
Canada-Netherlands Seminar on Health Care

The Hague, Netherlands
September 5 – 7, 2007

In September 2007, the Dutch Ministry of Health, Welfare and Sport hosted a Canadian delegation of health professionals and policy makers for a joint seminar on Health Care Reform to study recent policy and program initiatives in the Netherlands toward improving health system quality, safety and efficiency, to meet and share perspectives with peer professionals, and to explore opportunities for ongoing collaboration. This report summarizes key issues discussed, insights developed, and areas for further study.

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with the generous assistance of seminar delegates on behalf of the

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Introduction

The Netherlands and Canada committed in 2003 to further develop and support the special bond that exists between the two countries, in part by holding an annual seminar on an issue of mutual interest with an emphasis on questions of social and economic policy. The chosen subject for 2007 was Health Care Reform.

This report provides an overview of information presented on Dutch reforms, highlights common challenges facing the Dutch and Canadian health care systems, and considers possible areas for future policy dialogue.

The Canadian College of Health Service Executives (CCHSE) was engaged by Health Canada to provide leadership and facilitation for the event. John King, an Ontario Director for the College, was the facilitator for the Canadian delegation.

In September 2007 19 senior health professionals (see Appendix 1 for Canadian roster) from across Canada traveled to the Netherlands to have frank dialogue with and to learn from over 30 peers from the Netherlands (see Appendix 2 for Dutch Roster) about recently implemented Dutch Health Care reforms. Participants, representing hospitals, professional organizations, academic institutions and governments discussed the increasing societal and economic demands that both countries face with respect to patient safety, health care quality and access to services, and shared perspectives on how they are addressing these issues.

The objective was not only to share information but also to strengthen business and government relations in order to create a sustainable platform for ongoing exchange of ideas and collaboration.

Seminar Origins

On September 23, 2003, then Prime Minister Jean Chrétien of Canada and Prime Minister Balkenende of the Netherlands signed the *Joint Declaration on the Strengthening of the Bilateral Relations between the Government of the Netherlands and the Government of Canada*. The purpose of the Declaration was to strengthen "business-to-business and people-to-people" relations as well as to provide opportunity for organizations to meet and twin. The two governments intended that a broad range of stakeholders would participate in bilateral dialogues providing a regular exchange of views and perspectives. In 2005 and 2006 joint meetings were organized on climate change and foreign policy respectively. The chosen topic for the 2007 seminar was Health Care Reform.

The first Canada-Netherlands Seminar on Health Care was hosted in September 2007 in The Hague by the Netherlands' Ministry of Health, Welfare and Sport (VWS) and was designed to showcase key Dutch health system reform initiatives. Brief overviews of related Canadian activity were also provided to provide context for meaningful discussion. The expectation was that this would set the stage for a future reciprocal health seminar, to be hosted by Canada.

Why Canada – Netherlands?

The relevance of the Dutch health system to Canada may not be readily apparent. Indeed, the two countries differ significantly with respect to population density and immigration patterns. Furthermore, in health care the governance structure, public-private mix and role of insurers are major areas of difference. On the other hand, the Dutch and Canadian health care systems have been founded under similar principles of health care for all regardless of the ability to pay, and both countries face similar challenges as their still relatively young populations age, as expensive new medical technology becomes mainstream, and as resources become increasingly constrained.

Both Canada and the Netherlands have focused intensely on Wait Times, Patient Safety and Information/Communications Technology (ICT) in recent years. Both are also under increasing pressure to increase transparency and patient-responsiveness.

The Dutch system has been involved in the last two decades in a high degree of discussion, debate, and incremental reform with respect to system structure. Instead of government regulation and budgeting, the Dutch health care system is slowly moving towards increased responsibility and incentives for health care providers, health insurers and patients. Recently, two large scale reforms, overhaul of the insurance system for medical care and a nationwide hospital performance improvement program known as Better-Faster have attracted particular attention and appear to be having a positive effect.

Considering how each country has addressed their issues and sharing best practices, approaches to change and outcomes was anticipated to be both stimulating and productive.

Seminar Objectives and Format

Objectives and expected outcomes for the seminar were:

- To initiate dialogue, information sharing and networking among healthcare practitioners, medical associations, hospital management, and relevant levels of government in Canada and the Netherlands relating to three policy themes:
 - Patient Safety;
 - Change Management & Information and Communications Technology (ICT); and,
 - Waiting Times / Access to Health care,including the sharing of "best practices", innovations, problems encountered in the implementation of new programs, and problem-solving techniques applied.
- To identify future opportunities for collaboration such as future policy dialogues, joint work on specific health care challenges and/or personnel exchanges.

An ambitious two and one-half day agenda was designed to accomplish the objectives. Following brief introductions on the first afternoon, overviews were presented of two major recent reforms in Dutch health care: insurance reforms and the nation-wide Sneller-Beter (Better-Faster) program targeting hospital efficiency and quality improvement, in 24 pilot hospitals, 12 of which were represented at the Seminar.

On the second day, the first full seminar day, three workshops were conducted focusing on each of the three seminar themes: (1) Patient Safety, (2) Leadership, Change Management and ICT, and (3) Waiting Times. Each workshop was comprised of presentations from first Dutch and then Canadian executives, sharing approaches and experiences in their countries. Each workshop also included time for questions, answers and discussion. Following the third workshop a general "house of commons"-style question/answer/debate was held to begin identifying key insights and opportunities to learn further from one another.

On the third and final day, members of the Canadian delegation toured two Better-Faster pilot hospitals in Delft and Rotterdam both to see program implementations first-hand and to speak directly with practitioners on the front-line.

Facilitated debriefs of the Canadian delegation on site at the end of the Seminar and by teleconference after the group's return to Canada, as well as the co-editing of this paper, identified areas for further study and discussion.

A full program agenda and list of presenters is included in Appendix 3.

Within the confines of a two and a half day study tour it was only possible to "scratch the surface" of the two countries' systems, reform initiatives and opportunities for future dialogue. Presentations and discussions at this seminar were necessarily limited to the Hospital sector, and focused more heavily on reform initiatives than on the care delivery system itself.

Participants expressed a desire to learn more about other parts of the system, including Primary Care, Home Care/Long Term Care/Social Services and Mental Health Care. Canadian participants were particularly interested to better understand the Dutch approach to health human resources and overall system financing.

Overview of Health Care in The Netherlands

The Dutch health care system is publicly regulated, but privately-delivered. The system is administered by private health insurance companies, with health care services being delivered by privately-operated, not-for-profit hospitals and independent health practitioners. However, public financing continues to play an important role and is used to influence health care system accessibility and quality.

Health Care Delivery

Public satisfaction has traditionally been high in the Netherlands, with 73.2% saying in 1999 that they were "very satisfied" or "fairly satisfied" with their health care system, due in large part to its strong, well-developed system of primary health care.

