Gupta Strategists

'The Odyssey'

Study of Dutch hospitals 2006

Gupta Strategists

Book I

"Sing to me of the man, Muse, the man of twists and turns
driven time and again off course, once he had plundered
the hallowed heights of Troy.
"Many cities of men he saw and learned their minds,
many pains he suffered, heartsick on the open sea,
fighting to save his life and bring his comrades home.
But he could not save them from disaster, hard as he strove -
the recklessness of their own ways destroyed them all,
the blind fools, they devoured the cattle of the Sun
and the Sungod blotted out the day of their return.
"Launch out on his story, Muse, daughter of Zeus,
start from where you will - sing for our time too."

Such is the beginning of Homer's epic "Odyssey". The epic lyrically and enduringly sings of Odysseus the hero of Trojan war who overcomes countless enduring travails to reach home.

Quoting Homer to describe the development in Dutch hospitals in 2006 is nothing short of screaming for attention by being dramatic. But the voyage of Dutch hospitals is definitely an Odyssey. Consider the definitions of Odyssey from The Shorter Oxford Dictionary:

A long series of wanderings
A long adventurous journey
An extended process of development or change

In the light of these definitions there are indeed interesting parallels between Odysseus and the journey hospitals must make in the coming decades. The excellent state of our current hospitals has been achieved with much effort in the last fifty years. We like to complain a lot about our hospitals, but the state of healthcare is both historically and internationally excellent. Like the battle of Troy we have been successful. But the ordeal facing us now is much more arduous and dangerous. We must set course for totally different waters. The voyage shall be exhausting, and many may not even make it. The forces of change are tremendous and the will to change and confront is weakened. Our progress has also unfortunately been limited so far.

We are not a blind bard singing of lost heroes in heart breaking lyrical beauty. We are but analysts collecting, analyzing and reporting numbers. We hope that through the study we contribute our own tiny effort to the success of this momentous odyssey.

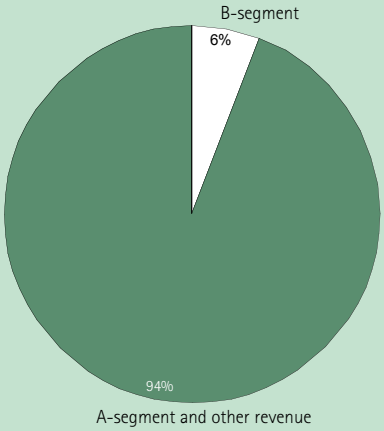
'The Odyssey'

Study of Dutch hospitals 2006

E1.

The B segment remains a small part of total revenues

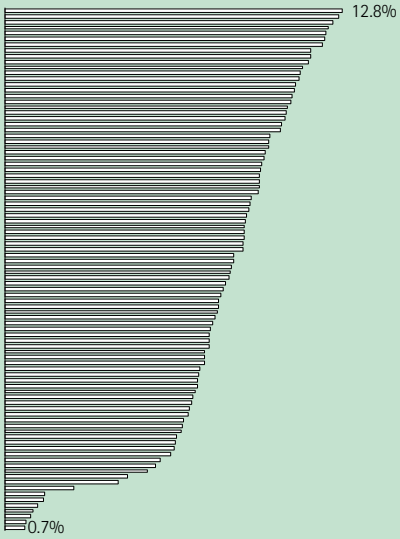
2006 revenue distribution total sector [%]



E2.

Dependence on B segment revenues vary tremendously

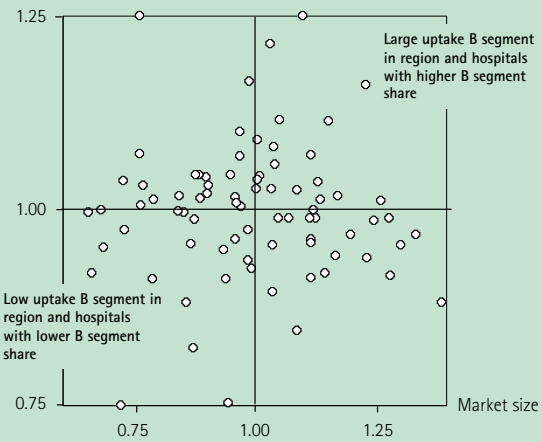
2006 revenue share of B segment per hospital [% total revenues]



E3.

