Ziekenhuisfusies, procesgang en resultaten
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Document Version
Publisher's PDF, also known as Version of record

Publication date:
2000

Link to publication in University of Groningen/UMCG research database

Citation for published version (APA):

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Summary

In the last 30 years, health care in the Netherlands has seen a large number of mergers of general hospitals. These mergers were not isolated incidents, but came about at a time when a great number of developments were taking place within health care. Examples of these changes include alterations to systems, the increased involvement of patients, the role of specialists in hospitals, technological developments and the role of insurers. If the part played by government up until the 1970s was in the main distant and facilitating, then from the middle of the decade government influence increased in terms of legislation and cost management. At the end of the 1980s, when it appeared that despite all the interventions made the cost of health care was still not properly under control, the government decided to set itself a new course. The plans emphasised an increase in market operations. First the Dekker Commission, then the Dunning Commission and finally the Biesheuvel Commission all proceeded to develop plans for market operations and funding, the package of provisions and the position of, and collaborative working relationship within, general health care. One decade later, it can be seen that only one part of all the proposed changes has actually been implemented. Regional experiments are indeed being carried out, aimed at both finding ways to defray costs for health care and the working relationship between the various parties; for each hospital there is one budget in which all costs have been accounted for and there are local initiatives in many locations for the purpose of better aligning the relationship between home care and hospital care.

As far as other developments are concerned, it is the change in the position of the health-care insurers which has become noteworthy. At present, the majority of health-care insurers operate nationally, health-care insurers have become the hospitals’ negotiating partners, contractual obligations have disappeared and the health-care insurers are taking part in the regional experiments. Furthermore, an increase in scale can also be seen to be a result of mergers.

General hospitals are becoming increasingly characterised as an integrated company which specialises in medicine. The emphasis in working practice is on diagnostic techniques, treatment and initial after care. Faster patient throughput is now evident compared to ten or twenty years ago because of the broadening in technological options available and an increase in knowledge. All kinds of out-patient treatments have evolved and bed-occupancy times are still falling.

When considering all these developments, the question to be asked is whether health care will benefit from a greater level of market operation. Whatever the case, there are presently a great many indications to the contrary, such as limited market access, restricted freedom of choice from the products on offer, etc. One great obstacle in the way of achieving market operations is the role of government. Since the time of the Dekker Commission’s plans, the government has put a number of measures in place which have ultimately failed to produce a clear framework and transparent structure within which market operations can take shape. Quite the opposite situation appears to exist, with it having become unclear to the parties in the field what to expect from government and just what margins exist for manoeuvre. The consequence is that many hospitals are adopting a very expectant attitude vis-à-vis government.
A total of 79 mergers took place between 1967 to 1994 inclusive, registering three discernible waves of activity. The first wave involved mergers of small hospitals for which quality improvement was an important motive. The second wave targeted new construction and pushing back over-capacity. The third wave was made up of mergers which were partly a result of government pressure and partly mergers designed to achieve top clinical status.

In general, the literature on hospital mergers mentions two motives: the survival motive and the market strategy motive. There are three clearly recognisable questions for merging hospitals to tackle: the way in which the two existing organisations should integrate; determining choices from the number of locations, and the way in which positions should be filled in these locations.

Little is known about the consequences for the environment posed by hospital mergers. What is understood is the increase in average journey times for patients. However, no data are available on the quality of care provided or on service provision.

The operation of merger processes correlates well with project-based working techniques. Important parties in the merger process include administration, directors, medical staff, the staff council and the service or sector chiefs. The role of these parties alters in the course of the process.

It should be noted that, intentionally and unintentionally, government activities were instrumental in effecting hospital mergers, for example through the beds reduction plan and through the combination of EVI procedure and functional budgeting, which made mergers interesting in terms of the perspectives they offered to hospitals, but also perhaps as a result of the outlined uncertainty in the government’s activity: a large (merged) hospital has more ‘countervailing power’ than two small hospitals.

The conclusion drawn from the literature on the subject is that much still remains unknown about hospital mergers. There are no insights into the results of mergers from either a quantitative or qualitative point of view. Furthermore, insights are also absent on the way in which merger processes are operated, as well as what the relationship is between the operation of merger processes and the results obtained from the merger process.

The following is a formulation of the problem for the purposes of the study:

“A great many hospital mergers took place in the period from 1967 to 1994 inclusive. Regarding this, perspectives are absent in an economic-organisational sense on the results achieved as well as on the relationship between the operation of the merger process and the results achieved from it.”

The following three research questions were formulated in addition to this:

• What do mergers of general hospitals provide in an economic-organisational sense?
• How are merger processes designed and in what ways are they operated?
• To what degree can neo-institutional theories be used to explain merger phenomena?

The study questions were investigated from an economic-organisational standpoint. To this end, some neo-institutional theories were employed, namely the “Behavioral Theory of the Firm”, the Transaction Cost Theory and evolutionary theories.
Additionally, Thompson’s ideas were used and (to a lesser degree) those of Mintzberg. Considering that the theories employed are general in nature and not specifically oriented towards (horizontal) mergers, comments have been formulated about mergers when discussing the theories.

