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Professionals under Supervision:
Performance-based Contracting in Hospital care & Home care

Outline of the paper

In this paper we present preliminary answers to the question of how performance-based contracting in (health) care[1] affects professional work by providing preliminary results about the way performance-based contracting is implemented in hospital care and home care. This paper adds to the existing theoretical knowledge about different types of contracts in different parts of the health care sector. We will show differences in payment systems and quality measures that are included in the contracts between care providers (hospitals and home care organizations) and purchasers of care (health insurers and care offices). This paper focuses on curative care organized by the Zvw (Health Insurance Act) and the AWBZ care market (Exceptional Medical Expenses Act). It disregards the domestic care services organized by the WMO (Social Support Act). Also, differences in the way the contract is set up and in the negotiation processes will be discussed. Before discussing the Dutch situation, the general background of problems concerning the introduction of the market-oriented health care reform of performance-based contracting in relation to professionalism will be presented. Secondly, the concepts of professionalism and performance-based contracting are discussed and linked to one another. Then, preliminary results based on orienting interviews and content analyses of policy documents and purchasing documents concerning performance-based contracting in hospital care and home care are compared. Finally, the implications for further research are discussed. Throughout this paper the main research question and research goals of the broader research project 'Professionals under Supervision' will not be lost out of sight so that the embeddedness of the preliminary results presented today within the broader project will be clear and understandable.

1. Introduction

Everywhere in Europe, governments are struggling to improve their healthcare systems performance in terms of increased efficiency and consumer-orientation (Helderman et al., 2005). Based on New Public Management (NPM) principles, market-oriented policy programs have been introduced that lead to a move away from hierarchical governance structures to market forms of governance. NPM promotes a stricter division between policy and implementation because of the belief that this increases the efficiency of public services (Dunleavy & Hood, 1994). Control on the 'relocated' implementation part takes place through systems of accountability (WRR, 2004; Pollitt & Bouckaert, 2000) by which monitoring systems and performance measurement play an important role. An essential feature of NPM is the use of contracts that link incentives to performance (Clarke & Newman, 1997; Denhardt & Denhardt, 2000), such as linking providers' budgets to, among other things, their

[1] (Health) care refers to both the curative health care sector and the care sector. From now on we will use the term 'health care' to refer to both sectors.

score on a clients' evaluation test. NPM theories assume that it is easier for governments to enter into a contract, but also to *end* a contract, with private parties than with internal government departments.

Via marketization welfare states promote competition and efficiency in the provision of public social services (Duyvendak, Knijn, & Kremer, 2006). In the health care sector, the pathway to the future shifted from one involving hierarchical, integrated service delivery and finance to one based on separating service purchasing and service provision. This separation of purchasing and providing services increasingly takes place through contractual relationships by which strategic forms of purchasing according to performance criteria are introduced. In the health care sector there is a shift from passive purchasing – whereby a predetermined budget is followed or bills are simply reimbursed retrospectively – to strategic forms of purchasing – in which proactive decisions are made about *which* health care services should be purchased or contracted, *how* and from *whom* (WHO, 2000). Clearly, health care providers always have received a global budget by which decisions have to be taken about the allocation of financial resources. However, the extent to which they are committed to be accountable for their performance (costs and quality) is far greater, more detailed and more strictly monitored than ever before.

Performance-based contracting (PBC) is the driving force of the Health Insurance Act that was introduced in the Netherlands in 2006. PBC is a way to enable regulated competition between health care providers. According to the RVZ (2008b) health care purchasing is the process that leads to a contract between a health care purchaser and the provider of care. PBC concerns the purchasing of health care, but entails more than simply allocating financial resources; it involves the negotiated agreement between health care purchaser and health care provider in which specific payment, quality and monitoring systems are included. In the most common form of PBC a base compensation for provided care is defined and there is an opportunity for additional compensation based on quality or even treatment outcome measures (Lu et al., 2003; Figueras et al., 2005). However, it is also possible that additional compensation occurs when requirements, set by the purchaser in advance, are met.

As governments put the implementation of policies at distance new modes of coordination are required (Mintzberg, 1979). PBC is such a mode and depends highly on accountability and performance measurement. It forces organizations to predict and control behavior, and therefore it appears likely that care providing organizations formalize the behavior of its workers. Mintzberg (1979) has demonstrated that an organization becomes more centralized and formalized in its structure when external control is extended. Outside control concentrates decision-making power at the top (centralization) and encourages more than usual reliance on regulations and rules for internal control (formalization). Actions have to be formalized because behavior has to be justified to outsiders. As PBC is undoubtedly connected to increased external control we assume that it leads to centralization and formalization within care providing organizations. Thus, PBC affects organizational structures because it demands internal changes in order to adapt to a new situation.

As PBC increases organizational centralization and formalization, it is worthwhile to consider the effects of these aspects of organizational structure on the work autonomy of professionals because autonomy is a crucial element of professional work and thus professionalism. According to

Mintzberg, “autonomy allows the professionals to perfect their skills, free of interference” (1979: 371). Others also suggested that professionalism is based on self-control (autonomy), which is founded in distinctive expertise, knowledge, and skills (Freidson, 2001; Knijn, 2000; Lipsky, 1980; Knijn & Verhagen, 2007).

Recently, there has been a wide and vested interest in changes in professional work and autonomy of professionals working in the public sector due to the introduction of market-oriented reforms such as PBC (e.g. Van den Brink et al., 2005; Bovens & ‘t Hart, 2005; Tonkens, 2008;). Long running suggestions have been taking place that a process of de-professionalization due to developments as marketization, managerialism and consumerism is underway (e.g. Exworthy & Halford, 1999; Noordegraaf, 2006). Marketization is believed to be particularly frightening from the point of view of the autonomous professional. As Freidson (2001: 3) stated: “Now, especially in the United States but also elsewhere, their position (*professionals, RO*) is being seriously weakened in the name of competition and efficiency.” However, few studies have tested the consequences of market-oriented reforms on professional work and autonomies empirically. A comprehensive theoretical account of how the mechanisms of PBC function, let alone their consequences for organizational structures and professional work are still missing. Professionals are increasingly being exposed to nonprofessional and outside control (Noordegraaf, 2007). Nonetheless, it remains unclear if professional autonomies are truly eroded because of PBC.

There are ample grounds for continued research on PBC and professionalism to provide as better basis for understanding their relationship. The central research question of the broader project ‘Professionals under Supervision’ focuses on the consequences of PBC for organizational structures, intrinsic job satisfaction (autonomy, purpose, self-fulfillment) and the work content (task variety, task complexity, task repetitiveness) of medical specialists, nurses and home care workers in the Netherlands. The current paper will help to answer that question. It focuses on the contracts and the contracting process itself. An attempt will be made to discover how the contracts that are used will affect professional work.

2. Theories on professionalism and (de)-professionalization

Studies on professionalism often take the definition developed by Freidson as a starting point. Freidson uses the term professionalism “to refer to the institutional circumstances in which the members of occupations rather than consumers or managers control work” (2001: 12). Apart from ‘professionalism’ Freidson distinguishes institutional circumstances in which consumers control professional work; he calls this ‘markets’ and a situation in which managers control the work of professionals; he calls this ‘bureaucracy’. According to Freidson, professionalism is about *discretionary specialized work* characterized by being theoretically based, discretionary knowledge and by its special status in the labor force. Also, there is “*exclusive jurisdiction in a particular division of labor created and controlled by occupational negotiation*”. Moreover, professionals have a *sheltered position in the labor market* that is based on qualifications created by the occupation that is retrieved through a *formal training program* that is controlled by the occupation. Finally, professionals have a *great commitment to doing good work* instead of focusing on economic gains by which quality is more

important than economic efficiency (2001: 127). The most important elements of his definition are professional control, intrinsic motivation and professional norms.

We believe a distinction should be made between professionalism, profession, professional and (de)professionalization because all concepts refer to a different level of analysis. Professionalism refers to the position of professionals in general, in the institutional context compared to the position of consumers and managers; this concerns a theoretical (abstract) level of analysis. We believe the aspects that Freidson attributed to 'professionalism' are elements of the 'profession' or 'occupation' (formal training, legitimized status in the labor market, discretionary specialized knowledge, commitment to doing good, sheltered position in the labor market).

The concept of 'professional' contains an affective component and is about individual workers. In this study the working definition of a 'professional' implies that a professional occupies a sheltered profession with an exclusive jurisdiction in the labor market, by which the work is characterized by discretionary specialized knowledge which has been gained through a formal training program. The professional is committed to doing good, believes his work should satisfy intrinsic needs, feels his tasks should contribute to a higher purpose and prefers to exert a certain degree of control over his own work. However, in this project the concept of 'professional' is treated as a continuum ranging from 'full' professional (Freidson, 2001: 108) to 'semi' professional (Etzioni, 1969: v). A distinction is made between highly specialized professionals (high skilled) and semi-professionals (low skilled). Etzioni compares semi-professionals to highly specialized professionals as follows: "their training is shorter, their status is less legitimized, their right to privileged communication is less established, there is less of a specialized body of knowledge, and they have less autonomy from supervision or societal control than 'the' professions" (1969: v).

The final concept is (de)professionalization. This process can occur on two different levels: 1. on an abstract level; it concerns the institutional component of professional work (professionalism). (De)-professionalization on this level indicates a decrease of importance of the position of professionals in the institutional context compared to the general position of managers and/or consumers. 2. (De)-professionalization can take place on an occupational level; the characteristics that Freidson attributed to a profession are the starting point. (De)-professionalization on this level means that a particular occupation or occupational group in fact loses some of its power and perhaps some of its very existence as certain components are not, or to a lesser extent, present (any more). In this project professional autonomy is regarded as the most crucial aspect of professionalism.

We believe that PBC has different consequences on the work of full professionals (medical specialists) than on semi professionals (nurses) or quasi professionals (home care workers) because of their differences in level of professionalism. This study will not answer the question whether the concept of professionalism is in need of reinforcement; it will look into the question what happens to professional work in terms of content and intrinsic job satisfaction (autonomy, self-fulfillment, purpose) as a result of the new coordination mechanism. It will study how the professional logic to govern public services alters because of contracting.

3. Theories on performance-based contracting

The separation of purchasing/contracting on the one hand and providing health care on the other hand is used to introduce market mechanisms. In that way, competition among providers of care will increase so that the overall efficiency levels would raise (Savas et al., 1998). Since PBC is an attempt to introduce market principles in the health care and welfare sector, we will elaborate further on the type of market we see in health care.

The argument that a market in health care purchasing could lead to beneficial outcomes goes as follows. “Let us assume a system in which citizens are free to insure with a purchaser of their choice (or none at all) at a premium reflecting expected personal costs of care. The mobility of patients requires that purchaser surplus depends on winning and retaining profitable membership. Purchasers are expected to maximize some concept of long-run financial surplus. In principle, these actions should promote, respectively: quality, choice, innovation and efficiency” (Figueras et al., 2005: 106).

