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Hospital Market Competition in the Netherlands

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A cornerstone of the ongoing reform process in the Netherlands is to introduce market competition in health insurance and health care provision to make healthcare more efficient, innovative and client-driven. To avoid adverse consequences of competition for the quality, accessibility and afforda-bility of health care, the new regulatory framework contains many legal provisions – sometimes denoted as 'public constraints' to competition – regulating the market behaviour of health insurers, providers of care and 'consumers' (Bartholomée & Maarse, 2005).

The general trend in Dutch hospital care over the last decades has been one of uninterrupted consolidation. Over the period 1981-2001 the number of general hospital organisations almost halved from 172 to 96 (the number of hospitals fell significantly less because many consolidated hospitals were multi-location hospitals).

Consolidations must be approved by the Dutch Competition Authority (Nederlandse Mededingingsautoriteit). Regulations are now stricter than in the past to avoid that market concentration will erode competition. As yet, no hospital chains have been formed in the Netherlands. Hospitals prefer to operate as independent organisational entities. Nevertheless, they gradually begin to realise that the current competition wave will require them to set up effective collaborative arrangements to reinforce their market position.

The most important objective of collaboration is to counteract the ongoing consolidation on the health insurance market where in 2008 the 'big four' had almost 90% of the market.

Independent Treatment Centres

A remarkable development since 2000 concerns the rapid increase of a new type of provider organisation which, unlike general hospitals, concentrate upon a limited range of medical services such as orthopaedic surgery, cataract surgery, diagnostic services or maternity care. The number of specialised centres or 'independent treatment centres' (ITCs) rose spectacularly from 31 in 2001 to approximately 160 by the end of 2006 (NZa, 2007). The waiting list crisis at the end of the 1990s and the competition vogue in the 2000s created a more favourable environment for ITCs and eventually led to new regulatory arrangements that now give them an almost fully-fledged position in health care delivery. The current legislation allows ITCs to provide care with overnight stay for certain categories of treatments.

The rise of the number of ITCs is somewhat misleading because so far, ITCs account for a very small part (about 1%) of total expenditures for hospital care. The real impact of ITCs on hospital care may be more in their influence on the performance (e.g. productivity and quality of care) of general hospitals rather than in the market share they gained. A strategy various hospitals have adopted is to set up ITCs themselves or to actively give support to entrepreneurial specialists in their hospitals.

For-Profit Hospital Care

Healthcare legislation traditionally contained a formal ban on for-profit hospitals and, as a consequence, all hospitals in the Netherlands have a notfor- profit status. However, the previous government announced it would lift the ban as part of its market reform in 2012. An important reason for this cautious strategy was that it did not consider the new hospital payment system by means of casebased payments (see next section) to be stable enough to permit for-profit hospital medicine at short notice.

The new government that took office in 2007 has come up with a revised proposal. For-profit hospital care will be permitted by 2010 in order to make it easier for hospitals to attract capital resources for investments. However, there will be restrictions to the extent hospitals can pay their shareholders a return on investment. Profits must be reinvested in hospital care. Furthermore, it is forbidden that financial reserves of hospitals, particularly in real estate, that were built up in the past in a 'protected financial environment' of full cost reimbursement, leak away to the commercial sector after hospitals have gone for-profit.

If the new regulatory framework for for-profit hospital care will indeed be based upon the social enterprise concept, it will obviously restrict the potential of the hospital sector for investors. This illustrates the dependence of hospital market reforms on political conditions.

Presently, various hospitals are reconsidering their legal status of private foundation to effectively operate as an 'entrepreneur in hospital care'. One can already observe an unprecedented proliferation of so-called private limited companies (PLCs), operating under a holding structure governed by the chief executive board.

