

Reforms and their influence on behaviour

The influence of reforms in the Dutch Healthcare sector on
managerial behaviour of general hospitals



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Management Summary

The Dutch healthcare sector develops quickly in recent years in order to increase efficiency by promoting competition in the hospital market place. However, it is unfamiliar what the consequences of those rapid and complex changes in the structure of the medical specialised care sector are for players within this sector. The goal of this thesis is to investigate what those developments mean for hospital managers' behaviour. This lead to the following problem statement: *Does and to what extent does reforms in the Dutch healthcare sector influence hospitals managers' behaviour?*

This cross-sectional study can be seen as an explanatory research which tries to identify causal relationships between independent variable 'industry structure' and dependent variable 'managerial conduct'. The SCP theory proves the theoretical relationship between these variables. This paradigm states that organizational conduct, firms' policies and strategies, is a function of industry structure (Andreosso & Jacobson, 2005; McWilliams & Smart, 1993).

In order to analyse structure on a more detailed level, the author uses Campbell's governance mechanism typology (Campbell, 1991). These governance regimes, combinations of specific organizational forms, are intervened by the State through its capacity to ratify or undermine new governance regimes (Campbell & Lindberg, 1990).

Chapter three presents the theoretical framework of this thesis. Due to the specific character of this study not all governance regimes fall within the scope of this research. The research area can be divided in two variables: the current transition phase in the healthcare sector; and the managerial behaviour of general hospitals.

The author selects four conduct factors which are relevant for this research. This selection, based on internal (NZa) interviews, consist of the elements business strategy, product choice, investments and internal organization. These factors might be influenced by several reforms in the current healthcare funding and financing.

Namely, Dutch hospital financing underwent considerable changes in order to transfer from traditional function-oriented budgeting to full performance payment (De Jong & Mosca, 2006). The introduction of the DBC system (2005) launches several governance policies in

the period 2005-2009 resulting from changes in legislation (NZa, 2009b). However, these measures create less desirable effects in current care funding. First, dual incentives arise due to the availability of two different funding systems (DBC and FB). The second dimension deals with the uncertainty regarding the sector's end perspective.

The author interviews nine hospital managers on CEO level in order to identify whether hospital managers are influenced by the negative consequences of the funding situation. Besides that, the author uses some validation instruments to maximize research reliability.

Regarding the conduct elements 'business strategy' and 'product choices', there is a homogeneous view that hospital behaviour is not influenced by dual and uncertain elements in current funding. Concerning the investment question and internal organisation, hospital managers can be divided in two groups based on the way how managers face funding uncertainties, namely progressive frontrunners and reactive laggards. The group to which managers belong heavily depends on manager's personality.

The overarching conclusion of this study, and answer on the problem statement, is that dual incentives in current funding, despite its impeding character, do not influence managerial behaviour fundamentally. However, future funding uncertainties do influence behaviour significantly, resulting in different managerial groups.

Therefore, creating clearness can be seen as the most important managerial implementation towards healthcare policymakers. Besides that, policymakers should take a less prominent position in order to give proactive hospitals more freedom to act like business companies.

This study focuses on unidirectional relationships between structure and conduct what can be seen as a limitation of this research. Namely, the SCP model develops during the time towards a model with interrelationships in different directions. Another limitation is the absence of one general conduct theory and the absence of the scientific support how these factors are selected. Finally, the use of interviews as tool to collect information limits results' reliability.

An interesting area for future research could be the question whether or not managerial background influence current managerial behaviour. Next to it, it could be interesting to pay attention to the relationship between hospital's performance and managerial behaviour.

Preface

This master thesis is written in order to complete the master program ‘Strategic Management’, offered by the Department of ‘Organisation and Strategy’. In order to write a master thesis, I did an internship at the Dutch Healthcare Authority (NZa) for four months. The link between strategic management and the Dutch healthcare sector might be unclear at first glance. However, the Dutch healthcare sector is in a transition phase towards regulated competition nowadays. Part of my research study is to investigate what those current reforms in a sector means for the organisation and management of players in this specific sector. From that point of view the link between my master thesis and master program might me more obvious.

I hope that this thesis will provide useful insights for policymakers and other stakeholders and will answer some important questions about the consequences of the current funding situation in the Dutch healthcare sector and the reforms already done last years.

Besides that, this preface gives me the opportunity to pronounce my appreciation to some people who supported me during the writing of my thesis and made it possible for me to do this study. Without their insights and knowledge this master thesis would not have been the same. First of all, I would like to thank my first supervisor, Professor Dr. Richard Janssen, for his support and guidance during my writing process and his useful comments on my thesis. Furthermore, I would also like to thank my second examiner, Professor Dr. Bert Meijboom. Besides that, I want to thank the Dutch Healthcare Authority (NZa) for offering me an internship in order to enable me to do this research. In particular, I would like to thank Mr. Marcel Vrijhoeven and Mrs. Neeltje Polman for their support during my internship, their advices, evaluations, time and collaboration in this four months period. Finally, I would like to thank my respondents for their time and cooperation.

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Chapter One – Introduction

1.1 Introduction

This chapter starts with a problem indication to sketch the problem area for this thesis. This will result in a problem statement which is split up into a number of research questions to answer the problem statement subsequently and gradually. When the research questions are formulated a paragraph is dedicated to the research design and data collection. This chapter ends with an explanation of the structure of this thesis.

1.2 Problem indication

Since the introduction of the DBC system and the freely negotiable B-segment in 2005 as well as the introduction of the Healthcare Insurance Act (ZWV) in 2006, the central governmental control of the Dutch care system, which has traditionally a non profit character (Meijboom et al, 2004), is gradually replaced by a decentralised system of regulated competition (NZA, 2009a; Meijer et al, 2010). This transition has to increase efficiency by promoting competition in the hospital marketplace (Douven et al, 2007; Den Hartog & Janssen) as a solution for the pressure on the labour productivity, considerable expansion of the care demand and the ageing society (Heuvel, van den; 2010). It is necessary to transfer from the traditional system of function-oriented budgeting (FB) to full payment for performance gradually and in a controlled manner so that risks remain minimal and predictable (NZA, 2008b).

Consequence of the current stadium of the transition is a dual situation in funding within the medical specialised care (NZA, 2009b), what results in risks concerning stability, continuity and dynamic of the sector (NZA, 2008b). An obvious governmental vision with regard to the composition and speed of introduction of the end model of full payment for performance is crucial since it creates regulation certainty (NZA, 2008b). However, the fall of the Dutch Cabinet and the dissension with regard to market-based healthcare reforms (Blijker, den; 2010) cause more delays and result in a situation that full payment for performance will not be realised on the short term (Douwes & Herderschee, 2010; Nederlands Dagblad, 18 March 2010). Performance payment is not completely cancelled, but the further perspective is ambiguous nowadays (Zorgvisie, 24 March 2010).

The SCP theory states that changes in industry structure influence managerial conduct (Porter, 1981). As a result of impressive changes in the healthcare sector, care institutions continue to

face a turbulent environment (Swayne et al, 2008, pp. 6). This makes the question how hospital managers deal with rapid and complex changes in the industry structure more relevant.

1.3 Problem statement

The goal of this thesis is to investigate what the current market conditions of the Dutch healthcare sector mean for the conduct of hospital managers. The problem statement which results from this is:

Does and to what extent does reforms in the Dutch healthcare sector influence hospital managers' conduct?

By reforms the author means the Dutch regulation regime in the current transition phase in the healthcare sector. 'Hospital managers' refer to managers of the Dutch general hospitals. By 'to what extent' the author means what could be factors which explore some behaviour of hospital managers. This research is a cross-sectional study since it will explore current behaviour. In this research, it is assumed that the data supplied by hospital managers are reliable and honest. So in sum, this research tries to explore the managerial behaviour of Dutch general hospitals in a situation of transition.

1.4 Research Questions

To solve the problem statement, the following five research questions must be answered subsequently. The first two questions are theoretical in nature, while the following three questions are more practical.

- 1. What is the theoretical relationship between structure and behaviour and how is it developed over time?*

This question can be used to indicate on a theoretical way how industry structure is related to firms' conduct. After that, there will be explored what this means for this investigation.

- 2. Which conduct factors are applied to hospital managers?*

This question has to be answered in order to indicate which conduct elements are relevant for this research.

3. *What is the current structure of the healthcare sector and to what extent is it restructured?*

By answering this research question an overview is given which structure elements could be related to managerial conduct. Besides that, this question describes the reforms in the healthcare sector.

4. *How do hospital managers react on current market conditions and how did they react in the situation before restructuring and how do they will react in the future after restructuring?*

This research question can be answered after having interviewed hospital managers. By a count-effectual way, the managers are being asked how they react to the current market conditions and how they should have reacted before and after restructuring.

5. *What does this mean for the healthcare sector?*

By answering this research question it will be clear what the managerial conduct of Dutch hospitals means for the healthcare sector.

1.5 Feasibility

This research intends to provide an insight on the influence of the healthcare reforms on managerial conduct. Market structure is identified as independent variable, while conduct is categorized as dependent variable. So, the structure can be seen as the context used to explore managerial conduct. This research is explanatory in nature because it tries to identify causal relationships between variables (Saunders et al, 2009; pp. 140). It is a cross-sectional study since the project is time constrained. Longitudinal elements are included to compare situation specific results. Cross-sectional studies often make use of the survey strategy (Easterby-Smith et al., 2008). For this research a survey is used to identify conduct of hospital managers and to explore the relationship with current market conditions. Data collection by means of a survey is useful to produce models of relationships between variables (Saunders et al., 2009; pp. 144).

The data source used to answer the problem statement is based on internal and external secondary data, as well as on primary data received from interviews with hospital managers. This external secondary data, available thanks to earlier appeared research, is collected from the online database of the Tilburg University. To be sure that data sources are reliable, top

journals are selected to tackle the problem statement. Key searching words, like ‘healthcare’, ‘structure’, ‘SCP’ and ‘governance mechanisms’, were used to find academic papers in databases like ABI/Inform, ScienceDirect and JSTOR. When reliable research papers are found, using the snowball method will provide other reliable research papers. Besides that, internal secondary data published by the NZa is used to answer some specific research questions related to the healthcare sector.

Qualitative primary data is collected since the problem statement has a specific character and not much is known about this topic. Data will be collected by means of semi-structured interviews because organizational context will influence the relevance of some questions. This means that central interview topics, related to the variables in the theoretical framework, are prepared. These topics are like a manual for the interview, but leave the option open to ask questions on other relevant topics as well. Specific information about the external environment of a particular general hospital is used as background information in interviews.

1.6 Structure of the thesis

Chapter two and three will answer the first research question and will present the theoretical framework. Chapter four will pay attention to the second research question. After that, the research questions are more amplified to the healthcare sector. Chapter five will deal with the current reforms in the healthcare sector. After a methodological chapter, Chapter six, Chapter seven will answer the fourth and fifth research question. After answering all research questions, Chapter eight will give conclusions of the findings, pays attention to the research limitations and will give recommendations for further research. At the end of this document the references and appendices are enclosed.

Chapter Two – The SCP paradigm

2.1 Introduction

This chapter will be used to indicate the relationship between structure and conduct on a theoretical way. Section 2.3 will explain the SCP paradigm and the elements it consist. Section 2.4 will clarify the causality between these variables followed by the role the Government plays in Section 2.5. Section 2.6 will summarize this paradigm and explain the role this paradigm plays during this research.

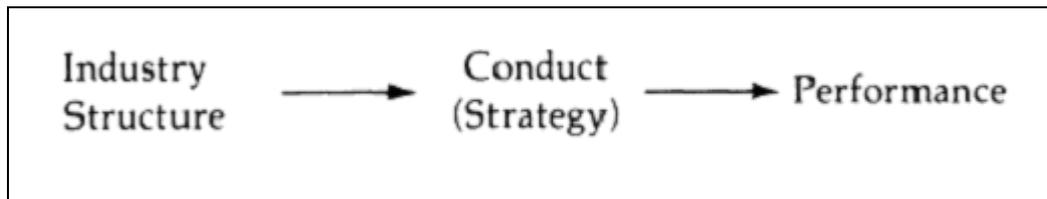
2.2 History

The Dutch healthcare reforms increased competition into the hospital marketplace (Douven et al, 2007; Den Hartog & Janssen). The competition concept, used by large number of economists in a variety of different ways, can be divided in three broad traditional conceptions of competition, namely the industrial organization (IO), Chamberlinian and Schumpeter economic version (Barney, 1986). The IO economic version, emerged during the 1950s and 1960s (Andreosso & Jacobson, 2005, pp.13), is incorporated most completely into current strategy theories (Barney, 1986). Industrial Organization was essentially emerged as an empirical study centred on the SCP paradigm (Andreosso & Jacobson, 2005, pp. 13), a model initially developed by Mason in 1939 and Bain in 1956 (Barney, 1986). The basic concept of this model, firm returns are determined by the industry structure, is fundamentally unchanged since the introduction.

2.3 SCP paradigm

The SCP paradigm, initially build up to support Government policymakers in formulating economic policy (Barney, 1986), is used to study economic sectors (Den Hartog, 2004). The basic point of the SCP paradigm, illustrated in Figure 2.1, is that industry performance is a function of organizational conduct, which is a function of industry structure (McWilliams & Smart, 1993). The exogenous industry structure determined the endogenous behaviour of firms; and the conduct of these firms jointly determined the collective performance (Porter, 1981). It is a systematic model for measuring the nature of industry competition.

Figure 2.1: The Traditional Bain/Mason Industrial Organization Paradigm



Source: Porter, M.E. (1981). *The contributions of Industrial Organization to Strategic Management*, The Academy of Management Review, 1991, No. 6, pp 609-620.

2.3.1 Structure

Industry structure, the determinant of conduct, means the context in which competition is occurred and consists of relative stable economic and technical dimensions of an industry (Porter, 1981). The traditional model includes three main structure elements, namely degree of buyer and seller concentration; conditions of entry and exit; and the degree of product differentiation (Andreosso & Jacobson, 2005, pp. 96). Porter (1981) and Barney (1986) add the number and relative size of firms, as well as the overall elasticity of demand. McWilliams and Smart (1993) add the number and size of buyers and sellers; extent of vertical integration; and technology.

2.3.2 Conduct

According to the SCP paradigm, the development of organizational generic strategies is a function of specific industry structure characteristics (McWilliams & Smart, 1993). Various elements of market structure influence price and production policy of individual firms (Mason, 1939). Conduct, the policies and strategies of firms (Andreosso & Jacobson, 2005, pp. 13), refers to activities of industry buyers and sellers, whereby sellers' activities include installation and utilization of capacity, research and development, pricing and promotional policies, and interfirm competition or cooperation (McWilliams & Smart, 1993). According to Porter (1981) conduct refers to the economic dimensions of firm strategy and consists of key decision variables such as quality, price, advertising, and capacity. Andreosso and Jacobson (2005, pp. 13) mention strategic alliances with other firms as conduct variable.

Mason (1939) explores that structure of markets results in differences in firms' behaviour including price, production and investment policies. Organizational behaviour could be divided in proactive styles and reactive styles (Miles et al, 1978). Reactive styles lack response mechanisms to face with a changing environment.

2.3.3 Performance

Economic performance is a broadly defined element which could be measured in terms of welfare maximization (McWilliams & Smart, 1993), profitability and efficiency (Andreosso & Jacobson, 2005, pp. 13) or in sense of social performance or innovativeness (Porter, 1981). Analyzing performance means an evaluation of market's conduct results (Delorme et al, 2002), because performance referred to the success a firm obtained in a market or industry (Panagiotou, 2005). Caves (1987) defines four criteria to analyse market performance, namely efforts to maximize consumer welfare, quality and diversity improvements of technology and goods, price and employment stability and producing an equitable distribution of products among customers with different needs.

2.4 Causality

A crucial aspect of the SCP paradigm is that if direction of causality was assumed from structure to conduct to performance (unidirectional causality), conduct could be ignored and directly could be looked to how industry structure influences performance (Porter, 1981). Firm behaviour is inherently treated as a black box (Thomas & Pollock, 1999). This relationship between structure and performance is derived from the microeconomic model of perfect competitive markets (Mc Williams & Smart, 1993).

However, the paradigm develops from a unidirectional causality in the early work towards an acceptance of the possibility that structure, conduct and performance are interrelated in different directions (Andreosso & Jacobson, 2005, pp. 14). Namely, more recent studies have disagreed with the narrow perspective and recognize a feedback effect in which performance affects conduct, while structure is affected by firm's conduct (Delorme et al, 2002). Firms could focus on adapting or creating characteristics of industry structure to obtain higher than normal economic returns (Barney, 1986). By attempting to drive out existing firms or by creating higher entry barriers to entrants, for instance with price or product policies, firms will affect rivals and suppliers and so market structure (Delorme et al, 2002).

Besides that, different groups of firms can exploit different structural elements of the same industry (Barney, 1986). The strategic group perspective, a set of firms that modify or exploit similar structural characteristics of a typical industry, argues that firms' strategic behaviour influences both the performance of an industry as the structure in which strategic groups are formed (Thomas & Pollock, 1999). So, the SCP paradigm remains the dominant model in

industrial economics, but most SCP work is much more open to different directions of causality nowadays (Andreosso & Jacobson, 2005, pp. 14).

2.5 State

Panagiotou (2005) recognizes a Governmental role in which public policy influence performance, structure and conduct by regulation, international trade rules, competition laws or taxes and subsidies. By focusing on structural characteristics of industries, Government policymakers can design regulations resulting in socially optimal intra-industry competition levels (Barney, 1986). The Government can wield influence to the market from social point of view, but contrary industrial organisations could oblige the Government to regulation or deregulation (Den Hartog, 2004, pp. 11).

2.6 Conclusion

In sum, the SCP paradigm considers conduct as a function of industry structure. Den Hartog (2004) already investigates relationships within the SCP paradigm related to the healthcare sector, but minimized the Governmental role in his research, a difference with this research. This research will investigate the role of Dutch Governmental healthcare reforms for managerial conduct of general hospitals. Therefore the author will just focus on unidirectional causality between structure and conduct. However, industry structure is influenced by market behaviour on the long term (Den Hartog, 2004, pp. 11). Therefore research results of this study will be used as a feedback tool to Dutch Government policy. The next chapter captures structure with support of the governance mechanism theory.

Chapter Three – The Governance Mechanisms typology

3.1 Introduction

In the previous chapter the SCP paradigm is elaborated and there is notified that this research is focused on the relationship between structure and conduct. In this research, the structure is theoretically captured with support of the governance mechanism typology, a typology found by Campbell, Hollingsworth and Lindberg (1991). This chapter will elaborate this typology in Section 3.2. Section 3.3 shows the role of the State on governance mechanisms and explores why the State is converted in the theoretical framework. The following sections present the theoretical framework and apply it to the Dutch healthcare sector.

3.2 Governance mechanism typology

Governance is an extremely complex phenomenon that best can be observed at industry level (Campbell et al, 1991). Campbell et al (1991) views industries as a matrix of interdependent social exchange relationships among organizations in order to produce market goods or services. *“Governance refers to the institutionalized economic processes that organize and coordinate activity among a wide variety of economic actors (Campbell and Lindberg, 1990).”* Because analyzing governance in a specific sector becomes an overwhelming task, Campbell et al (1991) emerged governance mechanisms to make analyses more manageable.

This governance typology, illustrated in Figure 3.1, identifies two important dimensions based on degree of formal integration and range of interaction. The first dimension distinguishes formal and informal types of organizations, while the second dimension distinguishes the bilateral extreme, only two organisations are involved, and multilateral extreme, all organisations are involved, forms of interaction between organisations. From those two structural dimensions, a typology of six ideal governance mechanism types can be derived in which each governance mechanism is associated with a typical organization form.

Governance regimes, combinations of specific organizational forms, coordinate economic activity among organizations in an industrial sector (Campbell and Lindberg, 1990). Markets, one of the governance mechanisms, are more than general systems which link buyers and sellers (Campbell et al, 1991). Prices serve an important role in coordinating economic activities within a market, because they discourage inefficient behaviour. Market exchange actors could choose to do not abide market rules to some degree in order to self-interested

behaviour, but therefore market alternatives play an important role to ensure that parties uphold their commitments to one another in a voluntary way. In case of opportunistic behaviour, actors run the risk of losing trading partners in the future. Another bilateral governance mechanism, contrary to markets, is hierarchy (Campbell et al, 1991). According to Campbell et al (1991): *“In many industries, actors build formal administrative and bureaucratic systems within a single organization to replace market contracting among autonomous exchange partners as the means by which they coordinate the flow of personnel, capital, and goods through the production and distribution process.”* Benefits of governance through hierarchy are the fact that it is an efficient way to manage transactions, reduce transactions costs and achieve economies of scale. Obligational networks, an organizational form between market contracting and hierarchical control systems, stand for a wide variety of interorganizational arrangements and contracting practices. Those agreements are less precisely specified and therefore more flexible than market contracts, which create stability in changing environments. On the other side, the actors retain their autonomy, like hierarchies, but they are relatively less permanent and deal with less coordination costs.

On the other hand, Campbell et al (1991) distinguish three types of governance in the multilateral side of their typology. Many multilateral organizations produce more collective goods; and will collectively share their resources, information and strategic incentives. Monitoring, one of the collective forms that coordinate economic exchanges among institutions, is an informal and unstable form of control, primarily dedicated to collect and share information as a collective good. The rules of exchange are tacitly recognized by actors. In contrast to monitoring, promotional networks consist of relatively stable groups of organizations, temporary alliances or coalitions, in which actors negotiate more explicitly about rules. In those promotional networks, only a few members of the sector are involved and will promote the collective interests of a sector's members. The third multilateral exchange form is called associations. Associations, formally organized membership affiliations, seek to create relatively stable and formal agreements in order to look to the sector's common interests. In some industries, associations exercise influence by playing crucial roles in the enactment and implementation of public policies for the industry.

So, Campbell et al (1991) presents six governance mechanisms, which must be seen as ideal types since not every empirical example perfectly fits in the descriptions. Besides that, it is

important to recognize that some of those governance mechanisms do have important relationships with the State.

Figure 3.1: A typology of Governance Mechanisms

Degree of formal integration	Range of interaction	
	Bilateral	Multilateral
Low: No discrete organizational structure	<p><i>Markets</i></p> <ul style="list-style-type: none"> • Self-liquidating sales • Spot-market contracts 	<p><i>Monitoring</i></p> <ul style="list-style-type: none"> • Extensive corporate interlocks for information sharing • Market-sharing agreements • Dominant-firm pricing
Moderate: Linked autonomous, but interdependent actors	<p><i>Obligational networks</i></p> <ul style="list-style-type: none"> • Follow-on weapons contracts • Long-term subcontracting • Franchise contracts • Inside contracting • Limited corporate interlocks to stabilize resource and capital flows • Small hierarchies • Joint ventures 	<p><i>Promotional networks</i></p> <ul style="list-style-type: none"> • Action sets • R&D alliances • Coalitions • Interorganizational clans
High: Bureaucratic administrative control structure	<p><i>Hierarchies</i></p> <ul style="list-style-type: none"> • Vertical and horizontal integration • Conglomerate • Job-control union contracts 	<p><i>Associations</i></p> <ul style="list-style-type: none"> • Trade association • Employer association • Producer cooperative • Unions

Source: Campbell, J.L., Lindberg, L.N. & Hollingsworth, J.R. (1991) *Structural Analysis in the Social Science: Governance of the American Economy*. Cambridge University Press 1991.

3.3 The State and Governance mechanisms

While some theories assume State intervention as a clear separation of State and economy, Campbell and Lindberg (1990) argues that some forms of economic governance are linked to a set of institutions, like the State. The State's influence, by defining and enforcing property rights, is always present in the economy, because it provides the legal framework in which contracts are written and enforced. When organizations reorganise their governance regime, this is called 'governance transformations' (Campbell and Lindberg, 1990). Those governance transformations are initiated by private actors, because they have to respond on changes in technology, markets and political or other conditions in their environment. Namely, the pressure for change could be reason to choose another governance regime to coordinate economic activity. The State often plays a role in this process, while it does not necessarily

initiate or lead the transformation. *“The State may deliberately create pressures for governance transformations as an actor by changing, or threatening to change, property rights. One of the most important ways in which the State influences the selection process is through its capacity to ratify or undermine new governance regimes”* (Campbell & Lindberg, 1990).

In sum, while Campbell et al (1991) distinguishes the State from the six governance mechanisms, the State does influence governance in many complex ways. They recognized important relationships between the State and some of the governance mechanisms.

3.4 Theoretical Framework

Chapter two paid attention to the relationship between structure, conduct and performance, while Section 3.2 and 3.3 describe governance mechanisms in order to specify industry structure. Together, both theories explore the way how the theoretical framework of this research is built up, as illustrated in Figure 3.2. One of the aims of the author is that a theoretical framework should be useable for other industries and sectors as well, something which is possible since the very general character of the framework. However, this research uses the theoretical framework specific for a study in the Dutch healthcare sector, as described in Section 3.5.

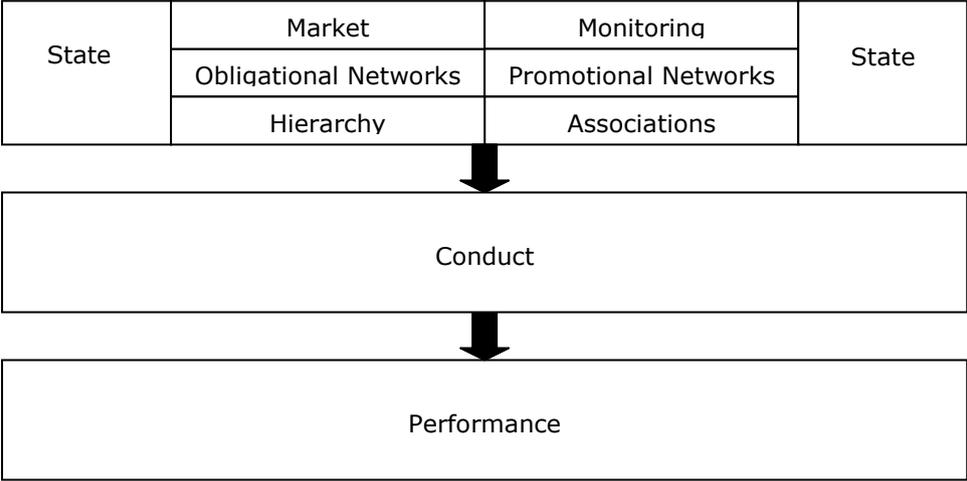


Figure 3.2 - Theoretical Framework

3.5 Theoretical Framework applied to the Dutch Healthcare sector

Governance regimes coordinate economic activity among organizations in an industrial sector (Campbell and Lindberg, 1990). This typology can be used to investigate different economic sectors. In this study the Dutch healthcare sector is chosen to investigate the relationship between structure and conduct in this specific area. Figure 3.3 presents the theoretical framework related to this sector.