As in every market, supply and demand exist in the health care market. In health care, market forces are present if care users are free to choose where they purchase care or take out health insurance, and health insurers are free to choose which care provider they purchase care from. Care providers are in turn free regarding the care they provide and its price and health insurers are free regarding the insurance they offer and its price. Providers (care providers and health insurers) compete with each other by providing care that is better and/or cheaper than those of their competitors. It appears that markets perform well under certain circumstances. First, when there is potential for a high level of competition. Second, when providers are not tied to specific purchasers due to made investment. Third, when uncertainty and complexity of products is relatively low and fourth, when few economies of scale apply. However, in health care these conditions are absent (Figueras et al., 2005: 49). Therefore, the health care there is a regulated market rather than an entirely free market. Although care purchasers and care providers have some freedom, this is restricted by rules and laws. In the Netherlands, the government wants to regulate the market and manage competition in order to prevent undesired effects and to protect the public objectives of quality, accessibility and affordability (RIVM, 2008). To summarize: regulated market forces are an alternative for both market organization and government intervention.

Interestingly, competition between purchasing organizations is relatively rare. The Netherlands and Germany are the only countries in Europe where such market-based reforms are taking place on the purchaser market (Figueras et al., 2005). This makes the Netherlands in interesting research topic, also for other European countries. Figueras et al. (2005) have found that a difference can be detected in terms of the type of organizations acting as purchasers (e.g. municipalities, regional or central governments, health insurers), the funding sources of purchasers (tax-based or social insurance), the degree of market concentration (how many organizations carry out the purchasing function) and the way these purchasers interact and most importantly, whether there is competition between them.

3.1 Contracting health care

In the Netherlands three different markets can be distinguished (figure 1):

- the *health care delivery market*: patients demand care and care suppliers offer care;
- the *health care purchasing market:* the health insurer purchases care from care suppliers;
- the *health insurance market*: patients take out insurance policies and health insurers offer insurance packages (RIVM, 2008).

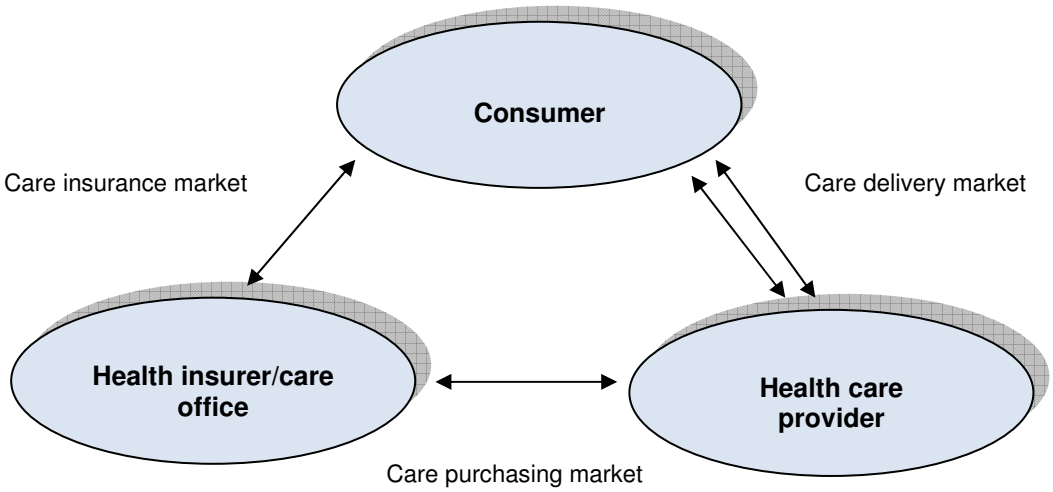

Figure 1: Market in the Dutch health care sector

Contracting care, or purchasing care, is the driving force of the new Health Insurance Act. In this research contracting care and purchasing care are treated as distinctive concepts. Whereas purchasing is defined as the allocation of funds to providers, strategic purchasing is described as a form of purchasing in which proactive decisions are made about *which* health care services should be purchased, *how* and from *whom* (WHO, 2000: 105). Strategic purchasing can also play a key role in improving health systems performance. In the literature contracting is defined as "the negotiated agreement between purchasers and providers about services they will provide in return for payment. It includes service specification, tendering, monitoring and reviewing contract performance" (Figueras et al, 2005: 6). Contracting is central to strategic purchasing and can be seen as a feature of the purchaser-provider relation and contracts are a "means to steer transactions" (Figueras et al, 2005: 31). The most visible parts of purchasing mechanisms are contracts. "Contracts are the mechanism through which agreements between individuals and organizations are coordinated" (Figueras et al., 2005: 84). It is the key device through which providers are influenced by purchasers.

Contracting is an essential element in the purchaser-provider split. The assumption behind the purchaser-provider split is that the state divides policy from implementation. Thereby, the state functions as a supervisory eye and private parties can actually implement or carry out social policies. If the government would only enter into contracts with efficient organizations that provide services of a good quality, competition between these quasi-businesses would emerge. As a result, service providers would work in more demand-oriented and efficient manner in order to enter into a contract with the government. The government externalizes some of its functions through sub-contracting and it

actually means that “the nature of power is exercised through contracting” (Clarke & Newman, 1997: 25).

3.2 Payment/reimbursement mechanisms

It can be argued that contracting is about coordinating transactions between purchaser and provider. Besides that, contracting is a tool to affect providers’ performance by including financial incentives in the contract. In the most common form of PBC a base compensation is defined and there is an opportunity for additional compensation based on quality or even treatment outcome measures (Lu et al., 2003). However, it is also possible that additional compensation occurs when requirements preliminary set by the purchaser are met, for example when a provider has acquired a certain certificate which reflects good performance or good quality according to the purchasing party. Thus, payment mechanisms incorporated in contracts determine how costs are reimbursed.

The type of incentives that can be used largely depends on the type of payment mechanism that is employed. Important elements of payment mechanisms regarding its impact on providers’ performance are whether the payment is prospective or retrospective, by which it is argued that retrospective payments can more effectively influence the quality of provision. The other dimension is whether the payment system is fixed or variable, by which fixed systems have a limit on payments whereas variable systems do not (Jegers et al., 2002). It is asserted that in general retrospective, more than prospective payments systems, and variable more than fixed payments systems, have the greatest possibility to include standards of quality in contracting arrangements (Waters et al., 2004: 375). It is clear that measuring and eventually comparing providers’ performance relies on reliable performance indicators.

In terms of health care and welfare markets, a distinction is made between a market with a single third party payer (like a national government) and a market with multiple third party payers (like social or private insurances schemes). Segall (2000: 64) argues that the single third party system is characterized by two features: separating funding public services from providing them (the purchaser-provider split) and the promotion of competition for contracts between (semi) autonomous providers (public and private). He furthermore asserts that systems with multiple third party payers, like the US, the Netherlands and Germany, promote competition between both insurers and providers, assuming that disenchantment was and is merely about the introduction of competition. Traditionally, in the Netherlands policy has been developed and implemented by “a massive neocorporate bureaucracy” (Busse et al, 2004: 30) that brought government agencies, quasi-governmental organizations, insurers and private organization of providers together. The transformation of public services focused on the de-intertwinement of responsibilities and power and took place under the credo of “less government, more market” (Busse et al., 2004: 30) and resulted in an accumulation of alterations and reorganizations that clearly changed the contractual relations between payers and providers of public services. Therefore we argue that the purchaser-provider split also occurred in systems with multiple third party payers. However, the split already existed to some extent but altered significantly due to changing contractual relations between the actors.

3.3 Type of contracts

The items that are nowadays most frequently covered in contracts are: “type and volume of services, duration, price, invoicing, extra-contractual referrals, eligibility, organizational requirements, levels of human resources and facilities, monitoring, remuneration levels, confidentiality of information, sanctions and rewards. Quality standards are a crucial item, usually including waiting times, outcome, audit procedures and targets” (Figueras et al., 2005: 188). In terms of the actual contractual agreements a distinction is made between 1. market-entry contracts including licensing and accreditation, 2. process contracts including input contracts such as salary contracts, performance contracts which include indicators to measure performance, service contracts in which the type of services to be delivered is at core, 3. block contracts including a budget for defined block of services, 4. cost-and-volume contracts which include payments for explicitly quantified services and 5. cost-per-case contracts which are based on single cost set per treatment such as Diagnosis Related Groups (DBCs in the Netherlands). In Western-Europe cost-and-volume contracts appear to be most common. However, cost-per-case contracts appear to become more important (Figueras et al., 2005: 192-3). In general, we can conclude that there is a trend of contractualization going on; there is a move to pro-active or selective forms of contracting according to performance criteria by which service- or performance-based contracts are used.

4. Linking performance-based contracting to professional work

PBC appears to affect organizational structures because it demands internal changes in order to adapt to a new situation. Through contracting external control on professional organizations is augmenting, and thereby transparency and accountability become more important. As the importance of transparency and accountability is on the rise, clear, finite and quantifiable goals become more important. This makes it easy for the middle-management to split complex tasks into simple tasks that can be outsourced. The result is a flat administrative structure in which rule-bounded professionals can easily fulfill their primary task, satisfying citizens’ needs as consumers. This is governing through performance, whereby performance is being measured by means of improvements regarding global measurable indicators (WRR, 2004: 48).

Contracting and the boost of supervisory bodies seem to force organizations to predict and control behavior, therefore it appears likely that they formalize the behavior of its workers. Mintzberg affirms that organizations become more centralized and formalized in it structure when external control rises. “The two most effective means to control an organization from the outside are (1) to hold its most powerful decision-maker – namely its CEO – responsible for its actions, and (2) to impose clearly defined standards on it. The first centralizes the structure; the second formalizes it” (1979: 289). A relationship is found between external control of an organization and the extent to which the organization is centralized and/or bureaucratized. Outside control concentrates decision-making power at the top and encourages more than usual reliance on regulations and rules for internal control. Effective means for external control are holding the top of the organization responsible (centralization of structure) and impose clear defined standards (formalization of structure). Actions have to be formalized because behavior has to be justified to outsiders.

External control leads to a loss of autonomy within the organization but also increases the power of the outside controller and changes the structure of the organization considerably, e.g. by concentrating more power at the top of the organization, tightening personnel procedures, more regulated reporting or more standardization of work processes (1979: 289-90).

As it seems likely that PBC leads to centralization and formalization, it is worthwhile to consider the effects of these aspects of organizational structure on work content (task variety, task complexity, task repetitiveness) and intrinsic job satisfaction (professional autonomy, self-fulfillment, purpose). Nonetheless, in order to be able to study these consequences, we first have to understand the process of contracting itself and the contracts that are used in health care. For that reason, we will from now on focus on two specific elements of PBC in the hospital care sector and home care sector; 1) the way contracts are set up (negotiation process) and 2) the payments systems and quality measures included in contracts.

5. Method

The preliminary results presented in this paper are based on data collected during orienting interviews (n15) and a content analysis of purchasing documents. Furthermore, policy documents, white papers and existing reports (NZa, ZN, RVZ) on purchasing and contracting in health care have been studied. The open interviews were held with relevant players in the field such as the director of a home care organization, home care workers, a medical specialist, financial manager hospital, legal advisor NVZ, policy consultant NVZ, jurist Actiz, an initiator network for self-employed home care workers, a contract manager purchasing 2nd line care health insurer, and a relation manager care office.

