View from the Netherlands

Professor Casparie, professor of sociomedical science at Erasmus University describes developments towards a national quality care policy in the Netherlands. In the Netherlands, as elsewhere, interest in quality and quality assurance in health care is growing. In fact, quality can be seen as a new paradigm and quality assurance as a new discipline with its own objectives and methods. In 1989 an initiative was taken in the Netherlands to develop a coherent and joint national quality care policy, which arose partly from an intended change in the Dutch health care system towards more competition. This article describes this initiative and its initial results.

Dutch health care system
The health care system in the Netherlands is a combination of elaborate government regulation on the one hand and the mainly private provision of health care facilities on the other. Both institutional and community health care providers are highly organised within professional societies. General patient organisations and associations of patients with particular diseases are growing in number. In the past few years patients’ rights, including the right to lodge a complaint, have been emphasised. The health care system is further defined by many consultative structures, with governmental advisory bodies on planning, organisation, and finance. In 1990 about 8-5% of the gross national product was spent on health care and 1-5% on social care facilities such as family care and care for the elderly.

Recognising some fundamental shortcomings and inefficiencies in the health care system, the government made proposals in 1988 for change towards a more competitive system and towards its self regulation. Particular shortcomings were the uncoordinated financial structure between hospital and home care, impediments to efficiency and substitution of care; lack of incentives for efficiency; and the government regulation of volume of care and price. New government legislation and regulation will be reduced and the three parties involved in health care—providers, patients, and insurers—will become more responsible for an effective and efficient service.

The changes include compulsory basic insurance for all by sickness funds and private companies providing about ninety percent cover, with an optional supplementary insurance of ten percent which currently covers dentistry, physiotherapy, and cosmetic surgery. The new system must allow competition between the two types of insurance companies. Furthermore, the providers of care have to negotiate with insurers to obtain contracts. Patients have more freedom to choose their own package of insurance and to select their own insurance fund. However, insurance companies confine reimbursement for treatment by providers with whom they have an agreement.

One of the main reasons for developing a national quality care policy was to assure good quality of care in a new system that had no government regulation. Another reason was that cost containment could jeopardise some aspects of care, such as accessibility and effectiveness. Moreover, the new system may prompt insurance companies to apply risk selection, which is against the interests of patients with chronic diseases or serious handicaps.

Quality assurance
Previous activities in health care quality related to quality assurance of clinical performance as well as of the structure and organisation of health care but were not integrated. They were more directed at improving quality rather than assessing and assuring quality and the term “quality” was often used not in the current broad sense but in terms of effectiveness and safety. For example, the government’s main instruments for improving and assuring the quality of care are legislation and regulation of care provision, health care facilities, and so on, along with planning and financing. The objectives are mainly the accessibility and safety of the health care system. Those providing the finance focus mostly on efficiency and appropriateness of care. The medical profession has always emphasised a high level of medical education as a guarantee of good quality of care provision by individual professionals. Doctors have always striven to achieve quality in their practice and to evaluate the effect of the care they provide, but these efforts have been mostly confined to individual health care providers using implicit criteria and dealing exclusively with the effectiveness of care. Quality of care has thus been equated with effectiveness of care.

In the past two decades the quality of care has gradually become a more collective responsibility of professionals, and within the procedures of assessment and assurance explicit criteria have also been used. The first systematic and structured approach to quality assurance started in the mid-1970s in some hospitals. Medical specialists together assess retrospectively the quality of care in relation to a specific topic, using explicit criteria. These topics include diagnostic and therapeutic interventions as well as organisational issues of clinical practice. To support these activities the National Organisation for Quality Assurance in Hospitals (CBO) was set up in 1979 by the National Medical Specialist Organisation and the Medical Association of Hospital Directors. In the early 80’s other health care professionals, such as general practitioners, nurses, and physiotherapists, followed suit, partly under the umbrella of CBO. Quality assurance within the nursing profession has been particularly successful. Medical peer review has been applied at some time in all hospitals in the past but regularly in only some hospitals. All practitioners apply their own quality assurance procedures more or less independently from each others disciplines, and multidisciplinary approaches are rare. In all cases quality was considered from a professional point of view. In the mean time the concept of quality has gradually become broader, so that efficiency, cost, and safety of health care...
have been included with effectiveness in professionals' definition of quality. Besides peers review studies, the medical profession has also emphasised the development of guidelines for care.1

In the early '80s, quality of care became a major concern of managers of health care institutions. Quality assurance was targeted not so much towards professional activities but more towards the organisation of care at an institutional level, the performance of departments, and last but not least, the preferences and opinions of patients. So, alongside the professional interpretation of the concept of quality, there was a place for consumers' views. The term "integrated quality of care" or "total quality management" was introduced.