B segment market size and market score vary enormously

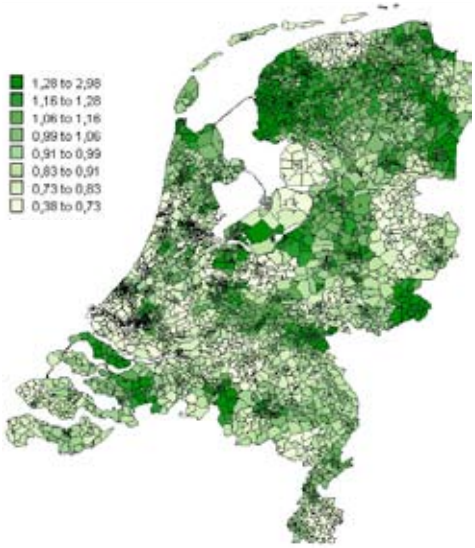
2006 B segment market size and market scores per hospital [relative to national average]



E4.

Large B segment variation across the Netherlands

Actual B segment revenue/expected B segment revenue 2006



Executive Summary

Third year on, the context and motivation of our annual hospital benchmark report should not require a detailed description for our regular readers. This year we have added one important measure on B segment performance. At the same time we have retracted reporting any quality measures on hospital care.

We report five main conclusions:

B segment size exploded but is still 6%

1) B segment size exploded in 2006 but is still far from 10% of the total hospital turnover (Exhibit E1, E2, E3, E4)

In 2006 the size of the B segment was EUR 885 million, up by 40% compared to 2005. Still B segment is but 6% of the total hospital turnover of nearly EUR 15 billion.

UMCs deliver a very small portion of their turnover as B segment, just over 1%. The small hospitals have the largest fraction of turnover as B segment, just under 10%.

Large regional and inter-hospital difference in B segment

It appears that there is a differentiation and specialization ongoing. Mainly the smaller hospitals appear to be focusing on B segment.

There is a large and inexplicable difference in the level of B segment across different communities in the Netherlands. In certain regions the B segment care is as much as 20% above or under the national average (Exhibit E4). At the same time within these communities certain hospitals are providing 20% more of B segment than one would expect and others 20% less (Exhibit E3).

The extraordinary growth of the B segment could be a registration issue. But at 40% growth and given the relative simplicity of B segment probably not all can be explained by DBC registration difficulties. Given that volume of care is mainly supply driven, easing supply as in B segment should lead to much higher volumes. At the same time not being able to control prices and insufficient competitive pressure may lead to further price increases. A 40% B segment size increase is a trend to watch as the B segment is further expanded in the coming years.

E5.

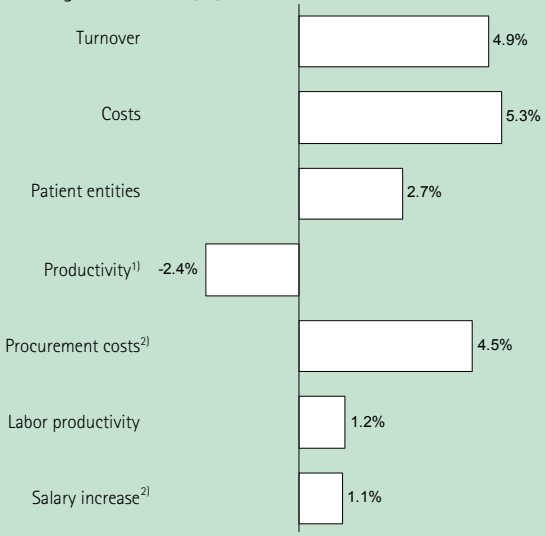
In few "Hot spots" patient churn is significant

Hospital areas with 2006 net churn (total production) above 7% of own production

E7.

Sector developments at a glance

Change 2005-2006 [%]

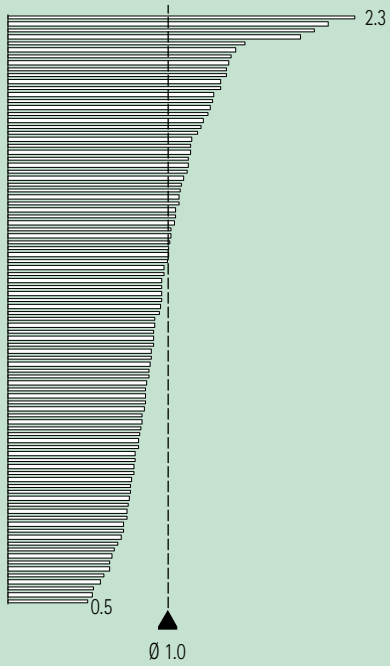


1) cost-to-serve EUR/patient entity
2) real

E6.