6. Preliminary findings

The findings about the introduction of PBC in the Dutch health care sector, the tenders, the negotiation procedures and the contracts will be described for the Zvw curative care market (including hospital care) and the extramural AWBZ care market (including home care) separately. After that a comparison will be made between the two sub-sectors in terms of its corresponding and distinctive features, but also in terms of its possible consequences for professional autonomy. However, we will start with a general section about the introduction of PBC in hospital care and home care, the juridical aspects of the contracts used and the way contracts are concluded in health care.

6.1 The Dutch case: from cost-containment policies to market oriented reforms

The implementation of market-oriented health care reforms that is taken place nowadays, in fact started more than 20 years ago. In 1987 the Dekker Committee recommended a series of market-oriented reforms such as regulated competition among health care providers and health insurers. Interestingly, rather than allowing more market freedom, the Dutch government fortified its control over the provision of health care in the 1990s. Due to the broad societal and political support for the plans of the committee, “the Dekker plans ha(d) risen again like a phoenix from the ashes” in the memorandum ‘Focus upon Demand’, published in 2001 by the Dutch Ministry of Health (Helderman et al., 2005: 190).

Halfway the 1990s the problem of waiting lists emerged. As Helderman et al (2005) state, the failure to resolve this problem opened a new window of opportunity for a new market-oriented reform plan. The memorandum of 2001 was remarkably comparable to the Dekker plans and important technical and institutional prerequisites for regulated competition had been introduced gradually throughout the 1990s. An example is the introduction of the 'restriction duty to contract care Act', which abolished to duty to contract care in physiotherapy and allowed for more space for health insurers to refuse a contract with a care provider. Even though price and supply controls were enforced in the 1990s, the idea of market-oriented reforms was never completely discarded and slowly anticipatory steps were taken in order to enable the introduction of market principles in the Dutch health care sector. In 1999 clients of extramural AWBZ care (Exceptional Medical Expenses Act) were treated in a more client-oriented manner; they had the possibility to choose between care in kind or a client-linked budget (PGB) that enabled them to purchase care from a care provider directly. In 2004 (AWBZ care market) and 2005 (ZVW curative care market) the duty to contract care was abolished; purchasers of health care, health insurers and care offices, no longer had a contractual obligation towards care suppliers. They were free to determine the care suppliers with whom they concluded contracts. This paved the way for competition between providers of health care. And since 2005 a part of hospital care has been subjected to price competition.

So, up to 2005 the Dutch government implemented cost containment policies (Schut & Van de Ven, 2005). The negative effects of these policies, such as long waiting lists, resulted in the actual implementation of market-oriented reforms from 2004/2005 onwards. For a schematic overview of the market-oriented policy changes in the Netherlands see figure 2.

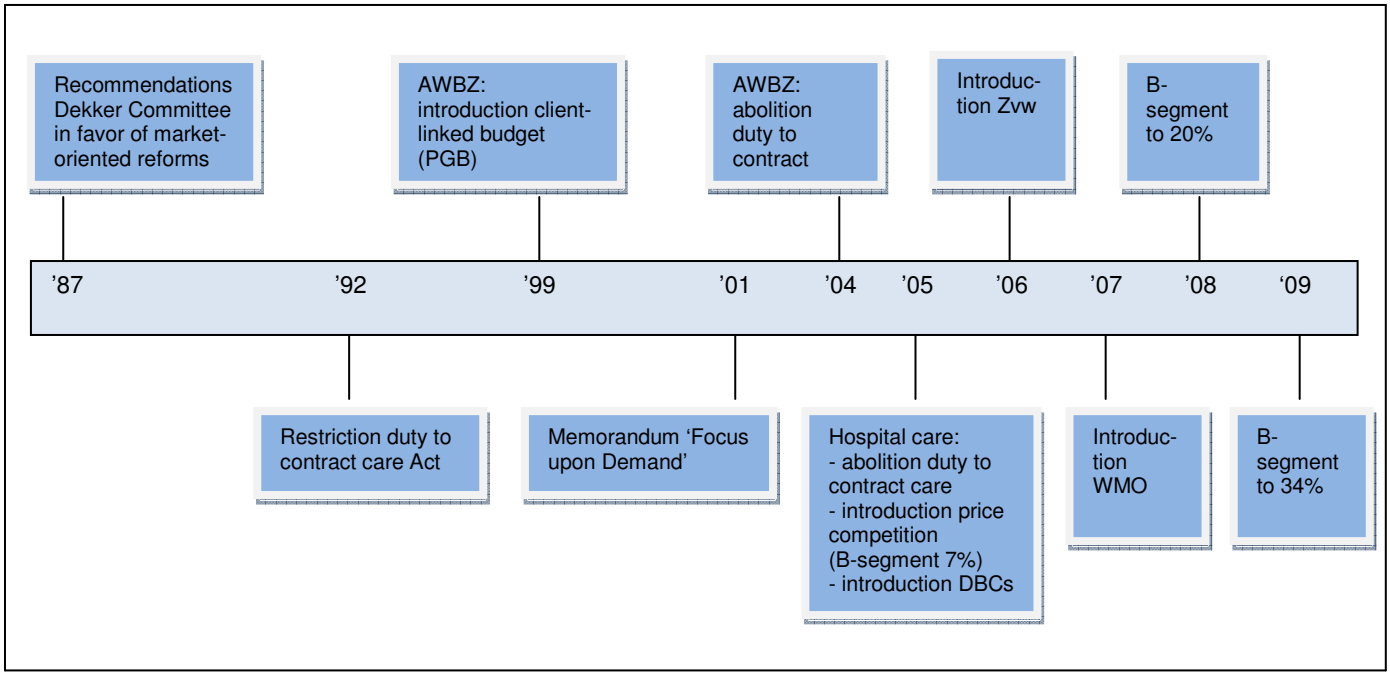

Figure 2: Relevant market-oriented policy changes (adapted figure from RIVM, 2008).

6.2 Performance-based contracting in the Zvw curative care market and the AWBZ care market

On the one hand we can argue that the introduction of contracting health care based on performance criteria started in 2003. On the other hand, 2004/2005 is a more accurately chosen starting point. Around 2003 purchasers of care (health insurers and care offices) started with organizing and arranging care actively. However, this does not involve taking pro-active decisions about the *purchasing* or *contracting* of health care. They did not make price arrangement for example but they did make budget arrangements combined with volume arrangements. And the duty to contract care was still active; health insurers sent standard contracts to all care suppliers. During that time, care purchasing mainly involved contracting care through standard contracts in the curative care market (Zvw) and UVOs (*Uitkomst van Overleg* – Outcome of Deliberation), a form of a standard agreements were used in the extramural care market (AWBZ). The tactical purchasing activities involving the contracting cycle of contract specification, selection, contracting only consisted of sending the standard contracts to care providers. The standard contracts did not specify provider performance in any way. In fact, standard contracts had the character of a payment agreement. Monitoring provider performance only took place by checking randomly whether a service, which was declared by a provider on the invoice, was actually delivered. Sometimes contracts were signed two or three years after they were sent to providers. On occasions, care providers and purchasers of care discussed operational problems they came across.

However, we believe PBC set in in 2004 and 2005. In 2004 (AWBZ extramural care market) and 2005 (hospital care sector) the duty to contract care was abolished. We consider this as a crucial step in the implementation of PBC as it meant that health insurers and care offices did no longer have a contractual obligation towards providers of care and they were allowed to differentiate the terms of the contractual arrangements. It is often argued that regulated competition has entered in the health care sector with the introduction of the Health Insurance Act in 2006. However, earlier steps were taken to enable regulated competition such as the introduction of free price negotiations in hospital care and the abolition of the duty to contract care.

6.3 Contracts in the health care sector

Within the Dutch health care sector three different contracts can be distinguished:

1. care provider – care user (the treatment contract/agreement)
2. health insurer – insured client (the insurance contract/agreement)
3. care provider – health insurer/care office (the health care contract/agreement)

In this study we focus on the third type of contract; the agreement between the care purchaser (health insurer/care office) and the care provider (hospital/home care organization).

The ‘contract’ or ‘agreement’ finds its legal foundation in Civil Law (*Burgerlijk Wetboek*). The contract is a juridical act. A juridical act can be defined as an act of one or more legal subjects who intend a juridical effect. Legally, the contract is defined as a multilateral legal action, at which a mutually fitting will declaration of both parties results in the creation of juridical or legal effects. So, when contracts are entered both parties set mutual legal rights and obligations. The contract is concluded because of an offer by one of the parties and the acceptance of that by the other party (sec.

6:217 par. 1 BW). Contracts in the health care sector are generally known to be complex and are usually only concluded after a certain period of negotiations between the health insurer or care office and the care provider (Hermans & Van Donk, 2007).

In general the content of contracts is free; this is based on the principle of contract freedom. In the health care contrarily, rules of coercive law will often dictate parties what the general content of the contract will be. By that, the private law juridical system has affected the principle of contract freedom (Hermans & Van Donk, 2007).

As Hermans and Van Donk describe (2007), health insurers and care offices often take initiative when the realization, content and design of health care agreements are concerned. They do this on the basis of their 'duty to care'. Contrary to a health insurer or care office, the care providing organization generally does not have the legal 'duty to care'. For health insurers and care providers, the latitude for the establishment of contracts and the content of the contract is still limited. This limitation is mainly imposed by legal regulations and governmental orders. However, certain latitude remains, if only because the health insurer is free to decide with whom they want to enter into a contract with (Hermans & Van Donk, 2007).

Concerning the general terms and conditions of a contract, just as the market sector, the health care sector makes use of standard contracts. General terms and conditions involves aspects of the contract such as delivery period, payment period and conditions, liability preclusion (as far as this is legally acceptable Sec.7:463 BW) and terms of guarantees. In legal jargon the party that has set the terms and conditions is called the 'user' and the opposing party is the 'other party'. However, apart from the standard contract care providers and purchasers of care often negotiate with each other to make agreements on items that are not stipulated in the standard contract. A contract often includes an appendix in which provider-specific agreements are concluded.

6.4 Performance-based contracting: tendering or negotiating?

Purchasing and contracting health care can occur on the basis of negotiations between the care provider and the purchaser of care or on the basis of a tender procedure. Tendering is a formal competitive bidding process where suppliers compete under strict rules for contracts. In the case of tendering, a distinction can be made between a tender based on the best price-quality-relation and a tender based on a bonus-malus system. In this second variant the price is determined by the extent to which care providers meet the purchasing requirements as set by the purchaser (NZa, 2008a: 17).