Health care organisations started to look towards business communities and to focus especially on the approaches and methods of the service industries in raising quality. However, an experiment started in some hospitals in the mid-'80s under the name of hospital audit was not followed up, because at that time no person or department in the institutions could be identified as responsible for ensuring the continuity of this quality system. Indeed, up until now, hospital medical staff are hardly involved in total quality management.

National policy for quality of health care

In April 1989, on the initiative of the Dutch Medical Association, a government sponsored conference was held on a national and comprehensive quality care policy, in preparation for the change in the health care system and also in line with target 31 of the World Health Organisation for 1984 which stated that by 1990 all member states should have established effective mechanisms for ensuring quality of patient care within their health care systems. At this conference the three parties: the providers (institutions and professionals), the patients, and the insurers were represented by their national organisations. The government and the advisory bodies were present as observers. In total about 40 organisations (80 members) participated. It was agreed that all three parties have an equal role within the health care system but that the primary responsibility for the quality of care lay with the providers. The task of the government has become more general and mainly directed at the basic level of quality of care (figure).

At a second conference in June 1990 several agreements, drawn up by a working committee on the basis of the conclusions of the first conference, were agreed between the three parties and by the government.2 In the meantime the national advisory bodies had drawn up reports on accreditation of health care institutions, on scientific research relevant to methods used within quality assurance, on contracts between providers and consumers, and on definition of terms. In September 1990 at a similar conference for the social sector – that is, for the care for disabled people and for elderly people – comparable agreements were reached (report of conference of quality of care for disabled and elderly sector, Utrecht, 1990).

Key agreements

The agreements relate to the responsibility of the three parties and the government, the development of internal quality systems, the development and application of criteria, and the means (finances, legislation, information) necessary to establish this quality care policy. They are as follows:

- Primary responsibility for quality of care lies with providers
- Criteria for care have to be developed, preferably by providers: if possible in consultation with patients and insurers, who have their own responsibilities
- Internal quality systems have to be developed in all health care institutions; they must be accessible for external review.
- External review is directed at internal quality systems; outcome of care may be reviewed as well
- Publication of data must be agreed to for quality assessment and quality assurance
- Providers must position themselves for external review, including publishing a yearly report
- Insurers are responsible for reviewing the efficiency and organisation of care
- Patient/consumer organisations are jointly responsible for reviewing the culture and the organisation of care

- Criteria for assessing quality of care must be included in contracts between provider and insurer; they must be developed in conjunction with patient/consumer organisations
- Patients' complaints and assessment of patient/consumer opinions must be included in quality assessments.

For example, criteria for quality of care must be included in contracts between hospitals and insurance companies; local patient organisations should contribute to formulating specific criteria, say on accessibility and organisation of care. Furthermore, every health care provider has to develop methods for measuring regularly patients' opinions about the care they receive, and the results must be used to modify the provision of care if necessary. Within the three years after these agreements the initiative by the providers to develop a procedure for establishing criteria had to be realised within six months and the establishment of criteria and implementation of internal quality systems within two or five years. Some of the agreements are directed at consultation between the parties and others are related to specific objectives that have to be realised with a stipulated time.

In line with the norms of the International Organisation for Standardisation (ISO-norms), quality was defined as the degree to which all the characteristics of a product, process, or service meet the requirements that originate from the goal of use.3 This means that quality is a relative term and that it concerns the aspect between what should be achieved and what has been achieved. Furthermore, it is a subjective judgement depending on the viewpoint of the assessor: patient, provider, or government. In the Netherlands the aspect approach is used, where quality is related to specific aspects of care such as effectiveness, continuity, safety, appropriateness, and information. For clinicians this definition implies that care is of high quality if it is effective, it does not waste resources, and it satisfies the patient as far as possible.

At the 1990 conference it was stated that external review should concern the measures taken to assure provision of high quality care and not the assessment of the quality of that care. As a consequence of this and because government legislation will largely disappear from the new system, internal quality systems need to be developed. A quality system implies that an institution
describes how procedures are to be carried out, who is responsible, how quality is measured, and which improvements should be made. Internal quality systems should facilitate and assure quality of care by providers, and they will offer the possibility for external review by insurance companies, the state inspectorate, and patient organisations. Only when these quality systems have been introduced into health care institutions can accreditation be considered. The agreements on criteria underline the contribution of patients and insurers to the quality care policy. Besides the external review of quality systems, patients as well as insurers can assess the quality of care of some defined aspects of care. The accountability of providers and insurers is expressed with the agreements on information and public reporting.

