‘Home-care and competitive bidding;

is it a match?’

A study about competitive bidding to purchase home-care in the Netherlands

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Preface

Writing a master thesis while having a job and following multiple master courses has been a challenge, but performing a study about a subject I find interesting has brought the necessary discipline to actually finish the master thesis. I chose to study the use of competitive bidding as a purchasing method of home-care for the reason of my employment at a purchaser of home-care at that moment, namely the regional care offices of the health insurer CZ. Observing the purchasers of CZ, I realised that using competitive bidding for the first time was experienced as complex. Purchasers and providers were searching for the best way to deal with the procedure and related elements and therefore I decided to analyse the purchasing method in depth. A year and a half later, I can conclude that I have learned a lot and the result lies in front of you. I hope it will bring some clarification for the purchasers of home-care in the Netherlands about the method and the complex deregulating market for home-care.

This master thesis would not have been what it has become without the extensive support, directions and the patience of my supervisor Marco Varkevisser, who always succeeded to bring me back on the right track. I also want to thank Harm Draad, purchaser of CZ, and his colleagues for their input for this master thesis.

After having said these words, I hope that you will enjoy reading this study report.

Summary

In this master thesis an analysis has been performed about the use of competitive bidding to purchase home-care in the Netherlands. Competitive bidding is being used by purchasers as allocation mechanism to select providers for contracting and with that making enough health services available for their insureds or citizens. The research question that has been answered, is the following:

"Under which conditions is competitive bidding a useful purchasing method for home-care in the Netherlands?"

The master thesis has been started by executing a study of literature to the general process of purchasing health services and distinguishes three different stages: selecting, contracting and financing. It has become clear that those three stages are related to each other in each purchasing process. When choosing competitive bidding as purchasing method to select providers for contracting, the purchaser should be aware of picking a way of financing that does correlate with the incentives the competitive environment brings along. For example, when competitive bidding is meant to increase competition and with that efficiency, it would not be correct to award contracts with duration of 10 years and pay providers by fee-for-service, which decreases competition and may lead to supplier induced demand, which may even cause an increase in total costs.

After having described the general process of purchasing health services, a study of literature has been performed to the different types of competitive bidding and its use in other developed countries. The purpose of competitive bidding is most often to increase competition on the market to reduce costs or improve the level of quality of care. The stages of the purchasing method are the following: specification of the health service, selection of winning bidders, determination of reimbursement, monitoring and evaluation. All stages must be included to make competitive bidding a successful purchasing method and it should be used when the health services are suitable to being purchased by competitive bidding. The health services should therefore (i) not needed to be delivered with urgency; (ii) be possible to specify in detail, including goals, activities and expected outcome; (iii) not be highly specialised or top-clinical; (iiii) needed to be provided for only a short time. The study of literature also provided lessons from other countries that should be considered to become aware of the possible effects and consequences. For instance, the level of competition on the market must be high enough, because providers with an economic dominating position do not experience incentives to operate more efficient and reduce their production costs. Another lesson that can be learned is that when providers are not monitored adequately, they may experience an incentive of reducing their level of quality of care, while reducing their production costs. The study of literature was ended by creating a checklist

that has been used later on to score the Dutch home-care market and the use of competitive bidding by Dutch purchasers.

The master thesis has been continued with an analysis of the current market for home-care in the Netherlands. Home-care is the umbrella term for all sorts of care that is provided to clients who live independently with some professional support. Two relevant purchasers in two different contexts are present for home-care in kind: municipalities purchasing housekeeping services financed by the Social support act (WMO) and regional care offices purchasing the rest of the types of home-care financed by the Exceptional Medical Expenses Act (AWBZ). It has become clear that the concentration on the market for home-care in kind is too high, meaning that the competition level among providers is low. The goal of purchasers is to increase competition and stimulate incumbents to reduce their production costs while maintaining or improving the quality of care. New providers should therefore be stimulated to join the bidding procedure. However, the context of the AWBZ has significant entry barriers such as the monopsonistic position of regional care offices and the fact that only 10% of the total production volume is being allocated by competitive bidding (while the rest is being guaranteed to incumbents). The context of the WMO does not come up with certain entry barriers and most municipalities have contracted 3 to 5 providers in a mix of incumbents and entrants. Municipalities seem to have succeeded to increase the level of competition in the market for housekeeping services. The quality of care has been measured by means of process quality indicators; output quality indicators are not yet developed.

After the analysis of the home-care market, attention is paid to the preliminary results of the use of competitive bidding in the Netherlands. Regional care offices have been using competitive bidding for two years now to allocate 10% of the total production volume to entrants and incumbents that are willing to grow. The rest of the production volume is being guaranteed to incumbents to make sure all clients in need of long term care can stay with the provider they are familiar with. An increase in efficiency can be observed: more volume is being purchased for the same amount of resources. The increase in efficiency can be explained as result of the use of competitive bidding, but also as result from the Covenant the Ministry of VWS has agreed with the present parties in the market. The concentration on the market is still too high and the NZa states that prices can still be lowered if providers are more stimulated to reduce their production costs. The development on the level of quality is not known, although more providers have become certificated in the last two years, which is positive, but does not guarantee a high level of provided quality and therefore an improvement or reductions in the level cannot be measured accurately.

Municipalities have been purchasing home-care for the first time, since the home-care type housekeeping services has been transferred from the AWBZ to the WMO in January 2007. Municipalities are obliged to use competitive bidding according to the European directive on public

procurement, just like regional care offices. They seem to have succeeded to increase the competition on the market for housekeeping services, although the concentration on the market is still unknown and the element of subcontracting is expected to have large effects on the market and must therefore also become transparent. The market has changed significantly by the mentioned transfer, because it had became possible for cleaning companies to join the bidding procedure for housekeeping services and incumbents have lost the freedom to be able to decide which type of housekeeping services was needed by their clients. Because of that, incumbents are currently dealing with too less low-educated (cheap) personnel and too much overqualified personnel to answer the indicated need for home-care of clients accurately, resulting in financial problems and the risk of discontinuity of care, waiting lists and less available capacity although it has been contracted. The quality of provided housekeeping services is also mainly measured by process quality indicators.

The checklist that was created as result of the study of literature is used to be able to draw conclusions about whether competitive bidding is a useful method to purchase home-care under the current market conditions in the Netherlands. The following conclusions are drawn:

- Home-care is suitable to be purchased by competitive bidding. Chronically ill clients in need of long term home-care may experience a burden when the indicated care is delivered by another provider each contract period, but there is no evidence about actually harming clients in that case. The absence of output quality indicators causes a risk, because providers cannot be monitored whether they have actually delivered the level of quality they have promised when bidding on a contract. This may create the incentive to providers to reduce their level of quality of care while reducing their production costs.
- The concentration on the market for home-care financed by the AWBZ is too high to create incentives to stimulate providers to reduce their production costs. The existing entry barriers may prevent new providers to enter the market and increase competition. Regional care offices and the NZa should make an effort to reduce the entry barriers by for instance performing a study about whether guaranteeing such a high percentage of production volume to incumbents is really necessary.
- The inexperienced municipalities were able to lower the prices on average. In the next year it will become clear whether the prices are too low and lead to bankruptcies. Municipalities should focus on developing purchasing skills by learning from their hired external consultants. They should also perform studies to the level of concentration on the market and the amount and effects of subcontracting. Stabilising the market while maintaining the increased level of competition in the market and support the contracted providers that deal with personnel problems are also relevant recommendations when becoming experienced purchasers.
- All purchasers should develop output quality indicators to prevent cheap providers lowering their quality to an unacceptable level in the interests of clients.

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Appendix

Introduction

This master thesis will analyse the use of competitive bidding as purchasing and allocation method by Dutch purchasers to contract home-care providers to make enough home-care available to their insureds. The research question that will be answered in the conclusion is as follows:

"Under which conditions is competitive bidding a useful purchasing method for home-care in the Netherlands?"

Four chapters will lead to the answer of the research question in the conclusion. First, the results of a study of literature will clarify the three different stages of the purchasing process in general to create a context in which competitive bidding can be placed. Those three different stages are (i) selecting, (ii) contracting and (iii) financing.

The use of competitive bidding as purchasing method for health services in other developed countries and theoretical concepts about competitive bidding are the contents of the second chapter. A checklist is created to be able to score the Dutch home-care market in chapter four, by means of those foreign experiences and theories about necessary market conditions and possible effects, consequences and incentives to providers and purchasers.

Chapter three will clarify the products of home-care, the current markets for home-care in the Netherlands, the level of competition and the position of purchasers and providers in those markets and the current and future institutional context. These elements together will create a detailed oversight of the context in which home-care is purchased to be able to draw conclusions about the usefulness of competitive bidding when applied in the described markets.

The preliminary results of the use of competitive bidding by the different purchasers in the Netherlands are described in chapter four. There will also be given some possible explanations for these resulting effects and consequences. The checklist that was created in chapter two will be used to score the presence of the necessary conditions to be able to give an answer to the research question.

The final chapter will draw conclusions about the suitability of home-care in the Netherlands to be purchased by competitive bidding and the presence of the necessary conditions on the home-care markets and with that an answer to the research question is formulated. Having answered the research question, recommendations will be given to the different purchasers and authorities to improve elements and solve problems on the market that prevent competitive bidding from achieving its goals, such as cost containment and/or improve the level of quality of home-care.

Chapter 1 Purchasing health services

The purpose of purchasing health services by for example private health insurers or authorities is to make sure that enough health care services are available for the insured beneficiaries and this can be executed in different ways. To create a context in which competitive bidding as purchasing method should be placed, this master thesis starts with distinguishing the three stages that are present in every process of purchasing health care. The various types of these three stages (selecting, contracting and financing) will be briefly described together with their advantages and disadvantages.

1.1 Selecting providers

Two ways of selecting providers for contracting can be mentioned. First, the purchaser decides in advance which providers are selected and approaches them for the contracting stage. The providers can become selected when having a well-known name and for example an acknowledgment of providing a certain level of quality. These providers will become familiar with the purchaser after some contract periods, which has the advantage that monitoring the contracted care providers will be less complex and expensive. This way of selecting providers will often be used in markets without effective competition, e.g. resulting from a shortage of health care providers. A disadvantage is the higher contract price that is charged by health care providers from the purchaser, because of their economic dominant position and their existing reputation of being an experienced and trustful health care provider (Mills, 1998).

Second, the purchaser invites all interested providers to bid on a contract, for example by means of press advertisements. By using a general invitation to reach enough potential bidders, all interested providers are allowed to bid (competitively) on a certain amount of production volume. The invitation of the purchaser must clarify the selection criteria he will use when judging the bids in advance, for instance the presence of quality indicators. The advantage of this way of selecting is the introduction of competition, giving participating bidders an incentive to reduce production costs and lower their price. The disadvantages are the formal procedure and the absence of trust and experience with new providers leading to the inability for the purchaser to ensure himself of the fact that the provider will deliver the promised and contracted care on the agreed level of quality.

1.2 Contracting providers by purchasers

1.2.1 General process of contracting

The reason of purchasers to contract with providers is to create some kind of relation to be assured of achieving their goals such as cost containment or improve the quality of care. Purchasers of health care services do not have as much information about the costs of treatments or quality improvements, which is the reason purchasers depend on providers to get some indication about actual production

costs (Mills, 1998). The general process of contracting is being described by Mills (1998) and contains the following stages:

1. Specifying the type of health care that is being contracted, depending on the analysis of the current and future need for this type of care of the present client population from a qualitative and quantitative point of view.
2. Defining the conditions of the care provision that is being contracted, such as the outcome or results after providing the care to achieve a specified level of quality and efficiency. The specificity of the contract specifications depend on the type of care, performance and way of financing. When the type of care to be contracted is for example a Diagnosis Related Group, the purchaser has knowledge in advance about which results can be achieved, which clarifies and simplifies the monitoring activities.
3. Monitoring the performance of contracted providers. An instrument that can be used for monitoring is to perform a patient satisfaction survey during and after the received care. This form of monitoring can be of great value when patients are being actively involved in the contracting process when given information by the purchaser about care providers, patient rights and patient satisfaction.

1.2.2 Different sorts of contracts

In general, three different types of contracts can be distinguished (Mills, 1998):

- Long-term, soft contracts: The contract is negotiable in volume, price and conditions until the end of the contract period. Soft contracts are also being called relational contracts and are common in situations of interdependency. Because of the long contracted period of time, a relation of trust can be developed between purchaser and provider. This trust results in the sharing of information, which will decline the information asymmetry. Besides that effect, the need for detailed monitoring will be less, which reduces the costs for monitoring. A third advantage is the provider who will be more inclined to investing in training, using more expensive, but more efficient equipment and researching for cheaper or effective forms of care. Because of these advantages, the agreed price will be higher compared with the price in short-term contracts.
- Short-term, hard contracts: The contract is fixed without any space for discussions about conditions and the contractee can take it of leave it. This type of contract is common in situations with large competition among the several presented providers and in situations of uncertainty about rapid changing policies of the government. The short-term contract positions the care purchaser as powerful, because he can get rid of the care provider after a short period in case of unsatisfying results. The great disadvantage is of course the absence of mutual trust resulting in the advantages of long-term contracts. Secondly, a contract price that is being fixed too low will create the risk of the provider skimping the quality of the delivered care. Depending on which goals the purchasers wants to achieve in the present situation, the decision will be made about which type of contract is being used.

1.2.3 Associated behaviour of providers to contracting

Three determinants can be used to develop a model to define behaviour which raises the costs of contracting with private health care providers (Vining, 1998):

- Tasks complexity

  The costs of contracting will increase with the presence of uncertainty about the contents of the contract, the presence of information asymmetry of the care to be provided in advantage of the provider and the level of complexity of specifying the care that has to be purchased (performance or output indicators). This is because uncertainty and information asymmetry might cause the risk of a contract-broke by the contractor or contractee or one of the two might wish to discuss already fixed contract-agreements again in a later stage.

- Contestability

  This is present in a situation where providers can switch easily from providing one type of care to a complete other type that covers the costs better than the first, without large switching costs. When patients and providers are bound to a specific region or governmental policy to consume or provide health services, providers will not be able to switch easily to provide another type of care. This is called low contestability and is an incentive for providers to ask higher prices to execute their usual performance, because the provider has the advantage of being part of a care-chain, which is not easily replaceable. This will give the provider a good position in situations of negotiations, which may raise the total costs of contracting.

- Asset specificity

  This means that the type of care delivered by one provider cannot be offered to another specific patient group or care chain than within the care chain he is currently part of. The provider has a vulnerable position and the purchasers refuse to pay more than the marginal costs of providing that type of care. The providers will in turn not agree with that offer and demand a higher price. Both parties will behave opportunistically; both strive to their own goods and interests.

1.3 Financing

The way of paying a contracted provider is of great relevance in the purchasing process, because when the purchaser has decided to introduce competition among bidding providers to reduce total costs, he has to use a suited payment system. Competition will bring certain incentives to contracted providers, such as reducing production costs to lower their bidding price. A wrong chosen payment system can bring other incentives that stimulate contracted providers to charge more costs than necessary which may even result in higher total costs.

1.3.1 Different types of payment systems

Payments to providers can be prospective, retrospective or a mix of both. They can also be fixed or variable. A prospective payment system (PPS) means that the provider is being paid before delivering the contracted health services; paying the provider after he has delivered the agreed health services is called a retrospective payment system (RPS). A mixed payment system means that the provider receives the difference between realised costs and prospective budget after delivering the agreed health services.

These variations create different incentives for providers to behave in certain ways while providing care. For instance, evidence has pointed out that the switch from retro- to prospective payments significantly reduces the extent and the resource usage when providing health services. Besides these considerable effects, the number of clients receiving a health service may decline after the switch, which can have three possible explanations according to Chalkley & Malcolmson (2000): "(i) Care organisations might choose to dump costly patients, (ii) the decline reflects a transfer of patients to non-PPS institutions and (iii) a decline in demand as a consequence of reduced quality of treatment."

1.3.2 Classification of provider payment systems

The provider payment mechanisms can be categorized into four different units of services that are being purchased namely (Waters, 2001):

1. Reimbursement of each separate health service provided (fee-for-service, cost reimbursement)
2. Reimbursement of all services related to diagnosis by one price (fixed fee per case / Diagnosis Related Group (DRG))
3. Reimbursement of all services related to a patient over a certain period of time (capitation)
4. Reimbursement of all services over a period of time by one price (global / line item budgeting)

Ad. 1. Reimbursement of each separate health service provided

The price of all separated health services can be determined in three different ways, namely (i) by providers, (ii) after negotiations between purchaser and provider or (iii) by governmental regulations. Reimbursing each separate health services has the large disadvantage of creating the incentive for providers to subscribe more care than necessary from medical technical point of view. This is called "supplier induced demand" when providers subscribe more care than necessary and by that charge more care to increase their revenues. This behaviour will increase total care expenditures and can be seen as a welfare loss for society. To reduce supplier induced demand, the purchaser can introduce supply-side cost-sharing techniques, such as other methods of financing health services like capitation or the diagnosis related financing method, which will make the provider bearing some financial risk to operate more efficiently.

Ad. 2. Reimbursement of all services related to diagnosis by one price

Providers are paid one price for the total amount of services an individual client need to for example stabilise his chronic disease. The (average) price for a certain Diagnosis Related Group (DRG) has been determined by evidence based medicine. The total revenue of the provider is the amount of DRGs he has agreed to deliver by contract. The financial risk of this average price will be beard by provider and purchaser, because a patient might need more or less health services than the average amount of care, on which the price is based. If a patient needs more care than the average amount of necessary health services, providing care will lead to higher costs than his revenues, but the provider may also keep the change, when a patient happens to need less care than the average patient, when for example the patient receives his treatment without any expected complications. The advantage of diagnosis related financial methods is the absence of the incentive for supplier induced demand by providers and it stimulates cost-containing behaviour of providers. A great disadvantage of the diagnosis related financial method is the incentive for providers to avoid costly patients, because of the financial risk, which is called risk selection. Besides that, there is the risk of providers reducing the quality of the provided care to patients and they might register more expensive DRGs than they had provided. Another disadvantage of using DRGs is the complexity and costs of developing and describing all DRGs that can be offered to patients (Langenbrunner, 2004).

Ad. 3. Reimbursement of all services related to a patient over a certain period of time

The third way of financing contracted providers is to pay a fixed tariff for the provision of total services a patient could need in a certain period of time. This method of financing is often being used in financing general or primary care physicians. The advantages of such a financial system are the absence of the incentive to supplier-induced demand and to stimulate providers to deliver cost-effective care. The provider will only subscribe and provide the necessary care, because he will not get paid extra. Besides this advantage, the provider has the incentive to provide preventative care, which contributes to total cost-control and the health improvement of the patient population. The disadvantage of capitation is the avoiding behaviour of providers of severe ill patients, who will probably need more care than the average patient. This reduces equity and access to care for patients who will need it more than any other patient. A well-developed risk-adjusted payment system based on real medical needs can be an effective instrument to overcome this disadvantage. Another disadvantage may be the incentive for providers to provide too less quality and quantity of necessary care, because the provider will not get paid more. A third disadvantage can be the possible behaviour of primary care providers to refer their patients more often to providers of secondary care to get rid of the high risk patients for the time being. This behaviour will increase total costs of care and leads to welfare loss. The use of utilisation management information by the purchaser may reduce this referral behaviour, because the provider will be compared with colleagues and risks a bad reputation (Langenbrunner, 2004).

Ad. 4. Reimbursement of all services by one price for the total client population over a period of time

Global budgeting is a way of financing large organizations having physicians being employed, such as hospitals. The organization receives a total budget at the beginning of the contract period to cover all costs of the care to be provided, like salaries, equipment and drugs. Global budgeting offers the provider more space to decide what kind of care he wants to provide against which costs during the contract period. Hospitals with more admissions per year and with a more severe ill population of patients can count on a bigger budget. The total costs of care are being limited by a global budget cap which is generally introduced by the government. This system of financing creates the same incentives of paying per DRG, because the provider bears with both methods a financial risk. The physicians are often being paid by salary which causes the incentive of under provision and the decline of quality of care (Langenbrunner, 2004).

Chapter 2 Competitive bidding as purchasing method in health care; lessons from other countries such as the UK, Canada and USA

2.1 What is competitive bidding in relation to purchasing health care services?

2.1.1 Definition of competitive bidding

In the literature many terms are being used to describe how health care could be purchased in a competitive environment. Competitive bidding is a purchasing method which is being used in many countries. Sometimes authorities are legally obliged to use it when purchasing health care and sometimes it is voluntary used by health insurers. The term competitive bidding is often used to describe the purchasing method by private companies; the term public procurement or tender is often used when pointing out the same purchasing method, but executed by governmental bodies to make enough public services available. The objective varies depending on what type of purchaser uses this instrument of purchasing, but the process is roughly identical.