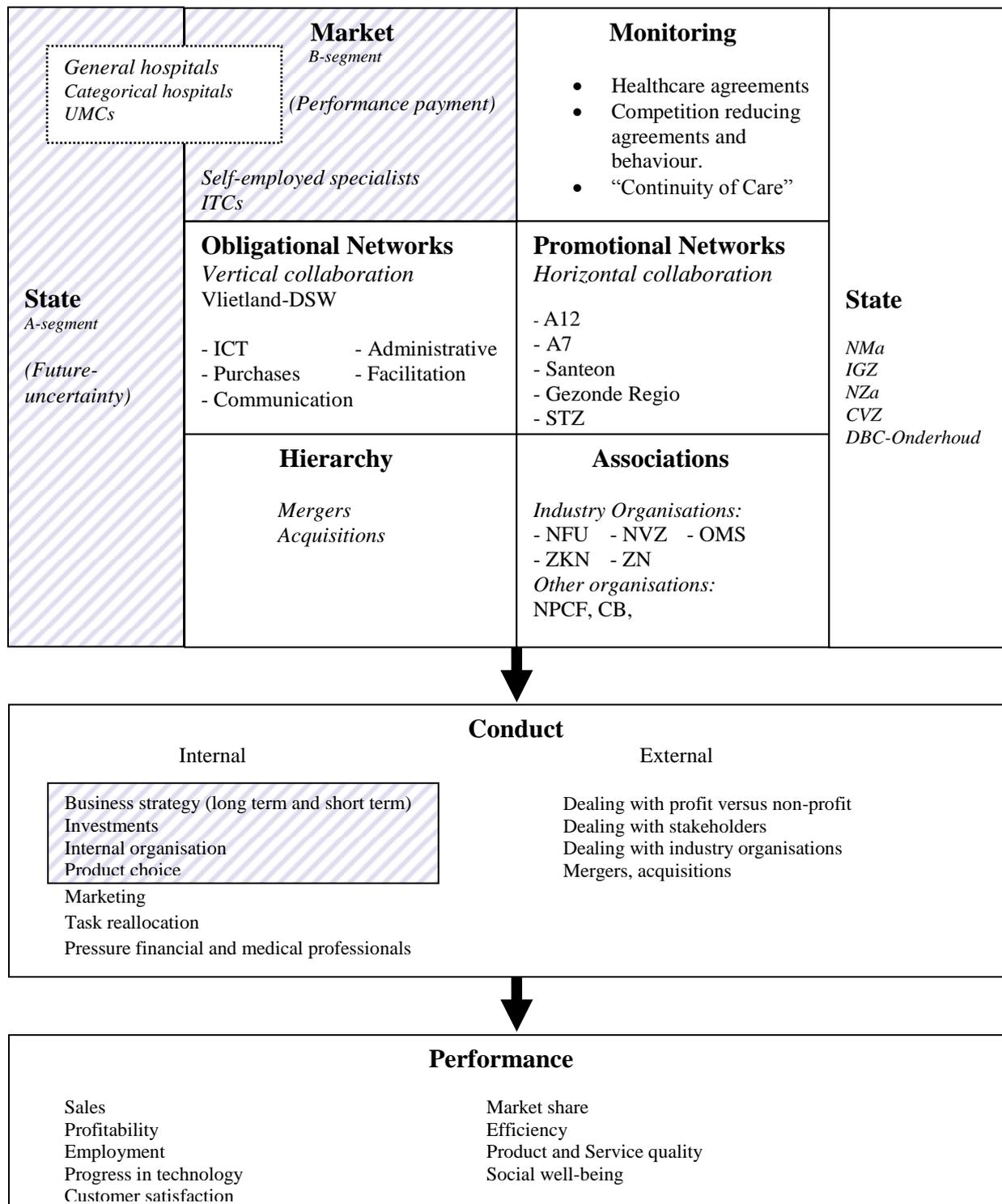


Figure 3.3 Theoretical Framework related to the Dutch healthcare sector

These structure elements could all have an influence on managerial conduct. However, to answer the problem statement of this thesis only the elements which developed and changed over the last years are investigated. For example, hierarchies and associations are very stable governance mechanisms which will not differ in great amount over a short period of time. Namely, since 2004 the supervisor NMa monitors the concentration of healthcare institutions, resulting in a decline of Dutch hospital mergers (NZA, 2009a). Also networks could influence managerial behaviour, but this thesis more focuses on the funding and financing of the healthcare sector. However, despite the fact that some governance regimes fall outside the scope of this research, these healthcare-related structure elements are described in Appendix E. Section 3.6 will narrow the subject of this thesis to the part of the healthcare sector which is most in development last years: the highlighted parts of Figure 3.3.

3.6 The transition phase as research area

It is more interesting to see what happened last years in the relation between market and State in the healthcare sector. The medical specialized care sector developed rapidly during the last years (NZA, 2009b). The Dutch healthcare sector, originally controlled by the central Government, is gradually replaced by a decentralized system of regulated competition (Meijer et al, 2010). Hereby, a shift is recognizable from State regulation towards performance payment with support of market-based healthcare reforms. The influence of those reforms on managerial behaviour is scope of this research and illustrated in Figure 3.4. The next chapters will more elaborately describe this research area.

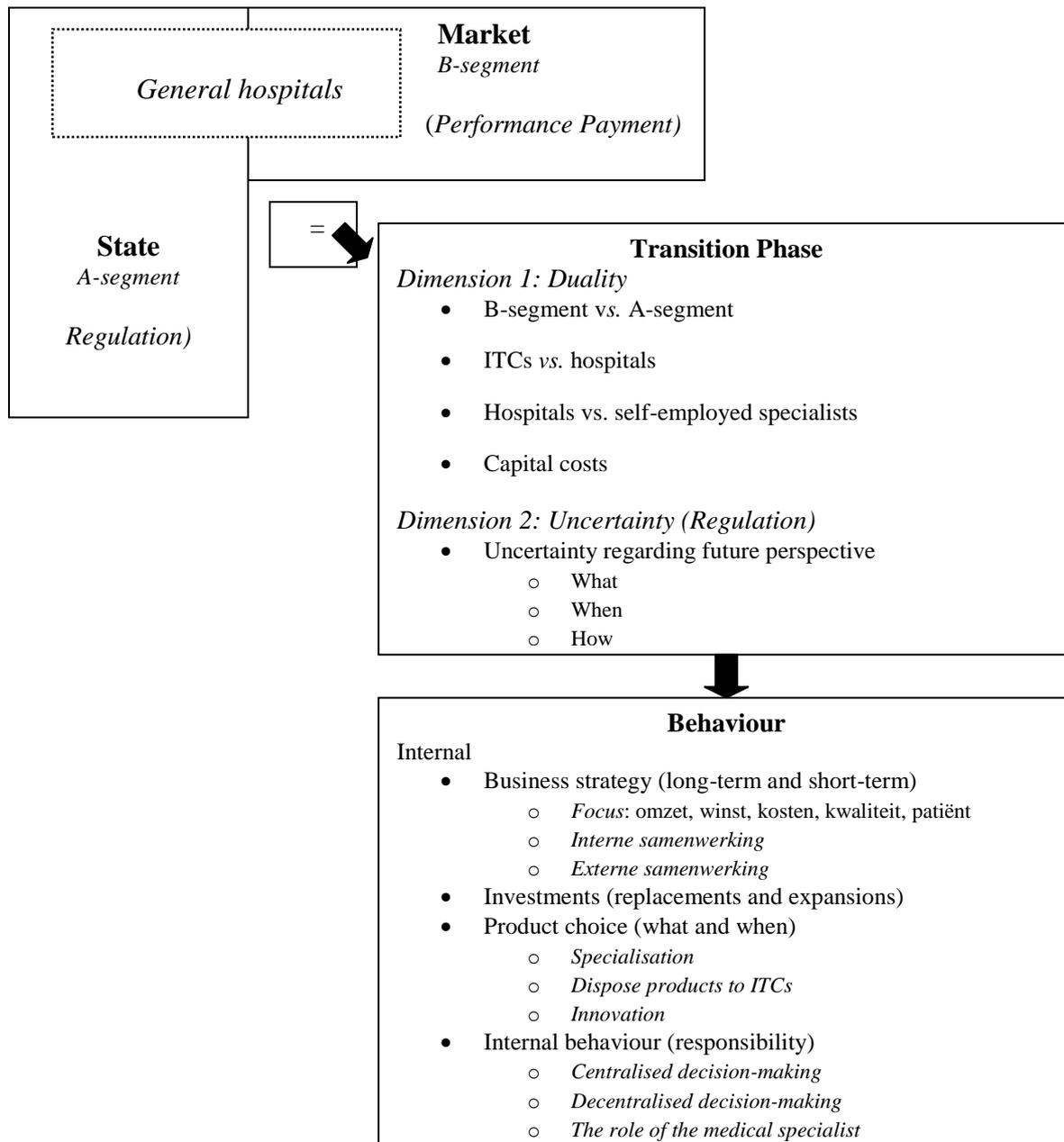


Figure 3.4 Research area

3.7 Conclusion

After describing the typology of governance mechanisms, this chapter presents the theoretical framework. This thesis uses this framework for a specific study in the healthcare sector. Due to the specific character of this study not all of the structure elements are part of the research area. This research area can be divided in two variables (Figure 3.4). On the one hand, the current transitions phase in the healthcare sector and on the other hand, managerial behaviour within the sector. The next chapters will declare these variables more extensive.

Chapter Four – Conduct in the Dutch Healthcare sector

4.1 Introduction

This chapter pays attention to the conduct part of the framework in relation to the healthcare sector. Chapter two mentioned some conduct variables, like strategy of firms, production policies and investment policies. This chapter will focus these aspects to the specific situation in the healthcare sector. Due to the fact that this research is explorative, innovative and related to a specific part of the sector, there is not one general conduct theory amplified to this research area. Internal interviews¹ are used to select the relevant conduct factors for this research². This results in four different conduct factors, which are described in Section 4.2.

4.2 Managerial conduct in the healthcare sector

4.2.1 Business strategy

“The term strategy has been defined in a variety of ways, but almost always with a common theme, that of a deliberate conscious set of guidelines that determines decision into the future” (Mintzberg, 1978). Porter (1981) defines strategy as the way how firms attempts to compete in its environment, while Mintzberg (1987) defines strategy as a pattern in a stream of decisions which could be distinguished in deliberate and emergent ones. Treacy and Wiersema (1993) distinguish three different business strategies: customer intimacy, product leadership and operational excellence.

However, managers and decision makers in non-profit organizations may differ in their goals in contrast to profit organizations (Feldstein, 1993). Therefore, Feldstein (1993) describes several theories which may be relevant to explore behaviour of non-profit organizations in the healthcare sector. *“Our simplest model of hospital behaviour assumes that the non profit hospital acts as through it were for-profit hospitals but returns its ‘profits’ to the community.”* However, whether hospitals have quantity or quality maximizing behaviour depends on the managerial preferences (Den Hartog and Janssen).

¹ With internal interviews the author means interviews within the NZa.

² The selection process of conduct factors is described in Chapter 6.

4.2.2 Product choice

Bain (1956) remarks that product differentiation reduces competition among established firms and could be seen as a barrier to entry. Namely, product differentiation results in high volume against high quality. Entry barriers are based on overall scale economies of product differentiation (Schmalensee, 1982). However, several demand factors affect product choice and this effect could be large enough to outweigh competitive effects in some cases (Mazzeo, 2000).

4.2.3 Investments

Hospitals create a certain investment space to be able to finance their goals (Webb et al, 1988). The investment strategy is seen as a process of organizational resource-investment choices (Bowman & Hurry, 1993). This is important for an organization because the invested resources often create a platform for other business strategies. Managers who sense high perceived environmental uncertainty will be conservative in investment options.

4.2.4 Internal organization

“In the literature relating to organizational behaviour is ambiguity in the use of the word control (Woodward, 1970, pp. 38).” Woodward (1970) defines control as the task of ensuring that activities are producing the desired results, like monitoring activities, reviewing feedback information and taking corrective action. However, the agency theory suggests that splitting some CEO tasks in an organization will facilitate more effective monitoring and control within an organization (Peng et al, 2007). On the other side, managerial goals may differ from shareholder goals (Ross et al, 2005). Consequence could be that managers ignore shareholder interest, especially in large and widely dispersed organizations.

4.3 Conclusion

So, there could be concluded that, despite the differences with the profit sector, the managerial conduct in the healthcare sector could be divided in four factors which might be influenced by several sector's reforms. The next chapter describes these restructuring components.

Chapter Five – Dutch healthcare reforms

5.1 Introduction

The previous chapter described the conduct factors which might be relevant for the study. This chapter will focus on the second variable of Figure 3.4, the transition phase in the healthcare sector. The healthcare sector developed rapidly during the last years. First, Section 5.2 will describe the history of the sector briefly. Then, Section 5.3 describes the reforming process of the sector followed by a description of the aimed end model in Section 5.4. The negative consequences of these reforms will be explained in Section 5.5.

5.2 History 1950-2005

Cutler (2002) subdivides international medical-care reforms in three consecutive patterns over the past century. The first wave occurred after the World War II with the creation of national medical-care systems in several countries in order to provide general access to medical care. Primary focus of the Dutch Government was to promote public health, guarantee minimum quality levels and ensure universal access to health services (Schut & Van de Ven, 2005). This caused an impressive legal and regulatory framework, resulting in enormous expansion of collective expenses on social certainty (CPB, 2006a).

Escalating healthcare expenditures caused a shift in focus of public policy towards cost containment, the second wave of healthcare reforms at the beginning of the 1980s (Cutler, 2002). *“The Dutch Government decided to replace open-ended hospital reimbursement system by a global budgeting system for hospitals’ operating expenses”* (Schut & Van de Ven, 2005). This supply regulation, expressed in established budgets and capacities, results in less pressure on healthcare expenditures (CPB, 2006b). However, negative consequences of this regulatory measures based on cost containment were the emergence of waiting lists and other inefficiencies in healthcare systems (Cutler, 2002; Laeven, 2008).

Therefore, a third wave came to existence focusing on incentives and competition in order to deal with costs and inefficiencies (Cutler, 2002) as well as introducing more private sector management styles by decentralising and improving institutional management (Groot, 1999). However, Cutler (2002) realises that incentive-based reforms are not always aligned with social optimal ways: *“A significant share of the population still sees medical care as a right, not a good”*. Therefore, the third wave of reforms did not follow the second one, but both

waves overlapped (Schut & Van de Ven, 2005). The Dutch Government introduced competition, but even maintained and tightened its control over supply and prices of healthcare services.

The seeds for the current reforms in the Dutch healthcare sector were sown with the committee Dekker in 1987 (Westert et al, 2009). However, the Dekker plan, which suggested to introduce more flexibility and effectiveness by means of competition, was judged as a too radical (Schut & Van de Ven, 2005). During the following fifteen years Governments have consistently worked on realisation of preconditions for regulated competition. This resulted in a new DBC (Diagnosis Treatment Combination, Diagnose Behandeling Combinatie) system in 2005 (De Jong & Mosca, 2006). Furthermore, since 2005, some regulated-market principles have been introduced as described in the next section.

5.3 Transition phase 2005-2010

The previous section described that organizing Dutch healthcare brought up continuous discussions about its structure and needs for reforms (De Jong & Mosca, 2006). *“Over the past 20 years some elements of competition were introduced. Hospital financing underwent considerable changes. It went from open-ended reimbursement in the ‘80s to the new DBC system in 2005”* (De Jong & Mosca, 2006).

Recently, the Dutch Government has as objective to strengthen demand control in the healthcare sector (NZa, 2009b). Therefore, several changes in the legal and regulatory framework and the funding and financing of the medical specialists care (demonstrated in appendix A, Figure 5.1) were made. This section pays attention to the governance policy in the period 2005-2009 resulting from the legislation changes. These governance policies are illustrated in Table 5.1 and are clarified in the next paragraphs.

Table 5.1: Policy measures 2005-2010

1. Funding systematic
Introduction of the DBC systematic in January 2005 (NZa, 2009b).
Introduction of performance payment in combination with free prices for 10% of the healthcare in 2005, the so-called B-segment (NZa, 2009a).
Expansion of the B-segment towards 20% of hospital care in 2008 and 34% in 2009 (NZa, 2009a).
2. Capital costs in funding systematic

The WZV (Wet Ziekenhuisvoorzieningen) is abolished in 2006 resulting in the introduction of a new Act, the WTZi (Wet Toelating Zorginstellingen) (NZa, 2009a).
On January 1 st 2008, the Netherlands Board for Healthcare Institutions (NBHI) (College Bouw Zorginstellingen, CBZ) of the WTZi is discharged for hospitals (NZa, 2009a).
As a consequence of the abolishment of CBZ, healthcare providers do incur financial risks on capital investments in the B-segment since 2008 (NZa, 2009b).
Introduction of the ‘transitional arrangement capital costs’ on January 1 st 2009 to introduce risk bearing for capital costs gradually (NZa, 2009b).
Introduction of the ‘guarantee arrangement’ per March 2010 in order to foresee in a conscientious transition when the Government will decide to reject budget funding (FB) (VWS, 2010).
3. Independent Treatment Centres (ITCs)
The Regeling Zelfstandige Behandelcentra (ITC regulation, 1998) has been cancelled since the WTZi came into force on January 1 st 2006 (NZa, 2007).
4. Medical specialists
The lump sum financing system for self-employed specialists, introduced in 1995, is abolished since January 1 st 2008 (NZa, 2009a).
Introduction of performance payment for medical specialists in 2008, because self-employed medical specialists are full funded based on healthcare performance per 2008 (NZa, 2009b).
Policy objective to budget the honorarium of medical specialists on the short term, with the healthcare provider as budget holder (NZa, 2010b).

1. Funding systematic

Introduction B-segment

In 2005 two major changes were introduced in medical sector (NZa, 2009a). First, the system of function-oriented budgeting (FB)³ is partially replaced by DBC⁴ funding. Secondly, for a selected number of DBCs some regulated-market principles have been introduced resulting in the so-called B-segment. Freely negotiable prices are established for DBCs in this deregulated segment. *“Next to the B-segment there is the so-called A-segment. A-DBC tariffs are fixed-price and determined by the Dutch healthcare Authority”* (De Jong & Mosca, 2005).

In sum, for DBCs in the A-segment standardised fixed rates are used and associating turnover is intended to cover hospital budgets (Buitenhuis, 2009). For B-DBCs, healthcare providers and insurers are, since 2005, free to yearly negotiate on prices, quality and quantity (NZa,

³ The FB system was introduced in 1983 to contain cost; budgets were based on a small number of parameters (Agrell et al, 2007).

⁴ A Diagnosis and Treatment Combination (DBC) includes all activities and interventions performed by the hospital and medical specialists, from the first consultation to the final check-up (Kerste & Kok, 2010).

2009a). These B-segment negotiations are supported by the use of uniform definitions of care performance with the introduction of the DBC system.

Expansion B-segment (2008 and 2009)

The proportion of freely negotiable production is enhanced from 10% in 2005, via 20% in 2008, to its current level of 34% of hospital care⁵ (NZa, 2008a). Therefore, insurers as well as providers get more freedom (NZa, 2008b) in order to respond to wishes of patients, to provide higher quality, and to achieve more efficient business management (Buitenhuis, 2009).

2. Capital costs in funding systematic

Budget funding

In budget funding, before 2008, hospitals received fixed fees for their capital costs, a compensation independent of realized volume (NZa, 2009b). Capital expenses are costs of interest and depreciation, resulting from investments in building and other capital goods. Neither hospitals, nor loan givers did incur any financial risk on capital investments, because these costs were integrated in hospital budgets. Compensation calculations were fundamentally based on investment amounts approved by the CBZ. This building regime of the WTZi required healthcare institutions to apply for a permit if they want to build (NZa, 2009a). Subsequently, this permit led to an individual compensation in hospital budgets for capital costs.

Despite introduction of the B-segment, capital costs belonging to this B-segment are still covered in budgets in 2005 (NZa, 2008a). In other words, the capital costs remain budgeted and from 2005 till 2007, hospitals transferred 12.5 percent of their B-DBC revenues to cover their budgets.

Abolition building regime (2008)

The Government did abolish the building regime on January 1st, 2008 (NZa, 2009a). Since this abolition, financing of new building and renovation projects was completely changed (Kriek & Dooyeweerd, 2009). The capacity question is transferred from the CBZ to the healthcare provider (NZa, 20009b). The permit has been expired and this gives hospitals the

⁵Consequently, hospital budgets are reduced for care that is transferred to this free segment. This top down decline of A-segment budgets in proportion with B-segment expansion is called 'budgetschoning' (NZa, 2009a).

freedom to invest in healthcare for its own account and risk (NZa, 2009a). Healthcare providers no longer need governmental permission to finance investments in buildings, industrial fixtures and ground.

As long as there is partial budgeting, compensations will continue in the A-segment, but in the B-segment construction costs should be earned back from DBC-proceeds since January 1st, 2009. In sum, investments did not be approved and risks are for providers one's own account.

However, the Minister (and Committee Havermans) aims that direct risk-bearing for hospitals is not desired (VWS, 2008). Therefore, the Minister formulates two regulations in order to spread risk-bearing of capital costs over several years, namely the transitional arrangement (2008) and a guarantee arrangement (2010) for capital costs.

- **Transitional arrangement Capital Costs (2008)**

In late 2008, a transitional arrangement (overgangsregeling) was established which includes that during three years, in descending degree, cost compensation will occur for capital cost which transferred to the B-segment in recent years (VWS, 2008).

- **Guarantee arrangement Capital Costs (2010)**

With complete elimination of budget funding in the future, institutions will run a risk on capital costs in the A-segment as well (VWS, 2010c). This risk is not provided by the transitional arrangement. Therefore, a guarantee arrangement (garantieregeling) is composed, in which institutions receives an in size decreasing guarantee (Appendix B, Table 5.2), for a period of six years, for the compensation of capital costs which they would have received in case of budget funding.

3. Independent Treatment Centres (ITCs)

ITCs were mentioned as “*admitted institutions for medical specialist non-clinical care*”, oriented towards activities which do not require a complex hospital infrastructure (CBZ, 1999). Since the introduction of the WTZi (2006) the ITC regulation⁶ is cancelled (NZa,

⁶ The ‘Regulation Independent Treatment Centres (1998)’ came into force under the jurisdiction of the Hospital Facilities Act (Wet Ziekenhuisvoorzieningen, WZV) (NZa, 2007).

2007). Before 2006, ITCs keep promise to the 24-hourscriterion⁷, but now they are able to provide all B-segment healthcare, with and without overnight stay, and all non clinical A-segment care. Under the WTZi there is no clear distinction between hospitals and ITC's in order to improve competition (NZa, 2008a). The number of ITCs is more than doubled in recent years (NZa, 2010a), partially caused by hospitals which launch itself an ITC (NZa, 2007).

4. Medical specialists

Approximately a quarter of the Dutch medical specialists work as salaried employees for hospitals, while the other three-quarter are self-employed (vrijgevestigd) medical specialists working like an entrepreneur (HEAD, 2008). For these self-employed specialists, the Committee Biesheuvel has pleaded a new remuneration structure resulting in the lump sum system in 1995. In this lump sum system, returns of the specialists were based on voluntarily agreements among specialists and insurers (NZa, 2010b). However, undesirable effects like production decline and waiting lists resulted in system adaptations (HEAD, 2008).

Introduction performance payment (2008)

Since January 2008, self-employed specialists will no longer receive a lump sum, but are funded based on price multiplied quantity, the so-called fee-for-service (NZa, 2008a). Since then, full performance payment based on DBC's does apply for self-employed specialists (NZa, 2008b). So, in contrast to specialists in paid employment, entrepreneurial specialists are full funded on care performances since 2008 (NZa, 2009b).

Budgeting medical specialists (2010)

The Minister of VWS intents to introduce a new budgeting model on the short term in order to control medical specialists' honorarium expenditures (VWS, 2010). Reason therefore is the exceeding of the BKZ (Healthcare Funding Framework; Macrobudgettair Kader) in 2008 and 2009. In this model the hospital acts as a budget holder, a difference with the current situation whereby the self-employed medical specialist declares to the insurers. As a result, hospitals could run risks when the honorarium budget is exceeded.

⁷ The 24-hourscriterion contained that residence in an ITC may not took longer than 24 hours (NZa, 2007).

5.4 Aimed end model of hospital funding

The Minister (VWS, 2010a) divides the aimed end model of performance payment in the Dutch healthcare funding in three different segments, as described below.

Free segment

The free segment contains of full performance payment based on comparable and cost homogenous healthcare performances. Healthcare providers and insurers could negotiate on free prices and free volumes. Due to the fact that compensations are integral, the compensations for medical specialists and capital costs are included in price negotiations as well.

Regulated segment

In the regulated segment there is full performance payment based on healthcare performances with free volumes and regulated and integral tariffs. A part of the care performances will structurally be placed in this segment, with respect to public issues. However, there will be some healthcare performances which will be racked to the free segment in the future.

Fixed segment

The fixed segment contains healthcare products for which it is not desirable to impute it directly to the individual customer. This fixed segment contains of specific healthcare functions or characterizations which have a public issue for customers.

However, in February 2010 the Dutch cabinet has fallen (VWS, 2010b). Therefore, the introduction of the end model is uncertain nowadays. It is unclear if the end model will be introduced in the future, and when and how. The next section pays more attention to this uncertainty.

5.5 Negative effects of the current funding situation

The policy measures, as described in the previous section, create some less desirable effects in medical specialised care funding (NZa, 2009b). The author divides these negative effects into two different dimensions: dual incentives on several funding aspects and uncertainty with respect to funding future.

5.5.1 Duality

The author recognizes the following different types of duality in the current funding situation:

1. Dual incentives between A-segment and B-segment.
2. Dual incentives with respect to capital costs in funding systematic.
3. Dual incentives between hospitals and ITCs.
4. Dual incentives between hospitals and medical specialists.