Primary care is for the most part provided by independent, community-based family physician (GP) practices which effectively serve as gatekeepers to specialists and inpatient hospital care for their rostered patients, resulting in both a “low referral rate as the majority of problems are treated by GPs (primary care constitutes two thirds of all ambulatory care contacts)” and a “very low prescription rate, with prescriptions given in about 66% of cases, compared to 75-95% in other European countries... Family physicians ‘specialize in common and minor diseases, in care for patients with chronic illnesses and in addressing the psychosocial problems related to these complaints.”¹

Secondary and tertiary care is primarily provided by in-hospital specialists through inpatient and outpatient facilities. As of 2004 there were 200 general hospitals, eight teaching hospitals and 28 specialist hospitals, but this number has reduced significantly due to merger and consolidation activity.

Beginning in the 1990s, in response to a mandated decrease in hospital beds and concurrent with hospital merger / rationalization activity, a new “transmural care” sector has evolved to bridge the gap between ambulatory and institutional care and has subsequently become widespread. Similar in practice in some respects to managed care in the U.S. and shared care in the U.K., transmural care has evolved bottom-up by care providers and is geared towards quality improvement, e.g. continuity of care, tailor-made care.

According to 2007 OECD data, as of 2004 there were 3.1 acute beds (decreased by 1/3 since 1980), 3.7 physicians and 14.5 nurses per 1000 population in the Dutch health care system. This compares with 2.9 acute beds, 2.2 physicians, and 10.0 nurses per 1000 population in Canada. Compared to other EU member states, The Netherlands has approximately 10% fewer physicians but a considerably higher number of nurses per capita. (Additional Dutch and Canadian comparative data is available in Appendix 4.)

The private sector plays a key role on the provider side of health care in the Netherlands. With the exception of public university hospitals, virtually all hospitals in The Netherlands are private, not-for-profit entities responsible for their own bottom lines. Physicians, including both primary care physicians and medical specialists in the hospitals are predominantly private entrepreneurs.

Public Health is managed at the municipal or district level under regional and national oversight. National oversight for the quality of care is the responsibility of the Health Care Inspectorate, which also oversees acute and primary care. The Dutch Health Care Authority oversees the health care market and competition. Public health emphasis has been on prevention policies, promoting healthy lifestyles, disaster planning, reducing health socioeconomic differences and reducing morbidity in the elderly.

The Netherlands has the highest rate of residential care for the elderly in Europe², although elderly people are increasingly staying in their private homes as long as possible, helped by additional care and support. Each residential home resident receives medical care from his/her GP. In addition, care subscriptions are available for healthy elderly living independently to have access to a residential home in emergencies.

¹ HiT summary: Netherlands, 2005, p.5.

² HiT summary: Netherlands, 2005, p.6

Mental Health services range from outpatient to long-term residential units, from psychiatric departments in hospitals to therapeutic communities.

Organizational Structure and Financing Prior to the 2006 Reforms

The health care system has long been health insurance-based with separate schemes defining three compartments of care governed by different ministries, legislation and insurer/insured and insurer/provider relationships:

1. A national scheme for Exceptional Medical Expenses including long-term care and high-cost treatment covering almost everyone living in the Netherlands and covered under the Exceptional Medical Expenses Act (AWBZ). The AWBZ compartment is financed by payroll deductions and government funds and accounts for 48% of total health expenditure³
2. Standard medical care covering Basic Expenses including primary care, hospital care and pharmaceuticals. The Ministry of Finance and the Ministry of Health, Welfare and Sport jointly oversee the standard policy scheme, which is implemented by private health insurers.

Coverage and payment provisions varied before 2006 for this layer, with lower income citizens and their dependents (65% of the population) being covered through compulsory state-run sickness funds (ZFW) financed by deductions from wages plus a government grant and private sector contributions. Higher earners (28%) were eligible but not obliged to opt for insurance for themselves (but not for their dependents) through voluntary private insurance, with premiums being paid directly by individuals, sometimes with some contribution from their employers. Finally, 5% of citizens were covered by special insurance schemes for public servants.

The "cut-off point" for compulsory sickness fund participation was seen to be a somewhat arbitrary source of inequity as well as a source of unproductive "gaming" around the cut-off. Since 2006 all citizens have been brought into the same coverage and funding scheme. (See below under "Health Insurance System Reform".) In total, standard medical care accounts for 47% of health expenditures.

3. Optional supplemental care including dental care, prostheses, hearing aids and other less necessary care the costs of which are largely covered by supplementary private medical insurance. Insurers are free to set the specific scope, conditions and premiums for supplementary insurance offerings. This compartment represents 5% of total health expenditures.

The Netherlands describes its system as one of "managed competition". While the government sets standards and the legislative framework, there is a unique balance of consumer, provider and insurer, which is intended to instill market forces into the Dutch system. This "magical triangle" has been the focus of Dutch health care reform as the main means to encourage market competition to boost efficiency, innovation, consumer-orientation and cost control. This has been evident since the 1990's through the increasing shift of responsibility for purchasing care from government to insurers.

³ Marcelis Boereboom, The Dutch Experiment: The Special Role of the Private Sector in Dutch Health Care, Ministry of Health Welfare and Sport, September, 2007.

Even prior to 2006, the state-run sickness funds negotiated with providers about the quality, quantity and, to a limited extent, price of services with a view toward encouraging market competition. In 2000 movement began toward the Diagnosis Treatment Combination (DBC) system, a diagnosis-related-group (DRG) type basis of hospital funding with introduction of performance-related payment for hospitals as a further lever to improve system effectiveness and to reduce wait times.⁴

Prior to 2006, specialist physicians were salaried employees of hospitals while General Practitioners were paid on a per capita basis for ZFW patients and fee-for-service for privately insured patients. Since 2005 specialist services have also begun to be reimbursed by the DBC system.

Finally, prior to 2006, hospitals could apply for and receive funding for major capital expenditures. This, too, is changing toward self-funding.

Key System Challenges

While patient satisfaction had been reportedly high, costs continued to escalate and wait times continued to lengthen due to access problems, delays and coordination / communication problems prior to the 2006 reforms. Total health care expenditure in the Netherlands tripled in terms of US\$ purchasing power parity (PPP) since 1980⁵, and in 2004 it accounted for 9.2% of GDP⁶. There was also an overall unease as to the payback being realized from increased spending, and in the context of the aging population and escalating health technology costs, it was believed that cost pressures could only increase.

Furthermore, patients were not active participants in their care, frequently undergoing unnecessary transfers and incurring unnecessary expenses, and patient safety was a growing concern. Health care consumers historically had little awareness of health care costs, consistent with other countries with national health insurance schemes, and were under no pressure to manage their consumption.

Transparency had previously not been a priority as cost and efficiency in health care was seen as a concern for the government, not for citizens. As well, while quality and accessibility were routinely tested against minimum standards and were deemed to be good by the Health Care Inspectorate, lack of transparency about and accountability for quality and accessibility failed to motivate the innovation and competition amongst providers envisioned by "the magic triangle". For example, provider profitability issues were often addressed not by problem-solving but rather by rationing services, resulting in further increasing wait times.

At a more macro level, life expectancy trends were not improving at the same pace in the Netherlands as elsewhere in the EU⁷, and perceived funding inequities remained

⁴ Note that Dutch DBCs have broader scope than DRGs elsewhere. Whereas DRG costs typically include only acute inpatient care, DBC costs in The Netherlands extend from associated outpatient visits prior to admission to rehab and care after discharge.

