Scale and health care

Summary

Background

This advisory report was prompted by disquiet in parliament. The Lower House of the Dutch parliament is deeply concerned about care institution mergers. They take the view that this could have an adverse impact on the quality, accessibility and diversity of health care provision. Accordingly, the Lower House wants the Minister of Health, Welfare and Sport to have the power of veto over mergers. It feels that a separate merger evaluation procedure for the health care sector is needed. The Minister has requested advice on this matter from the Council for Public Health and Health Care.

Facts

First the facts of the matter. In health care provision there is a clear trend towards increases in scale, which involves mergers for example. There is, of course, an explanation. In some cases, scaling up is a matter of pure financial necessity, in order to facilitate the provision of small-scale health care, for example. In addition, developments in science and technology are increasingly compelling health care providers to scale up their operations, and to concentrate knowledge. But the real explanation is that health care providers are very uncertain, and feel that they are exposed to numerous risks. Health care is in a state of transition from the public sector to the free market, a move which seems to heighten defensive behaviour. This is reflected in their decisions on matters of scale, and in their tendency to opt for increases in scale.

Mergers are increasingly giving way to cooperation between different care institutions or between professionals, with a view to chain formation for example. While the number of corporate bodies in the health care sector has clearly declined, the number of sites has not. In fact, within the purview of the Exceptional Medical Expenses Act (AWBZ), they have actually increased. Dutch care institutions have traditionally been very accessible, and it would appear that this is still the case today. However, acute care (which goes to the very heart of accessibility) is not up to scratch in qualitative terms, when measured against international standards. There is no evidence to suggest

that increases in scale have in any way detracted from the quality and affordability of health care provision.

Problem

So, if public interests such as quality, accessibility, and affordability are not at risk, what exactly is the problem? The problem is there is no agreement on the matter of responsibility. Who has the final say regarding decisions on matters of scale - the government or the care institution in question? In recent years, the policy line has been crystal clear. This is the job of the care institution, and any poor decisions with regard to scale will be punished by market forces. The only problem is that the market in question is not yet functioning efficiently, so poor decisions incur few penalties. The government is still heavily involved in the health care sector. On the one hand this creates obligations (and gives rise to expectations), while on the other hand it causes confusion about areas of responsibility. Does ministerial 'responsibility for the system as a whole' extend to decisions about scale taken by health care providers? This remains a politically contentious issue.

A secondary problem is that it is very difficult to assess increases in scale in terms of their implications for the public interest. For instance, increases in scale can sometimes benefit quality, while decreases in scale can result in improved accessibility. Another consideration is that while the distances that patients have to travel can be easily measured, quality is less tangible. This is a serious matter. Finally, it is worrying that all the fuss about mergers tends to distract our attention from the lack of policy with regard to innovation, tailored health care, and small-scale health care provision.

The link between scale and health care

An initial consideration. The parliamentary debate on mergers and increases in scale deals purely with the legal aspects, with the emergence of new and larger legal entities, and with institutions. But scale also affects the level of care experienced by consumers (at home, in the primary health care system, in small day-care units, and in hospitals). It is the latter consideration that is of the greatest importance to patients. Greater scale in legal terms may very well be consistent with small-scale tailored health care, indeed it is often an economic prerequisite for such care.

This indicates that the relationship between scale and health care is much more complex than it might at first seem. Small is not always synonymous with quality, customer friendliness, and efficiency. It can be quite the reverse in fact. In addition, there are numerous external forces which affect the relationship between scale and health care. These days, for example, the provision of good quality health care increasingly involves the pooling of expertise and technology. That requires centralization. And that means increases in scale. These considerations tend to argue in favour of 'tailored policy' and against generic measures aimed at the health care sector as a whole.

As stated, there is no hard evidence to suggest that scale increases in the health care sector take place at the expense of quality, affordability and accessibility. Indeed, in the case of some care functions, quality considerations suggest quite the opposite - greater scale is sometimes essential. Any additional scaling-up may well take place at the expense of accessibility. That would indeed be the case if scaling up were to be accompanied by a centralization of functions and/or by the closure of some sites. This is by no means a hypothetical situation. After all, health care providers are facing ever greater risks.

For most health care segments, the possibility of a decrease in accessibility is not a problem. Accessibility in the Netherlands is clearly good and, from an objective viewpoint, rapid accessibility is often not necessary, except in the case of acute care. Another consideration is that a decline of accessibility (or the possibility of such a decline) is not in keeping with clients' preferences. An additional problem is that these clients are well aware of their journey time, but not of the quality that they can expect. This makes it difficult for them to weigh these factors against one another.