1. Dual incentives between A-segment and B-segment.

A-segment versus B-segment
Duality due to the availability of two different funding systems (DBC system and budget system) (NZa, 2009b).
The A-segment is expressed in function-oriented parameters, while the B-segment is expressed in DBC's (NZa, 2009a).

Currently, there is a dual situation in funding of hospitals resulting in double administrative interferences (NZa, 2009b). The A-segment is expressed in a FB budget, while the B-segment consists of free prices multiplied with quantity.

2. Dual incentives with respect to capital costs.

The capital costs in current funding systematic
Duality arisen since hospitals receive individual budget compensation for capital costs in the A-segment, while in the B-segment compensations must be received from the generated sales (NZa, 2009b).
Duality since hospitals which starts building new hospitals under the building regime (CBZ) before January 2008 do have a more favourable position in contrast to hospitals which start building a new hospitals after January 2008 (NZa, 2009a).

As afore mentioned, prices for B-DBCs are freely negotiable, but the A-segment is still calculated based on the function-oriented budget system (NZa, 2009a). In the B-segment healthcare providers are bearing risks for their investments, while in the A-segment they receive guaranteed budget compensation. The transitional arrangements take care of a more stepped abolition of those certainties, but are not applied to healthcare providers without a permit.

3. Dual incentives between hospitals and ITCs.

Hospitals and ITCs

ITCs do receive their incomes based on full performance payment, because ITCs are not familiar with the budget systematic (NZa, 2007). On the other side, hospitals are partly funded with the budget systematic and do experience incentives to accommodate production by an affiliated ITC (NZa, 2009b).

ITCs do have maximum tariffs in the A-segment, while hospitals deal with budgeted tariffs in the A-segment (NZa, 2007).

There are dual incentives since ITCs receive their incomes based on full performance payment, while hospitals are funded for 66% based on the budget systematic and for 34% based on performance payment based on B-DBC's (NZa, 2009b). Factually is chosen to select a different time path for the introduction of performance payment for different categories of healthcare providers. Therefore, hospitals could benefit this difference in funding and tariffs by means of starting up an ITC.

4. Dual incentives between hospitals and medical specialists

Hospitals and medical specialists

Duality in funding, because financial incentives for self-employed specialists differ from hospitals' incentives since the abolishment of the lump sum (NZa, 2009b).

The abolishment of the lump-sum resulted in deviated incentives in the A-segment for self-employed medical specialists and the hospital (NZa, 2009b). Hospitals have to keep within the budget they agreed with the insurers. This budget is for 66% determined by production based on budget parameters, but extra production will result for 100% in extra income for a self-employed medical specialist. Like ITCs, self-employed specialists receive incomes based on full performance payment, while hospitals are funded for 66% on budgets.

5.5.2 Uncertainty with respect to the end perspective

As afore mentioned, negative effects of the current situation in hospital funding are divided in two broad dimensions. The second dimension deals with the uncertainty with respect to the end perspective. This uncertainty can be divided in three categories: what, when and how.

The uncertain way to performance payment	
What	Uncertainty with respect to the question if the aimed end model will be introduced in the future; if function-oriented budgeting will be reintroduced; or that the current dual funding situation might occur as end model (NZa, 2008b; NZa, 2009a; NZa, 2009b).
When	The controversial character of the Dutch Cabinet results in uncertainty with respect to the question when some policy measures will be introduced (VWS, 2010b).
How	Uncertainty whether to go further with a stepped extension of the B-segment or a direct step towards the end model (NZa, 2009b).

In the aftermath of the Dutch coalition collapse (the Dutch Cabinet has resigned since February 20, 2010) most policy objectives related to funding of medical specialist care are declared controversial (VWS, 2010b). This means that the outgoing Cabinet is not allowed to make any decisions regarding expansion of the B-segment or abolition of the FB system. This will result in regulation uncertainty about the funding future even since 2011.

In contrast, the objective to introduce budget funding for self-employed specialists was not declared controversial (VWS, 2010b). Namely, the Minister aims it necessary that budget funding for medical specialist will be introduced on the short term. However, the introduction is just a policy objective nowadays, because the NZa advised that introduction will not be achievable per 2011 (NZa, 2010b). So, there is uncertainty with respect to the introduction of the control model focused on honorarium budgeting.

In sum, the Minister of VWS pronounced the policy intention to go to a system of performance payment in the future (VWS, 2010a). Currently, it is not clear when and how performance payment will be introduced and what will be the exact end perspective (VWS, 2010b).

5.6 Conclusion

The transition phase in the Dutch healthcare sector did result in four duality problems and cause a lot of uncertainty in relation to the future. Those negative consequences could influence managerial behaviour of general hospitals. In the next chapters is investigated what the practical relationship is between the restructuring elements in the healthcare structure and hospitals' managerial conduct. In order to get insight in these empirical results, first the research methodology is described in the next chapter.

Chapter Six – Research Methodology

6.1 Introduction

The previous chapters of this thesis pay attention to the theory behind this research topic. Also attention is paid to the variables and theoretical relationships within the healthcare sector. In order to solve the problem statement empirical evidence has to be collected. To collect this data, a number of interviews are held with different parties in the field. Section 6.2 pays attention to the study design, while Section 6.3 explores the way the sample is selected. Section 6.4 and 6.5 deal respectively with the reliability threats and the validation instruments, followed by a conclusion in Section 6.6.

6.2 Study design

Section 1.5 gave an insight in the research feasibility. The study design is described as exploratory, a useful design for research areas which are not examined extensively (Baarda & De Goede, 2001). In the previous chapters secondary data is used to define the research area of this study. Besides that, qualitative primary data is collected since the problem statement has a specific and unknown character.

Because of the innovative, explorative and specific character of this research, it is difficult to link one general conduct theory to this research. In Chapter two the SCP paradigm is described and the literature pays attention to several conduct elements. To select the appropriate conduct factors (Chapter four) for this study, the author used several dialogues, discussions and internal interviews within the NZa⁸. The NZa, the Dutch healthcare Authority, is supervisor on all of the healthcare markets in the Netherlands, and monitors whether or not healthcare institutions implement the Care Insurance Act and the AWBZ⁹ correctly (nza.nl, 2010). So the four conduct factors are based on internal interviews, in contrast to the structural factors which are based on secondary data.

6.3 Research sample

In addition to the literature study, the author collected qualitative primary data in order to answer the problem statement. The research was conducted in nine out of 85 Dutch general

⁸ See Appendix D

⁹ The AWBZ (Algemene Wet Bijzondere Ziektekosten) has the objective to assure sustained and long lasting healthcare as well as the risks which could not be insured.

hospitals¹⁰. To study the relationship between the current phase in the transition of the healthcare sector and the managerial conduct of Dutch hospitals, the sample selection is just based on general hospitals. Reason therefore is that UMCs¹¹ are difficult comparable with general hospitals because of differences in objectives, subjects and income sources. Besides that, there are just eight UMCs which enhance the difficulty to make reliable comparisons. The sample contains two kind of general hospitals, the STZ hospitals and the more standard general hospitals. STZ, see appendix E, is a collaborating association of 27 big teaching hospitals, who provide high specialized medical care (stz-ziekenhuizen.nl, 2010). Those top clinical hospitals are large regional teaching institutions which have a part of the high specialist functions in the Dutch hospital industry, in contrast to UMCs which have all of these functions.

The sample (Appendix C) consists of nine general hospital managers on CEO level. Because the sample has to represent the whole population of general hospitals, different kind of hospitals, STZ as well as standard hospitals, are selected from different geographical regions, as illustrated in Appendix F. To check more elaborative whether the sample is representative or not, a data analysis is done in which the sample is compared with the total population. The confidential DIS Data used for this analysis is anonymously illustrated in appendix G. After comparing the national division per speciality in 2008, appendix G2, with the division per interviewed institution in 2008, appendix G3, there could be conclude that no outstanding differences are visible in both the A-segment and B-segment¹². So also based on product supply could be concluded that the sample is representative for the whole population. Therefore, conclusions done during this research could be based on the general hospital market as a whole.

After selecting nine hospitals, interviewees received an official letter in which is asked if they were willing to give an interview. The CEOs received some preparing information and question lists (appendix H) to be sure that the interview setting is clear and to save explanation time on the interview moment. To be sure that the question lists contain all relevant transition variables, some interviews and conversations with experts of the NZa are

¹⁰ The total number of Dutch healthcare providers is illustrated in table 6.1 in Appendix B.

¹¹ University Medical Centres (UMCs) are academically based hospitals interconnected to a university in order to educate medical specialists as well as doing research.

¹² Almost 50% of the care in the A-segment consists of surgery, medical science and cardiology, while more than 50% of the B-segment care consists of orthopaedics, gynaecology and surgery.

used to gather information. In the letter as well as in the preparing information, the announcement was done that all of the information is not one-to-one convertible to persons and/or institutions and the information will be mentioned on an anonymous way.

6.4 Threats to reliability

The *subject error*, occurred through the large amount of interviews on different moments of time, is minimized by interviewing in a very short time span. *Subject bias* is a serious threat to reliability, since managers have to judge their own behaviour. However, ensuring anonymity of respondents minimized the subject bias. *Observer error* will occur when different interviewers use different ways of asking questions (Saunders et al., 2009). Therefore, a high degree of structure in the interview schedule is necessary to minimize observer error. Besides that, taking notes during an interview will result in a higher amount of mistakes and therefore the author chose to use an audio recorder. *Observer bias* occurs when there may have been different ways of interpreting signals. This threat to reliability is minimized by interviewing an interviewee in pairs, the author accompanied with a NZa employee.

6.5 Validation instruments

The interview results could be used to answer the problem statement. However, using interviews to gather information creates the risk of gathering social desirable answers. Besides that, managers will not very often declare that they are responsible for negative results. The risk of pushing away the mistakes to other factors is therefore present. Reason enough for the author to use some validation instruments to enhance the reliability of empirical results. The following validation instruments, expounded briefly in the next chapter, are selected:

- Interview with the CEO of the Wfz¹³
- Interview with advisor of Twynstra and Gudde
- Data analysis

6.6 Conclusion

This chapter paid attention to the methodology of this research to make the research setting more clearly. The next chapter shows the empirical results and conclusions of this study in order to investigate the practical relationship between reforms and managerial conduct.

¹³ The Guarantee Fund for the Healthcare (Waarborgfonds voor de zorgsector, Wfz) is an undependable institution which gives healthcare institutions the possibility to contract very profitable loans, because they guarantee repayment and interest towards banking institutions.

Chapter Seven – Results, Discussion, Conclusion

7.1 Introduction

Chapter three describes the theoretical framework for the Dutch healthcare sector and declared that just a specific part of the theoretical framework, the market and State, is relevant for this investigation. This research therefore focuses on the research area as described in Figure 3.3. The previous chapter shows the interview setting and research methodology. In this chapter, Section 7.2 shows the interview results. These results are described as factually and objective as possible. Section 7.3 discusses the results of Section 7.2 with support of validation instruments. In Section 7.4, an overall conclusion is given with some recommendations towards the sector.

7.2 Interview results

This section describes results of interviews with general hospital managers. The section is divided in three different parts, corresponding with the different conduct factors. Namely, business strategy and product choice are combined, since the author recognized some overlap between these conduct factors during the interviews. Besides that, the italic sentences present some managerial quotes.

7.2.1 Business strategy and product choice

Business strategy

Regarding to their business management the interviews approve that all interviewed managers follow a deliberate strategic policy, resulting in specific choices and focus on key issues. However, some managers emphasize that strategy is not always a free choice, but partially determined by factors like location and history. In that sense, strategic policy build further on hospitals' background.

STZ hospitals profile themselves in their business strategy as institutions which are based on quality, innovations and education. These key points are sometimes combined with elements as efficiency, hospitality and flexibility. The more standard¹⁴ general hospitals emphasize quality less emphatically in their strategy. These hospitals mention collaboration, market share and product focus as most important strategic key objectives. However, the strategy

¹⁴ The author uses the word 'standard' for hospitals which are not STZ hospitals.

aims on ‘product focus’ is not guided by regulation aspects: *“The market is more dynamical since 2005 and we realized that providing all healthcare could be reason for our weak financial situation.”*

Funding effect on strategy

All managers also indicate that they will not include current dual funding elements in strategic business choices. Therefore, several reasons are mentioned, as illustrated in Table 7.1. The overarching reason is that a strategy must be defined autonomous of Governmental funding and not be based on external factors.

Business strategy is defined autonomously of the funding situation, because of the following reasons:	
There is a time-lag between the moment of developing and the moment of realisation of a business strategy.	
Hospitals have to keep close to their own identity, because of the uncertainty and ambiguity in the current funding situation.	
The Government and funding is a factor ‘X’ which can not be influenced by hospitals.	
“You can not adjust the wind, but you can adjust your sails.”	

Table 7.1

Funding effect on product choices

This autonomous strategic attitude is also recognizable in managerial behaviour regarding the product portfolio. Namely, all hospitals signify that unprofitable care in the A-segment will not be rejected based on the funding system, because of the reasons illustrated in Table 7.2. The overarching reason is that product rejection based on current funding situation is judged as short term policy, which could result in less desirable consequences in the long term. Therefore, institutions sometimes think in terms of performance payment: *“I take decisions based on the DBC price which I do not receive nowadays, but wherefore will be adjusted in the future.”* Besides that, hospitals mention reasons which are not directly related to funding, like hospitals’ strategic profile, patients’ care demand and geographical location.

Unprofitable care in the A-segment will not be rejected based on the funding situation, because of the following reasons:	
1.	Healthcare products which exceed FB budgets nowadays could be cash cows when performance payment with an adequate DBC compensation is introduced.
2.	Weaving faults in healthcare funding could be seen as temporary advantages, so rejecting

	production based on funding is judged as short term vision.
3.	New developments in the A-segment, like product innovations, will initially never covering all costs. Therefore, it is structurally not right to base decision-making on variable parameters.
4.	“We need cross-subsidization to compensate expensive healthcare in the A-segment.”
5.	“When we stop with the top of our strategic profile we should fall back to an average general hospital. This will negatively influence the distinctive abilities and survival chances of our hospital.”
6.	Abandon expensive healthcare products in the A-segment will affect hospitals’ profile.
7.	Unprofitable healthcare products are seen as crowd pullers towards patients and specialists.
8.	“We can not abstract from our duty of care, because the hospital will draw a hole in this region when some healthcare product will be rejected.”
9	“Our geographical location does not permit the hospital to reject specific healthcare products.”
10.	The patients’ demand of care is the key decision factor regarding hospitals’ product choices.

Table 7.2

Impeding factor

Although hospitals will not determine their strategic policy and product choices based on the current dual funding, this duality is to some extent seen by hospitals as an impeding factor (Table 7.3). Especially the double implementation expenditures are a major obstacle according to all managers. *“We do not make distinctions between A-segment and B-segment, but the double implementation expenditures can be seen as a disaster.”*

Besides the dual funding situation, the existence of the function-oriented A-segment also leads to several impediments, as shown in Table 7.3. Especially for expensive and complex care this is experienced as a hindering, because this care resides in the A-segment most of time. On the other hand, all managers think that the introduction of the B-segment has led to positive developments. It will give hospitals the opportunity to bargain on content and quality aspects of the healthcare profile. As a result, the possibility arises to be distinctive.

The current funding situation as an impeding factor:
The double administrative expenditures are a disaster with respect to the business implementation.
The A-segment contains limited information.
The A-segment is difficult for innovations.
The production limits in the A-segment are impediments.
The A-segment contains too many certainties, which will not stimulate competition.
The A-segment lacks the possibility to profit analyses, because there are no relationships between costs and revenues.

Table 7.3

Introduction performance payment

Managers consider an unambiguous funding for healthcare products necessary, so that decisions could be based on content instead of financial motives. Introduction of performance payment is widely seen as solution for above mentioned funding obstacles (Table 7.3). Besides that, the introduction is seen as a good development, because cross-subsidization is not needed anymore to compensate costly FB healthcare.

However, two hospitals observe that if full performance payment will be based on DBCs, hospitals still have to implement two administrations. The old operation administration (verrichtingenadministratie) has to be used in order to validate DBCs. This problem will be solved when the DOT system will be introduced. However, several hospitals argue: *“DOT is a better system. But the introduction will induce several adaptations, while the DBC system finally makes price comparisons possible nowadays.”*

Performance payment and product choice

Possible introduction of full performance payment could lead to a more considered choice within the product portfolio. On the one hand, hospitals agree that product specialisation will occur when performance payment is introduced. Consequently, scale economies will exist and this results in more quality and efficiency. One manager states that performance payment will result in more agreements among hospitals since cooperation prevents suboptimal amounts of production. Some other hospitals confirm this by mentioning that a concentrated market will arise with both production clinics with production lines and more ambitious hospitals focussing on innovative healthcare. *“Specialisation enhances quality of care.”*

On the other hand, some hospitals do not expect that performance payment will influence hospitals' product portfolio. A manager declares that product specialisation and concentration stands too far from the current hospital organisation and strategy. Other managers confirm this based on several reasons. For example, specialists prefer a broad healthcare supply. Besides it, hospitals can not abstract from their duty of care. Another reason is that the patient's healthcare demand is diverse: *“Therefore a hospital must have a broad product supply.”*

ITCs

Many managers declare that the current funding situation creates an unequal playing-field between hospitals and ITCs. Since performance payment is late in coming, managers increasingly consider establishing an ITC in order to face imperfections and impediments in the FB-segment. A manager puts forward: *“Disposing top clinical care is no option, through which other opportunities are searched in order to earn back financing.”*

Four out of nine hospitals establishes one or more ITCs nowadays and four other hospitals take this opportunity in consideration. Hospitals realize that they never found an ITC when there was no A-segment in the current funding. *“But managers strive for continuity, so they anticipate on the opportunities in the regulation.”*

7.2.2 Investments

Cost of capital regulation

Eight interviewed hospitals applied for a permit under the WTZi-regime before 2008; two of them just for a part of their total investment. Some managers of these hospitals emphasize explicitly that they also would have invest without a permit. One hospital did not apply for a permit: *“There is no permit applied, because we assume that funding would soon proceed to performance payment. As a result, we were not eligible for the transitional arrangement nowadays, since we did not have a permit. Currently, we could not apply for a permit anymore, since the system is abolished.”* This hospital declares that they experience cost of capital regulations as an obstacle, specifically due to the fact that the transitional arrangement (2008) is limited to investments with a permit. Other hospitals also criticise, based on several reasons (Table 7.4), the transitional arrangement and guarantee arrangement (2010).

The cost of capital regulation impedes hospitals, because of the following reasons:
The transitional arrangement is limited to investments with a permit.
The scope (time period) of the transitional arrangements is too short. Therefore, differences in the business environment of hospitals can not be removed.
It is not agile to introduce a transition arrangement ultimately two years after the old permit system is abolished.
In contrast to immaterial fixed assets, ghost buildings (spookgebouwen) do not belong to the transitional arrangements, while it is technical seen the same problem.
Nowadays, it is unclear how the interest will be compensated in a new system. So, there has to come a regulation which clarifies how the (currently low) interest rate will be covered when the interest rate will raise in the future.

Table 7.4

A broad mentioned argument is that managers assume that it is not agile that an old permit system is abolished and then it ultimately took two years before the transitional arrangement is finished. Another manager declares that the scope of the transitional arrangements is too short, resulting in an unequal playing-field for hospitals: *“We did enter new building and therefore we are 10% more expensive than our direct competitors, resulting in enormous price pressure.”* Another manager thinks that the current system lacks the intelligibility regarding interest compensations: *“Despite the low interest rate nowadays, there have to be a regulation which covers interest increases in the future.”*

Banks

The abolishment of the permit system creates a changing situation for banks as well. A manager puts forward: *“For hospitals profit making is not an objective, but a precondition for continuity. A good financial position is needed for access with loan providers.”* All hospitals declare that they recognize a more critical attitude of banks in negotiations. *“The Government had guaranteed payments in former times, but since 2008 the bank is at a risk as well and is therefore judging business plans more critical.”* Different reasons are mentioned for the critical attitude of loan providers, as illustrated in Table 7.5. Some managers argue that the financial crisis causes difficult negotiations; other managers mention the abolishment of the permit system as the reason behind it.

Lenders are more critical in the judgement of business plans due to the following reasons:
Negotiations with banks are more difficult due to the financial crisis.
The credit crisis did not play any role, because the healthcare sector will always grow and therefore remains interesting as investing area.
Banks are more reserved because the Government and the NVZ indicates that the number of hospitals will decline in the future till 60 and hospitals have to compose their restructuring plan by themselves.
The requirements for financial requests are influenced by the abolishment of the permit system.

Table 7.5

Three other hospitals mention that the credit market is changed as well. *“Fewer banks are investing in the healthcare sector, due to the extension of risks.”* For large finance requests, those banks provide credit together by means of a consortium. As a result a monopoly position comes into existence which influences negotiation positions of hospitals.

Business economic thinking

Despite the differences in reasons, all hospitals experience that banks are more critical regarding to business plans. Consequently, the bargaining position with loan providers has changed. *“Required are good business cases, good financial positions and a positive exploitation result. The requirements are heightened and de turn-around time of business case assessments is longer.”* From a social point of view, all managers see this critical attitude as a positive development, since it reduces inefficiency in new buildings. Hospitals observe that they examine the investment issue more from a business economic point of view since the abolishment of the permit system: *“Advantage of risk bearing investments is that we work more efficient and effective. There is been thought in cost prices and not in budget parameters.”*

However, two hospitals notice also negative consequences: *“The higher requirements to equity capital lead to more ‘dead money’ in hospitals. These financial buffers are covering the risks, but this capital can therefore not be used for useful and innovative healthcare.”*

Duality and uncertainty

Not any hospital makes differences for their investment issues between A-segment and B-segment, despite the dual funding situation. *“You will not invest specific in A-segment care, because you will retrieve a partial compensation with the transitional arrangement for a few years. That is short term thinking, while capital costs are established for 40 years.”* In sum, a hospital investment is seen as a whole and not divided in different segments. However, the uncertainty regarding the funding future impedes hospitals absolutely.

The degree of abstention

Three hospitals declare that they are restraint with respect to new investments, due to the decline of certainties regarding the investment issue: *“That impedes and forces us to a reserved position in the coming years.”*

Six other hospitals expound that they are not reserved regarding the investment issue. The critical view of banks forces them to formulate better business plans. These plans do not consist of regulation aspects (Table 7.6): *“When a hospital building endures for 40 years and there is a transitional arrangement for five years, then the loan providers still have to be satisfied for the other 35 years.”*

Regulation aspects do not impeding business plans for banks:
In business plans is calculated with a complete B-segment in order to avoid problems in the future due to funding changes.
The new transitional arrangements are not included by banks in their judgement of business plans, because it just diminishes a small part of the starting problem.
“We have conglomerated all negative factors in one business plan in order to determine the lower bound of our possibilities.”
Transitional arrangements are not included in business plans, because hospitals have to be able to do financings by themselves, also in the worst-case scenario.
“Windfall revenues in funding are just used as extra buffer for the future.”

Table 7.6

The Guarantee Fund (Waarborgfonds voor de zorg, Wfz)

Besides the relation with loan providers, hospitals could also secure themselves by the Guarantee Fund which protects institutions and in particular their loans. Secured hospitals are able to agree a lower interest rate with their loan providers. *“On the other hand, you take a risk for other hospitals which are member as well. Therefore, it is a good thing that the Wfz is very critical.”*

Seven out of the nine hospitals are members of the Wfz with the overarching reason to lower the banks’ interest rate. Four of them are secured for their investment currently. Some managers notice: *“The Wfz is more reserved with providing assurances, despite the fact that they are more needed than ever before.”*

Statutory prohibition on profit payout

The critical and reserved attitude of loan providers might be a reason to make use of other sources of capital. However, the law prohibits hospitals to have a for-profit motive¹⁵ (Kerste & Kolk, 2010) what could limit hospitals’ possibilities to use other capital sources. Five hospitals declare that they are not limited by this statutory prohibition, as illustrated in Table 7.7. Reason is that alternative capital providers, like shareholders and venture capitalists, expect higher return on investments than banks. One manager states that he fears conflicts between the profit-oriented attitude of capital providers and the healthcare-oriented choices of

¹⁵ Law article 3.1 and 5.2 Implementation Decree WTZi

hospitals. Another mentioned reason is that public money leak away from the care sector, although another manager saw that as a weak reason: *“We also pay interest to banks and buy in products from profit-oriented suppliers.”*

On the other hand, three hospitals declare that they want to get a for-profit character. The reason behind this is not based on capital providing per se, but more based on the consequences for the organisation. Attracting an external shareholder could result in more continuity, efficiency and control.

The statutory prohibition on profit payout <u>does not</u> impedes hospitals, because of the following reasons:
Capital providers, like venture capitalists and shareholders, are demanding higher return on investment than banks.
Hospital profits flow back in reinvestments or act as buffer for the future. In case of profit payout hospitals have to take shareholders part in hospital’s profit.
Conflicts could arise between the profit-based attitude of credit providers and the healthcare-related choices of hospitals.
Healthcare is partially financed by public money by means of premiums of the taxpayer. This public money should not leave the healthcare sector towards shareholders.
The statutory prohibition on profit payout <u>does</u> impedes hospitals, because of the following reasons:
A shareholder will result in more control, continuity, pressure and retention of knowledge.
The Law impedes us to use an obligation variant. There should be more incentives which enlarge the efficiency.
“The current proportion between debt and equity is irresponsible.”
The abolition of the Law may occur when conditions and restrictions are introduced, like a minimum percentage of equity or solvability requirements.

Table 7.7

7.2.3 Internal Organisation

During interviews with the nine CEOs regarding the internal organisation, in particular, the role of the medical specialist came forward in different ways. Namely, this role is quite topical during this research period, due to the threatening introduction of budgeting self-employed specialist.

Internal decision-making

All interviewed hospitals state that medical specialists are intensively involved in negotiations with insurers and hospital's decision-making process. However, the way how specialists are involved in an organisation process differs among hospitals. Some hospitals work with responsible entities (resultaatverantwoordelijke eenheden, RVEs), whereby specialists lead their business units. In other hospitals the role of the specialist is less decisive. However, in each hospital the specialist is involved in negotiations with the insurer. Three hospitals declare that they will finally take negotiation decisions. One of the reasons therefore is the friction of interests in the A-segment, due to the dual incentives between hospitals and specialists.

Dual incentives

In each interviewed hospital is the amount of self-employed specialists large in proportion to salaried employees. Despite some managers who certify self-employed specialists as more efficient, most hospitals do not recognize fundamental differences between these groups.

