The current issue and full text archive of this journal is available at
www.emeraldinsight.com/1477-7266.htm

Strategic behaviour of institutional providers in mental handicapped care in The Netherlands

Willem H. Van Harten
Netherlands Cancer Institute – Antoni van Leeuwenhoek Hospital, Amsterdam, The Netherlands
Marleen J.M. Veldhuis
University of Twente, Enschede, The Netherlands
Bernhard H. Hoeksma
Hoeksma, Homans & Menting, Enschede, The Netherlands, and
Koos J. Krabbendam
University of Twente, Enschede, The Netherlands

Abstract

Purpose – The purpose of this paper is to describe an inventory of the strategic responses of institutional providers of mental handicapped care to the strengthening of consumer choice through a personal care budget (PCB)

Design/methodology/approach – Semi structured interviews were conducted among 26 providers covering 52 per cent of the total market volume of about 100,000 clients annually.

Findings – A representative number of providers was included; on average a percentage below the national average of PCB users was found to be served. Of the 26 providers, 16 indicated adaption to their strategy in response to expected consumer empowerment. The actual deployment of this response in the organisations seemed not to be very thorough or explicit. Surprisingly, as a growing part of PCB-clients choose alternative providers, no concerns were raised concerning the possible emergence of new service providers.

Originality/value – Although the market share of PCB users is growing fast and existing providers do not seem to absorb this accordingly, a lack of market analysis and strategic behaviour of the traditional providers in response to this development was found. Based on this research growth of market shares of disruptive service providers can very well be anticipated.

Keywords Health services, Organizations, Non-profit organizations, Mentally handicapped people, Budgets, The Netherlands

Paper type Research paper

Journal of Health Organization and Management
Vol. 21 No. 2, 2007
pp. 184-193
© Emerald Group Publishing Limited
1477-7266
DOI 10.1108/14777260710736868

Introduction

In many countries strengthening the position of the patient, often also described as client or consumer, is an important driver for change in healthcare. This objective can be pursued by legislation on patient right and -councils, structuring of complaints-filing and other juridical aspects of the treatment relationship. Also in the financial system changes can be observed that are related to this development, such as diagnosis-related reward systems and case related budgets that can be decided on

المنارة للاستشارات
www.mana

by the patient. The trend of consumerism and outcome related financing is expected to continue for many years (PriceWaterhouseCoopers, 1999, 2005). Healthcare providers have to adjust their strategic behaviour to these trends in order to maintain or improve their position, but so far remarkably few studies have been published on this issue; especially case material from outside the USA and on other sectors than hospitals and nursing is scarce (Hewison, 2004). At the same time pleas for a development towards "evidence based management", both from outside and from within health care are becoming stronger. In view of this, providing insight in existing management practices can prove to be helpful.

One of the instruments that is used to improve the position of the client in healthcare is the introduction of the client-related personal care budget (PCB); depending on the condition of the patient a certain budget is provided by the insurance agency and within certain limitations the patient is free in his choice for the nature, amount and the provider of his care. In The Netherlands this was introduced in 1996 and in 2003 liberalisation-measures concerning the regulations guiding the use of these PCBs have been implemented.

In a survey covering 50 per cent of the total care volume for mentally disabled persons, an analysis was performed of the trends in PCB-use and the strategic anticipation of relevant care providers. Based on these data an analysis of these major market trends can be given as well as the challenges that especially "arrived" providers are facing.