⁵ HiT summary: Netherlands, 2005, p.2

⁶ See a selection of statistical comparisons in Appendix 4

⁷ 1960→2000 -- Netherlands: increased 4.5 years; Germany: increased 8.1 years; Belgium: increased 7.1 years; U.S : increased nearly 7 yrs per Wall Street Journal, September, 2007.

unresolved as citizens with higher incomes and those with lower incomes were subject to very different insurance funding arrangements.

Finally there was a belief that while innovation was occurring in pockets, the improvements were not being generalized and diffused quickly enough across the system.

Recent Dutch Health System Reform

Responding to the perceived need to improve performance and contain expenses, the Dutch health system has recently undertaken two significant change initiatives. Fundamental to the changes have been (1) The January 1, 2006 revision of the Health Insurance Act which leverages the system's private sector tradition toward increased market competition and which brings to bear select regulation in the form of public guarantees, and (2) a nationwide drive under the banner of the Faster Better program to improve hospital performance, and with it a drive for patient awareness and empowerment.

Health Insurance System Reform

As long ago as 1987 the Dekker Report recommended moving to a single national insurance scheme delivered by competitive insurers and providing basic medical care coverage for all in order to simplify the system and eliminate funding inequities; much debate ensued as to how to achieve this. In the intervening period, costs continued to rise and wait lists to lengthen despite initiatives to reduce them. In 2000 -2004 alone, health expenditures rose from 8% to 10% of GDP. At the same time EU legislation pressed for increasing market competition in all aspects of the community including health care.

Many incremental changes were undertaken over the 20 years preceding the 2006 reforms with the aim of shifting responsibility for purchasing care from government to insurers, generating market pressure amongst providers and strengthening patient involvement/choice in order to increase quality and reduce costs. For example, open enrollment replaced regional insurance monopolies to increase patient choice of provider and third party payer. However, during the same period mergers among hospitals and among insurers resulted in reduced choice. Similarly, while Sickness Funds gained liberty to select among practitioners (but not providers), this option was in fact almost never exercised.

On January 1, 2006 with introduction of the new Dutch Health Insurance Act (ZVW), a new reform process was initiated aimed at making health care more efficient, high quality, demand-driven, and innovative through introduction of market competition, enhanced contracting freedom for insurers and providers, consumer choice and public reporting of hospital performance.

Differential coverage and funding of basic medical care coverage came to an end as all residents moved to the same private insurance system wherein adults select an insurer and pay for mandatory standard coverage plus optional additional coverages. At the same time, key public guarantees toward "risk solidarity" were made including mandatory universal coverage for all, obligatory acceptance of all risks regardless of age or health risk by insurers to avoid adverse risk selection ("cream-skimming"), flat nominal per capita risk-independent annual health premiums supported by a publicly funded risk

equalization system and premium allowances for low income earners and young people. Those under 18 are covered free of charge.

Although standard coverage is fixed by law, care can be arranged by insurers in different ways. Costs of policies can also differ by coverage. In addition to the premium, the insured pays an income-related contribution through taxes, and the employer must compensate for these contributions. These income-related contributions are divided amongst insurers through a risk-equalization system.⁸ Higher standards of care in terms of both quality and cost were also guaranteed.

While the players in the "magic triangle" of consumer / insurer / provider remain the same, the relationships and options between stakeholders have been rebalanced. More freedom has been given to consumers to choose their insurers and thereby their service packages, and to insurers to negotiate prices, volumes and quality with providers. Furthermore, comparative information about insurance plan offerings and provider performance is provided online and elsewhere to increase public awareness and to help people make informed choices.

Early results have been favourable with 18% of the population changing insurers in the first year, more than the expected 5%, lower average premium costs than expected (7.6% lower in the first year and 2.7% in the second year) and a decrease in uninsured population. "Furthermore, cost growth is projected to decrease this year to about 3% after inflation from 4.5% in 2006. Waiting lists are shrinking, and private health insurers are coming up with innovative ways to care for the sick."⁹

On January 1, 2006, providers were also given greater autonomy in capacity decisions via abolition of the Hospital Planning Act. Since 2007, a new system of co-payments has been instituted, and health care prices have been increasingly liberalized with a goal of abolishing budgeting systems for providers. Future emphasis will be on building patient empowerment through increased awareness about quality of care and patient safety, informed purchasing, implementation of a national electronic medical record system and clarification / formalization of patient rights through law.

In this multi-step reform process mapped out through 2012, revised rules were scheduled to be introduced in 2008 for capital investments, and the ban on for-profit hospital care was to be lifted in 2012. However, the recent change of government leaves future plans uncertain.

Better-Faster (Sneller-Beter) Program

In 2004 the Dutch Ministry of Health, in partnership with the League of Medical Specialists, Dutch Association of Hospitals and Dutch Association of Nurses, launched the three-pillar Better-Faster¹⁰ (B-F) program, allocating €14 million over the four years (2004-2008) to hospital performance improvement in 24 pilot hospitals with an emphasis on efficiency, safety and patient empowerment.

⁸ An overview of post-insurance reform financing is presented in Appendix 5.

⁹ *In Holland, Some See Model for U.S. Health-Care System*, Wall Street Journal, Sept 6, 2007

¹⁰ "Better" here refers to being "healthy again"

The first pillar focused on increasing awareness. Experience and transferable best practices were captured both from leading international companies in other industries with respect to safety (Shell - oil), logistics (TNT – transportation), transparency (Aegon - insurance) and Innovation (KPN - telephone) as well as from health care. In addition, a database of health care best practices was structured covering such subjects as patient logistics, patient involvement and nursing quality, and numerous forms of communication were used to get the message out: website, newsletters, interviews, breakfast meetings with nurses, etc.

In the second pillar the Health Care Inspectorate initiated the annual publication of 26 hospital indicators emphasizing safety and quality of care consistent with the belief that measurement, transparency and public accountability will generate a new attitude toward continuous improvement and contribute to improved hospital management. In the coming year, the publication will be expanded to include 80 disease specific indicators, hospital standardized mortality ratios (HSMR) and evidence-based interventions.

In the third pillar, 24 hospitals¹¹ were selected to pilot performance improvements and accelerate the spread of best practices in four arenas: logistics, patient safety, patient-centred care and leadership. Hospitals applying to participate were required to demonstrate board and medical staff commitment as well as financial stability. The long-term goal is for demonstrated improvement in this first 20% of Dutch hospitals to lead reform uptake among the remaining 80%.

Program direction as well as support from consortium “breakthrough teams” -- consulting resources with specific expertise -- has been provided to participating hospitals through a consortium of the Dutch Institute of Healthcare (CBO), the College of Medical Specialists (iBMG) and the Department of Health Policy of Erasmus University (OMS). Ambitious performance objectives have been set for each project based on evidence and best practices. Every project has a business case at the front end, and key national professional associations have been active collaborators throughout. The program has grown from 100 projects in the first eight hospitals in the first year to 405 in the second year to over 700 currently in the third year.