Maarse et al. (2002) defines competitive bidding in health care as follows: “The purchaser invites care organisations to bid on contracts to providing some type of care to a specified category of clients.” Purchasing care by competitive bidding creates an incentive to providers to minimize costs and operate more efficiently, because of the chance of not being contracted, given the absence of contract obligation of the purchaser. The expected outcome of competitive bidding is saving expenses and/or improving the quality of care. Another advantage of competitive bidding is according to Maarse et al. the incentive it creates to match the necessary supply with the needs of the insureds. This incentive would not be so strong when using a non-competitive purchasing method. The supply assurance and the quality of care can be raised or optimized, if the specification and the output quality indicators of the contracted care are being formulated and executed well enough. If this task is not being performed properly, the purchaser itself will not be able to monitor the providers and sanction providers that will not keep their agreement after contracting.

2.1.2 Different types of competitive bidding as allocation mechanism

Competitive bidding as purchasing method is an allocation mechanism that can be set up in different designations, for example as an auction or beauty contest. Janssen (2004) describes auctions and beauty contests as allocation mechanisms that are mainly used by governments to allocate public services such as health care in general. He defines an auction as: “Firms typically have to make one or more financial bid(s) and the company with the highest or lowest bid wins the contract. Auctions can be single or multi-attribute; the latter are auctions where a bid has more than one dimension (price), for example also quality dimensions.” The definition of a beauty contest is described by Janssen as: “Firms have to submit a plan of how they will use the resources that are being contracted and they will have to provide credentials that make their plan trustworthy. A committee typically determines who

wins the contest." The main difference between the two is the judgement of the bids which is being done in a subjective manner with beauty contests but with an auction it is according to a predetermined score list. The score list is known in advance by the bidders and contracts are awarded objectively. Beauty contests can be executed with pre-advanced knowledge among the bidders about the criteria they are being assessed on, but it remains unclear how to score the different bidders on those certain criteria. When governments or insurers choose which allocation mechanism should be used when purchasing (public) services, they must determine how many contracts they want to allocate in advance and how winners must be selected which also depends on the allocation's objectives. In other words, before choosing between an auction and a beauty contest, they have to decide on the level of competition according to Janssen (2004).

2.2 The effects of competitive bidding for health care services: empirical evidence from the US

2.2.1 Asymmetric information about production costs

Competitive bidding is a purchasing method in which the price that is being paid will not be far above the costs of production, if there is enough competition present in the market. A non-competitive purchasing method does not reflect the costs of providing care just as well, which causes an information rent for the purchaser who does not know how much profit is exactly being made by the provider after contracting (McCombs and Christianson, 1987). This asymmetry of information can partly be solved when providers are invited to bid on a contract, because it creates an incentive to reduce the costs of production by potential providers to lower their price as much as possible to increase their chance of winning a contract.

2.2.2 Saving expenses as empirical result of competitive bidding in Arizona, USA

Paringer and McCall (1991) studied competitive bidding in the Arizona Health Care Cost Containment System (AHCCCS) which can be compared with Medicaid, the health insurance state program for the poor in other States of the USA. The results of competitive bidding in this system have been studied during a period of six years and have been compared with the results of Medicaid in other States. This comparison shows significant results on saving expenses, which were 25 percent. An exception on these savings had to be made for the sector of elderly care. This type of care showed to be more expensive than it was to be purchased in the traditional Medicaid system, but was not further explained in the literature.

The study also showed a critical condition of successful competitive bidding, which is the presence of competition among providers in the regional market. A competitive market is represented by many participators in the bidding process leading to the ability of purchasers to choose the most efficient provider. Although competitive bidding has saved expenses in Arizona compared to Medicaid, the competition between bidders has lacked for a great deal in the state. In the largest

county, local authorities could choose between six bidders, but in most counties there were only one or two participators competing with each other in the bidding process, during the six years of study. Lowering entry barriers may be of great importance to retain a higher level of competition in the market, but a balance has to be found between a higher level of competition and selection requirements such as financial stability of providers to participate in the bidding process. If the purchaser wants to create an incentive for new providers to enter the market, he will have to make sure that the bids of these entrants are not in great deviation with the current production costs. The inexperienced entrants might set too low prices to become awarded with a contract which could result in a financial crisis. What was not included in this study, but is relevant for the subject is that entrants could experience a disadvantage if incumbents are able to underbid entrants when incumbents do not have to deal with investments or other issues to get established.

Another conclusion that was drawn in the study of the AHCCCS is a decrease in the amount of loosing providers during the years of the study. Eventually all providers happened to receive a contract after bidding, which is also related to the dependency of the local authorities on incumbents and shows the low level of competition in the sector and the seemingly high entry barrier for entrants. The high chance for incumbents to be contracted might result in the development of a more regulated than competitive market which might even increase total expenses, because of the absence of the incentive to providers to operate most efficiently. The authors have also concluded that when providers can bid on long term contracts this might have negative consequences for the competition on the market that may also result in higher prices eventually. But on the other hand, local authorities can reduce their transaction costs when awarding multiple-year contracts. Awarding long term contracts creates a relation of trust between purchaser and provider which could result in a less intensive monitoring procedure by the purchaser. A relation of trust is valued as positive by purchasers and providers, but purchasers will have to remain monitoring the providers, because trust could create an incentive to providers to reduce their level of quality if their activities are not measured intensively.

In sum, Paringer and McCall (1991) found that the start of competitive bidding to purchase health care can result in a significant reduction of public expenses. Though it is unclear whether these savings would retain to be the result of the survey, if competitive bidding was studied over a longer period, because of the reduction in the level of competition with the growing chance of being contracted, long-term contracts and high entry barriers.

2.2.3 Effects on the level of quality of care

Besides those effects, Maarse et al. (2002) describe another effect which is a possible improvement of the level of quality of care caused by an increasing level of competition through competitive bidding. Quality of care is considered as one of the instruments of providers to present and improve their capabilities and distinguish from their competitors, when it is observed and measured. But the quality

of care could also decrease, if the level of competition is high and prices are set too low. In that situation providers may be inclined to lower the quality of care to decrease their costs.

2.3 How to use competitive bidding to purchase health care services?

2.3.1 Purchasing skills

Before using competitive bidding by authorities and private insurers to purchase health services, they should have obtained the necessary specific skills. These skills include collecting knowledge about market management, specification, competitive process, negotiation, regulation and monitoring to make sure that the purchaser knows exactly what to buy, from whom to buy and if the purchased care has achieved the objective. When markets are more imperfect, for example with the presence of monopoly power of providers and asymmetric information about treatments and costs, these skills increase in complexity (Kettl, 1993, in Smyth, 1997). Providers with an economic dominant position do not have an incentive to decrease production costs to be more efficient and are able to set their own price far above their production costs. Purchasers will have to use other instruments, such as benchmarking to know for example what the costs of production are, to make sure they will not be paying too much when contracting those dominant providers.

2.3.2 Stages in the process of competitive bidding

The purchaser initiates the process with all necessary stages of competitive bidding. Each stage has its own playing rules which have to be followed by all parties (McCombs and Christianson, 1987). Examples of these playing rules are disposing information about the type of care to bid on, the length of contracts and required performance indicators, which must be available for all potential participators. McCombs and Christanson (1987) have divided all necessary stages of the purchasing process as follows:

1. Specification of units of service;
2. Selection of winning bidders;
3. Determination of reimbursement of winners;
4. Treatment of losing bidders;
5. Contract enforcement and administration.

Ad.1. Specification of units of service.

When a government decides to fix the tariff for health services, the level of competition will be restrained. The NZa (2006) state that competitive bidding has limited advantages when providers cannot make a discount on their price. Competitive bidding will then only have one advantage: competition on quality of care. Free prices are suited for a competitive market and give incentives to providers to operate efficiently and compete with other providers. Maximum tariffs may be suited as

well, but will not have such a large effect on the level of competition than free prices, because maximum tariffs give a reference point of what the health service may cost. Bidding providers will therefore not be really inclined to lower their price far beneath the maximum tariff, while free prices forces providers to determine their price just above their production costs.

If the health services are suitable to be purchased by competitive bidding (see par. 2.4.1), they can be specified or determined in three ways, according to McCombs and Christianson (1987): Per patient, per episode of per unit of service. Specifying the provision of services 'per patient' corresponds with capitation as reimbursement method. The physician wins a contract to provide all health services for a certain amount of patients during some period of time. Health services that are specified "per episode' are for example types of home-care specified per hour. Diagnosis Related Groups are an example of specifying health services 'per unit of service' and the contracted care organisation receives the agreed price for the total treatment for a particular disease of an individual client.

Ad.2. Selection of winning bidders.

The study of Doran and Pickard (2002) on competitive bidding for community-based home-care in Canada describes a 'request for proposal framework (RFP)' to select bids of home-care organisations. The selection procedure included a performance framework that contained 28 variables that reflected expectations about four relevant themes of bidding providers: 1. client services; 2. work processes; 3. accountability framework and 4. human resource management. These themes describe in a detailed manner the presence of processes and professionalism of the bidding providers and are being used to select providers that joined the bidding procedure. Providers also had to determine the price of the home-care services into their bid, but it was not further taken into account in the study, because the study only paid attention to what extent Canadian authorities had included quality indicators into their competitive bidding procedure. The performance framework is included in this master thesis as appendix 1.

Research by Fisher et al. (1998) on competitive bidding for psychiatric services in the USA shows that providers with the lowest historical costs do not have a larger chance of being contracted after bidding. It seems not to be the most relevant factor when judging bids by purchasers. The chance of being contracted does actually grow significantly when the provider shows large experience with complex treatments. The purchaser will be able to have trust in the way of treating and the performance of the provider, which is apparently an important factor to gain production volume. (Fisher et al. in Chalkley and Malcomson, 2000)

McCombs and Christianson (1987) state that the purchaser has to decide which elements of the bidding providers are most heavily weighted during the selection procedure. This depends on the objective the purchaser wants to achieve, such as cost containment or quality improvements. He may choose between low entry barriers and experience or quality acknowledgments. Low entry barriers

stimulate new providers to bid on production volume. This increases the participating providers and with that the competition on the market. The disadvantage of contracting with new providers is the extensive support and monitoring on service delivery, to prevent unexpected outcomes. The absence of trust in new providers makes that purchasers have to pay much attention to the performance of the provider to prevent disappointing results at the end of the contract period. Besides that, there is the risk of the bid of the new provider being too low which might result in unexpected costs that exceed revenues during the contract period, because of a lack of experience and financial stability. A possible bankruptcy has major impact on the continuity of care, the freedom of choice of clients and for the purchasing process. If the purchaser chooses for experienced providers with quality acknowledgements, he can have a certain amount of trust in the provider which will give an incentive for the purchaser to lower the intensity of monitoring and supporting although trust does not guarantee a high level of delivered quality of care. Lowering the intensity of the monitoring process reduces the associated transaction costs and the risk of disappointing (financial) results, because of the experience of the provider with planning of the care and control of costs. The authors state that quality of care in general and financial stability are important issues when selecting winners by competitive bidding. According to McCombs and Christianson (1987) selecting multiple winners instead of one winner has more advantages than disadvantages.

Advantages of selecting (and contracting) more than one winner:

- In case one particular contracted provider has a financial problem, the purchaser does not risk a disruption in the continuity of care; clients can be transferred to other contracted providers if they have enough spare production capacity.
- The purchaser does not depend completely on one provider, when the need for care exceeds the maximum production capacity of this provider.
- The amount of participating providers bidding on a contract may increase, because the chance of winning a contract grows. Multiple winners can also give providers an incentive not to join the bidding process, when they expect the volume to be contracted is not that large when it is being divided by all winners. This disadvantage will further be described below.
- The threat of contract broke to providers has a greater value.
- Beneficiaries enjoy the freedom of choice with the presence of multiple providers.

Disadvantages of selecting multiple winners:

- Bidders will be less inclined to bid with prices almost equal to their cost equilibrium, when there are few potential participators in the bidding process. This will happen, because of the small chance of not being contracted with multiple winners.
- Risk selection might be used by providers if they are bearing financial risk while delivering the contracted care. This is likely to occur when they are paid by capitation rates. The multiple

providers will have an incentive to provide care to good risks and refuse the bad ones to prevent financial suffering. If there is only one winner, the provider may not able to refuse any patients, because bad risks will have no other provider to go to for treatment.
- Care providers may expect to win less production volume resulting in less revenue which will incline them to bid less attractive bids with higher prices.

Maarse et al. (2002) describes another disadvantage, namely a restriction of possible scale effects for providers, when the amount of production volume of possible winners decreases. Compared with the model of a single winner, one can say that the presence of risk selection will disappear, but contracting one provider in a region or sector will have a major disturbing effect on current market structures and the amount of potential bidders is likely to decrease after some contract periods.

Wagemakers and Brands (1999) advise municipalities the use of standardised questionnaires which have to be filled in by participators to place their bid, when purchasing publicly funded services. The information that is being collected by purchasers can be transferred directly into a framework, which increases transparency, oversight and the possibility to compare bidders easily. Judging the bids in a subjective way can also be prevented. According to the authors, the following elements should be the content of the question form:

- Financial information about the bidder;
- Experience of the provider with various types of care;
- Resources of the bidder (for example the amount of personnel/FTEs);
- Quality certificates of the organisation;
- Information about the strategies of the organisation concerning safety and environmental directives;
- Historical experience of the purchaser with the bidder.

If purchasers expect many bids in reaction of the invitation, they may choose a restricted procedure instead of an open one. When using a restricted procedure, all interested bidders may shortly present what it is they offer. After drawing up this inventory, the purchaser selects the providers who are being invited to present their bid in depth. A complex and time-consuming procedure can be prevented by this type of selecting. Another possible tender procedure, besides the open en restricted procedure is negotiation, which is only used in certain explicit situations, such as the situation in which there still is no perfect bidder found after the two mentioned procedures or when there is no time for an extensive judgement (Martin and Hartley, 1999).

Ad.3. Determination of reimbursement of winners

McCombs and Christianson (1987) distinguish two rules about which contract price should be paid to winning providers:

- Discriminative rule: Contracted providers will be offered the price of their own bid.
- Competitive rule: All contracted providers will be offered an equal price per unit. The

price can be set through using the highest, median or lowest bid that has been placed. This rule could result in a situation in which some providers are paid by a price which is above the price they offered. Politicians are expected to protest against this decision, because the conclusion of a waist of public resources may be drawn by this way of financing contracted providers. The competitive rule is comparable with first and second price-sealed auctions, described by McAfee et al. (1987) in which the potential providers bid separately of one another. The purchaser eventually decides with whom to contract and pays all contracted providers the same price which has the amount of the first or second highest bid. The second price-sealed bid is not often being used in practice.

Ad.4. Treatment of losing bidders

Advantages can be mentioned to allocating production volume to losing bidders. McCombs and Christianson (1987) describe the preservation of present market structures as advantage when losing providers can remain delivering care as they were used. The reduced chance on protest from provider associations is another advantage, when the losing providers might not experience the risk of bankruptcy that explicitly and may only have to shrink a little bid in capacity. It also increases the freedom of choice of beneficiaries, if they are allowed to choose for not-preferred providers. When choosing a not-preferred provider, the purchaser may for example decide to ask an out-of-pocket payment of the beneficiary. Paying a losing provider may decrease the competition during the bidding process, when providers expect to have enough revenues while providing care to clients that choose for a not-preferred provider.

Ad.5. Contract enforcement and administration

Contract enforcement can be divided into three stages: specification (paragraph 2.3.2.1), monitoring and evaluation. If the purchaser has decided on which elements the weight is being placed while selecting bids and the contracts have been awarded, he wants to be able to monitor and evaluate the performance of the contracted providers. The evaluation stage requires information about the performance of the providers including the presence of the indication on the need for care, the actual delivery of health services and the registration of this delivery, which is collected in the monitoring stage.

The study of Doran and Pickard (2002) on competitive bidding for community-based nursing services in Canada describes the subdivision of four elements about monitoring contracted providers by the Canadian regional purchasing offices to collect the needed information:

1. Monitoring the indication of the need for care and the registration. The purchaser monitors whether the contracted providers have indicated the necessary care to their clients well enough. The registration of the delivered services has to be based on the indication.
2. Monitoring service delivery. The provided care was being monitored on volume, declined referrals and level of nursing staff. The study showed that this way of monitoring was most successful if purchaser and provider cooperated intensively in cases of complex individual care arrangements.
3. Monitoring complaints, incidents or occurrences; information of clients about these subjects was collected and stored by the purchasing offices in a database. Certain information was being linked to the bid of the provider in the next bidding procedure.
4. Client satisfaction. The purchaser and the provider both collected data on client satisfaction about the provided care and the personal treatment by the purchasing office.

After collecting information about the performance by monitoring the contracted providers the purchaser is able to evaluate the total performance of the provider which should influence the judgement on the bid of this provider for the next contract period.

2.4 When to use competitive bidding to purchase health care services?

2.4.1 Types of care that are being suitable for competitive bidding

The NZa (2006) has determined to which conditions health services should fulfil to be suitable for purchasing by competitive bidding. First, there should be no urgency in providing the health services. A patient that is in need of urgent care has to receive the necessary care as soon as possible and should not have to pay attention to which provider is contracted and reimbursed. Therefore no financial restrictions should be placed by purchasers to providers (whether contracted or not) delivering the urgent care. Health services that can be planned and structured are more suitable to restrict complete freedom of choice of providers, because it will not cause any health damage.

Secondly, the health service that has to be purchased must be clearly defined and specified into detail. Purchasers have to know how the service should be delivered and to what level of quality, to be able to evaluate the performance of the contracted provider.

The third condition of the health service that is suitable for competitive bidding is health care which is not top-clinical and can be delivered by all contracted (not-specialised) providers.

A final condition of the type of care which was not included in the enumeration of the NZa, but should have been included according to my opinion, are health services that are provided for a short term. Time limited or short term care such as recovery care may be more suitable to purchase by competitive bidding, because the continuity of care will probably not be disrupted when the purchaser decides to switch to another provider after a contract period. The switch to another provider after a contract period may place a burden on clients that are in need of long term care when they will loose

the provider they have become familiar with and having to explain their medical history to the new provider all over again.

2.4.2 Competitive bidding by authorities of Member States in the European Union (EU)

In their book, Hermans and Buijsen (2000) describe the impact of the European Union on public procurement in EU Member States. In the last decades the EU has developed directives that have to be translated into national law and obliges all governmental authorities to use competitive bidding when purchasing works, goods, and services. The directive 92/50 EC describes which public bodies are obliged to use competitive bidding when purchasing health care with public resources. According to the directive, this counts for each institute that:

- Has been established with the specific objective of serving the general need, without an industrial or commercial character, and
- Has a legal personality, and
- Has activities which are being financed mostly by the State, by territorial or other publicly funded organizations, or is being supervised by the last or members of the direction, the Commission of Governance Commission of Surveillance, or is being funded for more than partial by the State, territorial bodies or other publicly funded organizations.

If an authority fulfils with all three requirements, he is then called a tendering institute. When contracting a service provider, which is defined as “natural or corporate body including public bodies offering services,” by means of “a legal written agreement which will be agreed between a service provider on the one hand and a tendering institute on the other,” he is obliged to use competitive bidding to select and contract the service providers when purchasing publicly funded health services.

Another condition included in the directive that obliges the use of competitive bidding is the minimum amount of public resources that is being contracted. If the production volume that is being contracted rises above this threshold (defined by the European Commission (EC)), the governmental body has to use competitive bidding as purchasing method. The EC reviews this threshold every two years and is currently being set on €249.000 as annual threshold for the sector of providing (health) services (Boer et al., 1999).

2.4.3 Critical factors of success

The NZa (2006) describes four critical factors of success for an auction, which is a specific type of competitive bidding to purchase maternity care by health insurers:

1. Equality of information

All bidders must have the disposal of the necessary information to bid on production volume. Equality between providers and transparency of the purchasing process are of great importance.

2. Equal conditions to bid

All conditions that are required to place a bid, should be the same for all bidders. There may not be any advantages to become contracted more easily for a single or group of providers.

3. The product or service to be contracted is clear

The definition of the type of product or service is clear and may not change after the auction, so all providers may not have to cope with unexpected events after being awarded.

4. The product or service has to be provided in the future

The purchasing process takes time to be prepared, executed and fulfilled. The service to be provided must not be delivered right after the auction, but has to be delivered in the future when the purchasing process is completed and contracts are being signed.

Fearon et al. (1999) state that the auction mechanism may function if more than three firms participate in the bidding process, which is an indicator for the present level of competition in the market.

2.4.4 Experienced difficulties in the United Kingdom

Smyth (1997) enumerates a number of problems that occurred in the UK when using competitive bidding for public services, such as health care.

1. Specifying which care should be contracted is complex, because it has to be measurable. A recent development is the transfer from input to outcome measurement. An example of input (or process) measurement is having some accreditation by providers to be allowed to participate in the bidding process. Accreditation is an instrument that can guarantee the minimum level of quality of care by setting standards for the education of physicians and nursing personnel. The limitation of input measurement is that it cannot measure the actual results of the delivered care. Therefore outcome measurement is desired, because it creates comparative data for the purchaser to be able to monitor the level of quality and performance. With long term contracts the purchaser can collect comparable data on the delivery of care by providers but long term contracts may be in conflict with the principle of competition among providers.