However, all managers recognize different incentives in the A-segment between hospitals and self-employed specialists, caused by the current regulation situation. Six out of nine hospitals declare that, despite the unequal incentives, the friction in interests is not translated towards daily management, as illustrated in Table 7.8.

Nevertheless, two hospitals mention that the different incentives result, to a limited degree, in organisational pressures. *“Differences among incentives are caused by the BKZ (Healthcare Funding Framework), where we have to deal with. Result is the emerge of waiting lists. The patient has no comprehension for that, but wants to be threaten.* These hospitals explores that this friction is the reason that they make agreements with self-employed specialists.

Unequal incentives in issues between specialists and hospitals caused by the current funding situation do not influence daily hospital policy, due to the following reasons.

“Frictions between specialists and hospitals are prevented by mentioning each others' interests.”

The argument that revenues flow back in the pockets of the specialist is recognized as short-term vision.

“Frictions in interests are compensated internal ('achter de voordeur').”

“Our good relationships with the specialists prevent frictions and problems.”

Unequal incentives in issues between specialists and hospitals caused by the current funding situation

do influence daily hospital policy, due to the following reasons.

In 2008, the hospital exceeds the production limits. The hospitals did not receive any revenues for this care, but the specialist continues receiving honorarium.

“Because of friction in issues, we are forced to make strict arrangements with our specialist.”

Table 7.8

Unequal income proportions

So, most hospitals do not see friction in interests as an essential problem. However, there are some other negative aspects in the current funding situation criticised by managers. Five out of nine hospitals mention that the funding situation results in an unequal partition of medical specialists' income. “*A trend caused after abolition of lump sum.*” Especially specialists with supporting functions¹⁶ are typified as big earners, because they are able to create high productions with help of hospital personnel. Therefore, managers think that, from social point of view, there have to come a solution for this remuneration problem.

Budgeting medical specialists

The honorarium issues could be solved by budgeting medical specialists' income. However, there is division among managers regarding this solution. Some hospitals are annoyed on it, as can be seen in Table 7.9. Overarching reason for this opinion is that there should be a fair starting point. Besides that, the agreeable internal atmosphere could be disturbed since the hospital will be budget holder. Another argument is that there is a shortage in supply of medical specialists: “*We are attached to the specialist with golden cords.*” Besides that, hospitals think that they do not possess the right tools to control incomes.

On the other hand, five out hospitals reacts more positive towards the intended budgeting model, though for some managers it also depends on the specific fulfilment of the model. These hospitals based their arguments on several reasons, as shown in Table 7.9. An important reason for their positive reaction is that the budgeting model makes it able for hospitals to control integral. Those managers do not expect that internal relationships will be disturbed, because they suppose it is not very complicated to find an honourable partition. Another hospital states that hospital's role will not change: “*Like in the past, hospital remains*

¹⁶ The radiologists, pathologists, medical microbiologists, anaesthesiologists and clinical-chemicals are often mentioned as big earners.

a gateway which will not exceed the honorarium budget.” Finally, some managers set values on performance incentives in a new system, for example by make incomes partially more variable. This will result in control of quality and innovation.

Two hospitals are more reserved with respect to honorarium issues. They pretend it is difficult to estimate the impact of possible budget introduction. *“Budgeting will lead to waiting lists, but every rose has its thorn. Namely, the current situation exceeds the BKZ, due to the volume expansion.” Lump sum did result in waiting lists and now the history will repeat itself.”*

Budgeting medical specialists <u>is not</u> a good alternative, because of the following reasons:
Hospitals have to arrange honorariums in a period of time in which self-employed specialists have to return 40% of their honorarium.
On national level is failed to make good arrangements, and as a consequence the honorarium question is threw down by the hospital on an oversimplified way.
“When hospitals become budget holder, the pleasant internal relationships between hospitals and specialists will be disturbed.”
There is a shortage in the supply of medical specialists, resulting in a difficult negotiation position for hospital managers.
First of all, there must be economized and cut undifferentiated and the exceedings must be neutralized, in order that we could start from a fair zero point.
Hospitals do not possess the right tools to deal with it.
Budgeting medical specialists <u>is</u> a good alternative, because of the following reasons:
Bringing specialists’ honorarium part of hospitals’ policy is a good plan, if they develop good instrumentation for hospital managers.
It gives hospitals the possibility to control self-employed specialists more integral.
The Government is not able to regulate honorariums, because specialists and hospitals will always be able to frustrate the system.
It enlarges hospitals’ opportunities to control, taking into account that it should not be very difficult to develop a righteous honorarium distribution.
Budgeting medical specialists is possible, due to the fact that the hospital do have good relationships with the specialists.
“The role of the hospital will not change, since we will remain a gateway which will not exceed the honorarium budget.”
With respect to the question ‘budgeting medical specialists’, a reserved (wait-and-see) attitude is taken, because of the following reasons:
“It is difficult to estimate the impact of the budgeting model.”
There is a reverse to every medal, since it is a choice between exceeding the BKZ or the cause of waiting lists.

Table 7.9

Lump sum

In sum, there is a division among managers regarding the budgeting model. Also in the period of lump sum there was a division among managers with respect to that system. Two hospitals state that the lump sum system met their requirements, because they made obvious agreements and there was a harmonised situation. Five out of nine managers criticize the lump sum system, because the hospitals' role was restrained, hospitals lack control, or it results in waiting lists (Table 7.10).

The lump sum system did not suffice, because of the following reasons:
Hospitals did have limited interference.
It was one big negotiation race.
It results in waiting lists.
Hospitals lack control.

Table 7.10

ITCs

Many hospitals do not expect that specialists will built up an own ITC. Namely, this will requires a lot of organisational efforts wherefore they are not educated. *“A hospital has 20 employees to support one medical specialist in his work.”*

According to other managers, some self-employed specialists see it as an interesting challenge to undertake these organisational tasks; because they think that they can manage healthcare more efficiently. Therefore, the introduction of RVEs lowers the need for these specialists to start up an own ITC.

Responsible Entities (RVEs)

Three hospitals declare that they decentralise their organisation in RVEs nowadays. In RVEs the specialist does have more influence and control on costs and revenues. The dual funding situation, nowadays, forces hospitals to make corrections for their entities, because the proportion of A-segment and B-segment differ between those entities. *“If there is one system, like performance payment, the internal control will be much more obvious, unambiguous and agreeable.”*

7.3 Discussion

The previous section described interview results as objective and factually as possible. In this section the author analyses and discusses these gathered results. Sometimes the author recognizes some contradictory or unclear elements and therefore uses some validation instruments. To sketch a complete picture of managerial behaviour in the healthcare sector, the author therefore interviewed Mr. Bellers, director of the Guarantee Fund (Waarborgfonds voor de zorgsector, Wfz), as well as Mr. Opheij, advisor of Twynstra & Gudde. These conversations are used to give a complete view or to nuance and confirm some contradictory and unclear managerial comments. For the same reasons, the author analysed some DIS Data in order to validate some interview results.

7.3.1 Business strategy and Product portfolio

Based on the interview results the author concludes that STZ hospitals distinguish themselves in their business strategy from standard hospitals. This strategy is defined autonomously of funding, despite several recognized material impediments. Also with respect to product choices there is an autonomous attitude, since hospitals do not reject unprofitable compensated healthcare products in current funding situation. Therefore, the author recognizes several reasons (Table 7.2), varying from funding-based arguments till reasons which are not directly related to the dual funding situation, like hospitals' profile or duty of care. Apart from that, the author considers the argument that hospitals can not abstract from their duty of care as a fallacy. Namely, the insurer has a duty of care in the current Dutch legislation. Hospitals only have a legal duty of care for emergency or acute care (Spoedeisende Hulp, SEH), the so-called 45 minutes norm.

All hospitals declare that they currently do not apply product differentiation. Half of interviewed hospitals do not expect, based on several reasons, that performance payment will indeed influence the product portfolio. However, there are several hospitals which expect, despite the fact that they currently do not apply product differentiation, that performance payment will result in a more considered product selection. However, this is contradictory with respect to declared reasons which are not based on funding (Table 7.2; quotes 5 till 10), like geographical location, patients' care demand, hospitals' strategic profile and appearance. Namely, these arguments also count under performance payment. This raises the question by the author if hospitals are willing to make fundamental choices.

- *DIS Data*

The author uses several validation instruments in order to answer this question. With support of data analysis an attempt is made to gain clarity in current hospitals' product choices. The DIS Data of interviewed hospitals¹⁷, anonymously available in Appendix G, is compared with the national average.

The national distribution per specialty is described in appendix G2 for both the A-segment and B-segment. This shows that for both segments certain healthcare products are significantly represented for the period 2006 till 2008. During these years no major shifts exists. Appendix G4 makes this development visible for each interviewed hospitals in order to test the trend on institutional level. It is seen that all interviewed hospitals follow the same trend as national distribution with respect to important healthcare products. Interviewed hospitals did not made fundamental alternations regarding their product portfolio as well.

In sum, the interviewed hospitals confirm the national trend regarding the product supply in the period 2006-2008. Hospitals indeed do not make fundamental choices in their product supply. So, the data analysis confirms the interview findings.

- *Advisor Twynstra & Gudde*

Despite data analysis confirms that institutions do not made fundamental product choices nowadays, the question remains relevant if hospitals will make these choices when performance payment is introduced in the future. A validation interview with advisor Opheij attempts to gain more clarity in this area.

Opheij declares that hospitals on large scale do make portfolio analysis. Hospitals do analyse cash cows as well as unprofitable care products. Unprofitable care products are often compensated with profitable products, the so-called cross subsidisation. Consequently, this cross-subsidization leads to a situation that hospitals remain all care products in their organisation. Therefore, unprofitable healthcare, like SEH, is not rejected currently. SEH is unprofitable but also the driving force of hospitals, resulting in an influx of patients for other divisions.

¹⁷ Besides the DIS Data, also the elaborated data analysis is represented in Appendix G.

Opheij declares that several elements prevent concentration and deconcentration based on rational economic motives. First, when performance payment will be introduced, there still will be profitable and unprofitable healthcare products. Therefore, also in case of performance payment there will be cross-subsidization. Besides that, personal motives and hospitals' convictions play an important role resulting in hospitals' intention to keep providing all healthcare products. Finally, current uncertainty with respect to sectors' end perspective is reason for hospitals to do not adapt product portfolios on a large scale. So, the author's doubt if performance payment will create product selections remains justified.

Besides that, the author observed that hospitals exhibit behaviour of local monopolists. The literature provides valuable insights into the product variety issue in monopolistic markets (Sorenson, 2000). According to Spence (1978), in a situation of local monopolistic competition firms are able to make product selections which are based on less rational motives. Local monopolists are able to supply products on a more large scale.

In sum, performance payment will not per definition lead to product differentiation. However, it is advisable to solve current funding impediments and dual incentives. Namely, since it is uncertain when dual incentives are smoothed, hospitals feel compelled to start up an ITC. These ITCs are used for tactical and strategic goals, but not for customer value.

7.3.2 Investments

The dual funding situation does not influence investment issues, since managers judge new hospitals buildings as a whole. However, uncertainty about the future regarding the funding situation does influence some managers, since it is not clear how capital costs will be compensated in the future. For example, some managers think that the current system lacks intelligibility regarding interest compensations and creates unequal playing-fields due to higher depreciation costs on new buildings (Table 7.4). However, the author thinks that these arguments do not match with Governmental objectives to include more competition incentives in the sector. Namely, these arguments also apply for profit-based business organisations. Besides that, many hospitals criticise the current transitional and guarantee arrangements. Hospitals also recognize loan providers' critical attitude. However, some managers owe it due to the credit crisis; other ones to the abolishing of the Governmental permit system.

Due to the fact that hospital managers mention different and contradictory reasons for banks' critical attitude, the author considers it necessary to create some clarity in this area. Therefore, the author uses a validation interview in order to clarify.

According to Bellers (Wfz), the combination of both the crisis and the regulation causes the current critical mindset of banks: *"The fact that capital providers and the Wfz have to be more critical with respect to business plans is caused by system changes, since there were Governmental guarantees in former times. But the fact that banks really judge critical and selective is caused by the credit crisis."* The author therefore considers it legitimate to wonder whether banks are still critical after the crisis, in a situation of more financial possibilities and encouraging shareholders.

The author distinguishes two managerial groups with respect to the investment issue. On the one hand, there are hospitals which are more reserved with respect to new investments due to the above mentioned decline in certainties (capital costs regulation; critical view of hospitals; future uncertainty regarding performance payment). On the other hand, there are hospitals which hardly encounter impediments of current decrease in certainties. The critical view of loan providers force them to prepare better business plans in order to convince banks. Regulation aspects did not impede them, because these aspects are not included in business cases.

This contradictory attitude of hospitals regarding the investment issue was reason for the author to validate business plan's quality. Bellers states that the quality of these plans is very diverse. *"In our experience hospitals often overestimate future developments. Risk management is not in the genes of current healthcare managers, since they are grown up in a low-risk system. However, plans which stand or fall by some very temporary regulations do not have much chance. Governmental regulations, like the guarantee regulation, are totally irrelevant for us, because we do not provide guarantees for two years, but for thirty years."* Therefore, the author states that transitional regulations do not support hospitals in their relations with banks.

A majority of interviewed hospitals is member of the Wfz. These institutions declare that Wfz is more reversed with providing assurances and uses longer run times in their assessments. However, Bellers nuances this: *"Previously there was a battle with CBZ for a building plan"*

which takes 5 till 10 years. After that, hospitals got a permit and then financing was just a formality. That is the frame of reference which managers use to compare the current situation. Nowadays, managers have to formulate a business plan resulting in a longer assessment time. However, in this time also the role of CBZ is included. And the total time is shorter than 5 till 10 years. Besides that, the assessment of business plans is a black box for hospitals resulting in longer run times.”

Furthermore, the author recognises that hospitals saw it as a problem that fewer banks are investing in the healthcare sector, often by means of a consortium. Bellers confirms this problem: *“The number of banking players reduced to three (Rabobank, ING, WBG), resulting in a low-competition situation. Competition is nil. Therefore, hospitals are more bounded to the consortium.”* In sum, Bellers confirms the signalled problem of managers. Besides that, the author concludes that there is managerial need for access to other capital sources. Above mentioned scarcity on the capital market makes these managerial wishes more legitimate.

7.3.3 Internal organisation

Section 7.2 shows that medical specialists are intensively involved in hospitals' decision-making. This collaboration is excellent, despite that all hospitals admit that there are unequal incentives in the current FB-segment. However, most hospitals declare that these incentives are not translated to daily policy. This is remarkable, since they previously declare that friction in interests will frustrate daily policy. In that sense, the author thinks that it is right-minded to place marginal notes whether managerial reactions were honest or a reaction on the current discussion of budgeting self-employed specialists. Hospitals which fear budgeting system therefore could represent a too rose-colored view of current reality in order to decrease the necessity of budgeting specialists.

However, all these hospitals understand from social point of view the necessity to solve the problem of unequal income proportions. Hospitals react different on the question if budgeting specialists' honorarium is the right solution. The author distinguishes two managerial groups regarding this question. On the one hand, there are hospitals which are negative towards introduction of this system. On the other hand, there are hospitals which are, based on several reasons, more positive. These groups include the same composition as regarding the investment questions. Therefore, the author labels one group as the more reactive and reserved hospital managers and the other group as managers which are more progressive and

active. This distinction is also recognizable with respect to the assessment of lump sum systematic.

Hospital managers argue that they do not expect that specialists will largely built up own ITCs. Devolving organisations in RVEs is seen as a possible solution to deduct the incentive for self-employed specialists to start an own ITC. However, the dual funding situation impedes hospitals on this aspect, because they have to make corrections for specific entities. Also therefore, introduction of performance payment will ease the internal control.

7.3.4 Conclusion

Regarding the conduct factors business strategy and product choices, there is a homogenous view that hospital's strategy is not based on dual and uncertain elements in current funding situation. However, the dual funding structure, combined with uncertainty with respect to performance payment, is seen as an impediment, what results in accommodating hospital products in ITCs. Hospitals which explore that they will make product selections when performance payment will be introduced, use the failure of performance payment as an excuse for not having to make fundamental product choices nowadays. This is confirmed by validation instruments, which add the argument that personal and irrational motives play a role in product decision-making.

Concerning the investment question, hospitals roughly can be divided into two groups. On the one hand, hospitals are reserved due to the reduction of several system certainties. Namely, this reserved position is caused by the changing relationship with capital providers, the capital costs regulation and uncertainties regarding funding future. On the other hand, there is a managerial group which is not obstructed to invest. These hospitals do not include uncertainties in their business plans and therefore are able to convince banks. Validation with Wfz confirms that business plans are very diverse. Apart from that, the dual funding situation, in contrast to the reductions in certainties, do not influence managerial investment behaviour. However, the reduction of certainties was an intended Governmental effect to stimulate business thinking.

The same hospital groups behave distinctive regarding the intention to budget medical specialists. On the one hand, there are hospitals which sees advantages of the budget system, while on the other hand, some hospitals are against introduction. So, the uncertainty

concerning this model, the moment of introduction and the content, really does play a role. Besides that, hospitals declare that they do not experience negative consequences of dual incentives between hospitals and specialists. The author has its doubts about it, based on reactions in the past. However, the dual funding situation does have impact on internal organisation processes. Hospitals which are divided in RVEs have to make correction calculations due to the dual funding.

The empirical results and analyses of this chapter prove to what extent the theoretical relationships between the two research variables are confirmed by managerial hospitals, as illustrated in the conclusion table below.

Main take-away

The overarching conclusion of this study, and answer on the problem statement, is that the dual funding situation and dual system incentives indeed impede the managerial conditions, without influencing managerial behaviour largely. The uncertainty with respect to future funding plays a more important and fundamental role; and the way how managers face these uncertainties results in two groups: frontrunners and laggards. The group to which a hospital or hospital manager belongs heavily depends on manager's personality.

	Business strategy	Product choices	Investments	Internal Organisation
Duality A-segment vs. B-segment	Only impeding effect	Relation ⁱ , but the author has one's doubt about it.	No relation	Relation, but with relation to RVE's.
Duality ITCs vs. hospitals	No relation	Relation	No relation	No relation
Duality capital costs in funding systematic	No relation	No relation	No relation	No relation
Duality hospitals and self-employed specialists	No relation	No relation	No relation	No relation ⁱⁱ , but the author has one's doubt about it.

Notification i: In that case a relation that the some hospitals declare that they will they will make product choices when performance payment is introduced. But not a relation in the sense that due to the duality in defrayment managers will make product choices nowadays.

Notification ii: The majority of hospital managers declare that there is no friction in interests, despite the fact that hospital and medical specialists differ in defrayment in the FB-regime.

Uncertainty	Business Strategy	Relation, homogenous group
	Product Choices	Relation, homogenous group
	Investments	Relation, division into two groups ⁱⁱⁱ
	Internal Organisation	Relation, division into two groups ^{iv}

Notification iii: One group of hospital managers is reversed in doing new investments, the other group is progressive.

Notification iv: One group of hospital managers is critical and reserved with respect to the budgeting honoraria medical specialists, the other group is more positive.

Conclusion table

7.4 Recommendations to the Dutch healthcare sector

Based on this study, the author wants to give the following recommendations to policymakers in the healthcare sector:

1. Uncertainty

The limited influence of the dual regulation situation on managerial behaviour means, on the one hand, that the Government can perhaps influence hospitals less than desired. On the other hand it means that the Government is not as annoying as often is said. The obscurity and uncertainty, however, do influence long-term decisions of hospitals and therefore an important recommendation to VWS is to give clarity and intelligibility to hospitals and other players in the sector.

2. Market concentration

Institutions do not make fundamental choices regarding healthcare products and the author expects that, based on this research, these choices will not be made in a situation of performance payment as well. So, when a more concentrated market is desired, the market will not be able to create such a situation by itself, because of hospitals' lack of product choices. Therefore, regarding this aspect, there still will be a role for the Government in the future.

3. Overarching branch organisations

Hospitals also declare that they sometimes feel not represented well by the overarching branch organisation NVZ. Explanation behind this is, according to the author, that the healthcare market is quite differentiated and diverse. Therefore, interests of individual institutions are not always the same as the collective interests of NVZ. When the NZa wants to gauge the opinion of the field in the future, it might be recommendable not only to listen to the NVZ, since a branch organisation mainly wants to face laggards. Therefore, it is important that also opinions will be collected on institution level in order to prevent that policy is too much focused on laggards. Namely, this could limit possibilities and playing area for frontrunners.

4. Monopoly

The AFM, Authority for Financial Markets, must be aware that the number of banks investing in the healthcare sector, especially when they invest together in a consortium, will result in a

monopoly situation for banks. Namely, when the only three healthcare investing banks finance together a funding request, there is no competition on the capital market anymore, resulting in negative effects for healthcare providers.

5. Statutory prohibition on profit payout

In order to enhance competition in the financial market, removing the statutory prohibition on profit payout might be a solution. A for-profit character for hospitals could also be a solution for the strict requirements of banks. A shareholder might bring more control and uniformity within an organisation.

6. Shopping behaviour

Some hospitals implicate that they will behave more like business entrepreneurs, due to the decrease of certainties. This decline will result in a larger playing-field and more possibilities for hospitals. However, hospitals still ask the NZa frequently to solve the negative consequences of the 'decline in certainties'. Therefore the NZa recognizes behaviour that some managers are able to just deal with the benefits, but not with the disadvantages of regulated competition. However, the decline in certainties occurs due to the intended objective to stimulate business thinking in the healthcare sector. Dealing with negative consequences is just one part of it. Therefore, the author considers it necessary that the NZa did not take a too prominent position in the solving process of negative effects of competition, since this is a component of the new system and should be solved by the market itself.

Chapter Eight – Conclusion

8.1 Introduction

The previous chapters gradually answer all research questions of this study in order to answer the problem statement. First, this final chapter gives a conclusion in Section 8.2 which answers the problem statement. After that, Section 8.3 gives some managerial implications, followed by research limitations in Section 8.4. Finally, Section 8.5 mentions some recommendations for further research.

8.2 Conclusion

The SCP paradigm indicated that organizational behaviour is a function of specific industry characteristics (McWilliams & Smart, 1993). The governance mechanism typology is used to make these structure characteristics more analysable. Governance regimes coordinate economic activity among organizations in an industrial sector (Campbell and Lindberg, 1990), like the Dutch healthcare sector.

The Dutch healthcare sector will transfer from a traditional system of function-oriented budgeting to full performance payment gradually and in a controlled manner (NZa, 2008b). Consequence of the current stadium of the transition is a dual funding situation in the medical specialised care and uncertainties in relation to the future (NZa, 2009b) what may affect conduct of hospital managers. Managerial behaviour can be divided in the conduct factors business strategy, product choices, investment behaviour and internal organization.

Based on empirical results of this research can be conclude that the dual incentives in current funding does not influence managerial conduct fundamentally. It is just an impeding factor in hospital's managerial policy. However, the future funding uncertainty does influence conduct significantly. The way how managers face with these uncertainties results in two different managerial groups: the progressive frontrunners and the conservative laggards. These conclusions result in some managerial consequences for policymakers in the healthcare sector, as shown in the next section.

8.3 Managerial implementations

The main recommendation towards healthcare policymakers is that they have to create a more unambiguousness situation in order to give managers the possibility to make long term plans

and decisions. Another important implementation for both VWS and NZa is the fact that they have to be alert that policy is not too much based on the defensive and conservative hospitals. This could limit the possibilities and options for proactive hospitals. Therefore, policymakers should take a less prominent position in order that hospitals could act more like business companies in the risky and freedom-based competitive world.

8.4 Limitations

The SCP theory, used by the author to map theoretical relationships, came into existence in the 1950s (Porter, 1981). This model developed during the time from the original unidirectional causal relationships towards a model with interrelationships in different directions. However, this study just focuses on the unidirectional relationship between structure and conduct and therefore this might be a limited view of the entire reality.

Besides that, this research did not use one standard and general accepted conduct theory. Conduct factors are determined after some dialogues and discussions with NZa's policymakers. The absence of a general theory based on managerial behaviour and the absence of the scientific substantiation with respect to the way how these factors are realised can be seen as a limitation of this research.

The study makes use of semi-structured interviews in order to collect empirical data. However, using interviews as tool to collect information does have several disadvantages. Namely, interviews contain some threats to reliability, despite the use of several validation instruments. Besides that, it is difficult to quantify the collected qualitative data, what could unconsciously result in conclusions which do harm truth.

The analysis and conclusion of this research demonstrate that the author distinguishes managers in two different groups. This distinction is based on interview results, which leave area for interpretation per definition. Therefore, the distinction between managerial groups is also based on interpretation of the author. In sum, other researchers may interpret results on another way.

Next to it, this research did not include a profit analysis. Therefore, there could not be concluded that proactive hospitals perform better than reactive ones. Finally, during an interview it does not always become clear if managerial comments belong to the manager as

an individual or to the hospital as a whole. The question if behavioural factors are related to managers or related to hospitals still remains unanswered. This could be seen as a limitation of this research; future studies might focus on the question to what degree a manager represents a hospital in his arguments.

8.5 Recommendations for future research

This study did not investigate the relationship between managerial conduct and their consequences for financial results. In that sense, this research is restricted to the relationship between structure and conduct, without including performance. Therefore, an interesting research area for future research could be the question whether or not differences in managerial groups do influence healthcare providers' performances and profitability.

Finally, the author distinguishes two managerial groups, defined by the author as forerunners and laggards. The progressive managers exhibit more characteristics of business thinking and are able to deal with a riskier world. However, it could be the case that the managerial background influences such behaviour. For example, a manager which has a business background might be more experienced in the process of dealing with risks than managers with a governmental background. Therefore, it could be interesting to pay attention to managerial background and the influence on behaviour in further research.

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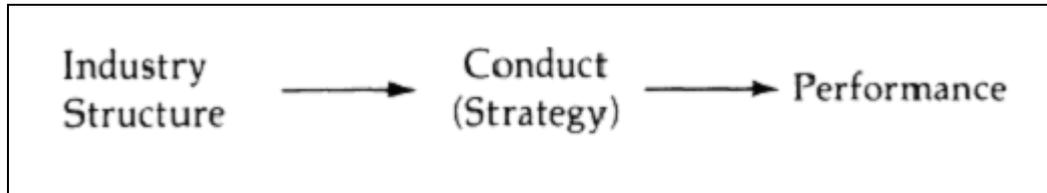
Others

Kentallen Nederlandse Ziekenhuizen (2008), Dutch Hospital Data, november 2009, Prismant kubussen.