Beyond project level improvement, the program has sought to create an improvement infrastructure and culture in order to ensure local sustainability. To embed results-driven quality management into strategic change, management contracts have been implemented with daily internal dashboard monitoring as well as external comparisons to encourage competition. In addition, a new national report, The Dutch Health Care Performance Report (DHCPR), began in 2004 to report biennially on 125 key performance indicators.

In the area of logistics improvement, program objectives included reduction of maximum waiting times to less than one week in outpatient clinics, 40-90% reduction in diagnosis and treatment throughput time, 30% reduction in length of stay, and 30% improvement in operating room productivity. Results after two years have been a 21% decrease in waiting lists, 47% reduction in diagnosis and treatment throughput time, 16% reduction in length of stay and 10% fewer surgery cancellations.

¹¹ 12 of the 24 hospitals were represented at the Canada-Netherlands Seminar on Health Care.

In the area of patient safety, objectives included introduction of a blame-free reporting system, 50% reduction in medication errors, 5% reduction in pressure ulcers and 50% reduction in wound infections. Reported results after two years have been implementation of blame-free reporting both internally and externally in every hospital, 30% reduction in pressure ulcers, 76% reduction in parenteral antibiotics, and 20% reduction in post-surgical pain.

A number of assessment mechanisms have been introduced through the Better-Faster program to empower patients by enabling them to provide feedback on their care and to make suggestions for improvements. Examples of such instruments include patient feedback systems, patient committees, shadowing and patient mirror meetings where clinicians observe patient interviews (with their knowledge) through one-way glass.

Key Learnings: Highlights

- Participants noted the affinity and shared core values between the Dutch and the Canadians, and felt that this would be conducive to continued collaboration. However, while they strive for similar goals, their means of achieving them is different.
- The Canadians found it interesting to contrast the two systems, finding more similarities than they had expected.
- Notwithstanding the apparent affinity and similarity in values, it was suggested that caution should be taken in making comparisons, and that the broader determinants of health need to be considered and taken into account.
- Participants found it particularly useful to see and were impressed by seeing the work that has been done around process redesign on the hospital visits.

Similarities and Differences¹²

- Demographics: Canada is approximately twice as populous as the Netherlands, but population density is much lower, and diversity is much higher. Both countries have relatively young but aging populations, and both countries share similar morbidity patterns.
- Health system goals: Both Canada and the Netherlands share similar values with respect to focus on health outcomes, accessibility, equitability, efficiency, sustainability and patient-focus.
- Health care system governance: Canada's Federal/Provincial/Territorial split and the variety of provincial governance/delivery structures contrasts with the Netherlands' strongly national and central policy approach. Canada appears to place greater emphasis on supply-driven system integration while the Dutch system focuses on demand-driven markets for health services.
- Overall the basket of acute health services, health expenditure levels (9.5-10.5% GDP) and distribution across levels of care are similar between the two countries. However, there is broader coverage in the Netherlands for Long Term Care and pharmaceuticals than in Canada.
- The two countries have different payor systems. Health care financing is tax-based in Canada and insurance-based in the Netherlands, although a significant share of health financing in the Netherlands continues to be via payroll deductions, which is applied to their risk-equalization program among insurers. Canada relies on multilevel-budget allocation mechanisms whereas the Netherlands is moving toward letting a regulated market between insurers and providers determine prices and budgets.
- The Netherlands is moving towards a results-driven, output-based DRG-like system of financing for their hospitals, something Canada has not yet moved forward with as a system-wide initiative. Global budgets still predominate in Canada.

¹² See also a selection of statistical comparisons in Appendix 4

- Infectious Diseases are an area of Public Health emphasis in both countries.
- Similar experimentation is occurring in both countries with Primary care vis à vis organizational integration (e.g. Family Health Teams) and clinical substitution (e.g. nurse practitioners).
- There are more medical professionals and hospital beds per 1000 population in the Netherlands than in Canada.
- Hospitals in both countries are private, not for profit. Specialists are integrated into hospital organizations, but have somewhat different privileging structures in the two countries.
- The Health Care Inspectorate plays a role in public accountability in the Netherlands that does not exist in Canada where accreditation is voluntary. The Provincial Auditor plays a strong role in some Canadian provinces in reviewing spending practices. As well, supervisors can be appointed where quality issues are evident. The Dutch Inspectorate is responsible for quality management and is empowered to visit / inspect anywhere, anytime to ensure the public trust is maintained.

System Reforms

- Critical success factors for system change in the Netherlands were
 - Multisectoral consensus and alignment of all players in the “magic triangle”
 - Concurrent action on all levels: strategically focused large system changes (Health care insurance, financing, ICT); Program/Project-based improvement (Better Faster); building improvement into daily work.
 - Coordinated, visible leadership by all parties including medical specialists and hospital administrators as well as collaboration of the national professional organizations.
 - A receptive organizational culture, including blame-free reporting of accidents and near accidents both internally and externally
 - A balance between intrinsic professional motivation and extrinsic pressure. Transparent measurement / comparison encourages competition.
- Participants noted the positive use of private insurers to push innovation through competition in such areas as patient safety, efficiency and equity. Furthermore, they were impressed by the public/private balance inherent in the public sector regulation of private sector delivery in the Netherlands and contrasted the freedom that insurers have to select their risks in the U.S. with the Dutch guarantee of coverage and equity for all under the watchful eye of the government as ongoing steward of the system.
- The Dutch presenters emphasized that Performance Improvement project sustainability is much higher when extrinsic pressure through increased transparency and accountability is balanced with the intrinsic motivation of the professionals, i.e.

- When management contracts include quality commitments tracked by routine (daily) dashboard review. Visible measurement / comparison encourages competition.
 - When medical staff and boards are involved
- Participants were impressed with Better-Faster program development, penetration and measurement as well as with the breadth of improvement projects undertaken. The Better-Faster Program principles and goals appear to be deeply embedded in changes underway in the hospitals and were strongly evident not only at the front line, but also in ICT development at the teaching hospital that participants visited. Process redesign is also happening throughout the health sector in Canada, but there is not a provincial or national approach.
- The Better Faster program used common processes, frameworks and expert resources to guide BF hospitals in their reengineering efforts
 - External advisors from the BF Consortium assisted each hospital, drawing as well from national breakthrough teams equipped with problem-solving frameworks to guide hospitals in their projects.
 - Common processes: e.g., every project had a business case; projects routinely begin with a national conference bringing teams from all hospitals together; the “breaking through” process incorporates a standard “Plan-Do-Check-Act” (PDCA) cycle.
 - Frameworks and infrastructure coming out of the program are publicly available to other hospitals.
- The Better Faster Program hospitals trying to pilot improvements at the same time as incorporating the financial reforms (second group) have on the one hand had more difficulty to innovate under tougher financial pressure but on the other have benefited from
 - Strengthened coalition between doctors and administration built through Better Faster; and,
 - Better understanding of costs through DRG-type analysis.
- In retrospect, selection of pilot hospitals for Better Faster should perhaps have taken ICT into account both in terms of capacity to support flows and to support measurement.
- Better Faster focused entirely on hospitals. Separate change programs are underway in nursing homes, public health and chronic care.

