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**HOSPITALS AND PRIMARY HEALTH CARE
IN THE NETHERLANDS**

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Report of a scientific meeting on the occasion of the designation of the Netherlands' Institute of Primary Health Care (NIVEL) and the National Hospital Institute of the Netherlands (NZI) as collaborating centres of WHO, held in Utrecht, on August 27th 1987.

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Symposia

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PREFACE

It is tempting to state that hospitals and primary health care should not be considered as antagonists, but as complementary to each other.

Harmonious statements always sell better than conflicting ones, certainly at an occasion where two research foundations: the Netherlands Institute of Primary Health Care and the National Hospital Institute of the Netherlands are being inaugurated together as collaborating centres of WHO.

In reality primary health care research and hospital research have not so much in common although there is a growing area of mutual interest.

Home care after hospitalization or cooperation between primary health care providers like the general practitioner and hospital consultants are subjects that can be studied from both sides, but better be studied from an integrated point of view.

With increasing technological possibilities, it is conceivable that monitoring of "hospital" patients increasingly takes place in the home situation.

This requires substantial adaptation both of the hospital and of the primary health care setting.

In this book the relationship between hospitals and primary health care will be discussed from the viewpoint of the hospital and the viewpoint of primary health care.

Readers will see that these viewpoints do differ indeed and that the world as seen through the eyes of primary health care is different from the hospital world.

A vital principle in Dutch health care policy like 'echelonizing' (the division of health care in strictly separated layers with regulated access) can be considered as a condition for an adequate health care organization or as a barrier for comprehensive care.

Nevertheless, the topics discussed do have much in common, but the viewpoints diverge.

Perhaps we can expect a further convergence of viewpoints and, who knows, a common presentation of both institutes when we will cele-

brate the first lustrum of the collaboration with WHO in 1992.

D. van der Meer

J. van der Zee

I. INTRODUCTION

1. INTRODUCTION

J. van Londen

The Alma Ata meeting in 1978 where the WHO introduced health systems based on primary health care in order to attain health for all by the year 2000 has been of great importance.

To achieve this objective a reorientation towards the entire health-care system is necessary. New challenges in terms of an integrated approach to preventive, curative as well as rehabilitative aspects of health care have to be met.

Needless to say that this approach implicates a real sharing of responsibility for individual care at home and at the first referral level between in-patient institutions and other local health services. In the primary care approach, individuals and communities are responsible for their own health (community oriented). In this conception particular attention is paid to the underprivileged as in a lot of countries women and children and in many societies nowadays the elderly are.

Despite the clear message of the Alma Ata report some people still think that, as the basis of decent health care, primary health care can exist on its own. For some theorists hospitals even have become a dirty word. In-patient institutions and community health services have sometimes been seen as separate entities, and even as rivals. Therefore it has to be stressed that never a health care system based on primary health care (effectively) could work without the involvement and support of the in-patient sector. Essential also is an efficient system of referring of patients who need more specialized care than can be given outside the hospital. The role of in-patient institutions is to support primary health care, not to supplant it. In-patient institutions have to provide adequate clinical care by methods acceptable to people and at affordable costs. They have to accept patients who have been referred to them by the primary health care facilities; and, if necessary, they have to refer them back to these facilities with relevant information needed for continuity of care.

To conclude: In-patient institutions, PHC workers, and other health-care providers have to become institutions without walls, providers without barriers, or in other words really dealing with people.

2. ASPECTS OF COLLABORATION BETWEEN HOSPITALS AND PRIMARY HEALTH CARE FROM THE VIEWPOINT OF WHO

W. Hubrich

Introduction

In 1977 the 30th World Health Assembly decided that the main social targets of governments and WHO in the coming decade, should be "the attainment for all citizens of the world by the year 2000 of the level of health that will permit people to live a socially and economically productive life." The shorter version of that resolution is widely known as 'Health for All by the Year 2000'.

The International Conference on Primary Health Care, in Alma-Ata, sponsored jointly by WHO and UNICEF and organized in 1978, approved this goal and confirmed that primary health care is the key to attaining the desired level of health throughout the world. Resulting from declaration, strategies for 'Health for All by the Year 2000' for global, regional and national levels were agreed upon.

The main principles of the Regional Strategy of HFA are:

- promotion of lifestyle conducive to health;
- reduction of preventable conditions; and
- orientation of the health care system to cover the whole population.

This calls for significant reorientation and alteration of the very heavily structured health care systems of most industrialised countries in Europe.

To facilitate necessary changes in Europe, the Regional Committee agreed in 1984 on the regional targets in support of the regional strategy for 'Health for All'.

Chapter 5 of the document, 'Appropriate Care', deals with the function of the health care system, based on primary health care in its different aspects. The main purpose of Chapter 5 is to stimulate a shift in health care focus from a delivery structure dominated by hospital-based curative care, to one driven by preventive primary care concerns.

The committee endorsed 65 regional indicators for reporting by every country to WHO their own progress in the areas specified by the regional targets.

Underlying the World Health Organization's commitment to the philosophy of primary health care is an acceptance that many factors influence health. Social, economic, demographic and cultural events

all exert an influence on health and the organization and provision of health care. While better nutrition, housing, education and living standards have increased life expectancy and reduced many health risks, inequalities in health exist in affluent countries as well as in the less wealthy countries.

Reconsidering the organization of health services

Within the last decades the impact of the economic recession in most of the European countries has led to an unpredicted rise in health costs, especially hospital costs that have forced the countries to reconsider the position of the health sector within the community, the distribution of work between primary health care facilities and the wider health care system as hospitals at the periphery, in order to increase the effectiveness of work at all levels of health care. This process of rethinking has been favoured through advances in medical technology and the increasing number of medical personnel.

In addressing these and other issues, governments have adopted a constellation of approaches, including changes in support of primary health care, decentralization, increase in community participation, reallocation of resources, changes in training of health personnel, and improvement of health planning at the central level.

Some common approaches in various countries are:

- strengthening the linkages of primary health care services and the hospitals, especially at the district level;
- providing increasing care by out-patient and community-based services, including social services - this is especially the case with certain population groups such as the elderly, mentally ill and the disabled; and last but not least;
- increasing responsibility of families and individuals for health.

In doing so, several countries agreed by law to give greater responsibility to the lower administrative levels as counties and districts while increasing the central accountability for health planning. The responsibility for the delivery of health care at the lower level (district level) cater mostly to the primary health care services and public health programmes, whereas the intermediate levels or central levels are often in charge of the more costly facilities such as hospitals.

As a consequence of the regionalization of health care services an increased number of new health care centres have been established. In countries where the health care concept has not been adopted per se it is more common to form groups of general practitioners.

The primary health care approach

It has become increasingly clear that in European industrialized countries the primary health care approach, which involves the entire health care system, including hospitals - from the university teaching hospital to the frontline hospital - is more necessary than ever before. Despite the increasing involvement of hospitals in primary health care activities, the tremendous reserve of hospitals for the support of primary health care has not yet been completely tapped.

What is PHC all about?

Although primary health care in several countries is composed of a different range of attributes, they are, however, commonly agreed upon:

1. **accessibility** - which emphasizes the role of PHC as the entry point to the health care system and the elimination of barriers to the receipt of care;
2. **comprehensiveness** - which relates to the range of services available from a single provider, including an appropriate level of preventive, non-disease oriented care. Comprehensive care incorporates hospital-based and specialized services without over-emphasizing such care;
3. **coordination** - which relates to the degree of "harmony" that is attained by the PHC provider as the "conductor" of the complex health care delivery "orchestra". The issue of the provider's ongoing relationship or "longitudinality", and the "continuity" of a provider within the episode of care, is often considered essential to the coordinating role of the clinician;
4. **appropriate social environment** - which relates to viewing the "patient" as part of larger social organizations. Treating the patient as a member of a family unit and as part of a community are examples of this type of concern, as is the issue of appropriate consumer input and control over the care delivery system.

PHC does not mean primary medical care or community health services in the traditional sense. Additional demands as community involvement, intersectoral action and selfreliance distinguish PHC significantly from the conventional concepts.

Of course, primary health care cannot exist without the support of hospitals and hospitals cannot fulfill their tasks in isolation from primary health care. Both have to form a supportive network of closely interlinked institutions and services.

Primary health care services, firmly rooted in the community, are in a position to provide appropriate care at the lowest effective level of care. This means cost-effective, close to the people but, of course, also, in good quality.

The antithesis between PHC and hospitals is false but it is common and of long standing. There is a deep-rooted impression in many countries that the higher level of health service the better care. As health care is provided in levels, the division of labour between the various levels of care, the allocation of resources and a well-established referral system between these levels are of paramount importance for the functioning of a well-balanced, integrated, comprehensive health care system.

Strong links are required between these levels and the community to assure people that they will receive the appropriate care, including highly specialized hospital care, if this is needed.

However, hospitals and PHC follow traditionally different approaches. Hospitals are concerned with individual patients and acute care being resource intensive which requires modern techniques (technology) and well-trained professional manpower. PHC advocates promotive and preventive activities as well as treatment and is oriented towards the needs of the entire population.

The need for increasing collaboration between hospitals and PHC stems especially from the overall acceptance of the principles of HFA. Despite the best collaboration, PHC and hospitals should not be mixed as they have been designed for different purposes. The referral system has to be organized in both directions. The hospital and/or specialists must be available for the general practitioner, e.g. when he needs special diagnostic procedures: X-rays, laboratory tests, etc. He has to send his patient to the specialist if he cannot treat him anymore and the specialist has to send this patient back to the general practitioner when he no longer requires specialist treatment.

The curriculum of medical students should better reflect the specific needs of PHC in the daily work. Hospitals can also play a supportive role in postgraduate training and continuous training of primary health care. There is no question that especially the potential of teaching hospitals in support of PHC can be more exploited

in this respect. The same goes for the various supporting services.

District health systems

The concept of district health systems based on primary health care is a logical part of the organization of national health systems based on primary health care, carried out in geographical districts that are small enough for clearly understanding the health problems of the population and for appropriate action, and large enough to permit the provision of comprehensive health care without an intensive sub-specialization.

A district health system based on PHC is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographical area. It includes all institutions and individuals providing health care of various kinds in the district. A district health system therefore consists of a large variety of interrelated elements that contribute to health in homes, schools, work places, and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level. Its component elements need to be well coordinated by an officer assigned to this function.

Although the organization of district health systems will depend on the specific situation in each country and each district, the essential characteristics of such systems and general principles are: equity, accessibility, emphasis on promotion and prevention, intersectoral action, community involvement, decentralization and integration of health programmes.

It is quite clear that decentralization is an important prerequisite for proper action and planning of health care services at such a level. Whereas in developing countries a district health system means the establishment of a proper infrastructure for health services. In most member states of the European region it means looking at the functional aspects, i.e. cooperation between hospitals and PHC services in different forms. It should include not only general practitioners, district nurses, etc. but also occupational health services, school-age health services, health services for special risk groups (mother and child health) as well as different counselling services available at this level.

Of course, despite the indisputable increase of the role of self-care, health education and health promotion, it is quite clear that

there is and will be still a demand for primary medical care and a comprehensive health policy as well as high-level governmental commitment. The district health system is also a reflection of that.

Trends

Although the situation within the health systems differs in several countries, all changes and activities in future have to take into consideration some common ongoing trends influencing the health care systems, e.g.:

- increasing pressure on cost-effectiveness;
- expansion of preventive measures;
- further development of technology, especially high technology;
- continued shift from in-patient to out-patient treatment;
- increase of patients awareness of available treatments (therefore patients will become more "demanding");
- new possibilities due to research, e.g. genetics or the pharmaceutical field.

To cope with all these problems, we have to adapt accordingly the network of health facilities, the cooperation between hospitals and primary health care services, social services, and other services contributing to health.

Having said this, it is clear that health cannot be the concern of health professionals only. Professionals from the other sectors, e.g. politicians, planners and lay people must be involved if the goals of "Health for All" are to be achieved by the year 2000.

**II. COLLABORATION BETWEEN GENERAL HOSPITALS AND PRIMARY HEALTH CARE
FROM THE VIEWPOINT OF PRIMARY HEALTH CARE**

1. INTRODUCTION: THE ROLE OF NIVEL AS A COLLABORATING CENTRE OF WHO

C. Olthoff

In the WHO policy document "Targets for Health" it is formulated that "by 1990, all member states, through effective community representation, should have developed health care systems that are based on primary health care and supported by secondary and tertiary care as outlined at the Alma-Ata conference" (target 26).

Of all 38 targets stated in the WHO-document, no. 26 may well be the most obvious. It should be remembered that, notwithstanding mutual differences between the various member states, over the last forty to fifty years a common notion did grow about the role of the hospital in the rendering of health care: the hospital was considered to form the basis of the system, providing leadership, controlling other levels of care and generally exercising the main responsibility for the entire range of care.

Although the hospital does not hold a fully dominating position in the Dutch health care system, it cannot be denied that the hospital is perhaps playing too important a role in our country as well.

The realization of target 26 in this context is by no means an easy task. The following suggestions may be made towards solutions. Building trust and confidence in primary health care among the general public and prestige for it among health professionals is perhaps the most crucial issue and one that requires a long term consistent policy.

No less important is the development of a clear concept what the content of primary health care should be, what the essential services to be delivered should be, what kind of personnel should be involved, what roles they should play and how they should cooperate with individuals, groups and communities.

Last but not least, in most countries, extensive changes will have to be undertaken in the present system of educating health personnel.

What can be done by NIVEL?

First it is of major importance that NIVEL continues to distribute and explain the findings of its research to the officials of the World Health Organization and to the other member states.

For this reason NIVEL will continue and where possible intensify the organization of and participation in meetings with that objective.

A second important form of support NIVEL can offer is the undertaking of research work. This work can be aimed at supporting and fortifying the policy objectives of the World Health Organization; another aim may be the evaluation and, where possible and desirable, adjustment of parts of that policy. The research findings also serve the development of complementary policy and supplementary strategies.

It is of great importance to attune the wishes of the World Health Organization regarding new research lines with the annual planning of research in progress at the NIVEL.

So far there have been intensive contacts in order to accomplish this attuning but full harmonisation probably requires more international comparative research.

Difficulties will be unavoidable in the process. At the same time, research findings on the conditions in the Netherlands cannot simply be considered applicable to the other European countries. Mutual differences in the various health care systems however provide us with the opportunity to learn from the research findings of other member states.

One man's fault is another man's lesson: only those who are ready to listen, can learn.

2. PRIMARY HEALTH CARE IN EUROPE: THE PLAN OF WORK OF NIVEL AS A COLLABORATING CENTRE OF WHO

J. van der Zee

The plan of work of NIVEL as a collaborating centre of WHO contains six topics, together representing a varied selection from the NIVEL research programme. These topics are:

1. International comparison of health care systems (with special attention to central European countries).
2. Conditions for primary health care development.
3. Underserved groups (inequality in health and health care).
4. Intersectoral collaboration (e.g. health care - social services).
5. Interface between primary health care and hospital care.
6. Home-nursing and home care.

Around these topics various activities take place, like the organization of conferences and meetings, the publication of research results and documentation of ongoing activities. Two of these topics are elaborated in this paper.

1. International comparison of Health Care Systems.
2. The interface between primary care and hospital care.

International comparison of health care systems

A major problem in international health services research is the establishment of criteria that are specific enough on the one hand and applicable in fundamentally differing health care systems on the other hand.

For the comparison of primary health care systems we derived a set of criteria from a study where we analysed the development of Dutch primary health care policy of the last fifteen years (NIVEL, 1987). With some adaptations the set could also be useful to describe and compare health care systems internationally.

The set of criteria consists of the following elements

1. is Primary Health Care population based (or is it client based);
2. is there a proper adjustment of funding and planning at the district level;
3. do primary health care providers have a strong position;
4. is there indirect access to specialistic medical care;
5. is there a controlled growth of hospitals;

6. is there a controlled growth of specialists.

The first criterion indicates whether primary health care is population or client based, that is whether it is public health care, concerned with the health of the population as a whole or rather intervenes after being consulted. Countries where the general practitioner is the central primary health care provider usually have a client based system, while countries with a strong public health sector usually have a population based PHC system.

A proper association of funding and planning is a major element in containment of health care costs.

In many countries there are barriers between the flow of money from the contributors (households, firms) and the receiving parties (hospitals, health care providers). Usually the receivers of health care funds try to occupy vital positions in the distribution of these funds.

The third and the fourth criterion deal with the position of PHC-providers on the one hand and secondary care providers on the other hand. The combination of a strong position of PHC-providers and a well controlled secondary care sector is most favourable for PHC development.

Most countries have found some way to control hospital costs (Abel-Smith, 1984) either by budgetting or by planning laws (although closing down a hospital is a rather exhausting job, irrespective of the legal opportunities) but effective control and steering of both hospital and specialistic medical care is not common in the European region.

Favouring PHC by concrete and effective measures is - as far as our knowledge goes - not a common feature of health care policy in spite of official rethoric.

With knowledge available about European health care a qualitative judgement of European health care is possible.

If we answer the questions successively and display the answers with the following signs:

- criterion clearly present;
- criterion clearly absent;
- criterion more or less present;
- no information,

A map of Europe can be drawn as follows.