Appendices

Appendix A – Figures

Figure 2.1: The Traditional Bain/Mason Industrial Organization Paradigm



Source: Porter, M.E. (1981). *The contributions of Industrial Organization to Strategic Management*, The Academy of Management Review, 1991, No. 6, pp 609-620.

Figure 3.1: A typology of Governance Mechanisms

Degree of formal integration	Range of interaction	
	Bilateral	Multilateral
Low: No discrete organizational structure	<i>Markets</i> <ul style="list-style-type: none"> • Self-liquidating sales • Spot-market contracts 	<i>Monitoring</i> <ul style="list-style-type: none"> • Extensive corporate interlocks for information sharing • Market-sharing agreements • Dominant-firm pricing
Moderate: Linked autonomous, but interdependent actors	<i>Obligational networks</i> <ul style="list-style-type: none"> • Follow-on weapons contracts • Long-term subcontracting • Franchise contracts • Inside contracting • Limited corporate interlocks to stabilize resource and capital flows • Small hierarchies • Joint ventures 	<i>Promotional networks</i> <ul style="list-style-type: none"> • Action sets • R&D alliances • Coalitions • Interorganizational clans
High: Bureaucratic administrative control structure	<i>Hierarchies</i> <ul style="list-style-type: none"> • Vertical and horizontal integration • Conglomerate • Job-control union contracts 	<i>Associations</i> <ul style="list-style-type: none"> • Trade association • Employer association • Producer cooperative • Unions

Source: Campbell, J.L., Lindberg, L.N. & Hollingsworth, J.R. (1991) *Structural Analysis in the Social Science: Governance of the American Economy*. Cambridge University Press 1991.

Figure 5.1: Principal changes in legal and regulatory framework (2005-2009)

Invoering Zorgverzekeringswet (2006)
Invoering van de basisverzekering; inwoners van Nederland moeten zich verplicht verzekeren voor het basispakket. Voor zorgverzekeraars geldt een acceptatie- en zorgplicht.
Geleidelijke afbouw van de ex-post risicoverevening waardoor zorgverzekeraars worden geprikkeld tot doelmatige zorginkoop.
Invoering Wet Marktordening Gezondheidszorg (2006)
Introductie van de DBC-systematiek (2005) en de ingezette doorontwikkeling van de systematiek naar een nieuwe zorgproductstructuur (DOT).
Invoering van prestatiebekostiging in combinatie met vrije prijsvorming in het B-segment (circa 10% per 2005, 20% per 2008, 31% per 2009).
Afschaffen van de lokale initiatieven (lumpsum) voor de vrijgevestigde medisch specialisten (2008). De vrijgevestigde medisch specialisten worden per 2008 volledig bekostigd op basis van zorgprestaties.
Invoering Wet Toelating Zorginstellingen (2006)
Afschaffen van het bouwregime (2008); hierdoor krijgen zorgaanbieders de ruimte om in het belang van de consument zelf afwegingen te maken ten aanzien van hun investeringen en capaciteit.
Liberalisering van de kapitaallasten in het B-segment (2008). Vanaf 2008 lopen zorgaanbieders meer risico over de kapitaallasten in het B-segment. Om deze risicodragendheid geleidelijk in te voeren, is op advies van de commissie nadeelcompensatie (Commissie Havermans) de overgangsregeling kapitaallasten ingevoerd.

Source: Nederlandse Zorgautoriteit (2009b). *Uitvoeringstoets van budget naar prestatie: Prestatiebekostiging binnen de medisch specialistische zorg*, October 2009.

Appendix B – Tables

Table 5.2 Guarantee regulation

Year	Guarantee percentage
2011	95%
2012	90%
2013	85%
2014	80%
2015	75%
2016	70%
2017 e.v.	0 %

Source: Brief VWS (Ministerie van Volksgezondheid Welzijn en Sport) 01 april, 2010. *Brief aan NZa betreft kapitaallasten*, kenmerk CZ/FBI-2987492, 01 april 2010.

Table 6.1: Number of Dutch Healthcare suppliers

	2004	2005	2006	2007	2008	2009
Algemene ziekenhuizen	90	89	88	87	87	85
Categorale ziekenhuizen	2	2	2	2	2	2
UMC's	8	8	8	8	8	8
Totaal aantal ziekenhuizen	100	99	98	97	95	93
ZBC's actief in B-segment	n.v.t.	37	57	68	89	125

Source: Nederlandse Zorgautoriteit (2009a). *Monitor Ziekenhuiszorg 2009*, May 2009

Appendix C – Interviewees

Drs. H.G.O.M. Berkers
Raad van Bestuur
Catharina-ziekenhuis Eindhoven

Dhr. R.L.P. Verreussel
Algemeen directeur Maasziekenhuis Pantein Boxmeer
Raad van Bestuur Pantein

Dhr. D.J. Verbeek
Voorzitter Raad van Bestuur
Groene Hart Ziekenhuis Gouda

Dhr. G.H.A.M. Van Berlo
Directeur financiën, control en informatiemanagement
Máxima Medisch Centrum Eindhoven

Drs. G.J.M. Van den Maagdenberg
Lid Raad van Bestuur
Sint Lucas Andreas Ziekenhuis Amsterdam

Dhr. P. Smits
Algemeen directeur
Maasstadziekenhuis Rotterdam

Dhr. H.P.J. Gerla
Voorzitter Raad van Bestuur
Sint Franciscus Gasthuis Rotterdam

Drs. M. Sint
Voorzitter Raad van Bestuur
Isala Klinieken Zwolle

Mw. drs. B.J.M. Gallé
Lid Raad van Bestuur
Jeroen Bosch Ziekenhuis 's-Hertogenbosch

Drs. H.J. Bellers
Directeur
Waarborgfonds voor de Zorgsector

Dr. W. Opheij
Partner
Twynstra Gudde Adviseurs en Managers

Appendix D – Internal (NZa) interviewees

Drs. M.S. Mulder
Directeur directie Zorgmarkten Cure

Drs. M. Mikkers
Stafhoofd stafafdeling Ontwikkeling

Dhr. K. Noorlag
Unitmanager unit Tweedelijns somatische zorg

Dhr. H. Van Vliet
Raadsadviseur

Dhr. T. Maas
Unithoofd O&I

Dhr. M. Vrijhoeven
Wnd. Unithoofd unit Tweedelijns somatische zorg

Mevr. N. Polman
Beleidsmedewerker unit Tweedelijns somatische zorg

Dhr. B.J. Haselbekke
Beleidsmedewerker unit Tweedelijns somatische zorg

Dhr. J. Visser
Beleidsmedewerker unit Geestelijke gezondheidszorg

Mevr. O. De Klein
Beleidsmedewerker unit Tweedelijns somatische zorg

Mevr. F. Zeldenthuis
Beleidsmedewerker unit Tweedelijns somatische zorg

Mevr. C. Ten Damme
Beleidsmedewerker unit Eerstelijns zorg en ketens

Dhr. M. Bovy
Beleidsmedewerker unit Eerstelijns zorg en ketens

Dhr. E. Stuivenwold
Beleidsmedewerker unit Tweedelijns somatische zorg

Mevr. M. De Groot
Beleidsmedewerker unit Geestelijke gezondheidszorg

Mevr. E. Gevers
Beleidsmedewerker unit Tweedelijns somatische zorg

Appendix E – Structure description

Description of the structure of the Dutch healthcare sector

State <i>A-segment</i> <i>(Future-uncertainty)</i>	Market <i>B-segment</i> <i>(Performance Payment)</i> <i>Self-employed managers</i> <i>ITCs</i>	Monitoring <ul style="list-style-type: none"> • Healthcare agreements • Competition reducing agreements and behaviour. • “Continuity of Care” 	State <i>NMa</i> <i>IGZ</i> <i>NZa</i> <i>CVZ</i> <i>DBC-Onderhoud</i>
	Obligational Networks <i>Vertical collaboration</i> <i>Vlietland-DSW</i> - ICT - Administrative - Purchases - Facilitation - Communication	Promotional Networks <i>Horizontal collaboration</i> - A12 - A7 - Santeon - Gezonde Regio - STZ	
	Hierarchy <i>Mergers</i> <i>Acquisitions</i>	Associations <i>Industry Organisations:</i> - NFU - NVZ - OMS - ZKN - ZN <i>Other Organisations:</i> NPCF, CB,	



Conduct	
Internal	External
Business strategy (long term and short term) Investments Product choice Internal organisation Marketing Task reallocation Pressure financial and medical professionals	Dealing with profit versus non-profit Dealing with stakeholders Dealing with industry organisations Mergers, acquisitions



Performance	
Sales Profitability Employment Progress in technology Customer satisfaction	Market share Efficiency Product and Service quality Social well-being

Introduction

Figure 3.2 of this thesis shows the theoretical framework. However, a lot of governance mechanisms fall outside the scope of this thesis, as is explored in chapter four. To keep the research as complete as possible, these factors are described in this part of the appendix.

Monitoring

Monitoring coordinates economic exchanges among institutions and is an informal and unstable form of control in order to collect and share information as a collective good (Campbell, 1991). The rules of exchange are tacitly recognized by actors. Therefore it is difficult to create an overview of these informal and competition reducing appointments in the healthcare sector.

Monitoring

- Healthcare agreements
- Competition reducing agreements and behaviour.
- “Continuity of Care”

Kaats & Opheij (2008) did a research to the reasons behind collaboration in the healthcare sector. They mention ‘collaboration’ as an umbrella concept for organizing among organizations. Collaboration is based on implicit or explicit appointments and agreements in several forms. They could differ from very formal and judicial contracts, with as extreme form joint ventures, to informal and verbal agreements.

Noordegraaf (2000) states in his book that behaviour of public managers is interweaved with political impulses and accidents. “*Managers do not behave rationally, as they cannot escape routines, traditions, conventions, and the like, which are the sediments of earlier social interactions*” (Noordegraaf, 2000, p.5).

A generally known form of informal collaboration in the Dutch healthcare sector is ‘continuity of care’¹⁸. The concept of ‘continuity of care’ crosses organizational boundaries in order to help healthcare providers to improve quality and maintain continuity (Haggerty et al, 2003). Continuity is mainly viewed as the relation between single practitioner and patient in primary care. In mental healthcare the relationship is established with a team rather than one single healthcare provider.

¹⁸ Continuity of care is the translation for the Dutch term ‘ketenzorg’.

There could be identified three types of continuity, namely informational, management and relational, as illustrated in the Figure E1 below. These types of continuity could benefit to better care (Haggerty et al, 2003).

However, whether or not healthcare providers decide to collaborate in an informal way mainly depends on personal motivations (Kaats & Opheij, 2000). Just a few motives are reducible to rational support and facts. The fundamental part is based on own convictions and personal motives, like making use of others' competences and bundling power.

Figure E1. Types of continuity

Three types of continuity

Informational continuity—The use of information on past events and personal circumstances to make current care appropriate for each individual

Management continuity—A consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs

Relational continuity—An ongoing therapeutic relationship between a patient and one or more providers

Source: Haggerty, J.L., Reid, R.J., Freeman, G.K., Starfield, B.H., Edair, C.E. & McKendry, R. (2003). *Continuity of care: a multidisciplinary review*, BMJ, Vol. 327, November 2003.

Obligational Networks and Promotional Networks

Campbell (1991) uses the term obligational networks for a variety of interorganizational arrangements and contracting practices. Another governance mechanism described by Campbell (1991) is promotional networks, which are comparable with obligational networks. But in contrast to obligational networks, a promotional network is multilateral.

Obligational Networks

Vertical collaboration
Vlietland-DSW

- ICT
- Administrative
- Communication
- Purchases
- Facilitation

A good and generally known example of an obligational network is the case 'Vlietland-DSW'. The intended concentration between Cooperation Vlietland and Vlietland hospital can be seen as a vertical concentration. Vertical concentration in the healthcare sector stands for

the merge of institutions which are active in different, but complementary, healthcare markets, like the merge of a hospital and an insurer (NZa, 2010a). A vertical acquisition involves firms at different steps of the production process (Ross et al, 2005). The acquisition by an airline company of a travel agency would be a vertical relation.

De intended concentration between cooperation Vlietland and Vlietland hospital is a kind of a vertical concentration, since cooperation Vlietland consists of healthcare insurer DSW, 163 general practitioners and three AWBZ institutions (NZa, 2010a). To judge a vertical concentration, it is important to determine if one of the parties got some significant market power (NZa, 2010a). When an insurer and a hospital belong together, this could influence the potential entry of new entrants to the typical market. Therefore the NZa advised a closer investigation towards the intended concentration.

The example of Vlietland-DSW can be seen as a vertical collaboration, because different kind of institutions will collaborate together. It is also possible that the same kind of institutions collaborate together, which is called horizontal collaboration. Despite the fact that horizontal collaboration not always per definition must be a promotional network (and vertical collaboration not always per definition must be an obligational network), in this paragraph, the author describes some multilateral examples of horizontal collaborations between healthcare providers.

Promotional Networks
Horizontal collaboration

- A12
- A7
- Gezonde Regio
- Santeon
- STZ

- STZ

In 1996 eight hospitals took the initiative to establish a foundation with the objective to give top clinical healthcare in the Netherlands an impulse. The foundation is grown towards a cooperation of 27 hospitals. The association of cooperating top clinical ‘teaching hospitals’ (STZ¹⁹) shows that they were an important and respected actor in the development of top clinical healthcare, educations, scientific research and innovation in the Dutch healthcare sector last years (STZ, 2010).

¹⁹ STZ stands for Samenwerkende Topklinische opleidingsziekenhuizen.

STZ membership requires responsibility which goes further than provide qualitative healthcare. The STZ association consists of 27 Dutch hospitals established in a network which focuses on three distinct areas: top clinical and top preferential patient care; medical and non-medical applied educations; and scientific research and innovation. Each STZ hospital is tested on 25 criteria and hospitals have to take measures when they do not meet STZ requirements. The STZ access conditions are amplified during the time.

Furthermore, STZ hospitals work together with other healthcare providers in their region. *“The level of care given lies between that of a university medical centre, and that of a general hospital. Agreements are in place between these hospitals and STZ hospitals to cooperate in their common fields of medicine and patient referrals”* (stz-ziekenhuizen.nl, 2010). More than 43% of the Dutch patient healthcare occurs in STZ hospitals as can be seen in Figure E2 below.

Figure E2. Dutch hospitals in 2008

	Aantal instellingen		Aantal bedden		Omzet (mln euro)		Patiënt-eenheden (miljoenen)	
STZ-ziekenhuizen	27	29%	18.100	40%	6.020	36%	19,2	43%
Overige algemene ziekenhuizen	58	62%	19.100	43%	5.380	31%	19,6	45%
Universitaire medische centra	8	9%	7.700	17%	5.500	33%	5,2	12%

Source: Kentallen Nederlandse Ziekenhuizen 2008, Dutch Hospital Data, november 2009, Prismant kubussen

- Santeon

A few years ago, some hospitals found the VSZ (Vereniging Samenwerkende Ziekenhuizen) to respond to healthcare developments (santeon.nl, 2010). This collaboration has now been renamed Santeon. Each hospital retains their own culture and identity, but they have lot of common elements. All collaborating hospitals are top clinical teaching hospital in various regions which provide highly specialised medical healthcare with support of top clinical facilities. The Santeon hospitals team up to achieve high quality, safety and hospitality.

“We exchange know-how, talent and skills. By doing so, innovations and improved treatment methods in one hospital are promptly available at the others. By cooperating in the

purchasing, human resources, automation and building management departments, we can cut costs, leaving more money for medical care (santeon.nl, 2010). In some circumstances, like rare disorders, patients are referred to other Santeon hospitals.

- A7

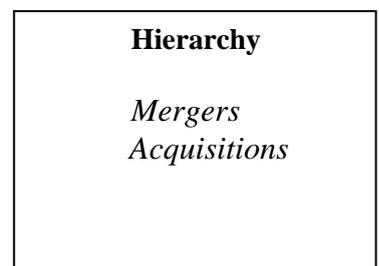
The A7 collaboration is a partnership of three hospitals (Nij Smelinghe Drachten; Antonius Ziekenhuis Sneek; De Tjongerschans Heerenveen) located nearby the Dutch national highway 'A7' (nijsmellinghe.nl, 2010). Objective of this collaboration is to make healthcare better and more transparent. The three hospitals release shared initiatives and practical and measurable healthcare appointments in order to create a better healthcare quality for the patient (antonius-frl.nl, 2010).

- A12

In 2007, four hospitals nearby the highway A12 join together in a consortium (Zorgvisie, 13 May 2009). This collaboration was based on health purchases, ICT, communication, facilitation and staff policy. These four hospitals²⁰ refounded their collaboration into a cooperation. Reason to cooperate is based on the fact that a merger will give too much managerial and administrative work. Besides that, the NMa will be very strict and precisely in this case, since the four hospitals together will acquire 20 to 30 percent market share in their region.

Hierarchy

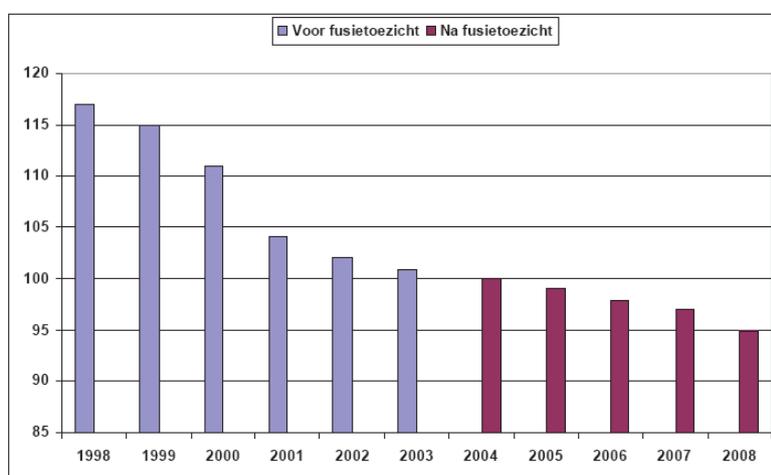
The last decades the number of general hospitals decreased in the Netherlands as a result of economies of scale (Halbersma et al, 2009). The number of hospitals has declined from 160 in 1985 to 95 in 2005, as illustrated in Figure E3. The decline in healthcare providers and the increasing scale per institution could result in situations where a healthcare provider will get too much market power. This could negatively influence price and quality of healthcare. Reason enough for the NMa to supervise concentrations of healthcare institutions since 2004 (NZa, 2009a).



²⁰ The four Dutch hospitals in the cooperation are: Bronovo Ziekenhuis in The Hague, Medisch Centrum Haaglanden, Zoetermeerse Lange Land Ziekenhuis and Groene Hart Ziekenhuis in Gouda.

In the period before 1998, there was no supervising on competition and market power (Halbersma et al, 2009). Also after foundation of the NMa in 1998, there was no control on concentrations in the healthcare sector. Up to January 2004, the NMa declared that due to the fact that there was Governmental regulation and control in the Dutch Healthcare sector, there was no possibility to develop an economic position of market power (Canoy & Sauter, 2009). However, the NMa did not realize the future consequences of mergers in a situation of regulated competition. In 2004 they reshape their attitude and opinion and proceed to judge mergers based on content.

Figure E3. Number of general hospitals in the Netherlands



Source: Halbersma, R.S., Kerstholt, W. & Mikkers, M.C. (2009). *Marktafbakening en marktmacht in de zorgsector*. Markt & Mededinging, Vol. 12, No. 2, April 2009.

A merger²¹ among two hospitals could result in two possible effects (Damme, van; 2009). On the one hand, a merger could result in economies of scale and this could increase the quality of healthcare. On the other hand, a merger could decrease the accessibility of a hospital or could make healthcare less payable.

When the NMa is judging concentrations, the crucial question they have to ask themselves is whether or not market concentrations will be a significant restriction for competition (Janssen et al, 2009). The last years a lot of mergers applications are judged by the NMa. However, the

²¹ The author used the term 'merger', but mentioned all kind of concentrations (like acquisitions).

NMa judged nine hospital applications for merger since 2004 and none of the applications was judged negatively (Van Damme, 2009).

Associations

According to Campbell (1991), associations are formally organized memberships in order to create relatively stable and formal agreements. The healthcare sector includes several types of formal organizations which are focused to promote members' interests. Therefore, this paragraph describes the more general and national associations in the Dutch healthcare sector.

Associations
<i>Industry organizations:</i> - NFU - NVZ - OMS - ZKN - ZN
<i>Other organizations:</i> NPCF, CB,

- NFU

The Dutch federation of academic medical centres, the NFU (Nederlandse Federatie van Universitair Medische Centra) is a collaboration of eight academic medical centres (nfu.nl, 2010). Their general objective is to keep the interests of this eight academic centres. Besides that, the NFU is an employers' association and negotiates with the Government and other employees' organizations on working conditions of academic medical centres.

- NVZ

The NVZ is the Dutch Hospitals Association and active in the Dutch hospital sector, in which a number of different organisations offering a coherent package of medical care (nvz-ziekenhuizen.nl, 2010). The NVZ focuses on the collective representation of members' need. Members are all general hospitals, as well as non-affiliated institutions in the Netherlands, like asthma centres or cancer centres.

“It is NVZ’s objective to create frameworks for its members that allow hospitals to respond flexibly to changes in the demand for care. A considerable part of the association’s activities therefore focuses on helping create conditions that are compatible with the sector” (nvz-ziekenhuizen.nl, 2010).

NVZ achieves this objective by means of lobbying, consulting with parties in the field or policy developments. Besides that, individual members have the opportunity to ask for advice or information regarding general or specific healthcare topics.

- OMS

De OMS (Orde van Medisch Specialisten) is a staff association for medical specialists and initiated by medical specialists (orde.artsennet.nl, 2010). This association focuses on the collective representation of the interests of both medical specialists in paid employment, self-employed medical specialist and academic specialists. Besides that, the association is responsible for the quality of healthcare provided by medical specialists.

- ZKN

The ZKN (Zelfstandige Klinieken Nederland) is one covering institution for all particular initiatives of medical specialists (zkn.nl, 2010). On this moment, ZKN represents eighty independent treatment centres²², which focus on different kind of medical specialities. ZKN only admits centres with the highest quality levels and therefore each centre which wants to join the ZKN will be tested on these quality requirements.

- ZN

ZN (Zorgverzekeraars Nederland) is the organization which represent the providers of care insurance in the Dutch healthcare sector (zn.nl, 2010). ZN is an association with nearly all Dutch healthcare insurers as member. *“The main activity of ZN is to achieve conditions in which the care insurers could operate in an optimal manner”* (zn.nl, 2010). They focus on the relationship between insurer and insured, supervisory bodies and the Government.

- NPCF

The Federation of Patients and Consumers Organisations in the Netherlands (NPCF) is the independent organisation which aims to strengthen the position of patients (npcf.nl, 2010). It was founded in 1992 to bring together hundreds patients and consumer organisations in order to speak as one voice in areas such as patients’ rights or access to care. *“The NPCF aims to strengthen the position of patients and consumers of healthcare by promoting their common interests by working with government, policymakers in national, regional and local institutions, professional organisations and providers of healthcare (home care, hospitals) and health insurance companies”* (npcf.nl, 2010).

²² Dutch = Zelfstandige Behandel Centra (ZBC’s).

Since the health reforms in the Netherlands, the NPCF is focused on access to care, quality of care and transparency in relation to the patient and consumer position. Because the NPCF is an independent organization, it is mainly financed by foundations for patients, grants from the Ministry of Health, Welfare and Sports and other foundations.

- CB

The Dutch Consumers' Association (Consumentenbond) is the association who represents the interests and values of all customers in the Netherlands (consumentenbond.nl, 2010). Their mission is to make it for customers, so also customers in the Dutch healthcare sector, easier to make the right decisions.

State

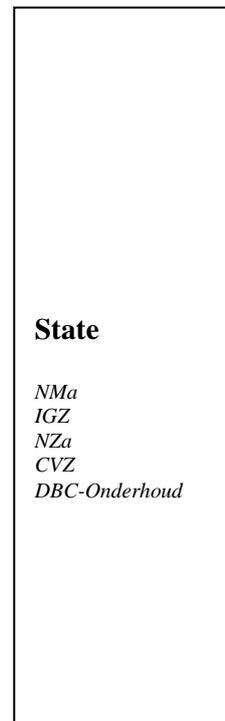
The problem statement of this thesis is based on the relation between state and market. However, as can be seen in the graphical structure description in the beginning of Appendix E, there are two elements of 'State' included in the framework. To answer the problem statement, the funding and financing, shaped by the Government, is described in chapter four. In this appendix are some governmental institutions illustrated, which are less relevant to answer the problem statement and therefore not included in the main text, in order to keep the view as complete as possible.

Therefore this paragraph describes several public authorities in the Dutch healthcare sector, as described below.

- NMa

The high values in the society nowadays create opportunities for business and consumers (nma.nl). However, therefore an effective and efficient competition enforcement policy is required, which must be independent and autonomous. The NMa takes care of the general competition enforcement as well as the specific regulation related to a typical industry, like the Dutch healthcare sector.

“The NMa’s statutory task is straightforward: ‘Making markets work’. We monitor effective competition and contribute to markets functioning properly. The effects of this mission have



become increasingly evident. Business knows that the NMa will take action against anti-competitive restrictions that inhibit their chances of success” (nma.nl, 2010).

So, the NMa ensures that competition in the Netherlands is fair and they also play a role in the healthcare sector. Healthcare providers, such as general practitioners, physiotherapist or pharmacists, may not enter into agreements which abuse a dominant position or will restrict competition (nma.nl, 2010).

- IGZ

The Healthcare Inspectorate (IGZ) promotes public health through effectively enforcement of the quality of health services (igz.nl, 2010). *“It advises the responsible ministers and applies various measures, including advice, encouragement, pressure and coercion, to ensure that healthcare providers offer only 'responsible' care” (igz.nl, 2010).* To ensure compliance with legislation, standards or guidelines, the IGZ can use various measures, like offering advice and recommendations to encourage healthcare improvements. The IGZ is also able to make use of disciplinary proceedings. Each case is examined individually by the IGZ in order to determine which enforcement measure is most effective.

- NZa

The Dutch Healthcare Authority (NZa) supervises behaviour of healthcare providers and healthcare insurers and monitors if they stick to the law (nza.nl, 2010). The NZa establishes rules and tariffs for the regulated part of the healthcare and creates conditions for competition for the deregulated and liberalized component of the sector.

