Gupta Strategists

‘The Twilight’
Dusk or Dawn

Study of Dutch hospitals 2005

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Executive Summary

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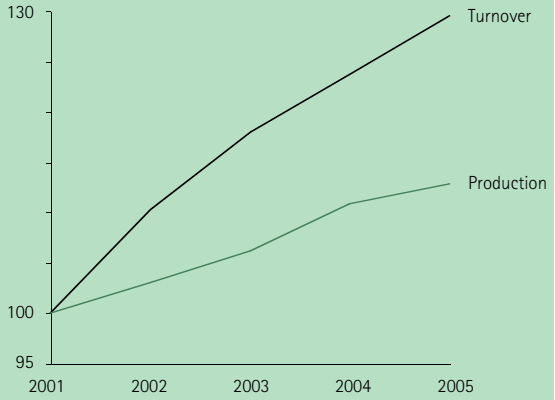
Exhibit 1.

Higher turnover per patient entity served
Turnover [2001=100] and patient entities served [2001=100]
2001-2005



Turnover increase outpaced production growth yet again
Growth of turnover and production [%]
2001-2005

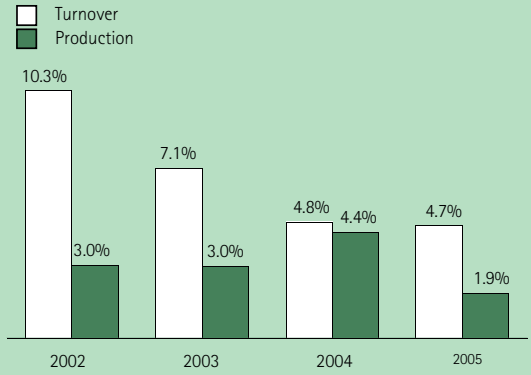
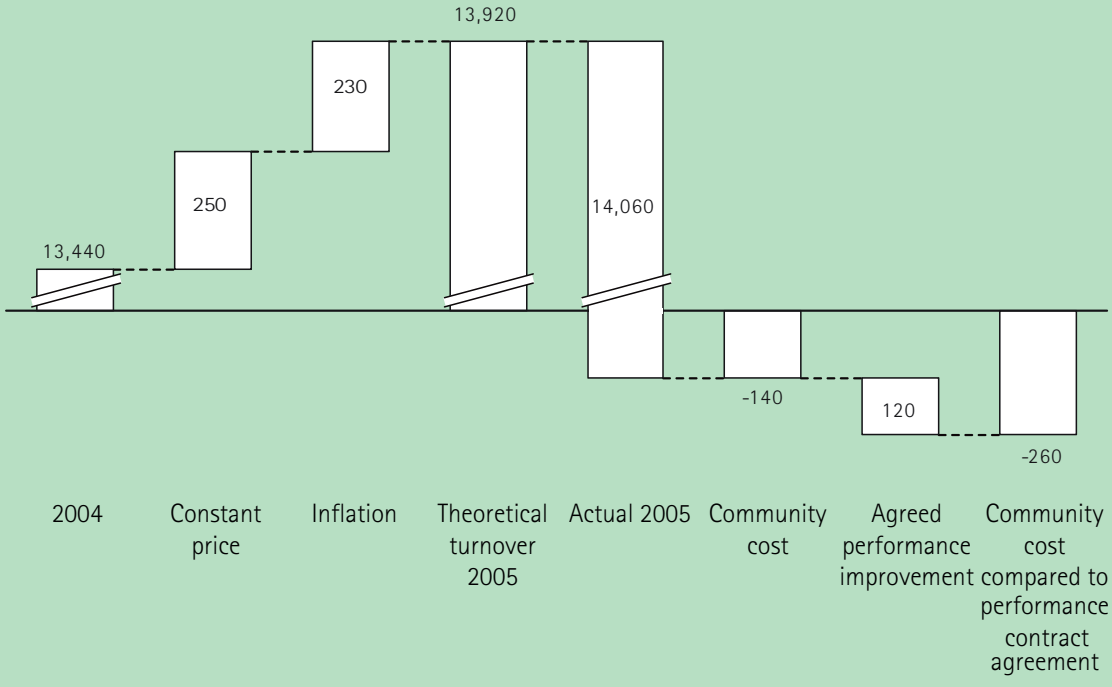


Exhibit 2.