Care of mentally disabled persons in The Netherlands

In this paper we will focus on various forms of chronic care for mentally handicapped. These are persons with an inborn or acquired reduced capacity in mental functioning, leading to a degree of disability and handicap that prevents them from adequate functioning in daily life. The care for mentally disabled in The Netherlands is regulated within the national chronic care insurance: the "Algemene Wet Bijzondere Ziektekosten" (AWBZ), in which mainly healthcare risks are covered that are considered to be "uninsurable". The institutions are financed through a fixed annual budget that partly fluctuates with the number of treated clients; care is so far mainly provided "in natura". The total number of clients that is using either residential-, day- or ambulatory care is estimated to be around 100,000; the total population in The Netherlands is around 16 millions and the annual budget of this sector was 2.8 billion Euro in 1999 (Kwartel *et al.*, 2000). In recent years the number of registered – mostly institutional – providers has been reduced from 231 in 1998 to 130 in 2002 mainly as a consequence of financial constraints imposed by the government. However, their is a wide variation in size and regional presence (Ministry of Health, 2003). Recently a process of modernisation has been started with the aims to increase the freedom of choice of the clients and to reduce waiting list problems; one element of this process was to provide the choice to clients to use either a PCB or institutional care provision. Furthermore the system will be redesigned in such a way that an objective indication-system is pursued in which function-related care can be designated. If the client does not choose for a PCB, the care can be provided by the institution of his choice that will be remunerated accordingly to the responsible (AWBZ) Insurance-office in his region. A personal care budget was initially equalling the annual amount that was spent on a client for a certain indication without the fixed costs for housing and investments. However, specific homecare

المنارة للاستشارات
www.mana

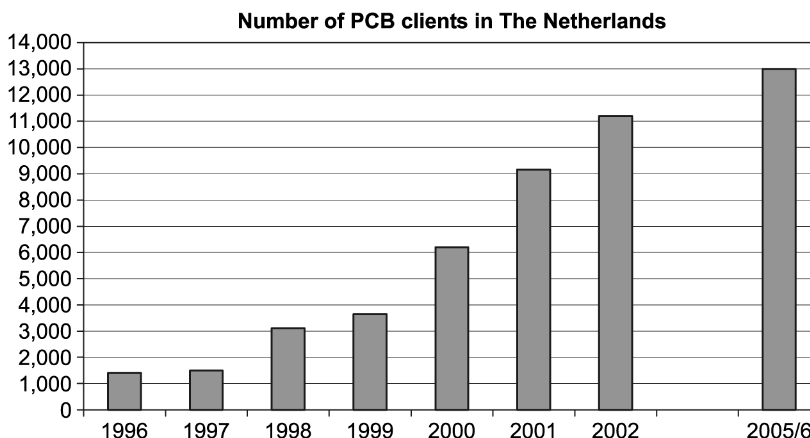
adaptations can be applied for by the municipal authorities. Examples of care provision through the PCB are employing a mix of formal an informal providers in someone's private home or renting a house for a limited number of clients and employing a (custodian/care) couple to provide almost continuous services. In practice parents or relatives seem to be able to creatively extend the services to a competitive level in a very efficient way. Clients that were interviewed in preparation of this research indicate that they expected an increase in "shopping" behaviour and saw adequate and comprehensive service information as crucial in the decision of clients to choose for and appropriate use of the PCB.

The PCB was initially introduced in a rather bureaucratic way, because there were doubts concerning the ability of clients/parents or relatives to use the funds in an appropriate way. After evaluation the system has been simplified in recent years and the client and his relations have obtained relatively great freedom in spending. Due to cost control measures, budget cuts were deemed necessary and related regulation is foreseen in 2005 but those were not taken into account in this paper.

The number of clients (or their parents) using the PCB has risen almost ten-fold in six years, from 1,400 after introduction in 1996 to 11,197 in 2002.

This means that in six years the number of mentally disabled clients served through a PCB arrangement has risen to over 10 per cent. Although no figures are available on case mix, it can be presumed that, especially initially, simpler cases are opting for PCB-use. The figures over 2003 and 2004 are not conclusively available as different agencies became responsible for various aspects of the PCB-regulations and the data were split over two registries. On request of the government an estimate calculated by Hoeksma *et al.* led to 12,528 in 2005 and 13,000 in 2006, indicating a more gradual increase in recent years (Figure 1).

As mentioned, PCB-users are not obliged to purchase their care from the existing providers. At the moment of starting the study there were no comprehensive data available concerning the alternative purchasing behaviour of PCB-users. Neither was any information present on the strategic responses from the traditional providers, apart from signs of continuation of the existing scaling process.