The introduction of competition in the Dutch healthcare sector gives healthcare providers and insurers more freedom and responsibility to negotiate on price (nza.nl, 2010). Rules and tariffs are more and more released, but the NZa will interrupt free competition when customer values and interests are at issue. In that case, the role of the NZa can be seen as independent supervisor of the healthcare sector.

- CVZ

The College for healthcare insurances (Dutch: College voor zorgverzekeringen) is both an advising and an implementing organization for the legitimate health Insurances Zvw and the

AWBZ (cvz.nl, 2010). The CVZ does have an important contribution in keeping the Dutch healthcare qualitative, accessible and payable.

The CVZ achieves this by implement their three core tasks:

1. Giving advice regarding the contents of the basic package of insured healthcare.
2. Dividing insurance premiums among insurers.
3. Implementing the rules for specific groups.

- DBC-Onderhoud

DBC-Onderhoud develops and maintains the DBC-systematic for the healthcare (dbconderhoud.nl, 2010). Besides that, they provide service to all parties concerned with the DBC-systematic.

After introduction of the Dutch Healthcare system (DBC system) in January 2005 further development and improvement was needed. *“The Dutch DBC system describes the total episode of care delivered in hospitals: so not only the inpatient care but also outpatient and day care”* (dbconderhoud.nl, 2010). The DBC-system does have his benefits, but there are also fundamental changes that are needed to combine these benefits with benefits of DRG-systems. These needed changes are implemented in a new system that is designed and will be introduced in the coming years, named DOT.

Conclusion

This part of the Appendix, part E, describes the whole structure of the Dutch healthcare sector. In the theoretical framework of Chapter three is illustrated that all governance mechanisms could influence managerial behaviour. However, to keep this research investigable, the author decides to fence this research to factors which are in motion. Therefore this research is defined to the current transition phase in the Dutch healthcare sector and is specifically focused on the relation between market and state. However, other factors, as described in this appendix, could influence conduct. For example, the presence of some associations or the possibilities to merge could influence strategies of hospital managers. So the author chooses to let these factors outside the scope of this research, but it still may be interesting elements for future research.

Appendix F – Hospital sample information

Annual Report data

Table F.1 General sample data

Institution Name	Place of Business	Region	STZ-hospital
Isala Klinieken	ZWOLLE	East	Yes
Maasziekenhuis	BOXMEER	South	No
Sint Lucas Andreas Ziekenhuis	AMSTERDAM	West	Yes
Het Groene Hart Ziekenhuis	GOUDA	West	No
Sint Franciscus Gasthuis	ROTTERDAM	West	Yes
Maasstadziekenhuis	ROTTERDAM	West	No
Jeroen Bosch Ziekenhuis	'S-HERTOGENBOSCH	South	Yes
Catharina Ziekenhuis	EINDHOVEN	South	Yes
Máxima Medisch Centrum	VELDHOVEN	South	Yes

Table F.2 Operating Profit 2008

Institutions Name	Operating Profit
Isala Klinieken	8.078.745
Maasziekenhuis	2.648.962
Sint Lucas Andreas Ziekenhuis	6.861.368
Het Groene Hart Ziekenhuis	3.087.147
Sint Franciscus Gasthuis	6.085.748
Maasstadziekenhuis	7.462.000
Jeroen Bosch Ziekenhuis	7.449.402
Catharina Ziekenhuis	6.171.000
Máxima Medisch Centrum	2.861.000

Table F.3 Revenue comparing in B-segment 2008 and 2007

Institution Name	B-segment 2008	B-segment 2007	Growth B-segment	Average Growth ²³
Isala Klinieken	52.001.664	23.269.261	223,48%	200%
Maasziekenhuis	12.582.690	5.259.675	239,23%	200%
Sint Lucas Andreas Ziekenhuis	26.542.871	11.992.189	221,33%	200%
Het Groene Hart Ziekenhuis	23.428.620	10.589.144	221,25%	200%
Sint Franciscus Gasthuis	31.390.089	12.817.676	244,90%	200%
Maasstadziekenhuis	31.782.000	13.526.000	234,97%	200%
Jeroen Bosch Ziekenhuis	42.431.269	18.346.401	231,28%	200%
Catharina Ziekenhuis	26.680.000	11.287.000	236,38%	200%
Máxima Medisch Centrum	35.407.000	14.421.000	245,52%	200%

²³ The B-segment is enhanced from 10% towards approximately 20% since January 2008, resulting in a growth percentage of 200%.

Appendix G – DIS Data belonging to the data analysis

G.1 Data Analysis

Introduction

Based on interviews with hospital managers, the question by the author is raised if hospitals are willing to make fundamental choices in their product portfolio. With support of the investigated DIS Data, anonymously illustrated in Appendix G2 till G5, the author tries to gain some clarity with respect to this question. Therefore, the DIS Data of the nine interviewed hospitals is compared with national average. Besides that, there must be mentioned that the data is based on the period 2006-2008. Namely, in 2005 hospitals did not completely provide their data on large scale and also for 2009 not all the data is completely provided²⁴.

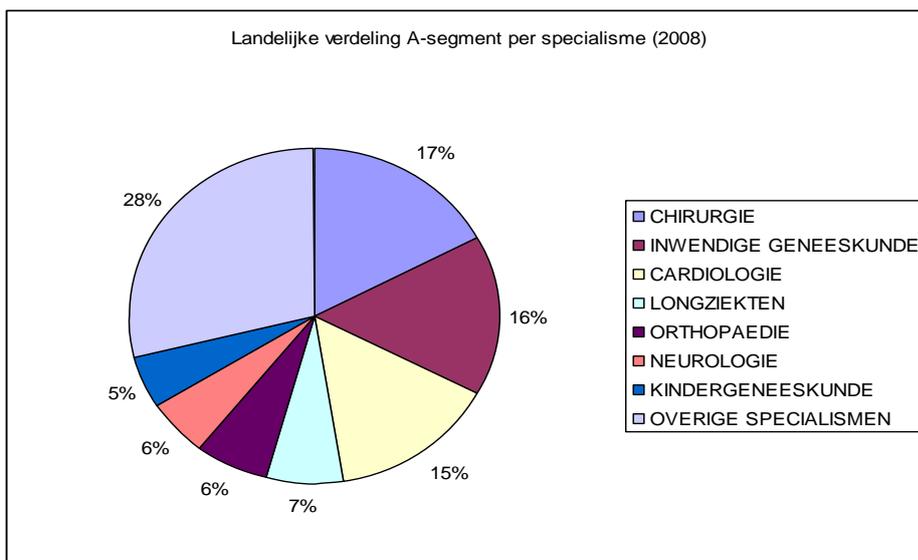
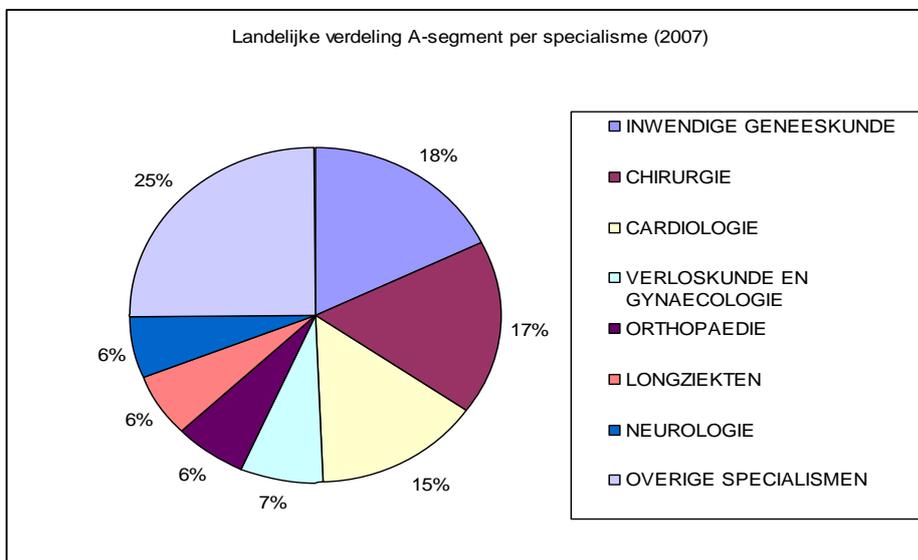
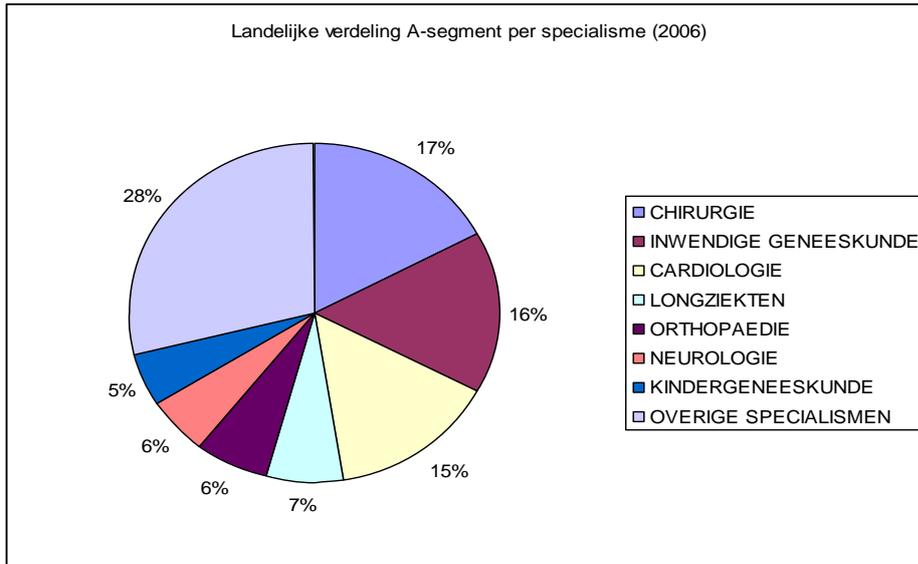
Appendix G2 illustrates the national distribution per specialism for both the A-segment and the B-segment. This distribution shows that in the period 2006-2008 the healthcare products cardiology, inward medical science (inwendige geneeskunde) and surgery can be seen as the three biggest pillars in the A-segment. The circle diagrams makes clear that on national level the healthcare products orthopaedics, surgery and obstetrics & gynaecology are during the period 2006-2008 the biggest pillars for the B-segment. During the three-year period no major shifts exists. Besides that, after enlargement of the B-segment in 2008 orthopaedics is becomes relatively smaller.

Appendix G3 illustrates the institutional distribution per specialism for both the A-segment and the B-segment in 2008. In 2008 the interviewed hospitals did not differ much from the national distributions. In order to investigate if institutions follow the same trend during the three-year period (2006-2008) Appendix G4 shows relative hospital distribution per specialism for this period. This appendix makes clear that all institutions do have the products cardiology, inward medical science and surgery as most significant pillars in the A-segment. Also in the B-segment the national trend is confirmed by which the same three pillars (orthopaedics, surgery and obstetrics & gynaecology) are the largest ones. Besides that, the national trend is confirmed that orthopaedics is relatively being smaller since 2008.

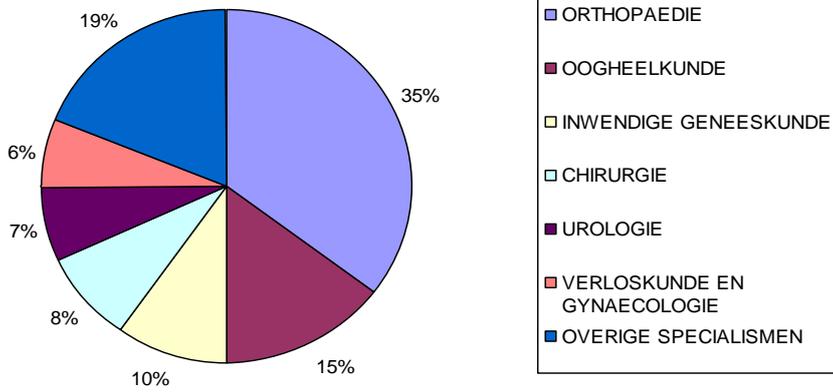
In conclusion, in both segments the national product trend is supported by the interviewed hospitals. Hospitals indeed do not make fundamental choices in their product supply. In that case, the data analysis confirms the finding in the interviews.

²⁴ This is proved in Appendix G5 (Table G5.1).

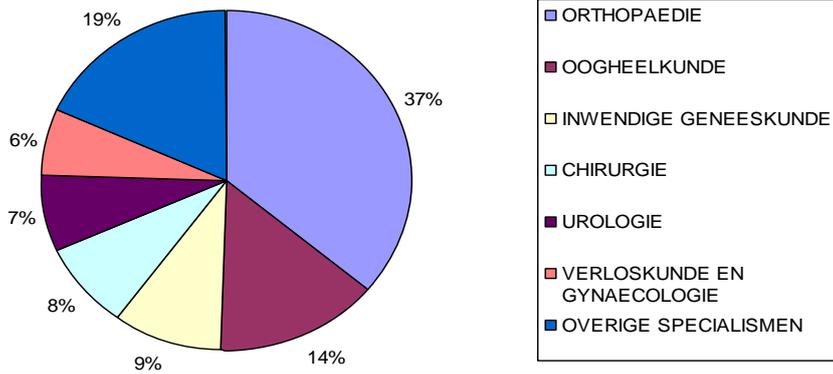
G.2: National distribution per specialisme (2006-2008)



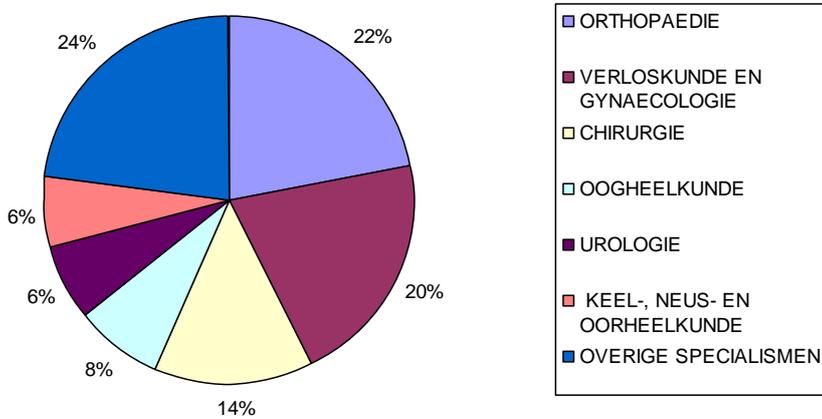
Landelijke verdeling B-segment per specialisme (2006)



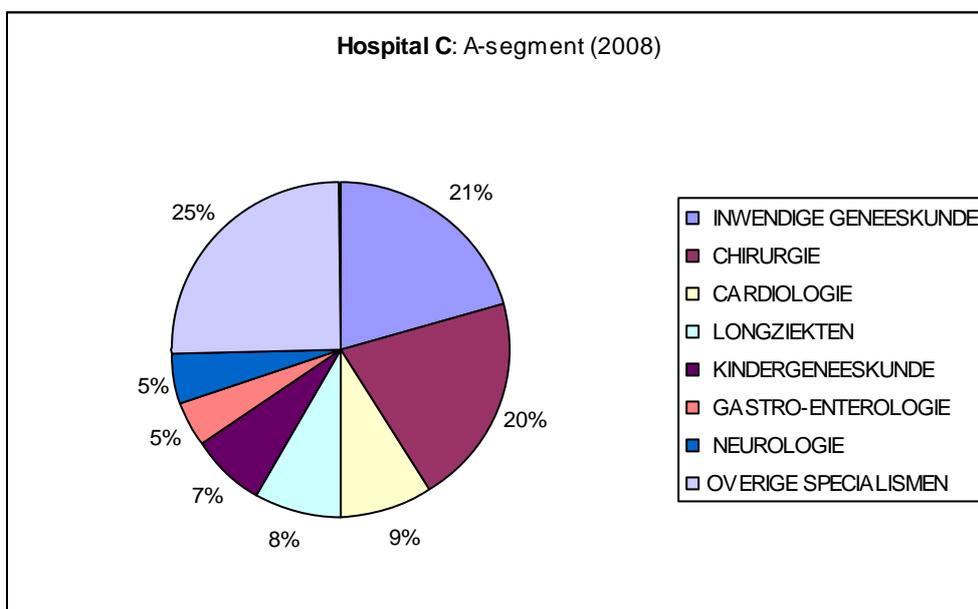
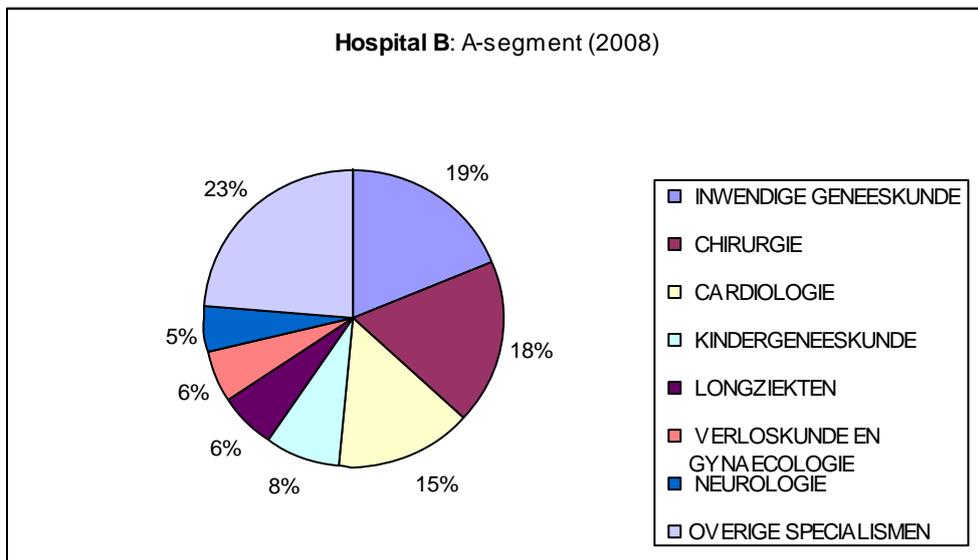
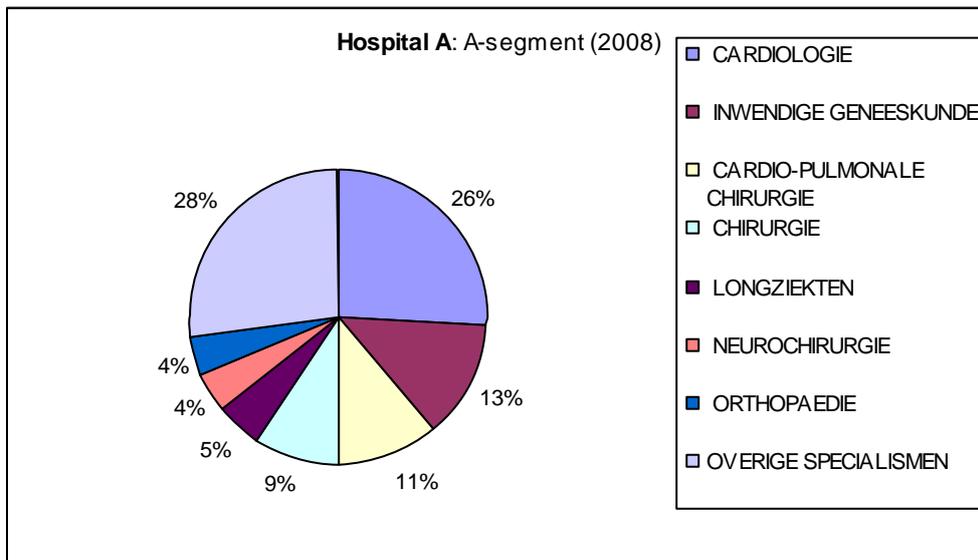
Landelijke verdeling B-segment per specialisme (2007)



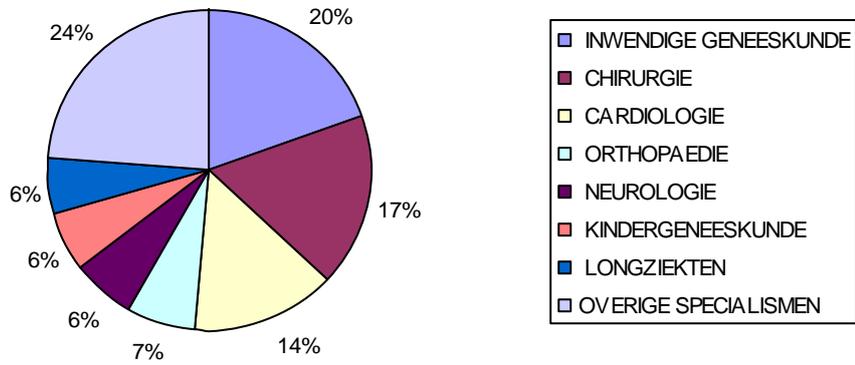
Landelijke verdeling B-segment per specialisme (2008)



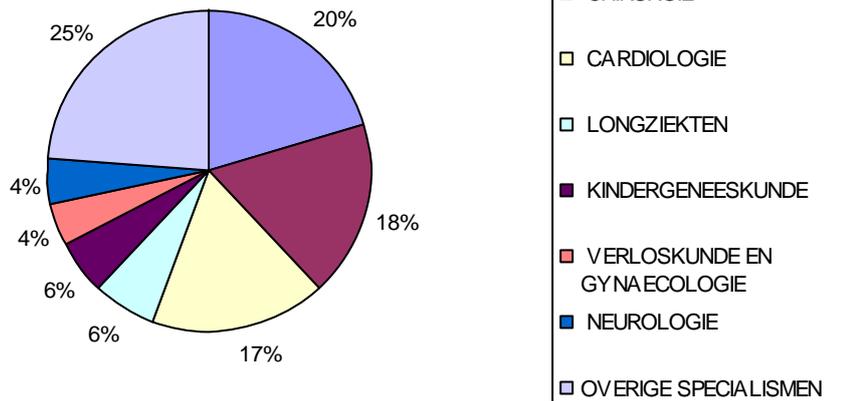
G.3: Institutional distribution per specialism (2008)



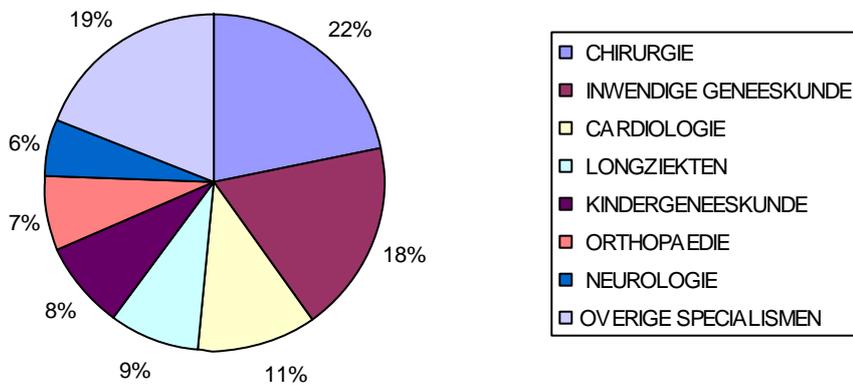
Hospital D: A-segment (2008)



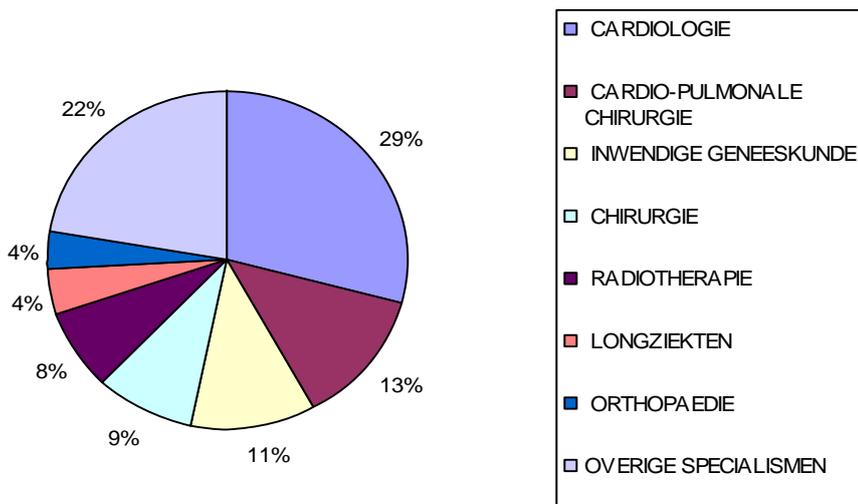
Hospital E: A-segment (2008)



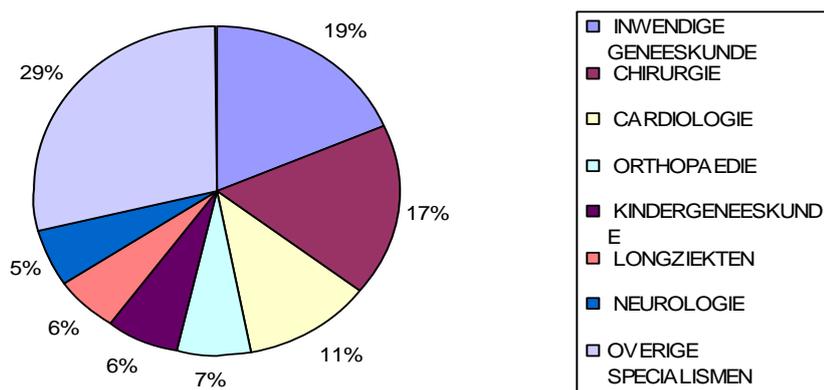
Hospital F: A-segment (2008)



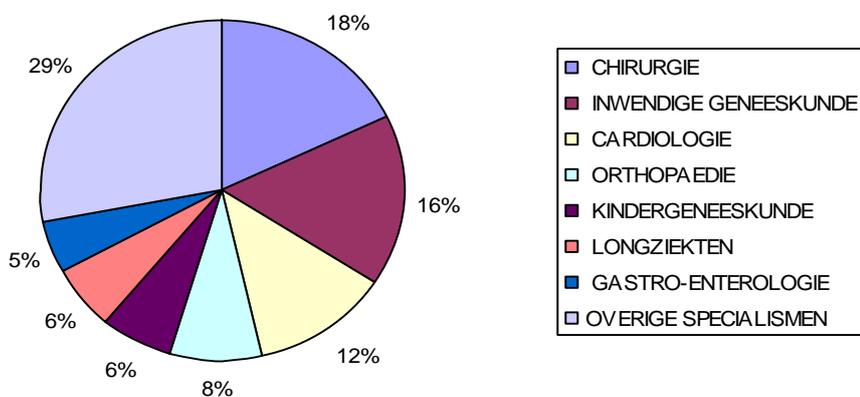
Hospital G: A-segment (2008)