Hospitals cost community more in 2005
Turnover development and additional cost of hospitals to the community 2004-2005 [EUR m]



Executive Summary

Dutch hospitals arrived...

Dutch hospitals arrived at a crossroads in 2005. The liberalization agenda in making over the long last decades was implemented for the first time, albeit slowly, in 2005. In this report we present the developments in Dutch hospitals in 2005. It is yet unclear if healthcare can be "trusted" to freer markets. Given the challenges of delivering high quality, constantly improving healthcare at a "fair" price for the coming decade, it is important to see how the gradual liberalization of healthcare markets in the Netherlands is developing.

... disappointingly at a crossraods in 2005

In this light, 2005 was a disappointment. Dutch hospitals might be at a crossroads. But the crossroads is also shrouded in the twilight. On some metrics, like FTE productivity, Dutch hospitals did gain slightly. But neither the overall cost productivity, nor financial health, nor market churn could be sustained in 2005. 2005 could be the dawn of a new era, but it could also be the dusk before a coming darkness.

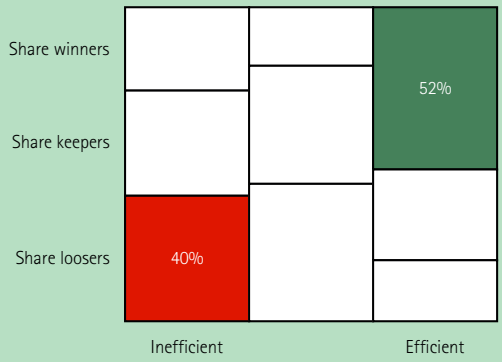
Based on our analysis of 93 Dutch hospitals we draw six main conclusions:

1) **Turnover grew faster than production in 2005. Reduced growth in care volume in 2005 brings additional risk. (Exhibit 1)**
   In 2005 patient entities, a measure of the volume of care delivered, grew slower than the turnover. While patient entities grew by 1.9%, turnover and costs grew by 4.7%. The volume growth of care in 2005 was significantly lower than levels in 2002-2004. In as much as this reflects unmet need for care, a future risk, both financial and medical, is in the making.
   The lower production growth and the higher turnover growth is a failure for the productivity improvement targets which have been much flouted in the sector, and were agreed in a rather modest multi-lateral performance contract between the hospitals and the government.

2) **The performance contract failed to deliver benefit. Loss of productivity meant Dutch hospitals posted a "net community loss" of EUR 140 m. In determining budgets, the future growth and productivity gains potential of hospitals must be considered. A "one size fits all" strategy is failing and shall continue to fail.**
   (Exhibit 2)

Exhibit 3.

Efficient hospitals win market share
Market share performance versus efficiency
2005 [% of all hospitals, each column is 100%]



Exh. 4B.

Patients in Groningen, Zuid-Holland en Rotterdam actively switched hospitals
Relative churn per hospital area 2005 [%]

