Dutch Health Care Performance Report 2010

Executive summary

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Executive summary

From a policy perspective, it is important to monitor how well the various parts of the health care system are functioning and whether all the people are benefiting equally from the resources provided. In view of the rising costs of health care, it is also relevant to find out whether those resources are producing sufficient returns – how efficient is the health care system? To monitor trends in the quality, accessibility and costs of health care, the Dutch Ministry of Health has commissioned RIVM to produce the *Dutch Health Care Performance Report* every two years. Using a finite set of indicators, this third edition of the report assesses the performance of the health care system in 2008 and 2009 and compares it to previous years and to other countries.

What findings stand out in the 2010 Performance Report? First of all, many strong points could be identified. The accessibility of Dutch health care is mostly excellent. Many parts of the system are delivering good-quality care, and demonstrable improvements have been made. Most users are consistently positive about the services they receive. The rising costs of health care are mainly due to the greater volume of services delivered. As the 2010 *Public Health Status and Forecasts Report* has reported, Dutch people are living longer, and the two additional life years gained are spent in good health (Van der Lucht and Polder, 2010). Disease prevention and health care are both critical factors in these health gains.

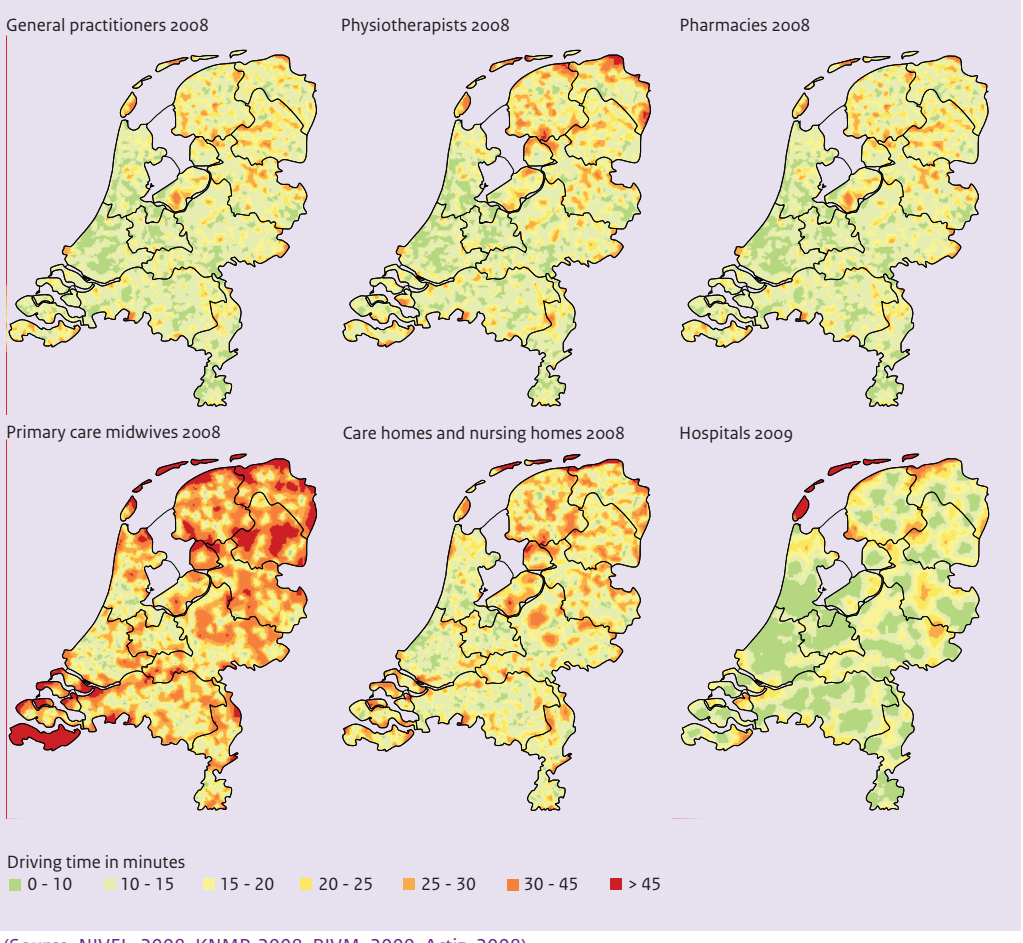
In contrast with positive findings like these, there is also evidence that Dutch health care is not living up to the high ambitions and expectations in every way. Accessibility is unsatisfactory in some areas, as evidenced by persistent waiting lists in certain sectors and the difficulty of reaching GP practices by telephone during office hours. Wide variations exist amongst health care providers in terms of both price and quality. The cooperation and coordination between different providers are not as good as they should be. Although quality improvement goes hand in hand with cost savings in some instances, this cannot be firmly concluded for the system as a whole. In fact, the total costs of care continue to grow at a fast rate, while the quality of care improves slowly. One prerequisite for a well-functioning system is that quality data must be available – and that it must also be put to use. The amount of available data has increased, but it is still insufficient for comparing health care providers in terms of quality and patient outcomes.

