

130: ECONOMISATION OF QUALITY IMPROVEMENT ASKS FOR SUPPORTIVE FINANCIAL INCENTIVE STRUCTURES - RESULTS OF THE APPLICATION OF A QUALITY/COST MODEL IN 5 DUTCH HEALTH CARE INSTITUTES

Custers T., Bouwmans C.A.M., van Ineveld B.M., Bandel A.P., Sol J.C.A., Klazinga N.S.

Objective:

To evaluate the applicability and added value of a quality/cost model as part of quality improvement efforts in Dutch health care institutes.

Methods:

A quality/cost model was developed and pilot tested on the process of cataract surgery in the Rotterdam Eye Hospital between 1994 and 1997. The model links quality improvement efforts with costing through a systematic calculation of failure costs related to suboptimal performance on pre-set process and outcome indicators. The further application and added value of the quality/cost model was tested between 1999 and 2002 in four hospitals and a rehabilitation centre. The model was applied on the following care pathways:

- treatment of patients with a columnfracture (Reinier de Graaf Hospital, Delft)
- anorectal malformations in newborns (Sophia Children Hospital, Erasmus MC Rotterdam)
- glaucoma treatment (Rotterdam Eye Hospital)
- mamma care (Elisabeth Hospital Tilburg)
- rehabilitation programme backpain (Roessingh Rehabilitation Centre)

Every institute went through a process during which the pathway was described in detail, indicators on medical effectiveness, efficiency and patientcenteredness were identified, costs related to indicator non-compliance were calculated, based on the first findings improvement actions were undertaken and end-results were measured. Apart from on-site support, regular meetings were held with all participating institutes and the two university groups that provided the support. Activities were evaluated both on programme and project level.

Parallel to the action programme a systematic analyses was made of the accounting and financing mechanisms in Dutch health care institutes and their potential impact on quality improvement efforts.

Results:

Four out of five institutes were able to complete the whole project. The quality/cost model proved to be applicable and failure costs (5 – 10% of the pathway costs) could be calculated and reduced through quality improvement efforts. The financial information proved helpful in convincing management of the use of quality improvement efforts and was in general seen as useful. However, calculating the costs proved a tedious job and in most institutes the accounting mechanisms were not detailed enough to provide the cost-data without additional measurements on time and resource use. It also became clear that the organizational structure, the internal accounting mechanisms and the overall reimbursement schemes of the hospitals provide adverse incentives towards changes that are both effective and efficient from the perspective of the primary care process. All participating institutes were looking for more effective ways to link quality improvement with cost accounting and finding a way were improvement of effectiveness, efficiency and patient centeredness is also worthwhile in monetary terms.

Conclusions:

A model that integrates the management efforts on both quality and costs proved to be applicable in care processes in Dutch health care institutes. However, present accounting mechanisms are not detailed enough yet to enhance systematic use and the incentives in the present financing systems are hindering synergy between quality goals and economical goals of the institutes.