the field, as well as in politics. In recent years health care professionals, patient organisations and the government have worked hard to improve the measurability of the quality of long-term care. An Evaluation Framework for Responsible Care has been developed. Institutions use this framework as a tool to account for the quality of care they provide. This framework was described previously in Eurohealth by Frijters.[7] The new Dutch government has now announced that they will invest an extra billion euro in long-term care, particularly in care for older people. Such an investment at a time of huge cutbacks in public spending indicates that there really is a sense of urgency to improve this sector.

Costs: do we get value for money?

In the period 2007–2009, health care expenditures grew at an annual rate of 6% to 7%, which is slightly more than in preceding years. The most recent OECD time-series data (2000–2007) show that the growth in Dutch real health expenditure was about average compared to other OECD countries. Health spending growth resulted largely from an increase in the volume of care – that is, more services were delivered. Since 2002, the volume of care provided by Dutch hospitals has grown by 4.2% per annum compared to an average price rise of 1.6%. Inpatient admissions grew by 3% yearly and day-patient admissions by 10%. At the same time, the volume of Dutch hospital care has remained relatively low by international standards. Interestingly, the price of medicines has fallen dramatically in recent years, but the volume of medication prescribed (the number of prescriptions filled) increased in 2008 by almost 15%. The volume of outpatient care grew substantially in different areas: by yearly averages of 5.5% in care for older people, by 8% per year in mental health care and by an average of 9% per year since 2004 in care for the disabled.

These growth figures may turn out to be critical from the perspective of public finances. Since 1990 the share of health care in total public expenditure has doubled (now being 20%) and health care has consumed a considerable part of national income growth. The question is whether this seemingly autonomous growth in the health care sector can be maintained in comparison with growth in other sectors, and whether it will affect the purchasing power of Dutch residents. The recent economic crisis and deterioration of public finances have rekindled the debate on health care spending.

High and rising health care costs may be less of a problem as long as investments pay off. Moreover, the removal of any waste or inefficiency in the health care system would alter health spending levels without adverse effects on quality and accessibility of care. Efficiency analyses of the relationship between costs and quality show that despite rising costs, overall mortality and avoidable mortality have dropped significantly since 2003. The same is true for most other western European countries. In international macro level cost-benefit comparisons, the Netherlands performs about average. Meso level indicators demonstrate signs of inefficiency, for example, the substantial variation in freely negotiable hospital prices, in the average length of hospital stays, in GP tariffs and in GPs prescribing cheaper generic drugs.

Final remarks

The Netherlands is facing the same health care challenges as many other European countries. How to control rising costs?

How can the system cope with an ageing of the population? How can it rise to the challenges of scarcity in human and financial resources, as well as to the rising numbers of the chronically ill? The Netherlands has chosen to adopt a system of managed competition with a range of measures that aim to protect citizens against undesired side effects of market forces (see the article of Van Ginneken et al in this issue) [8]. Health insurers and health care suppliers are primarily accountable for good quality care. Ministerial accountability concerns the functioning of the health care system at a macro level and 'the rules of the game'. The DHCPR helps the minister to carry out this role, by providing a monitoring instrument on all aspects of care.

It is still too early to draw firm conclusions regarding the successes or failures of reforms in the system. Nevertheless, it goes without saying that in a system of managed competition in which market forces play an increasingly important role, policy makers are facing new challenges regarding quality, costs and access.

We end by highlighting three issues.

It is assumed that health insurers do not simply purchase any health care service, but instead act as critical purchasers. In the DHCPR we concluded, however, that insurance companies mainly competed on the price of health insurance policies and the cost of health care services. In contrast, the quality of care is still of limited influence in the purchasing process. One of the underlying problems is that quality of care lacks transparency. Choice requires clear and valid information about providers. Several projects have started to collect and publish such information, but there is still a long way to go.

Easy access to health services is an important achievement. However, there might be a trade-off between access and quality. There is evidence that concentration of especially highly complex surgery improves quality and reduces mortality rates. Critical purchasers of care are looking for high quality providers and may selectively contract with those providers. This means that many patients may not be able to visit their nearest hospital. The system may have to make trade offs between access and quality. An interesting question is what differences in quality outcomes justify additional travelling time or waiting lists.

The same is true for the trade off between prices and access. Health insurers can offer cheap policies that restrict freedom of choice. By contracting only a limited number of health care providers, health insurers are able to negotiate for cheaper care for many services. In this case patients sacrifice some access for cheaper insurance. Interesting questions will concern whether insurees will accept such restrictions and what impact this will have on equity and quality in the long term, given that premiums are rising. Another question will be whether contracting changes the structure in health care markets (market power).

The DHCPR will continue to monitor trends in quality, accessibility and costs of Dutch health care. This information will be regularly updated at www.healthcareperformance.nl

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New HiTs on Greece and Spain

GREECE

Charalambos Economou
180 pages

Despite success in improving the health of the population, the Greek health care system faces serious structural problems concerning the organisation, financing and delivery of services. It suffers from the absence of cost-containment measures and the high percentage of private expenditure goes against the principles of fair financing and equity. Efficiency is also in question due to the lack of incentives to improve performance in the public sector. In addition, the oversupply of physicians, the absence of a referral system and irrational pricing and reimbursement policies are the factors encouraging under-the-table payments and the black economy. These shortcomings result in low satisfaction with the health care system expressed by citizens.

SPAIN

Sandra García-Armesto, María Begoña Abadía-Taira, Antonio Durán, Cristina Hernández-Quevedo and Enrique Bernal-Delgado
295 pages

The new Spain HiT focuses on the consequences of the totally devolved status of the health system, consolidated in 2002, and the implementation of the road map established by the 2003 Spanish National Health System (SNS) Cohesion and Quality Act. The reforms have paved the way for a brand new consensus-based policy-making process grounded in knowledge management, the effects of which are progressively starting to be evident.

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