Future of Dutch hospital care: royal patients in regional networks

The future vision and strategy of Dutch hospitals mapped, using the TAIDA model.

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Samenvatting
De Nederlandse zorgsector is een dynamisch veld, onderhevig aan verandering. De afgelopen jaren zijn door de overheid grote veranderingen doorgevoerd in het beleid om in te spelen op de zorg van de toekomst. Dit is van invloed op de hele zorgsector, een veel gehoorde klacht is: 'We moeten meer doen, met minder'. De klacht vindt zijn oorsprong in de stijgende zorgvraag, de krimpende arbeidsmarkt en de overheid die grenzen stelt aan de groei en uitgaven in de zorg. Ontwikkelingen als de steeds mondiger wordende patiënt en de ontwikkeling van medische technologie jagen deze trends aan.
Dit onderzoek spitst zich toe op de medisch-specialistische zorg; de zorg die geleverd wordt in ziekenhuizen. Het doel van deze thesis is om te onderzoeken hoe de toekomst van de ziekenhuiszorg in Nederland eruit ziet. De druk op het Nederlandse gezondheidszorgsysteem neemt toe, niet alleen door beleidsaanpassingen, maar ook door eisen die verzekeraars en patiënten stellen; verandering is nodig. De hoofdvragen zijn: hoe zien bestuursleden van het ziekenhuis de toekomst (2016) van hun organisatie voor zich? En hoe zorgen ze ervoor dat deze visie bereikt wordt? Deze studie is begeleid door het multinationale adviesbureau Capgemini Consulting, afdeling Public & Health. De resultaten van dit onderzoek kunnen hen helpen om hun kennis over de ziekenhuismarkt uit te breiden en om bestuursleden te inspireren and adviseren in hun veranderproces. Daarnaast zijn de resultaten verzameld om te gebruiken in een internationaal onderzoek om veranderprocessen tussen verschillende landen te vergelijken.
Er is een kwalitatief onderzoek uitgevoerd, bestaande uit een literatuurstudie en semigestructureerde diepte interviews met 20 bestuursleden van ziekenhuizen door heel Nederland. Het Tracking, Analyzing, Imaging, Deciding, Acting (TAIDA) model van Lindgren & Bandhold (2003) is gebruikt om de toekomstvisies te koppelen aan strategieën. Voor de eerste twee stappen is gebruik gemaakt van de literatuur; trends die relevant zijn voor de ziekenhuissector zijn gedefinieerd en aan de hand van deze trend zijn vier toekomstscenario's opgesteld. Deze scenario's zijn: super specialization, Royal patient, squeezing costs and patient awareness. Daarna zijn de bestuurders geïnterviewd om erachter te komen wat hun visie op de toekomst is en wat hun strategie is om de geschetste toekomstsituatie te bereiken. De ziekenhuizen zijn, gebaseerd op de antwoorden van de geïnterviewde ziekenhuisbestuurders, geplot in de scenariomatrix. Verder is de theorie van Kotter (2007) over het (effectief) begeleiden van verandering gekoppeld aan de succes- en faalfactoren die volgens de bestuurders bijdragen aan het bereiken van hun visie.
Uit de resultaten is gebleken dat veel bestuurders in het scenario 'royal patient' vallen; zij omschreven een toekomstbeeld passend bij Michael Porter's 'waardecreatie'. Dit betekent dat de patiënt centraal staat, geen 'one-size, fits all', kwaliteit is belangrijk en innovatie en specialisatie zal bijdragen aan de kwaliteit en efficiëntie van de zorg. Door uit te gaan van deze principes zullen vanzelf kosten bespaard worden en het zal een verbeterde marktpositie opleveren. Er zijn door bestuurders veel verschillende strategieën omschreven, afhankelijk van het type en de omvang van het ziekenhuis en de regio waarin ze gelegen zijn. Om een voorbeeld te noemen: topklinische ziekenhuizen kijken meer naar de kwaliteit van de inhoud van de door hun aangeboden zorg, terwijl basisziekenhuizen meer letten op de kwaliteit van hun service en bejegening. Een overkoepelende conclusie was, dat werken in regionale netwerken, ook met de eerste en derde lijn, zal leiden tot meer kwaliteit en efficiëntie voor de patiënt. Deze ontwikkeling wordt versneld door het recentelijk afgesloten akkoord tussen ziekenhuizen, verzekeraars en het ministerie van Volksgezondheid, Welzijn en Sport. Hierdoor zullen er zorgconcerns worden gevormd, die onderling de ziekenhuiszorg verdelen op basis van volumes en complexiteit. Echter, de huidige bekostigingssystematiek vormt een barrière voor het maken van portfoliokeuzes.
De patiënt (en ook de professional) zal meer moeten gaan reizen voor de beste kwaliteit van zorg. De professional zal meer verbonden zijn met het ziekenhuis, in plaats van met zijn eigen discipline. Volgens sommige bestuurders is de rol van de zorgverzekeraar overbodig, anderen hopen juist dat de verzekeraar meer een regierol op zich zal nemen. Dit wordt nog bemoeilijk doordat verzekeraars nu geen instrumenten hebben om kwaliteit te beoordelen. De Raad van Toezicht zal ook meer verbonden zijn en meer verantwoordelijkheid krijgen, maar ze moeten wel op de achtergrond blijven, hun rol wordt complexer door de vorming van grote organisaties.
Succesfactoren die genoemd zijn door bestuurders bij het leiden van verandering zijn: communiceren met de werkvloer, hun visie delen en duidelijk doelen stellen, een voorbeeldfunctie vervullen en problemen bespreekbaar maken. Bestuurders noemden bijna geen faalfactoren, degenen die dat wel deden zeiden voornamelijk dat je niet 'bovenop' de professional moest zitten. Een kanttekening bij het onderzoek is, dat er verschillende interviewers zijn geweest, waardoor er variëteit tussen de interviews is ontstaan. Een aanbeveling voor vervolgonderzoek is dus om één interviewer aan te wijzen. Verder reflecteert deze thesis de meningen van één bestuurder per ziekenhuis, hij/zij bepaalt niet alleen de visie en de strategie van het ziekenhuis. Hierdoor zijn de resultaten niet generaliseerbaar naar alle ziekenhuizen in Nederland. Voor vervolgonderzoek wordt geadviseerd om ook de change managers te interviewen.

Summary

The health care sector is a dynamic field and subject to many changes. In the Netherlands major changes in policy have been made by the government over the past few decades to anticipate on the health care of the future. This affects the whole sector. A common complaint is: 'We have to do more, with less'. This complaint often finds its origin in the cost cutting done by the government and the growing demand for care, while the labour force is decreasing. Examples of drivers for these trends are: the development of medical technology and the empowered patient, with its high expectations.

The purpose of this study has been to investigate the future of the hospital care in the Netherlands. The pressure on the Dutch health care system is increasing, through policy changes, but also through requirements of health insurers and patients. This requires change. The main questions are: How do members of the board of directors of Dutch hospitals see the future (2016) of their organization? And how do they manage to reach their vision? This research was commissioned by the multinational consultancy agency Capgemini Consulting, department Public & Health. The results of the research may help them to broaden their knowledge about the hospital care market and to inspire and advise hospital board members on their change process. Another aim of the research was to gather data to use them in international research, to compare change processes in health care in European countries.

A qualitative study was conducted, consisting of a literature study and semi-structured in-depth interviews with 20 hospital board members throughout the Netherlands. The Tracking, Analyzing, Imaging, Deciding, Acting (TAIDA) model of Lindgren & Bandhold (2003) was used to link future visions to strategies. For the first two steps literature was studied; trends relevant to hospital care were defined and on the basis of these trends four possible future scenarios were developed. The developed scenarios are; super specialization, royal patient, squeezing costs, patient awareness. Thereafter the hospital board members were interviewed to find out what their vision on the future is and what their strategy is to reach the outlined future situation. Based on the answers of the board members, the interviewed hospitals were plotted in the scenario matrix. Furthermore, the theory of Kotter (2007) was linked to the key success and failure factors that, according to the board members, will contribute to reaching their vision.

It was discovered that a lot of board members fit in the scenario 'royal patient'. They described that they aim to work according to the principles of Michael Porter's 'value-creation'. Value creation means that the provided care is patient-centric and quality is of major importance. Innovation and specialization will contribute to the quality and efficiency of care. Following these principles will automatically lead to cost reduction and an improved market position. A lot of different strategies were named by the board members, depending on the type and size of hospital and on the region they are located. For example, top clinical hospitals are distinguishing themselves based on the quality of the content of their work, but the basic hospitals are focusing more on the quality of their service. An overarching conclusion is, that working in regional networks will lead to more quality and efficiency for the patient. This development has been speeded up by the recent agreement between the Ministry of Public Health, Welfare and Sports, health insurers and hospitals about specialization of hospital care. This means that conglomerates will be formed, among which hospital care is distributed and concentrated based on volumes and complexity of care. Though, the current funding system forms a barrier towards making portfolio choices.

The patient (and also the professional) will have to travel further for the best quality of care. The professional will have to be more committed to the hospital, instead of to his own discipline. According to some board members, the role of the health insurers is redundant. Others, however, hope that the insurer will take a more directing role. Currently this is hard, because health insurers do not have instruments to measure the quality of care. The Supervisory Board will be more committed and responsible; its role will be more complex because organizations become larger. At the same time they have to stay in the background. According to the board members, success factors contributing to leading change are: finding a balance between the internal and external environment, communicating constantly with the work floor, sharing the vision and setting clear goals, setting an example and addressing issues. Few hospital board members mentioned errors. One type of error is, for example, looking constantly over the shoulder of the professional.

Some variety between the interviews is perceptible, which was due to putting multiple persons on the interviews. This thesis reflects the opinions of one board member per hospital. Yet, he/she is not on his/her own responsible for the strategy of the hospital. This means that these observations are not to be generalized to all the hospitals in the Netherlands. For further research it would be advisable to also interview change managers in hospitals and to appoint one single interviewer.

Preface

This thesis is the finish, the endpoint or better: the terminal of my study Health Sciences at the University of Twente. At the terminal I hope to purchase a ticket for the next flight, another adventure. In the five years I have spent at the University of Twente I learned a lot about health care and science, but also about organizing, networking and living my life as a student to the fullest. I feel that I have made use of every opportunity I came across and never stopped looking further; one of the reasons I conducted my research at Capgemini.

In those five years studying Health Sciences, there have been major shifts on the health care field. As stated in the summary: health care is dynamic. During my bachelor thesis on the diffusion of innovations, it became clear to me that I was interested in innovation and change, and the role of people in those processes. When I saw that Capgemini was looking for a master student that was interested in hospital transformations, it immediately caught my attention. It seems that there are so many things changing in the internal and external environment of the hospitals; financing and insurance systems, a rising demand and a different type of demand for care, staff shortage, development of medical technology and so on. The way in which the hospitals are managed and the form in which they exist seems to stay fairly the same. Or don't they? This observation raises some questions and those questions raise more questions, typically a topic that needs some scientific research.

Writing this thesis would have been a mission impossible without the Capgemini Hospital Transformations Project Team and especially Carlijn. She always managed to motivate me and support me in this research, but also to stay critical throughout. My exam commission was also helpful and showed genuine interest and commitment, although planning appointments was difficult with all the busy people. Third, I would like to thank Josephie. She offered me last-minute help with correcting my English. Last but not least I want to thank family and friends who gave me some distraction or a listening ear whenever I needed it.

I would like to end this preface with an anecdote, that actually summarizes my whole thesis. When we were interviewing board members, we started off with an introduction round. When I introduced myself and told the board member in question that I was writing my thesis about the future of hospitals, he reacted: 'Then you will be ready quickly, as there is none!'.