2. Competitive bidding causes high transaction costs, because of the complex selection procedure to compare bids and the contracted providers have to be monitored to ensure that the contractual agreements are being followed. This can be done, but takes a lot of time and money which might even exceed the financial advantages of this way of purchasing.

3. Contracting-out the specification and monitoring part of the purchasing process to private consultants may solve the mentioned problem of the high transaction costs, but could then cause the risk of authorities having completely no expertise at all anymore and loosing the contact with the field

of purchasing care services. Smyth (1997) advices purchasing governments to hire a consultant in the starting stage to learn the necessary purchasing skills (selecting, contracting and financing), after which the authority is able to execute the process successfully on her own. Learning the skills of a professional could prevent growing pains in the starting stage.

4. A shortage of providers could drive up prices, because of the big chance of becoming contracted as provider. The purchaser strongly depends on the present established providers who can set their own price, if entering the market is difficult for new providers. Introducing competition in a certain market may result in a less dominant position of incumbents. Janssen (2004) describes that it can be useful to allocate production volume in an asymmetric manner and with that lowering the entry barriers and stimulate entrants to join the bidding process. This can be necessary when established providers experience advantages compared to entrants and the entry barriers cannot be lowered by other instruments. New providers may decide not to enter the market, if the entry barriers are high, for example when the chance is low to gain some production volume or when the costs are high to start up providing care. Increasing the level of competition on the market can be done by allocating a certain percentage of the total production volume only to entrants and the rest of the volume to incumbents or to all participating providers.

5. Providers may be inclined to collude with each other in markets with some level of competition by making agreements on price and capacities with their competititors to reduce the risk of decreasing revenue and losing their share of the market. This is called an oligopoly and reduces the competition on the market and it might increase total expenditures, if there is no prohibition by the national government on this behaviour.

6. When the contracted care is being specified and monitored in detail, the purchaser does not depend completely on trust in the provider to behave properly. This might have a negative impact on the provider when he feels to be treated like a child, which could cause a decrease of the ambition of the provider to be innovative and a reduction in the manner of cooperation between the provider and the purchaser to solve problems in care chains for example. The exchange of information about developments and the current situation in practice will decrease and the provider will have an incentive to build some financial reserves to be capable of surviving unexpected financial depths.

7. If national authorities decide to mandate the purchasing responsibility to regional and/or local governmental bodies, it might have consequences for the level of competition and possibilities of the present market. Local institutions might have strong relations of cooperation with incumbents and may find it difficult to lower entry barriers and allow new participators in the process of bidding to

increase competition and pass along the interests of established providers. This depends on how firm these relations with established providers are and which goals need to be achieved by the government.

2.5 Summary

In this study of literature on competitive bidding many conditions are described to which the market should fulfil and how the method can and should be used to achieve the purchaser's goals. These conditions are derived from empirical studies about competitive bidding as purchasing method and can be seen as learning issues that purchasers are dealing with while performing the procedure. Those critical conditions are summarized in the following list and create a checklist to score the Dutch home-care market and the use of competitive bidding by Dutch purchasers in the fourth chapter:

- Is home care suitable for competitive bidding?
- Are all mentioned stages by McCombs and Christianson (1987) included in the process of competitive bidding?;
- Is the purchaser capable to perform his task properly with the necessary skills?
- Are the critical factors of success present according to the NZa?
- Is the level of competition in the market sufficient enough for effective competition during the bidding process?
- Have the existing legal prohibitions on economic misbehaviour proven to be sufficient?

Chapter 3 The market for home-care in the Netherlands

3.1 Home-care in the Netherlands

3.1.1 Defining home-care

Home-care is the umbrella term for all sorts of care that is provided to clients who live independently with some professional support. Home-care is being divided into six types, namely: housekeeping services, personal care, nursing, supportive attendance, recovery attendance and treatment (see figure 3.1). Almost all types of home-care are being delivered individually in the client's home situation, but attendance is also being provided to groups of clients in daily activity centres (ZN, 11-2006). If home-care cannot create a safe and efficient home situation, clients will be indicated for inpatient short- or long-term admission. Inpatient admissions are being reimbursed (when indicated) together with the six types of home-care by the Exceptional Medical Expenses Act (AWBZ) (NZa, 2007). Because inpatient admissions are not subject of this thesis, this type will not be discussed.

Figure 3.1 Division of home-care in six different types

Types (English)	Types (Dutch)	Content of the types
1. Housekeeping Services	Huishoudelijke verzorging	Cleaning activities, care of patient's family members, preparing meals.
2. Personal care	Persoonlijke verzorging	Support of activities of daily life (showering, getting dressed, go to toilet)
3. Nursing	Verpleging	Care of wounds, give medicines
4. Supportive attendance	Ondersteunende begeleiding	Financial administration, prevent social isolation
5. Recovery attendance	Activerende begeleiding	Teach and support how to run daily tasks, recovery of physical / mental diseases
6. Treatment	Behandeling	Multidisciplinary approach as cure or prevent progression of a disease

Source: ZN, 2006

3.1.2 Financing home-care

The AWBZ is a mandatory public insurance, which means that all Dutch citizens are obliged to pay an income dependent premium to their private health insurer to finance the AWBZ fund, which initially was established to cover all long-term expensive types of care that cannot be insured by a private insurer. All citizens have these seven types of care at their disposal as basic benefits, if necessary

(CVZ, 2004). The Ministry of Health, Welfare and Sports (VWS) has appointed 15 health insurers - that dominate in one or more of the 32 geographical regions- as concessionaires to execute and administer the AWBZ in that region. These health insurers decided to establish a corporate body for each of the 32 regions to keep the financial streams of the AWBZ separate from Cure insurance act (ZVw). These corporate bodies are called regional care offices ("zorgkantoren") and are mandated by the appointed health insurers to allocate the available resources throughout their geographical region and bear responsibility for the administration and execution of purchasing affordable and accessible care that is of high quality for the regional citizens (NZa, 11-2006). The regional care offices do not bear any financial risk on their expenditures, but function purely as executives concerning the allocation of available means throughout the different sectors (caring & nursing, mentally & physically disabled and psychiatrics) of the AWBZ in their region (ZN, 2-2006). To keep the AWBZ affordable, the macro budget is divided into regional budgets by the Ministry of VWS and maximum tariffs are being set annually by the NZa which may not be exceeded by providers and the regional care offices when bargaining about the price of home-care.

One type of home-care, housekeeping services (HS), has been transferred from the AWBZ to a new law which is called Social support act (WMO), in January 2007. This act is executed by the municipalities who bear the responsibility to meet the demand with enough supply and includes the process of indicating demand and contracting providers. It is expected that other types of home-care will also be transferred to the WMO in the future. These types are probably supportive attendance and personal care, because they are also meant to improve living conditions as housekeeping does also.

Some municipalities have chosen to contract out the purchasing tasks to experienced private health insurers to lower the associated transaction costs with the execution. For example the health insurance company CZ has established a profit-making enterprise to offer municipalities their services to execute the purchasing process by competitive bidding. Some 30 municipalities have contracted out their purchasing task to CZ in this first year.

3.1.3 Indicating home care

To claim home-care that is financed by the AWBZ, clients or their representatives should deposit a request for care and/or support to their activities of daily life. In the Netherlands, the central government has established independent regional care indication centres (CIZ) that bear the responsibility of indicating the need for care and support of those clients. The CIZ defines which and how much care is necessary to support the client. Having such an indication, the client turns to his preferred home-care provider (which in general must be contracted by the regional care office of that region) that is prohibited to start to provide the indicated care (NZa, 2007). The delivered care will be charged to the Central Administration Office (CAK). The charge will in turn be the base of an income-dependent deductible for the client, which is collected by the CAK.

Receiving an indication of the CIZ, the client may also choose a personal budget (PGB) instead of direct care in kind. The size of that budget is being based on the indicated types and hours per week. When clients choose for a PGB, they are expected to purchase the necessary care by themselves from a formal or informal care giver. In that case, the client takes account of the related administration, but enjoys the freedom to opt a provider that has no market allowance of the Ministry of VWS, such as an informal caregiver ("mantelzorger"). This master thesis does not go further into the implications and effects of the PGB, but will be restricted to home-care in kind, because this thesis focuses on competitive bidding as a method for purchasing home care, while individual patients do not use competitive bidding.

Since the introduction of the WMO, municipalities are also obliged to determine the need of their citizens for housekeeping services, but many municipalities have chosen to contract out this task to the experienced CIZs.

3.1.4 Current demand for home care

The Ministry of VWS has decided on what is an acceptable waiting time for the different types of home-care (Treekoverleg, 2000). For the types of care that include activities of daily life, such as personal care and nursing and also short stay, the maximum acceptable waiting time is one week from the moment that the preferred or appointed provider has received the client's indication in the online registration system (AZR). For other types of care such as housekeeping services and supportive attendance the maximum acceptable waiting time is six weeks. These acceptable waiting times are included into the contracts with providers and should be monitored by the regional care offices to make sure all indicated clients receive the needed care in time.

The Health Care Insurance Board (CVZ) has published in June 2006 a study to the presence and the development of waiting lists for outpatient and inpatient care in 2005. Their results where the following: "Despite the increasing amount of indications for home-care and the tendency of people with an indication for inpatient care choosing for a home-care outpatient arrangement in order to stay in their home situation longer, waiting lists have not grown." Apparently there was enough supply to answer to the increased demand. Explicit numbers of waiting clients could not be mentioned because the registration system (AZR) does not yet operate well enough. The accuracy of the regional waiting list registration system depends fully on the effort care providers to complete their administration and registration process within this system. Providers are obliged by contract to keep their waiting list in AZR up-to-date, but in case of contract failure providers are not often sanctioned.

Although these conclusions were drawn, the Ministry of VWS had to decide to increase the available financial resources for home-care with an additional 90 million euros (which is 0.5 % of total expenditure of 17.5 billion euros) in the summer of 2006. The reason for the additional funding was that the regional care offices mentioned at that time the presence of a large friction between the restricted supply and the rapid increasing demand. The general complaint was that the amount and

content of indications has risen with 14% in one year, due to a growing amount of elderly in need of long term care (CIZ, 2006) and the available resources which are translated in the national budget has not grown at that same rate (ZN, 2006). Statistics have warned for decades for a largely increasing demand and associated expenditure in the future on health care, especially for long term care for the elderly and chronically ill clients, because of the baby boom in the 50s and 60s and the growing tendency of the amount of chronically ill clients. Therefore this friction was expected by the national government to happen in the future, but not this soon and to this extent.

Freedom of choice of clients

Having received an indication to claim care that is funded out of the AWBZ, clients are in the position to choose a contracted provider in their region after having chosen for care in kind. This is because the regional care offices are not obliged to contract all providers with a market allowance since September 2004 (NZa, 02-2007). If they would want to choose for a provider that has not been contracted by the regional care office, clients have to choose for a PGB, instead of benefits in kind. With that PGB, the clients purchase the care they need by themselves and experience the freedom of being able to contract any provider they have chosen. In their monitor on home-care, the NZa state that 75% to 99% of the indicated clients choose for an explicit provider when claiming care (NZa, 06-2006). The remainder of the clients is being appointed to contracted providers by the regional care office according to the ranking of contract awards (see paragraph 4.1.2). This implies that regional care offices have influence on the choice of clients when picking a preferred provider during or after the process of indication, which may improve competition in the market when providers must operate efficiently to a high quality standard of care to attract enough clients.

3.1.5 Future demand for home-care

The NZa (2007) states that the demand for home-care is growing and will continue to do so in the next decade, because of the increasing amount of elderly, the trend of shortening inpatient admissions in hospitals and recovery institutions and the desire of clients to live on their own as long as possible.

The CIZ has attempted to explain the sudden increase of demand in one of their reports in 2006. The causes that are mentioned might have further implications for the future, such as the increased amount of elderly and their desire to live as long as possible on their own. The shortening of hospital admission might also increase the demand for home-care further, because of the changed hospital payment system that has been introduced in 2005. Hospitals are now paid by diagnosis treatment combinations (DBC) instead of a global budget, which has introduced an incentive to treat patients more efficient. All possible treatments are included in a DBC with an associated fixed price. Therefore hospitals bear financial risks if the length of stay of a patient is longer than the average patient with the same DBC. If patients are able to be dismissed, hospitals will try to make that happen

as soon as possible, which will decrease the total length of stay and increase the burden on home-care, if patients have to recover sooner at home (DBC onderhoud, 2007).

3.1.6 Summary

In this paragraph the concept of home-care is explained by describing the six different types, housekeeping services, personal care, nursing, supportive attendance, recovery attendance and treatment. These types are being financed by the public insurance schemes AWBZ and WMO if clients are in possession of an indication from the CIZ and if the indicated care is delivered by permitted and contracted providers. The demand for home-care has increased in 2006 more rapidly than expected and the Ministry of VWS decided to create additional funds.

3.2 Economic market characteristics

3.2.1 Supply side: providers

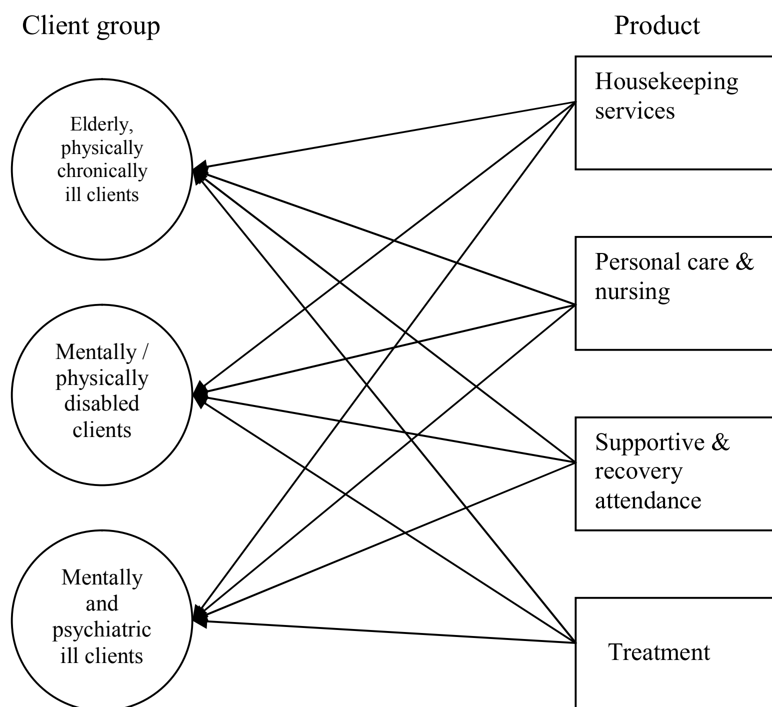
3.2.1.1 Relevant product and geographical market

To describe the current market for home-care in the Netherlands, it is necessary to define the relevant product and geographical market. Concerning the product market, a distinction has to be made at first between the market for inpatient and outpatient care. Within the market for outpatient care there can further be distinguished between the market for benefits in kind and a personal budget. The general definition of a product is: “A good and/or service which is considered to be substitutable by the consumer based on the characteristics, price or goal of use of that good” (NZa, 2005). On the market for home-care, substitutes in demand and supply are present. Substitute in supply means that clients can choose another provider delivering the same product or service (NZa, 2006). Substitute in demand happens when providers choose to provide care to clients with a personal budget instead of providing care to clients with benefits in kind despite a market allowance of the Ministry of VWS.

The Dutch governmental body that has been established, with the introduction of the Competition act, to monitor competitive markets on economic misbehaviour, is called NMa and has stated at first in 2004 a definition on what should be considered as the product of home-care in kind. The NMa recognizes all identical types from housekeeping services to treatment as separate product markets of home-care in kind. The NZa (2006) has extended this categorization by recognizing four markets for home-care by putting some types of care together because they can more or less substitute one another and because providers recently seem to focus more on one of these markets and not on separate types. The resulting four separate product markets are economically different from and not substitutable with each other, which are the following: 1) housekeeping services; 2) personal care and nursing together; 3) supportive attendance and recovery attendance together and 4) treatment.

The NZa (2006) points out that it is possible that these relevant product markets might be somewhat smaller or bigger in practice, because providers may choose to deliver all four products to one specific client group, for example mental disabled clients, but they may also choose to deliver one (or more) product to all client groups. Both possibilities can be observed in practice, which is clarified in figure 3.1. If providers choose to deliver one product to only one of the three client groups, that will decrease that product market to one-third of that total product market.

Figure 3.1. Providers may deliver one or more product(s) to one or more client group(s)



The relevant geographical market for home-care is defined by NMa (2006) in a decision on a merger between two home-care providers. The NMa recognizes two possible geographical markets for home-care, which are (i) the complete geographical region of a regional care office and (ii) the clearly defined area in which a home-care provider delivers home-care. This working area of a home-care provider is most often smaller than a total region, for example one or a few neighbourhoods or municipalities. The NMa concludes in her decision about this merger that the geographical market for home-care is at most as large as the region of a regional care office. The precise extent, however, may differ from region to region depending on the actual working areas of the presented providers.

3.2.1.2 Number and types of providers

As already mentioned, providers deliver home-care to three different client groups. These three groups are 'physical ill clients (including elderly)', 'mental and physical disabled clients' and 'clients with a

mental or psychiatric disease' and make that some providers choose to provide care to only one of these client groups. The client group physical ill clients currently accounts for 65% of the total home-care costs, the mental and physical disabled clients for 16 % and the clients with a mental or psychiatric disease for 19 %.

The number of providers that has been allowed to the market for home-care in kind has increased significantly in 2006 which might be caused by the introduction of the Market allowance act for care providers which released the stringent allowance requirements of the Ministry of VWS and allows home-care providers to make a profit by delivering home-care in kind. The actual number of providers in 2005 that has been permitted to offer a bid on production volume was 876. An increase of 8% has occurred in the following year and the actual number of permitted home-care providers rose to 943 in 2006.

Table 3.2 Increase in providers and amount of production volume

Year	Amount of contracted home-care providers	Contracted production (million euros)
2005	876	3.699
2006	943	3.760
Increase in percentage	107,64 %	101,65 %

Source: NZa, 2007

Table 3.2 shows the total amount of home-care providers that has been contracted in the mentioned years. In practice, some home-care providers choose to deliver home-care only to one of the three client groups and not to all sorts of clients with an indication of the CIZ for home-care. Those providers are often established for many years and focuses exclusively on one client group, but new-comers seem to specialise more on one type of home-care, such as attendance instead of focussing on one client group. The absolute number of providers that focus on one particular product market or one particular client group is unknown. The NZa (2007) state that there is a large variety in turnover of providers; "There are limited providers with a relative high turnover and many providers with a relative small turnover. About 10% of the providers deliver 75% of the total production volume." One may conclude that some large providers have an economic dominant position which will be described in depth in paragraph 3.2.1.3. The distribution of turnover among providers is shown in table 3.3.

The NZa (2006) concluded that almost all clients were able to choose from two or more providers to receive the needed care, except for the areas which are less populated areas. The freedom of choice in those less populated areas is limited to less than two providers, which might implicate a minimum scale requirement in this geographical market.

Table 3.4 Distribution of total budget among contracted providers in 2005.

Turnover	Number of providers	Total turnover in euros
> 100 million	4	544
75 – 100 million	1	87
50 – 75 million	3	167
40 – 50 million	8	343
30 – 40 million	22	765
20 – 30 million	21	527
10 – 20 million	22	298
< 10 million	795	968
Total	876	3.699

Source: NZa, 2007

3.2.1.3 *Market developments*

Besides the absolute number of providers, it is also necessary to know the concentration of providers on those product and geographical markets, the entry barriers and the compensating power of consumers, because all those elements have consequences for the freedom of choice of clients, the purchasing possibilities of the purchaser and provider's behaviour and possibilities to grow and innovate.

Concentration

Just like the European Commission, the NZa (2005) has used the Herfindahl Hirschman Index (HHI) to indicate the amount of competition among providers. The HHI measures the size of providers in relation to the market and is defined as the sum of squares of the market shares of each individual provider. The HHI can be pointed out in percentages or in points and can range from 0 to 10.000 (0^2 to 100^2, respectively a large amount of small providers and a single monopolistic provider). A low value indicates a competitive market with no dominant providers, while increases in the HHI means a decrease in competition.

Table 3.4 Indication of the amount of concentration in a certain market

Herfindahl Hirsch Index	Percentage	Points	Indicates
Below	10%	1800	No concentrated market / high competition
Between	10 and 18%	1000 – 1800	Moderate concentration / average competition
Above	18%	1800	High concentration / low competition

The NZa (2005) assumes that a high concentration can have negative consequences for the competition among providers. It seems that 13 of the 32 regions are as concentrated that it is

determined as a risk (> 1800 points) by the European Commission from the perspective of competition on a liberalised market. If the concentration is defined by all types separately, there is even a potential risk in 28 of the 32 regions. The risk of a too high concentration means that there are only one or two providers present in a region delivering one ore more products, who can behave independently without having an incentive to operate as efficient and/or as good as possible. The Dutch Competition act is the instrument that is executed by the NMa to monitor (together with the NZa by means of the WMG (Health care market structure act)) dominant providers to prevent them of misusing their economic power position. Any cooperation between providers may for example result in price agreements, the so-called collusions.