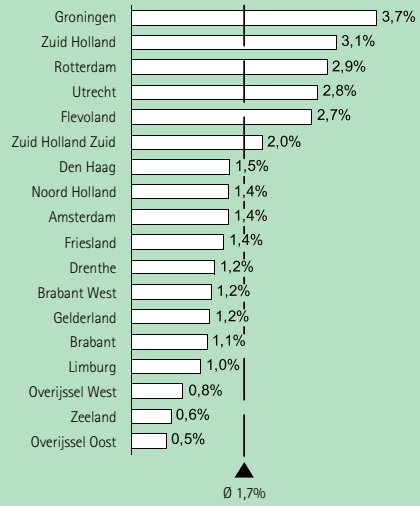
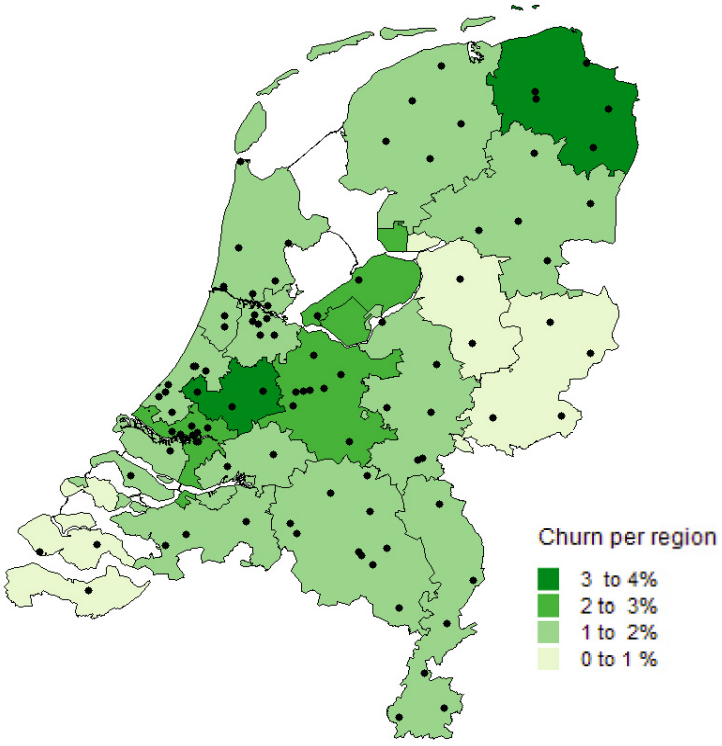


Exhibit 4A.

Groningen and Zuid-Holland Oost have highest churn rate
Churn per region 2004-2005 [%]



For 2005 hospitals had agreed to deliver a performance improvement of 1.15%. Without considering the technical aspects of the contract itself, we find that the higher turnover increase, and lower volume growth meant that hospitals posted a community loss of EUR 140 m. If on top of this the performance agreement of EUR 120 m is considered the total loss could be argued to be EUR 260 m. We conclude that the multi-lateral budget cut agreed in the performance contract did not work effectively.

We believe that such contracts are fundamentally flawed for two reasons:

a) Not all hospitals failed to improve performance. Performance improvement in 39 hospitals delivered EUR 120 m net community benefit[1]. However 54 other hospitals posted a community loss of EUR 260 m. "A single size fits all" strategy does neither justice to the 39 improvers, nor does it deliver benefit for the entire sector[2].

b) The future growth varies strongly per hospital, based on the underlying demographic trends in the care regions.

3) Efficient hospitals win market share (Exhibit 3). Churn in hospital markets did not increase (Exhibit 4A,B).

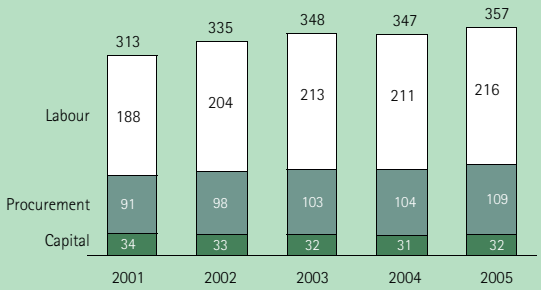
Efficient hospitals are more likely to win market share. More than half of the hospitals which were efficient compared to their own specific national peers won market share in their local markets. It appears cost efficiency is a good proxy for overall hospital performance. Perhaps a hospital that works cost effectively is also better at patient, family doctor, and insurer relevant issues, at thus wins in its local markets.