Source: Ministry of Health (2003)

Figure 1.
Number of PCB-holders in mentally disabled care in The Netherlands

www.mana

In a survey covering 26 traditional institutions and 52 per cent of the total care volume for mentally disabled people, an analysis was performed of the trends in care provision of those institutions for PCB-users and the strategic choices those care providers were considering in response to this development. Based on the data an analysis of the major market trends can be given as well as the challenges that especially "arrived" providers are facing.

Strategic issues in a changing care environment

Early papers about strategic management stress that companies can have different strategies and should organize the company differently according to the chosen strategy. An influential work on strategy is from Michael Porter (1980) concerning the firm's competitive position and its value chain; he mentioned three different strategies: cost leadership, differentiation and focus, and it is generally accepted that these are equally valid in healthcare. Although with considerable delay, the issue of strategic management has also entered the area of health care management. Ginter *et al.* (2002) applied the principles developed in industry on health care organizations and published a comprehensive work about strategic management of health care organizations. Using various case-studies they argued that also in health care strategic management principles are useful for providers in successfully competing in a continuously changing environment. However, apart from the obvious case-study material there is hardly any paper covering provider-groups or sectors as a whole. Moreover, we could not find publications concerning research on strategic issues in explicit non-profit branches (like care for disabled or psychiatry), whereas strategy in home- and hospital care seems to have been more widely explored (Reeves and Ford, 2004; Kottler, 2000). This might be explained by the fact that hospital and homecare are generally more inclined towards adopting business-like management tools as a consequence of the fact that market elements and competition seem to be more easily introduced in those sectors. Using those tools influences the way the mission is translated into the organizational culture, as often a new balance between professional- and management values is necessary. Especially in traditionally non-competitive sectors that are supposed to have adopted a rather "soft" management approach, a degree of resistance towards more business-like strategies and considerable delay in diffusion of the explicit implementation of strategic management principles can be expected.

A comparable development can be seen on the issue of marketing management as a strategic tool in an increasing competitive environment. Although Kottler (2000) recently published a monograph for the non-profit sector, based on this work for business-environment, serious case study material on non-profit healthcare is scarce, let alone comparative studies dealing with responses of providers in different market circumstances. In our research we investigated the behaviour of established health care providers reacting on the introduction of the client-related Personal Care Budget (PCB). We expected that these providers would tend to define more explicit strategies in line with the threats and opportunities the system would create.

Unlike the traditional system in which health care providers receive their budget more or less directly from the government, in the PCB system health care providers depend on the behaviour of patients for their income and new entries of formal and even informal providers are possible. Patients can decide to move from one provider to

المنارة للاستشارات

www.mana

another, and can even negotiate about price and quality of the care provided. The strategy of the government with the PCB system is to stimulate providers to be more focused on the patients needs and to increase competition in the "branche". Due to the resulting increased environmental uncertainly and competitive pressure we expect that strategic management will increasingly and explicitly be part of the leadership tools in those health care organizations.

According to Ginter *et al.* (2002) health care providers have different strategic options which are on one hand related to the product-scope (portfolio) of their organization and on the other to their competitive position. Related to their portfolio, providers can try to introduce new products in their current market (product development), to enter existing products in new markets (market development), to introduce new products in new markets (diversification); furthermore try to better serve current markets with current products (penetration). The strategic options related to the competitive position are trying to be the cheapest provider (cost-leadership), trying to offer a product which is unique to the market (differentiation) or to concentrate on a special niche in the market (focus). As a consequence in a number of organizations this can lead to a policy of integration with other providers in the same supply chain (vertical integration) as well as integration with providers in a different supply chain (horizontal integration). We were interested to find out whether and to which degree health care providers are considering the different strategic options in order to react on the challenges and threats of the PCB system. In literature it was also established that there is a relationship between strategy and culture of the organization. The chosen strategy should be in line with mission, vision, values and strategic objectives. Therefore our study also focused on the organizational culture in relation to the strategy that was considered as an answer to the introduction of the PCB system.

Methods and material

Based on the earlier mentioned theories on strategic behaviour and competition forces (Kottler, 2000) a questionnaire was constructed that contained items concerning market analysis, strategic behaviour, implementation of policy, including effects on organisational culture. Examples of questions are:

(1) *Market analysis*:
- What is the number and percentage of PCB clients your organisation serves?
- Do you have information on the future demands of PCB clients?