Enjoy reading!

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Abbreviations

AMC	Academic Medical Centre
CEO	Chief Executive Officer
DRG	Diagnose-related Group
EPR	Electronic Patient Record
ER	Emergency Room
GDP	Gross Domestic Product
GP	General Practitioner
ICT	Information and Communications Technology
ITC	Independent Treatment Centre
KPI	Key Performance Indicator
MinVWS	Ministerie van Volksgezondheid, Welzijn en Sport
	Ministry of Public Health, Welfare and Sports
NMA	Nederlandse Mededingingsautoriteit
	Dutch Competition Authority
OR	Operating Room
PDCA	Plan, Do, Check, Act
RIVM	Rijks Instituut voor Volksgezondheid en Milieu
	State Institute for Public Health and Environment
TAIDA	Tracking, Analyzing, Imaging, Deciding, Acting
TIFKAP	The Individual Formerly Known As Patient

1. Introduction

This thesis concerns the changes in hospital care, also known as medical specialist care, in the Netherlands that have to be made to keep medical specialist care future-proof; affordable, accessible, efficient and of high quality. This change is driven by factors such as health expenditure, that transcend the economic growth, aging, an increasing demand for health care, while the labour force is decreasing, and an increasing use of medical technologies. During this research the possible future scenarios for medical specialist care in the Netherlands have been looked at. The way hospital board members see the future of their organization and the way these board members cope with change was also dealt with. Before writing something about the future of medical specialist care, an introduction is given on what medical specialist care is and what the history of this type of care looks like.

1.1 Medical specialist care in the Netherlands

Hospital or medical specialist care focuses on the treating and curing of acute and chronic physical diseases. In a hospital, medical specialist care is provided as well as the nursing and caring for patients (Wieren, 2008). In the Netherlands there were 148 hospitals in 2009. Of the 148, 85 were general hospitals, 8 university medical centres, 32 specialized hospitals and 23 rehabilitation institutes.

In 2009 there were 13016 medical specialists working in hospitals, with an average annual growth of 2,5% (Dutch Hospital Data, 2010).

More persons are admitted to the hospital and more persons are visiting a medical specialist; in 2002 38% was visiting a medical specialist and in 2007 this was 41%. This number will continue to grow, because the population is aging and 57% of people of 75 years and older is suffering from a chronic disease. About 33% of people of 75 years old and above is suffering from even more than one chronic disease; multimorbidity (Hoeymans & Schellevis, 2009).

In 2009 15% of the population was 65 years or older, in 2040 this growth will reach its peak; 25% of the population will be 65 years or older (Verweij & Sanderse, 2009).

The costs of hospital care have also grown, as shown in table 1. In table 2 the hospital care is divided per age group. The elderly people, age 75 and older, have been covering a large share of the expenditure in hospital care.

The total expenditure on health care in the Netherlands is about 80 billion annually, with an average growth of 5 billion a year (see Table 1). To illustrate this: this is almost as much as the total budget for the Ministry of Defense (Ministerie van Defensie, 15 september 2009). A quarter of this expenses is spent on hospital health care; about 20 billion, with an annual average growth of 1,5 billion. Capgemini calculated a finance gap between 2010-2015 on the basis of total surgical procedures, expenditure on hospital services, inflation, growth in expenditure on pharmaceuticals and other medical non-durables on 10,9% of the GDP.

This has partly been caused by hospital tariffs that will rise further in the next five years, due to tightening government budgets and increasing number of treatments, and the costs of new treatments.

The hospital days have been reduced by 30% since 1994. One-day admissions have been more than doubled since 1994. Bed blocking, people waiting for after care in a 'wrong' bed, reduced from 6,1% in 2001 to 3,1% in 2006 (Bruin, Verweij, & Wieren, 2008).

In 2007 1,2 million people were working in health care, this is equal to 800.000 labour years, because a lot of

people worked part-time. In 2030 300.000 extra labour years will be needed, this is equal to 450.000 jobs –taking into account the people working part-time-, while the labour force is shrinking by half a million. In other words: there will be a shortage of staff (Lucht & Polder, 2010).

Various and complex problems will have to be dealt with in the future. The core problem of hospitals actually is: how to keep health care affordable, accessible and of high quality. It is also public problem, because almost everybody will need care sooner or later..

Table 1: Overview of expenditures in health care (Centraal Bureau voor de Statistiek, 2010)

Category	Subcategory	2007 Mln. €	2008 Mln. €	2009 Mln. €
	Hospitals, specialist clinics	**18 275**	**19 902**	**21 353**
	Mental health care	4 634	4 894	5 470
	General practitioners	2 425	2 439	2 505
	Dentists	2 021	2 193	2 371
	Paramedics	1 602	1 702	1 831
	Other	14 181	14 895	15 074
Total expenditures care		74 362	79 241	83 809
Total expenditures health care		43 138	46 026	48 602

Table 2: Hospital care per capita per age group (Blank & Wats, 2009)

Age	Costs per inhabitant (euro)
0	**3.591**
1-14	394
15-24	458
25-44	701
45-64	1.153
65-74	2.433
75-84	**3.506**
85+	**3.393**
Total	1.084

1.2 Research objective

Capgemini Consulting, department Public & Health, in Utrecht commissioned this research. They are, as a (multinational) consultancy agency, interested in the visions of hospital boards on the future and on how they cope with transformation or change. Hospital board members do not seem to share their (change) strategy with other hospital board members. The basis on which they decide to follow a certain course is often not clear and also the way they monitor their growth and development is vague (Castelijns, Kollenburg, & Oh, 2011). Capgemini wants to gather more explicit knowledge about change management in hospitals and about which

strategy to choose to achieve set goals in hospitals and to broaden their knowledge about the hospital market, to use it in their consultancy practice. This is of importance now, because turbulent times are approaching. Not only the empowered patient has to be dealt with, but also the rise of medical technology and IT in healthcare has to be faced. Besides, the roles of a internal and of external parties are changing. This requires another way of arranging hospital care. The results of the research will be published and shared during a congress, to which also hospital board members are invited. Hopefully, as a reaction to this event, hospital board members might be inspired and might enable Capgemini to help them in their change process with, for instance, implementing a change strategy.

Furthermore these results will be used for international research, to compare the hospital care organization of the Netherlands to other countries.

1.3 Research question

The problem described above is not completely new. For years, even decades, different institutions, government and organizations have been giving warnings. Every year the health care sector is facing cuts in its budgets. The newspapers report on staff shortage in hospitals and home care. People start new initiatives to handle or avoid the pile of paperwork and inefficient working.

In this research was conducted what hospital board members' vision is, what their strategy for the future is to achieve their vision, what the underlying reasons are for implementing the chosen strategy and how they monitor if they are on the right track. Therefore the following questions have been formulated:

What should the hospital care in the Netherlands look like in the future according to hospital board members?

Which steps towards this result should be realized by 2016 according to hospital board members?

With hospital board members, the members of the Board of Directors of the hospital are meant.

The future-proofness of a hospital depends on different factors. The factors selected in this research are based on themes that came forward in the literature and in combination with the long-term policies of general hospitals. A theme on a hospital's agenda is a goal they want to achieve within a certain period of time. Several resources/means can be used to achieve these goals. An important resource is collaboration; this can include a merger or an acquisition or also integration. The themes are explained in table 3. Working on the themes, however, will not automatically lead to a future-proof hospital. For instance, some personal characteristics and leadership qualities also influence future-proofness.

To help the board members visualize their future goals, the first question of the interview was: 'What should your hospital look like in 2016'. This was asked because 2016 lies within the government's term and it seems 'not done' to look further than a few years from now in the world of hospital board members. According to Jan Moen this is to avoid blueprint thinking (Moen, Ansems, & Hanse, 2000).

A (change) strategy is a sort of plan of action for the future. It determines the course of an organization, a goal, the context/situation in which the change is happening and the type of intervention/change that has to be implemented (Balogun, 2001).

Table 3: the themes on the agenda of hospital board members

Theme	Description
Quality and the transparency of quality	Quality is a broad theme, it can be defined as quality of the medical expertise and treatment, but also as quality of service. This factor is determined by things such as Consumer Quality Index or Consumer Assessment of Healthcare Providers and Systems; how consumers/patients perceive the quality of hospital care. Transparency can be shown through the implementation of DOT; Diagnose Related Groups on its way to transparency (DBC's op weg naar Transparantie). Quality is also influenced by patient logistics, waiting times, one-stop-shop, KPIs (key performance indicators) and value creation.
Patient safety	Patient safety is about avoiding preventable medical mistakes. This can for instance be managed by implementing safety systems like VMS (safety management system).
Market position	Hospitals can change their market position by expanding their catchment area, improving their operating profits or making strategic (portfolio) decisions; specialize, differentiate, provide only basic care, build European centers of excellence.
Cost containment	Costs containment can be achieved in various ways, for instance by reducing the bed blocking or the number of hospital days, by cooperating with other firms on the purchase of food and creating economies of scale, by working 'Lean' or by focusing on sustainability.
Efficiency	Efficiency can be improved by redesigning care processes through so-called 'chain' care or 'streets' of care. Another way is to make the organization flatter or redesign by implementing integrated care, key performance indicators or a balanced score card.
Innovation and knowledge management	A focus on innovation can include a special budget to motivate people to come up with innovative ideas. But also implementing an Electronic Patient Record (EPR) or making use of ICT in another way in the organization. A building project for the optimization of the arrangement of health care and the use of high-end technologies is another example of innovation. Knowledge management is about sharing information and knowledge through digitizing medical information with instant access.
Staff	Pay attention to the recruitment and selection of employees. Make sure they are committed to the hospital and give them the possibility to develop themselves by following courses, workshops or training. Another way to improve productivity and commitment is to pay attention to absentees due to illness. Commitment among medical specialist can be achieved by giving them more (financial) responsibility.

1.4 Background information

To understand the future of general hospitals, it is also important to know something about the history of general hospitals and the health care system in the Netherlands.

The origin of the Dutch health care can be found in Christianity. In 1819 the first Catholic hospital was founded in Breda. Until 1870 the number of Catholic hospitals had been slowly growing to 15 and only in the southern provinces. After 1860 hospitals were also founded in the larger cities. From 1900 until 1930 the number of Catholic hospitals grew from 50 till 120, that was about half of the total number of hospitals.

Due to the revolutions in science and medical technology in the 19th century, diagnostics and therapy underwent a major improvement. The first anaesthetic was given in 1846 and in 1876 the first hygienic measures were undertaken by Lister, as a result of which wound infections decreased by 95%. Also medical technology inventions, like the stethoscope and X-rays, played a major role in the development of hospital care.

The medical profession initially consisted of, on the one hand, contemplative internists and, on the other hand, surgeons. In 1865 there was a medical constitution that unified the medical profession. Shortly after that, the medical specialist was introduced. The number of medical specialists grew from 32 in 1883 to hundreds in 1910. The first operating room was built in 1880 in Utrecht, innovations were rapidly spreading and also the operating rooms underwent major improvements in a few decades.

In the same period the first Dutch nurse training started, which resulted in 900 trained nurses in 1900. Nurses became more important. Especially the head nurse earned respect of the doctors, because of her awareness and knowledge.

The first partnership between hospitals was founded in 1900, with the goal to share their knowledge. In 1941, during World War 2, the health insurance fund was implemented by the Germans. People who earned below the income limit were obliged to join an approved health insurance fund. This led to an increase in scale and the Dutch hospital sector was characterized by specialization. The number of admissions doubled, hospitals days increased with 150% and the number of beds grew with 90%. Only the hospital stay decreased, which, around 1920, could last months or even up to a year.