Excellent performance in many areas ...

Health care accessibility is a strong point

The Dutch health insurance system includes a broad basic benefits package under which practically all residents of the country are insured for health care costs. Co-payments are amongst the lowest in the OECD-countries. In comparison with six other affluent countries, the Netherlands has reported the smallest percentages of residents (1%) and people with chronic illnesses (3%) who forego a visit to the doctor for financial reasons. The essential health care services are also within easy reach.

Figure 1: Driving times to the nearest care services, 2008 / 2009



(Source: NIVEL, 2008; KNMP, 2008; RIVM, 2009; Actiz, 2008)

Most people (85%) say they generally experience no problems with the accessibility of health care. Some 90% of respondents queried about their health care experiences report that they always or almost always get the help they need. Such figures have remained more or less stable in recent years. In terms of health care utilisation (with the exception of dentistry), there is little difference between low- and high-income groups or between ethnic Dutch and ethnic minority groups.

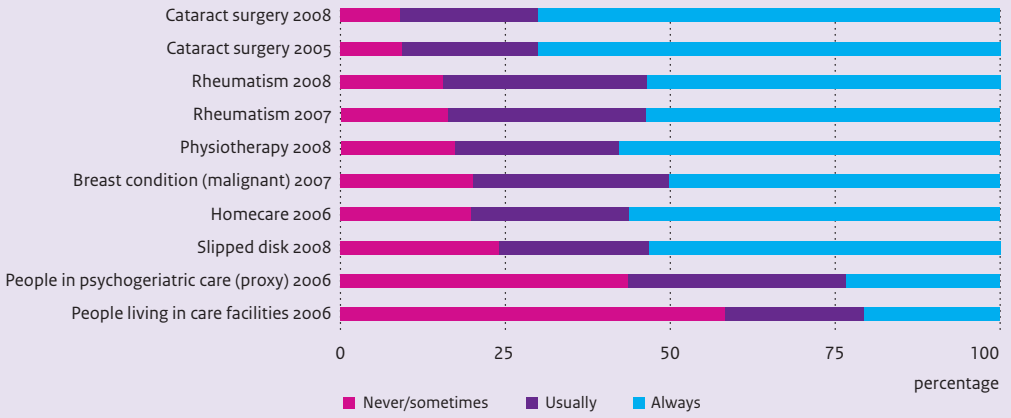
Quality of care stands out in many ways

The overall quality-of-care ratings for 2008 were much like those in 2004 and 2006. On many indicators, the Netherlands compared well with other affluent Western nations. Uptake of preventative screenings was high. Rates of avoidable hospital admissions were low, pointing to a strong primary care and outpatient clinical care. In almost two thirds of cases, general practitioners prescribed medicines in conformity with professional guidelines. Infant mortality further declined in 2008 to 3.8 per 1000 live births, thereby improving the Dutch standing on that indicator. The 5-year survival rate for cancer was high in international comparison.

General public remains positive about the health care system

Nine out of ten people surveyed gave favourable ratings to the Dutch health care system. More than 90% was satisfied with the interaction between them and health care providers, a percentage that has remained steady over the years. This finding is based on questions about whether professionals are polite and respectful, take patients seriously, listen attentively, allow enough time and explain things understandably. Clients in nursing or residential facilities, clients receiving home care and the legal guardians of clients in psychogeriatric care generally rated the services as professional and safe.