Patient Safety

- To many participants, the Dutch appeared to be farther ahead in general in public reporting of Patient Safety indicators. There is a commonality of agreement on a set of 30 indicators, soon expanding to 80, which will be uniformly reported across

facilities. Having a common set of indicators simplifies the previously uncontrolled variety of benchmarks being reported by private entities.

- The Hospital Standardized Mortality Ratio (HSMR) is gaining visibility in the Netherlands. This benchmark will be publicly reported, starting in 2008 and is expected to be used by the Inspectorate to flag potential hospital quality / safety issues.
 - The Dutch HSMR has seen a strong decrease each year in the last eight years despite increasing clinical complexity of patients. (This is not thought to be due to increased use of hospice care.) HSMR improvements are attributed to better screening options, treatments and surgical techniques.
 - HSMR analysis is being used to identify and address quality / safety issues. The Dutch experience is that the cause is often a combination of "small" problems – e.g. communications gaps with patients, medication errors.
 - HSMR is seen in the Netherlands to be a tool for clinicians to assess quality and safety, particularly when broken down by specific diagnosis groups.
- Rapid Response Teams (SITs), which include an intensivist, have been implemented in most Dutch hospitals. Nurses use SIT carts and a standard scorecard to assess patients to determine when to call the team. In future, HSMR will be leveraged to assess impact of interventions such as SITs.
- HSMRs are trending similarly in Canada with respect to improvement. Publication is planned for the end of November 2007. Quality differentials are narrower in the Netherlands than in Canada, and attention in Canada will be focused more on overall trends.
- There is increasing recognition in the Netherlands that attention to patient quality and safety can not only improve efficiency but also reduce costs.
- Better Faster approaches to patient safety resemble those of Canada's Safer Healthcare Now! campaign.
- Role of patient / consumer organizations
 - Patient-centredness is a part of Faster Better. Most hospitals have patient committees but understanding of safety issues is low, and there has been more success in involving patients in logistics issues than in safety issues.
- On the other hand, one doctor reported that in Mirror Meetings, patients frequently talk about safety issues. Patient Mirror Meetings are opportunities for patients discuss among themselves what happened to them, while the doctors listen and reflect. Physician behaviour changes are often quick and dramatic having heard patient feedback firsthand – e.g. faster response time to alarms in the ICU, understanding of issues for parents of chronically ill children.
- The Netherlands has an obligatory system for re-registration of medical specialists. A new system (IFMS) is being developed in the context of Faster Better to include a mandatory biennial 360-degree review of specialists based on a competence model. It will at first only apply to new medical specialists but is increasingly being used

voluntarily by hospitals and may become a mandatory part of re-registration in the future.

- In June 2007, a new national plan was launched in the Netherlands for Patient Safety with a goal of reducing hospital errors by 50% ¹³ over 5 years.

Change Management / Leadership

- Faster Better recognizes the importance of leadership, courage and exemplary best practice behaviour by all parties (hospital Boards, professionals & government), a new culture of non-punishing teamwork and management development to facilitate and spread large-scale change. Interdepartmental culture gaps appear frequently to be more challenging to address than gaps between hospitals.
- Publication of performance indicators has helped to bring focus and increase the sense of urgency around improving quality and safety
- There are various leadership-related initiatives ongoing within Dutch healthcare associations such as a network of CEOs/CMOs through the Dutch Hospital Association and a leadership master class program of the Dutch Association of Hospital Directors in collaboration with Business School Netherlands, but there does not appear to be a cohesive national approach to leadership development in the Netherlands.
- Both countries tend to source health leadership internally to the health care industry rather than tapping into other industries.

Information & Communications Technology

- The challenge of integration at the national or regional level for the Electronic Health Record is equally a challenge for the Netherlands as it is in most of Canada.
- The Netherlands appears today to have a higher proportion of primary care physicians (>90%) with electronic access to patient information and alerts than Canada (~23%) according to a 2006 study by the Commonwealth Fund. However, the statistics may be deceptive as patient databases in the Netherlands tend to be local without communication / data exchange across facilities or patient groups. For example, there are seven different and non-networked electronic systems for GPs in The Hague. Participants noted that the high penetration of Electronic Health Records among Primary care providers in the Netherlands may also be a natural consequence of the greater emphasis on Primary care in that country.
- To encourage physicians to adopt electronic systems, physician incentives, such as differential cost fee in their fee schedules, are used. In some cases, physicians are provided with hardware and software to encourage participation.
- While there appears to be high penetration of ICT in hospitals in terms of both distribution and functionality, Electronic Health Records at Erasmus are discipline-based rather than standardized, and Clinical Physician Order Entry (CPOE) systems are not integrated (e.g. separate for ICU, general use and oncology). Physician

¹³ Health Canada, Seminar Briefing Note.

adoption and compliance of the discipline-based systems, however is reported to be good.

- The balance between extrinsic pressure and intrinsic motivation is seen to be critical in moving forward with ICT patient records. In the Netherlands, the tradeoff has resulted in higher satisfaction with and utilization of electronic patient records, but non-integration across practitioner groups.
- Both countries struggle with issues of early adopters getting burned prior to the establishment of standards and competition for financial resources against initiatives addressing direct patient care.
- The Dutch government is investing 100 million Euros over the next four years to reimburse investments in ICT. While there have been efforts over the past 10 years to agree on and move toward minimum interoperability standards, getting parties to comply has been difficult. Over the past five to six years the focus has been on financial information to support DRG-type cost analysis. The focus is now moving to patient logistics, information and safety.
- In July 2007 a bill was introduced by the Dutch Health Minister to shape the parameters of a repository-based nation-wide electronic medical record (EPD) which will allow doctors and pharmacists to have access to patient medical histories. The bill also lays out the obligations of care providers and rights of patients. Target availability of the EPD is January 2009.¹⁴

Wait Times

- Surgical wait times were reduced significantly through a Better Faster process reengineering project at Groene Hart hospital as a result of recognizing calendar-driven staffing shortages, changing protocols to reduce unnecessary follow-up consultations, use of non-physicians (e.g. nurses) for more routine follow-ups and having surgeons follow-up on their own patients for improved continuity.
- Ironically, patient reaction to the access time reduction has been mixed as long waits were previously associated by consumers with high demand for a particular physician, and therefore presumably better quality.
- Insurers in the Netherlands are beginning to offer bonus incentives to doctors who are successful in lowering access times (e.g. < 6 weeks)
- Canadian Wait-time and Access strategy efforts were seen to be a parallel to Better-Faster wait time initiatives.
- Surgeon compensation structure appears to be an important factor in reengineering. Dutch surgeons are currently paid a flat fee per patient per year regardless of number of visits. Beginning next year, under the Diagnosis Treatment Combination (DBC) system, they will be paid one DRG (Diagnosis-Related Group) per patient per year.

¹⁴ Health Canada, Seminar Briefing note.

This differs from the Canadian system where surgeons are paid on a fee-for-service basis.