In 1965 the influence of religion on the hospitals ended and the region and government became of importance in the hospital sector.

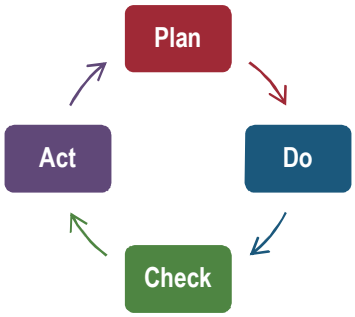
In 2006 there was a mayor reform in the Dutch health insurance system, before 2006 the German health insurance fund was still obtained. In 1990 was decided that this system would not be manageable on the long-term and therefore the following steps are taken between 1990 and 2006:

- Abolition of the monopoly of regional public health insurers
- public insured persons had the option of annual health insurance exchange,
- the financial responsibility of public insurers was gradually expanded,
- the requirement of contracting all outpatient care providers was abolished,
- there was a settlement system developed and introduced,
- fixed rates were replaced with maximum rates.

(RIVM, 2010)

2. Theoretical framework

One of the first models to promote organizational change is the Shewhart Cycle (often referred to as the Deming Cycle). It compromises four steps: Plan, Do Check, and Act. Translated to the future of hospitals, this means that the sequence is repeated continuously, with each iteration moving the hospital closer to its vision about the hospital in the future. Its real strength lies in its formulation of a process for exerting control in a rapidly changing environment, whether that is competing effectively in the marketplace or coping with budget constraints or an increasing demand for care (Cleden, 2009).



This cycle is the basis of many change processes. The PDCA-cycle is common to use in case of Total Quality Management; to improve quality of products and services. Which makes it less suitable to use as a model for this study. Moreover, the PDCA-cycle seems to be too limited for this study, for instance, PDCA does not take leadership into account, and is applicable in small-scale projects (Loon, 2009). Therefore, in this thesis has been made use of the T(racking) A(nalyzing) I(maging) D(eciding) A(cting)-model (Lindgren & Bandhold, 2003), which seems to have her roots in the PDCA-cycle. The TAIDA model focuses on organizational change in terms of future and strategy, which encompasses large-scale projects. In this chapter will be explained what the TAIDA-model is and how it was used in this research.

2.1 TAIDA model

Scenarios can be developed for several purposes and with several focuses. In this research the focus is to improve 'old' businesses; the existing hospitals, and the purpose is to find the right track to go into action; find the first steps on how to reach a desired future organisational form for hospital care. Scenario planning can in this case help to give insight in major changes in the future (Lindgren & Bandhold, 2003).

The two research questions can be linked with the help of the TAIDA model. The TAIDA-model was developed by Mats Lindgren and Hans Bandhold (2003) and is broadly explained in their book 'Scenario Planning: the link between future and strategy'. In the book different definitions of scenario planning are described:

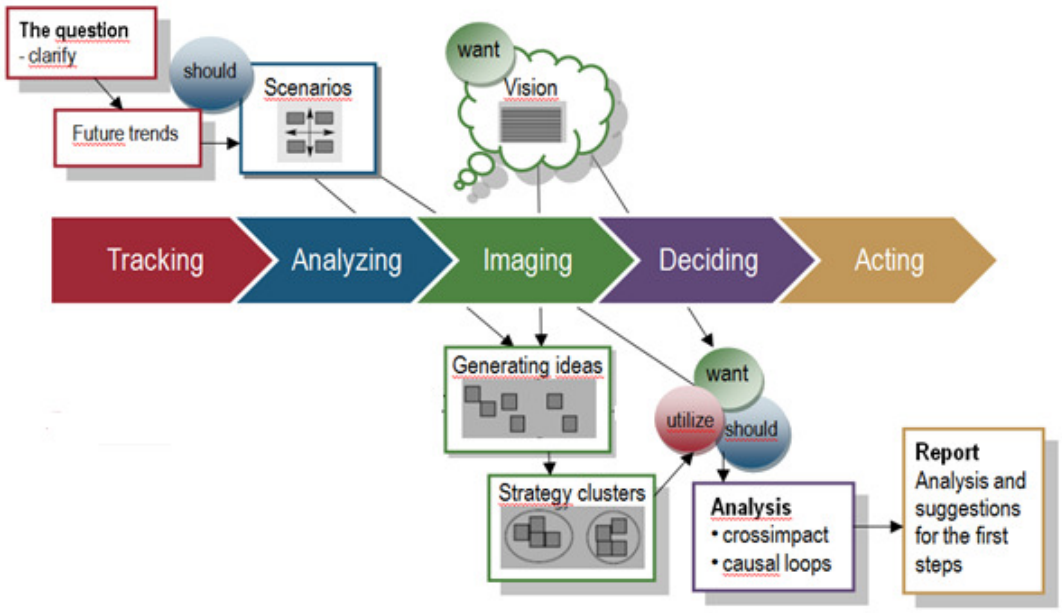
- 'An internally consistent view of what the future might turn out to be' (Michael Porter 1985).
- 'A tool [for] ordering one's perceptions about alternative future environments in which one's decision might be played out right' (Peter Schwartz 1991).
- 'That part of strategic planning which relates to the tools and technologies for managing the uncertainties of the future' (Gill Ringland 1998).
- 'A disciplined method for imaging possible futures in which organizational decisions may be played out' (Paul Shoemaker 1995).

(Lindgren & Bandhold, 2003)

Several scenarios can be developed on the basis of trends. A trend is a development that moves in a certain, more or less steady, direction for a longer period of time. A paradigm is a think-model, a vision that one has, that is formed on the basis of knowledge, contacts and experiences. Though, a paradigm also disturbs a different view of looking at things, because people tend to look only in their own way at the world. A scenario helps to think further than dominant paradigms (Idenburg & Schaik, 2010).

The TAIDA model consists of five steps to come from trends to the first steps of a strategy for the future. The steps are described in the book of Lindgren & Bandhold (2003), the relevant parts are explained below.

Figure 1: The TAIDA model (Lindgren & Bandhold, 2003)



- *Tracking.* The first step in the TAIDA process is defining a problem and a focal question. This is already done in the first chapter. Then the tracking can start. The main purpose of this step is to trace and describe changes in the surrounding world that may have an impact on the focal question. Tracking is about finding trends, drivers and uncertainties that need to be considered, since they influence the future of the 'question'.

- *Analyzing.* With the tracking done, the next step is to analyze changes and generate scenarios. The tracking phase often results in separate trends covering a lot of different areas. But the trends are not as disconnected as they seem at first glance; some trends recur as driving forces or consequences to other trends. A causal loop diagram will help to show these interrelationships. On the basis of this diagram a few main trends are identified. By knowing how the trends relate to each other, scenarios can be built. During the tracking phase there is often a number of trends that are likely to have a great impact on the focal question but are uncertain and not easily predictable. Other trends are so uncertain that they are called 'wild cards'. These wild cards could of course have a great impact on the focal question, but their predictability is so low that they have no meaningful use as a base for scenarios. People very often talk of worst-case and best-case scenarios, sometimes with a scenario moderated

somewhere between the two extremes. The problem is that people tend to really want only one scenario. They are likely to accept the better case and reject the worse as too bad even to consider. The result is that their view of the future may become one-dimensional and describe only one uncertainty, which may be good or bad. The dilemma is that the world of uncertainties is complex with a lot of aspects to handle. A profitable approach, which also is a dominating model for scenario building around the world, is to pick out two driving uncertainties that are considered together in a scenario cross. Four different scenarios will come out in the corners of the cross (Lindgren & Bandhold, 2003).

- *Imaging. A*fter gathering insights about plausible futures, it is time to create images of what is desired: visions. The previous steps help to understand what the future world may look like. That awareness can help to let go the present environment and move into future worlds when creating a vision. A vision is a positively loaded notion of a desired future. The vision has two main components. It creates meaning and gives identity, belief, guidance and inspiration. At the same time it is a focused target with clear expectations that hopefully leads to commitment. To determine the visions, the board members were interviewed. They were asked after their ambitions; how do they describe their hospital within a few years.

- *Deciding*. In this phase of the process development areas and strategies are identified to meet threats and achieve visions and goals. Deciding is the phase where everything is put together. The future environment is tracked and analyzed and the vision is in place. A certain course, a strategy can be defined.
  The theory of Reitsma, Jansen, van der Werf, & van der Steenhoven (2004) describes different approaches of leaders, it helps to cluster strategies. This theory was chosen because it is useful for consultants that have to lead change processes and it is a recent developed theory. Broadly, four types of approaches are distinguished

Approach	Features	Directing aspects
Directive	Take it or leave it. Emphasis on planning and process control	*Size of the group*: relatively small, due to the control possibilities. *Degrees of freedom concerning the content*: none. The content is given – implementation according this content is obliged. *Interaction*: restricted to transferring information; this is the way you are going to do it. *Role*: dictator, emphasis on the purpose and content. He puts others in the front as pioneers of the change and keeps them close. He monitors, verifies, corrects, so that happens what he has in mind.
Tell & Sell	Making change attractive and selling it (on a soapbox). Propositions are appreciated, but not always processed. Sensitivity towards the degree of which the change is adopted by the informal circuit.	*Size of the group*: relatively large *Degrees of freedom concerning the content*: space for inspiration, limited influence. *Interaction*: actors are informed and are allowed to think along *Role*: seller, tells the group what is decided or let someone else do that. Others are pioneers of the change. Keeps feeling about the change process, on the soapbox if needed.
Negotiating	Within the set framework,	*Size of the group*: relatively small (possibly a large

	looking for fitting changes. Active commitment of, especially, key figures. The content is not fixed in advance.	following). It has to be able to create a negotiating situation: a clear field of actors. *Degrees of freedom concerning the content*: framed. Freedom within the set framework to work on the content. *Interaction*: actors participate in decisions within the given framework. *Role*: creator of the frame. Creates and guards the framework. Creates negotiating situations. Leaves space for the actors. Decides in negotiating situations if the content fits in the framework or not.
Developing	Directs on the process; less on the content. Actors may get help (if desired). Interaction.	*Size of the group*: large. A lot of committed actors; sometimes the whole organization or the total network. *Degrees of freedom concerning the content*: a lot. Actors create the change content. *Interaction*: actors decide on and give shape to the change. *Role*: creator and source of inspiration. Gives direction through sharing the vision, creating goals and stimulate others to give shape to those goals. Facilitates help. Directs and guards the process.

A WUS analysis can help by elaborating the step of choosing a strategy. It is a single-impact analysis that deals with the three dimensions (Want, Utilize and Should). It will give a fairly quick answer to three questions:

- Does the strategy contribute to the desired direction of the organization (Want)?
- Does it utilize present strengths or assets of the organization (Utilize)?
- Does it match the future environment (Should)?

- *Acting.* Plans in themselves rarely give results. Acting is about taking action and following up. 'Acting' can have two different meanings in a scenario planning process. One is putting the strategies into action. This kind of action can make very good use of the traditional implementation toolsets that most organizations are well accustomed to. The other meaning has to do with the continuous follow-up work of the scenario planning process: monitoring environmental changes, defining processes for continuous environmental scanning, scenario planning and so on. For this last step the theories of Kotter (2007) about leading change are used, because he is a well-known, most cited, expert on leading change.

  In health care one has to deal with behaviour. The personal characteristics of a hospital board member might also play a role in how a hospital is managed. They can influence successes and failures and the strengths and weaknesses of the organization (Moen, Ansems, & Hanse, 2000).

  Kotter (2007) has defined eight steps for leading change. The steps are about the approach of a board member.