Figure 2: Experienced involvement of care users in decision making about care and treatment, 2005-2008

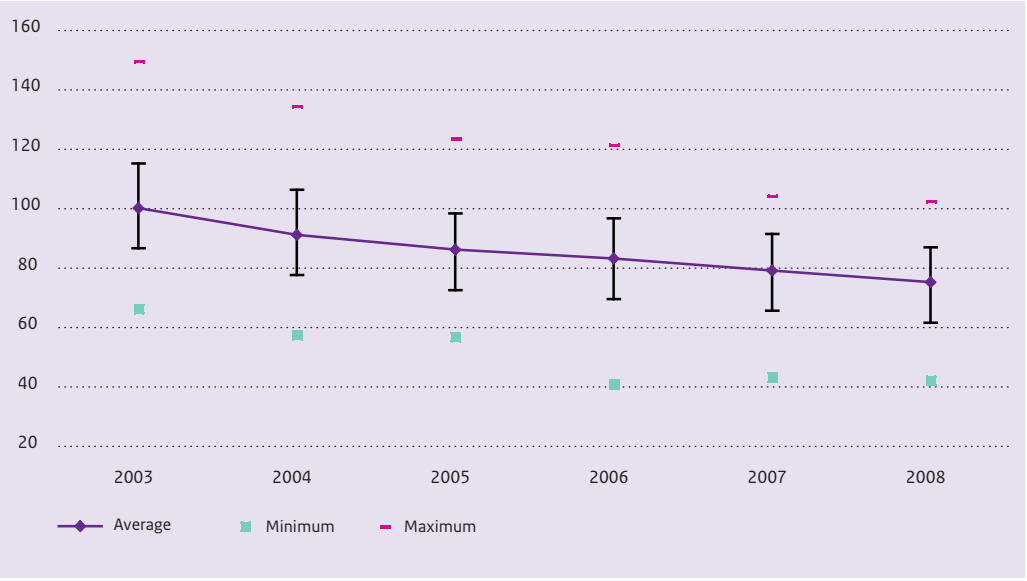


(Source: CKZ / NIVEL, 2010)

Safety is firmly on the agenda

In terms of health care safety, a number of positive trends have been evident in recent years. The percentage of nursing home and general hospital patients with pressure ulcers was halved in the past six to ten years. The percentage of malnourished patients in nursing or residential facilities declined somewhat. The number of structured consultation groups of pharmacists, GPs and other doctors about the safety of medication dispensation steadily grew. The standardised mortality rate in hospitals declined in the 2003-2008 period. The percentage of patients with chronic diseases who believed that one or more errors had been made in their treatment (17%) was the lowest in an international comparative study with six other affluent countries.

Figure 3: Hospital Standardized Mortality Rate, 2003-2008



(Source: Prismant)

Growth in health care expenditures mainly due to increase in the volume of care

In the period 2007-2009, health care expenditures grew at a faster rate than in the preceding years. The most recent, internationally available OECD time-series (2000-2007) shows that the growth in Dutch real expenditures was about average as compared to other countries. It 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 mounted by 4.2% yearly, as compared to the average price rise of 1.6%. Inpatient admissions grew by 3% and day-patient admissions by 10%. At the same time, the volume of Dutch hospital care has remained relatively low in an international perspective. Interestingly, medicine prices have 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 care for the elderly grew by yearly averages of 5.5% for outpatient care and 3.4% for nursing and residential homes. In mental health care, outpatient treatments increased by about 8% per year. The growth of care for the disabled was seen mainly in outpatient care, averaging 9% per year since 2004.

... but ambitions are high and improvement is feasible

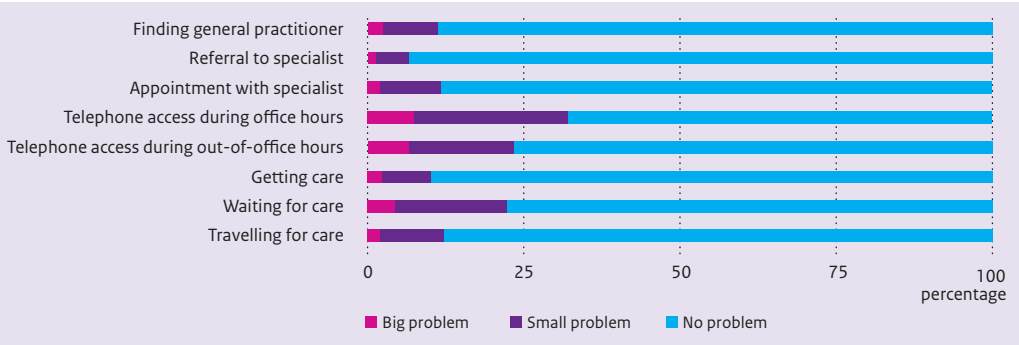
High ambitions and expectations

Dutch government policy shows high ambitions. 'The Dutch government believes the performance potential of the health care system can be substantially boosted if centralised state control makes room where possible for a more decentralised system of regulated competition' (VWS, 2004). One ambitious measure has been the comprehensive health care reform implemented in the past decade. Its primary aim was to secure a better balance between costs and benefits, thus preserving the affordability and accessibility of health care for present and future generations. The Dutch general public has high expectations as well; all people want the best possible health care, and at a reasonable cost. This makes it essential to detect any signals that parts of the system are not functioning adequately and need improvement.