Pay for Performance and Price Competition

A very important element of the ongoing market reform in the Netherlands is that it allows for some price competition in hospital care. For that purpose, the financial revenues of each hospital are split into two segments. In the A-segment, the tariff of each DTC (Diagnosis Treatment Combination) is still centrally regulated by the Netherlands Healthcare Authority (Nederlandse Zorgautoriteit) by means of maximum tariffs. Price competition between hospitals is absent here, though ITCs may offer lower prices. Another key characteristic of the A-segment is that the NZa sets an annual budget limit for each hospital. If the revenues of a hospital exceed its budget limit, the cost overrun will be set off retrospectively. Due to this arrangement in which DTCs are only used as an administrative tool to pay for hospital care, hospitals have no incentive to 'overproduce' in the A-segment. In the B-segment, however, hospitals and insurers are free to negotiate on the prices of DTCs. Contrary to the A-segment, there is also no budget limit in the B-segment.

The fraction of revenues for which price competition is higher for general hospitals than for academic centres. The fraction also differs by type of medical specialty. Information of the NZa indicates that negotiated prices are much more relevant for orthopaedics and ophthalmology than for neurology (NZa, 2007). There are various policy issues in price competition yet to be resolved: which part of hospital care will be open to competition? Will it be 70% as envisaged in earlier government statements or will it be a significantly lower percentage? The government has repeatedly argued that price competition is inappropriate for several forms of hospital care including emergency care and top-clinical care. A second problem concerns cost control. Will competition and the concurrent lifting of the budget ceiling elicit an uncontrollable growth of expenditures for hospital care?

As yet, there are a few signs that price competition may work. Nominal price increases in the B-segment were less than in the A-segment: 0% versus 1,5% in 2006 and 2,1% versus 2,5% in 2007 (the prices of ITCs are not included in these percentages). Another interesting finding was that price increases tend to be lowest in those specialty areas where ITCs have entered the market (examples are ophthalmology, urology and gastroenterology). However, the question is of course whether these effects are only temporary.

Furthermore, they may lead to cost shifting to other sectors of healthcare that are not in the equation. Interestingly, the NZa (2007) also found that insurers with a big market share were able to negotiate lower prices than small insurers. This result suggests that hospitals consider it very important to contract with the market leader in their region. As far as the growth of volume of hospital care is concerned, the NZa signalled a stronger growth of the volume in the B-segment

than in the A-segment over the period 2005-2007. In its view this may only be a temporary registration effect of the new

funding model. Nevertheless, it does not exclude the possibility of a supply-induced demand effect (NZa, 2008).

Capital Investments

The market reform also includes a major revision of the arrangement for the financing of capital investments. Under the previous arrangement, the costs of rent and depreciation were covered by a mark-up to the inpatient per diem rate over a 40-year period after the government had given its ap-proval to these investments. As a consequence, neither hospitals nor financial agents providing long-term loans to finance hospital investments did incur a financial risk. This arrangement is considered to be incompatible with competition.

Competition not only requires hospitals to make their own investment decisions, but also to make them self-responsible for financing these investments. For that purpose they will be paid a centrally-regulated 'investment' mark-up on the DTC-rate. In this new model, the hospital's room for capital investments is contingent on hospital revenues.

Policymakers expect that the new model will make all stakeholders more critical about capital investments and financing arran gements. Hospital investments are no longer a risk-free activity for hospitals and financing agencies.

Conclusion

If we put all the pieces of this article together, we can draw the general conclusion that hospital care in the Netherlands finds itself in a period of transition. The intro duction of market competition can be regarded as an important driving force of the ongoing alter ations in the ‘hospital landscape’. The mid-term consequences of the market reform can

hardly be overseen yet, the more so because various market-making decisions have still to be taken (e.g. as regards the scope of price competition and the introduction of for-profit hospital care) or still have to become effective (in particular, the introduction of a new regulatory frame work for capital investments). Though competition in hospital care is not new, it is fair to say that both the intensity and type of competition is rapidly changing. Many begin to see hospital care is as ‘business’. Patients also tend to become more critical on hospital performance. It is an interesting time for hospitals indeed!

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