1. Establishing a Sense of Urgency
   - Examine market and competitive realities
   - Identify and discuss crises, potential crises or major opportunities
2. Creating the Guiding Coalition
   - Assemble a group with enough power to lead the change effort
   - Encourage the group to work as a team

3. Developing a Change Vision
    - Create a vision to help direct the change effort
    - Develop strategies for achieving that vision
4. Communicating the Vision for Buy-in
    - Use every vehicle possible to communicate the new vision and strategies
    - Teach new behaviours by the example of the Guiding Coalition
5. Empowering Broad-based Action
    - Remove obstacles to change
    - Change systems or structures that seriously undermine the vision
    - Encourage the risk-taking and non-traditional ideas, activities, and actions
6. Generating Short-term Wins
    - Plan for visible performance improvements
    - Create those improvements
    - Recognize and reward employees involved in the improvements
7. Never Letting Up
    - Use increased credibility to change systems, structures and policies that don't fit the vision
    - Hire, promote, and develop employees who can implement the vision
    - Reinvigorate the process with new projects, themes, and change agents
8. Incorporating Changes into the Culture
    - Articulate the connections between the new behaviours and organizational success
    - Develop the means to ensure leadership development and succession

Kotter has also defined eight 'errors' for the approach :

1. *Not establishing a great sense of urgency*
2. *Not creating a powerful enough guiding coalition*
3. *Lacking a vision*
4. *Under communicating the vision by a factor 10*
5. *Not removing obstacles to the new vision*
6. *Not systematically planning for and creating short-term wins*
7. *Declaring victory too soon*
8. *Not anchoring changes in the corporation's culture*

(Kotter, 2007)

Besides, some key success and failure factors based on the personality of a leader/board member are of influence. Jan Moen has conducted a literature study of the characteristics of an effective leader in complex organizations in his book 'Lijden of Leiden' (Moen, Ansems, & Hanse, 2000).

Author	Characteristics of effective managers in complex organizations
Kotter (1988)	• Knowledge of the industry and the organization • Good internal and external relationships • Good reputation and career in a broad set of activities • Skills, among which common sense (analytical and strategic thinking), good interpersonal skills (empathy and sensitivity). • Personal values, such as a great integrity • Motivation, loads of energy and a strong tendency towards taking charge.
Yukl (1989)	• Self-confidence • Loads of energy

	• Emotional maturity • Stress tolerance • Good attitude towards their superiors • They are pragmatic, result oriented and experience pleasure from activities that require initiative and taking risks.
Bennis and Nanus (1986)	• Possess a vision • Positive self-image • High power to ask questions and listen • Strong focus on results • Ability to create clear, challenging goals
Kouzes and Posner (1999)	• Addressing the status quo • Inspiring a shared vision • Providing sufficient room for others • Setting a good example • Cheer a stabbing
Bass (1990) and Van Dijck (1996)	• Vision on further development of the organization. This creates a basis for trust and respect among colleagues. • Inspiration by communicating the vision in a penetrating manner. Symbols and setting an example support this process • Intellectual stimulation. There are new challenges, incentives and assignments given. • Coaching employees. Individual attention is vital. Leadership is aimed at changing or increasing the level of motivation and giving sense of people.

3. Methods

3.1 Research design

The conducted study is an exploratory, qualitative research. The future of hospital care was explored. At Capgemini a project team was put together, that met about once a month. During data analysis they have met more often to discuss the results and to improve the analysis. Furthermore, a soundboard was put together. They have met up once with the project team to reflect on the research.

Per step is described which methods were used;

- *Tracking:* tracing future trends that will be relevant for the hospital market. Mapping all the trends was been done by conducting a literature study. From April till June this literature study was conducted and an interview script was put together. The interview script consisted of three parts; the organization in 2016, the themes on the change agenda, with examples of how is worked on those themes and the (personal) key factors to success or errors in the approach.

- *Analyzing:* analyzing consequences and generating scenarios. In this step the trends were summarized using the causal loop diagram. A causal loop diagram shows the interrelationships between the trends. Then the scenario matrix was drawn, the axes of the matrix are based on two trends, which certainly are going to happen, only their direction is uncertain. Filling in the scenarios also was based on the literature study.

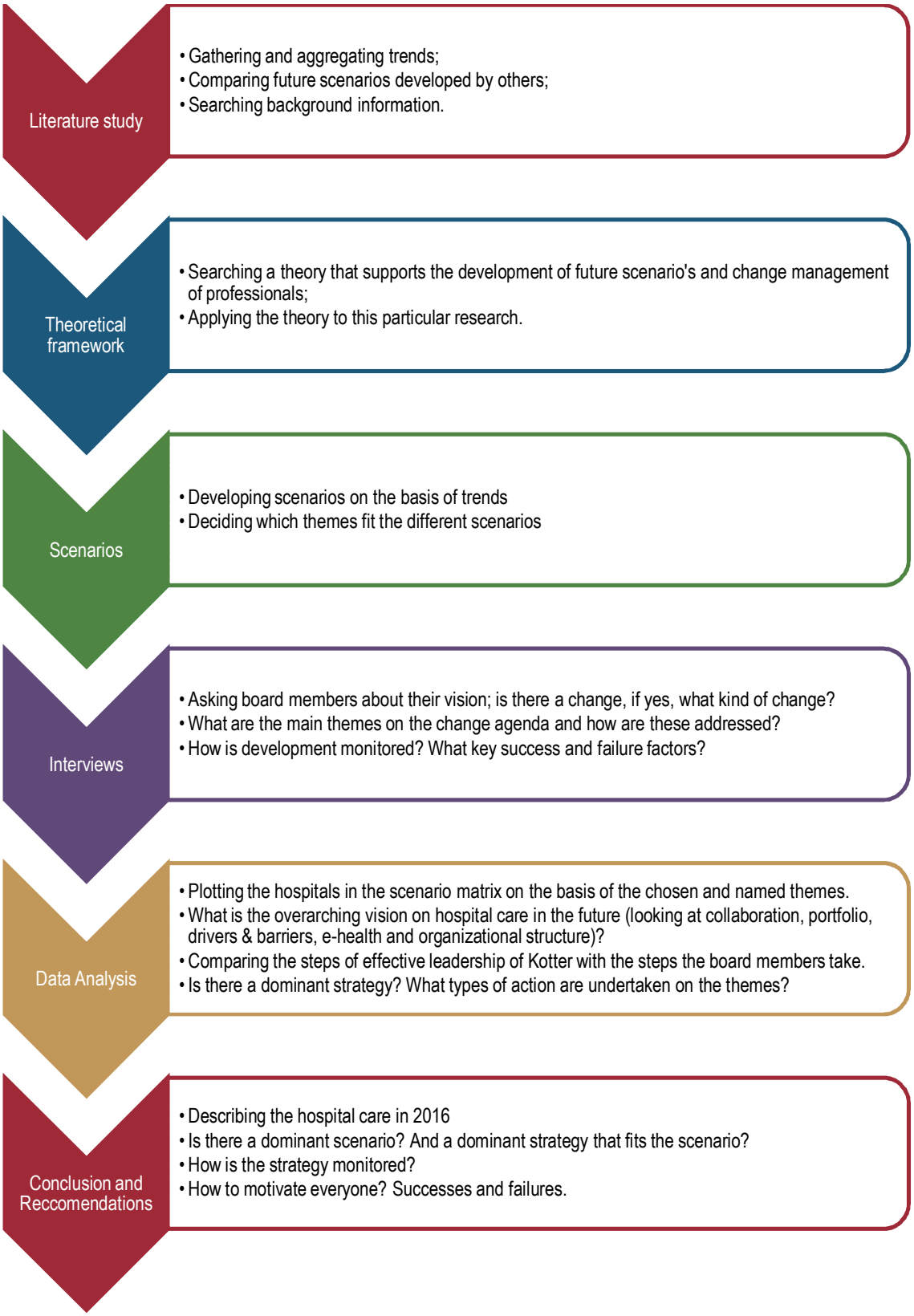
- *Imaging:* identifying possibilities and generating visions of what is desired. Generating a vision was done through field research; by interviewing the hospital board members during a one and a half hour, semi structured, in-depth interview. From June until August 2011 these interviews were held with the board members. During the interviews two to three persons were present.

- *Deciding:* weighing up the information, identifying choices and strategies. To distinguish the different strategies the board members named the theory of Reitsma, Jansen, van der Werf, & van der Steenhoven (2004) was used. A complete WUS analysis was too time consuming, but the questions were included in the interviews to determine which strategy works for the dominant vision. The board members were asked what their strategy is to reach their vision. What kind of 'tools' they use/utilize to monitor the development of their strategy. The 'should' question is addressed in the next step; 'Acting'.

- *Acting:* setting up short-term goals, taking the first steps and follow up our actions. Finally the board members were asked to name key success and failure factors. The answers were linked to the steps of Kotter (2007) described above, to see if board members skip some steps or if they add steps when they implement a strategy. The personal characteristics that some board members named were also looked at and they were linked to the personal characteristics that are included in the literature study of Moen, Ansems and Hanse (2000).

On the next page a schematic overview, a flowchart, of the research design is given.

Figure 2 : Flowchart research design



3.2 Overview of the literature

A literature study was conducted, which is shown in Appendix A, using the data and reports of:

- The Rijksinstituut van Volksgezondheid en Milieu; the state institute of public health and environment (RIVM, 2011) (RIVM, 2010)
- The book 'Diagnose 2025' (Idenburg & Schaik, 2010)
- The report 'Perspectief op gezondheid 20/20' (Raad voor de Volksgezondheid en Zorg, 2010)
- The report 'Niet van later zorg' (MinVWS, 2007)
- The report 'Volksgezondheid Toekomstverkenning 2010' (Lucht & Polder, 2010)
- The article 'Aanbod ziekenhuiszorg in 2020' (Blank & Wats, 2009)
- The report of BS Health Consultancy: 'Onderzoek naar toekomstscenario's in de ziekenhuismarkt' (BS Health Consultancy, 2009)
- The article published by Prometheus Healthcare Consulting: Toekomstscenario's zorginstellingen (Mierden, 2010)
- The article 'Gezondheidszorg en ICT 2020' published by PinkRoccade (Tillaard & Brake, 2011)
- The report of Wanless (2002): Securing our health taking a long-term view
- The report of the Economist Intelligence Unit; the future of health care in Europe (Wieren, 2008)
- The article of (Schimpff, 2008); the hospital of the future

These reports and articles were found by looking on the websites of governmental institutes, like: RIVM, RVZ and MinVWS. Furthermore scientific literature was searched. The theories and studies about changes and transformations in hospitals abroad were looked for in the search engine Google Scholar and the search engine FindUT of the University of Twente. The found articles had to be published after 1997, because the future in the articles before 1997 is now today. They have to be written in English or Dutch and the full text has to be available. By scanning the articles they were filtered on studying the future of the hospital in general, not on a specific department, for instance: the future of nursing or the future of the emergency department etc. They had to take every aspect into account, so for instance not only the quality and safety or the economics, and not focusing on one disease, like: real-time glucose monitoring in the hospital: future or now? Key words that were used are: scenario(planning), road mapping, health(care), 2020, 2025, future, hospital, trends, forecast, strategy.

3.3 Units of study and the method of selection

Hospitals can be divided into general, academic and specialist hospitals. A general hospital is a place that consists of facilities to examine, treat and nurse patients. Furthermore, in a general hospital doctors and nurses are trained. An academic hospital has the same activities as general hospitals, but scientific research is their core business. Specialist hospitals focus on a certain category of patients (for instance asthma or diabetes patients). In the Netherlands specialist hospitals often are rehabilitation centres (RIVM, 2011).

