

Good Governance in European Healthcare: **The Netherlands**

In collaboration with Henk den Uijl, NVTZ

The Good Governance Institute (GGI)



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GGI exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat – in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.



Good Governance in European Healthcare: The Netherlands

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Good Governance Institute

This report is part of a growing series of reports developed by the Good Governance Institute (GGI) that consider issues contributing to the better governance of healthcare organisations. GGI is an independent organisation working to improve governance through both direct work with individual boards and governing bodies, and by promoting better practice through broader, national programmes and studies. We run board development programmes, undertake governance reviews and support organisations develop towards authorisation.

Other recent GGI reports and board development tools have considered board assurance, patient safety, clinical audit, quality and safety of telehealth services for people with long-term conditions, diabetes services, better practice in treatment decision-making, productive diversity, the board assurance framework, integrated governance, governance between organisations and of course good governance.

GGI is committed to develop and promote the Good Governance Body of Knowledge

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Background to the piece of work

This short technical briefing paper is one of a series that GGI has produced, exploring good governance in European countries. Throughout these papers, we have been exploring:

- How healthcare organisations are governed
- What are the principles and national drivers of good governance?
- What are the pros and cons of the current governance structure?
- What are the future challenges for governance?
- How will governance adapt to the changing healthcare environment?

These essays have been produced based on GGI's own experience working with healthcare organisations, a review of existing literature, and from our conversations with key contacts.

We have become aware that governance has been developed to varying degrees between different countries, and we feel that some countries have a lot of learning and experience to share, and we wish to support and facilitate this transfer of knowledge.

Next, we wish to further explore these complexities both in the countries already reviewed, as well as, potentially, a wider group of countries, including those in Eastern Europe and Scandinavia. We will be creating a 'task and finish group' in order to collaborate with representatives from each country and work together to create an in-depth, research led paper on good governance in European healthcare. We plan to launch this at the EHMA Annual Conference in 2018.

Introduction

As elsewhere in Europe, the Netherlands is facing the challenge of ensuring effective healthcare governance in an increasingly complex environment. In the Netherlands specifically, these complexities relate to technological advances in medicine, a growing need for cost control, changes in the physician-patient relationship, and an introduction of competition, creating possible tension between competitive and collaborative activities.¹

Background to the healthcare system

The healthcare system of the Netherlands follows the 'Bismarck model', named after the Chancellor Otto von Bismarck who initiated the universal health insurance system in Germany in 1883. The model is 'based on a decentralised structure and a social insurance model with a private orientation.'² Before 2006, the system was a 'hybrid system based on social insurance, combined with a long-standing role for private insurance covering the better off.'³ In 2006 reforms took place which introduced 'three managed markets for a defined universal health insurance package, plus healthcare purchasing and provision.' Thus, the national government took a step back from direct control of volumes and prices, and took on more of a supervisory role over the markets.⁴ A single mandatory insurance scheme now covers all residents,⁵ with four insurer groups having 90% of the market,⁶ and there is competition between insurers for providers, and between hospitals for patients. However, the OECD has argued that in reality, although the government provides a website to help patients make healthcare choices, 'opportunities to make choices during the care process are limited, as is the extent to which patients exercise their notional choice.'⁷

In the Netherlands, around 95% of hospitals are private not-for-profit organisations operated by the third sector, but due to their functions consider themselves 'enterprises with a public purpose'. While commissioning of healthcare is done by the insurance companies, oversight of governance lies with the third sector organisations.

Current governance structures

Dutch hospitals are governed by a two-tiered board, consisting of an Executive Board and a Supervisory Board, both of whom have a Chair. The Executive Board is responsible for the day-to-day management of the hospital, and usually consists of 2-3 members. An Executive Board's members are appointed and discharged by the Supervisory Board, and with a few exceptions, there is no government intervention. Increasingly, Executive Board members are being appointed from outside the medical profession. In addition, medical staff are often involved in the appointment procedure. Medical staff are also involved in decision making, with some decisions requiring formal approval from medical staff and the employees' council, while the employees' council and clients' council have legal rights to voice their opinion.

Meanwhile, the Supervisory Board does not have oversight or involvement in the management of the hospital, but has a supervisory and advisory role and must operate 'at a distance' from the Executive Board. In addition to the appointment and discharge of Executive Board members, as mentioned above, the roles of the Supervisory Board include the supervision of the functioning of the Executive Board and its individual members, the appointment and discharge of an external accountant to the organisation, and approving specific decisions relating to, for example, the budget estimate, annual reports, property transactions, and consolidations. Supervisory Boards tend to have between 5-11 members, and meet around 6-8 times a year. Recruitment to the Supervisory Board is by co-optation, and it has been argued that membership of the Supervisory Board can often be based more upon social class rather than expertise.⁸

Hospitals in the Netherlands follow a healthcare governance code which is signed by various provider associations, including the Dutch Hospitals Association. Originally created in 2005 it has been revised several times since, and the most recent revision in January this year, by Brancheorganisaties Zorg (BoZ), is based on the following principles of good governance, with behaviours and cultures being more central than processes:

1. The principal of good care: societal legislation to operate and deliver good care to the 'client'.
2. Values and norms of governance: The Executive and Supervisory Boards must employ values which are fit for purpose to their role as a healthcare organisation.

3. Healthcare organisations should introduce conditions to ensure that stakeholders have the adequate level of influence. What is an adequate level of influence?
4. The Executive and Supervisory Boards are each responsible for the governance of healthcare organisations
5. Good governance means that the Executive Board governs the healthcare organisation, through its activities, in the context of societal needs
6. The Supervisory Board should practice accountable supervision by supervising the Executive Board with the societal purpose of the organisation in mind
7. The Executive and Supervisory Boards need to continuously develop their craftsmanship, and there is accreditation for this.

The governance code provides a regulatory framework for the functionality of the Executive Board and the Supervisory Board, and although there is no legal enforcement of the code, its impact is still significant.⁹

Hospitals are nevertheless required to explain deviance from the code, and, in the absence of a formal hierarchical relationship with the national government, hospital self-regulation is a prominent feature of healthcare governance.

Outside of the hospital setting, primary care and general practice are traditionally seen as the 'gatekeeper' to healthcare, as hospital services can only be accessed upon referral from a GP.¹⁰ Meanwhile, as elsewhere in Europe, the Netherlands is currently pushing to integrate health and social care services. At the pioneer sites of this work, new governance structures are being implemented to encourage and facilitate integration. For example, long term contracts between hospitals and insurers are being developed, in order to reduce income uncertainty as an increasing number of patients are treated in primary care rather than hospital based care, while bundled-payment models are providing a single payment for a range of related services. That said, these changes are being developed gradually, so as to avoid overwhelming providers with an increased risk burden.¹¹

Long term care was previously a responsibility of the government under special legislation, however, this too has now seen major decentralisation for the past few years. Long term care is now in the remit of individual localities, who each have several teams of nurses and social workers working together from different third sector organisations.

Pros and cons of the governance structure

Although the idea of independent boards is a good idea in itself, and steps are being taken to democratise these boards, there are various governance challenges surrounding the operation of Executive and Supervisory Boards in Dutch healthcare organisations.

A key criticism of governance of healthcare in the Netherlands is a 'lack of democratic legitimacy of the management and supervision of healthcare institutions.'¹² Firstly there are issues relating to the composition and role of the Supervisory Board in Dutch hospitals. As mentioned above, often social class, or social position, is a leading factor in recruiting members to the Supervisory Board, for example with mayors or local business representatives being appointed,¹³ which has resulted in poor functioning of the board in some cases.

In addition, there are concerns relating to the functioning of Supervisory Boards in general. For example, they are considered to have weak countervailing power, to not be well-informed (perhaps due to the fact that they are not appointed on expertise), and to be over-reliant on the Executive Board for information on the performance of the organisation.¹⁴ As a result, however, there has been a drive to increase the accountability and professionalization of board members, with a recent revision to the governance code stating that boards are to undergo self-assessment. This is in the context of wider attempts to democratise the Supervisory Board and ensure that it is as accountable as possible.

That being said, a fundamental question remains: who supervises the Supervisory Board?¹⁵

'How will boards deal with the democratisation of governance? Many boards are very used to looking inwardly, especially Supervisory boards or other stakeholders... The Supervisory Board is traditionally very invisible, locked up in the boardroom, and nobody ever knows they are there. Many members within an organisation never know what's in a Supervisory Board... they need to get out of the boardroom but this is a big challenge because the way of working is very entrenched and perpetuated.'

Henk den Uijl

As mentioned above, the governance code states that boards of healthcare organisations should govern paying attention to the interest wider society, with the following phrase included within the code:

'Public interests and organisational interests often run parallel. But not always. For the Supervisory Board, these public interests are part of the importance of the healthcare institution as a social enterprise.'

However, it has been argued that there may be a tension between the political elements of the public interest, and what the authorities may perceive to be public interests, and what actually does constitute public interest. As Henk den Uijl has argued, this comes down to a 'field of tension' relating to the Supervisory Board, which must operate 'not only in a multitude of interests but also in a multitude of different views of those interests.'¹⁶ Overall, it seems that there are a range of governance challenges related to the functioning of Supervisory Boards, and while steps are being taken to address these, this might not go far enough, especially given the ingrained attitudes within the boards themselves, and the difficulties involved in culture change.

'[There has been] big societal repression to our boards and a lot of suspicion around them, and [how they are] reconnecting to society and also to their organisation.'