If the threshold of 50% market share is being used as an indicator for a dominant position, there seems to be a risk in 9 of the 32 regions. Seen from the level of separate types, in nearly half of the regions an economic power position seems present (NZa, 2006).

Due to the liberalisation of the outpatient market one can observe a tendency to merge or cooperate between providers. The NZa (2005) monitors this trend with accuracy to signal premature negative consequences for competition and they advise the NMa if they expect a merger to decrease the competition on the market. The NZa distinguishes vertical from horizontal mergers.

Horizontal mergers

Horizontal mergers are mergers between providers that deliver the same (type of) product and can have two possible goals, namely to improve efficiency and/or to enlarge their market share. The merger will be welcomed by the NZa if it concerns two small providers that can gain efficiency by scale and scope advantages and by that reduce their production costs. The larger home-care organisation will be more able to compete with providers in an economic power position. If the merger is prepared between two larger providers, precaution is required; the NZa (2005) assumes that an even larger provider will not gain any efficiency due to scale or scope advantages after merging. In that case, the goals are probably to enlarge their market share to retain an economic power position. The Competition act obliges enterprises to inform the NMa when a merger is being prepared and if they will exceed the relevant annual turnover threshold. The NMa decided on 15 cases about concentration matters at the home-care market in 2005, of which 12 have been passed, one has been passed under certain conditions and two cases have been prohibited (NZa, 2006). In 2006, the NMa has decided on three cases about concentration matters at the home-care market, which have all been passed, because there were no reasons to be suspicious about too large market shares. No decision in merger cases between home-care providers has been made by the NMa in 2007, which implicates a decrease in merging activities between care providers, but according to the NZa (2006) the amount of mergers will be much higher than these formal numbers tell. The absolute number is not yet known, because for most mergers the existing turnover threshold is not exceeded. In that case, providers are not obliged to inform the NMa.

Vertical mergers

Vertical mergers are mergers between providers who deliver different types of products (NZa, 2005). The goal of such vertical mergers is to increase efficiency by improving the logistic speed of transfers within the chain after finishing sub treatments. The coordination between the different units of the chain is improved and by that the continuity of care. However, just like horizontal mergers, vertical ones may also decrease the degree of competition in a market. In total, three disadvantages are mentioned about this phenomenon by the NZa (2006) and the NMa (2005), which are at first the declined freedom of choice of the client. Once a client is inside a care chain, he will be referred to related members of the large vertical organisation. In theory the client retains his freedom of choice, but in practice he is expected to choose the fastest and easiest transfer to the vertically integrated provider. The second disadvantage is the strengthened market position with regard to the purchaser, because the latter cannot neglect this enormous organisation by refusing to contract. Regional care offices have the duty to make enough and accessible care available. If the purchaser chooses to neglect a large provider, he faces the risk of shortness of supply. Those vertical mergers that will exceed the threshold of turnover must also inform the NMa in advance to see if competition will be reduced by the presence of the large concern. Finally, vertical mergers that become large concerns can raise entry barriers and strengthen the market position of incumbents, because new entrants may experience difficulties to find enough clients.

3.2.1.4 Entry barriers

Several entry barriers are said to be experienced by entrants, which can be categorized into economic and legal barriers (NZa 2005). Economic entry barriers should be understood as starting investments, such as an office or a vehicle which are both necessary when entering the home-care market. The NZa state that this barrier will not be a reason not to enter a market, because these material investments can have other uses when the entrant decides to focus on another market than the outpatient home-care market after a while. The NZa (2006) further states that entrants could experience an entry barrier in not receiving enough production volume after the allocation of the available resources. New providers in home-care markets explain that they find difficulties to realise the contracted volume without having a well known name among the client population. Informal "mouth-to-mouth" advertising by clients is an important mean to have enough clients choosing for a home-care organisation, which is a large advantage for incumbents.

The admission requirement of the Ministry of VWS can be mentioned as a legal entry barrier (NZa, 2005). The actual requirements would not be that complicated to fulfil with, but the long lasting procedure to be permitted to provide home-care in kind is a general complaint of entrants. The Ministry of VWS states that the procedure takes 10 to 12 weeks on average. Another entry barrier, based on the legal institutional context, would be the monopsonistic power of the regional care office, because the new provider of home-care in kind financed by the AWBZ has the legal duty to compete

for production volume in his home region. Entrants therefore depend completely on that regional care office of becoming contracted for home-care in kind. On top of that entry barrier, the national representative of health insurers (ZN) has advised the regional care offices to guarantee 90% of their production volume to incumbent in the last year to ascertain the continuity of care to chronically ill clients. This implies that annually only 10% of the regional budget can be allocated among entrants and existing providers that are willing to extend their production volume.

Another situation is present for housekeeping services, since that type has been transferred to the WMO in January 2007. The WMO holds the municipalities responsible for purchasing enough available housekeeping services. With that, providers are allowed to bid on a contract for housekeeping services in another region than in their "own" region of establishment. Many new providers have competed for housekeeping contracts in more than one municipality, which might also be the result of the allowance of profit-making by home-care providers through the introduction of the Market admission act by care providers (WTZi) in January 2007. The market has changed significantly and which has large consequences for the home-care organisations that were used to get contracted for housekeeping services to support disabled clients (SP, 2007), for example because they had to compete with regular cleaning companies. The Ministry of VWS has reported on the progress and the consequences of the implementation of the WMO (2007) and concludes that 89% of the municipalities have contracted a mix of incumbents and entrants for housekeeping. Two percent of the municipalities have only contracted entrants and 84% of the municipalities contracted 3 to 10 providers.

Three entrants per region have on average entered the market for home-care in 2005 (NZa, 2006). The number of entrants in that market is on average two per region in the first quarter of 2006. One can conclude that a rise is observable, which might also relate to the permitted profit-making policy. The origin of these entrants is as follows: 13% of the total entrants already provided inpatient AWBZ care; 13% already delivered home-care in another region; the rest of the entrants were not contracted before to deliver care financed by the AWBZ. The new providers only covered one percent of the total volume of outpatient care in 2005 and 2006; therefore the competitive effects of the increase in entrants is not significant and can be more or less be neglected by incumbents.

3.2.2 Demand side: purchasers

3.2.2.1 Number and types of purchasers

Three types of purchasers are present in the current market of home-care, which are the regional care offices, the municipalities and individual clients with a PGB. The regional care offices, as concessionaires from the appointed health insurers to execute the AWBZ, bear the responsibility of purchasing affordable, accessible and high quality home-care for regional citizens (ZN, 2006).

As already mentioned, the Netherlands has been divided into 32 geographical regions with their own regional care office. The regional care offices are independent corporate bodies that have

been established by the dominating health insurer in that region. Their goal is to match the amount of health care provision covered by the AWBZ as much as possible with the needs of the regional citizens to fulfil their legal duty of making enough care available and accessible. Besides this task of purchasing and contracting, the regional care offices perform the duty of informing regional citizens about the available care and they perform the administration of their regional budget expenses and therefore they have to justify legally their performance to the NZa annually. This formal supervision by the NZa is being criticized by care providers, because it would not be strict enough. The performances of the regional care offices are being compared with each other by benchmarking to create transparency and to be able to detect the regional care offices with a bad performance. The benchmark would bring an incentive for those regional care offices to improve their performance in the next year (NMa, 2004). The Minster of VWS is formally able to dismiss the regional care office with a bad performance of his task, but one might doubt the credibility of this threat, because such a dismissal will have large consequences for the provision of AWBZ care in that particular region. However, negative publicity will be prevented as much as possible by regional care offices to preserve the good name of the private health insurer and this incentive forces the regional care offices to increase their performance. Despite this incentive, the NMa (2004) concludes that the regional care offices do not perform their purchasing task as well as possible and should pay more attention to the actual needs of the regional citizens. A bad purchasing policy of regional care offices does not cause a threat of switching insureds, because regional citizens cannot choose their preferred regional care office. This monopsonistic position of regional care offices is one of the reasons why the AWBZ is criticised and should change in the near future (NZa, 3-2007).

Municipalities are the other purchasers of home-care in the Netherlands since the housekeeping services have been transferred to the WMO in January 2007. The central government decides on the amount of the budget that is allocated to the municipalities, with which they have to arrange housekeeping to local citizens in need to increase their social participation (Verbeek, 2005). The task of municipalities is to arrange enough available housekeeping services and guarantee its quality. Municipalities are free to make their own purchasing policy which suits in the philosophy of the central government to decentralise interventions to shift cost containment efforts from the aggregate to the local level. Citizens cannot claim a certain amount of care, but the principle of compensation applies to the WMO, meaning that citizens have the right to hold their municipality responsible for the correct execution of their task (Gaay Fortman, 2006). The Quality act Care Providers (kwaliteitswet Zorginstellingen) does apply to providers of housekeeping services and requires a minimum level of quality. The municipalities bear a financial risk, because they have to fulfil the needs of the regional citizens with their limited budget. This creates an incentive to increase efficiency by making sharp price agreements with providers. Client organisations fear this incentive, because it might cause a reduction in the level of quality, when municipalities choose for cheaper services instead of maintaining quality of care (Gaay Fortman, 2006).

The municipalities are obliged to purchase housekeeping services by competitive bidding, if their expenses exceed the threshold of the European directive on public procurement. This obligation still exists if municipalities choose to contract-out the procedure of competitive bidding of housekeeping services to a private firm. In that case the contracting-out will have to be performed by competitive bidding instead of the housekeeping services.

Justification is demanded annually by the public representatives of the municipality, what means that the local government is obliged to publicize their performance. By means of benchmarking the performance will be compared to the results of other municipalities and creates an incentive to act in the interests of local citizens and increase the efficiency of the provision of housekeeping services. Citizens and interest groups are provided information by this benchmarking to pressure municipalities that perform below the average of municipalities, to improve their purchasing process.

Clients that have chosen for a personal budget after receiving an indication of the CIZ are the third type of purchaser of home-care. All types of home-care, except for treatment, can be received in a personal budget, which must be used to buy care that is similar to one of the 6 types. The budget holders are obliged to report their expenditures to the regional care office or the municipality of his residence. The number of budget holders has increased to 86.618 in July 2006 and had a total budget of 884 million euros which is almost 24 percent of the total budget of the AWBZ. The CVZ expects an increase in costs in 2006 up to 1.075 million euros (CVZ, 2006). Given this increase, one can expect that home-care providers will be more and more inclined to attract budget holders to deliver more home-care than they could get contracted for benefits in kind. To deliver home-care to budget holders, providers do not need a market entry allowance of the Ministry of VWS.

3.2.2.2 Future developments

Many institutions have reported that de AWBZ will change fundamentally in the future (RVZ 2005, CVZ 2004, NZa 2007-3, Netherlands Bureau for Economic Policy Analysis 2006 (CPB)), because of fundamental shortcomings. All institutions conclude that the AWBZ has included too many types of care and support for many client groups. This would create a threat of overlap with other provisions and might result in a shift to more demand for AWBZ care. The Minister of VWS (2007-3) has collected all reports and advices and stated that there are two possible options to create a more modern and steady system. The first option is to empty the AWBZ slowly and transfer personal care, supportive attendance and parts of recovery attendance together with the type short stay to the WMO. The other types as treatment, nursing, the other parts of recovery attendance and long-term stay should be transferred to the ZVw (RVZ, 2005). Because of doubts about the financial sustainability of private health insurers when insuring benefits that were thought to be uninsurable by private schemes, the second option is to keep those uninsurable benefits in the AWBZ, such as long term stay for congenital mental disabled clients. The Ministry of VWS has demanded a concluding advice of the

Dutch Social and Economic Council (SER), which is to be expected in December 2007. This advice will contain all doubtful elements such as financial sustainability, cost containment, incentives for innovation and high quality, market incentives and attention for the interests of clients. Although this advice still has to be developed, one can expect a transfer of home-care benefits to the WMO and ZVw, which will for certain have large consequences for the position of the present purchasers. One future change that will happen is that the regional care offices will be dismissed from their task of executing the AWBZ by January 2009 (NZa, 2007-3). The private health insurers will have to take over this task and they will experience an incentive to purchase care as efficient as possible, because of the financial risk they bear. The absence of the financial incentive lacks regional care offices to stimulate providers to provide home-care most efficiently. Health insurers will in turn use the available means to cover the needs of their insureds as well as possible, because of the competition on the insurance market and insureds responding to the performance (premium vs. quality of contracted care) of health insurers and switch from insurer in case of disappointing results (CVZ, 2004). Because the AWBZ was intended to cover uninsurable risks, one can wonder whether the financial risk is not too large for the private health insurers. The central government has the task to keep the market sustainable and therefore must prevent health insurers from avoiding bad risks (cream skimming). An instrument to do so is to extend the current risk adjustment system to keep insurers and providers acting in the interests of clients or insureds (RVZ, 2005).

For municipalities, the expected transfer of more home-care types from the AWBZ to the WMO will mean a large extension of their tasks and the related budget. Their financial risk will increase and with that the incentive to operate efficiently to reduce costs. It is of great importance that municipalities will obtain the necessary purchasing skills and knowledge as soon as possible, because the CVZ (2004) states that municipalities lack the expertise to execute their new and future tasks properly. Because they should purchase housekeeping services also in the interests of clients, it is important that client organisations develop some countervailing power to make municipalities purchase home-care in the interests of clients.

3.2.3 Provider-purchaser bargaining

3.2.3.1 Current institutional context

This paragraph describes how the process of bargaining, contracting and financing takes place in the current context.

The Minister of VWS has made agreements with the present parties in the market by three covenants. One covenant is between VWS and the national organisations of the different client groups, in which agreements have been made about the collective responsibility of cost containment of the AWBZ. The second covenant is agreed by VWS, the umbrella organisation of the health insurers (and regional care offices) (ZN) and CVZ and contains the agreed tasks and cost containment efforts of the regional care offices. The third covenant is intended to bridge between the first two and includes

agreements between all parties about the production volume at macro level, financial framework and efficiency (Gudde, 2006). The NZa has advised the Minister of VWS not to renew these covenants, because this way of governmental regulation would hamper the functioning of the market for home-care (NZa, 06-2006).

The market for housekeeping is being managed by the municipalities by means of the European directives on public procurement for services, when the annual expenditures of municipalities exceed the threshold of €249.000 (Burg et. al, 2005). As already mentioned, the market for housekeeping has changed significantly since the introduction of the WMO, because providers now have to bargain with another type of purchaser. The European directive on public procurement for services includes all elements of the procedure that have to be followed, for example the publication of the service that is being contracted in the Journal of the European Union. The municipalities must behave according to three principles, namely the principle of transparency, objectivity and non-discrimination. Municipalities are expected to close contracts for the period of one year at most, because they do not have much experience with purchasing housekeeping and contracting providers. When municipalities obtain some experience with this task, the contract period may become longer in order to give more guarantees to the contracted provider, which might lead to a lower price and more trust that can result in a less complex monitoring process.

The market for caring & nursing, supportive and recovery attendance and treatment is primarily managed by the regional care offices and home-care providers. Since September 2004 the regional care offices are not obliged to contract all providers with a market allowance, but they have the duty to purchase enough home-care in order to make sure that all clients with an indication can claim their needed care. As already mentioned, the national representative of the health insurers has decided to allocate about 90% of the total budget among providers that have been contracted in the past year to guarantee the continuity of care to clients who need long term home-care. The remaining 10% will be allocated among new providers and existing providers that are willing to extend their production volume.

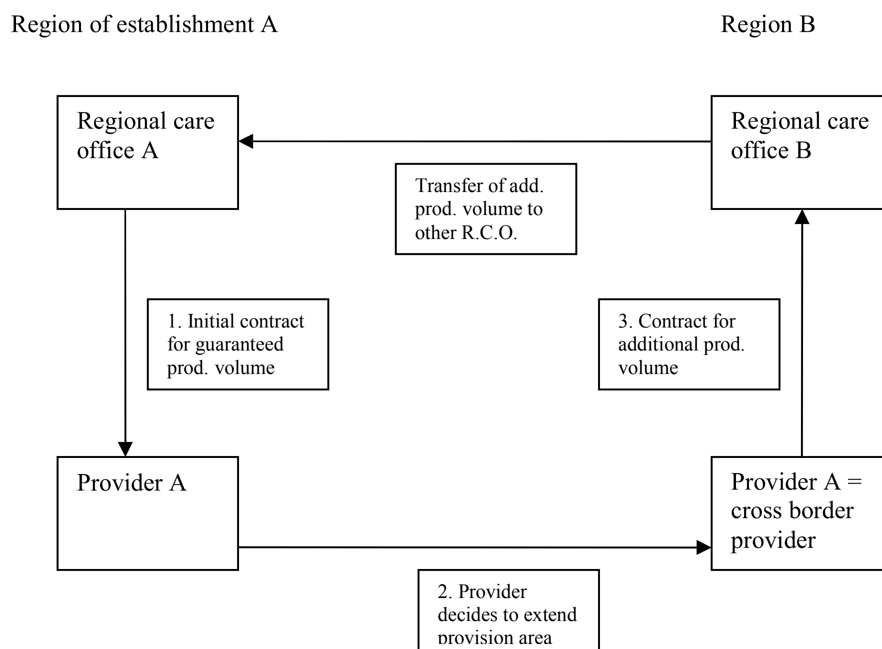
In the last couple of years regional care offices have become more and more conscious about the fact that the European directives on public procurement also apply to them. Almost all regional care offices have used competitive bidding to select the providers for the contract period of 2007. While executing the procedure of competitive bidding, the regional care offices also have to obey and follow the European directive on public procurement for services. Choosing to disobey the directive brings the risk of a prosecution and when the judge decides the followed contracting procedure is not legal, the regional care office might risk of having to run the contracting procedure all over again. This would be bad publicity for the regional care office and associated health insurer, it would cost a lot of

extra time and money and it would not be a good development for the care providing process, because all providers will eventually suffer from such a late second procedure.

The central government annually defines the macro budget for the AWBZ which is being allocated to the 32 geographical regions. Then, the maximum tariffs for all separate types of AWBZ-care are being defined by the NZa, which is also meant to contain costs. By means of the regional budget and the maximum tariffs, the regional care offices will run the contracting procedure after having selected the providers. The results of the bidding procedure (volume and price) are filled in on a budget-request form and send to the NZa who will formally judge the request. These budget request forms contain the total production volume of all different types of care that is contracted with each provider. The NZa accepts only one budget request form per provider, resulting in a complex contracting procedure when the provider delivers home-care in different regions. In 2005 and 2006 regional care offices were inclined to raise the entry barriers for cross-border providers by requiring a separate market allowance by the Ministry of VWS of these cross border providers. The NZa has given judgement against this unequal treatment, because it would reduce the competition on the home-care market. ZN has therefore demanded the regional care offices not to require such a separate market allowance and advised the regional care offices to make agreements with cross border providers about production volume. Since 2007, providers are free to bid on additional production volume in another region. If the provider is awarded for production volume in another region, the regional care office of that region transacts the agreed budget to the regional care office of the cross border provider's home region that has initially contracted the provider, because it has to be included on the one and only budget request form. Figure 3.2 clarifies the described construction. When the provider has bid on production volume in several regions with different prices, the budget request form is filled in with the average price.

The policy of the NZa of accepting only one budget request form does not improve the transparency about bidding prices and complicates the contracting procedure substantially. It would probably cause a higher administrative burden on the NZa, when they would accept different contracts of one provider with multiple regional care offices, but it would improve transparency about market shares and prices and reduces the complexity of the current contracting procedure.

Figure 3.2 Transfer of production volume between regional care offices when contracting cross border providers



Financing the agreed production volume is being done by monthly advanced transactions executed by the CAK, based on the approval of the NZa on the budget request form. After the contract period, the provider describes how much production volume he has actually delivered which is compared with the production volume that was contracted. When the NZa concludes that the provider has received too much money in advance in case he has not realised the production volume that was contracted, the NZa will claim the difference between realisation and contract volume. When the provider has delivered more production volume than was contracted, the provider does not receive the difference and he will end with a negative account. This is explained by the normal risk of an enterprise and the provider should have referred some clients to other providers in time, when he was about to exceed his production limit.

3.2.3.2 Transparency, quality and waiting lists

The quality of care is being regulated by different instruments. First, potential providers must receive permission of the Ministry of VWS to provide home-care in kind. Second, the permitted providers should behave according to several acts on quality ("Wet BIG", "Kwaliteitswet Zorginstellingen") applied by the Health Care Inspectorate (IGZ).