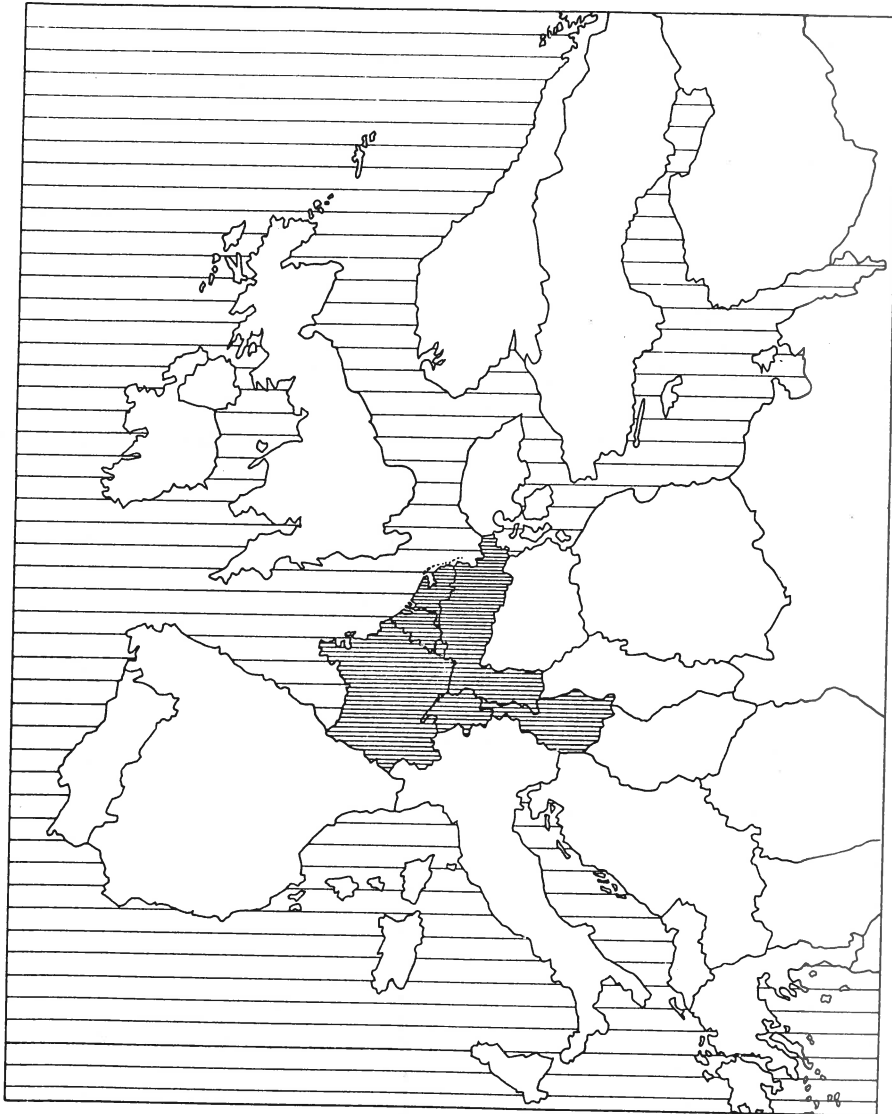
Figure 1: Criteria for assessing the strength of PHC in the European region



Nothern, Western, Eastern and Southern European countries have rather high marks on our list of criteria (although from the point of view of PHC the hospital based Swedish health care or the system of the GDR for example, have a rather poor performance) while France

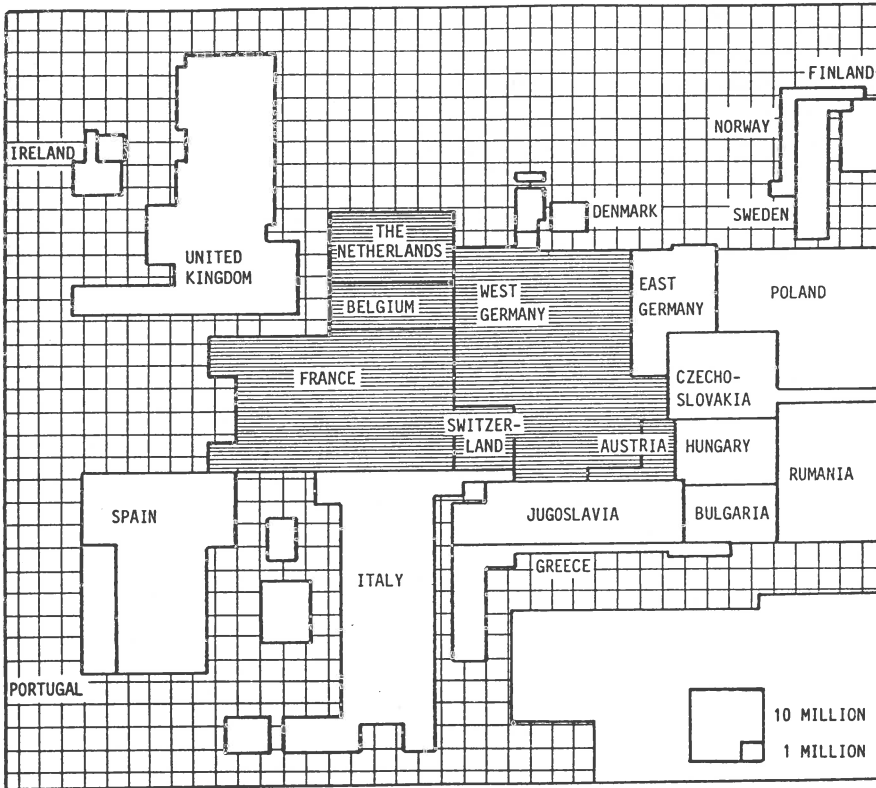
and the Federal Republic of Germany (including some smaller countries in their sphere of influence) are last on the list. A possible way of reacting upon this phenomenon is ignoring it. Then the European region will look like this.

Figure 2: Europe through the eyes of WHO



The centre of Europe is almost crushed by the weight of the peripheral states: A giant Finland makes France look like San Marino. This map can be named 'Europe through the eyes of WHO'. There is another distortion possible. Than we have the following map:

Figure 3: European countries transformed by size of population



Source: Kidron a.o., 1981

Here the countries of the European region have been projected according to the size of their population. Over 160 million people live in an area where the conditions for primary health care development are rather poor.

In the 'Plan of work of NIVEL as a collaborating centre of WHO' explicit attention will be paid to PHC development in these 'central European' countries. The study of conditions that give a clue for changes in the direction of strengthening primary health care in

'open' health care systems, is one of the major elements in the NIVEL plan of work.

The position of the Netherlands is somewhat ambiguous. If we consider the six criteria, the Netherlands show the following profile.

Rates for the Netherlands:

| | |
|---|-----|
| 1. primary health care population based | - |
| 2. planning/financing at district level | -- |
| 3. strong position of primary health care | + |
| 4. no direct access of specialistic care | ++ |
| 5. control of hospital growth | -/+ |
| 6. controlled growth of specialists | - |

Ad 1. In practice, primary health care in the Netherlands is predominantly curative care, although preventive and population based activities are included in the definition of PHC. So a minus for this.

Ad 2. About the calvary of the Dutch planning laws and the separation of planning and funding much has been said and written. At this moment chaos is absolute.

The Health Care Facilities Act, presented to Parliament in 1976, accepted in 1982 as a so-called Skeleton-Law, to be filled in by concrete measures of the Ministry of Health, is on the verge of withdrawal before it could come into action. Due to this administrative vacuum, there is no proper regional base for health care organization in the Netherlands. There is no 'district' valid for primary health care in the Netherlands; one counts easily more than 30 different regional subdivisions in the Dutch health care sector. A double minus.

Ad 3. Positive discrimination of PHC gets higher marks.

The position of PHC-providers improved in the last decade. The size of the general practitioners list decreased from 2960 in 1974 till 2380 in 1986, and a comparable increase in the number of dentists, district nurses, fysiotherapists took place. A plus.

Ad 4. There is a rather strict limitation of direct access to specialistic medical care. A double plus.

Ad 5. Control of hospital growth is less successful.

Financial control succeeded by budgetting hospitals (an effective, but crude measure because discouraging hospitals that were cost-effective before budgetting). The reduction of

hospital bed capacity however was delayed considerably. A plus/minus for this criterion.

Ad 6. Financial control of specialists failed completely till now. They are - as independent practitioners, but attached to hospitals - no part of the hospital budgetting measures. Agreements to curb the incomes of specialists failed to be effective. A minus.

Although the Dutch tend to emphasize the prominent position of PHC, the Netherlands belong, according to our criteria, to central Europe with regard to their health care system. Perhaps this is temporary, as new, drastic, measures to alter the mechanisms of health care funding will shortly be proposed to Parliament, but the situation in 1987 is as described above.

The interface of primary health care and hospital care

The second topic of our plan of work, that will be elaborated in this paper is a somewhat deviant view on the relation between primary and secondary medical care.

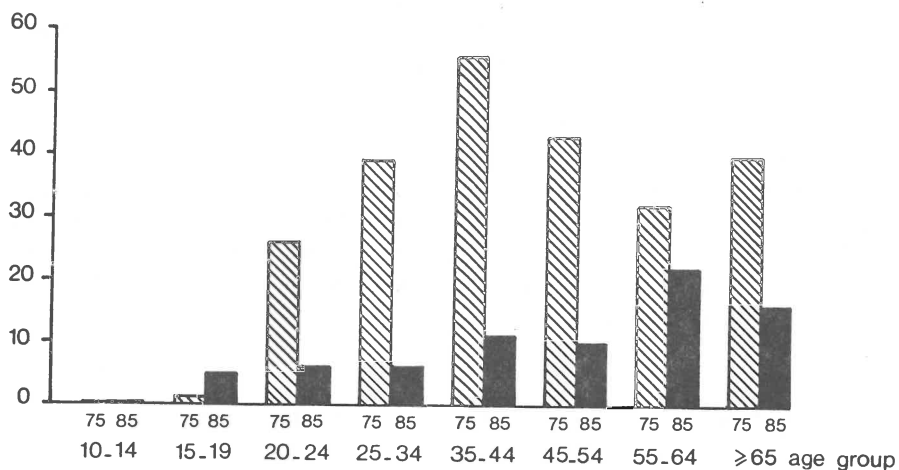
All over the industrialized world there has been a gradual and continuous shift towards specialistic medical care and a steady caving in of the responsibilities of the general practitioners. As a reaction upon this there are plans and programmes to restore the general practitioners task in the domain of minor surgery, to extend his possibilities to use complex diagnostic facilities, to point out the danger of a false positive referral and to claim a bigger share of the ambulatory care of chronically ill patients.

The reclaim of lost territory takes place around the borderline (a bit like the Iran/Iraq warfare) and circles around replacing out-patient specialistic care by the general practitioner's care.

Possibilities of substituting in-patient care like major operations by primary health care have less often been studied. There are interesting examples - like the use of cimetidine instead of stomach operations.

The effect of this can be seen for example in the following figure.

Figure 4: Morbidity recording in general practice. Numbers of men with an ulcer pepticum diagnosed by means of further examinations per age group per 10.000 for 1975 and 1985.



Source: Annual Report 1985
Continuous Morbidity Registration Sentinel Stations the Netherlands.

Here we see a sharp decline in the incidence of stomach-ulcers for men (for women the rates did not change) confirmed by further diagnostic examinations. A decline in mortality, due to (perforated) stomach-ulcers has been described in many publications, national and international.

One of the main hypothesized causes for this decline was the introduction of better medication around 1977, although some authors point out that the decrease in death rates started long before 1977, but accelerated since (Hoogendoorn, 1984).

The development of mortality-figures and hospital statistics gave reason to the programme-committee of the NIVEL-Sentinel practice network to repeat in 1985 the recording of stomach ulcers, that took place in 1975 for the first time.

We did not expect the number of confirmed diagnoses to decline - we expected a decline in operative treatment and hospital admissions. After all, if the causes of the decline were more effective medication, but the establishment of a proper diagnosis would require specialistic intervention (stomach x-rays, gastroscopy), than in our opinion, the number of referrals would not decline, but the number of operations and admissions would. Further questioning of the participants in the network yielded the following explanation. The new

drug is so effective that it is being prescribed for complaints that point into the direction of severe gastritis or stomach ulcers. In most cases complaints disappear, so the need for further diagnostics and specialist confirmation disappears in the daily routine of general practice. The example of Tagamet is well known, but even for one of the top surgical techniques like coronary bypass surgery, primary health care could be an alternative. Not, of course, by kitchen-table operations, but in this case too by proper medication, that can be monitored by general practitioners.

Some support for this thesis can be derived from the preliminary results of a comparative study conducted by the RAND-Cooperation in the United States. These results were presented at a conference in Copenhagen about regional variations in November 1986. The RAND-research compared by their well known method of systematic evaluation by showing successive combinations of criteria for operation to panels of general practitioners, cardiologists and cardio-surgeons in the United States and the United Kingdom (for their method see: Chassin a.o., 1986). The following discrepancies between British and American doctors were the result.

Figure 5: Differences between British and American doctors in indicators for CABS (RAND-Corporation - CABS study)

| | UK | USA |
|---|--------------|-----------|
| severe angina (class III and IV) on no or less than maximal medical therapy | no operation | operation |
| angina d'effort (class I and II) on maximal medical therapy | no operation | operation |
| severe angina (class III and IV) on maximal medical therapy | operation | operation |

Source: RAND-Study: Indications for selected medical and surgical procedures - coronary artery bypass graft surgery. Jacqueline Kosecoff and Robert Brook. Paper presented at the CCC conference about regional variaton in health care. Copenhagen, November 1986.

The results seem convincing. A first reaction can be: the British National Health Service has taken 'scarcety' too far. Although it is known that the 'life extending' effects of the operation are limited, the life improving effects are obvious. Angina at each step, before one is elected for surgery, is not to envy. The crucial element of the table, however, and the background of the discrepancy between the American doctors and their British colleagues is not to the tolerance for the patient's suffering but the 'maximal medical therapy'. British doctor's are convinced that practically all patients with angina d'effort could be kept free of complaints by proper medication. If that is true indeed, than a proper substitution of CABS is monitoring of cardiac patients by either general practitioners or cardiologist in an out-patient clinic. What is true for CABS could be applied to other operations too. Professor Morris Wennberg, an expert in prostatectomy-evaluation studies, states that evaluation studies tend to underestimate the negative effects of operations, because for instance unsatisfied patients choose another hospital for the treatment of complications or refuse to seek further treatment at all. 'Watchful waiting' is - according to him - a valid alternative for operation, as his studies also showed that the odds of early treatment were not better than of treatment in a later phase. If the risks were known more precisely, the choice for an operation versus ambulatory specialistic care or treatment by general practitioners, would be less hazardous. Well conducted outcome studies, where the alternatives are being compared without professional distortion could give each type of health care provision it's proper place and guide the patient's and doctor's decisions. It is clear from the examples that improvements in the effectiveness of non-invasive surgical techniques and medication will be of vital importance for the relation between institutional and ambulatory care. The balance might shift from the hospital to the out-patient clinic and from the out-patient clinic to home care and general medical practice. This requires a self conscious and well-equipped primary health care, supported by well conducted research. The opportunities for a shift of balance from hospital to home care are more favourable now than in the last decades. A challenge for primary health care.

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3. HOSPITALS AND PRIMARY HEALTH CARE IN THE NETHERLANDS

J.C. van Es

Design and functioning of the Dutch health care system

The development of the Dutch health care system, like in other parts of the western world, is characterized by a rapid growth of the hospital sector. This has its reflection in manpower, buildings, technical equipment and in financial statistics.

We have perceived that the mainpoint in health care shifted from extramural home care towards hospital care. This shift was caused by the turbulent development of medical knowledge and medical technology, which was fostered by the rapid growth of economic resources which enabled a nearly unlimited growth of hospital care.

Not less important was the lack of socio-political rules and regulations which could have limited the growth of the hospital sector. This lack contributed to the development of an incoherent health care system in which primary health care came in an inferior position. The results of this development were obvious. Originally, general practitioners did the bulk of the medical work; only in case they were not able to give a specific treatment or to make a diagnosis, patients were referred to the specialist. The rapid growth of specialistic possibilities made general practitioners in many cases less capable to handle these attainments and they had to refer more often.

In specialized medicine the norms and guidelines for justified behaviour of specialists were increasingly attached to technical medicine. This resulted in a decrease of returns of chronic patients to their general practitioner: specialists tended to overestimate their own role and thus to keep these patients under control.

This process had far reaching consequences for the clinical knowledge of the general practitioner: he came in a position in which there always was a security valve available in the possibility to refer a patient. This allows the general practitioner to keep the pressure on his clinical capabilities down; in other words: the urge to intensify his clinical knowledge and experience is low.

This attitude is reinforced by some other reasons. First, his patients in many cases show problems in which the somatic aspects are deluted by psychological and social problems, which need his attention and time too. The second reason is that the general practitio-

ner covers a wide range of problems which prevent him to go into depth. Finally, it can be argued that the remuneration system of general practitioners doesn't provide financial incentives to intensify this clinical knowledge.

This pattern of modern medicine and the expectation of patients today that for every problem there exists a rapid solution leads to various reactions of patients, general practitioners and specialists:

- **Patients** react in different ways. One reaction is to claim over-examination and overtreatment for their complaints. An adverse reaction is the increasing protest of patients and their organizations against medical practices. A third reaction is seeking help in alternative therapies.
- **General practitioners** also show different reactions. During a long period of time they tried to become more capable in psychosocial and psychosomatic medicine. This development was partly a response on patients needs and on the existing morbidity pattern, but it was also a kind of compensation for a poorer clinical task. Other general practitioners, or sometimes the same doctors, tried to establish a scientific approach to general practice, whereas others developed an anti-specialistic attitude.
- **Specialists** showed different reactions too. Some of them became annoyed and even irritated by the larger number of patients who did not really need their specialistic help but were nevertheless referred to them. Other specialists developed an arrogant attitude towards general practitioners, whom they considered as being nit-wits.