- Dutch participants noted that Canada appears to have an undercapacity of human resources whereas the Netherlands has both overcapacity and hidden capacity. While patients compete for GPs in Canada and 3.5 million Canadians reportedly do not have access to a GP¹⁵, the Netherlands has 16 million inhabitants and, with one to two day access times, has no issue with GP access.
- Dutch participants compared Canada today and the Netherlands five to six years ago with respect to waiting times. The Netherlands at that time diagnosed the problem to be one of performance, not capacity and has succeeded in finding / freeing hidden capacity. The focus since the early 2000's in the Netherlands has been a change to financing toward DBC, injection of additional funding to spark change and performance improvement programs such as Better Faster. DBC funding now accounts for 10% of funding, will increase to 20% next year and is expected to grow to about 70% of funding.
- Attention has also been directed toward moving patients and beds out of acute care and into long-term care. As well, treatment processes have been reengineered with pre-established programs for particular indications and centralized coordination of patient movement.
- The ability to look at wait times across the continuum of care, which was demonstrated at Erasmus, is powerful and necessary to understand and improve the wait-times continuum, from first visit to treatment.
- It was noted that the compactness of the Dutch geography makes queuing easier and has a positive impact on wait times.
- Today Dutch wait times are lower than Canadian guarantees for wait times.

Patient Centredness

- Patients are viewed and treated as consumers in the Netherlands – from choosing their own insurers to choosing which hospitals to go to, to having their input / feedback sought out and valued as an essential part of quality management.
- Patient feedback system / instruments have proved useful and have given Dutch clinicians more insight into patient perspectives / needs.
 - Patient committees and shadowing
 - Patient Mirror Meetings
- The Dutch Federation of Patient and Consumer Organisations is an umbrella of disease specific consumer advocacy organizations. Its focus is on influencing government, insurers and providers to pilot and spread best practices toward patient-

¹⁵ 2005 Canadian Community Health Survey

centred health care – care which allows patients to make choices and to be in control of their own treatment processes. Initiatives include a patient portal for secure access to their medical files / test results and self-recording of levels monitoring, access to patient record summaries for locum physicians and online appointment booking.

Opportunities for Further Study

During the Seminar, a few key themes emerged around which future exchanges could be organized. The planning for such exchanges with Dutch officials would benefit from clearly articulated areas of interest.

- Participants were impressed with the scale of improvement being undertaken through the Better-Faster program and the approach of funding numerous, simultaneous, largely autonomous pilots. While there are examples of process improvement initiatives in Canada, we do not appear to have the same “traction” across the country nor the same degree of experience sharing.
- There appears to be a more innovative approach to use of alternate levels of caregivers in the Netherlands. Looking at the university medical centre statistics (% of nurses), it seems clear that Netherlands hospitals rely much more heavily on other levels of caregivers, not just nurses, as compared to Canada. There are great opportunities to re-think the clinical boundaries of what people do in Canada as we try to address our professional manpower shortages.
 - clinical assistants – O.R. technicians, anesthesiology assistants
 - patients are triaged in the Dutch emergency rooms; 80% of the patients are taken care of by family physicians.

Having said this, it is important to consider not only the resource numbers but also the outcomes.

- There may be an opportunity to learn from the Dutch why they chose particular indicators to report on for Patient Safety, what they mean and how they arrived at common stakeholder agreement on the choice of indicators.
- Participants were very impressed with the powerful collaboration observed at Erasmus, a teaching hospital, vis à vis sponsoring innovation and change.
 - The CEO is a physician and the Dean of the Medical School is the hospital’s vice chair. The Board is a foursome of CEO, Dean, Financial person, Facilities person.
 - 250 million of the 750 million € budget is for research – impressive. “If you want to do something with patient safety, hire someone and do it right!”

- There is aggressive investment in innovation: each medical department has contributed 10% of its budget each year for three years toward an innovation fund (totaling 16 million € per year), with 4% going to IT and 6% to other equipment, information or clinical priorities identified by the medical departments.
- There is interest in pursuing opportunities for collaborating on design evaluation frameworks for clinical best practices. The Better Faster projects do provide for collecting local data, but how can this tailored local information be aggregated up to a broader level and applicability?
- Some participants suggested that Canada could look at the mirror method and other means of tapping into consumer psychology to improve focus on the patient -- to move us out of a "blame & shame" sensibility to one of "care & share".
- Participants commented on the small number of patients waiting in the hospitals visited and surmised that this would have a positive impact on the quality of work life.
- Some participants commented on the orderliness in the Emergency Rooms and Intensive Care Units that were visited. Is it because more care is scheduled? Better controlled? Is the difference societal? On the flip side, one participant commented that while business process reengineering is useful, fast is not necessarily good and she cautioned the group not to underestimate disorder but rather to be tolerant of it.
- GPs play a much stronger gatekeeping role in the Netherlands than in Canada. Participants noted that this might be a major contributor to the orderliness in the hospitals that were visited.

Dutch Aspects Canada Wants to Learn More About

- Overall system financing. Participants came away with mixed messages with respect to costs. Which system is more expensive – Canadian or Dutch? Which delivers better results? How different is the public/private mix in the two countries?
- There remain many questions about the insurance provider mechanism, but perhaps there are aspects of this mechanism that Canadian Ministries of Health could consider.
- Participants expressed interest in hearing more about the continuum of care – primary care, home care, long-term care -- as well as mental health, addiction... The emphasis is on regional integration in Canada, so it is difficult to understand the system when only focusing on the hospitals.
- In particular, in order for high volume elective surgery centres to work effectively given the associated short length of stay there would need to be very good relationships between hospitals and rehab / home care / long term care as well as some sort of regional integration structure. How do the contacts work?
- The seminar presented information mostly from a physicians' perspective. They appear to be the great majority of the providers – nearly 70% more per capita in 2005 than we had in Canada per OECD data. There is a desire to learn more about the physicians' roles.

- Physician remuneration is a strong health reform lever and impacts physician behaviour. Participants did not feel that they had a good enough understanding of how this works in the Netherlands. How much are the different professionals paid?
- Participants would be interested to see how other hospitals have approached process redesign.
- Participants would also like to learn more about
 - o Information management: regional and national strategies, e-mail policy and financing strategies
 - o Capital planning / financing
 - o Insurers regulation with respect to premiums to better understand what leverage insurers have to push reform. Participants would like to meet with insurer representatives to understand their points of view, how they assume risks, how they manage financially.
 - o The Dutch co-payment system.

Canadian System Aspects of Interest to The Netherlands

- The Dutch delegation expressed interest in a more in-depth presentation of other dimensions of systematic approaches to Patient safety in Canada including: further elaboration of Patient Safety benchmarking and other aspects which may both drive and benefit from advances in areas such as
 - Wait list driven process reengineering and culture change.
 - Educating professionals to work with teams rather than as independent contractors.
 - Use of simulations in Interdisciplinary Education.
- The Dutch delegation is very interested in the Canadian Health Leadership Network (CHLNet) and would like to develop something similar, potentially as the basis of a cohesive national strategy.
- There is a desire to learn more about the approach to ICT standardization in Canada from the perspectives of leadership, development of international interoperability standards, standards adoption by major vendors ongoing funding challenges (ICT vs. direct patient care), early adopter migration and privacy.
- There is also interest by the Dutch in exploring
 - o The political impact of F/P/T decentralization in Canada (Canada Health Act)
 - o Geographic challenges for acute care in Canada
 - o Integration of Prevention in the system

- Infections disease outbreak management in hospitals (e.g. SARS)
- Primary Care
- Homecare
- Pharmaceuticals
- Mental health

Concluding Remarks

The Canadian delegation evaluated the health seminar as excellent on all fronts – program content, quality of dialogue, program logistics and hospitality. A two and a half day seminar was insufficient time for the delegates to fully appreciate the complexity of one another’s health care systems, but provided an excellent overview and sufficient insight for Canadian delegates to formulate impressions and to identify areas of Dutch health care policy and delivery for further investigation and potential experimentation. In addition, there is a desire to broaden the dialogue outside the hospital sector as the tight focus on hospital-based care made it difficult to appreciate the primary care / community care context of intramural care and its contribution to system improvement.