In the past decennia regional care offices have made efforts to include quality indicators in their contracts with providers. There are three different types of quality indicators which are process, structure and performance indicators (CBO, 2007). The focus in the Netherlands has been on

certification and accreditation for care providers which has resulted in several quality certificates, which are process and structure indicators. These two types of indicators describe how providers should perform while providing care. Best known in the Netherlands is the HKZ-certificate. Care providers that pass this certification procedure are allowed to state that their internal processes are well organised, the client has a central position in their organisation, delivers valid results and continue to improve their provision of care and services (Sluis et al, 2007). This certification is a continuing process, because the provider is being annually judged on their performance and the period of certificate validity is restricted to three years. After this period the care provider will be tested again to make sure he still fulfils with the necessary requirements. The national representative of the health insurers (ZN, 2005) has summed all necessary inclusion criteria for the selection and contracting of care providers by regional care offices. The presence of the HKZ-certificate is part of those inclusion criteria, even as fulfilling with legal quality requirements, the presence of a privacy policy, the presence of a complaint procedure and the performance of client satisfaction survey once in every two years. Despite these guidelines, it seems that only 34% of the home-care providers have obtained the HKZ certificate in 2005, which clarifies that regional care offices cannot use this inclusion criterion too strictly (Sluis et al, 2007). Since certification does not automatically guarantee a higher level of quality, the NZa (2006) has the opinion that regional care offices should develop output quality indicators and include them into their contracts with care providers. Regional care offices will then be able to measure how well the provider has actually taken care of his clients, which is not possible with process and structure indicators. Output indicators are suitable to judge the contracted providers and can provide weight in the decision whether the contract should be continued with this provider for a following contract period. This will provide an accurate instrument to increase the quality of home-care and may also create competition on quality among providers instead of competition only on price.

The central government makes efforts to improve transparency in care providing processes and the financial administration of providers by introducing the directive "Administrative Organisation / Internal Control (AO/IC)". This directive obliges the contracted providers to publicise their organisational processes, such as the registration of production and charging behaviour by means of an accountancy statement (NZa, 2007). Regional care offices do now have a clearer view on the spending of public resources and will be able to monitor care providers more strictly.

Waiting lists are monitored by an online registration system (AZR) to which regional care offices and contracted providers have access. When clients receive an indication for home-care, the indication is placed in the registration system. If patients have a preferred provider the indication is send straight forward to this provider. When clients have not made a choice for a provider, the regional care offices will choose one instead and forwards the indication to that provider. The preferred provider has to accept the indication from the moment he starts to provide the needed care. Until the acceptance, the indication of the client is placed on the provider's waiting list. Regional care offices tend to monitor

this waiting list and demand providers to transfer clients to another provider if they are not able to start providing the indicated care within the period of acceptable waiting time. Providers have to use AZR according to the contract, because when they fail, for instance when accepting the indication long after they have started providing care, the waiting list information is not correct. In a certain situation the providers are demanded to keep AZR up-to-date. Some regional care offices copy the waiting list information to their website to publicise the actual waiting time of the contracted providers as a service to future clients or current clients choosing for a(nother) provider. The presence of waiting lists can occur when AZR has not been filled correctly, but it might also be the result of a failing purchasing process, when there has not been purchased sufficient care capacity throughout the region.

3.2.3.3 Current market results

In this paragraph the macro results of the current market will be described by the possible goals of the government: costs, quality of care, transparency, accessibility and efficiency.

The costs of home-care have increased in the past years, despite the discounts regional care offices have received after bargaining with home-care providers in 2005 and 2006 (NZa, 2006). The explanation for the rising costs are the increased demand of 3.0% in 2005 and the average tariff that has risen in that year, which resulted in an increase of 5.5% of total costs on the aggregate level. An explanation for the discount regional care offices have gained might be the fact that regional care offices are not obliged anymore to contract all permitted providers since 2004. This could point out an increase in competition among providers, but the discount may also be explained by the covenant in which the Minister of VWS has agreed with providers to deliver 1.25 % more care for the same price, which in fact is an efficiency gain. Therefore it is not clear what has caused the increased efficiency or discount of providers. The NZa (2006) states that more efficiency can still be gained in the home-care market after having concluded that the current maximum price is still higher than the average production cost. This means that providers could lower their price for the same amount of production volume if they are stimulated to do so. The absence of an incentive to force regional care offices to demand more efficiency would lack to stimulate providers in this way. The municipalities do experience a certain incentive, because they bear a financial risk when purchasing housekeeping. In the latter market, it is still too soon to draw conclusions on efficiency, because this purchasing process runs for only about seven months now, but there are signals (described in chapter four) that implicate an increase in efficiency.

The quality of home-care may have improved in the last years, but an exact measurement of this result is not yet possible. The focus of regional care offices, translated in contracts, has been on process indicators, because of the absence of output quality indicators. Home-care providers are stimulated to reach accreditation or deserve a quality certificate and some regional care offices have included this requirement in their contracts with providers (CZ, 2006).

Transparency of organisational processes of providers has improved since the introduction of the AO/IC directive. This directive claims transparency about how the public resources are spent and used by the care providers within their operational process by for example requiring annually an accountancy statement. Monitoring by regional care offices will be less complex with the improved transparency on organisational processes. Besides the transparency improvement, one can expect that the internal organisational processes have also been improved, because providers were obliged to clear up their registration processes, which might lead to efficiency gains when they conclude that their own organisation does not operate efficiently.

Accessibility can be divided in two elements from the perspective of clients, which are accessibility by clients who receive an indication to claim their right for care and the actual waiting time after receiving an indication. Clients do most often receive an indication from the CIZ within the legal period of six weeks and this element of accessibility is therefore fulfilled. The actual waiting time from having received an indication and placed on a waiting list has exceeded the acceptable term in the summer of 2006 for some types of home-care. At that time many providers decided to close their waiting list by refusing new clients, because their realised production volume exceeded the agreed production volume. The demand for home-care was larger than the expected growth rate and for that reason, as already mentioned the Ministry of VWS had to decide to spend 90 million euros additionally on home-care to make sure that clients would also receive their indicated home-care.

3.2.3.4 Contractibility of home-care

Home-care is contractible when all parties know ex ante what can be expected of the provider delivering the different types of home-care and when the results of the delivered home-care can be measured objectively.

In the Netherlands, home-care is specified by units of services, which are the six types of home-care that are divided into different performances. The type housekeeping services is divided into two performances which are “housekeeping services one” and “housekeeping services two” (HS1 and HS2). This distinction is based on the capability of the client to coordinate the housekeeping services. When a client is not able to tell the housekeeper what needs to be done, he will receive the indication for HS2, which relates to a higher tariff, because performing HS2 requires additional skills from the housekeeper. The type personal care is divided into three performances, namely basic, extra and specialized. All three are explained in detail in the policy directives of the NZa (CA-170, 2007) and related to the possible client groups. The performance ‘extra’ stands for the need for unscheduled care, which has a higher tariff than ‘base,’ because the home-care provider has to respond to the call during 24 hours, when a client is in need of unscheduled care. The performance ‘specialized’ is meant for a client group that is more complex to provide care to, such as mentally disabled clients with behavior problems. If a patient has an indication for personal care, extra and specialized, the provider is allowed to charge two additional fares above the base tariff.

In total, the NZa specifies 19 performances throughout the five types of home care (housekeeping services excluded) that are financed by the AWBZ. The regional care offices have the task to purchase a mix of those performances from different providers to match the supply as well as possible with the demands of the regional citizens. The question is whether this specification is detailed enough to monitor the providers strictly. Although the performances seem clear, it still has not been possible to develop performance or output indicators. This means that it is clear in advance which care should be provided to a client (personal care base for example), but not if the provider has performed as well as possible at the end (is the client clean, after a bath?). Measuring the performance of providers that deliver housekeeping services after being contracted by municipalities might be less complex. The type housekeeping services has two performances and both should result in a normal household (clean, meals, care for children). However, the municipalities have also not developed a set of output indicators to measure the actual results of the contracted provider after delivery.

3.2.4 Summary

This paragraph describes the four product markets and the existence of 32 geographical markets for home-care. Circa 10% of the providers deliver 75% of the total production volume. The concentration of providers on the market is high; one or two large providers with an economic power position are present in many regions which causes a low level of competition. Providers were inclined to merge in 2005 when more market incentives were introduced. The NMa has a strict procedure to monitor a proposed merger. Several economic and legal entry barriers have been described, but despite these barriers, the amount of providers bidding on production volume increased with 8% in 2006. However, the production volume for which the new providers were contracted was marginal and the effect of entrants on incumbents can therefore be neglected. Three purchasers are present, namely regional care offices, municipalities and personal budget holders. The regional care offices will be dismantled in 2009 and their task will be taken over by the private health insurers. Municipalities and regional care offices are obliged to obey the European directive on public procurement for services. Other types of home-care will also be transferred from the AWBZ to the WMO and the ZVw in the future, just like the housekeeping services. The distinction between both acts will be made between cure and social support. The costs of home-care are still growing, despite the discounts providers have been giving in the last two contract periods. The quality of care is not yet measured well enough; the home-care product seems well specified, but the absence of output indicators lacks a stringent measurement on quality of home-care.

Chapter 4 Competitive bidding in the Netherlands

4.1 Preliminary results of competitive bidding for home-care within the AWBZ

In this paragraph a description will be made about the procedure, the process and the results of using competitive bidding to purchase home-care by regional care offices. The procedure explains the framework the purchaser has chosen in which the process takes place. For example, the chosen procedure could be according the principles of an auction or a beauty contest and whether the purchaser uses an open or a closed method to invite bidders to join the tender procedure (see paragraph 2.1.2). Describing the process will give information about how the stages have been executed and for instance which criteria have been used to select bidding providers for contracting. In paragraph 4.2 the experiences of one regional care office (CZ) will be described, which will give an overview of the used procedure, the process and the results of one particular purchaser.

4.1.1 The procedure of competitive bidding by regional care offices

The NZa (06-2006) state that the principles of competitive bidding have been used by more and more regional care offices to purchase extramural care since 2006 as a response to the statement of ZN. The statement outlined that regional care offices are obliged to follow the European tender directives. This development is welcomed, although the part of the total production volume that has actually been allocated by competitive bidding is marginal (< 10%). Existing providers are guaranteed to receive at minimum 90% of their production volume to avoid discontinuity of care, resulting in fewer incentives to providers to offer efficient home-care that is of high quality. Therefore the NZa proposes an increase in the part of total production volume that is allocated by competitive bidding on the probation that continuity of care is not threatened. It is not clear what percentage of the regional budget is most optimal to be allocated by competitive bidding. Allocating a too large part of the budget by competitive bidding might threaten the continuity of care to chronically disabled clients, where a too small part of the budget decreases the competition level among providers, resulting in less incentives to operate more efficient.

Further details about the procedure regional care offices have followed to purchase home-care are unknown.

4.1.2 The process of competitive bidding by regional care offices

In their report about the performance of regional care offices in 2005, the NZa (11-2006) stated that all regional care offices have developed a transparent purchasing policy. They have used selection criteria which are equal to all bidders (new providers and incumbents). According to the NZa only one regional care office executed a questionable policy with possible unequal selection criteria, but it has become clear that this had not caused disadvantages for any bidder in practice. The purchasing policy

is judged by the NZa (06-2006) as transparent. All regional care offices have published their purchasing policy on their website in time and 19 of the 32 regional care offices arranged an information meeting to explain their competitive bidding policy.

According to the NZa (2005), providers seem to be inclined to extend their provision area to other geographical regions more often. This is a positive development from a liberalised point of view, because it reduces the concentration in markets with providers with an economic power position. The regional care offices do not experience this development as positive, because they find themselves spending their regional budget on the care for habitants of another region, while their regional budget is based on the amount and need of citizens in their region for which they bear the responsibility to purchase enough care. The NZa reported (11-2006) complaints of providers accusing some regional care offices of raising their entry barriers to cross border providers (formally established in another region). These cross border providers were required by many regional care offices to have a separate market allowance for each specific region to be able to join that bidding procedure, what made them complaint about an unequal treatment. ZN has therefore promised that regional care offices will not require such an extended allowance any longer to prevent cross border providers being demanded to establish several enterprises in each region they want to join the bidding procedure. As described in paragraph 3.2.3.1, ZN has advised regional care offices to transfer the agreed production volume with cross border providers to the regional care office of his home region. This may solve the problem of raising higher entry barriers to cross-border providers, but complicates the contracting procedure while the NZa has the policy of accepting only one budget request form per provider.

All regional care offices start their process by selecting the bidding providers who fulfil with the basic quality indicators (NZa, 06-2006). The price that providers have included in their bid is not weighted as selection criteria, because they will not exceed the maximum tariffs that have annually been set by the NZa. After having selected the providers, regional care offices use judgment criteria to score all selected providers. The offered price is included as judgement criteria by most of the regional care offices (see further below). The quality indicators that are used as selection criteria cover the quality requirements by law (Wet BIG, Kwaliteitswet Zorginstellingen) and three additional indicators:

- The presence of a quality system within the home-care organisations;
- The performance of a client satisfaction survey;
- Administrative performance (AO/IC directive).

The selected providers who fulfil with these requirements are offered a contract for most often one year and a guarantee of their production volume of the last contract period for 90% up to 100% by most of the regional care offices. Some regional care offices that do not offer a budget guarantee, offer a contract for a longer term than only one year. Two regional care offices offer contracts for two years and one regional care office for three years. If the selected providers score well on the judgment

criteria, they will be awarded by additional production volume. In case providers are guaranteed to receive 90% of their last production volume, there is still 10% left to allocate to the best scoring providers and entrants.

The providers who fulfil with these selection requirements are scored on a number of detailed judgment criteria, which vary in amount from 2 to 40 among the regional care offices. Examples of these judgment criteria are the price, quality in terms of accessibility (waiting lists) and administrative obligations such as keeping the waiting list registration system up-to-date. The report about the performance of regional care offices in 2005 (NZa, 11-2006) describes that 29 of the 32 regional care offices include the offered price as judgment criteria. The weight of prices as judgment criteria varies from 6% to 100% among the regional care offices. While price is a relative criterion which can easily be compared, quality is not that easy to compare as judgment criterion, because all regional care offices may explain quality in a different manner or use other elements to describe quality. Although this point diffuses the comparison of how regional care offices outweigh their judgement criteria, table 4.1 shows which and how the judgement criteria have been used to score the selected providers.

Table 4.1 Use and relative weight of judgement criteria by regional care offices.

Type of judgment criteria and relative weight	Number of regional care offices
1. Absence of clear judgment criteria	1
2. Just quality (price was not taken into account)	3
3. Most efficient offer (quality with a reasonable price): - Quality > price - Quality > price, but with space for negotiation - Quality = price - Quality < price	22 7 4 5 6
4. Just price criteria	6

Source: NZa (06-2006)

All selected providers are scored on the judgment criteria to create a ranking order of providers. The best scoring provider will be awarded with additional volume for the price she offered. If there is any volume left of the 10% allocation space in the regional budget, the second best scoring provider will be awarded by additional production volume. The order of providers is also being used by 16 regional care offices for distributing clients, who did not make a choice for a particular provider, to the providers with the highest scores to make them realise their production volume more easily.

The NZa concludes in her monitor (06-2006) that regional care offices find difficulties to make a clear link between a higher price to realise a higher quality. The reason for this difficulty can be found in different types of indicators, because price is defined as an indicator of result and quality is defined as a process indicator. When regional care offices have the dispose of specific quality output

indicators, providers and regional care offices may experience the relation between price and quality less complex, because of a more clarified link between these two factors.

4.1.3 The results of competitive bidding by regional care offices

All regional care offices were able to save expenses on average with 1.4% in 2004, with 2.9% in 2005 and with 3.2% in 2006 (NZa, 11-2006). But as already mentioned in paragraph 3.2.3.3 there are two possible explanations for these efficiency gains. The first one is an increase in the level of competition and the second one is the result of the covenant in which the Minister of VWS has agreed with providers to deliver 1.25% more care for the same price. Therefore it is not clear what has caused the increased efficiency or discount of providers. Despite the increase in efficiency, the NZa (06-2006) stated that more efficiency can be gained in the home-care market. They concluded that the maximum price is not equal with the average production cost. This means that providers could lower their price for the same amount of production volume if they are stimulated to do so. However, the absence of an incentive to regional care offices to demand more efficiency lacks to stimulate providers in this way.

Competitive bidding brings the risk of a reduced quality in case the competition among providers increases and if a reduced quality cannot be measured and therefore sanctioned easily. The quality focus of regional care offices, translated in contracts, has been on process indicators, because of the absence of output indicators. Home-care providers are stimulated to seek accreditation or deserve a quality certificate by regional care offices that have included this criterion into their selection process (CZ, 2006). At this moment one can state that the amount of certificated providers increases. Such a certification gives some degree of certainty about the level of quality a provider delivers, but does not guarantee a high quality standard. Therefore output indicators for home-care should be developed and this should be done, according to my opinion, by ZN together with the national representatives of home-care providers, the NZa and client organisations to reach acceptance among all present parties.

Since the regional care offices started to use competitive bidding to purchase home-care, one can observe (negative) side-effects and/or consequences. The first side-effect that has been observed is the phenomenon of subcontracting of the allocated production volume. Subcontracting can have negative consequences for the competition on the market, the freedom of choice of clients and the quality of care. Negative consequences for the competition on the market are caused by subcontracting if the provider with an economic market position also provides the care that in fact is contracted with his competitor, resulting in an even higher concentration of this dominant provider on the market. Hypothetically seen, it may happen that a regional care office has contracted two different providers to deliver the necessary home-care in a geographical market. If one of the providers subcontracts all his production volume to the other provider, the level of concentration on that market is 100%. This is not desired, because the absence of competition among the providers and the related incentive to behave

as efficient as possible to become contracted and awarded. Negative consequences for the actual freedom of choice of clients are caused when regional care offices think they have contracted more than enough providers, but the care is actually delivered by only one or two providers. Subcontracting can reduce the quality of care, because the provider who actually delivers the home-care is not directly monitored by the regional care office and his turnover may be smaller with the presence of an intermediary. This intermediary is the provider that has been contracted by the regional care office and has subcontracted his received production volume for a smaller price to gain some profits by subcontracting. Because there was not enough transparency about the extent of subcontracting, the NZa performed a research in 2007 and concluded that subcontracting accounts on average for 10% of the total contracted production volume for home-care benefits in kind. The home-care type supportive attendance is subject to subcontracting for 20% against 3% for the home-care type recovery attendance. The phenomenon cannot be prohibited, because providers are free to decide how to arrange the home-care that has to be provided. By means of a ministerial directive (Kaderregeling AO/IC), efforts are made to provide transparency into the allowed subcontracting processes to make sure that monitoring the contracted providers will be less difficult to perform.

A second side-effect that can be observed is the tension on the relation between regional care offices and the contracted providers. A few years ago the obligation to contract all permitted providers has disappeared and competition among providers has been introduced. Besides these large changes for providers, they are obliged to join the bidding procedure, because otherwise they would not retain their budget guarantee of 90%. And if they are being awarded, they will be monitored intensively, because regional care offices want to make sure their insureds receive what they have paid for. The bidding process and monitoring demands a lot of time and efforts to deliver all required documents about quality, registration and business processes. This burden is especially high for small providers and may not motivate new providers to join the bidding process and one can state that the relation between providers and regional care offices is under pressure. One way to release this pressure is to be clear and transparent in advance to providers on what is expected when it comes to monitoring the administrational organisation, but off course this does not completely solve this problem or side-effect.

4.2. Description of the use of competitive bidding by one specific health insurance company

An interview with an employee of the health insurer CZ has given insight into the way the five regional care offices of CZ has purchased home-care in the last two years. Those five regional care offices all have another region in the south of the Netherlands to focus on, but because they are all part of CZ, they perform their purchasing task according to the same purchasing policy. The regional care offices of CZ have followed the European tender directives and used a fixed purchasing policy. This fixed purchasing policy means that providers are invited to bid on production volume by price and

promised quality, such as the intention to become certificated, and they are not being able to negotiate about the amount of production volume they would want to receive. The regional care offices all decide for themselves which provider is being contracted and who will receive additional production volume on top of the production volume that will be guaranteed. CZ has started with competitive bidding as method to purchase home-care for the contract year 2006. In that first year, the regional care offices have used quality indicators as selection criteria as described in paragraph 4.1.2. The selected providers were further scored on the fulfilment of quality indicators and the offered price to create a ranking. Some elements of the used quality indicators have been the same in the selection and scoring procedure, which is changed in the following year. The quality indicators that were used as selection criteria for the contract year 2007 have not been used anymore to score the providers as well and other scoring criteria have therefore been included. For the contract year 2008 the NZa has decided that regional care offices must be able to use different purchasing policies for the different types of home-care. What the result of this decision will be in practice is unclear at this moment.