The health care sector needs to be segmented!

These were two subtle distinctions. However, a third such distinction is also required. The nature of the relationship between scale and health care is constantly evolving within individual elements and segments of the health care sector. Accordingly, segmentation is indispensible to reliable assessments of the scaling up process. Three segments stand out in this regard: acute care, scheduled specialist medical care, and long-term care (Exceptional Medical Expenses Act care).

First let's consider acute care. If this is properly organized, then the availability of care is not at issue. Is that currently the case? No, it is not, but various targeted measures and investments would certainly make it feasible. The most important of these are as follows:

- imposing legal controls (public sector responsibility!) on an acute care segment which is strictly limited to on-demand care (as defined in section § 3.1 of the advisory report) and which can be distinguished from non-acute care in clear-cut organizational, financial and spatial terms;
- such care takes the form of a chain cantered on the hospital's Accident and Emergency department;
- an advanced ambulance service with a fast response time which is medically and logistically linked to the closest indicated clinical facility.

In addition to such measures and investments, it is also possible to make savings (in terms of factors such as Accident and Emergency departments and control centres).

Then there is scheduled specialist medical care. That is now influenced by largely autonomous developments in the areas of science and technology. These advances force the system towards ever greater specialization and towards the centralization of knowledge, expertise and capital. At the same time, for other procedures, the reverse is true. Currently, there are a number of operations which can be carried out perfectly well in non-hospital facilities, in professional partnerships and/or in the primary health care system. We therefore see both centralization and decentralization, and both large-scale and small-scale facilities.

Supported by monitoring and the defrayment of costs, these trends will, and indeed must, lead to a radical transformation of the hospital system. In a few years, this system will be characterized by:

- a robust primary health care system which is also capable of providing specialized medical diagnoses (in combination with a number of outpatient roles);
- the centralization of medical knowledge, skills and technology in university medical centres and tertiary referral hospitals;
- together with a scattering of small, specialized medical clinics which are networked with the major hospitals,

but which are sited close to the primary health care system and to long-term care institutions.

Accordingly, this system does not incorporate small hospitals with a broad range of medical services.

In conclusion, long-term care (Exceptional Medical Expenses Act care). In this segment, large-scale administration and management coexist effectively with small-scale care and services. And this is how health care providers operate in practice. Things are on the right track. It is both necessary and possible to speed things up:

- by drawing a more radical distinction between housing and health care. This could be achieved by giving health care providers full responsibility for the financing of real estate;
- by using rates to reward small-scale solutions, and to discourage large-scale ones;
- by making the funding of health care provision dependent on a client-linked budget;
- by replacing health care offices with risk-bearing health insurance companies.

Three solutions for accessibility problems

The above-mentioned segment-by-segment approach can be used to avoid many accessibility problems, while at the same time improving quality. Yet more can and must be done. There are three ways of achieving substantial improvements in quality and accessibility and, where possible, of avoiding future problems in these areas:

- by transforming primary health care into a system of broad district-based centres for support, prevention, care and cure;
- by substantially expanding e-health as a substitute for the conventional care system;
- by encouraging, where possible, the use of integrated health care and disease management as alternatives to institution-based health care.

For the Minister for Health, Welfare and Sport, these three areas represent the best opportunities for developing 'scaling policy'. However, he will have to take responsibility for the further development of these areas (in the role of director).

A separate merger evaluation procedure for the health care sector?

The Lower House believes that the Minister for Health, Welfare and Sport should engineer a separate merger evaluation procedure for the health care sector. This would enable the Netherlands Competition Authority to take firmer action against merger plans.

As a means of countering any risks of scaling up, a merger evaluation procedure for the health care sector – in the form of a separate legal structure – would be a clear case of overkill. In principle, existing competition law is sufficient, although some areas could be further strengthened. The whole point of competition law is to protect consumers and to comply with their preferences by retaining customer choice and by countering any skewed incentives that favour increases of scale (abuse of a position of power).

In the absence of a clear causal link between the scale of care institutions and impacts on public interests, the preselection of merger plans as a target for government intervention is not logical. A more obvious approach is to set up a monitoring system to check for evidence that economic positions of power are being misused. Accordingly, the Council favours boosting support for the Dutch Healthcare Authority, the director of the health care market. The Dutch Healthcare Authority monitors developments in the various submarkets, and is tasked with giving priority to monitoring how the public interest is affected by increases of scale. The distribution model that the Council presented in its 2003 advisory report entitled *Marktconcentraties* (Market Concentrations) can serve as a guide here. If necessary, the Dutch Healthcare Authority could be granted greater authority to deal with substantial market power.