All these things in fact disrupted the design of a medical care system with a logical division of work between primary and secondary health care in reality.

It is quite understandable that a health care system without the operationalization of a comprehensive design and a health care system without built-in feed back mechanisms cannot function in an economical way. It leads to an overuse of technology and, by consequence, of specialistic medicine.

One of the ideas in re-designing the Dutch health care system is to stimulate primary health care to become more efficient and effective. It is then hoped that the tasks of the hospital sector can be reduced.

Recently ideas like this have (re)appeared in the report of the

Commission on Structure and Financing of the Health Care System (the Dekker-committee). In this report the commission has expressed an expectation of internal change in the health care system initiated by the free market mechanism. It is to be feared however, that in a situation in which the power in the medical field is distributed in an unequal way, primary health care stands no real chance to develop towards a direction opposite to the one it developed to during the last decades (Commissie Dekker, 1987).

WHO targets on the development of primary health care

In 1985 the WHO published its "Targets for Health for All"; targets which are formulated to support the European regional strategy to achieve the WHO goals.

The WHO formulated 38 goals: 12 of these goals are concentrated on changes in the morbidity and mortality patterns, 5 on changes in life styles, 8 on improvement of a healthy environment, 6 on health policy, 1 on research, and, important for us: 6 targets on the development of appropriate care.

It has been stated that the primary health care concept has not always been readily accepted in industrialized countries, and, besides that: primary health care in many cases is defined in a rather limited way. The first target from the chapter on appropriate care is as follows:

"By 1990 all member states, through effective community representations, should have developed health care systems that are based on primary health care and supported by secondary and tertiary care as outlined at the Alma Ata Conference" (target 26)

A further explanation makes it very clear that the secondary health care or hospital care has a 'supporting role' and only carries out the diagnostic and therapeutic functions that are too specialized to be carried out at the primary health care level. In a problem statement it is concluded that "a 'centralized' notion of the role of the hospital has characterized the health care system in almost every country during the last 40 years."

It is concluded that in many countries very little attention is given to research which assesses needs or resources. Less attention has been paid to create a coherent health care system which gives an answer to the existing needs and demands. This is also the situation

in our country where the value of primary health care is admitted in theory, but the health care policy does not create real opportunities to develop a strong and competent primary health care system. The intended decentralization of health matters, the limitation of the list of general practitioners and the initial support of the development of a voluntary quality control have only very limited effects.

Lessons for the Netherlands

One can derive from the WHO papers some of the conditions under which primary health care can be developed in a grand manner: "Building trust and confidence in primary health care among the general public and prestige for it among health professionals is perhaps the most crucial issue and one that requires a long term consistent policy".

To achieve this new, or renewed situation general practitioners and primary health nurses must become more competent and they must be given the opportunity to work in accordance to their competence.

It is absolutely clear that this is only possible when the government and the insurance companies design a coherent policy for the next 20 years, in which the education and continuing education, the structure of the health care systems, supported by laws and regulations, create a stronger primary health care.

It must be recognized that research must support the work of primary health care.

In the Netherlands primary health care oriented research will never be developed on a large scale in the existing research systems. One will need a real research policy, and this policy can only result from a top-down approach, which is possible in research councils, which nevertheless doesn't exist in our country. We have to be aware of this lack in our research system.

This all needs the political will to develop a strong primary health care based system. However, this political will can not be operationalized when the medical field, the primary as well as the secondary health care, don't cooperate in this development.

In order to achieve this aim, primary health care representatives must be convinced that they have to improve the medical capabilities of general practitioners and primary health nurses. They must be prepared to extend their job description in the diagnostic and therapeutic field and to realise the consequences of this description.

The challenge to the representatives of hospital medicine is even larger. They, specialists, have to limit their functioning and be prepared to delegate tasks to general practitioners.

If, from both sides, the basic attitude is developing, which includes a mutual acceptance and respect, a new relationship between primary and secondary health care can be realized. This relationship will be characterized by mutual consultations, a well defined division of labour and this all has to be supported by well considered logistics in health care.

One of the consequences will be that general practitioners and hospitals are more linked together than today.

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4. COMMUNICATION BETWEEN GENERAL PRACTITIONER AND SPECIALIST

F.M. Hull

Introduction

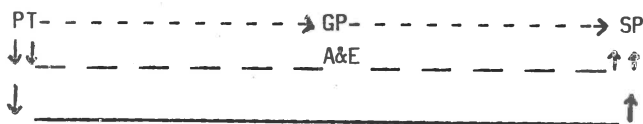
Referral by the primary care doctor to his specialist colleagues is an extremely important aspect of health care. Performed well it allows the patient optimal benefit of the skills of both family doctor and specialist. Unfortunately, because of misuse of referral and poor communication between them, a situation which offers enormous educational opportunities to both doctors is not only awasted opportunity but also extremely, sometimes unnecessarily costly. Improvement in communication between generalist and specialist could increase educational potential, reduce costs and benefit patients. It might also allow for audit and quality control of both primary and secondary care.

In this paper factors in patients and in doctors which influence referral in health care systems will be reviewed. I shall discuss variations in rates of referral and factors which influence levels of communication between general practitioners and specialists. Finally I suggest how education and audit might improve communication in, and outcome of, this nodal point between primary and secondary care.

Referral models

Within the health care system the most important single factor influencing referral is the way patients are insured for the costs of medical care. In private systems such as that in the United States (Hiatt, 1987) a few patients may be referred by general practitioners (as in the top line in figure 1) but the majority goes directly to specialists (as on the lower line). This militates against poorer sections of the community who often have no primary medical care other than that provided by accident and emergency departments of hospital clinics.

Figure 1: Referral model in private systems (e.g. USA, France).



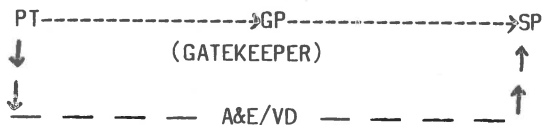
PT: patient
 GP: general practitioner
 SP: specialist
 A&E: accident and emergency department

SOME REFERRALS VIA GP, MOST DIRECT TO SP
 NB: A&E= 1° CARE FOR MEDICARE, MEDICAID IN USA

(Hiatt, 1987; Hull, 1979)

The private system is efficient for those able to afford the costs, it preserves the patient's autonomy and control of his own illness, may increase his satisfaction, and is speedy. But it has many disadvantages: it is very costly to patients (though may be less so to the State) and presents many difficulties for the patient especially with regard to access or choice of specialist. It is impersonal, since the specialist lacks the detailed psycho-social background of a patient known by the family doctor, and it tends to introduce unhealthy competitive attitudes in doctors increasing technology, defensive practices and costs.

Figure 2: Referral model in third party-insurance systems (e.g. Great Britain, The Netherlands)



MAJORITY OF REFERRALS VIA GP

PT : patient
 GP : general practitioner
 SP : specialist
 A&E : accident and emergency department
 VD : clinics for venereal diseases

In third party insurances, such as those run by the state in Britain or the sick funds in The Netherlands, the primary care doctor has a gatekeeper role (Dowie, 1983; van Es, 1986). Here relatively few patients enter secondary care through the accident and emergency department or clinics for sexually transmitted disease but the majority reach a specialist only after consulting the family doctor. In Britain in 1984 more than half of all new out-patient appointments were referred by general practitioners and most of the remainder were cross-referrals within hospitals of people originally referred from family doctors (Wells, 1986). However there is evidence that this is changing and that accident and emergency departments are dealing with patients that could have been treated by their general practitioners, 85% consult without first seeing their own doctors and two fifths of these were neither accidents or emergencies (Acheson, 1986). This probably reflects changes in accessibility of general practitioners especially 'out of hours'.

There are advantages and disadvantages in the gatekeeper function of general practitioners.

Referral by the primary care doctor is more cost effective, it allows selection of specialists most appropriate to patients' need and helps to minimise intra-specialist competition and high technology defensive practice. Though generally more personal it is also time-consuming, can lead to delay in diagnosis and definitive treatment and reduces patient autonomy and satisfaction with the care that he or she receives.

The gatekeeper function as such can be both an advantage and a disadvantage. This is because the filtering function of the gatekeeper may act as both block and facilitator of entry to secondary care. Too much blocking action prevents necessary and too much facilitating encourages unnecessary secondary care consultations.

Blocking factors include poor knowledge and attitudes of the family doctor and shortcomings in his diagnostic and communication skills. Facilitating factors involve his selection of the appropriate personal and professional skills of specialists and also his ability to bypass obstacles when urgent referral is necessary. Thus the ideal situation appears: the appropriate referral of individual patients to the right specialist at the right time.

Alas many factors militate against such an ideal (Hiatt, 1987; Aulbers, 1985). Time factors, financial factors and medical workload all combine to hinder ideal referral. Increasingly attention is turning to the use of non-medical personnel to improve matters. Experi-

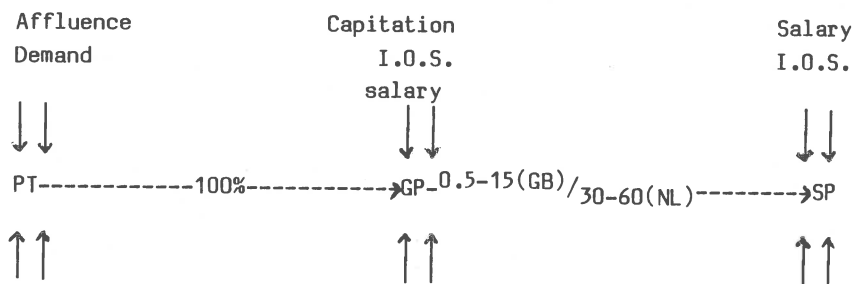
(Stilwell a.o., 1987) are interesting and more attention needs to be paid, especially in The Netherlands, to the provision of adequate secretarial help for primary care doctors.

Factors influencing referral

Factors influencing referral lie within the health care system (method of payment of doctors), the patient, the general practitioner and the specialist. Let us look at each in turn.

Health care system. A general practitioner paid either by salary or capitation has little to lose by immediate referral of a demanding patient, but if he is paid by item of service, as in Germany or Australia for example, he is more likely to manage the patient himself. Where there is capitation payment a contract exists between doctor and patient which may extend over many years, cementing the relation between them and increasing the doctor's knowledge of his patients psycho-social background.

Figure 3: Influencing factors in the health care system



Others

Source: Royal College of General Practitioners, 1971-2; CBS, 1984

Referral is also influenced by the specialists' method of payment. In Britain, where specialists are salaried, they are not keen on unnecessary referrals and sometimes say as much to primary care doctors. In The Netherlands many (but not all) specialists are paid on an item-of-service basis (Van Es, 1986) and, though they may be irritated at the trivial nature of some referrals, are consoled by the increasing weight of their wallets. In consequence they may be less likely to modify the attitudes of GP colleagues by feedback and tea-

ching.

This difference in payment between Britain and The Netherlands probably contributes to the very much higher referral rates in the latter country.

The patient. The patients knowledge of medical matters and his expectations are often inappropriate. Accessibility to primary care may be such that he is dissatisfied and demands something better. As Smith and Churchill (1986) point out, the accessibility of primary care depends on its availability (is it there?), its attainability (can I get at it?) and its acceptability (is it worth getting to?).

The general practitioner. Referral varies enormously between doctors (Dowie, 1983; Acheson, 1986; Wilkin a.o., 1987) and is influenced by many factors in the general practitioner. For example workload, use of time (number of patients on the list) and how it is rationed between patients (Morrell a.o., 1971; Wilkin a.o., 1984; Hull a.o., 1983). It also depends on a primary care team consisting of secretaries and other administrative staff, of nurses, especially family nurse practitioners (Stilwell a.o., 1987; Diers a.o., 1983), social workers and other non-medical health care workers.

Finally, with increasing size of practices more partners work together, each with different areas of expertise which may encourage referral within the practice, though this seems to happen rarely in Britain (Hull, 1972).

Dynamics within a practice or a practitioner which bear upon the decision whether to refer or not include knowledge, skills and attitudes.

Variations within family doctors must be examined. The generalist's knowledge base, by definition, needs breadth rather than depth but is ever in need of increasing and up-dating. This demands improvements in undergraduate, vocational and continuing medical education. Such teaching must also address the organisational, communication and diagnostic skills of practice. Even more important is attention to medical attitudes, particularly the doctors's response to uncertainty and his allergy to exposing himself to criticism.

The specialist. Among specialists, factors such as workload and stress have similar effects and these may be compounded by competition from other commitments such as private practice, research and teaching. Specialists too are subject to uncertainty which they may

relieve by cross-referral within the hospital. There is also the increasing threat of litigation pushing them towards highly technological and costly defensive practices.

Variations in the rates of referral

We should now look at how the complex inter-related factors we have discussed in the preceding sections are reflected in referral patterns in Britain and The Netherlands (table 1).

Table 1: Variation in referral pattern

| | GB | NL |
|-----------|---------|--------|
| variation | 0.5-15% | 30-60% |
| mean | 11% | 51% |

Source: Royal College of General Practitioners, 1971-2; 1981-2
CBS, 1984

This very wide range reflects the variables I have discussed and shows the huge variation in referral rate between two countries with a broadly similar health care system. The variation between doctors in one country (Acheson, 1986, Wilkin a.o., 1987; Royal College of General Practitioners, 1981-2) even within one partnership (Country Practice Revealed, 1983) is also large, implying a similar variation in quality.

This variation in quality led to a study of referral letters to departments of medicine in teaching hospitals in Birmingham and Amsterdam respectively (Hull a.o., 1986). Some results are shown in the tables 2 and 3.

Table 2: Quality of referral letters to the departments of medicine in teaching hospitals in Amsterdam and Birmingham, 1986

| Quality of letter | NL | GB |
|-------------------|----|----|
| | % | % |
| Poor/absent | 46 | 8 |
| Barely adequate | 29 | 18 |
| Good/excellent | 25 | 73 |
| n | 89 | 88 |

Source: Hull a.o., 1986

As can be seen from table 2 there is a marked difference in the quality of referral letters in the two cities. Though many factors influence this, I believe that this is partly due to the under-resourced nature of primary care in Amsterdam where adequate secretarial help is rare.

Table 3: Appropriateness of referral to the departments of medicine in teaching hospitals in Amsterdam and Birmingham, 1986

| Appropriateness of referral | NL | GB |
|-----------------------------|----|----|
| | % | % |
| Unnecessary | 15 | 6 |
| Inappropriate | 16 | 3 |
| Inadequate | 17 | 3 |
| Adequate | 21 | 10 |
| Appropriate | 31 | 68 |
| n | 89 | 88 |

Source: Hull a.o., 1986

In the study it was investigated whether the referral had been appropriate, that is to say, could a properly trained GP have managed without referral? Table 3 shows that in approximately two thirds of British, but only in one third of Dutch, referrals were considered appropriate.

Of course judgement of quality of letters and appropriateness of re-

ferral must reflect values, with all the attendant risk of subjectivity, nevertheless the differences are striking.

Factors influencing communication between general practitioners and specialists

An analysis of many factors influencing communication between general practitioners and specialists is undertaken at this moment at the Free University of Amsterdam. Preliminary analysis is revealing some interesting trends.

The poor quality of general practitioner letters is confirmed and, although specialist letters are better, their response to specific general practitioner requests are poor.

Specialist's letters sometimes indicate failure to understand the patients background and on rare occasions are rude to the family doctor.

All of this shows a need for change, particularly in the fields of education and audit: there is need for increased education of consumers and providers; there is also need for control of the quality of the work of both generalists and specialists through audit.

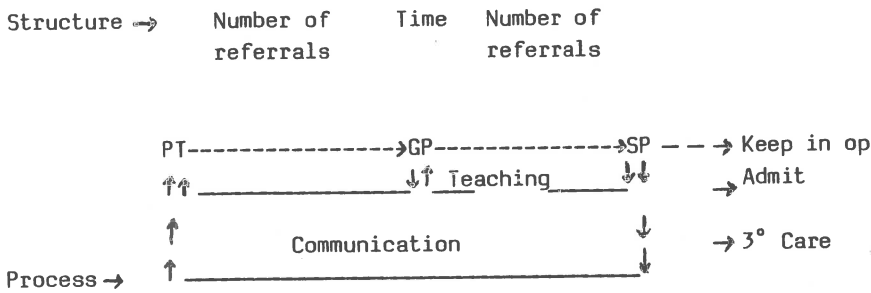
Education. Patients require continual teaching in how to get the best from their doctors. This demands initiative on the part of both government and profession aimed at broadening knowledge and changing attitudes (alteration of unrealistic expectation).

General practitioners need continuing education. They must also devote more time to living up to the meaning of the term doctor, teacher, by instructing their patients through health education.

Specialists need continual reminders of economy and reduction of cross-referral within secondary care. They also need to devote time to education of (and by) general practitioners. Social contact is also important; an interesting sidelight on the comparison between Birmingham and Amsterdam referral letters was the tendency of British doctors to address their specialist colleagues by first name whereas Dutch referrals were much more formal.

Audit. The point at which the patient and two doctors interact, provides an unique opportunity for audit which should be considered in the Donabedian triad of structure, process and outcome (1966). This can be illustrated by application to the referral model used earlier:

Figure 3: Examining quality of care.