[1] Community benefit and loss here is defined as turnover minus the EUR value of production based on the productivity of the year before corrected for inflation.

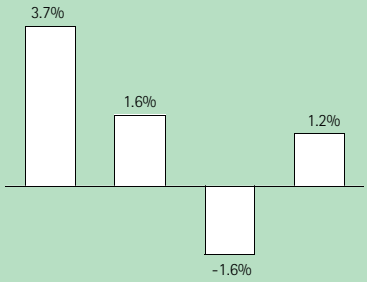
[2] This distribution of hospitals in "community benefit makers" and "loss makers" is based on historical perspective only. It is reasonable to also include a hospital's starting position in considering budget cuts. An efficient hospital has a lower improvement potential. We use this limited 2004-2005 perspective for illustrative purposes only. For more refined tastes, an efficient hospital can be defined on basis of our peer baskets, normalized for special care.

Exhibit 5.

Cost-to-serve increased again
Nominal cost-to-serve per patient entity 2001-2005 [EUR]



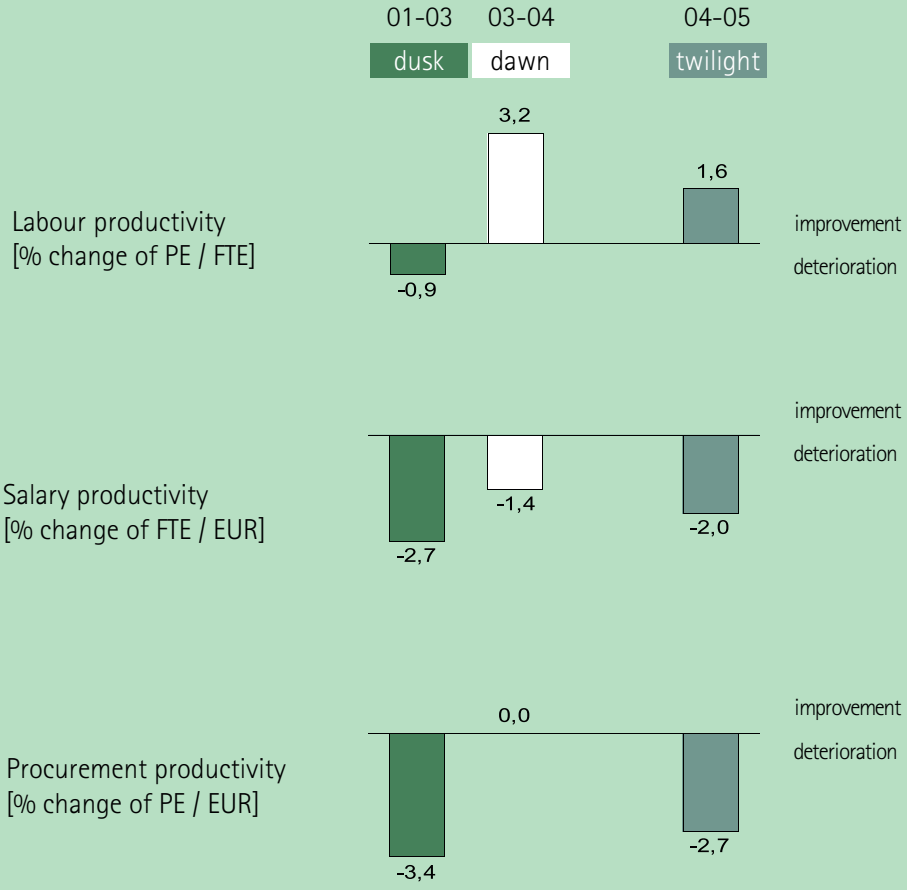
Cost increase was well above inflation
Real[1)] cost-to-serve change over previous year [%]



1) Inflation adjusted

Exhibit 6.