(2) *Strategic behaviour*:
- What type of care products do you consider to develop for PCB clients?
- Do you foresee new subgroups that you want to serve as a consequence of the PCB development?

(3) *Implementation*:
- What changes do you foresee in the care process design?
- Will organisational values change as a consequence of PCB growth?

This was piloted in a semi-structured version and conducted in a face-to-face setting ($n = 11$) or by telephone interviews ($n = 15$); most responders were members of

www.man

executive management. The institutions were selected through the networks of the research group. This could cause selection bias, but a wide variation in organisational size and regional spreading was obtained. All were well established and existed for many years. Five institutions declined to participate: two due to lack of time, one because of (perceived) limited relevance of the PCB and two without giving reasons. As some very large providers were included, by including 26 responders almost 50 per cent of the financial volume of the sector in 2003 was covered. Because of the relatively low number of responders only direct counting and simple percentages were used for statistics (Veldhuis, 2003).

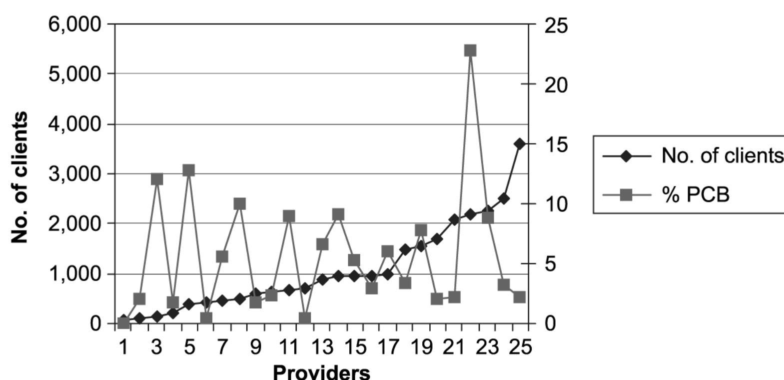
Results

There was a wide variation in budget size and number of clients per respondent; 17 organisations provided care for 0-1,000, 7 for 1,000-2,500 and 2 for 3,600 and 5,000 clients respectively. The annual budget-sizes ranged accordingly with 11 from 1-25 million €, 11 from 25-100 million € and 14 above 100 million €.

The percentage of PCB-clients showed a variation between 0 and 23 per cent and the average in the served population was 6 per cent, well below the national percentage (>10 per cent). The median, however, scored at 4.2 per cent indicating few organisations with relatively high numbers of PCB-clients; the highest scoring quartile of institutions scored between 8.9 and 22.7 per cent as shown in Figure 2.

When asked about important market developments remarkably few providers indicate to expect major changes due to the liberalisation of PCB-regulations or, as a consequence, a major growth in PCB-clients, only seven out of 26 (see Table I).

Looking at the characteristics of those organisations expecting a major increase, six of the seven have already more than 4.2 per cent PCB-clients. However, three of the four



Note: n = 26

Figure 2. Number of clients and percentage of PCB clients, per provider of mentally handicapped care

	Decline in PCB-use 0-20 per cent	Stabilisation of PCB-use	Increase in PCB-use	Major increase in PCB-use	Does not know
Number of responders	4	3	9	7	3

Table I. Expected PCB development

www.man

organisations anticipating a decline were to be found in the highest PCB-scoring quartile; no relation between present percentage and market anticipation could be established. Asked about strategic responses ten organizations responded by not having any intention to adapt their strategy; one of those had no PCB-clients so far and did not expect to develop the intent to serve any in the near future. 19 responders however expected an important positive influence on the client-orientation of their organisations.

Those organisations that indicated in general to adapt their strategy to the PCB-development (n = 16) commonly described their intentions in general terms like "improving the client orientation" or "performing through a favourable quality/cost ratio", whereas the existence of business plans with solid deadlines was not mentioned. However, if we categorize the translated responses in terms of strategic options, the following picture emerges:

(1) *Portfolio related strategy options*:
   - Product development ($n = 9$).
     Extending product range and strengthen flexible client focus.
   - Market penetration ($n = 3$).
     Focus on PCB clients through increased marketing efforts.