There are four types of hospitals interviewed in this study:

- General hospitals: STZ hospitals; these hospitals are members of the Association of Collaborating Top Clinical Teaching Hospitals.
- General hospitals: SAZ hospitals; these hospitals are members of the Association of Collaborating General Hospitals.
- General hospitals: Other hospitals; these hospitals do not fall into the category STZ or SAZ.
- Academic hospitals; hospitals that deliver top clinical and top referent care, scientific research is their core business

(Dutch Hospital Data, 2010)

The focus on the Netherlands was chosen, because every country has its own health care system and therefore its own way of financing and managing hospitals. Several differences between the states in the European Union are:

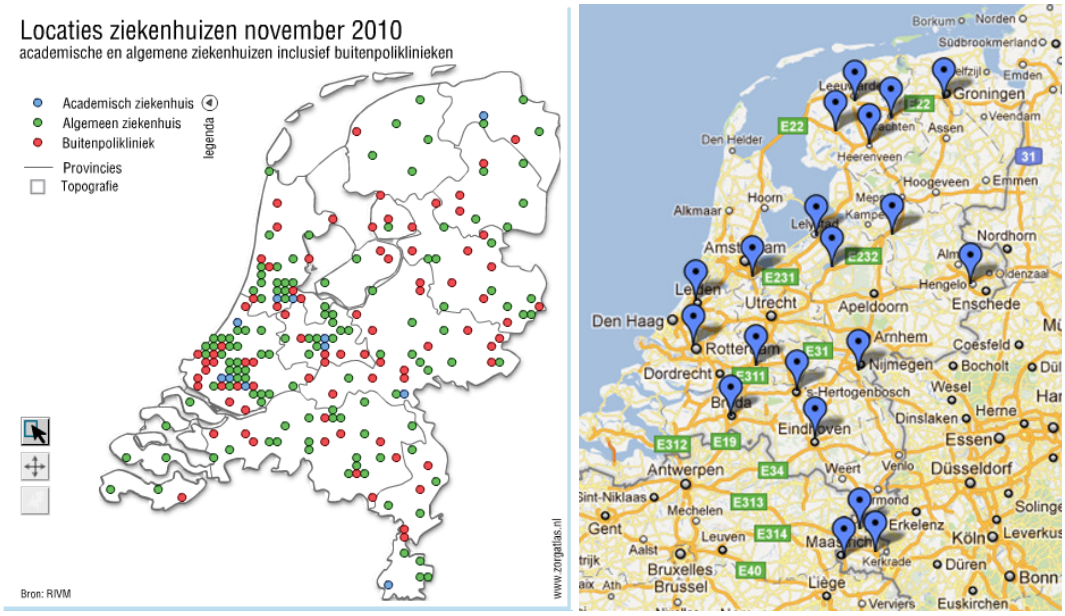
- benefit/cost-sharing regulations
- conditions required to obtain services
- conditions for service provision and quality insurance
- prices and primary payers.

For example, although all countries have reduced the number of hospital beds, they started from very different levels. Germany has nearly twice the European average amount of beds. And, despite a steep decline, Italy still has more than twice as many acute beds as the United Kingdom. (Wismar, Palm, Figueras, Ernst, & Ginneken, 2011)

The units of study are 20 hospitals: Academisch Medisch Centrum, Academisch Ziekenhuis Maastricht, Amphia Ziekenhuis, Atrium Medisch Centrum, Antonius Ziekenhuis Sneek, Canisius Wilhelmina Ziekenhuis, Catharina Ziekenhuis, Diaconessenhuis Leiden, IJsselmeerziekenhuizen, Isala Klinieken, Jeroen Bosch Ziekenhuis, Nij Smellinghe, Martini Ziekenhuis, Medisch Centrum Leeuwarden, Orbis Zorgconcern, Rivas Zorggroep, Sint Franciscus Gasthuis, Sint Jansdal, Tjongerschans, Ziekenhuisgroep Twente

The hospitals were selected based on the spread throughout the country, their size and type. Furthermore there was looked at the relations of Capgemini with hospital board members, but also at contacts that Capgemini does not yet have and find interesting to enter into relations with. During the interviews, some board members advised us to go to some hospitals that were not in our planning. For instance, because the board member in that particular hospital already had a term of office of twelve years and still managed to let his hospital grow. These hospitals were also added to our interview list.

Figure 3: Locations of hospitals in the Netherlands (left) and hospitals to be interviewed (right)



(Deuning, 2010)

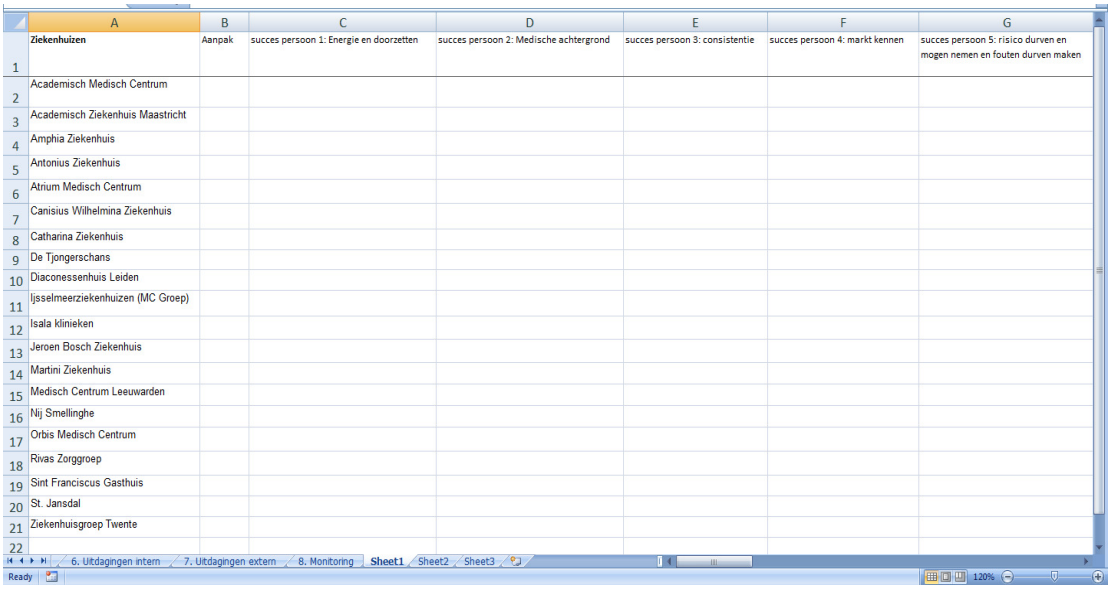
3.3 Interviews and data analysis

The vision of the hospital board members on the future of the hospital care and the future of their organization was asked to them straight away. Though, asking only this question would have been giving very divergent answers. To make the answers more comparable to the vision of other board members, the roles the different stakeholders play (patient, professional, supervisory board, health insurer) were also asked.

In order to divide the hospitals into the scenarios it was important that they named their spearheads for the next few years. By reading the annual reports, it could have been assumed that hospital board members are likely to name all kinds of themes in which they want to exceed. With all hospital board members naming all themes it would have been impossible to plot them into a scenario. Therefore the card-sort method was used; on a set of different cards the themes that are important to deal with for survival (see paragraph 1.4) were written. The board members were asked to pick out the three themes that have priority on their agenda. On the basis of these dominant themes, and the explanation of the board members on why they chose a certain theme, the hospitals were plotted into the scenario-matrix.

The next step was, to ask the board members on the basis of which underlying thoughts they chose for these main themes. Because it is interesting to know on which basis board members choose their spearheads. It is assumed that they do this based on expected future developments; trends. After defining the main themes, the strategy was discussed; the way hospital board members think and act according the main themes and how to reach the envisioned goals related to the themes. The strategies were clustered in an Excel-sheet, according to the theory of Reitsma, Jansen, van der Werf, & van der Steenhoven (2004) and were combined and filled in with the approaches the board members named. The same was done with the theory of Kotter (2007). The steps Kotter defines were put in an Excel-sheet and combined and filled in with the successes and errors the board members have named. In the end was visible where the gaps are and what was often named by the board members.

Example data analysis[1]:



	A	B	C	D	E	F	G
1	**Ziekenhuizen**	Aanpak	succes persoon 1: Energie en doorzetten	succes persoon 2: Medische achtergrond	succes persoon 3: consistentie	succes persoon 4: markt kennen	succes persoon 5: risico durven en mogen nemen en fouten durven maken
2	Academisch Medisch Centrum						
3	Academisch Ziekenhuis Maastricht						
4	Amphia Ziekenhuis						
5	Antonius Ziekenhuis						
6	Atrium Medisch Centrum						
7	Canisius Wilhelmina Ziekenhuis						
8	Catharina Ziekenhuis						
9	De Tjongerschans						
10	Diaconessenhuis Leiden						
11	Ijsselmeerziekenhuizen (MC Groep)						
12	Isala klinieken						
13	Jeroen Bosch Ziekenhuis						
14	Martini Ziekenhuis						
15	Medisch Centrum Leeuwarden						
16	Nij Smellinghe						
17	Orbis Medisch Centrum						
18	Rivas Zorggroep						
19	Sint Franciscus Gasthuis						
20	St. Jansdal						
21	Ziekenhuisgroep Twente						
22							

[1] Note: the names of the board members are confidential, during the data analysis the hospitals were given numbers.

4. Results

In this chapter the first two steps in the TAIDA model are discussed based on the literature study.

4.1 Tracking

A lot of similarities between the described trends in the literature were found. They were combined and that resulted in eight main trends. Below is explained in which direction(s) they can develop in the future. It is important to mention that a trend is an estimation of a possible future direction, it is not the absolute truth, but it is a probable tendency.

4.1.1 Younique

Younique stands for custom-tailored care. Patients prefer to be and stay longer at home, this means a shift from inpatient to outpatient care. Care will also be more disease-based instead of discipline-based, it will be more common to work in networks or chains and there are more (customized) treatment possibilities due to the development of medical technologies. In the future, everybody will be a patient because of the increase of chronic diseases. With as a result a changing demand for care: more patient-centric care. It is a mix of the following trends;

- Younique; a differentiation in care consumers (Idenburg & Schaik, 2010)
- One-to-one: directed treatment through medical technology (Idenburg & Schaik, 2010)
- A shift from inpatient towards outpatient care, more hospital admissions with less hospital days (Lucht & Polder, 2010)
- Consumerism: patients expect quality and safety, increasing demand for medical technology and high expectations of medical technology (Schimpff, 2008)

4.1.2 Prevention

In the Nota 2000 (Ministerie van Welzijn, Volksgezondheid en Cultuur, 1986) was first paid attention to prevention as a determinant of health. Through the years the focus on prevention has grown, because of several reasons. In the first place to prevent diseases and possibly more chronic patients. But also because of the development of medical technology. Of the patient will be expected to do a self-test at home first, before going to the General Practitioner (GP). This will lead to shorter waiting lists and a weaker increasing demand for care. On the other hand the introduction of more preventive measures will increase the flow towards the hospital.
People will also be more responsible for their own health. A shift will take place from cure & disease to behaviour & health. This trend is a mix of the following trends found in the following articles:

- Power to the patient: more do-it-yourself health care (Idenburg & Schaik, 2010)
- Prevention of higher priority (Idenburg & Schaik, 2010)
- Health status is a choice: more attention to lifestyle (Idenburg & Schaik, 2010)
- More self-testing through medical technology (Lucht & Polder, 2010)
- Thinking about (public) health (Lucht & Polder, 2010)
- More effective preventive measures and fundamental lifestyle changes will be promoted to encourage healthy behavior (Wyke, 2011)
- More responsibility for the patient (Wyke, 2011)
- Prevention (Schimpff, 2008)