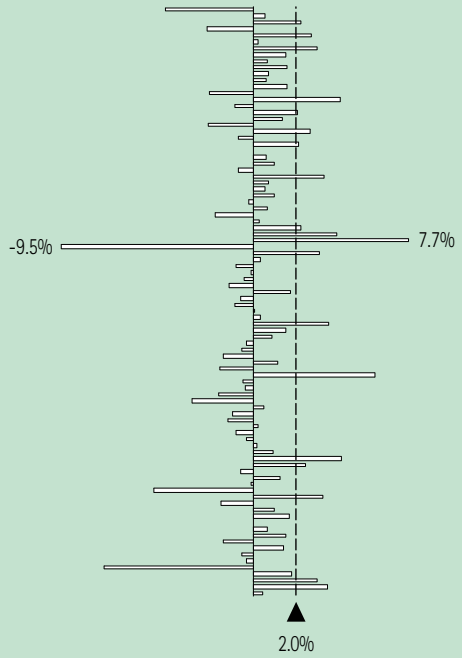
Some hospitals have extremely strong market presence, other are much weaker

2006 market score per hospital [actual production/expected production on basis of travel time]



Active switching between preferred hospitals: net churn is 2% but for several hospitals it is well above 5%

2005-2006 market score change [%]



2) The churn in markets is stable at 2%. But the chasm between market winners and losers is growing (Exhibit E5, E6)

Due to year-on-year switching some hospitals are gaining share at the expense of other weaker hospitals

The number of patients in 2006 who switched their hospital of preference as a fraction of the patients in 2005 was 2%. Since 2004 when we first starting following patient churn the preference dynamics are stable at 1-2%. Given the deregulation and patient choice mantra the churn rates are disappointingly low. On the other hand, at 2% every year the churn has significant consequences for many hospitals, given the fragile financial status of hospitals. The year on year churn when cumulated over the years has significant impact on hospitals. We find that the market share winners of previous years further won market share in 2006. "Hot spots" of competition between hospitals are emerging in the Netherlands. These "hot spots" are mainly urban and competitive regions but there also some rural and less competitive regions. In these regions there is year on year significant switching of patient preferences. This has meant that some hospitals won 20% and more of their natural market share, while others in the same community are performing at similarly depressed levels. (Exhibit E5 and E6).

3) The costs outpaced volume of care delivered. Procurement costs per patient entity grew by nearly 5% even after correcting for inflation. (E7, E8)

Costs increased faster than turnover and volume

In 2006 the hospital turnover increased by 4.9%. The hospital costs increased even faster at 5.3%. The patient entities in contrast grew by just 2.7%. Even accounting for inflation, the patient entity based productivity of hospitals declined. Procurement costs grew by 4.5% (on a like to like patient entity basis) even after correcting for inflation. The labor productivity, number of patient entities served per FTE, improved for the third year in a row, by 1.2%. But since salary increased on a real basis (inflation corrected) by 1.1% the net gain on labor productivity was zero. It would appear that the hospital staff could justifiably feel that they have been working harder and harder every year. Since 2004 the labor productivity has improved by nearly 7%. Despite this, the overall cost continues to increase.