Tender procedures make an entrance in parts of the health care market (maternity care, pharmacy), partly because this is demanded by rule and law but also because tenders are believed by the government and care purchasers to be a successful instrument to realize competition. In the European tender guidelines a distinction is made between A- and B- services. For A-services such as the construction industry, insurances and cleaning service a strict application of the instructions and a comprehensive and extensive duty to publish is required. For B-services such as hotel services and juridical services the instruction should be applied in a more general manner, there is a limited duty to publish and there is one specific rule about the announcement of the allocation to a tender (Hermans & Van Donk, 2007). Since March 2004 this Guideline 2004/18/EC of the European Parliament and the

Council concerning the coordination of the procedures for contracting out government operations for working, supplying and services is realized. The introduction of tender procedures forces the use of transparent, objective and non-discriminatory working procedures to set up and conclude a contract (RVZ, 2008a). The guidelines for tenders are applied to orders that are provided by 'contracted parties'. We talk about a 'contracted service' when the organization that invites for tenders concerns a 'statutory organization'. This means the organization was founded with the specific aim of meeting needs of public interest, other than that of commercial or industrial nature. Also, the organization should be financed by the state or another statutory organization (Hermans & Van Donk, 2007). So, for some parts of the health care sector (strict) European tender guidelines have to be followed while in other parts this is not the case. The question remains, are health insurers and care offices obliged to use the strict European tender procedure in the hospital care market and the AWBZ home care market?

Due to changes in financing systems there is no legal obligation for health insurers operating in the Zvw curative care market to make use of tendering since health insurers are not statutory organizations. Within the Wmo (Social Support Act), parts of the AWBZ and forensic care the European guidelines of tendering remain applicable, be it the category of 2B-services. The latter means no 'heavy' tender procedures have to be followed, but demands are required exclusively regarding transparency, objectivity and non-discrimination. Also, publication requirements are set for the purchaser of care in order to meet demands of publicity (RVZ, 2008a). Two important remarks have to be made in this context. First of all it is unclear whether municipalities (this concerns the Wmo) have to use the strict European guidelines of tendering when it concerns domestic care service. On the one hand, the European Commission argued that the strict tendering procedures did not count for 2B-services. On the other hand, domestic services concern cleaning, which was said to be part of the 2A-services; the part where services have to be tendered according to strict European guidelines. Also, it can be argued that tender procedures have to be applied since the municipality is the one purchasing the services, which obviously is a statutory organ. So, a lot of remains unclear if tendering in the Wmo is concerned.

Secondly, there is juridical discussion going on whether care offices have to the duty to tender. Again, opinions differ on this issue. According to Health Insurers Netherlands (ZN, 2009), the procedure used by care offices always has to be transparent, objective and non-discriminatory. However, in the Netherlands, health insurers are privately owned, both for profit and non-profit. This indicates that health insurers, but also care offices, are no statutory organizations; they are private organizations. From this last argument we could conclude that officially care offices do not have to use the strict European tendering guidelines.

Nonetheless, even though health insurers and care offices are officially not demanded to tender based on European guidelines, they can still decide to *opt* for a tender procedure. Organizations that decide to contract out service based on European guidelines voluntarily can choose between several procedures. There is a free choice between a public and a non-public procedure. In the AWBZ care market tendering often occurs on the basis of a public procedure by which the interested parties can submit a tender directly after the announcement of the tender in the

notice magazine of the EU. Based on objective selection- and allotment criteria that were notified in advance, the tendering service can choose between the submitted offers (Hermans & Van Donk, 2007).

Now the characteristics of the hospital care and home care market will be discussed separately. A focus will be upon the negotiation process, the nature of the contracts and the elements included in the contracts.

6.5 Hospital care market

6.5.1 The operation of the Zvw

Under the new Health Insurance Act (Zvw), all residents of the Netherlands are obliged to take out a health insurance. The system is a private health insurance with social conditions. The system is operated by private health insurance companies; the insurers are obliged to accept every resident in their area of activity. A system of risk equalization enables the acceptance obligation and prevents direct or indirect risk selection. The insured pay a nominal premium to the health insurer. The Zvw also provides for an income-related contribution to be paid by the insured. Employers contribute by making a compulsory payment towards the income-related insurance contribution of their employees (www.minvws.nl). With regard to the insured risks the health insurer has a duty to contract sufficient care (sec. 11 Zvw) which has to be designed in a way that the insured client, who faces the risk, by virtue of the Zvw has the care to receive care.

6.5.2 Was has changed in hospital care: price competition and the introduction of DBCs

In order to demonstrate how the situation in Dutch hospital care after 2005 differs considerably from the period before 2005, we will now briefly describe the changes that have taken place.

To contain the costs of hospital care, the Dutch government implemented the Functional Budget System (*Functiegerichte Bekostiging, FB-budgettering,* RO) in 1983 (NZa, 2007b). The National Health Tariff Authority (CTG), the legal precursor of the National Healthcare Authority (NZa), determined the budget for hospitals. A number of parameters such as the number of inhabitants in the surrounding area, the number of beds and the number of beds determined the hospitals' budget. These parameters were expressed in monetary units. Even though budgets were constrained, hospitals did negotiate about local production plans with the health insurers collective. Administrative tariffs on the products of hospitals were set by the CTG, but hospitals and insurers could negotiate about volume and quality. An important element of the FB-system was that hospitals and health insurers were "mutually obliged to contract with each other" (NZa, 2007b: 16).

For a proper operation of market forces it was important that health insurers and care providers had the freedom to negotiate with each other about prices, volume and quality. For this reason the free B-segment was introduced. Hospital care is now divided in an A and a B-segment. The A-segment is still regulated by the old FB budget system. Since 2005 the CTG/NZa did no longer set prices for the competitive B-segment where price negotiation is possible. In the B-segment the FB system has been replaced by a system of variable and performance-focused payment and financing

based on Diagnosis Related Groups (DBCs). Every year health insurers and care providers negotiate about the price, quality and quantity of the care performances in the B-segment (OMS, 2007b). Also, the negotiation process is “no longer multilateral but bilateral, with no mutual obligation to close any contract” (NZa, 2007b: 17). In 2005 7 percent of hospital care has been subjected to price competition and since 2009 34 percent of hospital is subject to free prices. It is expected that in 2011 approximately 50 percent of the total care will be part of the B-segment. In the A-segment, fixed prices exist that are set by the NZa. So, in the B-segment rates are established through contracts between health insurers and hospitals. In the A-segment health insurers negotiate with hospitals about the volume and quantity of DBCs whereas in the B-segment they also negotiate about prices. The costs of medical specialists, so their honorarium, are fixed. These rates have been set by the NZa and count for both the A- and B-segment.

Nonetheless, even in the A-segment there is a change compared to the situation before 2005. Negotiations with health insurers about the A-segment do not only relate to volume agreements in terms of FB-parameters, but also on the exchange of information, quality and the terms and conditions of advanced money (OMS, 2007b). Even so, the attention that paid to quality measures during the negotiations is limited.

In order to enable price competition, hospitals have been obligated to declare costs on the basis of DBCs. Since 2005 DBCs form the basis of performance-based financing hospital care by defining the care in products and attaching a price tag to it. A DBC is the entire process from the diagnosis by the medical specialist up to the, and including, (any) resulting hospital treatment. The combination of diagnosis and treatment results in a single rate that is charged by the hospital. Each DBC has its own code and its own rate consisting of hospital costs and medical specialist fees.

6.5.3 Limited use of market forces for academic hospitals

It is important to bear in mind that market forces are not equally present among the different types of hospitals in the Netherlands. Four different types of hospitals can be distinguished: 1. general hospitals, 2. academic hospitals (UMCs), 3. independent treatment centers (ZBCs) and 4. categorical hospitals. Per category of hospital the type of care that is provided differs. As a result, the price-competitive B-segment is not equally present among the hospitals. In this research ZBCs will be disregarded because they are considered to be private initiative and only focus on a specific segment of care. This also counts for categorical hospitals and therefore this type of hospital will also be disregarded in this study.

General and specialized medical care is divided into four segments based on the extent of predictability and/or consensus about the outcome of the provided care and/or standardization of care: 1. basic care, 2. complex care and top care, 3. main referral care and developmental medicine, and 4. first aid and (severe) multiple pathology. Segment 1 and 4 comprise a high volume of care and segment 2 and 3 a low volume of care. Medical specialists working in general hospitals predominantly deal with segment 1 and 4, unless they are working in one of the larger hospitals or in a categorical hospital (OMS, 2007a). Because of the high volume, the high level of predictability and standardization of care processes, segment 1 lends itself well for market forces. This partly goes for segment 2,

however, we are dealing with a relatively low volume of care here. Because of the high unpredictability, segment 3 and 4 are not suitable for market forces; this type of care has to be guaranteed through supply regulation (OMS, 2007a). This means that in academic hospitals (UMCs) the total care provision accounts for only a small part of the B-segment. The 'products' (DBCs) in the B-segment meet the following criteria: it concerns DBCs with an adequate turnover rate, adequately homogenous product, sufficient national spread in terms of number of DBCs per patient, it concerns care that is relatively easy to plan and it does not involve acute or life threatening diseases. As most care provided in UMCs does not meet these criteria, the use of market forces is limited in UMCs. For this reason, this paper will only focus on the contracting process in the B-segment. Therefore, we focus on general hospitals.

6.5.4 The contracting process: negotiations

In the hospital care sector contracting occurs on the basis of negotiations instead of a tender procedure. Every year health insurers and hospitals negotiate about the volume, quality and price (only B-segment) of the hospital care to be provided.

Selective contracting

Health insurers who use selective purchasing do not contract all of the health care that a given health care provider has available, nor do they have contracts with all health care providers. They only sign contracts for that health care provision and with those health care providers for which there is a real need. They make their selections on the basis of quality, price and efficiency (RVZ, 2008b). Health insurers and care offices seem quite reluctant to contract selectively. However, among health insurers the offer of preferred-provider contracts to their clients seems to become more common. An example of this is UVIT who offer youngsters a *'Zekur'* insurance policy. '*Zekur*' policy holders can gain financial (and qualitative) advantage because UVIT only contracted selected providers. With the preferred providers health insurers agree on higher volume arrangements. Some health insurers try to guide their clients towards particular hospitals through care mediation. Health insurers also make use of differentiated contracting: different parties get different contracts that differ in terms of attractiveness. One of the reasons why few health insurers contract selectively is because of the limited availability of performance-indicators that provide high quality information.

6.5.5 Negotiation delegations and negotiating power (purchasing power)

In the B-segment negotiations are lead by four different health insurers and one purchasing combination (appendix 1). In theory, all health insurers negotiate with all hospitals. The health insurers mostly send one or two care purchasers and a medical advisor to the negotiation table. In the B-segment hospitals are most often represented by one or more financial managers, a controller and in some cases one or medical specialists. Especially those medical specialists largely represented in the B-segment want to put in their word during negotiations.

By using purchasing conditions, the purchasing power of health insurers can be exerted. Purchasing power is market power at the purchasing side of the market. If the purchaser of care

possesses a considerable level of purchasing power he is perhaps able to enforce purchasing conditions on the care provider (Hermans & Van Donk, 2007). In the hospital care sector, health insurers mostly use the condition of 'systematic quality' in their purchasing model, which is often epitomized in quality certificates. Also, health insurers demand that care is being provided by professionals registered by the BIG Act[2].