(2) *Competitive position related strategy options*:
   - Product differentiation ($n = 3$).
     Investing in cost-quality ratio.
   - Focussing ($n = 1$).
     Focus on quality-image.

(3) *No strategy mentioned* ($n = 10$).

Although the quality/cost ratio was mentioned a few times as a focus of the differentiation strategy, there was no proof obtained of explicit internal deployment. A few organisations ($n = 7$) were just started (or experimenting) with internal cost systems and the most frequently encountered method was "activity based costing". Benchmarking initiatives as a means to obtain objective data concerning the competitive position were not mentioned.

The responders did not refer to any form of integration tendency as a consequence of the PCB; rather it seemed that in this regard other developments are of influence on the strategic choices of organisations. Especially the problem of ageing clients and possibilities to provide homecare as another consequence of more flexible regulations leads a number of responders to consider cooperation with nursing homes, psychiatric care or homecare. However this is probably an autonomous development within the branch and as a consequence it can be stated that integration policies as a specific consequence of strategic responses to PCB introduction were not encountered.

The actual translation of the strategic choices as a consequence of external development into the organisational structure or culture was indicated to be limited to training on client-orientation ($n = 6$), creating a front (= intake) office ($n = 16$), strengthening the IT-infrastructure ($n = 2$) or investments in costing-systems ($n = 7$). However, the actual number of organisations that were starting a front office was 24; this means that eight organisations were involved in tactical policy choices related to

المنارة للاستشارات
www.mana

customer orientation without positioning this as a strategic response to the PCB development.

Apart from stressing the need for a stronger client-focus as a form of "management by speech" and organising education concerning this issue ($n = 7$) no explicit policy choices were found to influence the organisations culture in a direction that was desired by the board. In general this was considered to be the expected and implicit consequence of external system changes.

Discussion and conclusions: is there a risk of emerging disruptive service providers?

Although the percentage of PCB-users had grown to more than 10 per cent of the total client-volume in the care for mentally handicapped in The Netherlands at the time of conducting the interviews, only an average of 6 per cent per interviewed institution was found and when looking at the median score this was only 4.2 per cent. The steep rise of PCB-users in recent years, combined with further liberalisation of the AWBZ-care in The Netherlands would presumably lead to strategic concern and action by executive management, but this response was not found. Only seven out of 26 interviewed institutions expected a major increase in PCB-users and even of those with a present high percentage, some expected a decrease. However, these expectations were not based on explicit market research or benchmarking activities.

At the same time the strategic options that were chosen by 16 of the interviewed organisations did not indicate a sense of urgency by showing a thorough follow up in consistently elaborated business plans.

The general picture emerging is that institutions, providing mental-handicapped care in The Netherlands do not perform adequate market research and seem indifferent or at least passive to potential shifts in client behaviour. However, when the intended liberalisation reinforces the trend towards further PCB growth in the coming years, a more gradual increase over 15 per cent of the client-market could be possible. Thus it seems logical to state that reinforcement of the strategic management functions on executive level is necessary when organisations want to gain a competitive advantage under these market circumstances.

An important question raised by these figures is that of the development of market shares. A major part of the providers serves a remarkably low number of PCB-users; as this was so far not a very competitive market, in contrast, figures that represent general market trends among the various providers would be expected. This causes questions to be raised as to what type of providers are increasingly serving the new PCB-users. Using this as feedback on our findings, a discussion with a limited number of representatives of client-organisations revealed a much more positive view on PCB-possibilities than existed among institutional management. Although an overview does not exist, examples mentioned were the "construction" of personal care networks with freelance providers, parents joining forces to establish small scale care homes and – more recent – even the start of a small scale franchise formula for entrepreneurial couples with a background in nursing. It might thus be that new providers are entering the market with services that differ from "established" organisations in such a way that the latter find it hard to take them serious. This could mean working with a considerably reduced overhead, less educated staff and providing "lean" services strictly responding to expressed needs, including informal

المنارة للاستشارات
www.mana

aspects in the services such as neighbours and relatives, to mention a few. It seems difficult to obtain a proper view on this development as new and entrepreneurial providers do not tend to be registered and only partly follow quality legislation. It might thus be that we are witnessing the emergence of "disruptive" services, that are initially attractive for only a limited group of users, but might have surprising market potential.