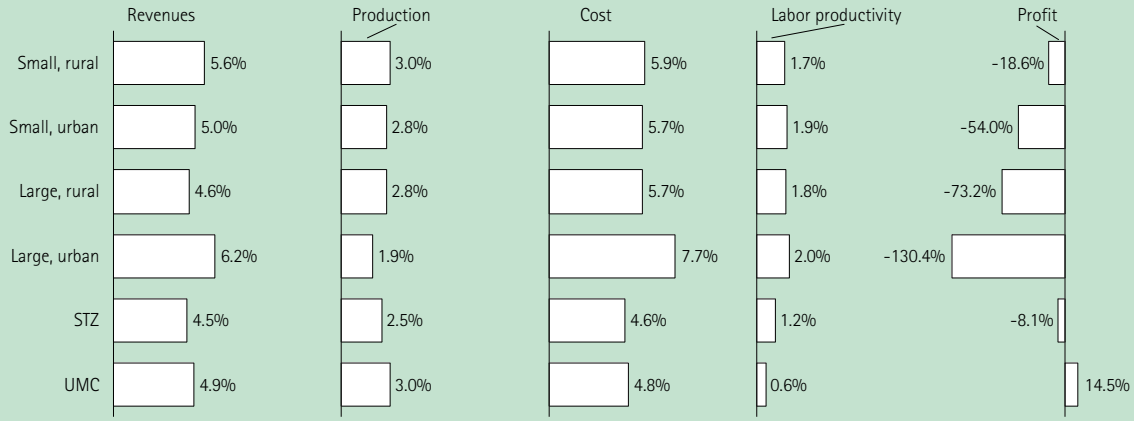
Procurement costs continue to rocket

Procurement costs are the main reason why hospital costs continue to increase. Procurement costs grew on a real basis by nearly 5% in 2006. As innovation tempo increases, procurement costs will further sky rocket.

E8.

Development per peer group at a glance

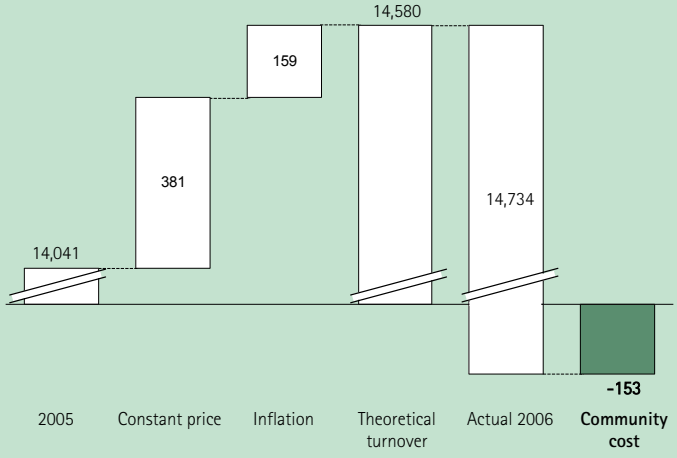
Change 2005-2006 [%]



E9.

Healthcare cost to the community well above inflation

Cost development 2005-2006 [EUR m]



It is imperative that hospitals seek scale and efficiency in their procurement processes. A differentiated strategy that addresses the cost structure, service level and innovation pace desired per product group and supplier must be formulated. Seeking alliances and pooling together the procurement and logistics within alliances is one possible strategy that has yet to emerge in the Netherlands.

Mainly as a consequence of spiraling procurement costs, hospitals cost an additional EUR 153 m after correcting for inflation (Exhibit E9). These costs might of course be fully justified provided the care for patients in terms other than patient entities was superior. This confirms that the current budgets of hospitals are too low compared to the actual cost increases. The gap between the budget and cost is particularly important since cost management is very much on the strategic agenda of hospitals, insurers and the government. Yet the cost increase continues to be higher than the turnover.

4) Large urban hospitals had the poorest performance in 2006. (Exhibit E9)

Due to financing, operations and competitive pressures large urban hospitals had the worst performance

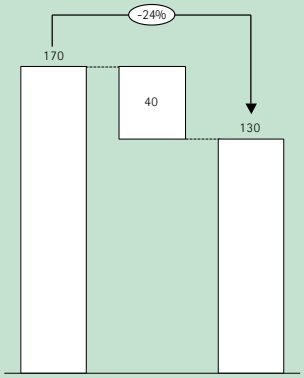
In our six peer groups the large urban hospitals posted the worse performance. The turnover increase in this group was the largest at 6.2%, but their costs increased even faster at 7.7%. At 1.9% growth in patient entities, the production growth in the large urban hospitals was also the lowest. As a consequence the productivity of the large urban hospitals declined the most. As one would expect, the profitability of the large urban hospital tumbled. It did so by more than 100%. As a consequence the large urban hospitals now have the lowest profitability. Part of this performance deterioration could come from competitive pressure. Large rural hospitals have done better. Perhaps competitive forces are beginning to shape the hospital landscape. Only UMCs managed to improve their profitability in 2006.

The issues around large urban hospitals must be addressed. These have the scale required to provide more complex hospital care. Also they should benefit from economies of scale. Yet both in operations and financing they have become a vulnerable group.

E10.

