Summary

In the trend of rising life expectancies, the Netherlands continues to lag behind a number of other European countries. Differences in the quality of care among individual hospitals and healthcare providers are inexplicably large. The quality of care in the caring sector is failing to deliver in a number of areas, while patient satisfaction could clearly be better. Results are also disappointing when it comes to prevention; unhealthy lifestyle choices such as smoking, excessive alcohol use and insufficient physical exercise are simply too entrenched. All financial preconditions are keyed to financing treatments rather than achieving specific results. Although the Netherlands has good access to healthcare and good average quality of care, the sector can and – according to the Council for Public Health and Health Care (RVZ) – *must* do better.

This advisory report by the RVZ explores if and how steering towards specific healthcare targets can contribute to enhancing the quality and efficacy of healthcare. Healthcare targets can differ depending on the nature of the care being provided. In the case of a cure the object can be recovery, for example, or improved movement or the elimination of physical impediments, whereas the concerns of care are focused more on preserving quality of life or improving a patient's prospects for reintegration. Setting targets makes it possible to prioritise and address developments that are making insufficient progress or moving too slowly. The RVZ sees opportunities for steering towards healthcare targets in the direct care that practitioners provide patients (micro-level), in the purchasing activities of health insurers and health service offices (meso-level) and in policy management by national and local authorities (macro-level).

The health of individual people is determined by more factors than the quality and efficacy of healthcare alone. Physical environment, behaviour and socio-economic factors are also important. Intersectoral cooperation is therefore a requisite for achieving longer life expectancy and better health.

In a number of paramedical professions and the mental health services and nursing sectors, treatment and care plans for chronically ill patients already set explicit targets for treatment and care. This is far less true where the object is to cure, though in a number of cases the relevant professional associations have established such indicators and standards for syndromes and treatments, with an agreed target for each type of treatment. Diabetes is one example.

Examples of the successful mutual exchange of outcome data, the sharing of which enables fellow treatment practitioners to improve their provision of care, are found both abroad and in the Netherlands. As a form of performance management, this exchange of equivalent data (*spiegelinformatie* in Dutch) gives care service providers a way to learn from one another. A good example is the Dutch Surgical Colorectal Audit (DSCA), in which providers keep meticulous records of the results of colorectal cancer treatments. Participating hospitals can compare their own performance with that of others and implement improvement measures where needed. However, effective performance management requires a large pool of statistical – and inter-comparable – data, which can spell a considerable increase in the administrative burden. That burden can be mitigated by recording data directly in patient files.

In the United States and United Kingdom, financial incentives have repeatedly proven an effective means to achieve explicit health targets. In addition to its Medicaid system, more than half of all

commercial health insurance providers in the United States run such ‘pay for performance’ projects. Health insurers in the Netherlands also take part in P4P, but on a smaller scale. And where care is concerned, information about using financial incentives in healthcare sector purchasing has made little headway in this country. Here, measurements of patient satisfaction could serve as a useful standard.

A major sticking point is the financing system. The DBC/DOT system currently used is based on rewarding performance of procedures and not on achieving results. The same holds true for the AWBZ, where financial stimuli are aimed not at the desired result, but at the provided care.

Various examples from other countries, including the Finnish North Karelia project and the British NHS Outcomes Framework, provide evidence that it is possible to effectively and explicitly direct actions towards achieving health targets. Attempts to do so have already been made in the Netherlands, for example in 1986 with the goals framed in the ‘Nota2000’, and in the 2006 ‘Kiezen voor gezond leven’ (‘Choosingfor a healthy life’) memorandum, aimed at prevention, which formulated quantitative targets for reducing the number of smokers, alcohol use and obesity. Ultimately, however, these targets were not achieved. They were too unrealistic, received too little support from professional and political circles and the measures themselves proved unfeasible.

In recent years, a growing number of tools have become available that could aid in formulating health targets that are realistic and acceptable. Examples include SimSmoke to cut smoking and the Health Inequalities Intervention Toolkit to close the health divide between different population groups.

The RVZ believes that steering towards explicit health targets is worthwhile, desirable and indeed possible at all levels of healthcare. Health targets can be achieved most effectively if all levels – from the individual treatment relationship to healthcare sector purchasing through to local and national policy – cooperate in steering towards a single goal, facilitated by access to a combination of intersectoral resources.

The National Institute for the Quality of Healthcare Services (Nationaal Kwaliteitsinstituut Gezondheidszorg) could play a pivotal role in the process of selecting and establishing quality indicators. To keep the administrative burden to a minimum, the vital outcome data will have to be recorded in medical files using a standardised system. This data must include not only the diagnosis and treatment, but also the end result.

All care service providers must be obliged to take part in performance management and to incorporate explicit treatment objectives in their treatment and care plans. Doing so will also give those providers an effective means to point patients at the responsibility they themselves bear for a positive outcome, for example by making lifestyle adjustments or adhering to their doctor’s recommendations (patient compliance).

Finally, the RVZ proposes focusing in on a few key areas in which known best practices can be developed into an integral framework for steering towards health targets. A logical course of action would be to start with those areas in which initiatives have already been formulated and which enjoy support from care professionals. The RVZ has identified eight best practices that can already be used in steering towards health targets.