The vision of the Council for Public Health and Health Care

This advisory report was prompted by concern in the Lower House of the Dutch parliament that increases in scale within the health care system might be prejudicial to the public interest in general, and to the accessibility of care in particular. We have found no evidence to support this view. However there are indications that there is the potential for problems to develop. Questions asked in the House mainly reflect doubts about the operation of market forces.

With regard to guiding the provision of acute care, the Council shares those doubts. In that area, the Council believes that

government regulation (central planning and budgeting) is called for. With regard to chronic (long-term) and elective curative care, however, the Council does not share that doubt. Quite the contrary in fact. The risks posed by increases in scale within these segments are more likely to result from excessively weak rather than overly strong market forces. The Council takes the view that the dominant stance taken by health care providers in attempting to obtain sufficient market share is a temporary stage in the transition to a demand-driven system of care. This transitional phase involves a great deal of uncertainty. Faced with increasing risks (including financial risks), health care providers are seeking balance and stability. The motto now is "Get what you can while the getting is good".

The Council advises the Minister to respect health care providers' responsibility for decision making on matters of scale. A separate merger evaluation procedure for the health care sector, as proposed by the Lower House, is not appropriate to situations in which the operation of market forces is the dominant regulating principle. There is yet another reason for opting out of this merger evaluation procedure. The relationship between scale and quality/accessibility of care is a complex one. Any attempt to regulate this relationship with a single evaluation procedure would be doomed to failure.

Given that health care providers are entirely responsible for matters of scale, they must also bear the full impact of the risks and consequences involved. Accordingly, progress must be made with the introduction of integrated performance pricing, with the expansion of the B-segment, and with the encouragement of selective health care purchasing. But above all, quality transparency must be enforced. This is the only way to creates an effective evaluation procedure (by consumers and health care purchasers) for decisions in matters of scale. The governance system is responsible for this, evaluation is left to the market.

The Minister must clarify the issues of public interests in relation to scale and health care, underlying standards, and relative ranking. When it really comes down to it, quality of care and the results delivered are the primary considerations, even if this at the expense of other public interests, such as accessibility.

The challenge for the government is to energetically promote the decentralization of health care, human scale care, and community-based care. The key to this lies in promoting and strengthening the primary health care system, e-health, disease management (that is, the integration of prevention, care and cure) and drawing a more radical distinction between housing and health care.

Rather than a separate merger evaluation procedure, there should be safeguards for quality and accessibility. How is this to be achieved? Here are some suggestions.

Recommendations

- Abandon any plans for a separate merger evaluation procedure for the health care sector. Push for a statement to be included in the protocol of cooperation between the Netherlands Competition Authority and the Dutch Healthcare Authority to the effect that the former will specifically address the latter's view, inasmuch as this differs from its ultimate decision concerning mergers (obligation to provide a statement of reasons).
- If it transpires that increases in scale pose genuine risks to public interests, then the Dutch Healthcare Authority could be granted greater authority to deal with substantial market power. The Council would also like to suggest that the Dutch Healthcare Authority apply its monitoring role more rigorously with regard to the effects of decisions on matters of scale.
- If necessary, make admission subject to the provisions of the Health Care Establishments Licensing Act, to impose conditions on categories of health care providers.
- Consider the possibility of including a provision in the WMCZ (legislation governing institutional democracy in the health care sector) requiring the boards of health care companies to look into alternatives to mergers proposed by client advisory boards; in addition to imposing an obligation to provide a statement of reasons on any board that adheres to its original plans.
- Reconsider the direction and financing of acute care, as defined in this advisory report.
- Continue relying on the operation of market forces (regulated or otherwise) for the other health care segments (the Health Insurance Act and the Exceptional Medical Expenses Act). That is to say: integrated per-

formance-related funding, extending free pricing, and short term selective health care purchasing.

- Push for the development of standards that demand a minimum number of operations/treatments per year. If it is impossible to comply, then it must be crystal clear that carrying out the operation/treatment in question is strictly prohibited. Create a legal basis for quality standards.
- Dispense with protective measures for small hospitals. Drop the notion that all hospitals should (or can) have a wide range of specialist medical functions (Netherlands Health Care Inspectorate).
- Direct the creation of an integrated primary health care service, as described in this advisory report. Use funding (Dutch Healthcare Authority) and quality policy (Netherlands Health Care Inspectorate), in addition to the small-scale provision of health care by means of e-health, disease management, distinguishing between housing and health care. Reward innovation, not conservation.