Productivity cycles through dusk and dawn to end up in a twilight area
Inflation adjusted productivity change [% per year]



In 2004 we found a churn of 1-2% amongst hospitals. We expected that the churn would increase with the introduction of B-segment. We found that it remained constant. In 2005 the churn was 1.7%. However there are significant regional differences. In Groningen and Zuid-Holland the churn is 3% and above, while in Overijssel en Zeeland it is less than 1%. The churn rate historically is constant between 1-2% per year. Given that the success of liberalization agenda must be its ability to enhance churn, 2005 was a disappointing start.

4) Productivity declined (Exhibit 5, 6)

In 2004 production had grown more or less in line with turnover, and on real basis hospitals improved productivity on both labor and procurement costs. In 2005 hospitals lost euro value productivity. Real cost-to-serve increased by 1.2%. On nominal basis all three cost-to-serve components, labor, procurement and cost of capital grew in 2005. 2004 improvement appears to be an exception in the light of the loss of productivity in 2005, and 2001-2003.

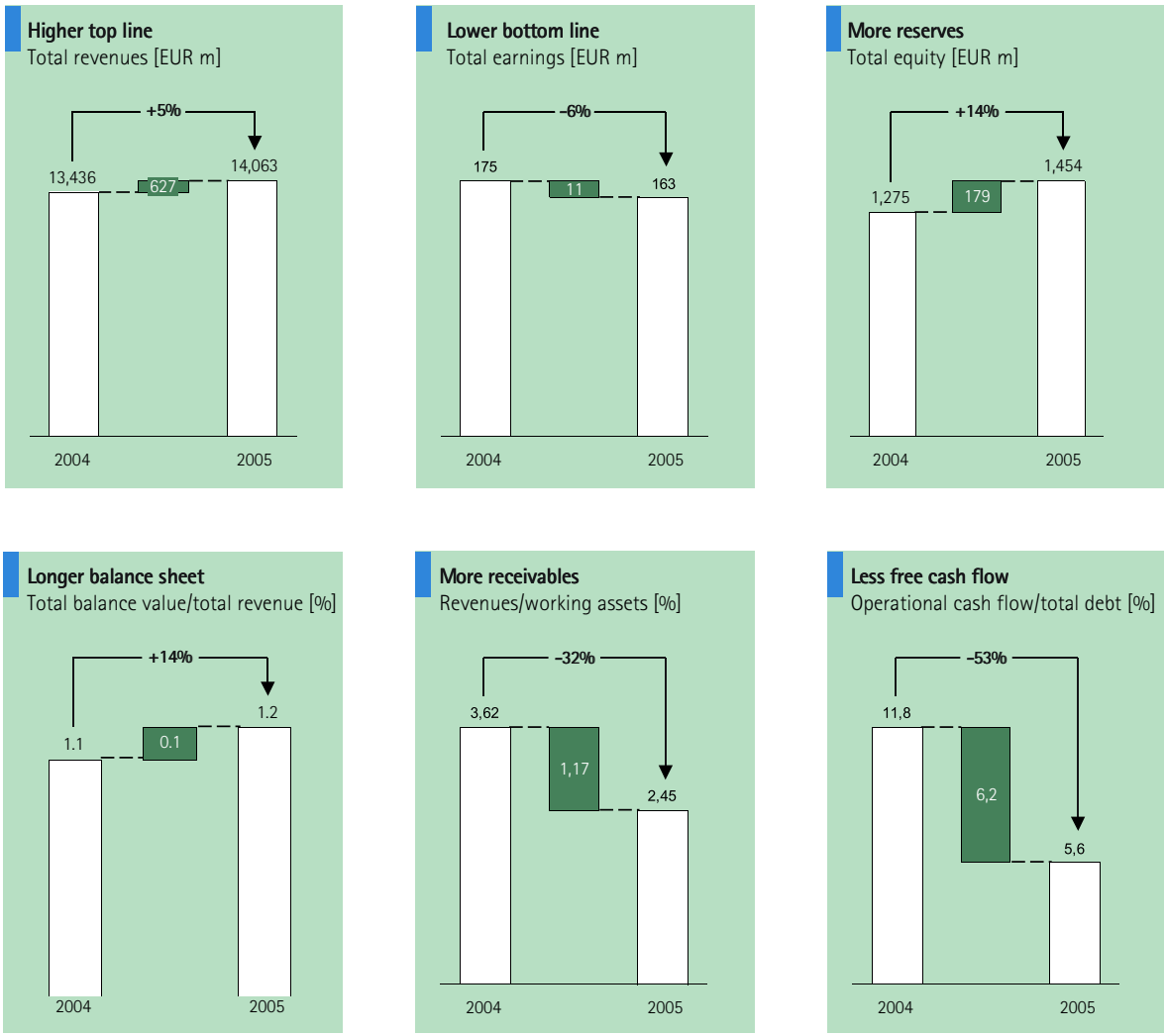
5) Hospitals financially slightly weaker (Exhibit 7)