Disruptive services are usually not different from a technical point of view, but have two essential characteristics. First, they present a set of performance attributes that is initially only valued by a minority of new or existing customers. Second, the improvement potential and the rate of improvement are such, that the new service can develop the potential to threaten existing market shares (especially of large established providers). Examples of disruptive innovations were the introduction of the PC and the low-price aviation companies (Christensen *et al.*, 2000). So far only a few authors have drawn attention of the potential to this "EasyJet" phenomenon for health care (Bower and Christen, 1995).

This phenomenon could be very important also in mental handicapped care, as new clients are commonly young parents with a modern, more consumer-like look on health care. As a consequence existing organisations could be surprised by the market potential of the disruptive service providers that seem already to be successful in attracting a percentage of the market of PCB-clients.

In general it can be stated that providers in the care-sector in The Netherlands tend to underestimate the potential consequences of PCB-growth. There seems to be a lack of market knowledge and explicit strategy to react on the tendency of consumer empowerment and to confront possible new providers. Further research is advised into the exact nature of strategic responses on market share developments of existing- and the nature of the services offered by those new providers.

References

Bower, J.L. and Christen, C.M. (1995), "Disruptive technologies: catching the wave", *Harvard Business Review*, January/February, pp. 43-53.

Christensen, C.M., Bohmer, R. and Kenagy, J. (2000), "Will disruptive innovations cure healthcare?", *Harvard Business Review*, September/October, pp. 102-15.

Ginter, P.M., Swayne, L.E. and Duncan, W.J. (2002), *Strategic Management of Health Care Organizations*, 4th ed., Blackwell Publishers, Oxford.

Hewison, A. (2004), "Evidence based management in the NHS: is it possible?", *J. Health Organisation Management*, Vol. 18 No. 5, pp. 336-48.

Kottler, P. (2000), *Marketing Management*, Prentice-Hall, Upper Saddle River, NJ.

Kwartel, A.J.J., Barnhard, M.C. and Vliet, C. (2000), *Care for the Disabled*, Brancherapport, The Hague, (Dutch).

Ministry of Health (2003), *Brancherapport Care*, Ministry of Health, The Hague, (Dutch).

Porter, M.E. (1980), *Competitive Strategy*, The Free Press, New York, NY.

Price Waterhouse Coopers (1999), *Health Cast*, Price Waterhouse Coopers, London.

Price Waterhouse Coopers (2005), *Health Cast*, Price Waterhouse Coopers, London.

Reeves, T.C. and Ford, E.W. (2004), "Strategic management and performance differences: non profit versus for-profit health organisations", *Health Care Management Review*, Vol. 29 No. 4, pp. 298-308.

المنارة للاستشارات

www.mana

Veldhuis, M. (2003), Inspelen of Doorspelen (Dutch), Master Thesis, University of Twente, Enschede, The Netherlands.

Further reading

Guo, K.L. (2004), "Organisational and management strategies in response to US market trends", *Journal of Health Organisation & Management*, Vol. 18 No. 5, pp. 370-9.

Pfeffer, J. and Sutton, E.W. (2006), "Evidence based management", *Harvard Business Review*, No. 1, pp. 63-73.

Wells, R., Lee, S.Y., McClure, J., Baronner, L. and Davis, L. (2004), "Strategy development in small hospitals: stakeholder management in constrained circumstances", *Health Care Management Review*, Vol. 29 No. 3, pp. 218-28.

Corresponding author

Willem H. Van Harten can be contacted at: w.v.harten@nki.nl

To purchase reprints of this article please e-mail: **reprints@emeraldinsight.com**
Or visit our web site for further details: **www.emeraldinsight.com/reprints**

المنارة للاستشارات

www.mana

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

المنارة للاستشارات

www.manaraa.com