Interestingly, with the recent mergers between health insurers, the purchasing power of health insurers is changing. In the past, health insurers were concentrated in a particular region in the Netherlands; this means they had a substantial market share in the regional hospital. The significant market share in the regional hospital resulted in a high purchasing power of health insurers since a large part of the care costs of the hospitals' clients were reimbursed by that particular health insurer. Recently, health insurers often operate on a more national, rather than regional, level. As a result, it happens that in some regions their market share is only six or seven percent. Obviously, the purchasing power of such a hospital is relatively small in that region.

It appears that for most health insurers the 20/80 rule is applicable: 20 hospitals are responsible for 80 percent of the care costs. Clearly, the negotiations with these hospitals are most important for the health insurer.

Most important topics during negotiations

An important topic during negotiations is the 'severity' of a hospitals' clientele profile. Especially academic hospitals often argue that they have a heavier client profile than general hospitals. As a result, they want a higher price for the DBC it concerns. Health insurers argue that this is always a difficult topic, because it is hard for hospitals to prove that they have to deal with heavier patients. Specialized hospitals such as the Rotterdam Eye Hospital have an above-regional profile, meaning that they attract patients from all over the country; often those with a more complicated profile. This is a tough issue during negotiations since these hospitals want to make special price arrangements. This topic becomes even more complicated when negotiations take place between a hospital manager and the care purchaser of a health insurer; generally both do not know much about the care substantive aspects of the DBCs. According to a care purchaser, the absence of objective measures of care weight makes it hard to determine whether a hospital is right in its claim. Often, decisions by health insurers are based on trustworthiness. According to the health insurers, hospitals differ in the extent to which they are open about their performance towards health insurers.

The more 'products' (DBCs) a hospital produces, the more money they receive. The DBC system does not contain volume limiting measures. The RVZ (2008a) implies that this makes it financially interesting for a hospital to produce more re-hospitalizations. However, from the interviews it appears that 're-hospitalization' is actually a topic discussed during negotiations between hospitals and health insurers. If a hospital has a high number of re-hospitalizations, the health insurer wants to

[2] BIG Act: In the Netherlands, the provision of healthcare services by individual practitioners is regulated by the Wet op de beroepen in de individuele gezondheidszorg (Individual Healthcare Professions Act), generally known by its Dutch acronym, 'BIG'. The purpose of this legislation is to safeguard and promote the quality of care services. It also protects patients against inexpert or negligent treatment by a healthcare provider.

know why. A complicating factor is that hospitals having a high number of re-hospitalizations often claim to have a heavier patient profile. In UMCs it frequently happens that a patient was treated elsewhere before they had a surgery in the UMC. As a result, the number of re-hospitalizations in UMCs seems high but can often be attributed to the more difficult client profile.

Interestingly, it appears that in general hospital 20 percent of the DBCs generate 80 percent of the revenues. For some UMCs 10 percent of the DBCs generate 90 percent of the revenues. Obviously, hospitals want to negotiate a high price for those DBCs that generate the highest revenues. This is also the reason why health insurers and hospitals only negotiate about the prices of approximately 10 or 15 percent of all DBCs, simply because the relative value of the remaining DBCs is small.

In recent years, hospitals run greater risks in terms of 'running the hospital'. An example of this is that hospitals have become responsible for the financing of buildings due to changes in the legal context. For hospitals it becomes increasingly important to raise their equity capital to a higher level. In the past, the equity capital was very low and this was partly encouraged by the government who stated that hospitals did not need equity capital since their revenues were guaranteed anyway. This attitude is changing. Hospitals have realized that it becomes harder to contract a loan. With the recent developments of the weak financial position of Orbis and the IJsselmeerziekenhuizen, banks have become more hesitant to provide hospitals with a loan. For a hospital to be able to finance a new building for example, it is important to have a high equity capital. Therefore hospitals increasingly focus on the obtaining a high margin during negotiations with health insurers. This development makes the issue of price negotiations even more important. Another possibility is that hospitals make long-range plans with health insurers in order to be able to ensure banks that they have a guaranteed cash flow. For some hospitals it has become more important to make an arrangement with the health insurer that allows the hospital to grow averagely three percent a year for the next four or five years, than it is important to agree high prices in the B-segment.

Another important aspect during negotiations is to finalize the price negotiations as soon as possible; if there is no price for a DBC, hospitals cannot declare these costs. For the health insurer it is also important to set the prices for DBCs as soon as possible because they need these prices to estimate their costs for the coming year. For the health insurer it is important to set the price of their insurance policy as soon as possible.

6.5.6 The contract

Within the hospital care sector, health insurers and hospitals make use of a standard contract. In this standard contract specific price arrangements are formulated. Contrary to the extramural AWBZ care sector, health insurers in the hospital care sector do not have a transparent purchasing model in the sense that the purchasing model and the standard contract are published online.

Quality agreements

Together with scientific organizations and patient organizations health insurers developed the 'DBC purchasing guide', which they use as a starting point for negotiations with hospitals. A step towards

the use of evidence-based contracting in the hospital care sector is the use of protocols that are often part of the DBC-purchasing guide. This guide provides an overview of quality characteristics per DBC. The health insurer determines to what extent the provided care meets the norms of the occupational group. Initiatives like this should make it easier to come to concrete quality arrangements. The extent to which health insurers actually gain insight in the technical-medical quality of hospital care depends on the attitude of the hospital; whether they are open about it or not. Measuring provider performance initially and subsequently monitoring performance on a structural basis based on the agreed contract and then judge providers on their performances occurs sporadically. As the care purchaser of a health insurers admitted: "if I look at our purchasing model…it consists of 20 excel spreadsheets and it only concerns information about prices."

Health insurers mostly use the national set of indicators such as the IGZ or ZN performance indicator set. Some insurers have designed their own, additional, set of indicators. For medical specialists it is an extra administrative burden if all health insurers use their own set of performance-indicators. It is often unclear what health insurers actually do with the sets of indicators. Health insurers also make use of the annual quality report of hospitals. Another quality criterion that is often required by insurers is the Consumer Quality Index (CQ Index). Interestingly, health insurers do ask hospitals whether they apply the protocols embedded in the ZN and/or IGZ set of indicators. However, most health insurers do not apply any sanctions when the hospital admits not to obey the protocols. In most cases the insurer demands the hospital that they will start using the protocol from now on. Compared to a couple of years ago, there is a difference in the sense that hospitals have to register that they work according to a particular protocol. Furthermore, some insurers discuss the results of the CQ Index with the hospitals. Nonetheless, currently provider performances are not linked to payments or reimbursements.

Production agreements & prices

Health insurers reimburse the costs of medically-specialized care. This concerns care '*that is customary provided by professionals'*, so it involves care the professional group usually or commonly *tends to provide* in a particular situation. In Dutch this is defined by the term *'plegen te bieden'* (sec. 2.1 par. 2 BW). With this formulation *'plegen te bieden*', combined with the term 'professional', the content and the scope of the care to be provided is determined. Care that is customary provided (*'pleegt te worden geboden*') concerns care which the occupational or professional group counts as the acceptable arsenal of care and which is provided in a way the occupational group considers as professional. By means of guidelines and standards set up by the professional group, one can determine whether we can talk about care which the professional group provides customary (*'pleegt te bieden'*). So interestingly it appears that a part of the professional autonomy in hospital care is regulated by law in the sense that knowledge about treatments is reserved for professional groups.

In terms of knowledge about care costs, it appears that health insurers have no or little insight in the actual costs a hospital makes. This means health insurers have no insight in the relation between the delivered product, its costs, and the price. Health insurers often come across inexplicable price

differences between hospitals. This occurs most often for DBCs that only take place sporadically. During the interviews one of the care purchasers gave an example in which the prices for the same DBC ranged between 800 and 3.200 euro among different hospitals.

When we look at price differences across the country, it appears that the board of directors and medical specialists of hospitals located in the more rural parts of the country believe that the region has insufficient potential for viable competitive initiatives (Orde, 2005a). Afraidness of competition and a clear profile of nearby care providers stimulate hospitals to invest in patient satisfaction. The RIVM Care Atlas (2009) shows that most hospitals are located in the West of the Netherlands (Zuid-Holland, Noord-Holland[3], Utrecht). From the interviews it became clear that, in the years 2005-2007, the price level of hospital in the Western region of the Netherlands is lower than the average national price level of hospital care. A plausible explanation for this is that many hospitals and ZBCs are located in the Western part of the Netherlands. Because there are less hospitals and ZBCs in the Northern and Eastern part of the country, prices in the region are above the national average. The Southern region shows a constant decrease of price levels, probably as a result of the competition from Belgian hospitals. All of this demonstrates that performance-based contracting has different consequences for hospitals located in various regions due to variances in the level of competition.

6.6 AWBZ care market

6.6.1 The operation of the AWBZ

"The Exceptional Medical Expenses Act (AWBZ) is a national insurance scheme for long-term care. This scheme is intended to provide the insured with chronic and continuous care which involves considerable financial consequences, such as care for disabled people with congenital physical or mental disorders. Everyone who meets the criteria spelled out in the legislation is automatically insured and consequently obliged to pay the statutory contribution. Generally speaking this means that everyone who is legally residing in the Netherlands and non-residents who are employed in and therefore liable for payroll tax in the Netherlands are insured" (www.minvws.nl).

When people need AWBZ care, they first need to get indicated by the CIZ (*Centrum Indicatiestelling Zorg*). This indication provides people with the right for care. The tasks of the health insurers are executed by care offices and they are responsible to ensure that people receive the care they actually need. This can occur by means of a client-linked budget (PGB), in this case the care consumer enter the care purchasing market directly, or by means of care in kind. Care in kind is purchased by the care office that purchases care by a provider of AWBZ care.

6.6.2 The AWBZ care market

For the extramural AWBZ market, including nursing and care (V&V), the care office possesses full freedom in deciding with whom they want to enter into a contract with; there is no duty to contract all

[3] With the exception of the region 'Noord-Holland-Noord'.

providers. Care offices do have to obey the duty to care, which involves the duty to purchase a sufficient volume of care to meet the demands for care in the region the care office is statutorily located. In the Netherlands 32 care offices exist. The health insurer that runs the care office is usually the market leader in that region. This means that consumers of care are dependent on the region they live in for the way AWBZ care is organized.

Contrary to care consumers in the Health Insurance Act, where a free market for health insurances exist, consumers of AWBZ care do not have an *exit* option when they are not satisfied with the contracted care. The only alternative they have is to choose for a client-linked budget (CLB). According to a report by the NZa (2007a) the absence of the *exit* option among care consumers makes that there are few stimuli for care offices to purchase high quality and efficient care and to listen demands of care consumers.

The government regulates the budgets of care offices. Care offices receive a budget comprising of administration costs, this compensates the costs the care office makes because of negotiations with care providers, and a budget for care costs. Care offices do not run the risks for these care costs. The NZa (2007a) states that the lack of financial risks for care costs will only stimulate care offices to keep the costs of administration down. The NZa assumes that care offices easily agree with the demands of care providers so that they can limit the period of negotiations in order to keep the administration costs as low as possible. This fear is not confirmed during the interviews; it seems care offices often have a strong purchasing position and do not easily agree upon providers' demands. Another risk is that care offices contract only a few providers, so that few contracts have to be made or that they do not offer new care providers a chance to enter the market. This risk is partly confirmed during the interviews; various actors mentioned that it is hard for new providers to enter the market. This could indicate that care offices try to minimize their administration costs.

