

## Ambulance care in the Netherlands

### Report 'Ambulances in sight 2006'

Management information (MI) is used for various purposes: policy and directing the individual organisation, data comparison and accountability, both internally and externally. In addition, a quality boost is expected. Ambulancezorg Nederland (Dutch Ambulance Care) opted to limit the set of data – which has to be measured and registered by all organisations in the same way – and to extend it gradually over the years. In 2006, the focus was on the logistics of the primary process and the personnel data. From 2008, the set will be extended to include medical details and to register incidents of aggression. The 2006 report may be considered a zero measurement. It is the first time within ambulance care that data has been collected at sector level for a report. The data is still in the process of development, the reliability and quality are not yet optimal. All organisations use the same definitions and measuring plans for registering data, but differences may occur because varying working methods are used in the regions.

#### The process of ambulance care

Ambulance care is provided on the instructions of the Ambulance Care Dispatch Centre (MKA). Patients are treated and transported, if necessary, to a care institution or to the patient's home address. Ambulance care is mobile care, it is subject to great varieties of urgency and planability, and relates to both the type of care indicated by the MKA and the care provided by the ambulance crew.

The sector has been awaiting the Dutch Ambulance Care Act [*Wet ambulancezorg – WAZ*] for some years. In accordance with this Act, the Regional Ambulance Service [*RAV*] is the designated organisation type for ambulance care. In anticipation of the Act, the sector is working towards creating RAVs throughout the Netherlands. These have now been set up in 18 of the 24 regions.



RAVs may be organised as both public and private-law bodies. The B3 foundations [*B3 stichtingen*] are also private-law bodies and follow the municipal collective agreement [*CAO*]. The public-law RAVs are based on a joint arrangement, the private-law RAVs are almost all foundations. As a result of these differences, there are various employment condition regimes in the sector. The public-law RAVs and the B3 foundations follow the municipal collective agreement, the private services have their own collective agreement. RAVs work closely with partners in the emergency care chain and with partners in the public order and safety chain. In the past decades, the sector has undergone huge developments. In 1976, there were still 236 services with 767 ambulances. In 2006, there were 34 ambulance care organisations with 668 ambulances. In the intervening years, the focus has shifted from transport to care.

#### Underlying conditions

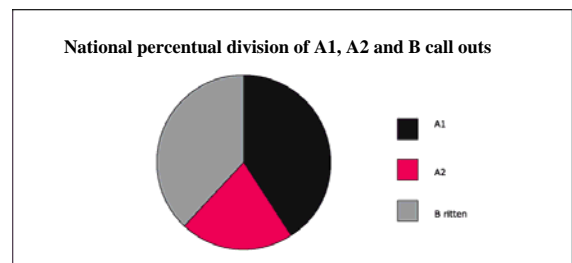
The ambulances available in the Netherlands are not all in use at the same time. Some are reserve capacity and are used during maintenance, damage and in the case of disasters and large-scale accidents. Every RAV region has a number of stations, and the ambulances are divided among these stations in order to spread the available capacity within the region to best effect. In late 2006, there were 190 ambulance stations in the Netherlands. In that year, nurses, drivers and MKA dispatchers were scheduled to provide ambulance care for more than 2.9 million hours.

## Production

Production is understood to mean the number of call outs handled by the ambulance services. In 2006, that total was almost 950,000. More than 80% (751,114) were claimable (call outs for which ambulance organisations conclude production agreements with health insurers). Urgent call outs made up 62% of the total.

## Performances

In 2006, ambulances took an average of 10 minutes to reach the patient following the report of an incident in the case of A1 urgency. For A2 calls outs, that was an average of almost 17 minutes. Attention is often focused only on how many call outs were carried out within the set standard and how long the call out took. This response time includes three elements: the time for accepting the call and issuing instructions, the turn out time and the travelling time.



Scope of A1 calls out in 2006 per RAV region

The ambulance care sector has imposed the standard 'at the scene within 15 minutes' under normal circumstances (A1). This is a planning standard rather than a care standard. Reaching patients within 15 minutes is not possible in every case. The standard is used to determine how many ambulance stations are required in the Netherlands, where they must be located and how many ambulances must be available. In an average of 91% of A1 call outs, the ambulance was at the scene within 15 minutes, irrespective of the circumstances. For A2 call outs, that figure is 92% (at the scene within 30 minutes).

## Personnel

Ambulance care is a small sector involving specialised personnel. In 2006, there were just over 4400 staff 3,900 worked as nurses, drivers of MKA dispatchers. The inflow, step-up and outflow within the sector are low. This is particularly due to the limited possibilities for function differentiation. In addition, research has shown that staff are content and do not readily leave the sector. That is the result of the extent to which they can work independently and the variety of work.

## Working conditions

In the context of the ambulance care health and safety agreement [*Arboconvenant Ambulancezorg*], which applied from April 2004 to July 2007, a great deal of attention was paid to absenteeism due to illness within the sector. The objectives of the health and safety agreement have been achieved. However, a focus on working conditions remains important. Average absenteeism in 2006 was 5.1%.