Waiting times and reach of services are not optimal in all cases

Although overall accessibility is good, several indicators in this report point to problems with accessibility. For 25% to 33% of clients in the mental health sector, waiting times for treatment were longer than the agreed standard. One quarter of hospital outpatient clinics reported that their waiting times exceeded the standard. The number of problematic cases on waiting lists in long-term care stood at 4500, unchanged in recent years. Poor telephone accessibility of GP practices during office hours was reported as a problem by many people; one third of emergency calls to general practices were not answered within the 30-second standard. A preventive intervention for depression was found to have improved its reach, but that still remained very small at 2%. Population screening for cervical cancer scored well in comparison to other countries, but had still not surpassed the 66% mark. The numbers of hard-to-fill vacancies in the health system mounted steadily, foreshadowing serious accessibility problems for patients and clients in the future.

Figure 4: Percentage of patients that experienced problems with access to healthcare services, 2008



(Source: CKZ / NIVEL, 2010)

Quality not always up to par

A number of indicators suggested room for improvement in the quality of care. Patients undergoing surgery for cataracts, varicose veins, slipped discs and hip or knee problems did not always experience improvement after the operation. Hip surgery and cataract operations scored best, with 65% of patients reporting improvement in functioning. The death rate within 30 days of hospital admission for an acute condition (heart attack, brain haemorrhage, stroke) was about twice as high in the Netherlands as in the European countries with the lowest rates.

Figure 5: 30-day hospital mortality for acute myocardial infarction (%), 2005 for the Netherlands and 2006-2007 for other countries; the Netherlands, United States, Western Europe, highest and lowest scoring countries

(Source: OECD Health Data, 2009)
* Denmark, Finland, Ireland, Italy, The Netherlands, Norway, Austria, Spain, Sweden, United Kingdom

Although concerted efforts have been made to preserve good practice in the long-term care sector, a combination of factors is threatening the quality and the safety of the care delivered in nursing and residential care facilities: hard-to-fill vacancies, increasing care intensity and heavy workloads for nurses and care workers. Although the (often highly dependent) residents generally expressed satisfaction with the care they received, one quarter of the legal guardians of psychogeriatric patients reported that staff 'never' had enough time for the clients, and only 22% answered 'always'. Research on moral dilemmas has shown that many nurses and caretakers in long-term care feel they cannot provide the care that is needed and that they wage a constant struggle with understaffing and work pressures. Only one third of the legal guardians of psychogeriatric patients rated the physical care of their charges as 'always good'. When clients had suffered falls, insufficient preventative measures were taken to avert a recurrence.

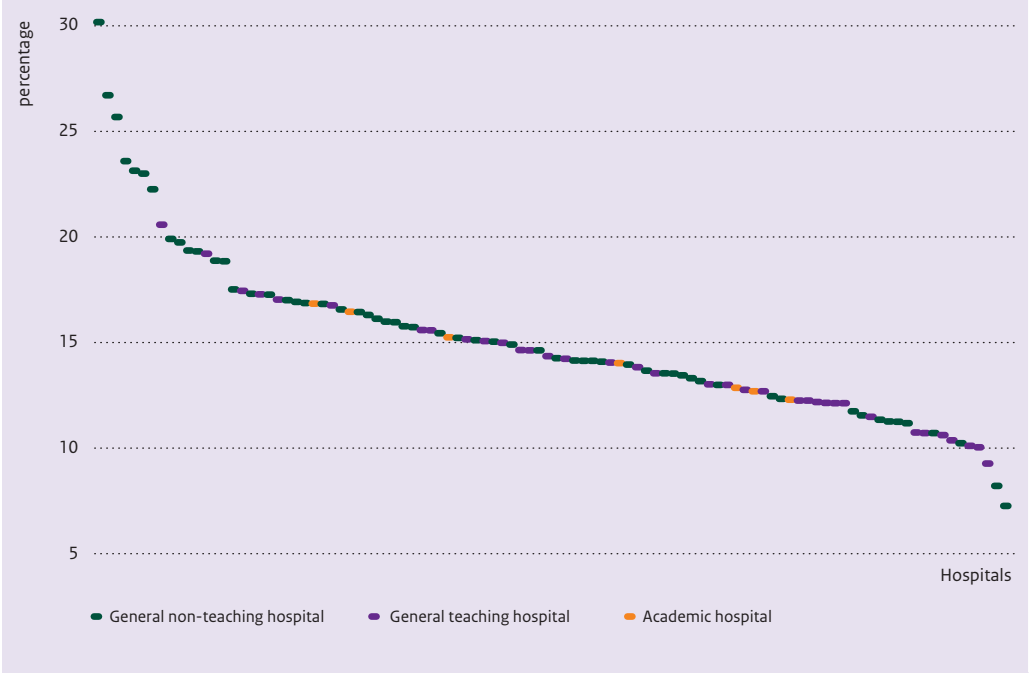
The coordination of care also needed improvement. Four out of ten patients with rheumatoid arthritis reported having to tell the same story several times to different health care providers, as compared to only 10% of patients with diabetes. In terms of safety, the Dutch health care system scored favourably in international terms, but some unsafe conditions persisted nonetheless: one patient in six reported having experienced minor or major medical errors during treatment, and in nursing or residential care facilities at least 7% of clients experienced a medication incident during one month.