Delegates from both the Netherlands and Canada were struck by the similarities in the issues they face in health care, yet the differences in solutions and problem-solving strategies. Appreciation was expressed by delegates from both countries for the value of seeing their own systems reflected in the others’ eyes.

Most importantly, new relationships have been formed among peer professionals, and a new network has been initiated to continue the exchange of information, innovations, and perhaps even for short-term personnel assignments.

Several Canadian participants have expressed interest in following up in a year’s time to see what has happened with the reforms in the Netherlands. What has worked? What bumps in the road were encountered? What happened with DRG’s (DBC)? What was the impact of publishing HSMRs? As well, members of the Dutch delegation have identified several aspects introduced by their Canadian counterparts that they would like to study and see in action.

Discussion has begun about a potential reciprocal visit by the Dutch to Canada, and various individual exchanges / collaborations are already planned, focusing on such diverse arenas a Global ICT Standards and Health Leadership Development. Several Canadian delegates anticipate following up with peers they met through the seminar, and it is Health Canada’s intent to check back in a few months to assess what further collaborative activity has been generated.

* * * * *

"Canada and The Netherlands have a lot of historical experiences and attitudes of mind that unite us. The inaugural Canada-Netherlands Health Care Seminar is a good occasion for the two governments to get together on a key area of public policy."

Ambassador James Wall

"Patient safety raises the floor; Quality improvement raises the roof."

"I'm looking forward to collaboration and tangible follow-ups with individuals."

Lianne Jeffs

"The Faster-Better program has really permeated everywhere and is practised at the front lines. I'm impressed with the development of the program, its penetration, the metrics pulling it together and the numerous projects themselves. It is truly embedded."

"Watching the CEO listening to and supporting a young physician's ideas was very impressive"

"The Inspectorate plays an important role in public accountability in The Netherlands. They ensure the public trust and the quality of the system. Canada doesn't have an equivalent entity."

Gino Picciano

"We have examples of process improvement in Canada, but we don't have the same kind of traction. Would provincial programs focus minds better?"

"I'm not as negative about insurance as when I went there"

Don Philippon

"We're stuck with nurses doing everything in Canada. They clearly rely on other levels of caregivers."

"The Netherlands appears to be succeeding in balancing the public concern of government with private sector interests through regulation. They have nicely used private insurers to push innovation."

Lynda Cranston

"Focus on the patient."

John Wright

"I'm impressed that, in the Netherlands, patients are thought of as consumers. They choose their insurers. They choose their providers. Their input and feedback is sought after and valued."

Jayne Simms-Dalmotas

"We would be well served in Canada to get away in the big university hospitals from the constant struggle between university and hospital. It would be better to form a corporation, combine the funding and get on with doing things."

John Wade

"We are not as far behind them on the ICT front as the Commonwealth Fund Study would have us believe."

"The Netherlands is promoting competition in the right direction from a patient safety, efficiency and equity point of view, and they're doing it very publicly."

Richard Alvarez

"The Canadian health care system can benefit from a closer review of the Netherlands's health care system. Conversely, the Netherlands would benefit from a closer liaison with the Canadian system."

John King

"The Dutch leaders have a lot to be proud of. The collaboration should continue. We have to walk the talk of partnership perhaps even so far as embedding / exchanging management."

Françoise Chagnon

"There's no substitute to finding out about best practices from other countries, especially like-minded ones such as the Netherlands."

Morris Rosenberg

Appendix 1 Canadian Delegation

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Appendix 3 Agenda

Wednesday, 5 September 2007

1. Opening of Conference and Speech
Ms. Lenie Kootstra, Director of International Affairs, VWS

2. Introduction into the Dutch Healthcare Reforms
Mr. Marcelis Boereboom, Deputy Director-General Health Care,
Director Curative Care Directorate, VWS

3. A Comparison Between the Two Systems
Professor Dr. Niek Klazinga, VWS, Researcher University of Amsterdam

Thursday, 6 September 2007

1. Project Better Faster and Introduction to Workshops
Mr. Boi Jongejan, MD, Director, Dutch Institute for Health Care Improvement
Mrs. Loes Pijnenborg, MD PhD, Project Manager (CBO), Better Faster
Mr. Peter Wognum, Senior Policy Advisor, VWS

2. Workshop – Patient Safety
Mr. Ir. Laurens Touwen, Chair Executive Board, Reinier de Graaf Group

Dr. John Wade, Funding Chair, Canadian Patient Safety Institute
Lianne Jeffs, Director Nursing/Clinical Research, St. Michael's Hospital

3. Workshop – Leadership, Management Change and Information Technology
Ron Treffers, MD, Member Executive Board, Dutch Hospitals Association and
Hagaziekenhuis

Richard Alvarez, CEO, InfoWay Canada
Don Philippon, Professor, University of Alberta

4. Workshop – Waiting Times and Patient Safety
 Dingeman Swank, MD, Surgeon, Groene Hart Hospital, Gouda
 Colleen Flood, Scientific Director, Institute of Health Services and Policy Research,
 Canadian Institute of Health Research
5. House of Commons/Lagerhuis Debate
 Moderators: Lennart Booij (BKB) and Peter Wognum

Friday, 6 September, 2007

- 1a. Field Visit – Reinier de Graaf Group, Voorburg
 Introduction: Simone van Kooten, Communication Manager
 Ir. Laurens Touwen, CEO
 Nursing Ward: Ms. Liesbeth Plomp, Co-ordinator
 Operation Room: Ms. Birgit Melse, Supervisor
- 1b. Field Visit – Reinier de Graaf Group, Delft
 Rapid Response Team: Mr. Peter Tangkau, Intensivist
 Tours: Bert Kleinlugtenbeld, Cluster Manager
 Intensive Care Unit, Rapid Response Team
 Emergency Room & Observation Unit
2. Field Visit – Erasmus Medical Centre, Rotterdam
 Welcome: Dr. Hans Büller, Chairman, Board of Directors
 Patient Safety: Els van der Wildern, Director, Patient Care
 Patient Access to their own Electronic Patient File
 Atie Schipaanboord, Deputy-Director, Dutch Federation
 of Patient and Consumer Organizations (NPCF)
 Iris van Bennekom, Director, NPCF
 Integrated Patient Care in Head and Neck Malignancy Patient
 Jose Hardillo, ENT Surgeon
 Heleen van Nispen, Process Director, Implementation
3. Evaluation and Discussion on Follow-up