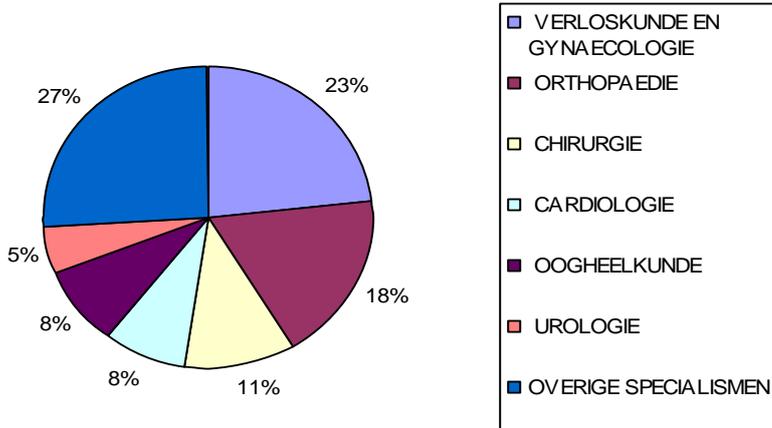
Hospital H: A-segment (2008)



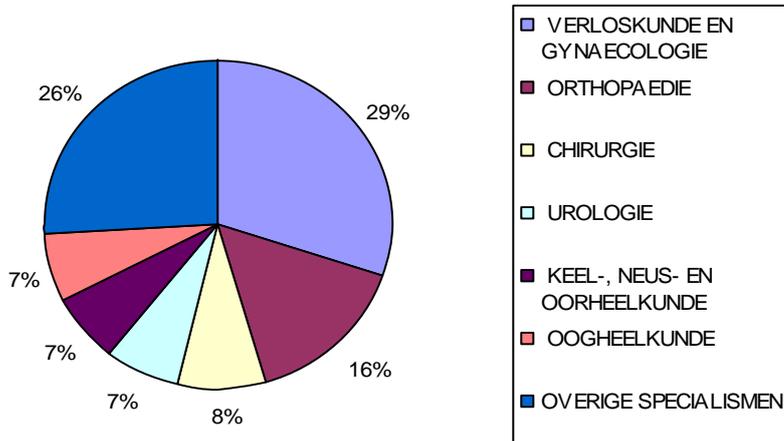
Hospital I: A-segment (2008)



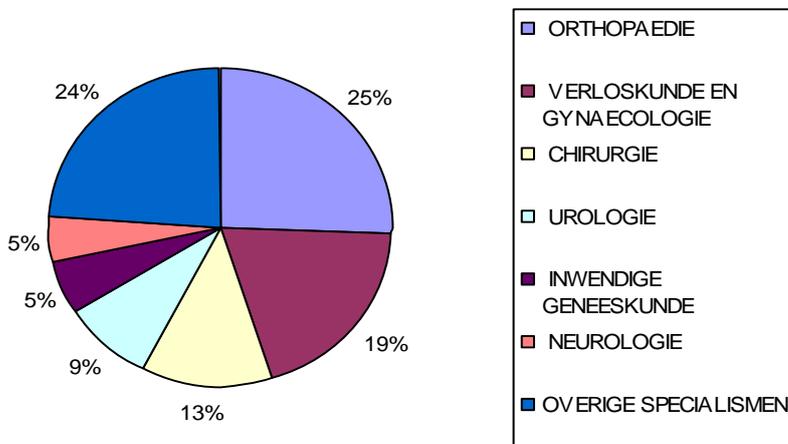
Hospital A: B-segment (2008)



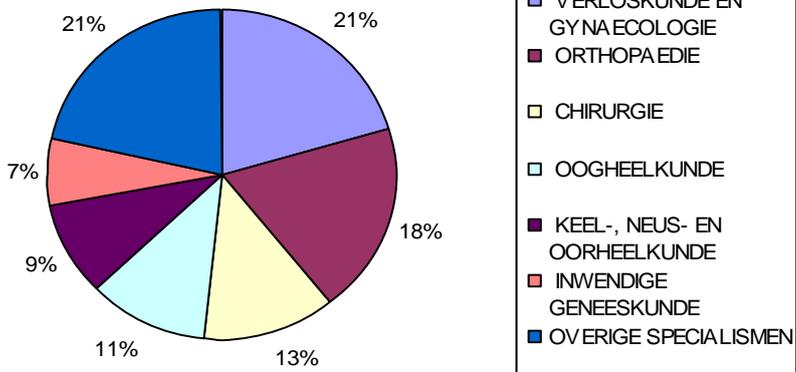
Hospital B: B-segment (2008)



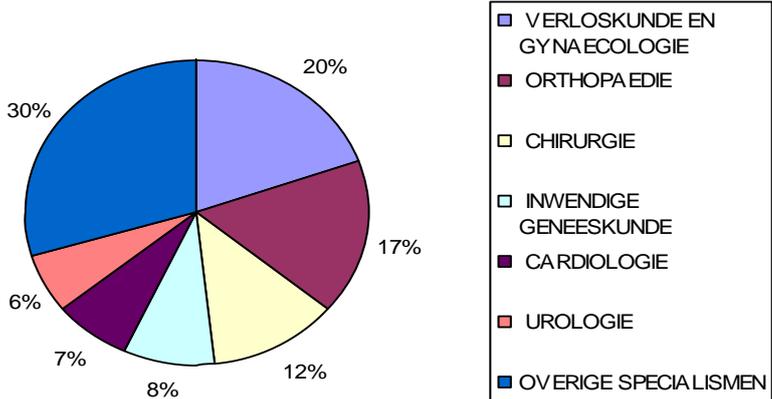
Hospital C: B-segment (2008)



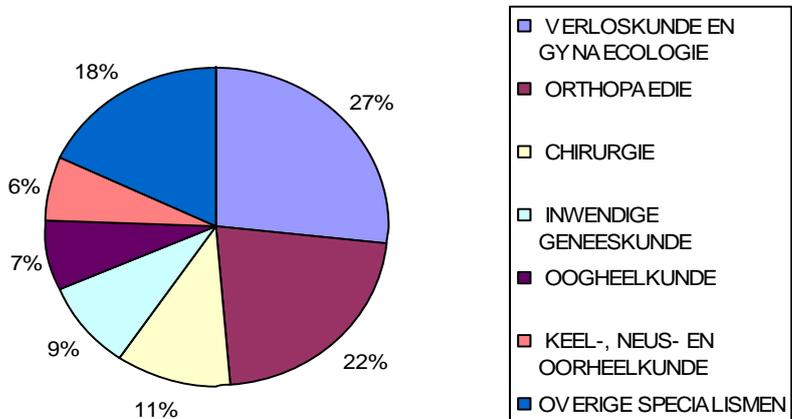
Hospital D: B-segment (2008)



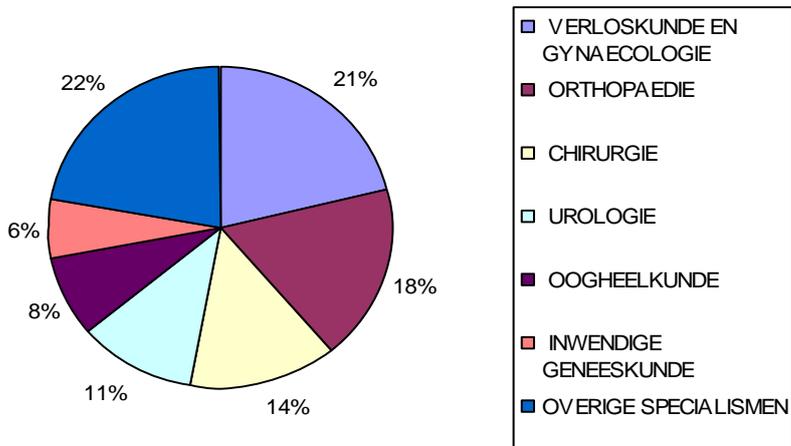
Hospital E: B-segment (2008)



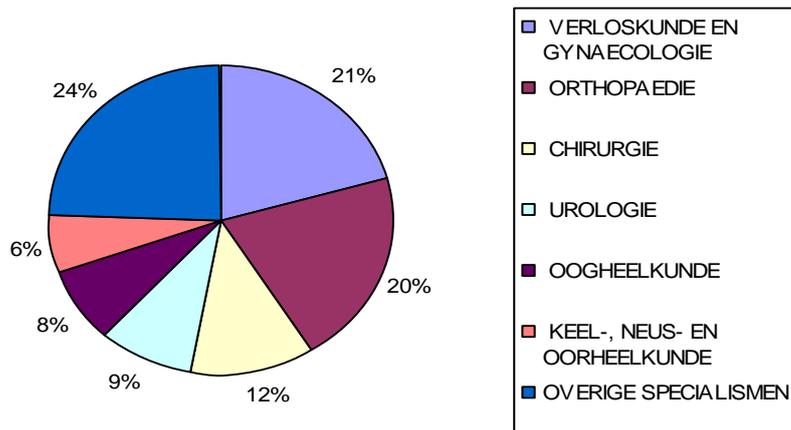
Hospital F: B-segment (2008)



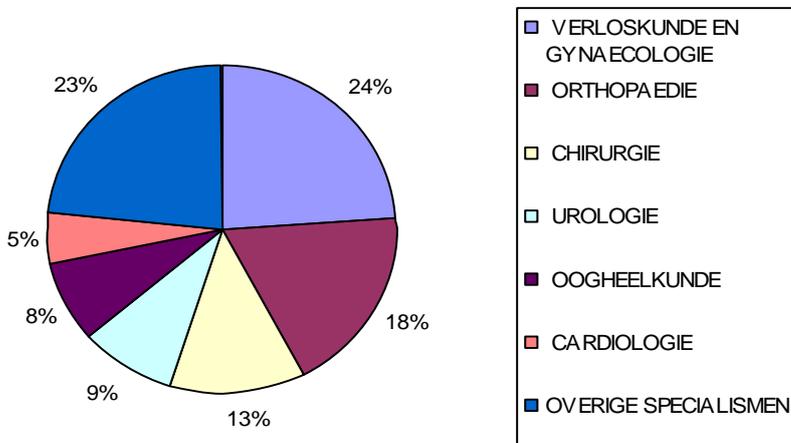
Hospital G: B-segment (2008)



Hospital H: B-segment (2008)



Hospital I: B-segment (2008)



G.4: Division per specialism on institution level (2006-2008)

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling A	ANAESTHESIOLOGIE	0,58%	0,60%	0,56%
	CARDIOLOGIE	24,87%	24,45%	26,15%
	CARDIO-PULMONALE CHIRURGIE	7,64%	6,90%	11,01%
	CHIRURGIE	10,42%	10,09%	9,14%
	DERMATOLOGIE	1,00%	1,22%	1,19%
	GASTRO-ENTEROLOGIE	3,05%	4,06%	2,97%
	INWENDIGE GENEESKUNDE	14,72%	16,57%	12,85%
	KEEL-, NEUS- EN OORHEELKUNDE	1,55%	1,89%	1,59%
	KINDERGENEESKUNDE	2,54%	2,66%	4,02%
	LONGZIEKTEN	5,03%	4,14%	5,02%
	NEUROCHIRURGIE	2,21%	2,86%	4,46%
	NEUROLOGIE	5,49%	4,39%	3,88%
	OOGHEELKUNDE	1,08%	1,04%	1,11%
	ORTHOPAEDIE	4,45%	4,89%	4,07%
	PLASTISCH CHIRURGIE	2,92%	2,68%	2,35%
	PSYCHIATRIE	0,06%	0,05%	0,04%
	RADIOLOGIE	0,24%	0,23%	0,60%
	RADIOTHERAPIE	2,38%	1,71%	2,80%
	REUMATOLOGIE	1,04%	0,93%	0,98%
	UROLOGIE	2,64%	2,57%	2,26%
VERLOSKUNDE EN GYNAECOLOGIE	6,07%	6,09%	2,95%	
Totaal Instelling A		100%	100%	100%

Institution A: The A-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling A	CARDIOLOGIE	0,00%	0,00%	8,48%
	CHIRURGIE	5,60%	5,45%	10,67%
	DERMATOLOGIE	0,84%	1,32%	2,09%
	GASTRO-ENTEROLOGIE	2,23%	2,90%	1,86%
	INWENDIGE GENEESKUNDE	8,39%	8,04%	4,03%
	KEEL-, NEUS- EN OORHEELKUNDE	4,02%	4,19%	4,71%
	KINDERGENEESKUNDE	0,94%	0,80%	0,61%
	LONGZIEKTEN	1,93%	1,86%	2,36%
	NEUROCHIRURGIE	6,26%	5,83%	2,58%
	NEUROLOGIE	2,89%	2,08%	3,64%
	OOGHEELKUNDE	17,40%	14,59%	8,38%
	ORTHOPAEDIE	32,69%	35,29%	18,01%
	PLASTISCH CHIRURGIE	1,73%	2,39%	3,42%
	REUMATOLOGIE	0,95%	0,71%	0,70%
	UROLOGIE	7,02%	7,37%	5,00%
VERLOSKUNDE EN GYNAECOLOGIE	7,10%	7,18%	23,45%	
Totaal Instelling A		100%	100%	100%

Institution A: The B-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling B	ANAESTHESIOLOGIE	0,05%	0,03%	0,07%
	CARDIOLOGIE	12,72%	14,17%	14,87%
	CHIRURGIE	19,50%	17,26%	17,53%
	DERMATOLOGIE	1,05%	0,86%	1,44%
	GASTRO-ENTEROLOGIE	1,35%	1,77%	3,16%
	INWENDIGE GENEESKUNDE	21,54%	23,30%	19,09%
	KEEL-, NEUS- EN OORHEELKUNDE	3,29%	3,60%	4,72%
	KINDERGENEESKUNDE	6,03%	5,19%	7,88%
	LONGZIEKTEN	6,77%	5,97%	6,12%
	NEUROCHIRURGIE	1,74%	1,76%	3,22%
	NEUROLOGIE	6,96%	5,20%	5,20%
	OOGHEELKUNDE	1,54%	1,39%	1,57%
	ORTHOPAEDIE	3,61%	3,35%	3,67%
	PLASTISCH CHIRURGIE	1,88%	2,19%	1,73%
	PSYCHIATRIE	0,28%	0,14%	0,32%
	RADIOLOGIE	0,39%	0,39%	0,50%
REUMATOLOGIE	0,17%	0,14%	0,25%	
UROLOGIE	2,72%	3,00%	3,03%	
VERLOSKUNDE EN GYNAECOLOGIE	8,42%	10,28%	5,62%	
Totaal Instelling B		100%	100%	100%

Institution B: The A-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling B	CARDIOLOGIE	0,00%	0,00%	4,46%
	CHIRURGIE	4,67%	3,85%	8,07%
	DERMATOLOGIE	0,60%	0,71%	0,75%
	GASTRO-ENTEROLOGIE	1,00%	1,15%	1,60%
	INWENDIGE GENEESKUNDE	9,79%	9,14%	6,07%
	KEEL-, NEUS- EN OORHEELKUNDE	5,65%	5,87%	6,73%
	KINDERGENEESKUNDE	1,55%	1,08%	0,45%
	LONGZIEKTEN	0,61%	1,44%	1,40%
	NEUROCHIRURGIE	12,10%	13,01%	4,69%
	NEUROLOGIE	4,76%	4,36%	4,22%
	OOGHEELKUNDE	11,42%	12,56%	6,65%
	ORTHOPAEDIE	32,96%	31,69%	15,61%
	PLASTISCH CHIRURGIE	2,48%	2,22%	2,35%
	REUMATOLOGIE	0,13%	0,12%	0,08%
	UROLOGIE	7,70%	8,54%	6,91%
VERLOSKUNDE EN GYNAECOLOGIE	4,58%	4,27%	29,96%	
Totaal instelling B		100%	100%	100%

Institution B: The B-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling C	ANAESTHESIOLOGIE	1,00%	1,00%	1,25%
	CARDIOLOGIE	8,81%	12,00%	8,89%
	CHIRURGIE	17,68%	15,70%	20,45%
	DERMATOLOGIE	1,97%	1,49%	1,89%
	GASTRO-ENTEROLOGIE	3,26%	3,46%	4,62%
	INWENDIGE GENEESKUNDE	23,98%	28,16%	20,75%
	KEEL-, NEUS- EN OORHEELKUNDE	1,94%	1,22%	4,16%
	KINDERGENEESKUNDE	5,97%	5,32%	7,05%
	LONGZIEKTEN	6,65%	6,38%	8,06%
	NEUROCHIRURGIE	0,79%	0,89%	0,83%
	NEUROLOGIE	6,77%	0,50%	4,58%
	OOGHEELKUNDE	0,71%	0,51%	0,77%
	ORTHOPAEDIE	3,87%	3,44%	3,25%
	PLASTISCH CHIRURGIE	1,69%	1,36%	2,09%
	PSYCHIATRIE	0,22%	0,10%	0,10%
	RADIOLOGIE	0,31%	0,30%	0,66%
REUMATOLOGIE	3,04%	2,76%	3,16%	
UROLOGIE	3,94%	3,76%	3,23%	
VERLOSKUNDE EN GYNAECOLOGIE	7,40%	7,11%	4,22%	
Totaal instelling C		100%	100%	100%

Institution C: The A-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling C	CARDIOLOGIE	0,00%	0,00%	4,40%
	CHIRURGIE	7,84%	8,28%	12,56%
	DERMATOLOGIE	6,12%	4,73%	2,91%
	GASTRO-ENTEROLOGIE	0,72%	0,93%	1,34%
	INWENDIGE GENEESKUNDE	7,03%	7,68%	5,39%
	KEEL-, NEUS- EN OORHEELKUNDE	3,02%	2,56%	2,47%
	KINDERGENEESKUNDE	0,34%	0,24%	0,17%
	LONGZIEKTEN	2,99%	2,87%	1,97%
	NEUROCHIRURGIE	5,65%	4,92%	3,00%
	NEUROLOGIE	3,74%	4,72%	4,81%
	OOGHEELKUNDE	6,87%	7,08%	4,01%
	ORTHOPAEDIE	36,18%	38,47%	25,84%
	PLASTISCH CHIRURGIE	3,43%	2,08%	1,55%
	REUMATOLOGIE	2,16%	1,86%	1,94%
UROLOGIE	9,48%	9,13%	8,56%	
VERLOSKUNDE EN GYNAECOLOGIE	4,44%	4,45%	19,07%	
Totaal instelling C		100%	100%	100%

Institution C: The B-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling D	ALLERGOLOGIE	0,00%	0,00%	0,34%
	ANAESTHESIOLOGIE	0,62%	0,67%	0,86%
	CARDIOLOGIE	11,97%	12,18%	14,13%
	CHIRURGIE	19,41%	17,33%	17,16%
	DERMATOLOGIE	1,52%	1,43%	1,87%
	GASTRO-ENTEROLOGIE	2,75%	2,60%	2,62%
	GERIATRIE	1,57%	1,56%	1,89%
	INWENDIGE GENEESKUNDE	19,62%	23,14%	19,77%
	KEEL-, NEUS- EN OORHEELKUNDE	3,20%	3,52%	3,15%
	KINDERGENEESKUNDE	5,77%	5,09%	5,88%
	LONGZIEKTEN	5,76%	4,95%	5,64%
	NEUROCHIRURGIE	0,39%	0,38%	0,39%
	NEUROLOGIE	6,85%	6,71%	6,35%
	OOGHEELKUNDE	2,21%	2,23%	2,39%
	ORTHOPAEDIE	5,06%	5,95%	7,07%
	PLASTISCH CHIRURGIE	1,93%	1,87%	1,59%
	RADIOLOGIE	0,27%	0,39%	0,66%
	REUMATOLOGIE	0,91%	0,76%	0,95%
	REVALIDATIE	0,00%	0,00%	0,00%
	UROLOGIE	3,42%	2,93%	2,86%
VERLOSKUNDE EN GYNAECOLOGIE	6,78%	6,30%	4,43%	
Totaal instelling D		100%	100%	100%

Institution D: The A-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Institution D	CARDIOLOGIE	0,00%	0,00%	4,10%
	CHIRURGIE	9,05%	9,16%	12,51%
	DERMATOLOGIE	0,73%	0,65%	1,48%
	GASTRO-ENTEROLOGIE	0,66%	0,81%	0,99%
	INWENDIGE GENEESKUNDE	13,53%	9,06%	6,65%
	KEEL-, NEUS- EN OORHEELKUNDE	6,83%	6,73%	9,05%
	KINDERGENEESKUNDE	0,86%	1,03%	0,52%
	LONGZIEKTEN	0,58%	0,74%	1,30%
	NEUROCHIRURGIE	2,44%	2,78%	1,28%
	NEUROLOGIE	4,95%	3,95%	4,08%
	OOGHEELKUNDE	16,49%	18,33%	11,31%
	ORTHOPAEDIE	31,05%	30,30%	18,49%
	PLASTISCH CHIRURGIE	0,91%	0,76%	1,09%
	REUMATOLOGIE	0,60%	0,31%	0,88%
	UROLOGIE	4,93%	9,62%	5,67%
VERLOSKUNDE EN GYNAECOLOGIE	6,38%	5,77%	20,59%	
Totaal instelling D		100%	100%	100%

Institution D: The B-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling E	ALLERGOLOGIE	0,27%	0,49%	0,47%
	ANAESTHESIOLOGIE	0,98%	0,96%	1,53%
	CARDIOLOGIE	19,23%	18,65%	17,45%
	CHIRURGIE	18,68%	16,88%	17,69%
	DERMATOLOGIE	1,65%	1,53%	1,69%
	GASTRO-ENTEROLOGIE	2,04%	1,45%	2,72%
	INWENDIGE GENEESKUNDE	22,66%	26,27%	20,47%
	KEEL-, NEUS- EN OORHEELKUNDE	1,75%	2,14%	2,71%
	KINDERGENEESKUNDE	5,14%	3,83%	5,54%
	LONGZIEKTEN	4,75%	5,70%	6,04%
	NEUROCHIRURGIE	1,56%	1,54%	1,81%
	NEUROLOGIE	5,02%	4,52%	4,45%
	OOGHEELKUNDE	0,62%	0,58%	0,73%
	ORTHOPAEDIE	3,13%	2,87%	3,47%
	PLASTISCH CHIRURGIE	2,07%	2,03%	3,29%
	RADIOLOGIE	0,50%	0,46%	0,92%
REUMATOLOGIE	2,00%	1,69%	2,29%	
UROLOGIE	2,62%	2,54%	2,24%	
VERLOSKUNDE EN GYNAECOLOGIE	5,33%	5,85%	4,49%	
Totaal instelling E		100%	100%	100%

Institution E: The A-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling E	CARDIOLOGIE	0,00%	0,00%	7,38%
	CHIRURGIE	6,27%	6,47%	12,10%
	DERMATOLOGIE	0,62%	0,47%	0,64%
	GASTRO-ENTEROLOGIE	0,95%	0,41%	1,64%
	INWENDIGE GENEESKUNDE	16,90%	14,16%	8,31%
	KEEL-, NEUS- EN OORHEELKUNDE	3,61%	4,48%	6,29%
	KINDERGENEESKUNDE	1,22%	1,47%	0,76%
	LONGZIEKTEN	0,81%	0,85%	1,24%
	NEUROCHIRURGIE	6,02%	6,36%	5,07%
	NEUROLOGIE	2,47%	3,06%	5,63%
	OOGHEELKUNDE	6,34%	6,81%	4,46%
	ORTHOPAEDIE	38,86%	42,27%	16,53%
	PLASTISCH CHIRURGIE	3,00%	2,00%	2,96%
	REUMATOLOGIE	1,13%	1,02%	0,95%
	UROLOGIE	7,09%	6,53%	6,41%
VERLOSKUNDE EN GYNAECOLOGIE	4,72%	3,65%	19,65%	
Totaal instelling E		100%	100%	100%

Institution E: The B-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling F	CARDIOLOGIE	13,21%	13,70%	11,33%
	CHIRURGIE	22,67%	19,89%	22,08%
	DERMATOLOGIE	2,02%	2,41%	3,02%
	GERIATRIE	0,00%	0,00%	0,06%
	INWENDIGE GENEESKUNDE	15,85%	15,91%	18,01%
	KEEL-, NEUS- EN OORHEELKUNDE	3,51%	3,97%	4,05%
	KINDERGENEESKUNDE	4,28%	5,18%	8,17%
	LONGZIEKTEN	8,39%	9,48%	8,63%
	NEUROLOGIE	6,80%	4,72%	5,64%
	OOGHEELKUNDE	2,64%	2,97%	2,99%
	ORTHOPAEDIE	6,56%	6,95%	7,33%
	PLASTISCH CHIRURGIE	0,15%	0,00%	0,00%
	RADIOLOGIE	0,04%	0,04%	0,02%
	REVALIDATIE	0,00%	0,00%	0,00%
UROLOGIE	4,76%	4,24%	4,86%	
VERLOSKUNDE EN GYNAECOLOGIE	9,13%	10,54%	3,80%	
Totaal instelling F		100%	100%	100%

Institution F: The A-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling F	CARDIOLOGIE	0,00%	0,00%	3,27%
	CHIRURGIE	9,24%	7,67%	10,85%
	DERMATOLOGIE	7,90%	7,50%	4,43%
	INWENDIGE GENEESKUNDE	14,45%	15,57%	8,74%
	KEEL-, NEUS- EN OORHEELKUNDE	4,65%	3,92%	6,40%
	KINDERGENEESKUNDE	0,68%	1,33%	0,65%
	LONGZIEKTEN	0,65%	1,21%	2,29%
	NEUROLOGIE	2,07%	1,70%	1,98%
	OOGHEELKUNDE	16,82%	16,67%	7,43%
	ORTHOPAEDIE	35,45%	34,86%	22,07%
	PLASTISCH CHIRURGIE	0,05%	0,00%	0,00%
	UROLOGIE	2,79%	4,63%	5,35%
	VERLOSKUNDE EN GYNAECOLOGIE	5,25%	4,94%	26,55%
Totaal instelling F		100%	100%	100%