The process of competitive bidding has been executed by CZ according to the purchasing cycle that has been subscribed by ZN (11-2006). The selection criteria that regional care offices have used are defined at aggregate level and have been described in paragraph 4.1.2. These selection criteria point out which allowed providers can be contracted by the regional care offices. The selection and scoring criteria are included in this master thesis as appendix 2. All selected providers are scored on three elements, namely:

- Difference between the offered price and the maximum tariff set by the NZa;
- Efficiency accounted by the delivery of hours on average within the indicated range of the type of home-care (For example, when the CIZ decides that a client is in need of 2 to 3.9 hours personal care per week, a provider is called efficient when he delivers on average 3.0 hours per week. One client may need more than that; another client may need a little bit less. When a provider finds himself in the upper half of the range, for example on average 3.6 hours per week, he does not provide as efficient as possible, because more clients receive more hours personal care per week than the average of 3.0);
- Quality criteria (appendix 2);

After scoring, the bidding providers are placed in a ranking order depending on the points they have scored. Maximum points are given to providers with the highest score when fulfilling all three elements mentioned above. Best scoring providers receive the status A, other provides the status B and least scoring providers the status C. The “A, B, C status-system” determines which percent of their realised production volume of their last contract-period will be guaranteed. (A: 97%, B: 94%, C: 90%). New entrants will receive the status D, because they cannot be guaranteed a percentage of their last allocated production volume. Having scored a high amount of points and the status A, will result in a high place within the ranking order, meaning that the provider will receive a high percentage of

additional production volume above their guaranteed production volume. The ranking and related allocation procedure of CZ is shown in the table below.

Table 4.2 Ranking of allocated production volume to less than 10 providers

Ranking	A-status Maximum % of the available production volume	B and C –status Maximum % of the available production volume
1	40%	30%
2	30%	20%
3	20%	10%
4	10%	5%
5 to 10	Dependent of left production volume to a maximum of 5%	Dependent of left production volume to a maximum of 3%

CZ Aanbestedingsdocument zorginkoop, 2007

Examples of the used quality indicators are the presence of a quality system, certification and the proper use of the registration system AZR. One can conclude that these quality indicators are focussed on input, rather than on output and performance. Another element providers are scored on, are the results of the last monitoring checks. The regional care offices of CZ monitor 25% of their contracted providers by checking whether the care that has been charged, has actually been delivered. Monitoring (only) 25% of the contracted providers would be the maximum percentage of what can be managed as administrative workload. The providers that are included in this monitoring check are mainly chosen when having an unusual charging pattern, unusual conclusions of the accountancy consultant or complaints of clients about the financial administration. The monitoring process is mainly meant to monitor the financial registration of the contracted providers, but also the presence and use of client files.

All bidding providers are scored on equal criteria and have received the same information. The purchasing procedure is published on the website, together with the selection and scoring criteria, where also can be found an invitation for an information meeting about the purchasing policy that will be used for the following contract year. Therefore one can conclude that the regional care offices of CZ have not disadvantaged cross border providers compared to regional providers, but they do discriminate entrants when guaranteeing such a large amount of production volume to incumbents.

A large increase in the amount of contracted providers can be observed, namely from 50 contracted providers in 2006 to 75 in 2007. The increase in providers is caused by a change in purchasing policy, namely all regional care offices can contract all cross-border providers. These cross border providers

may have been used to provide home-care in another region before, but have not been contracted before by other regional care offices than in their home region, as explained in paragraph 3.2.3.1.
The total amount of contracts has therefore increased significantly, but the number of budget request forms (no. of providers) send to the NZa may have not. Numbers about the increase of providers in 2007 are not known yet, because the NZa has not yet updated her monitor on the market.

Two entrants have not been contracted for the year 2007 by CZ for reasons of not having their allowance of the Ministry of VWS by the 1st of January 2007. One can conclude that this new policy of being able to contract cross-border providers as well, has extended the freedom of choice of clients, because these cross-border providers have not been published as available for regional citizens before, for the reason that they have not been contracted before.

The regional care offices of CZ have contracted providers for a reduced price on average compared to the prices in 2006, resulting in an increase of production volume that has been purchased for the same amount of regional budget. Despite this increase of production volume, CZ expects the purchased volume again will not be enough to answer the increased demand, just like what happened in 2006. As described in paragraph 3.1.4, in 2006 the Ministry of VWS had to decide to add extra resources to the regional budgets of regional care offices, because the latter complaint about a shortage of resources, caused by an unexpected large increase in clients' need for home-care. According to CZ, stringent problems are again about to happen, when clients cannot receive the indicated care within the period of acceptable waiting time.

4.3 Preliminary results of competitive bidding for home-care within the WMO

This paragraph gives an overview of the procedure, the process and the results of the use of competitive bidding to purchase home-care by municipalities. The year 2007 is the first year in which municipalities are obliged to purchase housekeeping services for their citizens. Therefore one must understand that municipalities still have to gain knowledge and experience to execute this task properly. The minister of VWS has asked for a study of the preliminary results of competitive bidding to purchase housekeeping services to be able to evaluate the process in this first year. The study has been published in March 2007 (Research voor beleid) and describes the most used procedures, which decisions have been taken during the process and what can be learned from the results and the consequences for the following years.

4.3.1 The procedure of competitive bidding by municipalities

Municipalities have used three different models of competitive bidding in total, namely the usual model in which providers compete with each other on price and quality of care. This fixed contract

includes the agreed price and the promised quality of care. The second model is the one with a fixed price and providers compete with each other on quality (Zeeuws model). This model goes with a frame contract which is without an agreement on the total micro production volume. The realised production volume of contracted providers will depend on the demand for care and clients' choice for providers. One advantage of this model is therefore the competition among providers just on quality of care and not on price, which prevents providers not to set their price too low resulting in a low level of quality of care and risk bankruptcy. The second advantage is that all existing providers will be retained on the market (if the offered quality of care is high enough) to guarantee the continuity of care. The third model has a maximum price and creates some type of competition among providers on price and quality of care. The difference with the first model is that providers cannot bid with a price above the maximum tariff to contain the total costs of the municipality.

The municipalities have most often used a one-step public tender procedure (79%), but some have used the two-step procedure in which a pre-selection point out which providers are allowed to bid on a contract (21%).

During the process of competitive bidding, municipalities were able to use the assistance of a helpdesk that was set up by the Ministry of VWS. The assistance was however not experienced as useful, because the helpdesk was not able to answering more complex questions, for example which necessary juridical aspects should be included when developing a contract. Two third of the municipalities hired external support and the rest was connected to a regional purchasing office. The need of assistance of municipalities was mainly focused on juridical assistance, knowledge about the provision of housekeeping services and project consultancy to execute the procedure in the little available time. The tasks of the hired external consultants varied per municipality, but they most often had an advising function or translated the view of the civil servants into the tender specification. Research has shown that many municipalities could not explain why certain choices have been made. The external consultant has made decisions without discussing them with the civil servants in advance. Many municipalities have stated to hire the external consultant again the next time because of the juridical complexity of following the European tender directives.

Probably because of the lack of experience municipalities had with competitive bidding, 17% of total municipalities had to cope with prosecutions from providers who thought the European tender directives were not followed properly. The Ministry of VWS collected information about the frequency municipalities were prosecuted during the process of competitive bidding. Of the 24 municipalities that have been prosecuted, four municipalities had lost the prosecution and three municipalities had won. The rest of the cases had not been decided by December 2006 and therefore not clear what the exact outcome is in total. In case the provider was right, the municipality had to start over their procedure again, which took more time than they had. In some cases the municipality

chose to continue the contracts of 2006 to make sure clients would not be left without housekeeping services.

4.3.2 The process of competitive bidding by municipalities

During the process the municipalities and the providers have experienced problems which should be avoided in a next procedure. Municipalities complain about the little time that was available and the large capacity that was needed to execute the bidding procedure. They also experienced a lack of juridical expertise and knowledge about the provision of housekeeping services. Another problem was the fear and commotion among clients for municipalities not paying much attention to the continuity of care when purchasing housekeeping services for the first time and contract only new providers instead of a mix of new and existing providers. Municipalities also experienced the financial risk they bear when contracting providers as problematic, because of the chance of contracting care that is too expensive or an unforeseen possible increase in demand by clients during the contract period, which both can lead to a negative account at the end. The financial risk has forced the inexperienced municipalities to find the optimal balance between price and quality, which was experienced as complex. The problems mentioned by providers when evaluating the bidding procedure were the following. Municipalities would have specified unrealistic high quality requirements against a too low price. Some providers may now deliver housekeeping services for a price that is below the production costs, according to other providers. It cannot be stated whether the price is below the most efficient or the current production costs. In case of the latter situation, one can state that providers may still be able to improve on efficiency, but in case of the first situation, providers might risk bankruptcy.

The procedure has demanded a large time investment from the providers, which is mostly experienced by providers that offered a bid in more than one municipality, because all municipalities may demand other specifications or requirements. The specification was not always clear and transparent. (New) providers lacked knowledge about differences (in for example production costs) between the products of housekeeping services. Uncertainty about keeping their job caused a lot of commotion among the providers' personnel. The last complaint providers had, was the fact that municipalities were allowed to change the mix of housekeeping products during the contract period (ex ante agreement) when for example a cheaper product is being indicated more often. The provider is obliged to deliver the product as indicated (for example more often a cheaper product than expected) and will therefore have a lower turnover than agreed in the contract.

Of all municipalities, 94% published the specification of what is required from the contracted providers in advance. In total, three different types of housekeeping services (HS) are specified by the municipalities. The first of all is HS1: basic housekeeping tasks by low educated caregivers ("alpha-hulp") which is specified by 97% of the total municipalities. The second type is HS2 which stands for

housekeeping tasks with some attendance for the organisation of the household. This type is specified by 78% of the total municipalities. The third type is HS3 and is meant to provide more complex attendance for a short period to households that are disrupted.

A quarter of the municipalities decided to close fixed contracts with providers. The distribution of production volume among the three products that have been contracted are as follows: HS1 27%; HS2 69% and HS3 4%. The rest of the municipalities (75%) have chosen to contract providers with a frame contract, which means that the price per product and the quality is fixed, but the production volume is not known in advance. Therefore it is still unclear which product is purchased and delivered most often at this moment during the current contract period. The selection criteria that have been used most often by municipalities are the following:

- Financial and economic stability of the provider (financial declaration of the bank);
- Quality of care (certification, existence of a complaints procedure, privacy regulations) which is specified by the following elements:
  - Provision of care within the time threshold (included by 97% of the municipalities);
  - Requirements on the patient information administration (91%);
  - Requirements on the willing to cooperate within the care chain (84%);
  - Agreements about the care provision between the provider and client are written down in a personal health file (84%);
  - Educational requirements of the executive personnel (81%);
- References or experience with providing housekeeping tasks;
- Performance and service delivery of the executive personnel (being able to speak Dutch);
- Being able to deliver all housekeeping products.

In the specification of municipalities is described how the different elements will be weighted. The price that was offered by providers has on average been weighted for 44% (varying between 10 - 70%). The offered quality of care has on average been weighted for 56% (varying between 30 – 90%). The conclusion that can be drawn from these facts is that municipalities seem to value quality in general more than price.

Some municipalities (31%) have included a maximum number of providers to be contracted, to prevent a high burden of administrative and relation management. Other municipalities decided not to include a maximum amount of provider to increase the freedom of choice of providers.

More than half of the municipalities (60%) choose to buy the housekeeping products per geographical area. The reason can be found in the fact that almost all municipalities (92%, mostly smaller municipalities) have cooperated with one or more municipalities when purchasing housekeeping services by competitive bidding. The cooperation enlarges the total geographical area, but the use of geographical submarkets creates the possibility for small providers to stick with one geographical submarket instead of the whole geographical market. Some municipalities (5%) have

also distinguished the product market into submarkets by specific client groups, such as mentally disabled clients. Specialized providers are in that case allowed to focus on their usual client group.

4.3.3 The results of competitive bidding by municipalities

On average, 10 to 16 providers have placed a bid per tendering municipality. The highest number of bidding providers in one municipality is 48. Table 4.2 shows the number of contracted providers by absolute numbers and percentages of municipalities. Of all municipalities 89% has contracted a mix of new and incumbent home-care providers. A new provider is an organisation that has not delivered any housekeeping services in that municipality before 1 January 2007. Nine percent of the municipalities have contracted only established providers and the rest of the municipalities contracted only new providers. Of the municipalities that contracted a mix of new and established providers, there is just one municipality that has contracted a cleaning company as one the two largest new providers.

Table 4.2 Percentage of municipalities contracting one or more providers

Municipalities (absolute numbers)	Municipalities (percentages)	Contracted providers
1	0%	1
2	0%	2
248	56%	3 – 5
120	27%	6 – 10
58	13%	10 – 15
14	3%	> 15

Source: Research voor beleid, 2007

The study of Research voor beleid (2007) also provided information about the sorts of contracts and contract period. Of all municipalities, 26 % has signed a contract with providers with a fixed price and production volume. The other municipalities has used frame contracts with a fixed priced but with an unknown production volume at the micro level, which depends on the choice of clients. The latter sort of contract belongs to the Zeeuws model, which is mentioned in paragraph 4.2.1. Table 4.3 shows the distribution of contract periods among municipalities.

Table 4.3 Distribution of contract periods among municipalities

Municipalities [1]	Contract period
3%	< 1 year
46%	1 to 2 years
45%	2 to 3 years
2%	> 3 years

[1] The summed percentage above is 96%, because 4% of the municipalities had not finished their contracting procedure at the time of the survey or has extended the contracts from the past contract period (regional care offices) to arrange a smooth transfer period.
Source: Research voor Beleid, 2007

The risk of losing production volume and turnover or a decreased price compared to the past years has made providers to place bids in more than one tendering municipality. Two thirds of the providers tried to compensate that loss by expanding their working area. Another reason to bid in another municipality was to grow as home-care provider by gaining more production volume. One third of the providers only focussed on their usual working area or selected only tender procedures which offered a large chance to gain production volume. Some providers mentioned in the interviews that they had made agreements about in which municipalities they would join the bidding procedure. They also made agreements with other providers about subcontracting, before placing a bid.

The competition on price (where possible) was high and resulted in prices that may be below current production costs. The prices for the different housekeeping product are on average quite the same with the tariffs in 2006. The price for one hour HS1 in 2007 ranges between €14 and €15,50 (highest price paid by one municipality is €18,50) and in 2006 the tariff for one hour HS1 was €15,20. One hour HS2 costs in 2007 between €20 and €23 (highest price paid by one municipality is €24,50) and in 2006 the regional care offices paid €24,30 per hour HS2. The municipalities are in general satisfied with these results, but the municipalities that pay a higher price compared to the price in 2006, have stated to use maximum tariffs in the next procedure to make sure they would not be paying too much. Providers have the opinion that the agreed prices are too low, because some providers offered a price below their production costs, just too make sure they would be contracted. The larger providers assume to being able to operate more efficient than smaller providers, because of substantial economies of scale. Therefore they expect the small providers will not be able to keep up with the larger providers and they may turn out to go bankrupt in the near future.

Providers have focussed on remaining their level of quality of care when lowering their price. Therefore competition among providers by improving quality has not been that large, but providers that tried to improve their quality to increase the chance of being contracted, focussed on earning a certification. New products have not been developed on a large scale, because providers had to put all their available time in the bidding procedure. The municipalities cannot conclude yet whether the level of quality has remained the same after this purchasing procedure, but they are observing the providers with the lowest prices closely.

Providers that were interviewed during the survey of Research voor beleid (2007) had the opinion that it was not possible to lower their prices more than they actually did. The low prices would eventually result in an impasse to remain or improve the quality of care, because investments cannot be done. Other providers said they are making efforts at this moment to increase the efficiency of internal processes and client centeredness within their organisation as much as possible to have a better result after the next procedure. Providers also said to improve the text of their bid and to match their offer more with the demands of the municipalities.

According to civil servants, care providers would have subcontracted in 65% of the municipalities. In 27% of the municipalities subcontracting would not be present. The reasons of providers to subcontract are that they could not cover the whole geographical area by themselves (42% of the subcontracting cases), or the provider did not have enough specific knowledge to deliver housekeeping services for a certain client group (36%). Another reason for subcontracting would be to make sure that clients were able to keep the provider they were familiar with.

The freedom of choice of clients became larger in theory, because the amount of providers that has been contracted this year has increased. In practice one may wonder if the choice for contracted providers has actually grown with the presence of such a large number (65%) of subcontracting providers. Client organisations argue that the amount of providers, clients can choose from, is not that relevant, because most clients have wished to keep their provider they are familiar with for years.

The consequences for the personnel of providers that have not been contracted anymore by municipalities are limited, because they were able to transfer their personnel to providers who did get contracted. Another solution has been subcontracting, and therefore losing providers were able to continue their provision of care to their own clients from the past, while being paid by subcontracting providers.

4.3.4 Side-effects and consequences of competitive bidding by municipalities

One important side-effect of the transfer of housekeeping services to the WMO is the shift of HS2 to HS1. The distribution of housekeeping products after indication in 2006 has been as follows: HS1: 85% and HS2: 15% (see table 4.4). Despite the indication, providers were given the freedom by the regional care offices to decide which type of HS should be delivered to a client, which resulted in another distribution of the different types of housekeeping services: HS1 was provided to 20-30% of all clients with an indication for housekeeping services and HS2 was provided to 70-80% of all clients.

Table 4.4 Difference between indicated and provided types of housekeeping services (HS)

	Indication distribution in percentages, 2006	Provision in percentages, 2006
HS1	85%	20 – 30%
HS2	15%	70 – 80%

The reason for the difference between the indication and the provision distribution may be the opinion of providers that their clients needed more specialised care than what the regional indication centres have indicated (HS1), but one may also consider the fact that providers were able to charge more to the regional care offices, than they would if providing just the indicated care.

After the transfer, municipalities became responsible for purchasing housekeeping services, they decided that providers must deliver the type of HS as indicated. This means that home-care

organisations have too many higher educated personnel who were used to provide HS2 and may be forced to fire many of their personnel, because they are overqualified and therefore too expensive to deliver HS1. On the other hand home-care organisations have too less personnel to provide more HS1 and may therefore not be able to realise enough production volume. This problem is not caused directly by competitive bidding as purchasing method but should be named as side-effect and causes the commotion among the housekeeping personnel and client groups who fear a reduction in the quality of care, when less educated personnel will take over the housekeeping tasks. This would mean a discontinuity of care and clients would loose their HS2 providers who may have delivered the housekeeping services for many years. Providers may also experience negative financial and personnel consequences.

Another side-effect is an increase in the amount of clients choosing for a PGB to make sure they can keep their housekeeper from the past (see paragraph 3.2.2.1). The providers that are not contracted by the municipalities explain to their clients that a PGB is the only way they can continue delivering housekeeping services to them. The risk of this phenomenon is that the clients may not all be capable to handle the administrative burden of a PGB. Traditional providers who encourage their clients to demand for a PGB have stated to be willing to support their clients with the associated administration.

The cooperation between municipalities and providers has become tensed since the use of competitive bidding. Existing providers may have invested in local long-term projects such as cooperating with other types of care providers to improve the total care to a specific client group, but may risk that their contract will not be continued by the municipalities. Therefore the investments are not paid back and short-term contracts may result in providers not willing to innovate. Municipalities demand from providers to create insight in their business administration. This takes a lot of time from providers, but also from municipalities who have to monitor whether their expenditures are used properly. Two other side-effects are that municipalities may have to cope with more expenditures than their available budget and providers have got a larger chance to receive more production volume when bidding in more municipalities.

4.4 Analysis of the results, problems and consequences of using competitive bidding

The results, problems and consequences of purchasing home-care by means of competitive bidding have been mentioned in the paragraphs 4.1 and 4.2 and will now be analysed using the theoretical insights gained in chapter two.

4.4.1 Is home care suitable for competitive bidding?

Table 4.5 gives insight into the suitability of the four different product markets to be purchased by competitive bidding. Paragraph 2.4.1 describes four elements the product markets should fulfil with to be suitable to be purchased by competitive bidding. Those four elements are: no urgency, ability to specify, no top-clinical care and short term care. Because the element of top-clinical care does not apply to all product markets, it is left out of the table.

Table 4.5 Suitability of the four home-care products to be purchased by competitive bidding

Suitability / Product	Urgency of receiving care	Manner of specification	Short / long term care
Housekeeping services (HS)	Acceptable waiting time is 6 weeks, HS is therefore not urgent	Fulfilled by the NZa, in policy directive CA-170	Could be both, distinction between HS in case of recovery and support for chronically disabled or elderly
Personal care & nursing (PCN)	In case of urgency the client might need care within 24 hours. In cases without urgency an acceptable waiting time is 1 week	Fulfilled by the NZa, in policy directive CA-170	Could be both, distinction between care in case of recovery and support for chronically disabled or elderly
Supportive attendance (SA) & recovery attendance (RA)	Acceptable waiting time: SA: 6 weeks RA: 1 week	Fulfilled by the NZa, in policy directive CA-170	SA is most often long term care, RA is short term (6 weeks to 6 months)
Treatment (TR)	Acceptable waiting time: 6 weeks	Fulfilled by the NZa, in policy directive CA-170	Short term (6 weeks to 6 months)

Source of the acceptable waiting time: Treekoverleg, 2000

The element of urgency only applies to the product markets personal care and nursing, when it needs to be provided within 24 hours. In situations when the general practitioner finds it necessary to start these types of home-care within 24 hours in the weekend, any (allowed) provider should be able to start to deliver the care and must be paid for it by the regional care office, whether he is contracted or not.

