

## Chapter 43

# Facilitating Continuous Improvement in Patient Care in a Dutch General Hospital

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### ABSTRACT

The economization of care has infiltrated the political and private domain, accessibility versus economically efficient distribution of resources. The hospital had to adapt to these developments. Implementing principles did not lead to sustainable improvement. A more systemic approach was chosen to create more value to patient-care. Involved as a head nurse, the author describes this process of organizational change on the basis of a case history of an orthopedic ward in a hospital in the Netherlands.

### INTRODUCTION

This reflective case history starts with describing a major organizational change in a general hospital in the Netherlands over a long period of time extending from 2003 to 2017. Prior to merging with another hospital in 2016, the hospital had a capacity of about 500 beds and a staff of 3200 employees. After the merger the hospital became twice as big. Dutch healthcare organizations are embedded in an increasingly complex environment, directly influenced by the social and political processes of liberalization, individualization, economization, and globalization (Schnabel, 2004; Klaveren, 2016). Besides the fact that individual Dutch and European citizens are more demanding with regard to their 'consumption' of healthcare, there are also national and international conventions (European Union) defining qualitative and quantitative standards for cure and care. "Economization is the growing dominance of financial

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and economic thinking in healthcare" (Van Hout & Putters, 2004, p. 130). In the Netherlands, from a political point of view, healthcare is a common good and has to be accessible to all people. At the same time the restricted national budget demands a more equitable or economically efficient distribution of resources (Berden, Houwen, & Stevens, 2015). Nationwide, the quantitative and qualitative demand for healthcare keeps growing. The reasons for this growth in demand are diverse and include:

- The explosive population growth after World War II. The large group of people belonging to the post-war baby boom generation is ageing and increasingly dependent on care;
- More extensive possibilities for cure and care under the influence of scientific, medical, and technological developments.

From both quantitative and qualitative perspective, it is the combination of politics, individualization, and the increase in patient interest groups that makes people claim the best affordable care (Putters, Breejen, & Frissen, 2009).

## **EVIDENCE-BASED OCD INITIATIVE**

### **Triggers for Change**

Hospitals have been subject to intensive reorganization. In the past few decades the public healthcare system has absorbed and adapted to a neo-liberal government agenda that promotes more 'efficient and effective' use of public funds, and increased involvement on the part of the private sector (Rankin & Campbell, 2009, on Canadian hospitals which are highly comparable to the Dutch situation). Increasing demand and costs means that healthcare is not available under all circumstances. The main goal of the healthcare system, to keep cure and care accessible to all citizens, is threatened by growing demand and increased costs. From the late 1990's, hospitals in the Netherlands were focused on a new way of financing healthcare and introducing a market orientation. The government had initiated a new way of funding healthcare by gradually introducing the concept of combining diagnosis and treatment ('Diagnose Treatment Combination', 'Diagnose Behandel Combinatie': DBC). Treatment was linked to a specific illness, and the costs of diagnostics and therapies were the subject of negotiation with health insurance companies who had to fund this care for their customers. Within the hospital budget, 70% of care has been funded in the historical way and 30% negotiable through the DBC method. At the same time, some types of cure and care are no longer being automatically paid for. People have had to fund these 'types' out of their own income or look for extra additional insurance for those particular types of treatment. Healthcare has become a trade-product with all the economic consequences that that entails. In 2010, this on-going economization of care was limited by government to its current level of 70/30%. In 2012 a new system was adopted with an even stronger market-orientation.

### **Change From a Technical Linear Approach**

Over the years the hospital implemented several projects to accomplish more efficient, patient-centered, accountable, and profitable care. The hospital started in 2003 in a very technical, top down kind of a

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