When a patient is referred to a specialist by a general practitioner he may be retained within the hospital as in - or out-patient or may be cross-referred to another specialist often in tertiary care. Structural audit is comparatively simple and involves counting numbers of referrals, the measurement of time delays and the specialist's behaviour in returning patients to primary care or retaining them in hospital.

Less easy is audit of the processes of teaching and communication between the three people involved.

Lastly, and most difficult, the measurement of outcome involves assessment of such indefinable parameters as patient satisfaction, rates of cure of specific diseases and the influence of delay upon them. There is a need to attempt to relate cost-benefit analysis to these imponderables.

Recommendations

In conclusion I offer some suggestions for possible ways forward:

- government sponsored media education of patients;
- better health education by all PHC team;
- increased use of nurses and nurse practitioners;
- better time usage by general practitioners;
 - . smaller lists;
 - . more ancillary staff — improved organisation;
 - . increased delegation.
- no item of service payment of specialists;
- increased mutual teaching of general practitioners and specialists;
- creation of new specialist medical "ombudsman", to monitor refer-

- als for quality of need and standards of communication;
- rewards and penalties for standards of quality.

These suggestions, if implemented, could improve care generally; it is not possible to improve referral without first improving overall standards of primary care.

First of all, we need far greater emphasis on the patient's responsibility to care for himself and for his use of the immensely costly system which should help him in his task of self-care. This means education by government making full use of the media.

We need to increase the role of health education within the primary health care team.

We need smaller numbers of patients for each doctor with increased numbers of ancillary workers in primary care, especially nurses and nurse practitioners. This will help to improve organisation and the provision of an appropriate level of care to meet individual needs. Within hospitals we need to abolish item-of-service payment for specialists which may prevent them from discouraging unnecessary referral.

There is a need for realisation that good primary care has much to teach specialist medicine and for improved joint continuing medical education of specialist and generalist. There should be time available for teaching and social contact between doctors in primary and secondary care.

I believe there is a need for the creation of a new specialist, who might be called an "ombudsman", whose function would be to improve relations between the first and second lines of medicine. Through careful monitoring of referrals, especially with regard to standards of necessity and communication, and by remedial education where needed, enormous improvements in efficiency could be achieved. Though such an ombudsman would need to combine the attributes of Emperor and Saint, with considerable powers of sanction and reward to support their role I am sure such people could be found.

I believe such change would improve communication between the general practitioner and the specialist to the benefit of patients and with the saving of infinitely more money than would be needed to finance the proposals.

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5. OBSTETRIC CARE IN THE NETHERLANDS

5.1. GENERAL OVERVIEW OF THE DUTCH OBSTETRIC CARE SYSTEM

J. van der Velden

Introduction

The Netherlands takes a unique position in the industrialized world because of its high percentage of home confinements in combination with one of the lowest perinatal mortality rates in the world. This peculiar situation is the result of a division of labour between hospital and primary care, which is accepted by a majority of the population and the professionals.

Table 1: confinements at home in % of all confinements, 1982-1985

| | |
|-------------|-------------|
| Netherlands | N.W. Europe |
| 35 | < 5 |

Source: CBS 1983-1986/Nordic Council 1983-1986/OPCS, 1983-1986

Table 1 shows that 35% of all deliveries still takes place at home, while the estimates for home confinements in other North-Western European countries are below 5%.

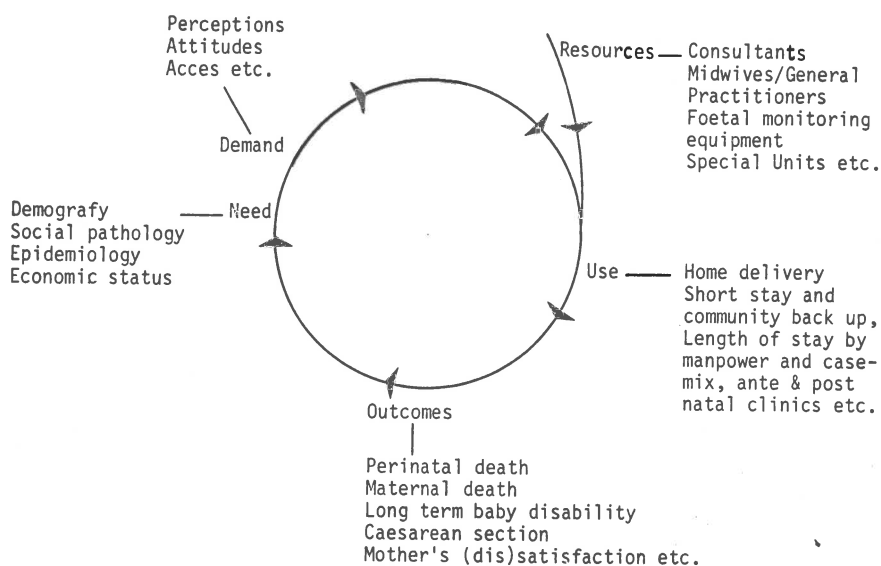
For the last 10 years this 35% is a relatively stable figure and the question arises what factors in the obstetric care system in the Netherlands contribute to this situation. The answer rests upon the firm attitude of the Dutch pregnant women preferring home delivery and a still continuing, extremely hot debate among professionals.

It is this debate we would like to discuss for some detail in this paper. Attention will be paid to the organization of maternity services in the Netherlands and how these services should be appraised.

Organization of obstetric care

Figure 1 pictures the theoretic framework that can be used for assessing maternity services.

Figure 1: The health cycle: assessing maternity services



We will go through this model consequently. First some crude data:

Table 2: crude birth rate and total fertility rate in the Netherlands and Europe

| | Netherlands | Europe |
|----------------------------------|-------------|--------|
| Crude birth rate (1980-1985) | 12.1 | 13.9 |
| Total fertility rate (1980-1985) | 1.51 | 1.88 |

Source: CBS/WHO (1987)

We have however to add to these figures that there has been a steep rise in the number of births over the last two years caused by the group women 30+, who had their first baby.

Going further into a model we arrive at the obstetric care system,

including demand, resources and use. Here we will be dealing with the organization of the system, while in section 5.2. a quantitative assessment of services is carried out.

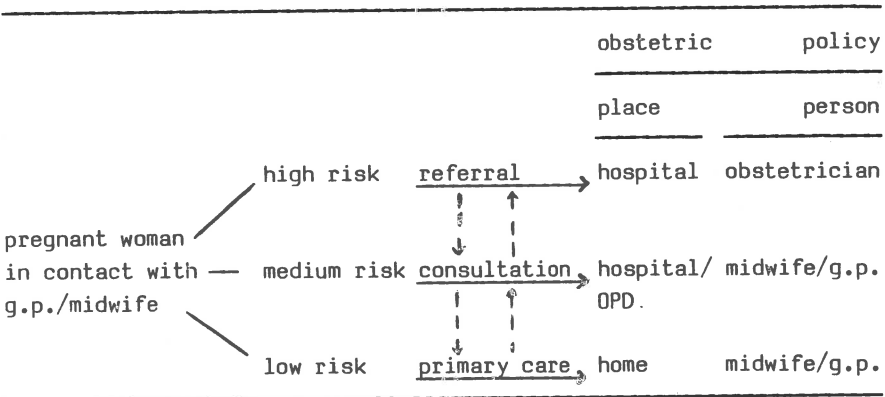
The organization of obstetric care in the Netherlands is based upon the idea that pregnancy and delivery constitute physiological events, which entail little risk for mother and child. Pregnant women therefore have a free choice of delivering their babies at home or in a hospital. However, in cases of increased risk, pre- and/or intra- and/or postnatal care should be provided under the responsibility of an obstetrician in a hospital.

The referral of these cases should take place on the moment the increased risk has been determined. This implies a careful selection of women at risk at the primary care level.

In this process, the midwife plays a crucial role. Midwives have a unique status in the Dutch obstetric care system because they are allowed to independently perform maternity services at the primary care level. Moreover, this profession takes a relatively strong position in the obstetric market: if a pregnant woman can choose between a general practitioner and a midwife, the publicly insured woman - ± 65% of all pregnant women, belong to this category - must consult a midwife if she wants refunding from her insurance.

Figure 2 shows how the selection process, initiated by the primary health care worker should work ideally.

Figure 2: Selection of pregnant women to different categories of obstetric care according to the degree of risk involved



When consulting the general practitioner or the midwife for the

first time the pregnant woman will be assessed for risk factors. Three possibilities can be mentioned:

- . If she has been assessed at high risk, the pregnant woman will be referred directly to the hospital for pre- intra and/or postnatal care.
- . If she has been assessed at medium risk, a consultation between general practitioner/midwife and obstetrician should be arranged, the outcome of which determining whether she will be referred or not. Usually, women belonging to this group deliver in a hospital/OPD-setting i.e. short stay under the responsibility of a general practitioner or midwife
- . If she has been assessed at low risk, pre- and postnatal care is performed at the primary level and the delivery takes place at home, even though the expecting mother is allowed to deliver at the hospital.

During pregnancy and/or delivery new risk factors may come forward, making referral necessary. The latter is indicated by the interrupted lines in figure 2.

The question arises how the level of risk is determined. For more than 30 years a carefully composed list of risk factors is in operation for this purpose, based on empirical and clinical experience but not yet on calculations of relative risks (Kloosterman, 1985). A total review of the list has been carried out recently (Ziekenfondsraad, 1987).

We conclude this section on the organization of obstetric care in the Netherlands with two final remarks.

First, to enable a high quality of intra - and postnatal care a national network of specially trained nurse-assistants is functioning. These nurse-assistants can be called any moment for assistance during delivery and are available for 8 days after the delivery as home helps.

Secondly, risk during pregnancy/delivery may arise abruptly, making acute referral necessary. The fact that in the Netherlands the nearest hospital is always at close distance allows for an immediate execution of this referral.

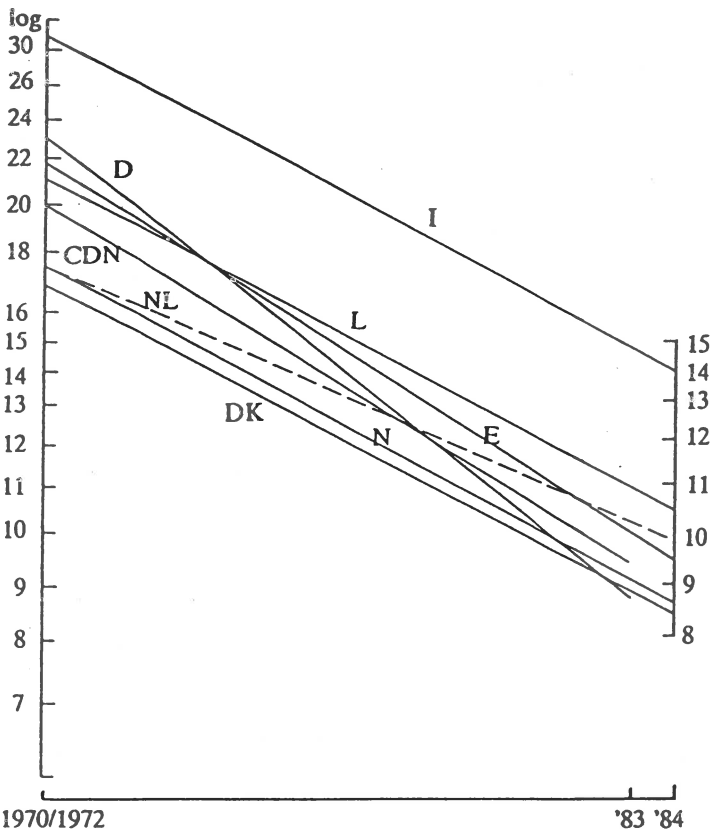
Evaluation

If we look at the outcome side of our model it is amazing to discover that besides the routine data such as perinatal mortality rate/maternal mortality rate/no. of caesarian sections etc., little attention has been paid to the evaluation of the selection system it-

self. Analyses on sick fund data (Smits, 1981) and general practice figures (Van der Velden, 1984) leads to the conclusion that in only about 70% of the cases the selection by the primary health care worker was done properly.

The most relevant and widely used outcome figure is still the perinatal mortality rate (PMR), which for the Netherlands came down from 17.6 per 1000 in 1970 to 10.1 per 1000 in 1986 (figure 3).

Figure 3: Age and parity adjusted perinatal deaths per 1.000 births in Italy (I), Federal Republic of Germany (D), Luxemburg (L), England (E), Canada (CDN), Netherlands (NL), Norway (N) and Denmark (DK), 1970/1972 and in the most recently known year



Source: Hoogendoorn, 1986

International comparison on PMR by Hoogendoorn (1986) revealed that

the Netherlands was getting more behind in the ongoing decrease of PMR and he believed the still high percentage of home confinements was the major cause.

The study has been criticized, because it did not take into account the facts that not all countries use the same inclusion criteria and that there is a difference in the percentage of underreporting (Keirse, 1987).

Besides this, it is in my opinion more important to know which pregnant women in social terminology are at risk for perinatal mortality rather than the knowledge that prematurity, dysmaturity and congenital malformations are the main contributing factors (Van der Velden, 1987).

Moreover, more attention must be paid to long term baby and maternal mortality, morbidity and disability for a better appraisal of the outcome of our home confinement system.

On the other hand there is already much evidence, that the present system is highly cost-effective compared to systems in surrounding countries (Butter/Lapr e, 1986) and that at the same time the maternal satisfaction of a successful home delivery is extremely high.

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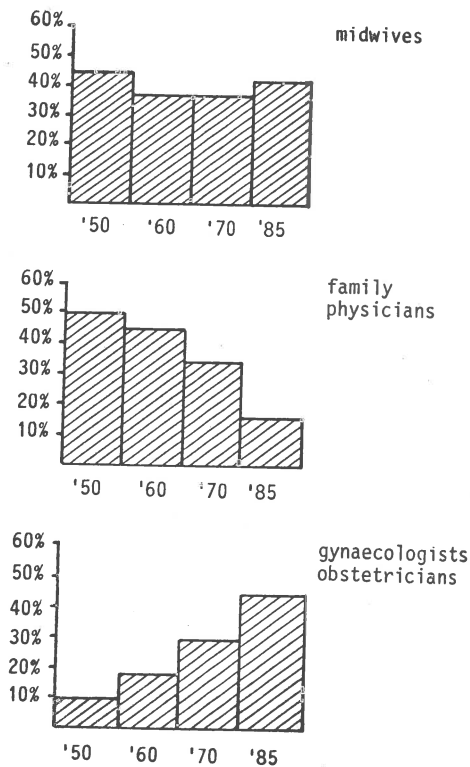
5.2. Explanation of increasing hospitalization of obstetric care in The Netherlands

L. Hingstman and H. Boon

Introduction: shifts in the delivery of obstetric care

One of the indications of the increasing medicalization and hospitalization of pregnancy and delivery in the Netherlands is the important shift between the share of the three professional groups involved in carrying out deliveries. This is shown in figure 1.

Figure 1: Proportional distribution of births by obstetric assistance in The Netherlands during the period 1950-1985

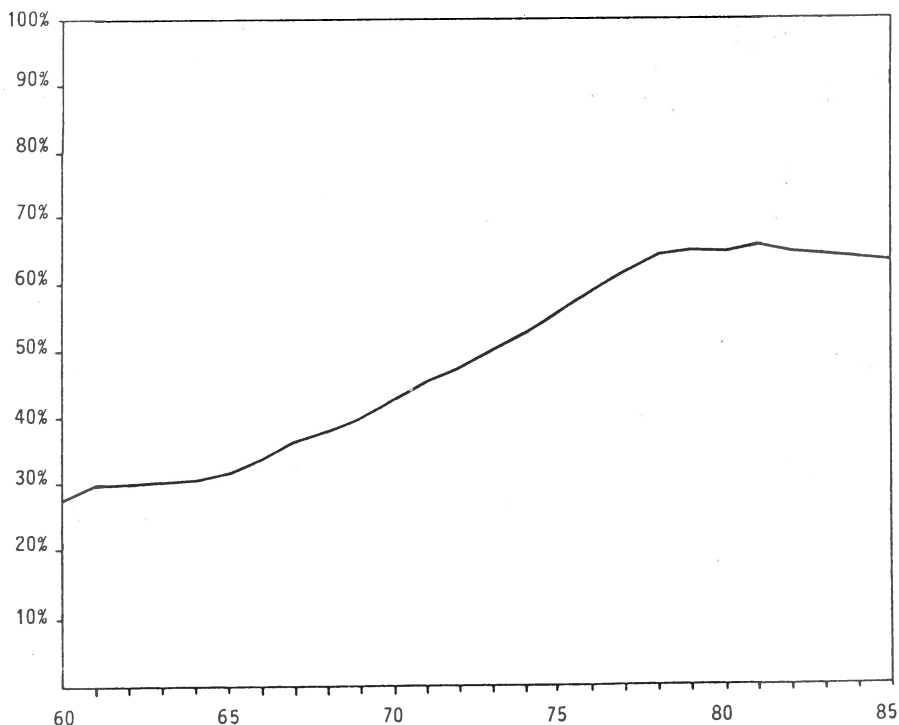


The share of general practitioners has fallen substantially from 46% of the total number of confinements in 1950 to 16% in 1985. The share of obstetricians on the other hand has increased from 17% to 42%.

The midwives' share remained rather stable in this period. In 1985 this figure was 42% (CBS, 1985).

The shifts just mentioned resulted in an increasing number of hospital deliveries over the past thirty-five years as shown in the next figure.

Figure 2: Percentage of hospital deliveries in The Netherlands, 1960-1985



In 1960 almost 25% of all births were delivered in a hospital. This percentage has risen every year until 1978; since then it is stationary at about 65% (CBS, 1985).