All types of home-care have been specified in detail by the NZa in their policy directives on performance description. These performance descriptions include the goal of the product, which activities belong to the product and which client group might be in need of this product. These activities can be seen as quality process indicators, because it clarifies what is expected from the contracted provider in advance. The activities or process indicators can be measured to monitor the contracted provider, which makes it possible in theory to purchase the relative products separately from different providers. In practice, this may not be desirable from the perspective of clients in need of more than one product, when all products are delivered by different providers. Output quality indicators are not included in the performance descriptions of the NZa and regional care offices have still not succeeded to develop a set of parameters to judge the resulting performance of contracted

providers. For example, the regional care office can measure whether the client has been given three meals a day, if necessary, but not if the amount of clients that is underfed has reduced in the last contract period.

The fourth condition of suitability is short or long term care. Time limited or short term care, such as recovery attendance, may be suitable to purchase by competitive bidding, because the continuity of care will probably not be disrupted when the purchaser decides to switch to another provider after a contract period. Most products of home-care are delivered in both situations. The distribution of client's needs for long and short term care is unknown, but it will not be desirable to distinguish all products into long term and short term sub-products and use different purchasing methods for long and short term types of care. Therefore it is recommended to sign contracts for a longer period than one year when using competitive bidding to extend the continuity of long-term care to chronically ill clients to make sure they do not have to switch from provider after each contract year.

4.4.2 Are all stages mentioned in the literature usually included in the processes of competitive bidding?

In this paragraph will be described whether the municipalities and the regional care offices have fulfilled all five stages described by McCombs and Christianson, which are the following:

- Specification of units and services;
- Selection of winning bidders (compared with the criteria of Doran and Pickard, 2002);
- Determination of reimbursement of winning bidders;
- Treatment of losing bidders;
- Contract enforcement and administration.

The specification for home-care is per episode or time period, because the tariffs for all functions are defined and paid for per hour. The production volume is also described in total hours a provider has to deliver. Regional care offices have to use maximum tariffs per hour, but municipalities have varying policies: some use fixed prices, some use maximum tariffs and some municipalities did not have a policy on tariffs.

Almost all regional care offices have selected multiple winners, which is positive seen from a liberalised perspective, because that may increase competition when the chance of being contracted is higher. Doran and Pickard (2002) have created a list of selection criteria that should be used by purchasers when selecting providers that have placed a bid. These selection criteria are divided into four themes, namely:

- Service requirements (accessibility, continuity, client centeredness, timelines);
- Work process (internal communication, cooperation in a community care chain);
- Accountability framework (internal structures, registration, insurance, client satisfaction);

- Human resource management (educational level of personnel, working conditions)

Paragraph 4.1.2 describes the selection procedure that has been followed by regional care offices. The regional care offices first used four inclusion criteria to select the providers (quality indicators by law, quality system, client satisfaction activities and administrative performance). Secondly, they used judgement criteria to score the selected providers to create a ranking order of best scoring to least scoring providers which is used when awarding contracts and production volume. These three inclusion criteria are in conformity with the themes of Doran and Pickard, but this cannot be said about the judgement criteria. The judgement criteria vary largely among regional care offices, which is the reason why one cannot conclude whether they fulfil with the selection criteria of Doran and Pickard. Regional care offices will therefore be recommended to pay attention to the judgment criteria they use and this may be an element that should be clarified by ZN or the NZa to make sure all regional care offices use the same transparent and necessary criteria.

Paragraph 4.3.1 has given a description of the selection criteria that most municipalities have used. The division into themes by Doran and Pickard has been done in a different manner, but the mostly used selection criteria by municipalities all fit into one of those four themes. For example the requirement of municipalities of being financial and economical stability of the provider fits into the accountability framework of Doran and Pickard.

The manner of reimbursing the winning providers is determined by the discriminative rule (see paragraph 2.3.2.3) for all types of home-care. The contracted providers will be offered a contract with the price of their own bid by municipalities and regional care offices.

Losing bidders are not offered a contract by regional care offices and municipalities as McCombs and Christianson (1987) proposed (see paragraph 2.3.2.4). But one can wonder if existing providers can actually lose after a bidding procedure for the AWBZ, because 90% of their production volume in the past is guaranteed on average. Therefore existing providers can lose at maximum 10% of the production volume of the last contract period, which will not lead to bankruptcy. The WMO has changed a lot for existing providers, because incumbents could now lose their complete production volume for housekeeping services, which also has occurred. These losing providers had to transfer their personnel to winning providers and caused a lot of tumult.

Doran and Pickard (2002) have described four elements that should be included when following the bidding process, when speaking about contract enforcement and administration. These four elements are monitoring:

- The indication of the need for care and the registration;
- Service delivery;
- Complaints, incidents or occurrences;
- Client satisfaction.

The regional care offices do fulfil with those four elements. The indication is being designed by the CIZ and providers are being checked on the presence of an indication when providing home-care to

clients, the registration of their service delivery and charging behaviour. They also demand providers to execute a client satisfaction survey and register complaints and incidences from clients and use this information in the bidding procedure. In the case of the municipalities, one cannot conclude at this moment that the monitoring process is complete and fulfilled with the four elements mentioned above, because it is too early in their starting year. But three of the four elements are already monitored except service delivery.

4.4.3 Presence of the necessary skills of current purchasers

The obligation to contract all allowed providers has gone for the regional care offices since September 2004. This forces the regional care offices to determine which mix of products have to be purchased to fulfil with their duty to provide enough care to their regional insureds. Some experience and negotiation skills with purchasing home-care have been developed, but the client population has a large diversity, the home-care they need is not quite homogenous and sometimes complex. The existence of waiting lists for some specific products makes one doubt whether the purchased supply or existing capacity is enough to answer the demand for home-care. Therefore the conclusion can be drawn that regional care offices should pay more attention to matching their purchasing policy with the needs and demands of their citizens.

The municipalities already had some experience with purchasing wheel chairs and other material aids to support disabled citizens, but they did not have any experience with purchasing basic care products such as housekeeping services and they did not have any insight in the market and its existing providers. This explains the large amount of municipalities that hired a professional to get some knowledge or advice about for example the juridical process. The municipalities should consider learning from their advisors to become capable of executing the purchasing process by them. The study of Research voor beleid (2007) mentioned that some municipalities could not explain why certain decisions have been made during the competitive bidding process. Being responsible to provide enough home-care for the citizens in need, requires knowledge of what is happening in the field. Consulting professionals to purchase home-care is appropriate, but there should be some kind of cooperation between the municipalities and the consultant during the purchasing process.

4.4.4 Are the critical factors of success fulfilled?

The four critical factors of success of purchasing care services by competitive bidding that were summed by the NZa (10-2006) are the following:

- Equality of information;
- Equal conditions to bid;
- The product or service to be contracted is clear;
- The product or service to be contracted should be provided in following contract period.

In their judgement, the NZa (11-2006) has concluded that all regional care offices do fulfil with the first two factors when purchasing home-care in 2005, except for one regional care office which had a purchasing policy that might not treat all participating bidders in the same way, but it had not limited new providers to enter that geographical market. All other would have treated all bidding providers the same way, but at the same time the sub-regional providers have complained about a difficult entrance to bid in another region than the region of their establishment. ZN has stated to demand the regional care offices stringently to release the possible restrictions to sub-regional providers. The third critical factor of success has already been described in paragraph 4.4.2 and will therefore not be paid attention to. The last critical factor of success is formally not quite fulfilled, because the contracting procedure is completed by 1 March of each contract year. The providers therefore provide care before the contract has officially been signed and checked by the NZa, but this will not cause a risk of budget loss, because of the budget guarantee and providers have still the rest of the contract year to limit their provision of services if their production volume would have been decreased.

Six percent of the municipalities did not specify the tender subject exactly, which caused the fact that providers did not have all necessary information to place their bid in time. The contracting part of the procedure was still not completed in 12% of the municipalities by the end of March of 2007, which is also formally not correct. These municipalities are being recommended to start the next bidding process earlier in time. It has not caused any difficulties this first contract year, because almost all municipalities made an exception by continuing the existing contracts to guarantee the provision of care in the first months of the current contract period.

4.4.5 *Is the level of competition among providers sufficient during the bidding process?*

In the current market for home-care financed by the AWBZ, there are several entry barriers which are mentioned in detail in paragraph 3.2.1.4. There has been made a distinction between economic and legal entry barriers. Present economic entry barriers could be the starting investments such as cars and an office, the absence of a well-known name for new entrants and the fact that regional care offices guarantee more than 90% of the production volume to incumbents. Legal barriers that have been experienced by new entrants are the long duration of the market allowance procedure of the Ministry of VWS and the monopsonistic purchasing position of the regional care office. For reasons of those existing entry barriers one may conclude that new entrants are not being stimulated to enter the market for home-care in kind, which is not a good development for the competition on the market for AWBZ home-care. The concentration on the market should be according to the European Commission less than 1800 points on the Herfindahl Hirschmann Index. According to the NZa (par. 3.2.1.3), the concentration on most of the regional the home-care markets is above this threshold, meaning a lack of competition among providers. A low level of competition on the market is seen as a risk, because providers with an economic dominant position are able to behave as they wish like setting their own price. In some (less-crowded) geographical markets there are only one or two providers willing to

provide home-care and therefore contracted for reasons of scale-effects and the presence of a minimum amount of clients. More contracted providers in certain areas may not be desired when they are not able to earn more than their production costs. In more crowded areas, one may say that increasing the competition among providers by stimulating new entrants to join the bidding proves would give incumbents an incentive to operate more efficient, as the NZa has stated that providers could still improve their efficiency and that the tariff is still above the production costs of providers. As already mentioned regional care offices do not bear any financial risk and therefore lack to stimulate providers to operate more efficient.

The market concentration, and with that the level of competition between home-care providers and cleaning companies, for housekeeping services financed by the WMO is not known. Entry barriers do only exist in a small matter, because new entrants may only experience a disadvantage compared to incumbents when it comes to the absence of a well-known name and starting investments. These entry barriers will not be a reason not to enter the market for housekeeping services and one can conclude that this is a positive development to increase competition on this market. Municipalities bear a financial risk and have contracted on average 3 to 5 providers, 27% of the municipalities has even contracted 6 to 10 providers. This would imply the presence of a competitive playing field. But the consequences of subcontracting must be included in this implication what may mean that the actual market share of providers (contracted or not) maybe much larger than it seems when observing contract information. Subcontracting must therefore be studied to define the absolute level of concentration on the market. Although this is not known yet, many newspapers have written about the negative consequences of the purchasing policy of municipalities have on the position of providers and clients, which also implicates an increase in the level of competition, because incumbents are forced to operate more efficient to reduce costs and remain financial stable.

4.4.6 Have the existing legal prohibitions on economic misbehaviour proven to be sufficient?

The existing legal instrument is the Competition act, executed by the NMa, which monitors all enterprises in the Netherlands, including home-care providers. The Competition act prevents providers to merge when the result would be an economic dominant position leading to the ability to set their own prices. The NMa monitors the markets closely and have not yet had to sanction misbehaving providers. The Competition act does not apply to regional care offices, because they are not seen as enterprises with economic activities. The advice of ZN to regional care offices to guarantee a large amount of the production volume to incumbents is therefore allowed and cannot be judged as economic misbehaviour. This may be different when health insurers take over the task of regional care offices, if the advice is interpreted as collusion by the NMa, because the Competition act does apply to private health insurers.

Chapter 5 Concluding remarks and policy recommendations

This concluding chapter will give an answer to the initial research question and describes which problems occur in the current market for home-care that have to be solved for competitive bidding to be successful; i.e. to achieve the purchasers' goals, such as containing costs and retain or improve the level of quality of home-care. Separate conclusions will be drawn about the home-care markets financed by the AWBZ and the WMO since two types of purchasers operate in a different institutional context. Policy recommendations to (partly) solve the problems addressed in this chapter are presented in the final sections.

5.1 Research question

The initial research question, formulated in the introduction of this master thesis, is the following:

"Under which conditions is competitive bidding a useful purchasing method for home-care in the Netherlands?"

From this thesis it follows that in general competitive bidding can only be a useful purchasing method when (i) the product of care itself is suitable for such a competitive method and (ii) when purchasers have enough providers to choose from when selecting bids. These providers must not have an economic dominant position in the market, meaning that the concentration level on the supply side of the market should not be too high. The competition on the market should give an incentive to providers to reduce their production costs to lower their price while retaining or improving their level quality of care to increase their chance of being contracted or even receive additional production volume. Entry barriers should be low to reduce the advantages of incumbents and stimulate new providers to enter the market and compete with incumbents to receive production volume. But because home-care is not a perfect economic market where demand and supply immediately respond to each other and where information asymmetry about for example production costs is absent, the effects of using competitive bidding can be different than expected in advance.

5.2 Conclusion on the suitability of home-care to be purchased by competitive bidding

Before drawing conclusions on the necessary market conditions that are mentioned above, conclusions are first drawn about the suitability of the product home-care that is currently being purchased by competitive bidding. When using the term home-care, one must read home-care in kind purchased by municipalities and regional care offices. The market for home-care purchased by individual clients with a personal budget is beyond the scope of this master thesis, because individual clients do not use competitive bidding to purchase the care they need. This master thesis has shown that in general the

different home-care types in themselves are suitable to be purchased by competitive bidding, because all types are specified in detail by the NZa in their home-care policy directives, all types are not top-clinical care and almost all clients do not find themselves in an urgent situation and therefore do not need home-care within 24 hours. The clients who do need home-care within 24 hours should receive what is necessary delivered by any provider available, whether contracted or not. After 24 hours the follow-up home-care can be delivered by a contracted provider. Therefore the element of urgency in itself is not a reason to state that such home-care is by definition not suitable to be purchased by competitive bidding. A final element of suitability identified in this thesis was the element of long or short term care. Many clients need home-care for a longer period, such as elderly or chronically disabled clients. Long term care would not be quite suitable to be purchased by competitive bidding, because it may cause disruptions in the continuity of care, meaning that the clients receive the indicated home-care every contract period from another provider. There is no evidence that a disruption in the continuity of care may cause medical problems to clients, but it will not be experienced as positive by clients and it can partly be solved by extending the contract period to two to three years (see further par. 5.4.3). Although all types of home-care are specified in detail - meaning that the goals and all possible activities of the different home-care types have been described, which clarifies what is expected of the provider while delivering care to indicated clients - a well developed set of output quality indicators is still absent. This means that the types of home-care are well defined about what kind of home-care the provider should deliver (process quality indicators), but whether the provided home-care has actually resulted in for example a more stable household or an increase in the participation of clients within society cannot be measured and guaranteed (yet) by purchasers and providers. The conclusion can be drawn that the absence of output indicators results in the inability of purchasers to compare the promised level of quality with the actual delivered level of quality of contracted providers and therefore the inability to sanction contracted providers if necessary. This creates an incentive for providers to reduce their level of quality, when decreasing their production costs. If the performance of providers can be measured more accurately by output indicators, the outcome can play a larger role when purchasers have to decide which providers should be contracted and this may result in less incentives to purchasers to select the ‘best’ providers instead of the ‘cheapest’ ones.

5.3 Conclusions on fulfilling with the necessary conditions by the home-care market of the AWBZ

The home-care markets financed by the AWBZ do not yet fulfil completely with the mentioned necessary conditions to be able to state that competitive bidding is a useful purchasing method to achieve the goals of containing costs and remain or improve the level of quality of home-care. The concentration on the supply side of the market is too high, resulting in an economic dominant position for some large providers who can set their prices without having to pay attention to competitors. These dominant providers do not have to behave in a competitive way and they do not experience an

incentive to reduce their production costs, increase efficiency or compete on quality indicators, for instance improving the satisfaction level of their clients. The dominant providers cannot be neglected by regional care offices, because they are forced to contract these large provider to make enough home-care available for their regional clients. To solve this problem, the competition on the market must be increased by stimulating new providers to enter the home-care market. Three entry barriers prevent the entrance of enough new providers and a significant effect these new entrants have on the competition among present providers. These three entry barriers are:

1. The large percentage of production volume that is regionally guaranteed to incumbents.
2. The monopsonistic position of regional care offices.
3. The procedure of the Ministry of VWS of market allowance would take too long.

Ad. 1. Production guarantees for incumbents

When allocating production volume, all regional care offices guarantee their regional incumbents at least 90% of their realised production volume of the last contract period. The reason of guaranteeing this high amount of production volume to incumbents is too make sure that clients in need of long term home-care do not have to switch provider after the contract period and it can therefore be seen as guaranteeing the continuity of long term home-care. Remarkable is the fact that the regional care offices or ZN did not perform a study on what is the best way to deal with the trade-off between continuity of care (guaranteeing production volume) and the desired level of competition on the market. The amount of 90% guaranteed production volume is high and clearly decreases the level of competition on the market, because new providers cannot really compete with incumbents if they can only receive a small percentage of the total production volume that is being allocated. As mentioned in chapter three, incumbents can in fact (almost) neglect the effects of new entrants on the market. According to my opinion some disruption in the continuity of home-care is not a reason to handle such a high percentage of guaranteed production volume and decrease the level of competition on the market significantly. A necessary condition to accept a disruption in the continuity of home-care once in every two to three years is the transfer of a detailed registration of the home-care provision to an individual client to the next provider to reduce the burden on clients.

Ad. 2. Monopsonistic position regional care offices

The monopsonistic position of regional care offices does also cause an entry barrier for new entrants, because they are obliged to join the bidding process in their home region and depend completely on the purchasing policy of that regional care office to become contracted. If contracted, it has become possible to join other bidding processes in different regions since 2007. From an economic perspective this is clearly a positive development and gives an incentive to providers to extent their working area into other geographical markets. Despite the possibility to receive production volume by several regional care offices, the contracting procedure is still rather complex, because all related regional care

offices have to transfer the amount of production volume that has been agreed with the cross border provider to the regional care office of the home region of that provider. The reason for this is the fact that the NZa – in its role as supervisor of the AWBZ - accepts only one budget request form per provider. It would be much less complex if all regional care offices can contract independently any provider they select without having to communicate with the regional care office of that provider's home region and depend on the initial contract the provider has signed with the regional care offices of his home region.

Ad. 3. Administrative procedure takes too long

New entrants need permission from the Ministry of VWS to provide home-care in kind. After being allowed the provider may join the bidding process of the regional care office of his home region. The allowance procedure will take 12 weeks at maximum if all necessary information is send to the Ministry of VWS in time. Research by the NZa reveals that providers have complained that this procedure takes too long. My interview with CZ also showed that two new entrants could not be contracted as this insurer intended, because these providers did not receive their allowance in time. For this reason, the NZa should demand the Ministry of VWS to accelerate this procedure to make sure the allowance procedure in practice does not function as an entry barrier.

5.4 Conclusions on fulfilling the necessary conditions by the home-care market of the WMO

With the transfer of housekeeping services to the WMO on 1 January 2007, municipalities now bear the responsibility of making enough housekeeping services available for their citizens. Many municipalities hired external consultants, which is a positive development when lacking purchasing skills and experience. Chapter four has described that some municipalities do not know why the external consultant has made certain decisions during the procedure. This must be prevented in the following years, it is necessary for municipalities to learn from external consultants and to know which purchasing policy since they are responsible for purchasing enough housekeeping services.

The exact concentration level on the supply side of the home-care market (housekeeping services) financed by the WMO is not known, but will probably be reduced, because most municipalities have contracted three to five providers and 27% of the municipalities have even contracted six to ten providers. Another reason why one can expect the competition on the market has increased, compared to 2006 when regional care offices purchased the housekeeping services, is the fact that incumbents have protested against the purchasing policy of the municipalities, including the fact that they had to compete and share their production volume with commercial cleaning companies for the first time, since the transfer of the housekeeping services to the WMO. Apparently, entry barriers have not been that high, because nearly all municipalities have contracted new entrants. The conclusion can be drawn that municipalities have succeeded to increase the competition on the market and reduce the price for housekeeping services on average, but the impact of subcontracting is not

known which should be clarified to be able to define the current concentration on the market and draw conclusions about whether the allocation of production volume is spread enough.

Providers complain about the price that is currently being paid is too low and that some (small) providers will get bankrupt in the (near) future. To my opinion, however, this conclusion cannot be drawn yet, because it is still too soon in this first year of contracting by municipalities. After the first year, it will become clear whether those cheap providers have succeeded to reduce their production costs and seeming to have remained their level of quality. If they will succeed in providing housekeeping services for a lower price than before, they will give an even larger incentive for other providers to reduce their production costs and increase efficiency as well. As described in paragraph 5.2, conclusions about the effects on the quality of care can actually only be drawn, when the output or results of the delivered home-care can be measured. Output quality indicators are still not available and therefore it is unclear whether the level of quality of the housekeeping services has improved or has decreased now that it is being purchased by municipalities by competitive bidding.

Incumbents experience large personnel problems during this first year of being contracted by municipalities, because they are obliged to deliver the care that has been indicated. The indication changed substantially compared to the years before when they were contracted by regional care offices and were able to decide by themselves which type of housekeeping services their clients need. Much cheaper care (housekeeping services 1) has to be delivered in 2007, resulting in a loss of revenues and a large amount of too expensive overqualified personnel. Municipalities should support these providers to make sure that the continuity of care is arranged by attracting cheaper personnel to make them able to deliver housekeeping services type 1 and to replace the overqualified and more expensive personnel into functions to deliver the home-care types personal care or supportive attendance.