4.1.3 The sky is the limit/Technology development

People have high expectations of health care in the future. On the area of technology development, but also on the area of accessibility; 24/7, 365 days a year. Health care will be more a global issue, patients will go abroad

for treatment. A patient in the Operating Room (OR) in the Netherlands is operated by a surgeon in Italy. Also on the field of diagnosis; a test can be done in the Netherlands on Tuesday, processed in India on Tuesday night and the patient will know the result on Wednesday morning. This trend is a combination of the trends below:

- Health care to heaven: high expectations of the quality and experience of care (Idenburg & Schaik, 2010)
- Care without borders: globalization of care (Idenburg & Schaik, 2010)
- Consumerism: high expectations of patients (Schimpff, 2008)

4.1.4 Caring is sharing

Through the development of medical technology and through internet it will become more common for patients to search on the Internet first for their possible disease. Also the interaction between patient and doctor will become more digitized, for instance by e-mailing and chatting with a medical specialist. It is also expected of patients to search on the Internet for possible diagnosis and treatment. More information will be registered –for instance in the EPR-, which will lead to more transparency. Hospitals can be benchmarked or more information about treatments is public. Patients will expect an efficient flow of information. This is a combination of the following trends:

- Googleritis: digitizing consumer-care interaction (Idenburg & Schaik, 2010)
- Caring is sharing (Idenburg & Schaik, 2010)
- Improving the collection and transparency of health data, leading to better investment decisions (Wyke, 2011)
- Digitization (Schimpff, 2008)

4.1.5 Fear for care

In the hospital yearly 1700 deaths could be prevented and 30000 patients suffer from avoidable health damage (Idenburg & Schaik, 2010). By knowing more, through digitization and by knowing more, people can get scared. Health care is a complex field, that a lot of people do not understand. Patients are more anxious because of what they know and/or what they do not understand. A merger of the following trends led to this trend:

- Fear for care: level of safety and complexity of health care (Idenburg & Schaik, 2010)
- More care-related infections (Lucht & Polder, 2010)
- Consumerism: patients expect health care to be (more) safe (Schimpff, 2008)

4.1.6 Who cares…?

The number of people with chronic diseases has been growing. The people suffering from multimorbidity has risen. All these people have to be taken care of, while there is not enough personnel. A solution would be increasing the flexibility of personnel, not working for one hospital, but more health care institutions. And possibly founding an international hospital staff or distance medicine. This trend is the result of a combination of the following trends:

- Who cares…? Increasing demand, but a decreasing capacity to provide care (Idenburg & Schaik, 2010)
- Increasing demand for personnel (Lucht & Polder, 2010)
- More visits to the GP (MinVWS, 2007)
- Staff shortage (MinVWS, 2007)
- Governments will have to tackle bureaucracy and liberalize rules that restrict the roles of healthcare professionals (Wyke, 2011)
- Shortage of professionals (Schimpff, 2008)

4.1.7 Redesigning the health care chain

The amount of people with chronic diseases has been risen. The number of elderly people will continue to grow, because of the baby boom, the decreasing mortality and the growing life expectancy. This will lead to more patients and an increasing demand for care. A more prominent role for the GP as gatekeeper is therefore needed. Because of multimorbidity, professionals are forced to work together. This will lead to more collaboration between different echelons. Care will become more specialized and targeted at the disease. This stimulates working in chains and networks. The trends described in the literature are:

- Keeping the elderly longer vital and healthy (Idenburg & Schaik, 2010)
- More chronic diseases and multimorbidity (Idenburg & Schaik, 2010) (Lucht & Polder, 2010) (MinVWS, 2007) (Schimpff, 2008)
- Redesigning the health care chain (Idenburg & Schaik, 2010)
- Increasing life expectancy due to a decreasing mortality (Lucht & Polder, 2010)
- Keeping the universal healthcare model will require rationing of services and consolidation of healthcare facilities, as public resources fall short of demand (Wyke, 2011)
- General physicians will become more important as gatekeepers to the system and as co-coordinators of treatment for patients with multiple health issues (Wyke, 2011) (Wyke, 2011)
- Care pattern is changing from discipline-based to disease-based (Schimpff, 2008)
- Wave of hospital mergers will occur (Schimpff, 2008)
- Care concentrated in specialized hospital units (Schimpff, 2008)

4.1.8 Saving lives, saving costs

With the current policy the costs will inevitably rise in the future, with the additional problems, like the Baumol-effect. The Baumol-effect is a rise of salaries in health care jobs that have not experienced an increase of labour productivity in response to rising salaries in other jobs which did experience such an increase in labour productivity. The problem with the costs is not new, hospitals try to think of something new to save costs continuously. Currently, there are new entrants, like foreigners, who charge lower prices. Or the development of more independent treatment centres (ITCs). Hospitals could focus more on sustainability to save costs. By downsizing or enlarging of hospitals, they could experience economies of scale (producing more or less is cheaper on average) or economies of scope (creating synergy through a collaboration). The following trends were predicted and were used as a basis for this trend:

- Saving lives, saving costs: competition, reification and entrepreneurship (Idenburg & Schaik, 2010)
- The check please: more demand, more costs (Idenburg & Schaik, 2010)
- Working green: sustainability (Idenburg & Schaik, 2010)
- More medical technology will also lead to more costs (Lucht & Polder, 2010)
- Rising health expenditures (Lucht & Polder, 2010) (Wyke, 2011)
- European governments will need to find a way to improve collection and transparency of health data in order to prioritize investment decisions (Wyke, 2011)
- Efforts will be made to suppress health expenditures (Schimpff, 2008)

4.2 Analyzing

The stage of analyzing consist of two steps; analyzing the interrelationships between the trends en generating scenarios.

4.2.1 Analysis of the interrelationships between the trends

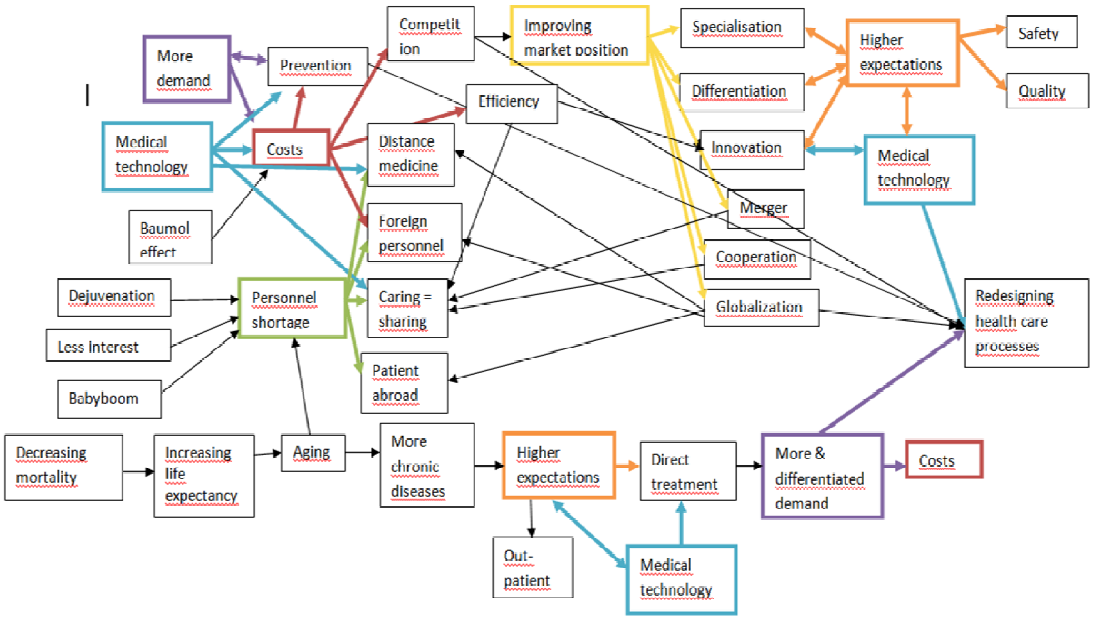
Defining the interrelationships between the trends was actually a bit done in paragraph 4.1, by grouping the trends found in the literature. In the causal loop diagram below is shown how the trends are related to each

other. The trends in a colour appear more than once in the diagram and/or have many causal relations, this is done to prevent a ravel of arrows. A few defined causal relations are explained below.

Medical technology will make prevention more common, for example because there are more (reliable) selftests on the market. The development of medical technology is also the development of E-health, like telemedicine and E-consult. Or the further development of electronic patient records, through which medical specialists and other disciplines will share information about a patient faster and easier. But, medical technology has to be paid for and will make health care also more expensive.

Medical technology will also increase demand. More possibilities to improve diagnosis and treatment will encourage demand. An increasing demand and dejuvenation in combination with aging will lead to personnel shortage. Aging is caused by decreasing mortality and increasing life expectancy. Aging will lead to more chronic diseases and multimorbidity. Because of medical technology and patient empowerment, patients will find more on the internet, which leads to higher expectations. Higher expectations and medical technology reinforce each other. Because medical technology leads to more treatment and diagnosis possibilities leads to higher expectations and higher expectations make researchers do more research which leads to more possibilities.

Figure 4: Causal loop diagram of the trends in health care



4.2.2 Building scenarios

The driving uncertainties in this research have been based on the trends: 'Redesigning the healthcare chain', 'Younique' and 'Saving lives, saving costs'. These trends were translated to the axes 'disease-based' versus 'discipline-based' and 'value-creation' versus focus on 'cost containment'. The decision for these trends was partly based on exclusion; the development of medical technology is certain, it would not be likely to say that that will stagnate before 2016. This also goes for 'who cares…?' and 'fear for care'. Personnel shortage will occur, there is no uncertainty in that by looking at the (estimated) numbers. Safety is almost a precondition in hospitals, especially since hospital related infections occur more often. The development of prevention is uncertain and also depends on the funding system.