Despite the turnover growth of 5%, the net results of the hospitals declined by 6% to EUR 163 m. 4 hospitals alone, UMC Utrecht, LUMC, AZM, and Zorggroep Noorderbreedte, were good EUR 54 m (33%) of the net results. The large financial gains made in 2004, were reversed in 2005. This is a logical consequence of the declining productivity of the sector. Introduction of DBCs wreaked havoc on the financial performance of hospitals. The balance sheet got much longer, the receivables grew and less free cash was available from "normal" operations. However, hospitals were more than adequately financed for the anticipated problems. In fact on average the entire sector had received more money upfront than required on basis of production. Thus there were no overall liquidity consequences.

6) Performance of hospitals is not aligned with incentives

In a rational world money would follow patients. A hospital that attracts patients and wins share would have higher turnover and book better financial results. Similarly a hospital that improves its productivity would also improve

Exhibit 7.


Higher top line
Total revenues [EUR m]
+5%
13,436
627
14,063
2004
2005
Lower bottom line
Total earnings [EUR m]
-6%
175
11
163
2004
2005
More reserves
Total equity [EUR m]
+14%
1,275
179
1,454
2004
2005
Longer balance sheet
Total balance value/total revenue [%]
+14%
1.1
0.1
1.2
2004
2005
More receivables
Revenues/working assets [%]
-32%
3,62
1,17
2,45
2004
2005
Less free cash flow
Operational cash flow/total debt [%]
-53%
11,8
6,2
5,6
2004
2005

its financial position. If insurers are the new directors of hospital procurement, than they would seek alignment and create incentives for hospitals to reward and punish their performance. We report the market, operational and financial performance ranks of all Dutch hospitals. And for the first time we also report the hospital that booked the best performance improvement on all three measures in 2005. Unfortunately, our conclusion is that incentives are not aligned with hospital performance. Money does not follow patients, and neither does productivity improvement always result in better financial results. None of the six hospitals, one in each category, that won the highest market share in 2005, were also the financial winners. Money does not follow patients. Only two of the hospitals that improved their cost-to-serve were financial improvement front runners. Money also does not follow productivity improvement in hospitals. Aligning incentives with individual hospital's performance is critical if the sector's overall performance is to improve.

Following 'The Pied Piper of Hamelin' last year, this year we present 'The Twilight', a study on the key developments in Dutch hospitals in 2005.

Having worked for leading hospitals and insurers in 2005-2006, we have come to better appreciate the complexity of delivering and managing healthcare. We hope this report helps the sector further improve its performance.

Gupta Strategists is a boutique consulting firm dedicated to deliver strategic value to the healthcare sector. Combining client work with independent studies we aim to contribute to the development of our clients and the sector.

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