In an attempt to provide care offices with more stimuli to purchase efficient care, the regional contracting headroom was introduced in 2004. Contracting headroom limits the costs of care the care office is allowed to make; it is the maximum budget of the care office. As the NZa (2007a) points out, the efficiency stimuli produced by the contracting headroom are scant, because the care offices are not risk-bearing for the costs of care. When the contracting headroom is exceeded, care offices fetch back the overrunning costs pro rata among the care providers who have increased their production compared to the year before. Nonetheless, the RIVM (2008) points out that the vitality of the AWBZ market is hampered because of the existing budget guarantees for care providers. The financial risks involved for care providers are limited as budget guarantees are often between 80 and 100 percent. Interestingly, from the orienting interviews it becomes clear that the height of the budget guarantee is increasingly linked to a providers' performance. This will be discussed in the section 'production agreements' and 'quality agreements'.

6.6.3 Contracting process: tendering with post-tendering negotiations is gaining popularity

Tendering is gaining popularity in the extramural AWBZ care market (see figure 3). In 2008, most care offices applied a tender procedure as a way to contract care. Under strict rules for contracts care

providers compete for a contract. After the care office received the bids and tenders, and before the letting of contracts, post-tendering negotiations take place between the care office and the care provider. In most cases a tender model is used that is based on a bonus-malus system. The price is determined by the extent to which care providers meet the purchasing requirements that were set by the purchaser.

Model of purchasing	Number of care offices 2007	Number of care offices 2008
Tender	16	24
Negotiations	14	6
Remaining	2	2

Figure 3: Typologies purchasing policy care offices. Source: NZa (2008a: 29).

Generally all care offices apply the same contracting process (see figure 4). First of all, the care offices develop a purchasing plan. This plan is the result of a regional market analysis, including a sector specific analysis (e.g. GGZ, V&V). Once the purchasing requirements as well as the selection criteria (also referred to as assessment or purchasing criteria) are established in the Program of Demands (*Programma van Eisen*), the allocation follows more or less automatically from the tenders submitted by care providers (RVZ, 2008a: 43). The submitted tender includes general information, the filled out assessment criteria form and the bid.

The Program of Demands is a way to test whether a provider is suitable. Based on price, quality and efficiency parameters the care office makes production agreements with the selected care providers. In most cases these parameters are included in a bonus-malus system. When the tenders are submitted, the care office scores the tenders on the extent to which they meet these purchasing criteria. Based on the assessment scores and the offered price reductions the care office finalizes the ranking of providers and develops a list of selected providers. In some cases the care office determines the budget guarantee based on the assessment criteria scores. For example, a high score leads to a budget guarantee between 98 and 100 percent while a low score leads to budget guarantee between 80 and 90 percent. Per group (for example three groups with a different budget guarantee), the care office sets up the ranking of providers based on the offered price reduction. The score of providers on these criteria affects the volume they are allowed to produce or the height of the budget guarantee. For a care provider it is very important to be on this list of selected providers. If you are not selected to be on the list, you are not allowed to provide care in that particular region. The higher the care provider is ranked on the list, so the more 'points' they were awarded by the care office, the more care they are allowed to provide.

Then the care office divides the 'care to be produced' among the contracted care providers. According to ZN (2009), this occurs on the basis of a transparent and objective judgment. The three key aspects of the tender procedure that are often applied by care offices in the extramural AWBZ care market are transparency, objectivity and non-discrimination. Various care providers explained that it is still very difficult for a home care organization to enter a new market; so, to start to provide care in a region they were not serving before. It was argued that even though care offices have to be non-discriminatory, the system of the 'old-boys network' is still very much present in the home care

sector. From the interviews it appears care providers often through doubts upon the extent to which the criteria of objectivity and non-discrimination are present in the care offices' operations. This is technically possible, as care offices are not obliged to apply the strict European rules for tendering. The ambiguities about the application of strict European tender guidelines seem to place care offices in a powerful position; they have a dominant position in the contracting procedure as they set the selection criteria. But it remains unclear to what extent they actually meet the demands of objectivity and non-discrimination, because of the ambiguous, loose and free interpretation and application of European guidelines.

1. Dissemination purchasing documents
2. Bid/tender by care provider
3. Care offices decides (upon):
   - if the care provider meets the suitability requirements and the purchasing conditions;
   - the number of assessment points/score
   - the preliminary percentage on the basis of which the production agreements will be decided upon;
   - the extent to which the care provider does (not) meet the required target norms*;*
   - if the care provider meet the requirements to apply for a long-range plan (if applicable).
4. Negotiations about:
   - improvement agreements
   - extra price reductions
   - completing production agreements
5. Care office negotiates with best providers about:
   - growth options (often a maximum of ten percent growth rate for providers is applied)

Figure 4: Purchasing/contracting procedure

Program of demands: suitability requirements and general terms and conditions

In the Program of Demands, the care office sets the guidelines for the tender procedure. Care providers are not scored on the demands; these requirements are regarded as a precondition to get a contract. Next to the suitability requirements (*geschiktheidseisen*) stated in the Program of Demands, the care office applies general terms and conditions. The general terms and conditions focus on service, delivery conditions, quality agreements such as the appliance of quality improvement projects and agreements on information provision to the care office.

Three examples of suitability requirements stated in the Program of Demands applied by care offices will be given: 1. The organization will fulfill the requirements of the Regulation annual reporting care providing institutions (*Regeling jaarverslaglegging zorginstellingen*) and the policy requirements AO/IC (administrative organization/internal control). 2. The organization has a quality system at their disposal, in which the national quality framework (*Kwaliteitskader Verantwoorde Zorg*) for the relevant care sector is included. 3. The organization is in command of a thorough business administration which can ensure a timely provision of data on the realized production to the care office and the own contribution to the CAK.

The general terms and conditions often involve the condition that the organization demonstrably implemented the health care sectors' governance code. Another example is that the care provider has to apply an invariable system of care planning, in which an agreed care plan is determined for each

client on a yearly basis. Moreover, the care provider has to work with the sector-specific nationally applicable quality framework, in which, next to self-reporting, a 'client evaluation survey' is included.

Selection criteria

Care providers are scored by the care office based on the selection (or assessment) criteria. This score, combined with the offered price reduction, determines whether a provider is selected. It also determines the height of the budget guarantee and the height of the production volume. The selection criteria can involve the following elements, but the focus can differ per care office. Points awarded can depend on the willingness to deliver guaranteed care, regardless of the production agreement, extra points are awarded by the care office. The care office often offers more points if the care provider is willing to reimburse the delivered care based on the average bandwidth. A bandwidth ranges for example between four and eight hours for a particular care function or category. The care office offers more points if the care provider is willing to reimburse the care costs based on the average bandwidth of six hours. Some care office offer 15 points (maximum) if the provider is willing to use only 50 percent of the bandwidth. Some care offices award points based on the outcome of a client evaluation test, the CQ index or based on the score of the indicators of *Kiesbeter.nl*. Often, points are awarded by care offices if care providers possess certain quality certificates. Some care offices award points for a timely provision of the production numbers by care providers. Care offices sometimes value the existence of a work satisfaction study among employees.

6.6.4 Negotiation power (purchasing power)

In general it can be argued that the purchasing position of care offices is strong, since care providers can only enter into a contract with the care office in the region they are statutory located. For this reason, the care office finds itself in a monopolistic purchasing position. It appears that care providers have a strong impression that the care office pulls the strings. Care offices, on the other hand, state that they do not have the impression that they have a stronger position during negotiations. It is striking is that especially in the more competitive areas such as Rotterdam, where a large number of care providing organizations are located, care providers have the idea that the care office has a dominating role. This view is confirmed by various care offices who stated that the presence of a large number of care providers enables them to play a more dominant role in the discussions with care providers. The existence of the dominant position of care offices in a competitive environment, is supported by the idea most interviewees have, that prices of extramural AWBZ care seem to be lower in competitive environments such as Utrecht or Rotterdam according to the interviewees. In the more rural areas the purchasing power is less present than in areas with a high population density. Care offices *have to* contract these providers in order to meet the duty to contract care. Rural areas are often less attractive for care providers because they need a lot of travelling to go from one client to another. In some cases the care office offers a bonus to care providers who are willing to work in thinly populated areas.

Interestingly, data provided by the NZa (2008a) portray a different situation; a higher concentration of care providers is related to higher prices. Figure 5 shows the following: the higher the

HHI, the higher degree of concentration of care providers, and the lower the price reduction realized by the care offices. These data contradict the idea that a high number of providers, leads to lower prices of care. A possible explanation could be that a high number of care providers, indicate a high demand for care as well. It is possible that care offices are forced to contract many providers in order to serve its duty to care. This brings care providers in a dominant position. This is a plausible explanation in a market where care demand in various regions exceeds care supply.

Concentration degree care supply 2008	**Number of regions (total = 32)**	**Unweighted average**	
HHI[4]		**Price reductions '07**	**Price reductions '08**
> 3000	3	-1.8%	-1.1%
<3000 > 1800	7	-2.9%	-2.1%
<1800 > 1000	14	-3.0%	-2.3%
< 1000	8	-4.0%	-3.2%

Figure 5: Concentration degree care supply – realized savings in price reductions by care office in 2007 and 2008. Source: NZa (2008a: 66)[5]*.*

In accordance with the results from the interviews, the results from the NZa also demonstrate that organizations that have a higher market share, are better able to negotiate a high price. Figure 6 shows that the larger the care provider in terms of regional market share, the harder it is for the care office to realize a price reduction (lower price). The NZa (2008a) provides several explanations for this: in some cases the larger care providers score higher on quality parameters, which leads to a higher price. Sometimes larger care providers bid a higher price, which is unfortunate for the care office, because the provider has a dominant position in the market. New providers often have to offer a low price, because they score low on the purchasing requirements. It appears new providers literally pay a high price to enter the market.

	Weighted average	
Category of care providers 2008	**Turnover rate total extramural AWBZ care market**	**Price reductions**
Top 5 care providers (n=160)	65.4%	-1.7%
Subtop 6 t/m 10 (n=160)	15.9%	-3.2%
Smaller providers (n=581)	14.9%	-4.2%
New providers (n=308)	3.8%	-5.5%
Total market (n=1209)	100%	-2.5%

Figure 6: Price reduction offered by providers in relation to their regional market share. Source: adapted figure NZa (2008a: 67) [6]*.*

6.6.5 The contract

In the contract the care office and the care provider make agreements about the nature, volume, quality and price of the provided care. The contract is a standard contract consisting of three parts: 1. A care provider-related part comprising details about tariffs and production agreements, 2. A part

[4] HHI = Herfindal Hirschmann index, a way to measure the degree of concentration of supply.
[5] Figure is based on extramural V&V (nursing and care sector) and extramural GHZ (care for disabled).
[6] Figure is based on extramural V&V (nursing and care sector) and extramural GHZ (care for the disabled).

consisting of general terms and conditions and enclosures such as the *Zorgbrede Governance Code*, and 3. Specific care provider-related agreements such as an agreement about the conclusion of a contract for more than one year. Various care offices offer the possibility to conclude a contract for more than one year. We will now focus on particular elements of the contract: the quality agreements, production agreements and prices, and the use of bandwidths.