Institution F: The B-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling G	ANAESTHESIOLOGIE	0,30%	0,37%	0,63%
	CARDIOLOGIE	28,73%	29,04%	29,05%
	CARDIO-PULMONALE CHIRURGIE	12,07%	10,12%	12,80%
	CHIRURGIE	8,87%	8,98%	9,04%
	DERMATOLOGIE	1,37%	1,72%	2,30%
	GASTRO-ENTEROLOGIE	1,51%	1,58%	1,99%
	GERIATRIE	0,95%	1,01%	1,22%
	INWENDIGE GENEESKUNDE	12,24%	13,98%	11,08%
	KEEL-, NEUS- EN OORHEELKUNDE	0,98%	1,20%	1,34%
	KINDERGENEESKUNDE	2,46%	2,06%	2,35%
	LONGZIEKTEN	5,49%	4,52%	4,10%
	NEUROCHIRURGIE	0,06%	0,06%	0,07%
	NEUROLOGIE	2,83%	2,69%	2,76%
	OOGHEELKUNDE	1,11%	1,27%	1,66%
	ORTHOPAEDIE	3,62%	4,04%	3,78%
	PLASTISCH CHIRURGIE	1,18%	1,33%	1,61%
	PSYCHIATRIE	0,02%	0,02%	0,03%
	RADIOLOGIE	0,37%	0,28%	0,41%
	RADIOTHERAPIE	8,19%	8,05%	7,86%
UROLOGIE	3,34%	3,27%	2,72%	
VERLOSKUNDE EN GYNAECOLOGIE	4,31%	4,43%	3,20%	
Totaal instelling G		100%	100%	100%

Institution G: The A-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling G	CARDIOLOGIE	0,00%	0,00%	4,91%
	CHIRURGIE	8,62%	7,52%	13,89%
	DERMATOLOGIE	0,89%	1,31%	1,23%
	GASTRO-ENTEROLOGIE	1,07%	1,09%	1,99%
	INWENDIGE GENEESKUNDE	12,10%	11,52%	5,89%
	KEEL-, NEUS- EN OORHEELKUNDE	3,75%	2,61%	4,84%
	KINDERGENEESKUNDE	2,16%	1,34%	0,82%
	LONGZIEKTEN	0,97%	1,42%	1,73%
	NEUROCHIRURGIE	0,36%	0,47%	0,24%
	NEUROLOGIE	3,77%	4,50%	4,68%
	OOGHEELKUNDE	16,70%	15,11%	8,08%
	ORTHOPAEDIE	29,73%	33,77%	17,82%
	PLASTISCH CHIRURGIE	3,78%	3,24%	1,73%
	UROLOGIE	9,36%	12,33%	11,09%
VERLOSKUNDE EN GYNAECOLOGIE	6,73%	3,75%	21,06%	
Totaal instelling G		100%	100%	100%

Institution G: The B-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling H	ANAESTHESIOLOGIE	0,44%	0,37%	0,43%
	CARDIOLOGIE	11,31%	10,30%	11,27%
	CHIRURGIE	16,50%	16,26%	17,07%
	DERMATOLOGIE	1,70%	1,62%	2,11%
	GASTRO-ENTEROLOGIE	3,57%	3,26%	3,47%
	GERIATRIE	2,82%	2,62%	2,98%
	INWENDIGE GENEESKUNDE	19,55%	22,14%	18,55%
	KEEL-, NEUS- EN OORHEELKUNDE	2,54%	2,79%	3,07%
	KINDERGENEESKUNDE	5,23%	4,42%	6,26%
	LONGZIEKTEN	5,11%	4,60%	5,66%
	NEUROCHIRURGIE	0,14%	0,17%	0,27%
	NEUROLOGIE	6,61%	5,97%	5,49%
	OOGHEELKUNDE	2,24%	2,25%	2,17%
	ORTHOPAEDIE	4,96%	5,85%	6,75%
	PLASTISCH CHIRURGIE	2,83%	3,03%	3,18%
	RADIOLOGIE	0,58%	0,54%	0,88%
REUMATOLOGIE	1,84%	1,84%	1,54%	
UROLOGIE	5,29%	5,11%	5,07%	
VERLOSKUNDE EN GYNAECOLOGIE	6,74%	6,85%	3,80%	
Totaal instelling H		100%	100%	100%

Institution H: The A-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling H	CARDIOLOGIE	0,00%	0,00%	3,43%
	CHIRURGIE	6,32%	5,92%	11,71%
	DERMATOLOGIE	0,94%	0,93%	1,22%
	GASTRO-ENTEROLOGIE	0,83%	0,62%	1,61%
	INWENDIGE GENEESKUNDE	9,07%	10,34%	5,85%
	KEEL-, NEUS- EN OORHEELKUNDE	4,95%	3,68%	6,05%
	KINDERGENEESKUNDE	0,59%	0,78%	0,39%
	LONGZIEKTEN	0,98%	1,03%	0,92%
	NEUROCHIRURGIE	1,37%	0,91%	0,67%
	NEUROLOGIE	6,05%	5,18%	5,75%
	OOGHEELKUNDE	17,81%	18,73%	8,00%
	ORTHOPAEDIE	32,90%	34,93%	20,44%
	PLASTISCH CHIRURGIE	2,33%	2,10%	3,01%
	REUMATOLOGIE	0,58%	0,61%	1,53%
	UROLOGIE	9,11%	8,69%	8,71%
VERLOSKUNDE EN GYNAECOLOGIE	6,16%	5,54%	20,71%	
Totaal instelling H		100%	100%	100%

Institution H: The B-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling I	ALLERGOLOGIE	0,00%	0,01%	0,03%
	ANAESTHESIOLOGIE	0,19%	0,25%	0,54%
	CARDIOLOGIE	10,47%	9,95%	12,27%
	CHIRURGIE	20,28%	19,43%	17,98%
	DERMATOLOGIE	1,43%	1,76%	2,34%
	GASTRO-ENTEROLOGIE	4,53%	4,18%	5,02%
	INWENDIGE GENEESKUNDE	19,66%	18,99%	16,19%
	KEEL-, NEUS- EN OORHEELKUNDE	1,86%	2,70%	3,29%
	KINDERGENEESKUNDE	4,95%	4,95%	6,47%
	LONGZIEKTEN	5,59%	6,13%	6,00%
	NEUROCHIRURGIE	0,06%	0,17%	0,10%
	NEUROLOGIE	4,75%	4,39%	4,83%
	OOGHEELKUNDE	1,11%	1,25%	2,32%
	ORTHOPAEDIE	7,58%	8,73%	7,95%
	PLASTISCH CHIRURGIE	2,25%	2,35%	2,50%
	PSYCHIATRIE	0,11%	0,12%	0,08%
	RADIOLOGIE	0,43%	0,46%	0,46%
	REUMATOLOGIE	2,44%	2,52%	2,49%
UROLOGIE	4,58%	4,56%	4,13%	
VERLOSKUNDE EN GYNAECOLOGIE	7,75%	7,11%	5,02%	
Totaal instelling I		100%	100%	100%

Maxima Medisch Centrum: A-segment per specialism

INSTELLING_NAAM	SPECIALISME	2006	2007	2008
Instelling I	CARDIOLOGIE	0,00%	0,00%	5,14%
	CHIRURGIE	9,45%	9,43%	12,59%
	DERMATOLOGIE	0,59%	0,63%	0,82%
	GASTRO-ENTEROLOGIE	1,17%	1,41%	2,04%
	INWENDIGE GENEESKUNDE	7,10%	8,27%	3,88%
	KEEL-, NEUS- EN OORHEELKUNDE	3,24%	3,87%	4,99%
	KINDERGENEESKUNDE	0,91%	0,69%	0,41%
	LONGZIEKTEN	0,97%	1,11%	1,46%
	NEUROCHIRURGIE	1,22%	1,72%	0,58%
	NEUROLOGIE	6,84%	5,30%	4,60%
	OOGHEELKUNDE	14,04%	15,44%	8,05%
	ORTHOPAEDIE	31,15%	33,84%	18,27%
	PLASTISCH CHIRURGIE	2,93%	2,19%	2,08%
	REUMATOLOGIE	1,11%	0,96%	2,39%
	UROLOGIE	10,91%	8,31%	8,78%
VERLOSKUNDE EN GYNAECOLOGIE	8,37%	6,84%	23,92%	
Totaal instelling I		100%	100%	100%

G.5: Division A-segment vs. B-segment

Table F5.1: Division A-segment versus B-segment for each interviewed hospital (2006-2008)

		2006	2007	2008
Hospital A	A	91%	91%	84%
	B	9%	9%	16%
Totaal		100%	100%	100%
Hospital B	A	88%	89%	79%
	B	12%	11%	21%
Totaal		100%	100%	100%
Hospital C	A	88%	89%	78%
	B	12%	11%	22%
Totaal		100%	100%	100%
Hospital D	A	87%	88%	79%
	B	13%	12%	21%
Totaal		100%	100%	100%
Hospital E	A	91%	91%	84%
	B	9%	9%	16%
Totaal		100%	100%	100%
Hospital F	A	86%	86%	76%
	B	14%	14%	24%
Totaal		100%	100%	100%
Hospital G	A	94%	94%	89%
	B	6%	6%	11%
Totaal		100%	100%	100%
Hospital H	A	90%	89%	81%
	B	10%	11%	19%
Totaal		100%	100%	100%
Hospital I	A	90%	89%	79%
	B	10%	11%	21%
Totaal		100%	100%	100%

Table F5.2: Division A-segment versus B-segment for total population of general hospitals (2006-2009)

		2006	%	2007	%	2008	%	2009	%
LANDELIJK	A	8.632.018.312	89%	9.183.725.024	89%	9.392.952.869	80%	7.342.648.080	71%
	B	1.037.679.290	11%	1.160.147.429	11%	2.329.151.540	20%	3.066.596.988	29%
Totaal landelijk		9.669.697.602	100%	10.343.872.453	100%	11.722.104.409	100%	10.409.245.069²⁵	100%

²⁵ The total population (table F5.2) illustrates that institutions did not fully declare for 2009, since for 2009 a higher declared DBC amount may be expected than in 2008 based on the trend in 2006-2008. However, 2009 does show that the B-segment is enhanced in 2009 based on the division between the A-segment and B-segment.

Appendix H – Questionnaires

H1: Questionnaires regarding to interviews with hospital managers

Vorbereidend materiaal interview Ziekenhuisbestuurders

Nederlandse Zorgautoriteit

Context

In de jaren 2005-2008 zijn een aantal stappen in de regulering en bekostiging van zorg gezet: de invoering van de DBC-systematiek, de invoering en uitbreiding van prestatiebekostiging met vrije prijzen en de invoering van volledige prestatiebekostiging voor vrijgevestigde medisch specialisten. Met deze stappen is centrale overheidssturing in het Nederlandse zorgstelsel geleidelijk vervangen door een gedecentraliseerd stelsel van gereguleerde concurrentie. Concurrentie op de ziekenhuismarkt zou als oplossing moeten dienen voor de druk op arbeidsproductiviteit, stijgende zorgvraag en afnemende beroepsbevolking.

De stappen die in de jaren 2005-2008 zijn gezet, zorgen echter wel voor een duale situatie in de bekostiging van de medisch specialistische zorg. In het kader van het afstudeeronderzoek dat ik verricht vanuit de Nederlandse Zorgautoriteit (NZa), tracht ik in beeld te brengen wat de duale reguleringssituatie en het onzekere eindperspectief impliceert voor het gedrag van ziekenhuisbestuurders.

De structuur van dit interview bestaat uit een viertal verschillende thema's, gerelateerd aan verschillende gedragsaspecten. Als eerste zal worden gekeken naar de bedrijfsstrategie op lange en korte termijn. Vervolgens zal worden onderzocht welke invloed de regeringssituatie heeft op investeringskeuzes van ziekenhuizen. Daarna wordt aandacht besteedt aan productkeuzes en tot slot zal de interne organisatie bekeken worden. Door middel van deze aspecten dient een goed beeld te ontstaan van het gedrag van ziekenhuisbestuurders en de relatie met de regulering.

Binnen de context van dit interview wordt de huidige reguleringssituatie geïllustreerd door de volgende dualiteiten:

- Dualiteit in bekostigingstypen

Er zal worden gekeken naar de dualiteit in bekostiging, voortkomend uit een verschil in bekostiging tussen verschillende typen zorgaanbieders (bijvoorbeeld ziekenhuizen die deels nog een budget hebben versus zelfstandige behandelcentra die reeds volledige prestatiebekostiging kennen) en het feit dat binnen ziekenhuizen twee bekostigingssystemen naast elkaar lopen (volledige prestatiebekostiging in het B-segment en budgetsystematiek in het A-segment).

- Dualiteit in kapitaallastenregulering

Per 1 januari 2008 is het bouwregime van de WTZi voor de ziekenhuizen buiten werking gesteld. Zorgaanbieders die klinische zorg met verblijf aanbieden (A-segment), krijgen hierdoor de vrijheid om voor eigen rekening en risico investeringen in zorgvoorzieningen te doen. In principe moeten ziekenhuizen de kosten van bouw per 1 januari 2009 terugverdienen uit de DBC-opbrengsten. Echter, tot op heden loopt de nacalculatie in het A-segment via de budgettering door. Hiermee worden risico's door de overheid afgedekt. Bij overgang op volledige prestatiebekostiging vervalt in beginsel deze nacalculatie. In het B-segment is nu reeds sprake van volledige risicodragendheid van kapitaallasten.

- Dualiteit door ongelijke financiële prikkels tussen ziekenhuizen en medisch specialisten

Door afschaffing van lokale initiatieven (lumpsum) is er in het A-segment sprake van afwijkende financiële prikkels. Ziekenhuizen kennen budgettering binnen het A-segment. Voor alle medisch specialisten (exclusief medisch specialisten in loondienst) geldt binnen het A-segment volledige prestatiebekostiging op basis van DBC's.

De vraag is op welke wijze en in welke mate deze dualiteitsaspecten invloed uitoefenen op het bestuurdersgedrag. Daarnaast zal in dit interview aandacht worden geschonken aan heersende onzekerheid over het eindperspectief (wel/geen volledige prestatiebekostiging) en zal worden gekeken wat de invloed van deze onzekerheid is op het bestuurdersgedrag.

De resultaten van dit interview zullen worden verwerkt in mijn afstudeeronderzoek en zullen op vertrouwelijke wijze gebruikt worden en niet 1-op-1 herleidbaar zijn naar individuele personen of instellingen. Hierbij dient opgemerkt te worden dat er geen goede of foute antwoorden zijn. Na afloop van het gesprek zal ik een kort gespreksverslag aan U doen toekomen. Hierdoor krijgt u de mogelijkheid om te controleren of de hoofdlijnen correct zijn weergegeven. Tot slot heeft U ook altijd de mogelijkheid om achteraf opmerkingen, aanvullingen of toelichtingen door te geven. Uiteindelijke bevindingen en conclusies voortkomend uit de diverse interviews, zullen waar mogelijk gebruikt worden als aanbevelingen richting de Nederlandse Zorgautoriteit (NZa).

Navolgend treft u per thema de hoofdvragen aan die ik tijdens het interview aan u wil voorleggen.

Alvast bedankt voor uw medewerking!

Met vriendelijke groet,

Twan Klijn

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Thema 1: Bedrijfsstrategie

Onder bedrijfsstrategie wordt in deze context de bedrijfsstrategie op lange en korte termijn verstaan. Hierbij kan worden gedacht aan **realiseren van** groei, het vergroten van het eigen vermogen, het verbeteren van de kwaliteit, de service aan de patiënt verbeteren, het verlagen van de kosten, het bekend komen te staan als landelijk expertisecentrum, het aangaan van samenwerkingsverbanden, etc.

1. a. Hoe typeert u uw bedrijfsstrategie? Zit er een verschil tussen de strategie op korte en lange termijn? Waarom heeft u voor deze strategie gekozen?
2. a. Is de aanwezigheid van twee separate bekostigingsystemen (het A-segment en het B-segment) van invloed geweest op de keuze voor uw bedrijfsstrategie?
b. Heeft de aanwezigheid van twee separate bekostigingsystemen (het A-segment en het B-segment) invloed op de mate van succes van uw bedrijfsstrategie?
c. Hanteert u in het A-segment een andere strategie dan in het B-segment?
3. Maakte u in het verleden, toen er sprake was van volledige budgettering, andere keuzes in uw bedrijfsstrategie?
4. Wat zou de invoering van volledige prestatiebekostiging voor uw bedrijfsstrategie betekenen? Wat houdt u tegen om deze strategie nu al te gaan hanteren?
5. Wordt uw strategie ook beïnvloed door andere aspecten, zoals de duale kapitaallastenregulering of de afwijkende prikkels met medisch specialisten?

Thema 2: Investerings

Onder investeringen verstaan we in dit kader investeringen in gebouwen (renovatie, nieuwbouw, onderhoud) en investeringen in bepaalde medische technologie.

1. Heeft u de afgelopen periode intensief geïnvesteerd? Hoe valt de investering te typeren?
2. a. Maakt u in uw investeringskeuze onderscheid tussen het A-segment en het B-segment?
b. Heeft de aanwezigheid van een duaal reguleringssysteem op het gebied van kapitaallasten invloed op uw investeringskeuzes?
c. Heeft de aanwezigheid van een duaal reguleringssysteem op het gebied van kapitaallasten invloed op de mate van succes van uw investeringen?
3. Hoe was uw investeringsstrategie in het verleden, toen er sprake was van volledige budgettering?
4. Wat zou de invoering van volledige prestatiebekostiging voor uw investeringskeuzes betekenen? Wat houdt u tegen om dit investeringsbeleid nu al te gaan hanteren?
5. Hoe is de relatie met uw kapitaalverschaffers? Is er naast banken sprake van andere kapitaalverschaffers?
6. Spelen de volgende elementen nog een rol bij uw investeringsbeslissingen?
 - De wettelijke onmogelijkheid om winst uit te keren;
 - Het beschikbare eigen vermogen
 - De afwijkende prikkels met medisch specialisten

Thema 3: Productportefeuille

Productkeuze is een breed begrip waarbij gedacht kan worden aan elementen als de mate van specialisatie, het doorverwijzen van bepaalde patiënten naar andere aanbieders op basis van onderlinge afspraken, het bewust aanbieden van een breed pallet aan zorgvormen, het afstoten van productie naar ZBC's of de mate van innovatie.

1. Welke bewuste keuzes maakt u ten aanzien van uw productportefeuille?
2. a. Maakt u binnen deze keuzes onderscheid tussen het A-segment en het B-segment?
b. Beïnvloed het duale bekostigingssysteem, de duale kapitaallastenregulering of de afwijkende prikkels ten aanzien van medisch specialisten uw keuze?
3. Maakte u andere keuzes toen er sprake was van volledige budgettering?
4. Wat zou de invoering van volledige prestatiebekostiging voor uw productkeuzes betekenen? Wat houdt u tegen om dit investeringsbeleid nu al te gaan hanteren?
5. In hoeverre heeft u de afgelopen periode zorgproducten afgestoten richting ZBC's en wat is de reden voor deze keuze?

Thema 4: Interne organisatie

In dit thema zal aandacht besteedt worden aan de vorm van besluitvorming binnen uw organisatie (centraal of decentraal) en de rol van de medisch specialisten binnen het besluitvormingsproces.

1. Kunt u een schets geven van de wijze waarop belangrijke interne besluiten worden voorbereid en genomen?
2. Is het besluitvormingsproces veranderd door de overstap naar gereguleerde marktwerking in het algemeen en de aanpassing van de bekostiging in het bijzonder?
3. Verwacht u verdere veranderingen in de wijze van besluitvorming op het moment dat wordt overgestapt naar volledige prestatiebekostiging?
4. Wat is de rol van medisch specialisten in de besluitvorming?
In welke mate beïnvloedt de ongelijkheid in prikkels tussen medisch specialisten en het ziekenhuis de interne organisatie (verantwoordelijkheid)?

Overige

1. Zijn er nog andere elementen in de huidige fase van de zorgstructuur die invloed hebben op het gedrag van uw dagelijkse beleid?
2. Heeft u zelf nog opmerkingen en/of vragen die u graag aan mij wilt meegeven?

Hartelijk dank voor uw medewerking!!

H2: Questionnaires regarding to interviews with validation instruments

Vorbereidend materiaal interview Waarborgfonds

Nederlandse Zorgautoriteit

Context

In de jaren 2005-2008 zijn een aantal stappen in de regulering en bekostiging van zorg gezet: de invoering van de DBC-systematiek, de invoering en uitbreiding van prestatiebekostiging met vrije prijzen en de invoering van volledige prestatiebekostiging voor vrijgevestigde medisch specialisten. Met deze stappen is centrale overheidssturing in het Nederlandse zorgstelsel geleidelijk vervangen door een gedecentraliseerd stelsel van gereguleerde concurrentie. Concurrentie op de ziekenhuismarkt zou als oplossing moeten dienen voor de druk op arbeidsproductiviteit, stijgende zorgvraag en afnemende beroepsbevolking.

De stappen die in de jaren 2005-2008 zijn gezet, zorgen echter wel voor een duale situatie in de bekostiging van de medisch specialistische zorg. In het kader van het afstudeeronderzoek dat ik verricht vanuit de Nederlandse Zorgautoriteit (NZa), tracht ik in beeld te brengen wat de duale reguleringssituatie en het onzekere eindperspectief impliceert voor het gedrag van ziekenhuisbestuurders.

De gesprekken die met algemene ziekenhuizen gevoerd zijn, bestonden uit een viertal thema's, gerelateerd aan verschillende gedragsaspecten. Allereerst werd gekeken naar de bedrijfsstrategie op lange en korte termijn. Vervolgens werd onderzocht welke invloed de reguleringssituatie heeft op investeringskeuzes van ziekenhuizen. Daarnaast werd aandacht besteedt aan productkeuzes en tot slot is gekeken naar de interne organisatie van het ziekenhuis.

In deze interviews werd de huidige reguleringssituatie geïllustreerd door de volgende dualiteiten:

- Dualiteit in bekostigingstypen (volledige prestatiebekostiging in het B-segment en budgetsystematiek in het A-segment)
- Dualiteit door ongelijke financiële prikkels tussen ziekenhuizen en medisch specialisten (voor specialisten geldt binnen het A-segment volledige prestatiebekostiging op basis van DBC's)
- Dualiteit in kapitaallastenregulering

Per 1 januari 2008 is het bouwregime van de WTZi voor de ziekenhuizen buiten werking gesteld. Zorgaanbieders die klinische zorg met verblijf aanbieden (A-segment), krijgen hierdoor de vrijheid om voor eigen rekening en risico investeringen in zorgvoorzieningen te doen. In principe moeten ziekenhuizen de kosten van bouw per 1 januari 2009 terugverdienen uit de DBC-opbrengsten. Echter, tot op heden loopt de nacalculatie in het A-segment via de budgettering door. Hiermee worden risico's door de overheid afgedekt. Bij overgang op volledige prestatiebekostiging vervalt in beginsel deze nacalculatie. Met ingang van 2011 wordt de garantieregeling van kracht, waardoor instellingen gedurende een periode van 6 jaar een in omvang afnemende garantie geboden krijgen voor de kapitaallastenvergoeding die zij onder budgetbekostiging zouden hebben gehad. In het B-segment is nu reeds sprake van risicodragendheid van kapitaallasten.

Gedurende de interviews met verschillende bestuurders van ziekenhuizen kwamen wisselende geluiden naar voren ten aanzien van de invloed van de kapitaallastenregulering op het investeringsgedrag van ziekenhuis. Ook kwam in deze gesprekken de rol van het Waarborgfonds naar voren. In dit interviewgesprek zou ik graag willen weten hoe vanuit het Waarborgfonds voor de Zorgsector (wfz) naar bepaalde zaken gekeken wordt en welke rol het Waarborgfonds heeft in de zorgsector.

De resultaten van dit interview zullen worden verwerkt in mijn afstudeeronderzoek, waarbij dient opgemerkt te worden dat er geen goede of foute antwoorden zijn. Na afloop van het gesprek zal ik een kort gespreksverslag aan U doen toekomen. Hierdoor krijgt u de mogelijkheid om te controleren of de hoofdlijnen correct zijn weergegeven. Tot slot heeft U ook altijd de mogelijkheid om achteraf opmerkingen, aanvullingen of toelichtingen door te geven. Uiteindelijke bevindingen en conclusies voortkomend uit de diverse interviews, zullen waar mogelijk gebruikt worden als aanbevelingen richting de Nederlandse Zorgautoriteit (NZa).

Navolgend treft u per thema de hoofdvragen aan die ik tijdens het interview aan u wil voorleggen.

Alvast bedankt voor uw medewerking!

Met vriendelijke groet,

Twan Klijn

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Investerings in de zorgsector

Onder investeringen verstaan we in dit kader de investeringen in gebouwen (renovatie, nieuwbouw, onderhoud) en investeringen in bepaalde medische technologie door algemene ziekenhuizen.

- Welke algemene ontwikkelingen heeft u de afgelopen jaren opgemerkt ten aanzien van investeringen door ziekenhuizen?
- Welke gevolgen heeft dat voor de rol van het Waarborgfonds?
- Kunt u beschrijven hoe het aanvraagtraject bij nieuwe aanvragen verloopt?
- Wat is de invloed van de afschaffing van het WTZi-vergunningensysteem voor het investeringsgedrag van ziekenhuizen? Welke gevolgen heeft dat voor banken en het waarborgfonds?
- Heeft het afschaffen van het WTZi-vergunningensysteem invloed op de mate van kredietverschaffing?
- Heeft de aanwezigheid van een duaal reguleringssysteem op het gebied van de kapitaallasten invloed op het investeringsgedrag van ziekenhuis?
- Hoe wordt vanuit het Waarborgfonds gekeken naar de garantieregeling tot 2017?
- Welke veranderingen merkt het Waarborgfonds op ten aanzien van de relatie tussen ziekenhuizen en banken?

Overige

- Zijn er nog andere elementen in de huidige fase van de zorgstructuur die invloed hebben op het investeringsgedrag van ziekenhuizen en beoordelingsgedrag van kredietverschaffers?
- Heeft u zelf nog opmerkingen en/of vragen die u graag aan mij wilt meegeven?

Hartelijk dank voor uw medewerking!!