From agreement to action

By common consent of all the participating organisations, a national committee supervises the implementation of the agreements and will stimulate further development of the national quality care policy. The committee comprises representatives of these organisations, and supervision is achieved by regular inventories and stimulating the implementation of the resolutions by mutual discussion and demonstrating projects that have developed within the various sectors.

By the end of 1991 an inventory of the development and existence of elements of quality systems within institutions and professional societies was complete. Furthermore, an inquiry among all national organisations and the government on the progress of the quality care policy regarding the other agreements has been published. Overall, much activity has been started, possibly because of the conferences. In more than half of the 23 professional societies peer review between colleagues is functioning effectively, and in three organisations (of medical specialists, general practitioners, and psychologists) external review by colleagues from other institutions is taking place. Nationally, most societies are developing guidelines for care. Recertification exists in all academic societies, but there is still discussion whether it should be based on quantitative data, such as hours committed to providing care and postgraduate courses, or on assessment of quality assurance activities. The box shows the main quality systems in the medical profession.

At present complete quality systems as described above do not exist in institutions. However, in most sectors efforts are being made to bring more quality assurance elements of such systems that are already functioning, of which dealing with patients’ complaints is the most important. Other elements include infection control, necropsy meetings, and measurement of patient satisfaction. In two organisations ISO-norms are used as reference point for developing a complete quality system. In eight of the 14 national organisations of institutions such as nursing homes and institutions for handicapped people mutual visits among institutions have been or will be applied.

However, many of these activities, even though they started after the conferences, are mainly restricted within particular sectors or organisations. It seems clear that each party first wants to establish its own quality care policy, partly because some organisations need to catch up with others, but also because there is still uncertainty about the exact direction of the change in the health care system. That is also the reason why most insurance companies have a wait and see strategy. More important, however, is the position of the third party: the patients/consumers as an organisation and a countervailing power in self regulation, with the providers and insurers as the other parties. At present the parties’ association still lacks the human resources, the means, and the structure to operate effectively.

In some national projects, however, the three parties cooperate, in line with the agreements. For example, the national organisation for home care has taken an initiative to develop quality systems and criteria for care for its institutions. The initial framework which then has to be developed within the individual institutions, has been established by a working party of consumers, insurers, providers, and government. Within the regional institutions for ambulatory mental care an instrument for measuring patient satisfaction has been developed. Cooperation between patients, providers, and the state inspectorate. In addition, a consensus development conference, sponsored by CBO, on diagnosis and treatment of asthma in children has resulted in working party draft guidelines set up by representatives of patient organisations, by providers, and by insurers.

At the mean time the government has put forward a bill on quality of care in which all institutions are obliged to develop internal quality systems and to submit an annual report on their quality activities. In the Netherlands, health care insurance is being drawn up in addition to several laws that strengthen patients’ position regarding confidentiality and the relationship between health professionals and patients.

Conclusion

The conferences on quality care policy in the Netherlands have played a critical part in trying to coordinate the many and varied health care quality activities into a joint and coherent policy. The first step towards achieving acceptance by individual institutions and professionals is forming a consensus. The conferences agreement has been the dissemination of information.

In keeping with the consultative and consensus culture in the Netherlands, it was essential that these three parties—patients, providers, and insurers—together with the government, made national agreements. However, this tripartite conceptual model is more complex in practice: at the conferences agreements have to be made not only about what and when something should be done but also about who has to do it locally and with which parties should be involved in that particular activity. In general and abstract terms the national agreements therefore serve as the framework in which quality care can be applied locally. To discuss progress to test the activities in practice against the agreements; and to make new agreements, if necessary, will require a permanent national platform with representatives of all organisations.

**Main quality systems within the medical profession**

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<th>Target</th>
<th>Method</th>
<th>Undergraduate and postgraduate curriculum</th>
<th>Specialist training</th>
<th>Continuing education</th>
<th>Clinical performance</th>
<th>Patient relationship</th>
<th>Clinical competence</th>
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<td>Visit</td>
<td>Accreditation</td>
<td>Guidelnes for care</td>
<td>Peer review</td>
<td>Disciplinary tribunal Complaints procedure</td>
<td>(Re-)certification</td>
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5 Frissen MAG. Afspraken over kwaliteitsbeleid [Agreements on quality care policy]. Medisch Contact 1990;45:872-5.
8 Bering R. Kwaliteitsbeleid. Wat er van "Leidschendam" terechtkwam [What has turned out of Leidschendam Quality Care Policy Conferences]? Medisch Contact 1992;47:241-4.