Wide variations in price and quality

At 184 euros, the highest consultation fee for an out-of-hours general practice cooperative was over five times the lowest fee of 35 euros in 2008. Average hospital charges for a hernia operation ranged from 1000 up to 2500 euros.

GPs differed by nearly 30 percentage points (49% vs 77%) in the numbers of their medication prescriptions that conformed to the professional guidelines. The percentages of hip fracture operations within 24 hours of hospital admission varied between 67.5% and 100% across hospitals. The percentages of unplanned Caesarean sections performed on low-risk women varied widely from 7% to 30%.

Figure 6: Percentage of unplanned Caesarean sections performed on low-risk women, 2004-2008



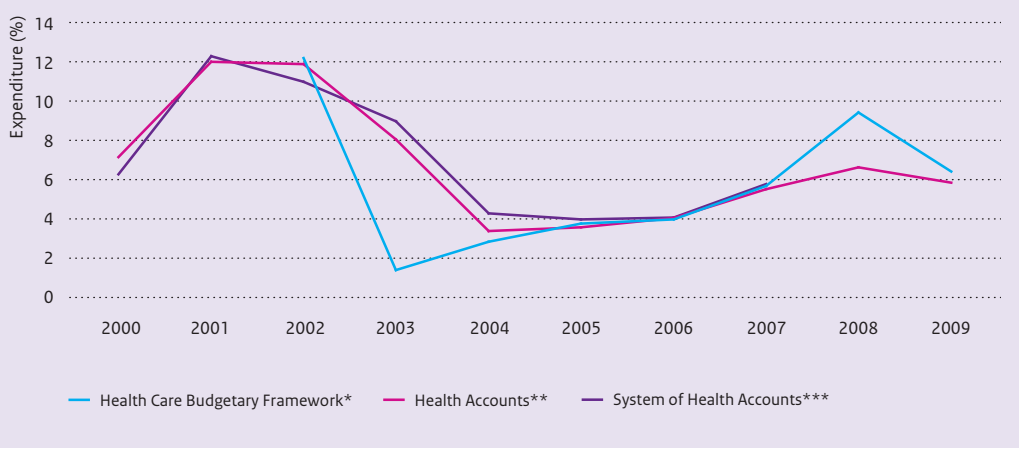
(Source: Stichting Perinatale Registratie Nederland)

For some conditions being treated in the mental health sector, the percentages of patients dropping out of therapy ranged from below 5% to 28%. In nursing and residential care, the numbers of fall incidents varied between facilities, with 15% of the care homes sharply diverging from the average.

Balance between costs and quality could be better

From the indicators we used to measure the performance of the Dutch health system and compare it to that in other Western countries, we may conclude that the Netherlands lies somewhere in the middle. Our two previous performance reports reached a similar conclusion. Clear progress has been made in certain areas. Quality has improved in some respects, while the health care expenditures grew at an average annual rate of 6% to 7% between 2007 and 2009.