Quality agreements

In general, care offices join in the national quality frameworks. Care offices generally assume that the existing quality systems such as HKZ, ISO and Perspekt are seamlessly attuned the content of the systems to themes, indicators and work processes as laid down in the sectorial quality frameworks. The sector V&V (nursing & care) applies the quality framework 'Safe Care' (*Kwaliteitskader Verantwoorde Zorg*, RO). Furthermore, agreements are made concerning the filling out and sending of the Year Report Social Accountability (*Jaardocument Maatschappelijke Verantwoording*), which provides an integral justification of the care provider. Quality warranting occurs on the basis of two pillars: 1. the yearly self-evaluations, which are partly based on registrations concerning the content of care and 2. a client evaluation study. This study is executed randomly, once every two year with a nationwide accepted instrument (ZN, 2009).

Besides this, some care offices apply financial stimuli to support quality improvements. An example of this would be that care providers receive a higher price if they score well on the client evaluation test. However, various actors explained it is still too early to settle accounts based on realized quality performance, especially in terms of outcome. For that, a thorough and univocal information system is required which provides scores on the quality performance indicators. Nonetheless, care offices increasingly link provider performance to the budget guarantees providers receive. Though, measuring provider performance initially and subsequently monitoring performance on a structural basis based on the agreed contract and then judge providers on their performances occurs sporadically.

Production agreements & prices

For the agreements on production the care office allocates 'production headroom' to contracted care providers. In recent year various models have been applied to allocate production headroom. These models vary on two principles: 1. a differential allocation of "Q" (volume) or 2. differentiation in "P" (price). Whichever model is being used, the care office always applies previously set selection criteria. Both models differ as follows:

1. Differential allocation of "Q" (volume) in which some providers receive a higher volume ceiling than others, based on their performance on relevant criteria (ranking). At the start of the year a production ceiling is allocated. New clients (care users) who do not have a 'preferred provider', are 'softly guided' towards care providers with the highest ranking (ZN, 2009).
2. Differential determination of "P" (price) in which some providers receive a higher price than others and vice versa, based on their qualitative performance, the application of rewarding innovative practices and working according to 'best practice' guidelines. In this model, the allocation of

production is volume is determined by the choices clients make. If it turns out that the maximum "PxQ"-budget is insufficient to meet the indicated care demand – regardless the efficient use of means – the care office has the obligation to enable an increase in production volume.

Interestingly, what is in fact happening in the extramural AWBZ care market is a combination of the "Q" and the "P" model. It appears that most care offices, as a starting point, use the "P" model. In the past, care offices applied the standard price that was determined by the NZa and they negotiated about the volume with care providers. Since 2008 the idea of fixed prices is partly abandoned; the NZa still determines maximum prices but now care offices try to arrange a price that is lower than the maximum price. In most cases the agreed price is lower than the maximum price set by the NZa. In recent years care providers and purchasers contracted care on average several percentages below the current maximum prices. It appears that in 2009 the realized price reductions (in relation to the maximum NZa tariff) were between 6.6 percent and 3.0 percent (Actiz, 2009). The margin of price negotiations is partly dependent on the broader governmental policies. In case the government enforces an efficiency deduction or efficiency cutbacks (this means the maximum prices decrease), the margin will diminish.

It seems the risk of budget maximization is lurking, however, for various reasons this is not happening. First of all, care offices believe it is hard for care provider to *generate* new clients. Since the CIZ indicates potential clients, care providers only provide care to people who received an independent CIZ indication. Furthermore, care offices have a limited regional budget. On the website care offices publish the remaining regional budget so care providers can see how much is left. It appears difficult for care offices get an increase in regional budget from the Ministry of Health in case the budget exceeded. Obviously, it remains hard to argue that the price model is a 'money-follows-client' model where the volume is completely free, because the regional budget of care offices is bounded by the Ministry of Health.

From the interviews it appeared that in the Rotterdam region price reductions by the care provider are highly rewarded by the care office. In Rotterdam the care office of Achmea awards 5 points if the provider is willing to offer a price reduction between 1 and 2 percent, 10 points if the provides reduces its prices between 2 and 5 percent. If the provider is willing to offer a price reduction of 5 percent or more, Achmea awards 15 points. The more reductions on prices the care provider offers, the higher the efficiency score awarded by the care office. Some new (smaller) providers (so providers who were not active in that particular market in that particular region the previous year) offer a large price reduction in order to be able to deliver AWBZ-care in that region. They feel that they have to do this because otherwise they will not receive a sufficient score and will eventually not be able to provide care in that region. Other care providers say "we will miss out on the efficiency points, but we will compensate this with our high scores on quality issues". However, not all care offices focus heavily on these price reductions.

Bandwidths

When a client receives an indication, it is defined in product categories. For each category a bandwidth of number of hours is defined. For example, Mrs. De Bruin needs personal care. The CIZ indicates Mrs. De Bruin and reports that category 4 is allocated to her. Category 4 knows a bandwidth of four to eight hours. It appears that care offices stimulate care providers to work efficiently by saying: if you use only 50 percent of the bandwidth, so four hours, you receive extra points on the ranking. In some cases the care office says: if you use more than 60 percent of the bandwidth, you do not receive any points or you even receive fewer points. Since 2008 the NZa applies a bonus/malus system; if a care provider uses more than for example 60 percent of the bandwidth, a malus (surcharge) has to be paid by the care provider. Some care providers felt they were punished twice by the introduction of this system in case they decided to provide as much care as was allowed by the bandwidth. On the one hand they were punished by the care office because they obtained fewer points on the ranking. On the other hand, they were also punished by the NZa because they had to pay a surcharge.

The logic behind the bonus-malus system is that it forces care provider to work efficiently. If a care provider uses only five hours of the bandwidth of nine hours, they have four hours left to provide care to another client.

6.7 Discussing & comparing performance-based contracting in hospital care and home care

For providers of care the legitimization of the contracting parties on behalf of the 'rank and file' professional plays an essential role during the juridical design of the contract but also during the negotiations (Hermans & Van Donk, 2007). Interestingly, there are signs that the home care sector is more characterized by unilateral decision making than the hospital care sector, where bi- or multilateral decision making processes seem to be more common during the contracting process. One of the things that have become clear is that the nature of contracting is different in the hospital care sector compared to the home care sector. Whereas the health insurers in the hospital care sector use negotiations as the contracting procedure, care offices in the extramural AWBZ market use tender procedure to contract care. Tendering is a strictly formalized process in which care providers compete for contracts under strict rules whereas negotiations are based on the idea that contracts are concluded based on a dialogue between care purchaser and care provider. Because of this difference, it seems that there is more room for demands or ideas of care providing organizations and its professionals in a contracting process based on negotiations. Also, the purchasing guide that is used as a guideline among health insurers is developed by patient organizations, the professional group and health insurers. In the home care sector contrarily, the purchasing models are merely developed by the care offices. Nonetheless, certain crucial elements of the purchasing model of care offices are partly designed by the professional group, such as the *Kwaliteitskader Verantwoorde Zorg*. So, it has become clear that professionals, predominantly medical specialists, in the hospital care sector appear to have a greater say during the contracting process than professionals in the extramural AWBZ care market.

Also, it appears that care offices make use of both selective and differentiated contracting, whereas health insurers hardly make use of selective contracting but only use differentiated

contracting. So in the extramural AWBZ care market it often happens that certain providers do not get a contract with the care office. In both sectors different parties get different contracts that differ in terms of attractiveness. Moreover, both care offices and health insurers apply the concept of 'preferred providers'; with certain parties they agree on higher volume arrangements. Interestingly, a common remark by health insurers is that they do not make use of selective contracting because of the lack of a well-developed set of performance indicators. They argue that they do not have adequate insights in the performance (quality and costs) of hospitals. This same statement is often made by care office when asked why there is not enough vitality in the AWBZ care market. It is questionable whether the absence of selective contracting in hospital care, and the presence of selective contracting in home care, is so strongly related to the presence of a well-developed and accessible set of performance indicators.

Another difference concerns the demand of additional quality requirements as expressed by the care purchaser. It appears that care offices only slightly demand additional quality requirements, whereas hospitals often have their own set of performance indicators next to the existing IGZ and ZN indicators. Sets of performance indicators often require the registration of activities; an administrative task. On the one hand it is understandable that health insurers want to get a grip on the activities performed by hospitals. On the other hand, currently it is often unclear what health insurers actually do with the retrieved data about provider performance. If the collected information appears to be of little importance for the actual conduct of the health insurers business, it is recommendable to weigh out the advantages over the disadvantages for professionals in terms of increased administrative tasks.

The quality requirements also have another consequence for professional work. Due to the quality criteria, workers have to work with protocols and guidelines more often. One could argue that this leads to a decrease in professional autonomy. However, this is debatable since most of the quality frameworks in the health care sector have been developed in collaboration with the professional group. It is a topic for discussion whether protocols and guidelines designed by professionals themselves still curb their professional autonomy.

One aspect of contracting that is important for professional autonomy concerns the sector-crossing term '*plegen te bieden*'. This term concerns all professions that are registered in the Individual Healthcare Professions Act (BIG Act). This legal criterion, which states that care purchasers have to reimburse care costs of that care which professionals commonly tend to provide, registers professional autonomy by law. In the hospital care sector it concerns the work of nurses and medical specialists. In the home care sector it only concerns the work of nurses. This criterion offers care offices more freedom in terms of the way care provision takes place. Health insurers contrarily, are confined in their freedom of how care provision should take place.

There is also a similarity in the way performance-based contracting takes place. Both health insurers and care offices make use of standard contracts that are further completed during oral (post-tendering[7]) negotiations. Also, in both sectors the care purchasers take the initiative to conclude a

[7] In the case of the extramural AWBZ care sector.

contract. Because of this initiative on the purchasers' side, there is more power at the side of purchaser since they often set purchasing or selection criteria that the care provides has to meet up to.

Focusing on the hospital care sector, it is striking that raising equity capital appears to be one of the most important topics during negotiations between insurers and hospitals. The importance of this topic is partly the result of changes in the legal context, such as the integration of fixed costs related to assets (e.g. buildings) in the DBC prices. Since January 2009 the costs of construction have to be partly earned back by DBC revenues (NZa, 2009). Nonetheless, it remains unclear how this strong focus on prices and long-range plans between care purchasers and hospitals will affect the work of professionals in the short and long run.

In the home care sector, in terms of efficiency related agreements, the two most important agreements concern the reduction of tariffs or prices and the provision of care within the bandwidth of the indication category. The strong focus on price reductions by care offices might stimulate care providers to supply care at a price that is hardly sufficient to cover the costs of care made by the home care organization. If care providers agree on these low prices only to get selected by the care office, the quality of care could be seriously endangered. On the one hand the price reductions might stimulate care providers to work more efficiently. On the other hand, if prices are unreasonably low, care providers might whittle on the quality of care in order to break even. This is predominantly the case for new care providers; they often have to offer an extremely low price in order to get selected by the care office.