5.5 Policy recommendations

As the conclusions have been distinguished by purchaser and context, my policy recommendations are also distinguished by context and referred to the different purchasers.

5.5.1 AWBZ

The level of competition in the regional markets for AWBZ-financed home-care has to increase to make competitive bidding really a useful method to purchase home-care and achieve the goals of containing costs and retaining or improving the level of quality of home-care. This should be achieved by stimulating new providers to enter the market for home-care in kind, which might be realised by adapting the following policy recommendations:

- Regional care offices should perform research to find out which percentage of the total production volume should be guaranteed to incumbents to prevent negative (medical) consequences of discontinuity of long term home-care.
- The NZa should ask the Ministry of VWS to accelerate the procedure of market allowance for new entrants.
- The NZa should change their policy of accepting only one contract per provider, because it complicates the contracting procedure between regional care offices and cross border providers, it limits the transparency about market shares and prices and it decreases the independency of regional care offices to handle their own purchasing policy by having to communicate with other regional care offices about initial contracts with that cross order provider.
- When individual private health insurers indeed take over the task of regional care offices by January 2009 as intended, they should make use of the skills, experience and knowledge of regional care offices of how to purchase home-care when choosing to use competitive bidding as purchasing method. It would be an inefficient duplication if each individual private health insurer will have to develop all the necessary purchasing skills by themselves when the skills and knowledge is available at the experienced, but dismantled regional care offices.

5.5.2 WMO

The market for housekeeping services has changed substantially with the transfer of this type of home-care from the AWBZ to the WMO. Municipalities had to start using competitive bidding to purchase the housekeeping services without the knowledge about and experience with the purchasing method itself and the specific ins and outs of the market for housekeeping services. Large consequences for the incumbents can be observed, such as an increased level of competition and problems of overqualified and too less personnel to deliver the indicated housekeeping services. The focus of municipalities in the next years must be to stabilise the market and learn from the followed procedure and external consultants to become experienced purchasers of home-care, with the expectation of other types of home-care that will also be transferred from the AWBZ to the WMO. The following policy recommendations should be adapted:

- Municipalities should develop purchasing skills to be able to bear the responsibility of purchasing enough housekeeping services with a clear procedure by using the advice of an external consultant, but making decisions on their own.
- Municipalities should perform research to the exact presence of subcontracting to be able to define the current concentration on the supply side of the market and draw conclusions about whether the allocation of production volume is spread enough. Municipalities should also require information and thus transparency about the manner and presence of subcontracting when signing a contract with a selected provider.

- Municipalities should support contracted providers to attract cheaper personnel to make them able to deliver housekeeping services type 1 and to replace the overqualified and more expensive personnel into functions to deliver the home-care types personal care or supportive attendance. This is of great relevance, because many incumbents had to deal with a different policy of another purchaser resulting in the need to change their strategy to be able to deliver all housekeeping services they have contracted. Providers might not be able to deliver housekeeping services 1, which is also a problem for municipalities bearing the responsibility of making enough housekeeping services available to their citizens when the continuity of care cannot be guaranteed.

5.5.3 General recommendations

This final section contains some general recommendations that are of relevance for any purchaser of home-care in the Netherlands. Competitive bidding requires a certain level of competition and the presence of output quality indicators to be able to state that it is a useful method to purchase home-care with in the interests of clients. In addition to the policy recommendations mentioned above, the following ones should also be adapted:

- The purchasers of home-care should develop together with the representatives of providers and client organisations a set of reliable output quality indicators to be able to measure the delivered quality of care and evaluate whether the delivered level of quality equals the promised level of quality of home-care. When developing output quality indicators, one must start by defining what the goal of delivering the specified type of home-care is. For example, the goal of the home-care type supportive attendance is to support clients in the organisation of their household to delay an inpatient admission. Then, one must collect information about the number of clients with a certain indication for supportive attendance needing an intramural admission annually. With that information, a decision has to be made about what standard will be used to indicate the performance and what can be expected of the performance of contracted providers. An example of an associated output quality indicator could be that 80% of the clients having received supportive attendance did not need an inpatient admission in the last year. Purchasers will than be capable to score and evaluate the performance of the contracted providers and give an incentive to providers to retain or improve their performance while increasing efficiency.
- Purchasers should introduce the use of contracts for a longer term than one year, for example two to three years. This would bring several advantages, namely:
  - reduce the administrative burden on the purchaser and the providers;
  - improve the continuity of long term home-care to clients;
  - increase competition among participating bidders, because there is more to gain in terms of future revenues, but it may also decrease competition when losing providers have to wait for two to three years to join the bidding process again.
  - create some relation of trust between provider and purchaser, resulting in a possible incentive for

the provider not to decrease the level of quality of care and this may reduce the intensity of the monitoring process.

A condition for using longer term contracts is a stable policy context created by the national government. In situations in which a health system reform is about to be introduced, purchasers will not be able to promise production volume to contracted providers for a longer time, because purchasers may be forced to change their purchasing policy by unexpected national developments caused by the health system reform. Before introducing longer term contracts, purchasers however should perform research to the impact on the level of competition to decide how to weigh the pros and cons of longer term contracts.

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Appendix 1 Abbreviations

AWBZ:	Exceptional medical expenses Act (Algemene Wet Bijzondere Ziektekosten)
VWS:	Ministry of Health, Welfare and Sports (Volksgezondheid, Welzijn & Sport)
HS:	Housekeeping Services (Huishoudelijke verzorging)
NZa:	Dutch Healthcare Authority (Nederlandse Zorgautoriteit)
NMa:	Netherlands Competition Authority (Nederlandse Mededingingsautoriteit)
CVZ:	Health Care Insurance Board (College voor Zorgverzekeringen)
WMO:	Social support act (Wet Maatschappelijke Ondersteuning)
ZVw:	Cure insurance act (Zorgverzekeringswet)
CIZ:	Care indication centres (centrum indicatiestelling zorg)
CAK:	Central administration office
CZ:	a specific health insurance company in the Netherlands (centrale zorgverkeraars)
AZR:	Online registration system (AWBZ-brede zorgregistratie)
DBC:	Diagnosis- treatment combination (diagnose-behandel combinatie)
WTZi:	Market admission act care providers (Wet Toelating Zorginstellingen)
WMG:	Health care market structure act (Wet Marktordening Gezondheidszorg)
RVZ:	Council for Public Health and Health Care (Raad voor de volksgezondheid en zorg)
CPB:	Netherlands Bureau for Economic Policy Analysis (Centraal Planbureau)
ZN:	Dutch Association of Health Insurers (Zorgverzekeraars Nederland)

Appendix 2 Performance framework for Request for Proposals by Doran and Pickard (2002)

Theme 1 Service requirements

Variable	Operational definition
Accessibility	Ability to provide service 24 hrs. day, 7 days per week, 365 days year. Ability to provide service in different settings, including home, school, work, other residential.
Continuity and Consistency	Ability to provide a certain number of consistent RNs.
Client centeredness	Ability to provide service in relation to client needs, choice, references, culture, religion, language, autonomy.
Effectiveness	How the agency will achieve desired results or outcomes. How the agency measures client outcomes
Timeliness	Timeliness of staff in delivering service and timeliness of agency in responding to a client referral
Volume of service staff mix	Does the agency have the capacity to provide service by RNs and RPNs? Does the agency have processes to ensure that clients receive service from the right level of skilled provider? Ability to provide a specified RN/RPN ratio for the delivery of a specific volume of service.

Theme 2 Work process

Variable	Operational definition
Agency-CCAC communications	Frequency of reporting to CCAC case manager.
Record management	Ability to manage client records in a confidential and legal manner. Includes the storage, retention, and destruction of records.
Supplies and Equipment	Ability of agency to provide nursing staff with equipment necessary to carry out general duties (e.g., stethoscopes). Specification of equipment/ medical supplies CCAC will provide on rental basis.
Program partnerships	Ability of the agency to establish partnerships with the “community at large”, other service agencies.

Theme 3 Accountability framework

Variable	Operational definition
Information system	Ability to communicate technologically, hardware and software requirements. Financial structures such as billing and accounting processes.
Quality improvement	Procedures for quality monitoring and improvement, evidence-based practice, methods for achieving client outcomes.
Risk management	Identification, assessment, management and documentation of potential risks that impact client health and safety and/or agency staff.
Insurance	Professional liability/ malpractice, automobile, and/or general insurance.
Mission/ Organizational Structure	Compatibility of the provider agency mission statement with the CCAC’s mission/values. Structures delineating lines of accountability.
Client satisfaction	How the agency responds to client complaints, client satisfaction assessment; requirements regarding “occurrence reporting”.

Policies/ procedures	Evidence of structured policies and procedures for abuse, confidentiality and consent.
Workload Management	How workload and productivity standards are established.

Theme 4. Human Resource Management

Variable	Operational definition
Staff professional Standards	RN/RPN registration status with College of Nurses
Staff recruitment	Plan regarding staff recruitment and hiring. Criminal record checks, strategies for dealing with shortages
Staff professional Development	Formal continuing education, orientation for new nurses.
Staff performance Evaluation	Process for performance appraisal, frequency of appraisal, professional standards.
Staff supervision	Staff to supervisor ratio, supervisory support 24 hr. basis, access to medical advisor.
Employee satisfaction	Evidence of commitment to employee satisfaction.
Participatory Environment	Teamwork, leadership and staff participation.
HR indicators	Availability of data on staff turnover, grievances.
Employee Remuneration	Compensation policies, compensation for mileage, benefits and overtime.

Appendix 3 ***Used selection and judgement criteria by the health insurance company CZ***

Eigen verklaring landelijke selectie- en uitsluitingscriteria

Naam inschrijver :
Adres :
Postcode en woonplaats :

1) Is de instelling per 1 januari 2007 gevestigd in de regio van het zorgkantoor waarmee de overeenkomst wordt aangegaan?
Ja* nee

2) Beschikt de instelling over een formeel vereiste toelating voor de levering van AWBZ-zorg?
ja nee

3) Verklaart de instelling te voldoen en zich te houden aan de wettelijke eisen. Met name de AWBZ, de WTG, Kwaliteitswet zorginstellingen, Wet Klachtrecht Cliënten Zorgsector, Wet BIG, WGBO (indien en voor zover van toepassing), WBP, Wet medezeggenschap cliënten zorgsector, Mededingingswet. Daarnaast de Regeling jaarverslaglegging zorginstellingen en de beleidsregels AO/IC?
ja nee

4) Beschikt de instelling over een werkend kwaliteitssysteem dat de landelijk vastgestelde normen verantwoorde zorg garandeert, of is de instelling daar aantoonbaar naar op weg. Het kwaliteitssysteem is landelijk en/of internationaal erkend, gaat gepaard met een onafhankelijke toetsing, zo mogelijk leidend tot een certificaat ?
ja nee
* Omcirkelen wat van toepassing is

5) Beschikt de instelling over een adequate bedrijfsadministratie waarmee:
- Gegevens over de oplegging van de eigen bijdrage binnen 4 weken na afloop van een maand/periode kunnen worden aangeleverd bij het CAK?
- Productie-realisatiecijfers binnen de door het zorgkantoor gestelde termijn worden aangeleverd?
- In ieder geval het “bericht zorgtoewijzing” kan worden ontvangen en de berichten “melding aanvang zorg”en “bericht mutaties” kunnen worden aangeleverd bij het zorgkantoor, conform de standaarden die door het CVZ zijn vastgesteld?

ja nee

6) Stemt de instelling onvoorwaardelijk in met de in bijlage 6 opgenomen overeenkomst?
ja nee

7) Beschikt de instelling over een vastgelegd privacybeleid?
ja nee

8) Is de instelling adequaat verzekerd voor bedrijfs- en beroepsaansprakelijkheid?
ja nee

9) Is een van de onderstaande omstandigheden van toepassing?
- jegens de instelling is bij een onherroepelijk vonnis of arrest een veroordeling uitgesproken op grond van artikel 140, 177, 177a, 178, 225, 226, 227, 227a, 227b of 323a, 328ter, tweede lid, 416, 417, 417bis, 420bis, 420ter of 420quater van het Wetboek van Strafrecht van deelneming.

- de instelling verkeert in staat van faillissement of van liquidatie, de werkzaamheden zijn gestaakt, voor de instelling geldt een surseance van betaling of een akkoord of een andere vergelijkbare toestand ingevolge een soortgelijke procedure die voorkomt in de op hem van toepassing zijnde wet- of regelgeving van een lidstaat van de Europese Unie;
- jegens de instelling is een rechterlijke uitspraak met kracht van gewijsde volgens de op hem van toepassing zijnde wet- of regelgeving van een lidstaat van de Europese Unie, waarbij een delict is vastgesteld dat in strijd is met zijn beroepsgedragsregels;
- de instelling heeft in de uitoefening van zijn beroep een ernstige fout begaan, vastgesteld op een grond die het zorgkantoor aannemelijk kan maken;
- de instelling heeft niet aan zijn verplichtingen voldaan ten aanzien van de betaling van de sociale zekerheidsbijdragen overeenkomstig de wettelijke bepalingen van het land waar hij is gevestigd of van Nederland;
- de instelling heeft niet aan zijn verplichtingen voldaan ten aanzien van de betaling van zijn belastingen overeenkomstig de wettelijke bepalingen van het land waar hij is gevestigd of van Nederland;
- de instelling heeft in ernstige mate schuldig gemaakt aan valse verklaringen bij het verstrekken van de inlichtingen die voor de offerte kunnen worden verlangd, of die inlichtingen niet heeft verstrekt.

ja nee

Zo ja welke omstandigheid:……………

De instelling verklaart met de ondertekening dat hij deze verklaring naar waarheid heeft ingevuld.

Naam instelling:
Plaats : Datum:
Naam :
Handtekening :

Eigen verklaring kwaliteit, wachtlijsttoetsing, materiële controle en administratieve performance

Naam inschrijver :
Adres :
Postcode en woonplaats :

Kwaliteit

1) Welk percentage van alle in zorg zijnde cliënten valt op 1-12-2006 onder een certificaat of werkend kwaliteitssysteem?
100%* 50% of meer 25% of meer
Certificaten en verslagen van meest recente audits in kopie toevoegen.

2) Welk percentage van de in zorg zijnde extramurale cliënten (PV, VP, OBalg en AB) valt op 1-12-2006 onder een certificaat of werkend kwaliteitssysteem?
100% 50% of meer 25% of meer
Certificaten en verslagen van meest recente audits in kopie toevoegen.

3) Heeft er in de periode 1-12-2004 tot 1-12-2006 een onafhankelijk cliënt tevredenheidsonderzoek plaats gevonden dat representatief is voor hele organisatie (productmix en locaties)?
Ja nee

Zo ja, onderzoeksresultaten in kopie toevoegen.

4) Zijn de resultaten van het tevredenheidsonderzoek:
- opvraagbaar: ja nee
- gepubliceerd op de website: ja nee
* Omcirkelen wat van toepassing is

5) Is er een schriftelijk oordeel van de cliëntenraad over het kwaliteitsjaarverslag?
Ja nee
Zo ja, schriftelijk oordeel in kopie toevoegen.

Wachtlijsttoetsing

1) Meldt de aanbieder de aanvang zorg met meer dan 90% met de juiste ingangsdatum?
Ja nee

2) Meldt de aanbieder de aanvang zorg met meer dan 90% binnen drie werkdagen?
Ja nee

3) Meldt de aanbieder einde zorg met meer dan 90% met de juiste einddatum?
Ja nee

4) Meldt de aanbieder einde zorg met meer dan 90% binnen drie werkdagen?
Ja nee

Materiële controle
De antwoorden op onderstaande vragen (over materiële controle) dienen in overeenstemming te zijn met de uitkomsten van de meest recente controle van het zorgkantoor.

1) In hoeveel procent van de gevallen is er sprake van een geldige indicatie(GGZ: verwijzing door huisarts)
Percentage:………

2) In hoeveel procent van de gevallen is een getekende zorgovereenkomst afgesloten met de cliënt?
Percentage:………

3) In hoeveel procent van de gevallen is er een zorg of behandelplan aanwezig?
Percentage:………

4) In hoeveel procent van de gevallen bevat dit plan een doelstelling?
Percentage:………

5) In hoeveel procent van de gevallen bevat dit plan activiteiten gericht op het doel?
Percentage:………

6) In hoeveel procent van de gevallen zijn evaluatiemomenten gepland?
Percentage……….

7) In hoeveel procent van de gevallen is de evaluatie uitgevoerd gericht op doelstelling en bijgewerkt in zorgplan?
Percentage……….

8) In hoeveel procent van de gevallen is de evaluatie besproken met de cliënt en/of vertegenwoordiger?

Percentage……….

9) In hoeveel procent van de gevallen past de gedeclareerde zorg binnen de indicatie (of voor de functie behandeling in GGZ: in hoeveel procent van de gevallen is de gedeclareerde zorg vastgelegd in het zorgplan)?

Percentage……….

10) In hoeveel procent van de gevallen past de gedeclareerde zorg binnen de omvang van de indicatie (geldt niet voor de functie behandeling in de GGZ)?

Percentage……….

11) In hoeveel procent van de gevallen voldoet de gedeclareerde zorg aan de voorwaarden van het product/tarief?
Percentage……….

12) In hoeveel procent van de gevallen blijkt de gedeclareerde zorginzet uit het dossier?
Percentage……….

Administratieve performance

1) Sluit de nacalculeerbare productie 2005 (gemeten als prijs maal volume per prestatie) voor meer dan 98% aan bij de ingediende productie monitor over 2005?
Ja nee

2) Sluit de maandelijkse productie monitor over de eerste 6 maanden van 2006 voor wat betreft de functies PV en VP voor meer dan 98% aan bij de CAK gegevens over deze maanden (gemeten in uren)?
Ja nee niet van toepassing

3) Heeft u over de eerste 9 maanden van 2006 de maandelijkse productie monitor in meer dan 90% van de gevallen tijdig aangeleverd?
Ja nee

4) Hoe hoog is ultimo 2005 de RAK uitgedrukt in een percentage van de aanvaardbare kosten 2005?
Pecentage……….

5) Is de nacalculatie 2005 vóór 1 augustus 2006 aangeleverd bij het zorgkantoor?
Ja nee

6) Wat was het resultaat van de laatste AO/IC verklaring?
Rood oranje geel groen

Naam instelling:
Plaats : Datum
Naam :

Handtekening:

Samenwerkingsverklaring hoofdaannemer/onderaannemer

De ondergetekenden:

………………….., gevestigd te …… aan de …….., te dezen rechtsgeldig vertegenwoordigd door haar directeur, …………………………., hierna te noemen: “Hoofdaannemer”

en

de ………………………., gevestigd te ……… aan de …………, te dezen rechtsgeldig vertegenwoordigd door haar directeur, ………………………., hierna te noemen: “Onderaannemer”

overwegende dat:

- Hoofdaannemer meedingt naar de gunning van de aanbesteding van [onderwerp en Aanbestedende Dienst].
- Hoofdaannemer in het kader van voornoemde Opdracht Onderaannemer wenst in te schakelen;
- Partijen op de hoogte zijn van de eis dat Onderaannemer instemt met het bepaalde in deze verklaring;
- Partijen aldus het volgende wensen vast te leggen.

Verklaren te zijn overeengekomen als volgt:

1. Deze Overeenkomst wordt gesloten onder opschortende voorwaarde van een Overeenkomst tussen Aanbestedende Dienst (verder te noemen ‘Opdrachtgever’) en Hoofdaannemer aangaande de aanbesteding van [onderwerp aanbesteding].
2. Onderaannemer erkent het recht van Opdrachtgever om te laten toetsen of Onderaannemer daadwerkelijk voldoet aan de selectiecriteria indien en zoals door Hoofdaannemer opgegeven bij de beantwoording van het Selectieformulier.
3. Onderaannemer verplicht zich tenminste dezelfde geheimhouding te betrachten welke Hoofdaannemer aan Opdrachtgever verschuldigd is.
4. Het gestelde in deze Overeenkomst laat de eindverantwoordelijkheid van Hoofdaannemer als bedoeld in de Overeenkomst tussen Hoofdaannemer en Opdrachtgever onverlet.
5. Partijen doen over en weer afstand van het recht ontbinding van de onderhavige Overeenkomst te vorderen, zowel door middel van een buitengerechtelijke verklaring als door rechterlijke tussenkomst.
6. Indien een bepaling van deze Overeenkomst of van overeenkomsten die daarvan het gevolg zijn nietig, niet-rechtsgeldig of niet uitvoerbaar blijken te zijn, laat dit de overige bepalingen onverlet.
7. Op deze Overeenkomst is Nederlands recht van toepassing.

Aldus overeengekomen, in tweevoud opgemaakt en ondertekend:

Hoofdaannemer	**Onderaannemer**
Naam:	Naam:
Datum:	Datum:
Plaats:	Plaats: