

# Introducing performance measurement in the Dutch health care sector: joining up in a multi-actor self-regulatory system

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## **Abstract**

Medical quality assurance is traditionally dominated by specialized self-regulatory professionals, organized in scientific societies of medical specialists, medical associations, trade unions and several umbrella organizations. The Dutch case is not different. However, in the wake of a major operation to reorganize Dutch health care on a free(r)-market basis, a political and societal quest for transparency has led to an interest in the performance of medical institutions. In this context, the Netherlands Health Care Inspectorate introduced a system of performance measurement for hospitals to be used for their quality inspections, and is involved in the development of an entirely different second system for the sake of public information on the quality of hospitals. Following theory on decision making in social networks three challenges for performance measurement for hospitals are formulated, all referring to gaining authority and support from all those (public and private) bodies that already were assuring quality themselves. Central question in this paper is how these two initiatives take on these challenges. It concludes that the strategies from both seem to be each others opposites, which can be explained by the turbulence of the institutional system of the Dutch health care sector. This turbulence also threatens the effectiveness of both initiatives if their gained authority and support are seen as a given.

## **1. Introduction**

The Dutch health care sector is in reform. The Dutch government strives to move the sector to a freer market in which clients and health insurance companies have more freedoms to choose between health care services of different institutions. An important condition for this freer choice is transparency of the quality of those services. However, the Dutch health care sector historically hasn't been the best example of transparency. To improve transparency many actors have embraced performance measurement and are developing performance indicators for health care institutions. This paper reports about two of these initiatives in which the Dutch Health Care Inspectorate is involved. They both refer to performance measurement of hospitals.

We start with a brief description of the Dutch health care sector reform (section 2) and the main actors that are involved in it (section 3). After this we conceptualize the problem of introducing performance measurement in the health care sector using social network theory. This results in three challenges of introducing performance measurement in a health care sector: commit the hospitals, compare fairly and mind the (institutional)

system (section 4). In sections 5, 6, and 7 we look for the answer how the Dutch Health Care Inspectorate, consciously or not, takes on these challenges. These findings are based on desk study and 10 interviews with key players, being employees of the Inspectorate on different levels, other developers of indicators, health insurance companies, representatives of the professions and hospitals. We conclude with a reflection on the effects of the initiatives (section 8) and a brief summary (section 9)

## **2. The Dutch health care reform towards a regulated market**

The introduction of the Health Insurance Law (ZVW) on the 1<sup>st</sup> of January 2006 formally marked the reform of the Dutch health care system. This reform was accompanied by a number of invasive changes in the organization of Dutch health care and had large consequences for the positioning of health consumers, health insurers and health providers. The primary motivation for the system reform was to change the existing and supply-driven health system into a system which is receptive to the societal demand for health care. Although the expenses of health care maintained at a relatively constant level up until the year 2000, the upcoming of waiting lists for hospital care was generally seen as an important and undesirable side effect of Dutch government policy. Therefore in the new health system the central steering on health care supply was to be replaced by more decentralized steering on health care demand, mainly in the hands of the health insurers. In order to stimulate this demand driven organization in the new health system, market processes were introduced in the hospital care.

The notion of market processes in health care however is controversial. Due to a number of characteristics of the health care sector the chances of a successful development of a free health market are limited. On the one hand information asymmetry between health providers and health purchasers or consumers is a restricting factor. On the other hand the uncertainty concerning the nature, volume and effect of health care are limiting factors which can lead to undesired outcomes of free market processes (Arrow, 1963). As a consequence of these possible market deficiencies, the Dutch government decided to introduce regulated market processes in a part of the hospital care. At first the Diagnose-Treatment-Combinations (DBC) were introduced in 2005 as an instrument for transparency of the hospital care. Free pricing was introduced for a limited number of easy-to-schedule and non-emergent DBCs. Prices, volumes and quality for DBCs in this so-called “B-segment”, which now represents 20% of the total hospital production, are the outcome of negotiations between health providers and health insurers. For the remaining 80% of the hospital production, the so-called “A-segment”, prices are still set by the Dutch Healthcare Authority (NZA), a public organization for supervision on the functioning and development of health markets for consumers, health insurers and health providers. Another form of market regulation is the fixed wage-tariffs per DBC that medical specialists receive (with exception for facilitating medical specialties per 2008). Also the introduction of the obligatory basic health insurance for Dutch inhabitants has set some boundaries on market processes in the sector as health insurers cannot reject applicant for this standard insurance nor differentiate the premium for this standard health insurance based on the differences in the risk profiles of their insured. In addition the composition of the package of essential health care which is covered by this standard health insurance is determined by the Dutch Committee of Health Insurance (CVZ), a public institution responsible for the execution of the Health Insurance Law. A last and

extensive development in the regulated market is the introduction of yardstick competition for the A-segment of the hospital care per 2009. This means that also the prices of DBCs in the A-segment will be negotiated by health insurers and health providers. Condition for this free-pricing mechanism is that the average price per DBC of a hospital's total DBC-production will be compared with the average price per DBC of the total national DBC-production. When the price per DBC exceeds this national average price per DBC, hospitals themselves will have to cover for these surplus costs.

### **3. Dramatis Personae: key players in the Dutch reform**

In the Dutch Health care sector a large number of public and private organizations are involved in monitoring the medical quality in the context of the reform of the Dutch health care system. The main public actors involved are the ministry of Health, Welfare and Sport (VWS), the Netherlands Health Care Inspectorate (IGZ; from now on "Inspectorate") and the Dutch Healthcare Authority (NZA). The ministry bears responsibility for the development and quality of the Health Care sector as a whole. The medical quality assurance is delegated to the Inspectorate, which monitors the quality in health institutions and reinforces the quality norms and laws for the Dutch Health Care sector. The primary focus of the NZA is the supervision on the functioning and development of the markets for healthcare providers and insurers.

#### *Management*

A number of organizations representing managerial actors in the hospital care sector are involved in medical quality assurance as well. The Dutch Federation of University medical centers (NFU) and the Dutch Hospitals Association (NVZ) are umbrella organizations. Also the individual hospitals participate in medical quality assurance. In the first place they do by registering and communicating the necessary information; in the second place by formulating hospital standards for quality of treatment and the monitoring of operations.

#### *Professional*

In addition to the public and management actor also organizations of medical specialist are concerned with medical quality assurance. For example, the various scientific societies of medical specialists formulate guidelines for medical practice within their own specialism. In a later stage the scientific societies were consulted for the development and formulation of content related performance indicators and for the evaluation of the existing set of performance indicators which was used by the inspectorate. Also the Association of Medical Specialist (OMS) represents the interests of medical specialists in the hospital care. Both the OMS and the scientific societies for the various medical specialties organize quality visitations to monitor the quality of hospital care and construct guidelines when improvement of quality is needed.

#### *Patients, Health Insurers and Certifying organizations*

Numerous disease-related patient organizations and a number patient and consumer federations like the NPCF (Federation of Patients and Consumer Organisations in the Netherlands) and the Consumentenbond play a role in the assurance of medical quality in

the health care sector. These patient and consumer organization also got interested in the use of performance indicators which primarily focus the quality of service.

Both individual health insurers and ZN, the sector organization of health insurers contribute to the quality assurance in Dutch hospitals. Like the patient and consumer organizations health insurers make less use of strictly medical performance indicators but more on indicators for the quality of service and hospital waiting times. A difference with other organizations involved in medical quality insurance is that the performance measurement of health insurers mainly focuses on the B-segment of the hospital care in which the prices of DBCs are freely negotiable. Finally a various organizations for certification and accreditation of hospitals or specialized departments within hospitals are setting norms for the medical quality and certifying output as well as quality management systems and people. Examples of these organizations are the Dutch Institute for Accreditation Hospitals (NIAZ), the Foundation for Harmonization of Quality-evaluation (HKZ) and the Dutch Institute for Health Care Improvement (CBO).

#### **4. Three challenges of performance measurement for hospitals**

The Dutch health care reform had a need for more transparency of health providers as a consequence. Without this transparency the newly obtained freedoms of clients and health providers to choose between health care services, seem rather worthless. To improve this transparency the idea of performance measurement has gained much popularity. The idea is simple. The hospitals inform their environments (i.e. health insurance companies, clients, Inspectorate) about what they have done in the past year. This information enhances comparability of hospitals. However, implementing this simple idea could be quite complex, because medical quality assurance is traditionally dominated by specialized self-regulatory professionals, organized in scientific societies of medical specialists, medical associations, trade unions and several umbrella organizations (Schepers and Casparie, 1997). A study on performance measurement in this sector should respect this multi-actor context. That's why we have chosen a network perspective for our study. We assume that introduction of performance measurement happens in a networked context. This means that it takes shape in decision making processes in which a variety of mutual dependent actors is involved (Chisholm, 1989; Scharpf, 1997; O'Toole 1997, Koppenjan and Klijn, 2004). This variety and mutual dependencies make that a hierarchical decision concerning multiple actors is vulnerable for unforeseen effects, heavily compromising its intended effectiveness (De Bruijn and Ten Heuvelhof, 2008). Usually no single actor can dominate decision making on a hierarchical basis. So if we consider the health care sector as a network, we may assume that introduction of performance measurement for hospitals may not be the result of a decision by a single actor, but the result of a continuing interaction process between multiple actors (Cohen c.s., 1972; Crozier and Friedberg, 1980). Effectiveness in such a network is conditioned by mutual dependency and variety. The way one should respect this mutual dependency and variety depends on the characteristics of the networked system. We'll translate these notions in three challenges.

##### **1. Respecting mutual dependencies: Invite to cooperate**

Most organizations that request information to hospitals have some source of enforcement power. The Inspectorate has hierarchical power to enforce regulation on the

quality of health care, insurance companies and clients have potential market power. However, to use this power well they are strongly dependent on the willingness of hospitals to provide useful information. This provision is self-evident if the requesting organizations have insight in the ins and outs of the hospitals. This is, however, rarely the case. This makes the hospitals and the requesting organizations mutually dependent<sup>1</sup>. That's why it is necessary for outside organizations not just to request information, but to commit hospitals to the aim of providing this information. For several reasons this commitment is not guaranteed.

- The main problem is that in the health care sector knowledge on the primary process typically is hidden deep in the organizations of hospitals, even in the brains of their professionals. This makes it hard for outsiders to get to the true quality of the primary process, determined heavily by the operational decisions of professionals. Professionals typically have a lack of incentives to provide information about their processes, for this may erode their autonomous position in which they thrive well (Mintzberg, 1983, Freidson, 2001).
- Information requests often take the shape of a request form. A form always is a reduction of the complex reality of the professionals. A classic example to this is the mortality rate. A high mortality rate may be interpreted as a sign of problematic quality. One might also claim that good hospitals have higher mortality rates, for critically-ill patients may be sent to good hospitals to maximize their chances to live. If a request form simplifies such realities, the professionals may not accept the form as a representation of their work, which provides an incentive to shirk (Downs, 1967; De Bruijn, 2002).
- Information requests usually follow a chain from outside organizations through a (quality) manager to professionals. This means that the quality of information is not only dependent on the willingness of professionals to open up, but also on the manager's willingness. For these managers other incentives are apparent. Performance measurement is a potential threat (or opportunity) for the image of the hospital, which is very important in a market-like system. The potential for damage to this image is even higher if the provided information goes to the public domain.<sup>2</sup> This provides little incentive to managers to push their professionals to open up. Secondly, it is not in the interest of the manager to attract any attention to organizations with some enforcement power, either in a positive or in a negative way. This disincentive to attract attention becomes more apparent if the likeliness and potential impact of sanctions become higher. On the long run this strategy, if adopted by many hospitals, threatens the validity of performance measurements. All results might tend to the grey middle. (De Bruijn, 2002)

The challenge is to commit both managers and professionals of hospitals to the performance measurement system.

## 2. Respecting variety: Compare fairly

<sup>1</sup> Compare with the relation between 'principals' and 'agents' as described by institutional economists; in which a principal has formal authority over the agent and the agent has better access to information resources (e.g. Jensen and Meckling, 1976 ;Waterman and Meier, 1998)

<sup>2</sup> De Bruijn calls this the "Law of diminishing effects": the relation between the consequences for bad performance figures and the validity of the results has an optimum (De Bruijn, 2002).

Most performance measurement systems are used to compare the quality of hospitals. However, due to the complexity of the primary process and the organization of the sector there is no consensus on the question how to measure quality. In fact, many competing quality definitions may co-exist that, in themselves, all might be legitimate. This was illustrated nicely by a Dutch article from Maarse, in which he compared two ranking lists from widely-read Dutch media ('Algemeen Dagblad' and 'Elsevier'). Both media use different methods as a basis for their lists. A high score of a hospital on the one appeared to be no guarantee for a high score on the other. In fact, the correlation was just 0.194. The graphic looked like a 'star-filled sky' (see figure 1). Quality of hospitals seems to be multiple. Therefore a variety in judgments and lists may remain.

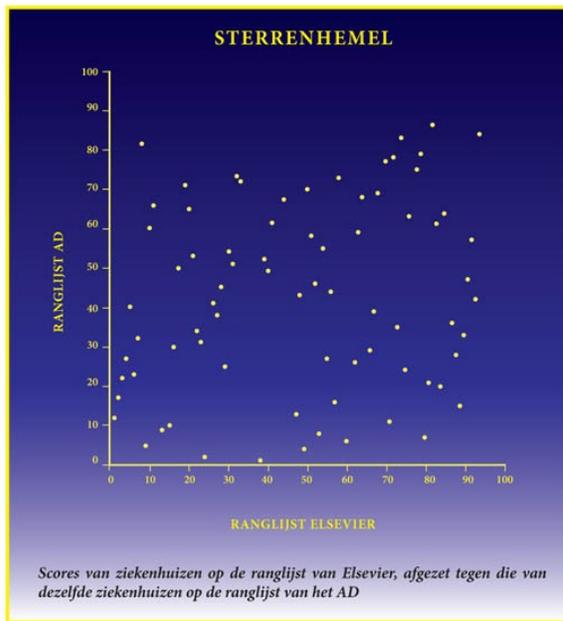


Figure 1: A 'star-filled sky' (Maarse and Van Velden, 2004)

There are more reasons why measuring quality of hospitals is a story of variety. It may be attractive for requesting organization to develop their own indicators or pose specific demands on existing indicator lists, for at least three reasons:

- *The threat of de-investment.* The different visions on measuring quality of health care already co-exist quite some time. Such visions comprise (among other aspects) of the use of indicator types and methods. Roughly three types of indicators could be distinguished. Structure indicators provide information about the organization of a health care system or the conditions that are necessary to deliver good health care. Examples are the presence of facilities and the composition of a team of specialists. Process indicators provide information about the factual use of procedures and guidelines and therefore indicate the actual health care process. Outcome-indicators provide information on the results of structure and process. The mortality rate is an example of an outcome-indicator. Requesting organizations also differ on the measuring methods they use, such as the use of independent auditing commissions, measuring frequencies, rewarding-

- and finesystems, etc. These visions don't disqualify each other. But organizations that have specialized themselves in using their own vision have just that to lose. They have invested a lot in measuring quality based on a specific vision and are not keen to give that up and connect to a different, jointly developed, vision.
- *Individual standard setting legitimizes.* A somewhat theoretical extra aim of developing indicators is the obtenance of legitimacy. Performance measurement, implicitly or explicitly, imply the setting of norms and standards. This has a legitimizing effect on the standard setter and enhances the position in their network (Schepers and Casparie, 1997; Brunsson e.a. 2000). This legitimacy may vaporize when indicators will be developed and used jointly with other actors. This might explain silent resistance against joint initiatives for performance measurement by standard setters as quality institutions, medical associations and umbrella organizations.
  - *A variety of aims.* The aims of performance measurement may vary per requesting organization. Performance measurement may add to transparency of health care, which is an important motive for client organizations to be involved in it. Performance measurement may also be a possible steering instrument. That's why the Health Care Inspectorate use it for their enforcement of health care quality regulation. And that's why health insurance companies use their indicators for the purchase of health care. A third possible aim of performance measurement is learning about quality. This aim is more popular at the hospitals and their umbrellas. A single indicator rarely suits all possible aims. For example, so called 'volume-indicators', which measures the number of times a specific medical operations has been performed per hospital, may be useful for steering ends, but not for learning.

The challenge is respecting the variety of quality definitions, measurement methods, positions and aims.

### 3. Mind the system

Given the variety of quality definitions, measurement methods, positions and aims one might expect that it is hard to formulate a single set of indicators that satisfies everybody's needs. Indeed, it provides incentives for every actor to create its own transparency. Question is whether this variety of indicators is problematic. This is a more systematic issue. A variety of indicators theoretically respects the complexity of the situation. Some redundancy might reduce the possibility of erratic measurements and might respect the interests of actors and their quality definitions (e.g. Landau, 1969). These advantages of redundancies seem to be beneficial for the public interests. But what is the cost of this redundancy? One typical backside of redundancy is efficiency (Low c.s., 2000; Womack and Jones, 1996). In this case this efficiency problem translates into the paperwork of fulfilling the requests, which comes down to the hospitals. Hospitals historically don't feel eagerness to do lots of paperwork, so complaints of hospitals for administrative burdens are predictable. Still an extensive rise of paper work could hamper efficiencies of health care considerably. The conceptual problem here is that the variety is beneficial for some actors (typically requesting organizations and clients) and costly for

others (hospitals). This possibly malfunctioning incentive structure is a more systematic problem of introducing performance measurement.

The challenge is balancing variety and uniformity.

In the following chapters we'll describe how the Inspectorate takes on these three challenges, distinguishing two initiatives in which the Inspectorate is involved.

## **5. The “Basisset Prestatieindicatoren Ziekenhuizen” (Basisset)**

From 2000 on the Inspectorate was faced with two developments. First, the reform in Dutch health care was upcoming. In the wake of this operation ‘transparency’ was gaining popularity as a value in the health care sector. From 1989 on annual meetings of hospital managers were held to improve this transparency (the so-called Leidschendam-conferences). One of the spin-offs of this initiative was the NIAZ, which is a medical quality institution that runs an accreditation system for hospitals, mainly using process indicators for their accreditations. In the years a majority of hospitals have been accredited by NIAZ. OMS and NVZ (and later NFU) started to develop a performance measurement system for internal use. Second, Dutch central government embraced ‘selective oversight’, which means that oversight priorities are set by the use of a risk analysis. Two visions by central government implied the use of selective oversight by inspectorates. The Inspectorate started to develop a performance measurement system to serve both transparency aims and for prioritizing their inspection work. Later OMS, NVZ and NFU decided to join the Inspectorate in its system. With this combination, the system could profit from support from managers and professionals backed by a potential hierarchical power of the Inspectorate.

The authors would develop performance indicators for every upcoming year, resulting in questionnaires sent to hospitals. The hospitals return the questionnaires. This information is important input for the agenda of annual inspection visits to hospitals.

The first Basisset was introduced in 2004. It was a result of continuous negotiations between the authors, supported by the knowledge of RIVM, a Dutch governmental knowledge institute. Main issues of discussion between the authors were

- The type of indicators: the Inspectorate preferred outcome indicators, the sector representatives preferred structure and process indicators. It became a mix.
- The involvement of scientific communities: especially the OMS wanted to involve the scientific communities in a structural way. This hasn't happened for the sake of a quick introduction of the Basisset. This quick introduction would give a signal to the sector that performance measurement is a new reality. That's why the authors took a 'better-done-than-perfect'- attitude for the first year.
- The accountability for publications: the questionnaires of the Basisset were sent to the hospitals with a request to fill in as carefully as possible and return to the Inspectorate. By this return the information enters the public domain. The sector representatives wouldn't take any responsibility for publications and interpretations of this information after provision by the hospitals.

Shortly after the introduction of the Basisset a critical moment in the cooperation between the authors emerged. As a result of the 'better-done-than-perfect'- motive the quality of the Basisset and the information it generated were suboptimal. This, together with the limited involvement of the profession, resulted in resistance of professionals and managers. The anger was also fed by the not very nuanced first ranking list of the *Algemeen Dagblad*, based on the information generated by the Basisset. A group of some 40 hospitals announced to refuse to send information to the next Basisset. This situation has put a lot of pressure on NVZ, NFU and OMS, for they are both authors of the Basisset and sector representatives. They tended to resign from the Basisset without further conditions that would limit the position of the Inspectorate and would ensure the involvement of the profession in the development of the indicators. In December 2005 the authors signed an agreement that acknowledged these demands. In this agreement several other 'rules of the game' can be found such as the limitation of the amount of indicators and a limitation of the amount of changes for a following year. The agreed procedures still exist and are followed until this day.

## **6. The “Programma Zorgbrede Transparantie” (Transparency Sets)**

Around 2004 performance measurement was becoming very popular. In that year ZN (an umbrella organization of health insurance companies) introduced their 'Inkoopgids' (Purchase Guide). This was important for them, for in the future an increasing amount of health care services would become subject of the free market. The Guide was meant as an instrument for prioritizing their purchasing behavior in the future. Client and consumer organizations (NPCF, Consumentenbond) developed indicators from a client perspective and several newspapers and magazines committed their own research for measuring quality.

Health insurance companies will play an important role in the future health care market. Their indicators therefore are of strategic importance for hospital managers and professionals. The OMS was keen to guarantee the involvement of the profession in the performance measurement of insurance companies. This involvement was not guaranteed by the initial Guide. Therefore the OMS initiated a pilot to develop sets of disease-specific indicators. This development happens in multidisciplinary groups, consisting of medical specialists, health insurance companies, NPCF (an umbrella organization for patients) and the CBO (an authoritative quality institute). Each developed set is authorized by scientific communities and adopted by health insurance companies. After the pilot NVZ, Consumentenbond, NFU and VNVN joined in. At least 10 sets of indicators have been developed, another 15 till 18 sets will follow this year. There is more to come in years after. Eventually an amount of 80 sets are planned to be published until 2011. On account of the Ministry of Health Care the Inspectorate founded an administrative bureau (“Bureau Zorgbrede Transparantie”) in 2007. The Inspectorate is not involved in the development of indicators or authorization. The Inspectorate is setting up a campaign to announce the coming of the Transparency lists, mainly focusing on the merits of transparency as enabler for clients and insurance companies to choose between health care services.

The development of indicator lists for “Zorgbrede Transparantie” is happening fast, but still large scale implementation is an event for the near future. Basisset, Guide and Transparency sets are still co-existing.

## **7. Two initiatives with the Inspectorate; two entirely different models**

We have formulated three challenges for performance measurement in the health care sector:

1. Invite to cooperate; Committing both managers and professionals of hospitals to the performance measurement system.
2. Compare fairly; Respecting the variety of quality definitions, measurement methods, positions and aims.
3. Mind the system; Balancing variety and uniformity as values.

In this section we compare these two initiatives in how they tackle the three challenges.

### 1. Invite to cooperate

*Basisset: Relatively hierarchical introduction* The introduction of the Basisset wasn't really an invitation to the sector to cooperate, but a rather hierarchical order. Backed by the Minister the Inspectorate introduced the Basisset quickly and directly linked it to the enforcement policy of the Inspectorate. The motive was 'better done than perfect', which implied a tradeoff between introduction time and support for the set, sometimes in favor of quick introduction.

*Transparency sets: Relatively emergent introduction* The introduction of the Transparency sets was the result of a pilot initiated by OMS, CBO and ZN. After the success of this pilot other actors, including the Inspectorate, joined in. The Inspectorate has an administrative role and has no hierarchical position regarding the content. In this role the Inspectorate doesn't impose the use of these sets to the sector. It's attraction for the sector to use these sets for their information provision is the broad support for it and the potential use of these sets by actors with market power.

*Basisset: Loose coupling scores and effects, centrally coordinated by the Inspectorate* Although the Basisset has been introduced relatively hierarchically, the Inspectorate has been rather careful with the use of the generated information. The incentives to answer information requests strategically have been mitigated by a loose coupling between information gathering and enforcement. This means that bad scores don't directly result in enforcement by the Inspectorate. The information generated by the performance measurement only served as an input of annual inspections, not as an output. This guarantees that during visits by inspectors professional inspectors and hospital managers have room to explain and interpret the information. Such a 'loose coupling' potentially mitigates the effects of bad scores and therefore doesn't scare hospitals too much to provide useful information.

*Transparency sets: Coupling scores and effects subject of dispersed decisions*

The consequences for bad scores at Transparency lists are in hands of individual clients and insurance companies. They, in future, will have more freedoms to choose for particular services in particular hospitals. The extent to which the coupling between scores and effects is loose varies per actor. The effects are not the result of a centrally coordinated policy, but a number of dispersed individual decisions by actors with different policies and perceptions.

## 2. Compare fairly

*Basisset: Limited representation of the sector*

A fair comparison between subjects of performance measurement may be guaranteed by representation of actors with important knowledge and high stakes. For the Basisset this representation has been limited. The cooperation between Inspectorate, OMS, NVZ and NFU emerged by coupling two initiatives. Other actors that could have added to the support and the content of the Basisset haven't been invited to join in. The result is that the managers and professionals are represented on the highest aggregation level (the management of umbrella organizations). Other actors (like clients and insurance companies) are not represented.

*Transparency sets: Wide representation*

For the Transparency sets a wide array of actors is represented in the development of indicators: clients, insurance companies, quality institutions, academic hospitals, general hospitals, professionals and Inspectorate. This means that a wide array of interests and quality definitions are incorporated in the process of indicator development and authorization.

*Basisset: Limited amount of aims*

As a consequence of the limited representation, a limited amount of interests has to be served by the Basisset. Main aim of the Basisset is selective oversight by the Inspectorate. All authors subscribe to this aim and the selections of indicators are made to this end. The sector representatives are involved because they value a proper development process and representation as important.

*Transparency sets: Large amount of aims*

Officially the main aim of the Transparency lists was creating transparency for clients and health insurance companies, eventually opening up the market. Transparency, however, is a broad aim. There are more unofficial (sub)aims to mention. Health care institutes may use the indicators for societal accountability ends. Health insurance companies may use the indicators for de facto steering, creating incentives for health care institutions to anticipate on indicators. And in future the Inspectorate may use the sets for their oversight tasks, instead of the Basisset. It is, however, not yet clear how this is going to happen.

## 3. Mind the system

*Basisset: Inspectorate plays a leading role*

The Inspectorate took a leading role in the introduction of the Basisset. It was the initiator. It still manages the link between the Basisset and enforcement. In this role it determines what health care process should be subject to performance measurement by the Basisset. Finally the Inspectorate is owner of the Basisset and fully accountable for the publication of the results. As a consequence, the Inspectorate is problem owner of any system-related issue caused by the (introduction of) the Basisset.

*Transparency sets: Inspectorate plays a following role*

This is not the case for the Transparency sets. The Inspectorate isn't the initiator, but joined in later on. The Inspectorate 'just' runs a secretary bureau. It is neither exclusively responsible for the content, nor for the amount of sets and indicators.

*Basisset: One integral set*

The Basisset is 'just' one limited set that implies one information request per year. However, the Basisset was also one of the first centrally coordinated indicator sets and as such an easy set to accuse for bringing more administrative workload. Some argue that this is only temporarily, because the hospitals have to switch their information systems to output-oriented information provision. Now many other performance measurement systems have come along, it is hard to tell whether the workload for the Basisset is or will be decreasing.

*Transparency sets: Many specific sets*

The Transparency sets include an increasing amount of disease-specific indicator sets. The growing amount of sets implicates an administrative workload for hospitals to come. The potential of the Transparency sets is the consensus among actors and their willingness to use just these indicators and not others. This serves both comparability and a potential mitigation of workload.

Table 1 summarizes the main characteristics of the two performance measurement initiatives.

Challenge	Aspect	Basisset	Transparency set
Invite to cooperate	Introduction	By hierarchy; 'top down'	Emergent; 'bottom up'
	Coupling results and consequences	Loose; centrally coordinated	Subject of dispersed decisions
Compare fairly	Representation	Limited	Wide
	Amount of aims	Limited	Large
Mind the system	Role Inspectorate	Leading	Following
	Amount of sets	One integral set	Many specific sets

At a glance the two initiatives seem almost, but not entirely, each others opposites. The differences are striking. Are these differences the result of conscious strategies by the Inspectorate? Our suggestion is that this is just partly the case. Many vital choices behind

the Basisset are not conscious strategies made in a vacuum, but the result of a roaring introduction period and heavily determined by the conditions at the moment of introduction. For example, the relatively hierarchical introduction was possible because this was done in a period wherein a political and societal demand for transparency (caused by the upcoming reform) hadn't been met by substantial well-worked out initiatives. The willingness of NVZ, NFU and OMS to cooperate also helped, for the hierarchical introduction could be combined with (at least formal) support. Other characteristics, like the involvement of scientific communities in indicator development, seemed not so much a choice, but an outcome of an interaction process between the authors after the little crisis in 2005.

The Transparency sets are introduced in a period of abundance of performance measurement initiatives. This explains the need for support and quality assurance. This need is hard to satisfy in a hierarchical way. It results in choices for a large amount of representatives, aims and quality definitions.

## **8. Discussion: a continuous challenge**

The two initiatives took the three challenges of performance measurement for hospitals differently. But do they adequately? At this moment, this is hard to determine. The Basisset has its fifth anniversary and the Transparency sets have hardly seen the light of day. However, based on the interviews we can formulate three potential threats for the future, inherent to the dynamic nature of decision making in networks. This implies that taking the three challenges isn't a matter of a single choice on a moment in time, but a continuous adaptation to changing conditions.

### *Loose coupling as intended, but hardened by media*

The coupling between scores and effects of the Basisset is intended to be loose. It is, however, hardened by publications in the media. The *Algemeen Dagblad* publishes a ranking list on an annual basis, based on the Basisset. Although their methods and outcomes are contested continuously, these ranking lists are known by a broad public and form important references for mutual discussions between hospital managers. As a consequence, a bad score potentially results in considerable image damage of the hospital, which makes it harder to invite the hospitals to commit to the Basisset. It is still unknown whether this is also an issue for the Transparency sets, for most indicators haven't been published yet. One can say it is rather unattractive for national media to publish ranking lists based on the Transparency sets, for these sets are disease-specific. A broader public may be found for aggregated lists of hospitals. It is easier to base such lists on aggregated information like generated by the Basisset.

### *Restraint in the amount of indicators feeds need for exclusivity*

The Transparency set respects a wide variety of interests, quality definitions and aims. This, however, has its price. A logical consequence is the huge potential amount of indicators. To limit the workload for hospitals, important for their commitment, some restraint is needed in the amount of indicators per set. Restraint implies compromising on just these interests and aims, making each set suboptimal for all involved authors. This involves some discipline from actors to use the indicators from the set, for there are

incentives to formulate exclusive, optimal, indicators. The more actors are involved, the higher the chance that not all of them will afford that discipline in the long run. This could feed the workload for hospitals and decrease the commitment power of the Transparency sets.

*No consensus about the nature of the overload problem and system responsibility*

There is little consensus about the administrative workload for hospitals. One agrees that it has increased. Some state that this is inherent to performance measurement. Others blame a lack of coordination between requesting organizations. A third considers the increase of workload as temporarily, a result of a switch for hospitals to adapt their quality systems to performance measurement. This adds to the question whether there is a problem to tackle. It is hard to determine future trends in workload. A further question is who must tackle this potential problem. Changing an incentive structure, so that the same actors that profit from the variety of indicators also bear the costs, typically is the task of an organization with system responsibility. In the current transition period of the reform it is hard to point out who this should be. The Inspectorate is responsible for the Basisset, but not for other initiatives, including the Transparency sets. Alternative candidates are the NZA as the market authority or the Ministry of Health Care as the initiator of the reform. It is doubtful whether they will initiate far-reaching actions, for the philosophy after the reform implies reluctance of governmental action in favor of the free market. And, added to this, it is questionable whether this problem is conditional for the functioning of the market or the result of it.