Henk den Uijl

Furthermore, Executive Boards have also come under criticism in recent years. Remuneration of Executive Board members is often considered too generous, with a 'golden handshake' system often in place.¹⁷ Attempting to resolve the issues of excessive remuneration, the Dutch Ministry of Health has intervened in hospital self-governance, taking the position that hospital chief executives are paid using public funds and that the government is responsible for offsetting cost overruns, it has now set a maximum remuneration level for chief executives in healthcare organisations.¹⁸

The growth of competition in the Dutch healthcare system has also brought about increasing challenges to hospital governance. For example, augmented competition means an upgrading of the role of the insurers, who are taking on the role of 'regional planners'.¹⁹ Therefore, how does this impact the role of the providers? There is also an increased focus on quality measurement, with a focus on patient experience and satisfaction, public reporting, and rankings of organisations.²⁰

Alongside, the focus on quality, there is also an increased financial responsibility for boards to take on. With it being likely that large organisations may soon suffer bankruptcy, boards must ensure that they are alive to this issue. Meanwhile, despite this competition, cooperative elements still remain, for example, there is price regulation and the Ministry of Health sets the total budget for hospital care, and may also intervene if they consider that accessibility to healthcare is at risk. This hybridity has led to proposals for the development of for-profit hospital care, albeit with many restrictions and regulations. This complicated structural and regulatory environment may pose a governance challenge to healthcare organisations.²¹

The decentralisation of long term care has also brought about governance challenges. With teams coming together from different organisations, the question is raised of who leads these teams? If a healthcare practitioner is working across organisations, they cannot be working as an individual actor. Furthermore, how should those in charge of governance be accountable to both their own organisation, and the others with which they are working?

The steps towards integration will also continue to pose governance challenges, particularly within an environment of competition. For example, separate funding for providers of health care, social services, and public health is still leading to major conflicts of interest as organisations continue to work in silos.²² And, similarly to challenges being faced in the UK, it will no doubt be difficult for organisations to share accountabilities and risk as they remain to be funded separately, and singularly responsible for delivering the principles of the governance code.

How future proof is the current governance system?

Following an attempt to nationalise healthcare in the Netherlands, the country's third sector now has enormous potency in healthcare. However, with the increasing involvement of the national government in healthcare, healthcare organisations will need to be able to deal with this reality.

Clearly, despite the recent steps taken towards democratising healthcare governance in the Netherlands, there are still steps to be taken to ensure that governance, and the healthcare system as a whole, serves the Dutch population as effectively as possible. This is evidenced by the rise of new models of healthcare organisations:

'Increasingly [there are] a lot of healthcare co-operations, networks of care... mainly ignited by citizens who are dissatisfied by the healthcare provided by the third sector... the rise of these organisations form a threat but also pose as sign that something is wrong with traditional methods.'

Henk den Uijl

Perhaps most significantly, the current model of Supervisory Boards is not sustainable, and the composition and operation of Supervisory Boards needs to be reviewed, and possibly even completely reformed. By ensuring that appointments to Supervisory Board are based upon expertise rather than local prestige, this will both further the democracy and accountability of the system, whilst also ensuring that the board has the knowledge required to effectively oversee the governance of the organisation and supervise the Executive Board.

Without this happening, there may be a risk that Supervisory Boards are not able to negotiate the challenges that their organisations will face in the coming years. One of these is the growth of competition within the hybrid system, as discussed above, which includes a focus on quality measurement. While this focus on improvement of quality may well bring benefits, it is important that governors of healthcare organisations are able to adapt to a complex and adapting environment. Furthermore, they will need to possess the financial acumen to manage the risk of bankruptcy that some organisations are facing. As it stands, with Supervisory Boards being criticised for not having sufficient knowledge of the sector, and not challenging and countervailing Executive Boards effectively, organisations may struggle to rise to this challenge.

'there is a sense of urgency... nobody really has an idea as to how to do this'

Henk den Uijl

A further challenge facing the healthcare sector in the Netherlands is the number of fusions and mergers that have been taking place in the past 30-40 years. In the 1970s, the Netherlands had 250 hospitals. Now, there are only 80. Whilst this in itself will have brought about some significant governance difficulties, it also brings future challenges that organisations will need to adapt to. For example, in long term care, there are now nationwide organisations that have become so large that they are unwieldy and unable to adapt to the changing environment. Organisations such as this are now fading out, as they are too slow and old-fashioned. If the merging of organisations continues at the pace it has been in recent decades, there is a risk that they will be less likely to cope with the complex environment in which they are operating.

This complex healthcare environment also includes a drive towards integration of health and social care services. However, the current governance structures may not be the most effective in facilitating this. As mentioned above, the growth in competition, and the impact this has on governance of organisations, will be a challenge in itself. However, boards may also need to strive to be more outward looking, rather than remaining the insular boards they are often seen as at present, in order push forward progress in the integration of health and care.

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