The increase in the share of hospital confinements is partly due to the growing importance of the so-called short stay hospital confinements. These are confinements where birth is delivered in the hospital, but immediate pre- and postnatal care is provided entirely or partly at home. In recent years the share of short-stay hospital confinements in the total number of deliveries has rapidly increased. In 1970 this figure was 2,5% by 1983 it had increased to 36%

(GHI, 1984).

In 1987, a study was undertaken investigating the development towards the hospitalization of confinements (Hingstman a.o., 1988). Since there are hardly any data available making longitudinal analysis possible, cross-sectional analysis was used to gain insight into the organization and structure of Dutch obstetric care. This means the authors analysed the current situation with respect to the degree of hospitalization on a regional level. Since explanatory variables of current regional differences in the degree of hospitalization are not static, understanding the current regional pattern provides insight into the causes of the process of hospitalization itself.

Figure 3: Proportion of births delivered at home in the total number of births per Economic Geographic Region in 1984

% home deliveries

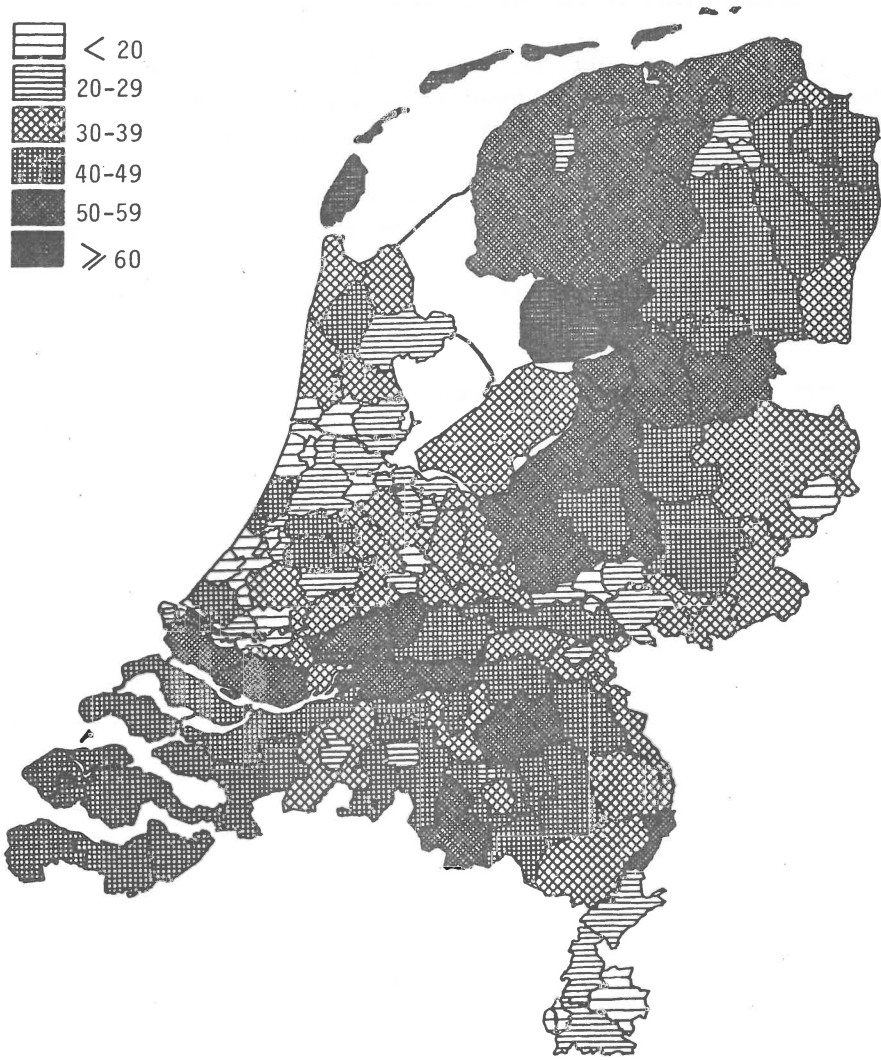


Figure 3 shows that the proportion of births delivered at home, is not equally distributed over the Netherlands. In some regions more than 60% of all births are delivered at home. In other regions this figure is less than 15%. the number of home deliveries is relatively

high in the northern and south-western parts of the Netherlands. These parts are characterized by relatively low population densities.

The obstetric model in the Netherlands

To gain some insight into the forces behind the increasing hospitalization of confinements, attention will be paid to factors that might explain regional differences in the proportion of births delivered at the hospital.

These factors can be summarized by two questions.

1. Do regional differences exist in the supply of obstetric facilities in hospitals
2. Do regional differences exist in the demand for obstetric facilities in hospitals.

We have elaborated these questions through a number of hypotheses which are shown in figure 4.

Figure 4: Hypotheses on the increasing hospitalization of confinements in the Netherlands

HYPOTHESES

| | effect on hospitalization |
|---|---------------------------|
| (supply side) | |
| * general practitioners with obstetric practice | - |
| * gynaecologists-obstetricians | + |
| * midwives | - |
| (demand side) | |
| * urbanization | + |
| * average income | ± |
| * percentage nulliparae | + |
| * ethnicity | - |

+ = increase
 - = decrease
 ± = opposite effects

Supply. As far as supply is concerned, we expect the presence of a hospital (including employed gynaecologists/obstetricians) to be positively related to the proportion of births delivered in a hospital. In this respect the following arguments may be stressed. First of all, in the case of a normal pregnancy, the expecting mother has a free choice in having her baby at home or in a hospital (short stay). We expect this decision to be effected by the distance between home and the nearest hospital: when greater distances are involved, the inclination of the expecting mother to have her child in a hospital will be less. In case of a forced hospital confinement, as a result of a medical indication, the supply of gynaecologists/obstetricians

is important. The literature shows that referrals made by general practitioners are affected by the distance to the nearest hospital (Posthuma a.o., 1977; Kruidenier, 1977; Wijkel, 1983) as the distance to the hospital increases, the number of referrals to medical specialists (including gynaecologists and obstetricians) tends to decrease.

The second factor that might have a negative impact on the proportion of hospital confinements is the presence of family physicians, who practise obstetric care.

Finally, the presence of midwives in an area might have a negative impact on this proportion. A midwife will probably be less inclined than a general practitioner to refer pregnant women to a gynaecologist/obstetrician for fear of "losing" a patient. In contrast to the general practitioner, obstetric care is the only source of income for a midwife.

Demand. As far as regional differences in demand for obstetric hospital facilities are concerned, we expect areas with a high level of income to have a larger proportion of (short stay) hospital confinements. In case of a normal pregnancy, people with high incomes can afford a (short stay) hospital confinement more easily than do the lower income groups. This is because costs of short stay hospital delivery are not fully compensated by the (private and public) insurance funds, so the patient has to contribute to the costs. This means that the latter groups probably more often have their baby at home (midwife, general practitioner).

A second factor that might influence demand for an obstetric hospital facility is the cultural difference between rural and urban areas. Because people in rural areas are not referred to a medical specialist as quickly as people in urban regions, they probably have less experience in visiting hospitals. This may increase the threshold barrier for women in rural areas, preventing them from having their child in a hospital.

The third factor, affecting demand for obstetric hospital concerns parity. We know that more women who are pregnant of their first baby deliver in a hospital than do women who have had children before. On the one hand they are referred to a obstetrician/gynaecologist more easily for reasons of medical safety and caution; while on the other hand they are more likely to prefer a hospital confinement themselves for the same reasons.

Finally the ethnicity of a region possibly affects demand for obstetric hospital facilities. On the basis of results of research con-

ducted in the Netherlands, we expect a positive relation to exist between the percentage of home-confinements and the relative number of mediterranean immigrants in a region (Doornbos a.o., 1985).

Results and conclusions

In order to test the above hypotheses we have used multiple regression analysis. We found that all independent variables turned out to be significant with exception of the 'supply of midwife' variable. The direction of the observed relations between the degree of hospitalization and the independent variables corresponded to our expectations except for ethnicity.

Which conclusion can be drawn from this analysis? In general the regions with a high degree of hospitalization are the more urbanized areas in which a large share of the births delivered are nulliparae. These areas are characterized by a large supply of obstetricians, a relatively small number of general practitioners who practise obstetrics, and a relatively high income-level.

On the basis of this cross sectional analysis we can conclude that the process of hospitalization of delivery which has taken place in the Netherlands over the past decades is to a substantial extent the result of a number of more or less related general socio-economic and culture processes. These are: the increased urbanization, prosperity, supply of obstetricians and obstetric hospital facilities; an increased share of nulliparae in the total number of births and a decrease in the supply of obstetric care by general practitioners.

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6. HOME CARE AFTER HOSPITALIZATION

T.J.J.M.T. Kersten

At the turn of the century home care after hospitalization was not yet an issue for the health authorities. The simple reason is that no hospitals in the modern sense of the word existed. Only the poor people, their houses being inadequate for nursing, were admitted to the so-called poor houses.

With the rise of modern medical technology the need for hospitals, especially designed for the cure and care of all people (not only the poor) with severe health problems was felt.

In more recent times it was realized that a lot of patients need additional nursing and home help after being discharged from the hospital. Despite a successful medical treatment in the hospital their health condition worsened instead of getting better, due to the lack of professional follow-up help. Although hospitals offer great benefits, they also introduced a new problem: the problem of continuity of care.

Aspects of home care

In the early seventies a demographic development enhanced attention to the concept of home care: the ageing of the population. The fact that old people need a lot of medical and nursing care focussed attention on less expensive alternatives to hospital care.

Although there was (and still is) no hard research based evidence, home care is regarded as financially more attractive in this respect than hospital care or clinical care in general. So home care might be an important substitute for hospital care. First of all as a possibility to avoid hospital admission altogether and secondly as a way to discharge patients at an earlier time.

The reasons for looking at home care as a meaningful substitute for hospital care were not only economic. Another reason lies with the growing awareness of hospitalization having not only beneficial but also harmful effects on the patient. And finally, many patients themselves prefer staying at home instead of going to the hospital.

Untill now I distinguished between two aspects of home care. The first aspect is related to the concept of continuity of care: continuation of adequate professional help when people are discharged

from the hospital. The second aspect involves the substitution of hospital care for home care: home care as a replacement of more expensive hospital care. These two aspects, continuity and substitution are the two most important aims one has in mind, organizing a programme for home care after hospitalization.

The central question dealt with in this paper is as follows: how can optimal continuity and substitution be gained in a health care system. In other words, what conditions have to be met by the system to bridge the gap between hospital and home?

First I will discuss these conditions in general and after that I will discuss in what way these conditions are fulfilled in a number of health systems in Europe.

Conditions for adequate home care

A. Sufficient supply of out-hospital workers that are well equipped for delivering home care.

This condition seems very obvious, but it is not fulfilled everywhere in Europe. For example in France the necessary district nurses were not present in the traditional system. What kind of care do people need at their homes after being discharged from the hospital?

In the first place home help (basic caring) should be mentioned. When the "hotel-function" of the hospital is no longer present, people - especially older, single handed persons - need somebody to wash the dishes, do the laundry and so on. In a study that was undertaken by NIVEL, the interviewed patients themselves also gave higher priority to home help than to nursing care (Verhaak, 1985). After home help is realized, people can in principle stay at home. But of course this is not enough. After being discharged from the hospital, patients also need medical help from a general practitioner and perhaps also from time to time need out-patient care from a specialist. Besides that nursing activities need to be done, like giving injections, looking after wounds and washing the patient. Some patients will need paramedical help, for instance from a physiotherapist. Finally, special equipment and adaptations may be needed at home.

Special emphasis should be put upon the organization of the different home care provisions. Especially when all the facilities are organized vertically, there will be problems of coordination.

B. In-hospital and out-hospital workers need to cooperate closely to provide home care.

Continuity of care can only be reached, if district nurses are informed by hospital nurses in good time before a patient is discharged. Moreover, the general practitioner must receive the necessary medical details about a patient in time.

As far as substitution of care is concerned it is very important for hospital workers to know what kind of home care can be offered to the patient. Selecting patients for home care whom cannot be given proper care at their homes will frustrate both patients and home care workers. On the other hand, keeping patients in the hospital that could be helped at home will result in less substitution than is possible.

For those reasons, all hospital workers who are involved in discharging a patient should look at him with the eyes of home care workers. To stimulate this, out-hospital workers might be involved in the decision of hospital discharge in the same way as hospital workers take their part in the decision regarding the hospital admission of patients that have been selected for hospital admission by home care workers.

An important pre-condition for the cooperation of in- and out-hospital workers with regard to home care is that they must be able to contact one another easily. The most rigorous solution for this problem is bringing specialists, general practitioners, hospital nurses, district nurses, etc. together in one organization. In almost all European countries however, this solution is far away from reality.

Another solution is to organize in- and out-hospital care in clearly defined districts so that it is relatively clear who is responsible for the home care of a patient. In health care systems that are not district-based out-hospital workers have to communicate with a number of general hospitals (and vice versa). This hampers a smooth organization of home care after hospitalization.

C. In- and out-hospital workers must have a common interest in home care

In many systems hospitals and out-hospital workers have their own separate financing system/budgets. This may also hamper the adequate provision of home care.

In- and out-patient workers will both try to maximize their budgets, but they will not necessarily maximize their efforts in favour of home care. The latter can only be reached if the financing system gives incentives to both parties, for example by preparing a joint budget for the in- and out-hospital-care in a district.

In some countries the incentive for using home care facilities is not financial. For instance in the United Kingdom many patients are confronted with waiting lists, before they are admitted to the hospital. This narrow supply of hospital beds gives the hospital staff a reason to cooperate in a home care scheme. If at the same time home workers can be motivated to give some extra effort, the goal of a common interest in home care for in- and out-hospital workers has also been reached.

Home care should be equally expensive to the patient as hospital care

In most health systems the costs of in-patient care are totally reimbursed by the health insurance funds. The reason for this is probably that hospital care is regarded as a medical and human necessity there is also no suspicion of abuse. No one who is healthy likes to be in hospital. However, when home care is concerned, people who watch the costs are inclined to emphasize the patients own possibilities and responsibilities. However, when it comes at cutting down health care expenses, governments sometimes seem to regard home care as a relative luxury, to be paid (partly) by the patient himself. It is obvious that the patient prefers staying in a hospital, when home care gets more expensive.

Home care after hospitalization in France, Great Britain and the Netherlands

Looking at the pre-conditions for an optimal structure of home care after hospitalization, the "district health system" concept of WHO offers many elements that are usefull.

WHO advocates a district with a unified health infrastructure rather than a structure that is based on particular diseases or patient groups, a so called vertical structure. In this concept the district hospital plays an important role that goes beyond the provision of in-patient care. Hospital staff has to support primary health care. The Thirty-ninth World Health Assembly put particular emphasis on district health systems based on primary health care. However most

of the Western European health systems are not organized in districts with a unified health system. In most countries special arrangements have to be made to make home care after hospitalization possible. Some examples are discussed below.

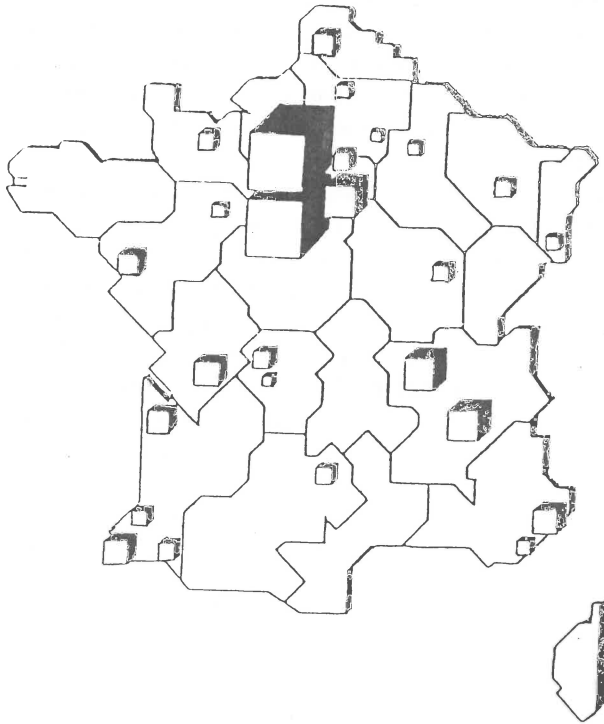
Traditionally, in France there are no strong organizations that offer home care. Home nursing, as provided for instance by the district nurses in Great Britain has only started in 1980 and the services are not available yet all over the country. Home nursing is especially meant for the elderly.

There are separate organizations that take care of home care after hospitalization. In the beginning, that is to say, in the early seventies, home care after hospitalization was initiated by hospitals because of a shortage of hospital beds. That is possibly the reason why these services are called "Hospital at home" (in French "Hospitalisation à domicile"). In France it has two aims.

The first aim is to provide professional home care after hospital discharge. Specially trained aides who perform a mixture of home help and nursing activities are employed by the "Hospital at Home Service". The second aim is to coordinate in- and out-hospital care. The "Hospital at Home Service" is not available in all of France.

Some area's, especially the Parisian region, are relatively well provided but other area's are not (figure 1).

Figure 1: "Hospital at Home Service" in France



Source: Enquête 'Hospitalisation à Domicile', 1985

As far as France is concerned the main problem of organizing care after hospitalization appears to be the absence of basic home care provisions.