## **9. Conclusion**

A major reform of the Dutch health care sector in favor of a freer market has led to a need for more transparency of health care institutions. The Dutch answer to this need was introducing performance measurement. In the Netherlands the Health Care Inspectorate has been involved in two entirely different initiatives for performance measurement for hospitals. The “Basisset Prestatieindicatoren Ziekenhuizen” was a pioneer between several other performance measurement initiatives. It was introduced relatively hierarchically with limited representation, aims and indicators. Hospitals are seduced (if not forced) to cooperate by a coupling with the enforcement tasks of the Inspectorate. The quality of the indicators is ensured by involvement of scientific communities. The recently initiated “Programma Zorgbrede Transparantie” is a bottom-up-initiative providing multiple disease-specific indicator sets, supported by a wide variety of actors and satisfying many aims. A reason for hospitals to cooperate is the future market power of the clients and insurance companies that are involved in developing the set. The quality of indicators is ensured by a development process involving scientific communities, clients, insurance companies and quality institutions.

The rise of performance measurement has led to an increase of workload for hospitals. A potential problem is that there seem to be no natural incentives to mitigate this increase, because those that profit from a variety of different information requests to hospitals don't bear the costs of it. There is no consensus on the question whether the administrative workload is enduring and worth solving and, if so, who should solve this. A further future research topic could be the trends in the quality of the information provided by the hospitals. In this paper, this quality has been presented as a function of

commitment power of the performance measurement system. This commitment power is, however, not only the result of a purposeful strategy of the Inspectorate, but also of the way the environment reacts on the performance measurement system. Especially the media is, in times of increasing market power of clients, a threatening factor, for their interpretations of results of performance measurement are widely read, which potentially leaves hospitals reluctant to show the back of their tongues.

## References

- Bruijn, H. de (2002) *Managing Performance in the Public Sector*, London: Routledge
- Bruijn, H. de and E. ten Heuvelhof (2008) *Management in Networks; On Multi-actor Decision Making*, London: Routledge
- Brunsson, N., B. Jacobsson and Associates (2000) *A World of Standards*, Oxford: Oxford Press
- Chisholm, D. (1989) *Coordination without Hierarchy*, Berkeley: University of California Press
- Cohen, M.D., J.G. March and J.P. Olsen (1972) A Garbage Can Model Of Organizational Choice; in *Administrative Science Quarterly*, 17: 1-25
- Crozier, N. and E. Friedberg (1980), *Actors and Systems*, Chicago: University of Chicago Press
- Downs, A (1967) *Inside Bureaucracy*, Boston: Little, Brown
- Freidson, E. (2001) *Professionalism; The Third Logic*, Cambridge UK: Polity
- Jensen, M.C. and W.H. Meckling. (1976) Theory of the Firm: Managerial Behavior, Agency Costs and Ownership Structure; in *Journal of Financial Economics*, 3 (4): 305-360
- Koppenjan, J.F.M. and E.H. Klijn (2004) *Managing Uncertainties in Networks*, London: Routledge
- Landau, M. (1969) Redundancy, Rationality, and the Problem of Duplication and Overlap; in *Public Administration Review*, 29: 346-368
- Low, B., E. Ostrom, C. Simon, and J. Wilson. (2000) Redundancy and Diversity in Governing and Managing Common-Pool Resources. Bloomington, Indiana: IASCP Conference, Indiana University

Maarse, H. and M. van Velden (2004) Nutteloze Informatie; in *Medisch Contact*, 44 (in Dutch)

Mintzberg, H. (1983) *Structure in Fives: Designing Effective Organizations*, Englewood Cliffs: Prentice Hall

O'Toole, L.J. (1997) Treating Networks Seriously: Practical and Research-based Agendas in Public Administration; in *Public Administration Review*, 44

Scharpf, F.W. (1978) Interorganizational policy studies; Issues, concepts and perspectives; in: Hanf K. & Scharpf, F.W. (eds.) *Interorganisational Policy Making. Limits to Coordination and Central Control*, Beverly Hills: Sage, p. 345-370.

Schepers, R. and A. Casparie (2000) Continuity or Discontinuity in the Self-regulation of the Belgian and Dutch Medical Professions; in *Sociology of Health and Illness*, 19 (5)

Waterman, R.W. and K.J. Meier. (1998) Principal-Agent Models: An Expansion? In *Journal of Public Administration and Theory*, 8 (2): 173-202

Womack, J. and D.T. Jones. (1997) *Lean Thinking: Banish Waste and Create Wealth in Your Corporation*, New York: Simon and Schuster