Total hospital profits tumbled

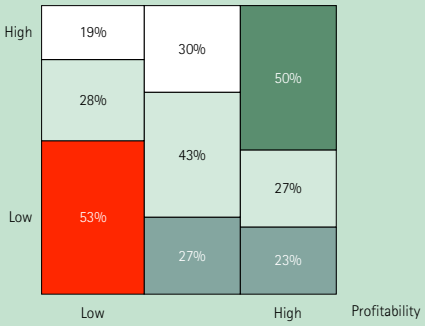
Earnings Dutch hospitals [EUR m]



E13.

Majority of the hospitals with low equity also reported low profitability and vice versa

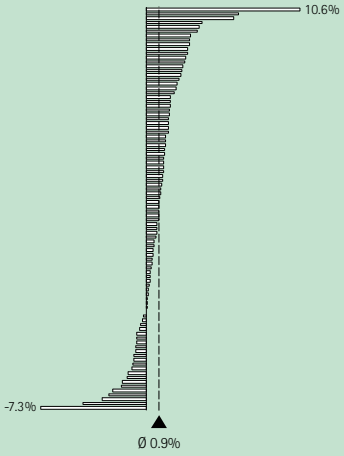
2006 Profitability versus equity [% of all hospitals, each column 100%]



E11.

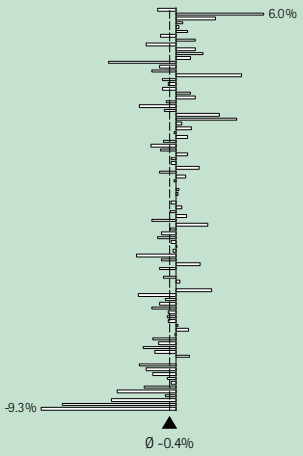
The financially strong and the weak...

2006 Profitability of Dutch hospitals [% revenues]



... and the weak got weaker

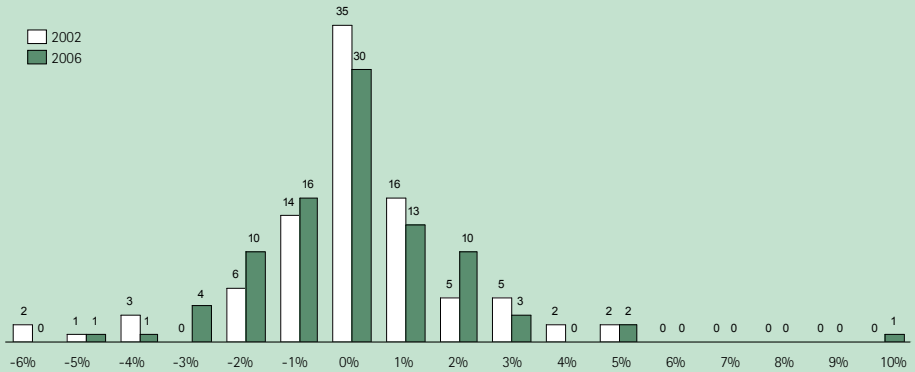
2005-2006 Change in profitability Dutch hospitals [%]



E12.

Spread in profitability in Dutch hospital sector increased between 2002 and 2006

Distribution curves of profitability development [%]



5) The profitability of all hospitals, UMCs excluded, tumbled. An increasing number of hospitals with low equity and declining profitability are are financially vulnerable. (Exhibit E10, E11, E12, E13)

Profitability tumbled

The profit of the sector declined to EUR 130 million, a drop of 24% compared to 2005. We estimate that correcting for the financial gains made on surpluss financing the "underlying" profitability of the hospitals was only EUR 90 m. This is but 0.6% of the turnover.

Sizable group of hospitals has both low equity and making losses

Next to the average profitability, the differences between hospitals were staggering and increasing. There are clearly big winners and a growing rank of loss making hospitals. Averages in a sector as diverse as hospitals were always suspect, but they are now becoming even more irrelevant (Exhibit E11, E12).

Most worrying is an increasing group of hospitals with low equity and increasing losses (Exhibit E13). This is clearly a vulnerable group. With both market forces and yardstick competition in the fore, this group needs watching out for. In contrast a big group of hospitals had both better equity and profitability. Instead of an equitable distribution we find that the ranks of both the weakest and the strongest are swelling. The differences amongst hospitals are widening. Clear winners and losers are in the making.

Winners and losers emerging

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