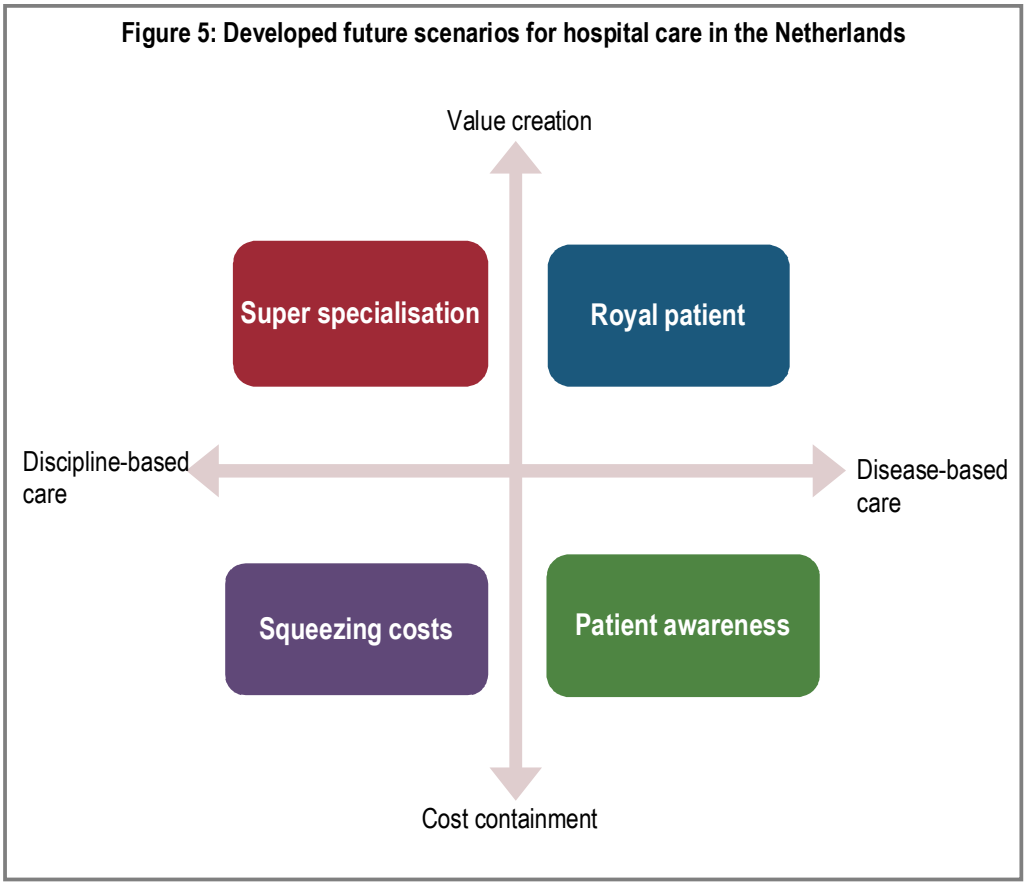
Redesigning health care is something fundamental. It already is a much-discussed topic on the Dutch political, insurer and hospital agenda. Some hospitals are merging or cooperating with other hospitals or care organizations. They are looking for new organizational structures to operate in.
'Saving lives, saving costs' and 'Younique' are two trends that are counteracting with each other. Or don't they? Michael Porter came up with the term 'value-creation', which actually means that focusing on the patient will automatically lead to a more efficient organization. In other words: quality will automatically lead to cost reduction. Currently, hospitals are thinking and acting according to budget constraints. They are used to the old system, directed by the government, that focuses on budgets.
Value creation is about creating value for the patient in a distinctive way, in a field where the patient can choose between different providers and treatments. Value driven competition is based on 8 principles:

- competition on the level of the disease;
- transparency of quality;
- rewarding innovation;
- free entrepreneurial activity;
- organizing care around the disease;
- integrated care;
- financial incentives for care providers and health insurers;
- incentives for investment of third parties.

According to Michael Porter (2008), by aspiring to the favour of the patient, the quality of care will improve, innovations will be realized and care will be organized more efficient. Health insurers will take a directing role and will look for quality. As a result of that, health care providers will differentiate, specialize, innovate and excel. Information about quality will become transparent and patients will choose for quality, which leads to health insures looking for quality to serve their clients. This is a vicious circle. More 'commodities' for the same money will be realized; more health (care) per paid euro. Direct responsibility for delivering good care is carried by the professionals. It is all about the product mix; a patient with a heart attack needs a quick treatment and a patient that needs planned surgery will pay more attention to customer service (Boer&Croon, 2008).
The other end of the axis is about focusing on cost containment, working efficiently. A patient does not have to choose in such an organization, its treatment is already chosen, based on costs. While in case of value creation, the outcomes count, in case of cost containment, the measures count.

Discipline-based vs. Disease-based care: for over 100 years, medicine organized itself based on the physician's discipline training such as Medicine and Surgery, or their subspecialties of cardiology and cardiac surgery. But the patient, who needs care from multiple specialists, from multiple disciplines, is not interested in the old organization. He or she wants to know that the physicians are working as a team for the patient's immediate benefit. As more and more diseases are chronic and require knowledge from different disciplines for its treatment, the patient wants and expects a team approach. He wants a single unified plan of care and is not interested in the physician's or the institution's organization around disciplines (Schimpff, 2008).

Figure 5: Developed future scenarios for hospital care in the Netherlands



The matrix above will give a schematic overview of the different possible future scenarios. The scenario 'squeezing costs' is most similar to the current situation and the situation 'royal patient' is a scenario that fits the thought of Michael Porter about value creation. The description of the scenarios might be a bit exaggerated to show their mutual differences. To give an idea about how the world might look like on health care area a broader description of each scenario will be given in the text boxes on the next page.

Collaboration is almost inevitable in the future, before reading the scenarios, a short explanation is written in this paragraph to explain different sorts of collaboration.

Different organizational structures for hospitals are conceivable in the future. The terms 'concentration' and 'integration' refer to collaboration. There are two types of concentration, namely; horizontal integration and vertical integration.

A collaboration is "horizontal" when there is an agreement between two or more organizations that are active on the same level (or levels) of the market. Horizontal integration includes mergers, joint ventures and contracts. Joint ventures and contracts are both forms of alliances. A merger occurs when two or more independent organizations merge into one organization. An acquisition occurs when one company acquires control over another company. An alliance occurs when two or more organizations work together to achieve joint and individual goals. Products, services and technologies are exchanged, shared or jointly developed.

Collaboration is 'vertical' when two or more organizations collaborate, that are active on different levels of the market. An example is a hospital working together with a nursing home, or a health Insurance company. Forms of vertical integration are care in chains and networks.

Chain and network care is also known under the designation 'integrated care'. Integrated care is a coherent set of efforts by various health care providers under one recognizable controlling function, whereby the client

process is central. Briefly, the demand of a patient is presented to the network of health care providers and based on the demand the type of care is determined and provided by different health care providers (Duysters & Man, 2003).

Squeezing costs

Focus

The focus in this scenario lies on costs and care organized based on disciplines.
The patient is not in charge, everything is decided for him/her and there is no ability to choose a treatment or provider. The GP is the gatekeeper and refers patients to the hospital if needed. Different hospitals are not cooperating, if a patient comes to the hospital he/she is treated in that hospital (unless a patient needs a very specialized treatment, then he or she is referred to an academic hospital). This scenario is based on the scenario of the beer, developed by PinkRoccade (Tillaard & Brake, 2011)*. It is characterized by a short term focus: how to avoid high costs now. Horizontal concentration is upcoming; a lot of hospitals try to merge or form alliances to improve their market position. But the medical specialists do not want to work together in chains, because they are afraid to lose their autonomy and their specialty on a certain area. Board members stick to their habits and they do not feel a sense of urgency for change. The Board of Supervisory does not play a major role and is composed of 'notables in the region'. The organization is large, very layered and hierarchic; the board is far from the workplace. They also do not dare to confront with the medical staff. The focus lies on solidarity, cost containment and efficiency* (Tillaard & Brake, 2011)*. Quality and service is of less importance, this scenario is very comforting for patients that have difficulty with understanding the health care system and prefers that the doctor decides what is best for them. The funding system is an incentive for production; more patients, means more money.*
This scenario actually reflects the current situation.

Terms

LEAN, cost containment, economies of scale, large general hospitals, power to insurance companies, benchmarking

Examples

The hospitals of a few years ago, controlled by budgets.

Super specialization

Focus

In this scenario the focus lies on value creation and discipline based care. This scenario is based on the open-innovation structure (Mierden, 2010). *This means hospitals will make use of innovations like medical technology and new medication to treat patients more precise.*
To create value it is important for hospitals to distinguish themselves from others. They will do this by specialization. Smaller general hospitals will have a hard time to distinguish themselves in this environment. Some medical specialists will decide to specialize themselves further and will found an ITC with their colleagues. A risk of super specialization is, that it will be hard to educate (more) general doctors. Academic hospitals are actually examples of super specialized hospitals, although they also offer more general hospital care, to fund the more expensive, top referent care.
The GP's role is the one of gatekeeper, he will refer the patient to the medical specialist.

Terms

Independent Treatment Centers, Specialist Hospitals, specialization, innovation differentiation, GP in charge, product leadership, hospitals with a 'fake' academic status.

Examples

Oogziekenhuis, Sint Maartenskliniek; founded with the thought of patient centeredness, providing a more specialized treatment to patients with a specific visual or orthopedic disorder.

Royal patient

Focus

In this scenario the focus lies on value creation and disease based care, based on the thought of Michael Porter (Boer&Croon, 2008). *Hospitals will make use of innovation and high-end technologies. Actually the same as in the 'specialization'-scenario. Though, in this scenario care is based on diseases. This means hospitals will cooperate to create networks and chains, based on diseases, in order to provide patients the best specialized care. The difference between primary, secondary and tertiary care will disappear. Patients will not be referred by their GP or other medical-specialists anymore, the hospital will take charge, in the role of case manager of the patient. Care is organized around the patient. Patients are empowered: they will be able to make their own choices in care providers. They will travel to receive the best possible care. In the article of PinkRoccade they call these patients 'TIFKAPS': the individual formerly known as patient* (Tillaard & Brake, 2011).
Prevention will be an integrated part of health care, since this will lead to the best outcome for the patient. Health care is performance based; it is about the outcome for the patient and optimization of the health care process. The product mix is of importance, no 'one-size, fits all'. Hospitals will stop growing; more care is distributed to other health care providers.

Terms

One-stop-shop, sustainability, working 'green', differentiation, specialization, innovation, high-end technology, network organizations, chain care, ITCs, patient empowerment, working patient-centered, multidisciplinary teams, integrated care

Examples

Diabeter and Dementienetwerk

Patient awareness

Focus

Focus on costs, with hospital care organized based on diseases. The echelons will disappear. This scenario is based on the thought of HMO collaboration and the efficiency dependence model (Mierden, 2010).

Medical specialists will found ITCs because of financial reasons.

The patient can choose his/her own provider. Though, insurance companies will make deals with providers. If a patient wants another provider, he/she will have to pay for it out of their own pockets (BS Health Consultancy, 2009). *The professional is also made aware of efficiency; they know the costs and benefits of every treatment. They are partly responsible for the financial status of the hospital. Besides, they are also (financially) committed to the hospital.*

To pre-empt the staff shortage and its costs, hospitals will look for quick and cheap solutions. Like personnel from abroad or introduce more nurse-practitioners and volunteers. The hospital in this scenario has two criteria for providing care: 1. Care is only provided if there is a profitable margin on a treatment, and 2. If providing that type of care is an addition for the patient in that region.

Hospitals will work together in networks and chains to contain costs of, e.g., procurement. They are setting up shared service centres, in which the administration and meals are organized for multiple hospitals. They will expand, to benefit from economies of scale. Safety is of major importance, because an image of low quality will make this type of hospital go down the drain.

Terms

Nurse-practitioners, preferred providers, mergers, alliances, conglomerates, economies of scale, cost containment, LEAN, DRGs, working patient-centric.

Examples

IJsselmeerziekenhuizen, a focus factory.

Certain themes match certain scenarios. On the basis of chosen the themes, and the explanation that supports their choice, can be decided towards which scenario a hospital expects to move.

4.2.3 Super specialization

The themes Innovation, Quality and Staff fit the super specialization scenario. Innovation and knowledge management makes further specialization possible. Quality of care is important in this scenario, to meet certain rules and regulations, but also because the patients expects this. Staff makes specialization possible.

4.2.4 Royal patient

Royal patient is about patient-centric care, the needs of the patient; the product mix. Quality is important in terms of care, but also in terms of service. Staff is responsible for both types of quality. The focus on quality and on the patient will automatically lead to efficiency.