Unlike France, Great Britain does have domiciliary care service. British district nurses are cooperating closely with general practitioners; home help is arranged by the social service. Inspired by the French, in 1978 a project for home care after hospitalization was started in Peterborough. The French concept of 'Hospitalisation à domicile' was implanted unaltered in the National Health Service system, and called "Hospital at home". The main purpose was to offer a solution for the shortage of hospital beds.

From France special nurses and so called "home health aides" were contracted to do the actual nursing at the patients' homes. However, despite the fact that home care schemes worked well in France, they didn't at all in Britain. General practitioners preferred working together with their own district nurses instead of cooperating with the nurses of the new scheme.

District nurses objected to having their "own" patients looked after by nurses of the scheme. And also the patients themselves preferred the nurses who were familiar to them.

Later on the "hospital at home scheme" in Peterborough was changed by giving the district nurse a central position in the scheme, so the existing services were strengthened, instead of creating a totally new service.

Special emphasis has been put upon the coordination between hospital and home care. A community nurse, called a "liaison sister", selects patients for the home care scheme, together with the hospital nurses. She also informs the district nurse and the general practitioner about the coming discharge of a patient.

The Peterborough case made it very plausible that the main problem with home care after hospitalization in Great Britain is a problem of coordination between the hospital and the domiciliary care services.

In The Netherlands, the situation regarding home care after hospitalization is much more similar to Great Britain than to France. District nursing and home help services are both present and one of the main problems seems to be the coordination between in- and out-hospital workers. It is striking to see that in some parts of the Netherlands, for example in the province of Friesland, the same kind of solution was applied to coordination problems as it was in Peterborough. A district nurse, called 'continuity-nurse', is working in the hospital. Consulting together with the hospital nurses she selects patients and she also takes care of the communication with the general practitioner, district nurse and so on.

Recently NIVEL has started a study to compare the benefits of this solution to other structures that have been chosen in The Netherlands to overcome the gap between in - and out-hospital services.

Because of the international parallels between the problems connected to home care after hospitalization, I think international study programs would be very useful in this respect.

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**III. COLLABORATION BETWEEN GENERAL HOSPITAL AND PRIMARY HEALTH CARE
FROM THE VIEWPOINT OF THE GENERAL HOSPITAL**

1. INTRODUCTION: THE ROLE OF NZI: AS A COLLABORATING CENTRE OF WHO

P. Emondts

As an institute that is founded and maintained by the association of Dutch Hospitals the main aims of the National Hospital Institute are stated within the borders of our country and focussed on the improvement of the contribution of hospitals to the national health care. The Institute tries to achieve these aims by research activities in the field of cost containment, regional health planning and cooperation, quality and effectiveness, care for the elderly and strategic management; as well as by the counseling and training of health care management in intramural care and collaborating facilities in semi- and extra-mural care.

This designation to a world wide organization as WHO was nevertheless possible through the fact that the management of the hospitals in this country are willing to take a look over our boundaries and eager to learn from the experiences of foreign health-care-providing organizations.

On the basis of this broad view, the Institute was always put in a position that made it possible to sustain a network of international contacts within Europe as well as beyond this continent.

In connection with this subject I want to mention the most valuable relations that we maintain with the other hospital institutes in Europe and the very useful contacts that are supported within the International Hospital Federation.

In addition to these international relations however, the tightening of our relation with the WHO by becoming a Collaborating Center is of an other dimension.

Not only will the Institute, and with her the Dutch Hospitals, profit from the experiences of other members of the WHO, we also express the aspiration to undertake activities in research and counseling that will serve other country's health care systems. This will be attempted by extending the objectives of some of our national activities as mentioned in the Plan of Work, by taking part on WHO studies and consultations together with participants from other countries and by facilitating counseling relations of NZI staffmembers in other countries as WHO advisers.

Although in the Netherlands we still have topics that, we think, can be improved, a fact is that our health care system is of a very high

level in comparison to some less fortunate countries. By sharing our experiences in achieving this system and preserving it, we can express our solidarity with the aim of the WHO to realize health for all in the year two-thousand.

By working on health care problems in other less advanced systems we might even find that, in a medical and technical most sophisticated health service, one can easily lose contact with the fundamental questions on health and illness and create refined solutions to health care problems that in the end do not meet the essential needs of people seeking help.

This brings me to the conclusion that the collaboration between the Regional Office for Europe of the World Health Organization and the National Hospital Institute of the Netherlands can be beneficial for the health care in Europe in general but will also be advantageous for the improvement of the Dutch health service in particular.

2. PLAN OF WORK FOR THE NATIONAL HOSPITAL INSTITUTE OF THE NETHERLANDS AS A COLLABORATING CENTRE OF WHO

V.F.J. Baalman

In this paper we elaborate on the objective, the organisation and the activities of the National Hospital Institute. Also, attention is paid to activities that are part of the plan of work connected to WHO.

The National Hospital Institute (NZI)

Objective. The objective of NZI is to support the hospital sector in the Netherlands to deliver adequate, human and affordable health care.

From this definition we can see that the focus is put on the role of the hospital in the health care system, instead of focussing on the hospital as an institution of professional workers, aiming for acknowledgment by their colleagues.

It is of great importance to see hospital care as a possible solution to certain health problems chosen for by society. In this perspective, it is the responsibility of the hospital to guide the activities of different professional groups in the organization to collective care for the real needs of a population.

NZI tries to clarify that role of hospital care.

Maybe in contrast with other scientific centres, NZI does not only study phenomena in a laboratory setting, but also wants to change things in real life and wants to take responsibility in achieving a, what we think is, better health care providing.

Activities are levelled on institutions as well as on the region and on the national layer where we try to change respectively the way care is given, how people and organizations relate to each other and what policy is developed. That means that NZI makes an explicit approach in its activities and that initiators can choose to share that approach and use the activities to change, or not to share it and use the NZI effort as an advise that can be followed or not.

Organization. The National Hospital Institute is founded by members of the Dutch Hospital Association and mainly funded by them as well. They have the right to nominate all the members of the board of governors. This does not mean however that all boardmembers are proposed and descended from the hospital domain.

The budget of the NZI is mainly formed by the voluntary yearly contribution of the hospitals but is also raised by contract research for non-members such as the government, sick funds, trade unions etc. Extra money is paid mainly for individual counseling and training activities, again by the hospitals and their managers.

The multidisciplinary staff of the institute consists of 145 people in 120 full-time equivalents, including supporting staff. They are working in teams on the different projects and are trained and managed in basic groups. The four main fields of interest formulated in the working programme of the institute up to 1989 are:

- . strategic management including interorganizational cooperation;
- . planning and financing and their interdependancy;
- . the development of national policy and guidance;
- . care for the elderly.

The projects are concentrated in these fields and are operated in the four areas of hospital care: acute hospital care, nursing homes, mental health care including youth care and care for the mentally disabled what leads to a broad working domain.

Activities. NZI-activities include the following subjects:

- **Research activities** are not aimed at changing the frontiers of fundamental science but try to apply scientific methods in health care and health care management on different levels. These activities are always executed in cooperation with the health institutions involved, what makes the implementation of ideas in practice a natural process of development.

The close organizational relation with the hospitals is an advantage for the institute to commit the health institutions to the work that is done and to achieve real changes along the way.

- **Counseling activities** will often be part of the research projects as they are effected as described above. Besides that, advice is given on general management and organizational issues for health institutions that seek that service.
- **Training activities** consist on the one hand of short courses and workshops dealing with actual problems such as budgetting, the institutional plan, regional planning, cooperation between different health institutions, where every year more then a hundred managers and policymakers participate. On the other hand there are management programmes for intramural management, topmanagement and poli-

cymaking, and policy and organization in the health service and these programmes will take up to seventy-five members each year.

- **Information and documentation** finally focusses on the collection, editing and publication of facts and figures by the statistical department and on the service that is given for everyone working or studying in health care by the library and the documentalists on a wide range of literature in this field.

The plan of work of NZI as a collaborating centre of WHO

The activities of the institute related to WHO deal with the dissemination of information about the Dutch health care, preparing country contributions to different studies, compiling overall studies on several subjects and participating in working groups, networks and consultation meetings of the WHO. These activities strongly relate to the objectives that NZI has formulated in her national working field.

The fields where the collaborating relation with WHO started already are the following:

- **Care for the elderly** is for a long time subject of investigations in our institute and fits well in the WHO target 27.1.1: developing integrated services for long-term health care.
- **Hospitals in support of PHC services** is part of our field of interest on the institutional level called "Strategic Management" and is well developed in the field of somatic care, but also strongly developing in longterm care and mental health care. The WHO objective on PHC based health care systems does very well agree with the goals of the NZI on integrated health care and "de-echelonizing".
- **The organization of health services on a regional and district level** relates to the development of guidance systems as well as to the interorganizational cooperation and regional planning.
- The WHO objective to improve the efficiency of the **management of health care institutions** as part of a comprehensive health service, has a close relation with the view that the NZI has on the role of hospital care in the health service. Activities in this field will deal with information systems for management and pro-

fessional decision making, cost-combatting strategies and new methods of management including the role of the professional in health care management.

This subject is in the Netherlands back in focus again since a national working party, the "commissie Dekker" has proposed the market-mechanism as the regulating system for health care and the financial cuts of the government will go on in the next future.

3. SUPPORTING COLLABORATION ON THE INSTITUTIONAL LEVEL

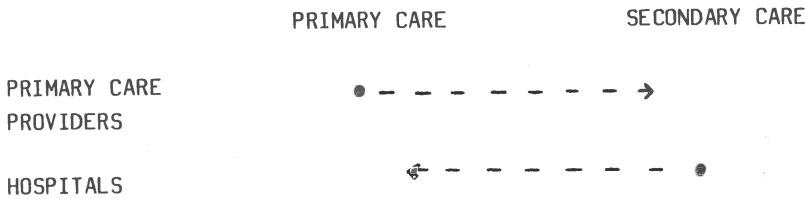
J. Vissers

Introduction

Collaboration between hospitals and primary health care is a policy-issue of growing interest on different levels in health care. Recent policy-documents of the Ministry of Health in the Netherlands (WVC, 1986; Commissie Dekker, 1987) emphasize the importance of the relation between primary care and secondary care in improving the overall-quality of health care.

A number of policy-measures are concerned with this relation and are even failing because of the complexity of the relation between primary care and secondary care. The grown division between providers of primary and secondary care is regarded as a major barrier in this respect. Continuity of care, for example, requires more involvement of hospitals in primary care and of primary care providers in secondary care (see figure 1).

Figure 1: shifts in involvement of primary care providers and hospitals with primary care and secondary care.



The National Hospital Association - the association of hospitals in the Netherlands (NZR) - emphasizes in their policy-documents the supporting role of hospitals towards providers of primary health care, for example, by giving general practitioners access to diagnostic facilities and by enlarging the possibilities of consultation (NZR, 1983-1987). Moreover, the developments of care within the hospital (shorter length of stay, growth of day surgery and ambulatory care) require a closer cooperation between hospital care and primary health care. In its most recent document (NZR, 1987) the National Hospital Association mentions a few areas of substituting hospital care for home care combined with support by the hospital. These arguments for a growing interest in cooperation apply also to

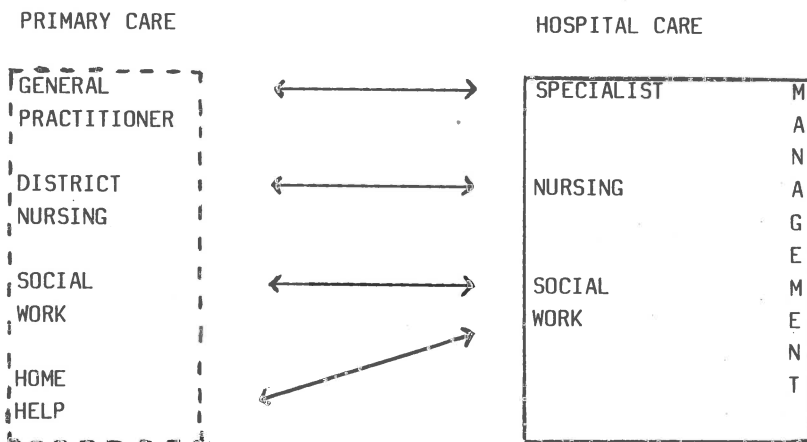
the institutional level. Hospitals - specialists and management - become increasingly aware of the importance of a good relation with primary care providers in the catchment area of the hospital. This has to do with the legitimacy of the hospital and, sometimes, the survival of the hospital in the long run.

The N.Z.I.-programme on collaboration

Collaboration between hospitals and primary health care has been part of the working programme of the National Hospital Institute for a number of years. Starting with two research-projects (one about the impact of diagnostic facilities for general practitioners on the consumption of hospital care, and another about the impact of the closure of the inpatient services of a hospital on the workload for primary care providers), the present projects are more directed to effectuate real changes in the relation between hospital care and primary care.

In the beginning most projects were mainly looking at the relation between general practitioners and specialists. Gradually, other professional lines between primary care and hospital care were included (figure 2).

Figure 2: parties involved in N.Z.I.-projects on collaboration



The figure shows the main parties involved in N.Z.I.-projects on collaboration and the communication-lines between them. The dotted box on the left side indicates that in primary care there is hardly

any overall organisation or management. Request for a project normally comes from a hospital, but projects on collaboration between primary care and hospital care are always commissioned by both.

The goals of the programme on collaboration are:

- to support the hospitals in their effort to improve the relation with primary health care;
- to develop concepts for improving the cooperation between hospitals and primary care.

The N.Z.I.-programme on collaboration focusses on four areas:

- **management support.** Support is offered to hospitals, that are faced with a bad relation with primary care providers. Based on questionnaires and interviews with primary care providers the bottlenecks in the cooperation are identified and advice is given how the cooperation can be improved.
- **structural collaboration.** If a hospital wants to structure its collaboration with primary care providers in its catchment area and vice versa, advice is given about the organisational design. These designs may vary from very loosely forms (consultations, regular meetings, etc.) to more tight ones, like a foundation of the hospital and primary care providers to improve the collaboration.
- **collaboration and substitution.** Hospitals, that are willing to experiment with substitution of care, are offered support in realising and evaluating the desired changes.
Substitution could be either a shift from inpatient to outpatient care (and its impact on primary care) or a shift from hospital care to primary care and home care.
- **workshops and conferences.** Each year a workshop or a conference is organized to transmit the experiences of hospitals and the N.Z.I. on the collaboration with primary health care. Target groups are: hospital management, medical staff members and heads of outpatient and nursing departments.

An example: innovation of health care collaboration in the "Oost-Achterhoek"

The following example concerns a project that has during the years been prominent on the different areas mentioned in the foregone paragraph.

The "Oost-Achterhoek" lies in the eastern part of Holland, along the German border (figure 3).

Figure 3: The "Oost-Achterhoek" area

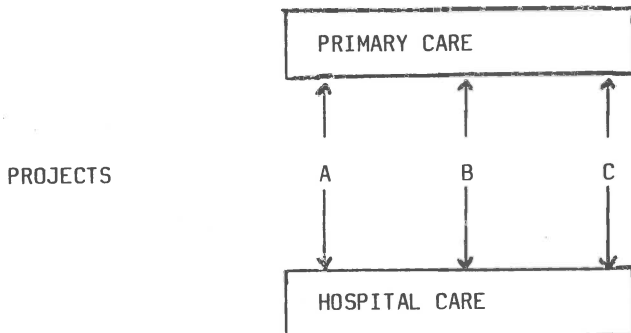


There are four small towns in this area, ranging from 8.000 to 30.000 inhabitants. The total population of the area numbers 90.000 inhabitants. Originally, there were four small hospitals, each of 100-150 beds. A merger of the four hospitals into a new one of 350 beds in Winterswijk resulted in resistance of the population and general practitioners. The hospital management decided, that free-standing outpatient facilities would stay on the different locations. Moreover, the National Hospital Institute was asked to advice how to improve the disturbed relation with primary care and to look at the contribution of the outpatient facilities.

At each of the locations working groups were installed with professionals from primary care and from the hospital. These working groups had to identify bottlenecks in the cooperation and to advise about the outpatient facility. As a result of these working groups all parties concerned stated that they were willing to continue the grown cooperation. A decision was made to form a foundation with as

main purpose to promote a better collaboration between the hospital and primary health care. A grant for an experiment of three years was given by the Ministry of Health. The experiment has started in 1987. The role of change-agent and initiator - during the research-phase performed by the National Hospital Institute - is now performed by a specially designated project-coordinator. The projects, that are part of the experiment, concern: communication between professionals in primary care and hospital care, continuity of nursing care, care for the elderly, substitution of hospital care by home care, the supporting role of the outpatient facilities. Each of the projects links primary care with hospital care (figure 4).

Figure 4: the projects as links between primary care and hospital care.



In this way it is hoped that at the end of the experiment the interaction and collaboration between primary care and hospital care has increased and improved.

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4. COLLABORATION BETWEEN GENERAL HOSPITAL AND PRIMARY HEALTH CARE

4.1. COLLABORATION FROM THE VIEWPOINT OF THE PROFESSIONAL: EXPERIENCES FROM THE DIAGNOSTIC CENTRE MAASTRICHT*

P. Pop

Introduction

In many places of the Netherlands, we can see the development of health care activities aimed at the improvement of the collaboration between medical specialists and general practitioners.

The question, which motives medical specialists may have to participate in collaboration projects, is hard to answer. In general, medical specialists perceive themselves as being very occupied with rational patient care in the setting of a well organized hospital, using the newest ideas and techniques. For them, the general practitioner is often someone who, working outside this sophisticated environment, is trying to deal with vague complaints and uncertain diagnoses; if things get serious, he has to carry the patient over to the medical specialist. Also, at the moment the Dutch medical specialist has to face increasing criticism, growing medical unemployment and a tendency of his income to go down.