Five hypotheses were formulated on the basis of this theoretical framework. In the neo-institutional theories, the emphasis lay on the transaction cost theory. The core of this theory, depending on the circumstances, is that organisations can let their transactions run via the market or via the organisation, and in so doing they economise on transaction costs (also sometimes defined as the costs of co-ordination and motivation). As well as a description of the theory, extensive attention has been afforded to existing criticisms of the transaction cost theory. Given that the transaction cost theory is relatively static in character (the theory describes why organisations/people economise on transaction costs and which factors are involved in that choice without going into the how and why of it all), the “Behavioral Theory of the Firm” and evolutionary theories are used since these theories provide perspectives on such matters as how decision and selection processes operate in organisations. From an organisational viewpoint, Thompson describes how organisations co-ordinate their work processes and incorporate operational mechanisms. Mintzberg has developed six configurations of organisational structures based partly on Thompson’s ideas.

The hypotheses, formulated on the basis of the theoretical framework, target the question whether the merger of hospitals gives rise to changes in the relationship between management costs and production costs, the development of the budgetary share that is provided to hospitals for health care, the way in which hospitals structure the organisation following merger, the course taken in the merger process in relation to the results, and the way in which the structuring of commercial services occurs.

The fourth chapter constitutes the link between the theoretical framework and the case studies in Chapters 5, 6 and 7. Some important developments are discussed in terms of the methodology within economics (logical positivism versus interpretative perspective). Alongside these developments, the Van Strien regulatory cycle is also considered. The case study choice is motivated on the basis of the methodological view, and the requirements necessary for compliance of the case study are elaborated upon. Finally, the means by which the formulated hypotheses are made operational are considered and which problems needed to be solved in that regard. Particular attention is given to explain how the terms ‘management’ and ‘production’ can be defined. This exploration results in an analysis in the study of the relationship between management costs and production costs from three different approaches.

Chapters 5, 6 and 7 contain a description of the case study as carried out at the Noord Limburg Hospitals Foundation, the Martini Hospital and the Drechtsteden Hospital.

The eighth chapter contains the results from the study and in this chapter there is a link back to the theories employed and hospital practice.

The study supports the first hypothesis: merger leads to a decreased relationship between management costs and production costs in the three hospitals studied. This was supported by all three of the approaches taken. Less straightforward is support for
the second hypothesis. In one of the merged hospitals there was a case of a rising budget for health care, in the second hospital there was a case of a marginal increase and the third hospital showed a slight decrease in the budgetary share for health care. The study provides no support for the third hypothesis. In one of the hospitals divisionalisation of the organisation occurred while this was not the case in the other two hospitals. It should be noted in this regard that partial divisionalisation did occur in one of the other two hospitals at a later stage. The fourth hypothesis does find support in the study: in the hospitals studied, a correlation can be seen between the operational side of and course of the merger process and the results achieved. The study lends no support for the fifth hypothesis. All hospitals evidenced autonomous development of commercial services; only in a few areas can it be shown that the development of commercial services is related to developments in health care. In summary, the study supports the first and fourth hypotheses, some support for the second hypothesis and no support for the third and fifth hypotheses. A remark should be made in relation to this: a relationship can be observed in the study between the first and third hypotheses: merger profit is a consequence of the organisation’s divisionalisation in two of the three hospitals. In other words: there is no relationship between the merger and the intention to have the organisation divisionalised, but there is a relationship between the divisionalisation of the organisation and the merger profit realised.

A second point of importance is that merger profit is only realised once a situation is seen to exist in which procedural rationality has the upper hand over political rationality.

In the discussion following this on the theories employed, it is stressed that in all three case studies the context in which mergers occurred was influential on the course of the merger process and on the results. The results achieved were in any event dependent at the time on the way in which the process progressed. Furthermore, it appears that the hospitals in the study took particular advantage of opportunities which arose in the hospital’s area and they did not specifically economise on transaction costs. Finally, two areas are touched on for further study. Firstly, it is advanced that through broadening the framework, the transaction cost theory is helped by adding the terms ‘power’ and ‘influence’, and, alternatively, that curtailing of the theory’s scope may provide improvements regarding the applications for which it can be used. With respect to this, if the regulatory cycle is also employed, then a multi-disciplinary approach would appear to be a choice holding a wealth of opportunities in both cases. A second approach for further study is in the application of socio-technical methods when structuring merging hospitals, so enabling work processes and structures to be joined together in an improved manner.

For practical purposes, a procedure is developed which shows in key steps how a suitable option could be given form. It is also shown that merger processes help create good and timely changeovers from administrative mergers to participant mergers. The merger profit to be realised depends on factors of execution and the organisation and not on administrative factors. A last point for attention is the way in which the commercial processes fit in with developments in health care.

It is the researcher’s opinion that the design of commercial services should be made to fit much more closely with the design of the primary process.