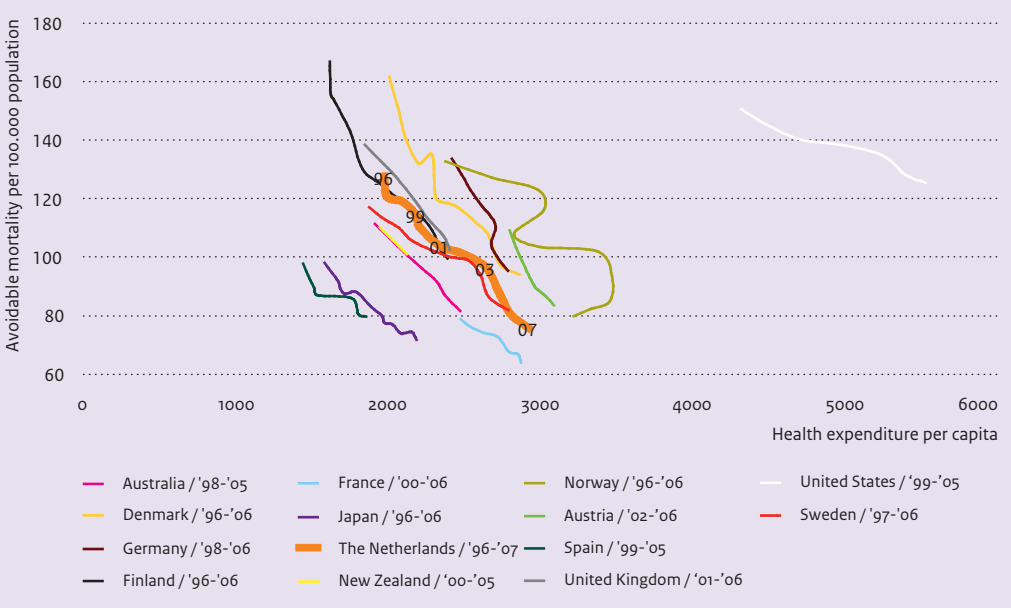
Figure 7: Annual growth in health expenditure (%), 2000-2009



(Source: VWS, 2009; VWS, 2010; CBS, 2009; OECD Health Data, 2009)
Health expenditure according to * Ministry of Health, ** Statistics Netherlands, *** OECD

If we illustrate this with a direct cost-benefit comparison between health care expenditures and avoidable deaths, then the Netherlands does not stand out in the comparison. Avoidable mortality declined rather rapidly in most countries between 1995 and 2008, whilst health care expenditures rose at a comparable pace. As avoidable mortality is an indicator of the rate of death from illnesses such as asthma, influenza or appendicitis that could have been effectively treated in an adequately functioning health care system, the avoidable mortality rate reflects the unique contribution of health care to health.

Figure 8: Avoidable mortality per 100.000 population and health expenditure per capita (US$ PPP), 1996-2007*



(Source: OECD Health Data, 2009; WHO, 2009)
* US$ Purchasing Power Parities (PPP) is an exchange rate that corrects for differences in purchasing power between countries

Since 2005, Dutch hospitals have been allowed to freely negotiate with health insurance companies about the price of a number of designated services – the 'B-segment'. The question now is whether this has led to more efficient care in comparison with the state-regulated A-segment. This report concludes that while price trends in the B-segment have been moderate, the total expenditures have nevertheless increased due to expansion in the volume of care. That does not seem to bode well in terms of cost containment. Still, it remains difficult to interpret figures and draw firm conclusions on the basis of the limited data now available.

Quality of care lacks transparency and is not yet a driving factor

The Dutch health care reforms implemented in recent years were intended to foster a system of regulated competition. An underlying aim was to give health care consumers a more pivotal role in the market, thus resulting in affordable and good-quality health care for all. Such an outcome will require time and patience. At present, insurance companies are mainly competing to limit the prices of insurance policies and the costs of health care services. The quality of the care is still of limited influence in the purchasing process. This applies to both curative and long-term care. Regulated competition assumes that insurers and consumers alike have complete, transparent information available on the quality as well as the price of health care products. However, suitable information about quality of care, and about patient outcomes in particular, is still lacking.

Concerns about the availability of data on health care and public health

The data currently available cannot yet be adequately analysed in terms of demographic characteristics such as socioeconomic status and ethnic background. That makes it difficult to judge whether all people have equal health care opportunities (equity). Much of the current information about health care providers is based on self-reports, and the quality of that information is subject to dispute. There are also concerns about the continuity of some important data registries; failure to maintain these would threaten the ability to monitor developments in the health care system. Subsequent editions of the *Dutch Health Care Performance Report* will further assess the trends identified in the present report. They will also provide more detailed analysis of the effects of the recent health care reforms. For 'government at a distance', reliable data is of the essence. The report ends by pointing out the current gaps in the available information systems and knowledge.

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