All these factors will not increase his motivation to collaborate with general practitioners. Nevertheless, medical specialists take part in collaboration projects with general practitioners. They do so, forced by the need for goodwill, by budgetary problems of the hospital (managing boards are pressing for better relationships with general practitioners) and by the understanding that elementary changes in health care are needed.

By describing experiences and activities of the Diagnostic Centre Maastricht, this paper pictures several ways of how collaboration between medical specialists and general practitioners can be organized and what conditions have to be fulfilled in order to achieve successful collaboration.

* Maastricht is the capital city of the province of Limburg.

Activities undertaken by the Diagnostic Coordination Centre Maastricht

In 1972, the Department of Health asked the Central Advisory Board for Health care to advise concerning the diagnostic facilities for general practitioners in the Netherlands. On the basis of their report it was decided to start an experiment with Diagnostic Centres, for which in 1977 Maastricht became a candidate. After an interim period till 1987, the Diagnostic Coordinating Centre Maastricht - located at the university hospital - was officially founded.

The activities of the Coordination Centre can be clustered according to four goals. Attention will be paid to each goal successively:

A. Providing an opportunity for general practitioners to order diagnostic investigations using hospital facilities.

Activities related to this first goal can be summarized as follows:

1. the development of procedure-agreements regarding frequently ordered diagnostic investigations;
2. evaluation of, and advise about the diagnostic policy of individual general practitioners;
3. consultation with medical specialists about specific diagnostic problems by telephone;
4. clinical conferences on primary health care problems;
5. organisation of regular meetings between clusters of collaborating practitioners and medical specialists to improve personal relationships.

In the experimental period, **procedure agreements** were made regarding the indications for frequently ordered investigations by general practitioners. These agreements were achieved in good collaboration between general practitioners and medical specialists. The level of adherence to these agreements was checked and the results were regularly reported to the general practitioners.

It turned out that general practitioners do not adhere well to procedure agreements, if these concern simple routine investigations. They do adhere better, however, if more complex technical diagnostic investigations are involved.

Feedback of the results of these analyses to the group of general practitioners as a whole was not very effective in improving this situation; it did improve, however, with a personal feedback to every general practitioner regarding his or her own performance. The

results of this experiment regarding procedure agreements are described in detail in the thesis of Beusmans, a general practitioner from Maastricht (Beusmans, 1986).

Based upon our experience, that feedback regarding diagnostic performance had more effect when reported to individual practitioners, we started to **evaluate** the diagnostic performance of each individual general practitioner in the form of regular reports and added some **advice** for improvement.

In practice, this means, that every general practitioner from Maastricht (there are 78 general practitioners in this area) receives a report twice a year.

How does this system work?

The basis of the analysis is the form, on which the general practitioner marks the ordered investigations. On this form he has to mention relevant data for ordering these investigations, such as signs and symptoms, findings of physical examination, diagnosis or probabilities, questions, reasons for ordered investigations etc.

These data are the background against which the reason for the ordered investigations is considered. The data are summarised in an evaluation form, which contains the following items:

- number of patients for which tests were ordered;
- quality of the clinical information given;
- reasons for the examinations ordered;
- deviations from the expected diagnostic strategy, or the procedure agreements;
- advises and opinions relative to diagnostic in general and regarding individual patients;
- aspects of management based on the results of the diagnostic investigations.

These analyses of diagnostic performance are appreciated by general practitioners; about 70% react on paper with comments and answering of questions.

It appears that these reports act clearly on the diagnostic behaviour of general practitioners.

Table 1.

Table 1: Numbers of laboratory investigations (blood, urine, feces), performed at the university hospital of Maastricht, 1979-1986

| | 1979 | 1980 | 1982 | 1983 | 1984 | 1985 | 1986 |
|--------------------|---------|--------|---------|---------|---------|---------|--------|
| Biochemistry tests | 46.156 | 44.328 | 49.108 | 45.537 | 51.775 | 46.569 | 39.576 |
| Haematology tests | 44.172 | 41.236 | 48.072 | 52.948 | 59.556 | 53.437 | 30.609 |
| Serology tests | 10.329 | 8.572 | 8.724 | 8.192 | 8.554 | 7.329 | 5.518 |
| Urine/feces tests | 2.212 | 1.848 | 2.524 | 3.858 | 4.137 | 3.559 | 3.328 |
| Bacteriology tests | 1.256 | 1.272 | 2.172 | 1.679 | 1.845 | 2.558 | 2.508 |
| Totals | 104.125 | 92.256 | 110.600 | 112.114 | 125.867 | 113.452 | 81.539 |

The evaluation/advice process started in the second half of 1985. Looking at table 1 we can see that in this year the ongoing increase in the number of laboratory-investigations stops. The year 1985 shows a slight decrease in the number of requests and in 1986 the decrease in total of ordered investigations with respect to 1984 is no less than 35%.

We believe this decrease to be the result of a better diagnostic performance on the basis of our regular feed-back system.

The third activity regards **consultations**. This is a conversation by phone, on request of the general practitioner, between medical specialist and general practitioner concerning a specific patient problem, using only the information given by the general practitioner. These consultations are carried out in an organized fashion: relevant diagnostic data of the patients are given in advance and reports of the consultations are made.

In 1984 we performed an analysis of 508 of such consultations given by the internist of the university hospital. Table 2 shows some results.

Table 2: Effect of consultations* between medical specialist and general practitioner on medical treatment and referral by general practitioners, Diagnostric Centre, Maastricht, 1979-1984

| Effect upon: | consultations | Number of % |
|--------------------------------|---------------|-------------|
| Medical treatment/control G.P. | 306 | 68.6 |
| Referred to out-patient clinic | 121 | 27.1 |
| Admitted to hospital | 19 | 4.3 |
| Total | 446 | 100.0 |

* 446 first consultations, 62 follow-up consultations

From the table we can see, that in some cases these consultations can prevent referrals to out-patient clinics. In practice however, only a limited number of general practitioners is regularly making use of this consultation system.

Clinical conferences, especially meant for general practitioners, take place every month. In these meetings, diagnostic and therapeutic aspects of frequently occurring diseases in general practice are discussed by experts in general and clinical practice. These discussions are the basis for procedure agreements and protocols.

Regarding the fifth and last activity within the first goal, to **improve personal contacts** and to get as many general practitioners and medical specialists as possible involved in the improvement of the collaboration between primary and secondary health care, regular meetings are organized between (groups of) collaborating general practitioners and specific medical specialists. In these meetings, common health care affairs and professional problems are discussed.

B. Improving the communication and collaboration between general practitioners and medical specialists

The following activities are developed in accordance to this goal:

1. meetings of general practitioners and medical specialists to discuss problems of communication and collaboration between primary and secondary health care and their respective institutions;

2. site visits of medical specialist to general practitioners to discuss specific patients management problems;
3. establishment of a network of contacts within the hospital and between primary and secondary health care workers in order to improve our system of postgraduate education for general practitioners;
4. establishment of facilities for strategic management for general practitioners.

In the conviction, that communication and collaboration between general practitioners and medical specialists will only be improved on the basis of good personal contacts, the Steering Committee for the relation between primary and secondary health care organises **meetings** for general practitioners and medical specialists to discuss bottlenecks in relationships and factors which create problems in this respect. During these days, there is ample time and opportunity to strengthen personal contacts. For these meetings, the Steering Committee provides a comprehensive scenario and prepares a final report with conclusions and recommendations.

Recently, a project was started, in which representatives of three clinical departments, those of Orthopaedics, ENT and Dermatology, **site visit** three health care centres and discuss patient problems with the general practitioners at these centres.

These visits are especially meant to improve the problem-solving capabilities of the general practitioner. Also, in this way personal contacts can be strengthened and the medical specialist can transmit technical skills to general practitioners. As a result, referrals to the out-patient clinics of these departments, may start to decrease.

As far as **postgraduate education** for general practitioners is concerned, Maastricht has chosen for the following system: items, considered to be of importance for general practice medicine, are brought together in a five-year curriculum. This curriculum incorporates various educational principles and devotes major attention to aspects of evaluation.

General practitioners and medical specialists work in close collaboration to prepare and implement these activities. For this, a network of contacts within the hospital and between primary and secondary health care workers as well as with the educational department of the Medical Faculty of the Maastricht University have been developed.

Regarding the fourth activity related to the second goal, a plea has been made recently to **establish an office** to support general practitioners in their contacts with institutes like the hospital and the university. For a period of 4 years, the Hospital of Maastricht will pay for such an office, which will be connected with the Diagnostic Coordinating Centre.

C. The development of health care activities which take place at the interface of intramural and extramural health care

Two projects related to this third goal are in a phase of implementation at this moment:

1. a multidisciplinary approach to the geriatric patient;
2. medical specialists visiting particular categories of patients at their homes.

Regarding the first project, the programme of a **multidisciplinary approach** for the geriatric patients has been developed for two reasons: it should as much as possible prevent inter-specialist referrals for geriatric patients with mixed problems, such as somatic, psychic and social, and it should prevent unnecessary long stay of these patients in the hospital.

For this, the necessary investigations will be executed in an out-patient day-care setting. The results of this approach will regularly be evaluated.

Regarding the second project, a year ago an inquiry was sent to general practitioners and medical specialists with questions about the desirability of medical specialists to **see particular types of patients at home**. Especially patients which are chronically ill or in a terminal stage of a severe illness, were considered to be candidates for such an approach.

From the results of this inquiry, it became clear, that both general practitioners and medical specialists have the impression, that a great percentage of these patients can indeed be treated at home.

In mutual consultation the framework for such medical specialists visits will be worked out.

D. Initiate, stimulate and execute research directed towards questions concerning the relationships between primary and secondary health care

In order to achieve this goal, a distinction was made between projects regarding the development of health care (such as the multidisciplinary geriatric approach, home visits by medical specialists etc.), projects evaluating the diagnostic impact of symptoms and signs associated with diseases frequently occurring in general practice (such as urinary tract infections, gastro-intestinal blood loss etc.), and, finally, projects evaluating several ways of collaboration between general practitioners and medical specialists regarding specific diseases such as diabetes mellitus type II.

Also related to this fourth goal, a project regarding the optimal ways to exchange patient information between the Diagnostic Centre and general practice is in the process of development.

Evaluation

Over the years, in Maastricht an increasing number of activities aiming at strengthening both primary health care and the collaboration between general practitioners and medical specialists have been established.

These activities were incidental before the period of the Diagnostic Centre, but have thereafter increasingly been based on clear goals and plans, derived from these goals. A Steering Committee acts as a motor for a number of these activities.

Experience in Maastricht makes clear that it is impossible to make progress on the road to strengthening primary care and better relationships between general practitioner and medical specialist without the availability of additional manpower, time, energy and money. A lot of impeding factors are to be found on this road such as the low level of organization in the primary health care, the ivory tower mentality of many secondary care institutes, and the divergent interests of general practitioners and medical specialists.

As a summary, we have tried to formulate the conditions for successfully improving the collaboration between general practitioners and medical specialists as follows:

- good personal contacts between general practitioners and medical specialists;
- the presence of an institute for coordination and management;
- the presence of an active Steering Committee with a model func-

tion;

- structural contacts between clusters of collaborating general practitioners and medical specialists of various clinical departments;
- the development of procedure agreements and protocols with appropriate evaluation and feed-back systems;
- the establishment of facilities to support general practitioners in developing and executing specific health care management strategies;
- finally, active support from the staff of medical specialists, the association of general practitioners, the hospital administration, health insurance companies, and government institutions and officials.

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4.2. COLLABORATION FROM THE VIEWPOINT OF THE MANAGEMENT: EXPERIENCES FROM THE BLEULAND HOSPITAL IN GOUDA

L. Lodewick

Gouda, a town of 60.000 inhabitants, is the focal point of the Mid-Holland region which numbers about 200.000 inhabitants.

Mid-Holland is a predominantly agricultural area. It is served by approximately 80 general practitioners and about the same number of district nurses.

There are two hospitals, Bleuland Hospital being the larger with 430 beds and 55 specialists. By Dutch standards, the hospital provides a virtually complete package of services.

This paper deals with the activities undertaken by the Bleuland hospital in the field of collaboration between hospitals and general practitioners. Special attention will be paid to the role of the management in this proces and the bottlenecks for collaboration.

Motives for cooperation with general practitioners

Years of hospital experience have learned that the provision of health services does not stop at the hospital doors. It is for this reason that periodical consultations have been held for almost 15 years between the Bleuland hospital nursing unit and the district nursing unit over the transfer of patients and the steps to be taken to bring hospital care into line with subsequent care and vice versa.

At the national level, health care policy in the Netherlands is aimed at reducing hospital care and strengthening primary care. One possible way to achieve this is the opening of hospital facilities such as laboratories and X-ray department to general practitioners. Bleuland hospital has taken such priorities into account in forming its own hospital policy.

A final motive for investing a considerable amount of thought and energy in cooperation with general practitioners is to consolidate the position of Bleuland hospital. That is to say, failure to initiate and explore the possibilities for cooperation could undermine the credibility of the hospital in the long run.

The role of the hospital management in the collaboration process is threefold: not only should it support existing initiatives, it should itself be prepared to create the right conditions for nurturing and channeling the growing cooperation between specialists and

general practitioners.

Finally, management has an important role to play in monitoring the practical effects of the terms of cooperation agreed upon by professionals.

The "Bleuland hospital case" can serve as an example of how these objectives can be achieved.

Activities undertaken by the Bleuland Hospital

The first initiative of the hospital management was to set up an investigation among general practitioners and specialists into existing forms of cooperation, into their adequacy, into the need for changes and the willingness to invest time and energy in realising such changes.

This investigation was of considerable strategic importance, despite the fact that it did not reveal any spectacular new information.

After this inventory had been completed - it emerged that the general feeling was that changes and improvements were necessary and that the necessary animus was also present - , various initiatives were undertaken. They can be classified into three levels: macro, meso and micro.

At the **macro level** a symposium is held every year with the slogan, "Better Together and Together Better". The basic components of this symposium are:

- a high degree of self-study and work of the participants;
- small group discussions between general practitioners and specialists chaired by professional discussion leaders;
- consultations that, if possible, lead to concrete agreements. Moreover, the consultations provide an opportunity for doctors and specialists to become better acquainted with each other's point of view which is also regarded as important.

All general practitioners and specialists in the region are invited to the annual symposium. The participation is very large: about 70% of all doctors are present, equally divided between general practitioners and specialists.

Among the subjects that have been discussed on these meetings, the following recent examples can be mentioned.

- communication between general practitioner and specialist;
- arrangements made between general practitioner and specialists on supplying the patient with information;
- letters of referral and dismissal;

- boundary-lines between the competencies of general practitioners and specialists.

At the **meso-level**, every month a meeting is held between representatives of general practitioners and a certain specialism. Participants can submit items for the agenda beforehand. Minutes are taken at the meeting, and copies are sent to all general practitioners and the respective specialists.

Such meetings have already been held with representatives of all clinical and paramedical specialists. On average, 10 representatives of general practitioners participated.

A broad spectrum of subjects have been handled, e.g.:

- policy matters (abortion, first-aid policy, the availability of facilities for diagnosis)
- agreements on the division of responsibilities between general practitioners and specialist (for example in the case of heart patients and patients with breast cancer)
- agreements on the division of responsibilities between specialisms (between ear, nose and throat specialists and lung specialists, cardiologists and child doctors, and orthopaedists and surgeons).

At **micro-level** there is a project running at this moment between the five surgeons and the nursing staff of the surgical wards of the Bleuland Hospital and the general practitioners and nurses of a district health centre in Gouda with the slogan "Sooner home - better of?"

In this experiment post-operative care that would normally be given in the hospital is administered as a form of primary care.

Only a limited number of categories of patients are involved (for example, patients that would return home after gall-bladder operation on the third day). The experiment will be conducted for one year. At the end of this period the consequences of such shifts in care for the hospital and its specialists and for primary care will be assessed and the views of the patients on this initiative will be noted.

Finally, a particular initiative has been taken in this region concerning the treatment and care of diabetic patients. For several years the hospital has collaborated closely with health professionals (specialists, general practitioners, nurses, dieticians, pharmacists etc.) and patients to draw up a protocol for the diagnosis and treatment of diabetes. The protocol is intended for health care

professionals.

A second product of this initiative is an extensive information booklet for diabetic patients.

Both products will be presented in autumn at a congress and also at an information market for patients.

Evaluation

Finally, a word of warning about a number of serious bottlenecks and problems.

- Doctors participating in the various initiatives are under no form of mandate whatsoever. Arrangements and protocols drawn up by others are not followed automatically.
- The fact that general practitioners are only organized in a very rudimentary way may be an important factor in this. The motivation of those involved varies greatly from person to person; at the same time the level of motivation fluctuates over a period of time.
- Initiatives often lead to high expectations. If these are not fulfilled, frustration and even opposition to those who started the process follows. The resistance to new projects is thus increased, a consequence that must be avoided at all costs. For this reason, next springtime a congress for general practitioners and specialists will be organized in which all our projects will be evaluated.