Appendix 4 Selected Facts & Figures

<u>WHO 2000</u> (190 nation rankings)	Canada	Netherlands
Attainment of Goals		
Health Level (DALE)	12	13
Health Distribution	18	15
Responsiveness Level	7-8	9
Responsiveness Distribution	3-38	3-38
Fairness in Financial Contribution	17-19	20-22
Overall Goal Attainment	7	8
Health Expenditure per Capita	10	9
Performance		
Health	35	19
Health System	30	17

<u>CIA World Factbook 2007</u>	Canada	Netherlands
Population estimate	33,390,141	16,570,613
Area (km ²)	9,984,670	41,526
Population density (per km ²)	3.34	399
Median age	39.1	39.7
Birth rate (births per 1000 population)	10.75	10.7
Death rate (deaths per 1000 population)	7.86	8.69
Net Migration (migrants per 1000 population)	5.79	2.63
GDP (USD)	1.088 trillion	612.7 billion
GDP per capita (USD PPP)	35,600	32,100
GDP real growth rate	2.7%	2.9%
Unemployment rate	6.4%	5.5%

<u>OECD Health Data 2007</u>	Canada	Netherlands
Total Expenditure on Health		
% GDP	9.8%	9.2% (2004)
USD per capital (PPP)	3,161	3,094 (2004)
% Public Expenditure	69.6%	62.5% (2002)
% Pharmaceutical Expenditures	16.7%	11.5% (2002)

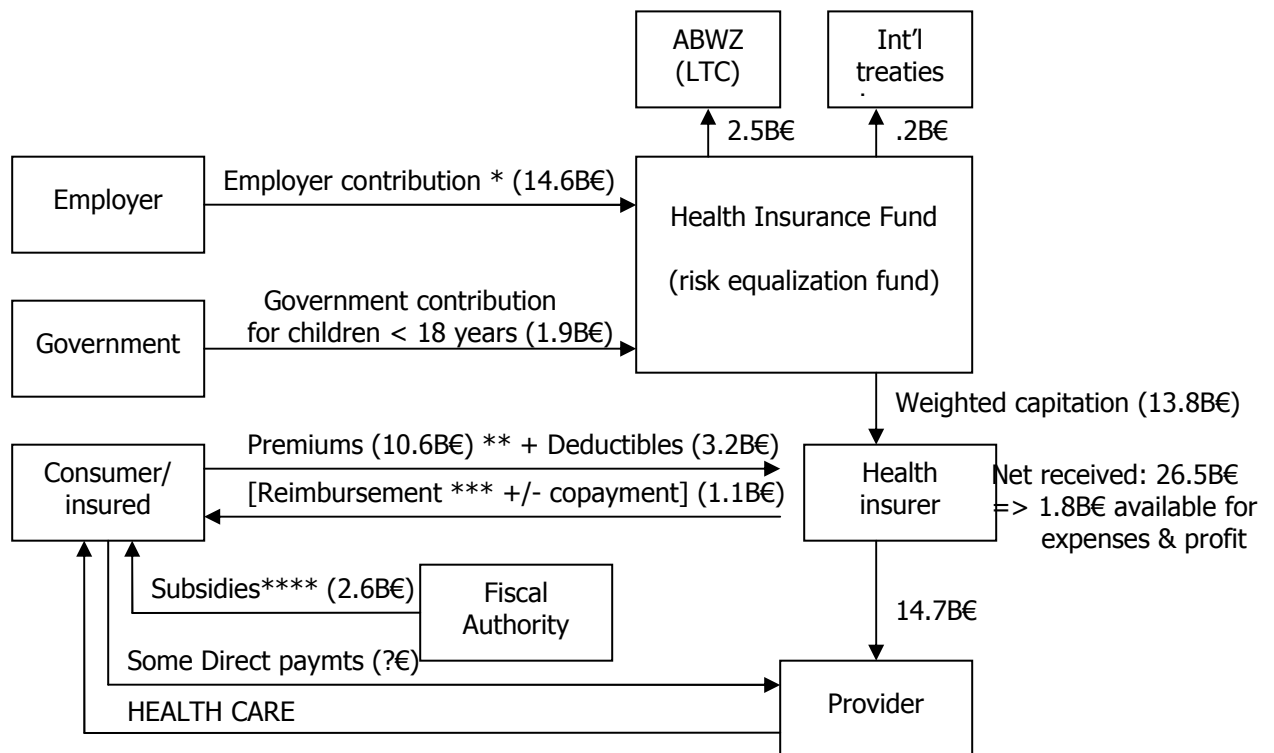
Practicing Health Professionals			
Physicians per 1000 population	2.2	3.7	(2005)
Nurses per 1000 population	10.0	14.5	(2005)
New Graduates			
Medical graduates per 1000 physicians	25.8	29.1	(2004)
Nursing graduates per 1000 nurses	25.3	25.6	(2004)
Acute beds per 1000 population	2.9	3.1	(2004)
MRI per 1000 population	5.5	5.6	(2005)
CT Scanners per 1000 population	11.2	5.8	(2005)
Life Expectancy			
f / m at birth	82.6/77.8	81.4/76.9	(2004)
f / m at age 65	20.0/17.7	19.8/16.3	(2004)
Infant mortality per 1000 live births	5.3	4.4	(2004)
Causes of death			
cardiovascular per 1000 population	147	186	(2004)
respiratory per 1000 population	77.8	66.9	(2004)
diabetes per 1000 population	102	70	(2004)
Tobacco use - % population over age 15	17.3	31.0	(2005)
Alcohol in liters per capita	7.9	9.7	(2003)
% Obese	18.0%	10.7%	(2005)

<u>WHO - World Health Report 2006</u>	Canada	Netherlands	
% of population aged > 60 years	17.5%	18.9%	(2004)
Practicing Health Professionals			
Midwives per 1000 population	0	.12	
Dentists per 1000 population	.59	.48	
Pharmacists per 1000 population	.67	.19	

Appendix 5 Dutch Health Insurance Flows

The following schematic illustrates the funding flows for medical care and gives a sense of the relative magnitude of the flows, using 2006 funding numbers (in Euros) provided by the Dutch Ministry of Health, Welfare and Sport.

- The insured pay their premium (10.6€) and the upfront deductible (3.2€). This adds up to 50% of total premium. People who don't use care receive (part of) their premium back (1.1€). The insurers receive the other 50% through the risk equalization fund (13.8€).
- A small part of the fund goes to the long term care scheme or to bills due to international treaties.
- The health insurers received 27.6€ in total, but have to reimburse consumers with no-claims, so they net 26.5€. After care has been provided, the insurers pay the providers (14.7€) – some insured pay for care themselves and are reimbursed; this amount is unknown and is therefore excluded. Insurers therefore end up with a total of 1.8 billion for expense coverage and profit.



* Income-dependent employer contribution = 6.5% on the 1st 30,000€ of income

** Employee contribution: the average cost was 1050€ per person in 2006

*** Reimbursement: adults get part of their fixed premium back if they use less than 255€ (not including GP visits) in any one year

**** Subsidy for low income citizens. This comes from general government revenues.