The fact that most care offices finance on the basis of average bandwidths seems to encourage the provision of 'hastily care' and it could affect professional autonomy negatively. First of all it is awkward that the care office apparently mistrusts the judge of the CIZ, the official indication institution. If there is a bandwidth of four to eight hours, there is room for a professional interpretation of the situation; some clients will need only four hours while others need seven. The fact that the indication category starts with four hours for example, seems to indicate that this is the absolute minimum for that type of care. This structure of indication categories allows room for professional autonomy. But if care offices, encouraged by the NZa, start to finance on the basis of average bandwidths, or even enforce a malus if care providers use more than 50 or 60 percent of the bandwidth, the room for professional autonomy decreases.

Another interesting finding in the home care sector is the issue of 'applying strict European tender guidelines or not'. First of all, results from the interviews have showed that there is ambiguity about the need to apply strict European guidelines for tendering. It appeared that inventive reading of the law allows for multiple interpretations. It seems as if the umbrella organization of health insurers (ZN), also the responsible for care offices, decided to remain in the middle of this ambiguity: care offices only have to be transparent, objective and non-discriminatory in their tendering process. However, according to some care providers, the power of the 'old-boys-network' is still very much present in the home care sector. This presumes that is remains questionable to what extent the tendering process is actually transparent, objective and non-discriminatory. The vagueness and

indistinctness around the requirements concerning tendering gives care offices freedom in the way they carry out this process.

6.8 Conclusion

From the preliminary results we can conclude that performance-based contracting has been introduced in both the hospital care sector and the home care sector (AWBZ part). In both sectors contracts are concluded between care purchasers and care providers in which specific payment, quality and monitoring systems are included. Nonetheless, the contracting process and the contracts itself are given a sector-specific interpretation. Interestingly, there appears to be a difference in the consequences of contracting care based on performance criteria for the professional autonomy of professionals working in the hospital care sector and the home care sector. It seems that the professional autonomy of professionals working in the home care sector is affected to a greater extent than the autonomy of professionals working in the hospital care sector. In order to grasp the consequences of performance-based contracting on professional work completely, there is a need to understand *how* performance-based contracting affects the work of professionals and why there are differences in consequences.

Literature list

Actiz. (2009). *Rapportage Actiz Ledenonderzoek. Zorgcontractering 2009*. Utrecht: Actiz.

Bovens, M. and P. 't Hart. (2005). *Publieke Verantwoording: zegen en vloek.* In W. Bakker and K. Yesilkagit (eds.) *Publieke Verantwoording.* Amsterdam: Boom, p. 245-264.

Brink, G. van den, Th. Jansen and D. Pessers (eds.) (2005). *Beroepszeer.* Amsterdam: Boom.

Busse, R. (2004). *Disease management programs in Germany's statutory health insurance*. System Health Affairs, 23: 56–67.

Clarke, J., & J. Newman. (1997). *The managerial state.* London; Thousand Oaks; New Delhi: SAGE Publication Ltd.

Denhardt, R.B. and J.V. Denhardt. (2000). *New Public Services: serving rather than steering.* Public Administration Review, 60: 549-559.

Duyvendak, J. W., T. Knijn & M. Kremer. (2006). *Policy, People and the New Professional.* Amsterdam: Amsterdam University Press.

Etzioni, A. (1969). *The Semi-Professions and their Organization: Teachers, Nurses and Social Workers.* New York: Free Press.

Exworthy, M. and S. Halford. (1999). *Professionals and the New Managerialism in the Public Sector.* Buckingham: Open University Press.

Figueras, J., R. Robinson and E. Jakubowski. (2005). *Purchasing to improve health systems performance.* European Observatory on Health Systems and Policies Series. New York: Open University Press.

Freidson, E. (2001). *Professionalism: The thrid logic.* Cambridge: Cambridge University Press.

Helderman, J., F. Schut, T. van Grinten, and W. van de Ven. (2005). *Market-oriented health care reforms and policy learning in the Netherlands.* Journal of Health Politics, Policy and Law, 30: 189-209.

Jegers, M., K. Kesteloot, D. de Graeve and W. Gilles. (2002). *A typology for provider payments systems in health care.* Health Policy, 60: 255-273.

Knijn, T. (2000). *Marketization and the struggling logics of (home) care in the Netherlands.* In M. Harrington Meyer (ed.) *Care work: gender, class and the welfare state.* New York and London: Routledge, pp. 232-248.

Knijn, T. and S. Verhagen. (2007). *Contested professionalism: payments for care and the quality of home care.* Administration & Society, 39: 451-475.

Lipsky, M. (1980). *Street-level bureaucracy: dilemmas of the individual in public services.* New York: Russell Sage Foundation.

Lu, M., C.A. Ma, and L. Yuan. (2003). *Risk selection and matching in performance-based contracting.* Health Economics, 12: 339-354.

Mintzberg, H. (1979). *The structuring of organizations.* Englewood Cliffs: Prentice-Hall.

Noordegraaf, M. (2006). *Professional management of professionals.* In J. Duyvendak, T. Knijn and M. Kremer (eds.) *Policy, People and the New Professional.* Amsterdam: Amsterdam University Press, pp. 181-193.

Noordegraaf, M. (2007). *From "pure" to "hybrid" professionalism: present-day professionalism in*

ambiguous public domains. Administration & Society, 39: 761-785.

NZa. (2007a). *Uitvoerinstoets. Care voor de Toekomst. Voorstellen voor de korte en lange termijn.* Utrecht: Netherlands Health Authority (NZa).

NZa. (2007b). *Monitor ziekenhuiszorg 2007: een analyse van de marktontwikkelingen in het B-segment.* Dutch Healthcare Authority, NZa: Utrecht.

NZa. (2008a). *Extramurale AWBZ-zorg. Analyses van de marktontwikkelingen in 2007 en 2008.* Utrecht: Netherlands Health Authority (NZa).

NZa. (2009). *Monitor ziekenhuiszorg 2009. Tijd voor reguleringszekerheid*. Utrecht: Netherlands Health Authority (NZa).

OMS. (2007a). *Positioneringsnota. Medisch specialisten in dienstverband in de periferie.* Utrecht: Order of Medical Specialists (OMS).

OMS. (2007b). *Medisch specialist in perspectief. Een visie op de toekomst van de medisch-specialistische zorg.* Utrecht: Order of Medical Specialists (OMS).

Pollitt, C. and G. Bouckaert. (2000). *Public management reform.* Oxford: Oxford University Press.

RIVM. (2008). *Dutch Health Care Performance Report 2008.* Bilthoven: National Institute for Public Health and the Environment (RIVM).

RVZ. (2008a). *Zorginkoop.* Den Haag: Council for Public Health and Health Care (RVZ).

RVZ. (2008b). *Health Care Purchasing.* English summary of the report '*Zorginkoop*', Den Haag: Council for Public Health and Health Care (RVZ).

Savas, S., I. Sheiman, E. Tragakes and H. Maarse. (1998). *Contracting models and provider competition*. In: Saltman, R.B., Figueras, J. and Sakellarides, C., eds. *Critical challenges for health care reform in Europe*. Buckingham: Open University Press.

Segall, M. (2000). *From cooperation to competition in national health systems - and back? Impact on professional ethics and quality of care*. Journal of Health Planning and Management, 15: 61-79.

Tonkens, E. (2008). *Mondige burgers, getemde professionals*. Amsterdam: Van Gennep.

Ven van de, W.P.M.M. and F.T. Schut. (2009). *Managed competition in the Netherlands: still work-in-progress.* Health Economics, 18: 253-255.

WHO. (2000) *The world health report 2000. Health systems: improving performance*. Geneva: World Health Organization.

WRR. (2004). *Bewijzen van goede dienstverlening.* Amsterdam: Amsterdam University Press.

List of abbreviations

AWBZ	Algemene wet bijzondere ziektekosten (Exceptional Medical Expenses Act)
BIG	Wet beroepen individuele gezondheidszorg (Health Care Professions Act)
CAK	Centraal Administratie Kantoor (Central Administration Office)
CIZ	Centrum Indicatiestelling Zorg (National Care Assessment Centre)
CLB	Persoonsgebonden budget (Client-linked budget)
CTG	College Tarieven Gezondheidszorg (Health Care Tariffs Board)
CTZ	College Toezicht Zorgverzekeringen (Health Care Insurance Regulatory Board)
DBC	Diagnose behandeling combinatie (diagnosis treatment combination)
GGZ	Geestelijke gezondheidszorg (mental health care)
HKZ	Stichting Harmonisatie Kwaliteitsbeoordeling in de Zorgsector (HKZ Expertise Centre on Quality Review in Health Care)
IGZ	Inspectie voor de Gezondheidszorg (Health Care Inspectorate)
ITC	Independent Treatment Centre
NVZ	Nederlandse Vereniging van Ziekenhuizen (Dutch Hospitals Association)
NZa	Nederlandse Zorgautoriteit (Dutch Healthcare Authority)
Orde	Orde van Medisch Specialisten (Order of Medical Specialists)
PGB	Persoonsgebonden budget (client-linked budget)
RIVM	Rijksinstituut voor Volksgezondheid en Milieu (National Institute of Public Health and the Environment)
RVZ	Raad voor de Volksgezondheid en Zorg (Council for Public Health and Health Care)
V&V	Verpleging & Verzorging (nursing & care)
VWS	Ministerie van Volksgezondheid, Welzijn en Sport (Ministry of Health, Welfare and Sport)
WGBO	Wet geneeskundige behandelingsovereenkomst (Dutch Medical Treatment Act)
Wmcz	Wet medezeggenschap cliënten zorginstellingen (Participation of Clients in Care Institutions Act)
Wmg	Wet marktordening gezondheidszorg (Healthcare Market Regulation Act)
Wmo	Wet maatschappelijke ondersteuning (Social Support Act)
WRR	Wetenschappelijke Raad voor het Regeringsbeleid (Netherlands Scientific Council for Government Policy)
Wtg	Wet tarieven gezondheidszorg (Health Care Tariffs Act)
WTZi	Wet toelating zorginstellingen (Health Care Institutions Act)
ZBC	Zelfstandig behandelcentrum (independent treatment centre)
ZN	Zorgverzekeraars Nederland (Association of Dutch Health Insurers)
Zvw	Zorgverzekeringswet (Health Insurance Act)

Appendix 1: Health insurers 2009

Multizorg (inkoopcombinatie)	– De Friesland – DSW – Fortis ASR – ONVZ – PNO Ziektekosten – Salland verzekeringen – SR – Zorg & Zekerheid – AZvZ – FBTO
UVIT	– De Goudse – IZZ – IZA – Trias – UMC – Univé – Univé Zorg – VGZ
Menzis	– AnderZorg – Menzis – Confior – Azivo
Achmea	– Avéro – Groene Land PWZ – Interpolis – OZF – OZB – Zilveren Kruis – Agis
Delta Lloyd	– Delta Lloyd – OHRA Ziektekostenverzekeringen – OHRA Zorgverzekeringen – CZ OZ Zorgverzekeraar

Source: NZa, 2009: 26.