APPENDIX

DRAFT PLAN OF WORK FOR THE NETHERLANDS
INSTITUTE OF PRIMARY HEALTH CARE (NIVEL)
AS A WHO COLLABORATING CENTRE IN PRIMARY HEALTH CARE

1. BASIS FOR COLLABORATION

- 1.1. Fruitful contact between the WHO Regional Office for Europe and the Primary Health Care Institute of The Netherlands (NIVEL).
- 1.2. NIVEL is the only institute in the European region engaged exclusively in PHC research.
- 1.3. Fields of expertise, longstanding experiences and research projects in health care research carried out by NIVEL are relevant for both national and comparative international purposes.
- 1.4. A majority of ongoing and planned activities of NIVEL are closely related to the activities of the Primary Health Care Programme of WHO's Regional Office for Europe.

2. MECHANISMS FOR COLLABORATION WITH WHO'S REGIONAL OFFICE FOR EUROPE

- 2.1. Conducting studies and research projects which are mutually agreed upon by the WHO Regional Office for Europe and NIVEL as well as applying the outcomes of the study reports. Note that all documentation and bibliography used for these studies should be made available to the Regional Office.
- 2.2. Providing expertise through institutional or individual activities (e.g. by consultants, temporary advisors, etc.) to WHO activities when requested (i.e. WHO meetings, studies, training activities, etc.).
- 2.3. Arranging and hosting meetings and training activities in collaboration with the Regional Office.
- 2.4. Producing and disseminating reports and other documentation/information concerning common activities.
- 2.5. NIVEL and WHO's Regional Office for Europe will negotiate their commitments on an annual basis.

3. PREVIOUS COLLABORATION WITH WHO'S REGIONAL OFFICE FOR EUROPE

- 3.1. NIVEL has participated, as a national centre, in the WHO study on Primary Health Care Development in the European Region (Phase I of the Study - national level) during 1986 and has presented a country contribution to the Study accordingly.
- 3.2. Dr. J. van der Zee, Scientific Director of NIVEL attended the First Consultation of the WHO Study of PHC Development in the European Region (23-25 April, 1986) which developed the Protocol for the above Study.
- 3.3. Dr. J. van der Zee, Scientific Director of NIVEL participated in the WHO Working Group on Information for PHC (Kuopio, Finland, 9-12 December 1986) and contributed to the WHO-publication (H. Vuori and M. Rimpelä eds) about this subject.
- 3.4. Mrs. J.M. Bensing, General Director, took part in the Marrakech-consultation about the European Research Action Plan in november 1985.
- 3.5. Dr. P.P. Groenewegen (Deputy Scientific Director) attended the WHO consultation on care for the disabled, Edinburgh 1986).
- 3.6. NIVEL has constantly kept the WHO Regional Office for Europe informed of the activities performed by the institute.

4. MAIN AREAS/DIRECTIONS FOR COLLABORATION WITH WHO'S REGIONAL OFFICE FOR EUROPE

(a) Short-term areas of collaboration (within the first 4 years)

- 4.1. Monitoring the development and implementation of PHC in European Region and exchanging information accordingly.
- 4.2. Research on selected PHC principles, e.g. equity, accessibility and acceptability, resource allocation according to needs, intersectorality, etc. as well as on supportive measures for PHC.

- 4.3. Identification of effective methods to serve population groups with special needs.
- 4.4. Integration of PHC, social and other related services at the community level.
- 4.5. Integration of primary, secondary and other levels of care as well as health care or health-related institutions in the system.

(b) **Long term areas/directions of collaboration**

- 4.6. Coordination of community resources with special reference to district infrastructure and function.

**LIST OF COLLABORATIVE ACTIVITIES
WHO'S REGIONAL OFFICE FOR EUROPE**

RELATED TO THE ACTIVITIES OF

**WHO/EURO'S PHC PROGRAMME OUT-
PUTS**

NIVEL ACTIVITIES

26.1.1 & 26.1.2:

An assessment of PHC roles and functions in representative countries of the Region and examples of policies and legislative, economic and structural measures adopted to strengthen PHC as the basis of the health care system.

(a) Country contributions to the Study on PHC Development in the European Region (Phase 2 of the Study - district level); 1987.

(b) Organization of the Second Consultation of the Study Group to develop and discuss the Protocol for Phase 2 of the Study (to be held in Utrecht, Netherlands, March 1987)

Responsible person: Dr. J. van der Zee, Scientific Director, NIVEL

26.1.3:

An assessment of the benefits of applying PHC principles and services in different countries of the Region.

(a) **Participation in the Final Consultation of the Study on PHC Development in the European Region to assess the usefulness of the application of PHC principles (to be held in Winter, 1987/88)**

Responsible person: Dr. J. van der Zee, Scientific Director, NIVEL

26.1.4.:

National debates on roles and functions of PHC in health systems by 1987 and ongoing to 1991.

(a) ongoing documentation of primary health care (1987-91) to be made accessible to the WHO Regionale Office in the form of study reports.

Responsible person: Dr. J. van der Zee, Scientific Director, NIVEL

26.2.1.:

Examples of improved collaboration between hospitals and PHC services.

(a) The interface between primary and secondary care in Europe (European intercountry Study) 1987. Contribution to be forwarded to the Regional Office.

Responsible person: Dr. J. van der Zee, Scientific Director, NIVEL.

27.2.1.:

Approaches to identify needs for services personnel and financial support for PHC.

(a) Remuneration and income of general practitioners (1987).

Responsible person: Dr. J. van der Zee, Scientific Director, NIVEL.

(b) Report on changing the payment system of general practitioners (1989).

Responsible person: Dr. P.P. Groenewegen, Deputy Scientific Director, NIVEL.

(c) International network of Sentinel Practices (1987). Exchange of information for international comparison.

Responsible person: Dr. A.I.M. Bartelds.

(d) Primary care information systems. Assessment of effectiveness of PHC information systems.

Responsible person: Dr. J. van der Zee, Scientific Director, NIVEL.

28.2.1.:

An identification of effective methods to reach and serve high risk, vulnerable and underserved groups and their implication for the provision of PHC services.

(a) National Study of morbidity and interventions in general practice (1988). Research reports to be submitted to the Regional Office.

Responsible person: Dr. J. van der Velden.

(b) Conference on chronically ill persons in the community (1990). Implementing the results of Dutch National Morbidity and Intervention Survey in general practice.

Responsible person: Dr. J. van der Velden.

(c) PHC and rehabilitation in the Community. Continuous research on the role of physiotherapy in the community. Research reports presented to the Regional Office (1987 and further).

Responsible person: Dr. P.P. Groenewegen, deputy Scientific Director, NIVEL.

(a) Participation in a Working Group and Integration of social and related services (1987)

Responsible person: Dr. D. Wijkkel.

(b) International Conference on Integration of health care and social work (1989). International exchange of conditions and obstacles for improving collaboration between health care and social work.

Responsible person: Dr. W.G.W. Boerma.

(c) Research report on evaluation of an experimental structure of PHC in a new town (1987).

Responsible person: Dr. H. Sixma.

30.1.2.:

Recommendations for coordination of health, social services and other sectors concerned with health-related matters at the local level.

OTHER WHO/EURO PROGRAMME OUTPUTS NIVEL ACTIVITIES

HOSPITAL PROGRAMME

26.2.2.:

An assessment of the impact of demographic, morbidity and social changes on the function and role of hospitals in the health care system.

(a) A comparative analysis of hospital admission rates (Report to be made available to the Regional Office by 1987).

Responsible person: Dr. P.P. Groenewegen, Deputy Scientific Director NIVEL.

HEALTH TECHNOLOGY ASSESSMENT PROGRAMME

31.2.4:

Quality assurance of health care and models to ensure appropriate care.

(a) Research report on PHC and technological innovations (1988).

Responsible person: Dr. P.P. Groenewegen, Deputy Scientific Director NIVEL.

(b) Research on cooperation with-in PHC and quality of care (1988).

Responsible person: Dr. D. Wijkel.

NURSING PROGRAMME

27.2.4:

Recommendations as concerning roles, functions and training in nursing, practice for PHC in European setting.

(a) Home nursing in Belgium and the Netherlands (1987). Report on changing needs in care of the elderly.

Responsible person: Mrs. A. Kerkstra, Ph.D.

(b) Conference (with international participation) on home nursing: international exchange of information about home-care systems (1989).

Responsible person: Mrs. A. Kerkstra, Ph.D.

DRAFT PLAN OF WORK

FOR THE

NATIONAL HOSPITAL INSTITUTE OF THE NETHERLANDS,
UTRECHT, THE NETHERLANDS

AS A WHO COLLABORATING CENTRE

FOR THE WHO PROGRAMME ON

HOSPITALS AND OTHER HEALTH INSTITUTIONS

1. EXECUTIVE SUMMARY

AGREEMENT

The National Hospital Institute of the Netherlands to become a WHO Collaborating Centre in the area of Hospitals and other health institutions.

PERIOD OF COLLABORATION

Initially for four years.

AREAS OF COLLABORATION

Initially:

- (1) long-term institutionalized care for the elderly;
- (2) hospitals in support of PHC-services;
- (3) organization of health services at district/regional level;
- (4) management of hospitals.

COLLABORATING CENTRE

The National Hospital Institute of The Netherlands
Oudlaan 4
Utrecht
The Netherlands
Tel.: 030 - 739911

HEAD OF THE
COLLABORATING CENTRE

The Head of the Collaborating Centre for the first designation period is:
Dr. Douwe van der Meer
Director
National Hospital Institute of the Netherlands

MECHANISMS OF
COLLABORATION

The main forms of collaboration between WHO and the Collaborating Centre will be as follows:

- (1) conduct studies mutually agreed upon by WHO and the Collaborating Centre and application of reports resulting from such studies;
- (2) provision of expertise by the Collaborating Centre to WHO activities as needed;
- (3) arrangement by the Collaborating Centre of meetings and training activities;
- (4) establishing a network of contacts within the Netherlands to extend the cooperation between WHO and national institutions with regard to the hospital and programme.

COMMITMENTS

The Collaborating Centre and WHO will have the following commitments within the limits of their own programmes and budgetary restraints. The commitments will be specified in the Plan of Work an negotiated annually.

The Collaborating Centre

- (1) manpower for studies, meetings and training activities agreed upon in the Plan of Work;
- (2) facilities and other necessary working conditions for personnel participating in activities included in the Plan of Work;
- (3) training facilities;
- (4) other resources needed for the successful completion of the activities included in the Plan of Work.

World Health Organization

- (1) seed money, if necessary, for the initiation of activities agreed upon as part of the Plan of Work;
- (2) recruitment of the representatives of the Collaborating Centre as consultants and temporary advisers when appropriate;
- (3) editing and reproduction of reports and documents resulting from the activities included in the Plan of Work in accordance with the established WHO policies and procedures;
- (4) dissemination of information concerning training activities organized by the Collaborating Centre;
- (5) awarding, when appropriate, fellowships to participants of training activities organized by the Collaborating Centre;
- (6) recruitment of consultants or temporary

advisers for training activities organized by the Collaborating Centre if needed;

- (7) facilitating the establishment of contacts between the Collaborating Centre and other bodies when necessary and appropriate;
- (8) providing the Collaborating Centre with appropriate WHO documents and other material.

WORKING LANGUAGES

English.

REVIEW MECHANISM

The review mechanism will consist of two parts:

- (1) annual reports by the Collaborating Centre to WHO and
- (2) annual or biennial review meetings between representatives of the Collaborating Centre and WHO. These meetings should preferably take place in Utrecht.

PLAN OF WORK

See section 3 of this document.

2. INTRODUCTION

The National Hospital Institute of the Netherlands (Nationaal Ziekenhuisinstituut - NZI), founded in 1968, has the objective to support the Dutch hospital health care institutions in their task to deliver to the population adequate, human and affordable health care. The NZI undertakes applied scientific research, counseling, training programmes and provides information for the health care institutions and public health in general.

The NZI is a project organization in the form of a foundation with approximately 120 staff members. It collaborates closely with the National Hospital Council which is the association of all hospitals in the Netherlands. Nine board members of the NZI have links with the National Hospital Council. The other four, including the president, are independent. All board members are appointed by the National Hospital Council.

The NZI concentrates upon a great variety of activities which are carried out by health services, in particular hospitals and other health institutions, focussing on the following:

- cost containment;
- regional health planning and cooperation;
- quality and effectiveness;
- care of the elderly;
- strategic management.

2.1. Enhancing the development of health services at large (including counseling)

The NZI works on allocating the various functions of health care (in-patient and out-patient services) to the appropriate levels whilst clarifying the responsibility of the government at national, regional and municipal level. Advice and information on strategic management is supplied to the Government and the Hospital Association. The NZI supports the Hospital Association with regard to their contribution in the process of law-making and development of financial systems. Advice sought from the NZI by individual hospitals is supplied on request.

2.2. Conducting training activities

The NZI organizes frequent training courses, such as:

- post academic courses on the relation between policy-making and organization of health care;
- general management courses;
- internal management intended for heads of departments;
- courses for medical specialists;
- courses for head nurses;
- training courses on specific subjects.

2.3. Quality and effectiveness

Various activities dealing with quality and effectiveness are underway which aim at stimulating effective control of the quality of care and the effective use of resources. These include the work of nurses and out-patient care in general.

2.4. Care for the elderly

One of the research projects underway deals with the functioning of geriatric departments in general hospitals. Another research project is concerned with the functioning of all services dealing with the care for the elderly (hospitals, nursing homes, community-based care, self-help and mutual care activities). Geriatrics in hospitals is considered an important issue by the NZI.

2.5. Cost-containment

Several activities being undertaken by the NZI aim to find ways and the consequences for the most cost-effective treatment of patients whilst being involved in experiments concerning the financing of health services at the different levels. Activities include:

- analysis of the consequences of the ageing of the population for developments in the need of care;
- experiments with a system of cost calculation, which can be used for internal decision-making about allocation of resources to fulfil patient care functions.

2.6. Other directions

Psychiatry and the problems of the mentally retarded are the most important issues amongst the other activities carried out by the NZI.

3. PLAN OF WORK

Collaboration will start in the following areas:

Initially:

- (1) long-term institutionalized care of the elderly;
- (2) hospitals in support of PHC-services;
- (3) organization of health services at district/regional level;
- (4) management of hospitals.

3.1. INITIAL COLLABORATION

3.1.1. Long-term institutionalized care of the elderly

Related Regional Office Objective and Output:

Objective 27.1. To support Member States in organizing the infrastructure of health service delivery systems so that they meet the expressed needs of the community and involve them in the provision of health care.

Output 27.1.1. Examples of integrated services for long-term health care and involvement of families in care by 1988.

NZI Activities:

(a) Country contribution to the study on institutionalized long-term care (1987)

Person responsible: Dr. Martin Boekholdt.

(b) Compilation of overall study on institutionalized long-term care (1988).

Person responsible: Dr. Martin Boekholdt.

(c) Hosting Working Group on coordinating long-term institutionalized care especially with regard to efficient interaction with PHC and reintegration of patients into their communities and families (1988).

Person responsible: Dr. Martin Boekholdt.

(d) Follow-up action according to the recommendations of the above-mentioned Working Group (1989-1990).

Person responsible: Dr. Martin Boekholdt.

(e) Information in this area on pilot activities in the Netherlands (1988/89).

Person responsible: Dr. Martin Boekholdt.

3.1.2. Hospitals in support of PHC-services

Related Regional Office Objective and Output:

Objective 26.2. To promote more effective support from secondary and tertiary care levels to the primary health care system.

Output 26.2.1. Examples for improved collaboration between hospitals and PHC services by 1988.

NZI Activities:

- (a) Participation in network of institutions on monitoring and facilitating the support of hospitals to PHC-services (1987 and ongoing).

Person responsible: Dr. Vincent Baalman.

3.1.3. Organization of health services at district/regional level

Related Regional Office Objective and Output:

Objective 27.1. To support Member States in organizing the infrastructure of health service delivery systems so that they meet the expressed needs of the community and involve them in the provision of health care.

Output 27.1.2. Recommendations on the advantages of regionalization of services, and the integration of hospitals and other health care institutions by 1989.

NZI Activities:

- (a) Country contribution to the study on the organization of health services at district/regional level (1987).

Person responsible: Dr. Vincent Baalman.

- (b) Participation in Consultation on the organization of health services at district (regional) level (1988/89).

Person responsible: Dr. Vincent Baalman.

- (c) Preparation of a paper on the allocation of functions in hospital care (including the role of small hospitals) based on the experience of the Netherlands (1987).

Person responsible: Dr. Eddy Riegen.

3.1.4. Management of hospitals

Related Regional Office Objective and Output:

Objective 27.3. To stimulate Member States to improve the efficiency of the management of health centres, hospitals and other health institutions as part of comprehensive health services.

Output 27.3.1. Recommendations on improved data collection for planning and managing health care and resources from 1987.

NZI Activities:

(a) Participation in Working Group to review information needs for management decisions in hospitals and to make recommendations for appropriate use of information systems (1987).

Person responsible: Dr. Johan Lettink.

Output 27.3.5. An analysis of the impact of medical decision-making on hospital costs and efficiency (by 1990).

NZI Activities:

(a) Country contribution to the study on cost-combatting strategies in the hospital sector (1987).

Person responsible: Dr. Johan Lettink.

(b) Follow-up of the development concerning the interaction between the work of doctors and the economic aspects in hospitals (ongoing until 1990).

Person responsible: Dr. Gijs van Lammeren.

Output 27.3.6. Management models at clinical level by 1989.

NZI Activities:

(a) Preparation of a paper on new methods of management of hospitals, based on the experience of the Netherlands (1988).

Person responsible: Dr. Vincent Baalman.

(b) Participation in Consultation on models related to medical and nursing clinical decision-making in hospitals (1989).

Person responsible: Dr. Vincent Baalman.

LIST OF PARTICIPANTS

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