4.2.5 Patient awareness

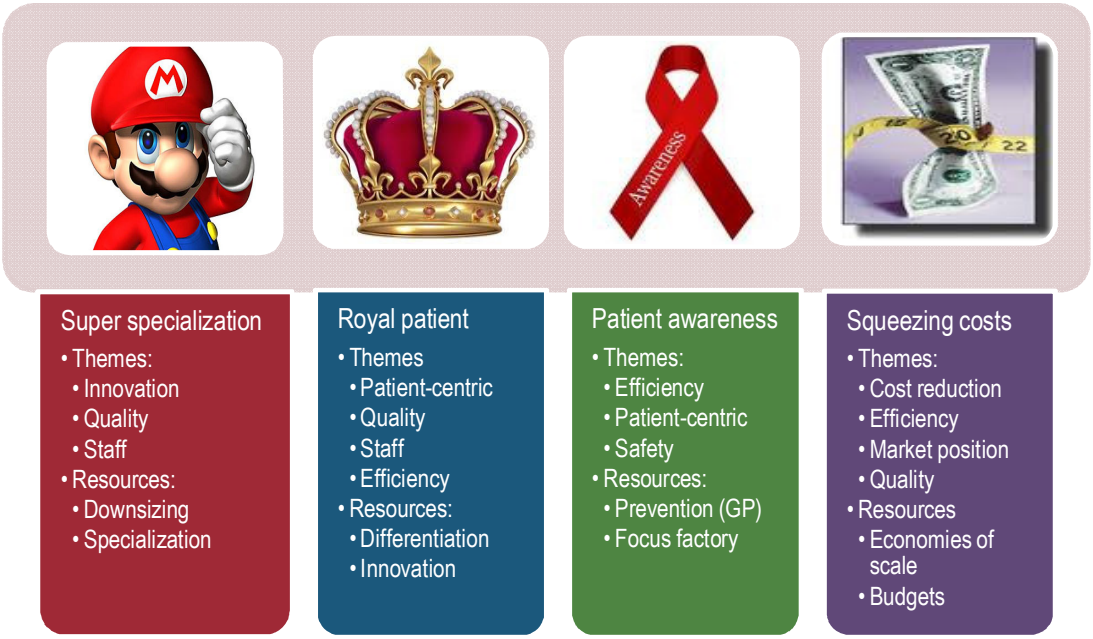
The theme efficiency is of importance in this scenario. All professionals have been made aware of costs and benefits, on the other hand they also look at the needs of the patient. Prevention and safety are interesting themes on the board's agenda.

4.2.6 Squeezing costs

Looks like the situation of the last fifty years. Government demands the health care sector every year to contain more costs, budgets decide the course of the hospital. On the other hand, the government and the patient expect high quality.

A schematic overview is shown in figure 5.

Figure 6: Characteristics Future Scenario's



4.3 Imaging

In this paragraph is discussed what hospital board members identify as upcoming trends, on which they react and which actually are their drivers for change. Furthermore their vision towards the future is discussed and on the basis of these answers, the scenario they fit in best are determined.

4.3.1 Political influence: specialization, distribution and concentration

One hospital named political influence as a driver to change. Against four hospitals that named it as a barrier, among others for contradicting itself regarding competition by setting the annual growth at 0%. Politics was not found as a trend in the literature study. Because of recent developments, however, it plays a major role for the board members.

During this research, the hospitals, insurers and the Ministry of Public Health, Welfare and Sports came to an agreement about the specialization of medical specialist care through distribution and concentration. The thought behind this agreement is, that if care is more specialized, quality will be improved (MinVWS, 2011). This means that patients and/or specialists will have to travel further, because hospital care will be distributed and concentrated throughout the country. The insurer will have to apply 'selective contracting'; only treatments that are performed above a certain standard (for instance, 50 operations a year) will be contracted. This means medical specialists will perform these procedures more often, which will lead to quality improvement (practice makes perfect). Seven hospitals foresee this as a problem, because insurers do not have instruments to assess the quality of a treatment.

Nine hospitals named these volume standards set by insurers as a trend, a driver for change. They will be forced to think about their portfolio and how to distribute care in their region. Through collaboration with other hospitals these volume standards can be achieved. Another way to achieve these standards is to decide to focus only on a few disciplines and repel others.
This will also lead to competition in the region, five hospitals named this as a driver. Three hospitals do not plan to make any choices in their portfolio, mainly because they are located in an isolated area. Their hospital is the only large hospital in the area and the smaller hospitals are already sending patients in need of specialized care to the large one, because they cannot guarantee quality and 24/7 service.
Especially emergency care will need to be concentrated in the region according to eight hospitals, because this discipline requires sometimes high specialist care and 24/7 accessibility. This will also go for intensive care, obstetrics and oncology. One hospital board member expressed his doubts about concentrating emergency care, according to him it would probably disturb the relationship between patient and hospital.

4.3.2 Younique: Patient empowerment
Patient empowerment, part of Younique, was named by five hospitals. Patients expect more transparency of quality. They hope to find this by searching on the Internet. Care need to be organized around the patient. On the other hand, some hospitals stated that, if the problem of increasing demand and costs has to be solved, the 'greedy' patient should be slowed down first.

4.3.3 Younique: From inpatient to outpatient care
Four hospitals stated that the residential function of the hospital will disappear. Mainly chronic and elderly patients should be treated elsewhere. Chronic patients can be monitored by their GP and through self-management by telemonitoring. A hospital experienced that this also increases the therapy compliance. Three hospitals named the shift from inpatient to outpatient care as a driver for change. Elderly people also stay longer at home, before moving to a nursing home. Van der Lucht en Polder (2010) also defined this as a trend, patients also wánt to stay at home longer.

4.3.4 Saving lives, saving costs; increasing demand and cost containment
The trend 'saving lives, saving costs' was named by board members. The solution Wyke (2011) brings up: "European governments will need to find a way to improve collection and transparency of health data in order to prioritize investment decisions", was given response to by the Dutch government through the agreement described above. The main problem in distributing and concentrating care is the so-called 'cross-subsidizing'. On low risk, high volume treatments[2] some profit is earned, with this 'profit' the high risk, low volume treatments are paid. If hospitals will only perform low risk, high volume treatments, competition will become tougher, which makes the prices drop. Hospitals that will only perform high risk, low volume treatments will go bankrupt. Seven hospitals named increasing demand and budgeting as a driver for change. This is a trend that was described by Schimpff (2008) as 'Consumerism'. Patients have high expectations of (targeted) treatments and the development of medical technology, which will make the demand for care increase.

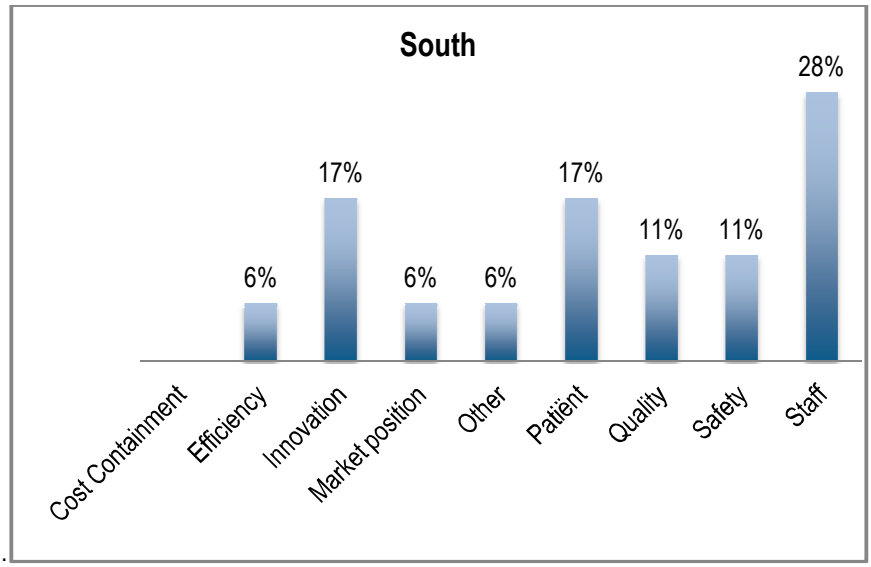
4.3.5 The sky is the limit: European competition
European competition forms a part of the trend 'the sky is the limit'. It was described by Idenburg and Van Schaik (2010) as care without borders; the globalization of care. Two hospitals in the south of the Netherlands named

[2] Low complex care consists of easy to perform surgery with a short hospital stay, without appealing for highly specialized knowledge or infrastructure. Low complex care merely has a high volume. Examples include cataract surgery and orthopaedic procedures for hips and knees.
High complex procedures rely heavily on medical technology, medical facilities and highly specialized knowledge. It is often limited to a number of interventions or treatments per year. Examples include treatment of some cancers and transplants. (Blank & Wats, 2009)

European competition as a driver for change. Their hospitals are close to the Belgian and German border. With patients becoming more mobile, they have to stay ahead in terms of service and innovation of the hospitals abroad. Another possibility is to collaborate, for instance by founding an European Centre of Excellence or an European Academic Centre.

4.3.6 Who cares...?: Aging and a decreasing labour fore

Looking at the defined trends, aging and staff shortage is named respectively three and four times. Noteworthy is, that this is mainly named by hospitals in the south of the country[3]. Therefore they probably also chose most for the theme 'staff' compared to the other regions. The board members explained that Limburg (southern province) is declining. There is a lot of rejuvenation and aging. This makes it hard for them to recruit new personnel.



4.3.7 Redesigning the health care chain

When looking at redesigning the health care chain, different models will be possible. Most of the hospitals agree on and encourage the fact that GPs take over a lot of care. For instance chronic patients: they do not have to be in the hospital that often as they are now, according to hospital board members. Some of the hospitals also have started initiatives to support GPs; helping them with cardiac patients in case of doubt, giving them diagnostic tools and making them part of the Emergency Room staff. This is an example of vertical integration. Other examples of vertical integration are the four interviewed hospitals that collaborate with nursing homes and three with home care organizations.

Also on non-medical business processes hospitals start to work together. For instance, by founding shared service centres for the back-office (personnel administration, purchasing) or by outsourcing the cleaning work.

Regarding horizontal integration; four out of twenty respondents are planning a merger. A problem with mergers and acquisitions is, that hospitals are not allowed to make too many agreements or to acquire a monopoly position in the region. This was also stated by Wyke (2011): "Governments will have to tackle bureaucracy and liberalize rules that restrict the roles of healthcare professionals.". Although, in this case it is about organizations instead of professionals.

[3] Further data analysis based on region, type and size of hospital and background of the board members can be found in Appendix E.

These (restricting) rules are set by the Dutch Competition Authority (NMa). Three hospitals appointed the NMa as a barrier for change. Ten hospitals are collaborating; five collaborations are between top clinical and general hospitals, four are between academic and top clinical hospitals and one between academic hospitals. Eight hospitals stated that they were orienting on collaboration, of which six were between top clinical and general hospitals and two between academic hospitals. The Northern provinces are trying to organize a regional partnership. In Friesland the insurer 'De Friesland' is starting up a project between four Frisian hospitals. And a hospital in Groningen, in Drenthe and in Friesland are also looking for collaboration possibilities. One Frisian hospital is 'invited' to both projects, but participating in both projects does not seem to be a possibility.

To come back to the different models for hospital care in the future, hospitals broadly described three models:

1. Patient visits professional; seven hospitals envisioned a model in which patients travel to receive the care they need. In the beginning this model applies to high risk, low volume hospital care. Patients will receive pre- en post-operative care in their 'own' hospital, but the complex procedures will be performed in qualified hospitals. A lot of hospitals do not think it is efficient to let patients travel for simplistic procedures, especially when it concerns elderly people. Some hospitals are already applying this model.
2. Professional visits patient: two hospitals named the rise of regional departments (maatschappen), they work as a travelling party for a few hospitals in the region.
3. Patients are referred : some hospitals are isolated in the region, the smaller hospitals in the surroundings are referring their patients to the large hospital. Or hospitals that are not offering all the (highly) medical specialist care refer their patients to hospitals that do offer that care. Some hospitals already have agreements about referring patients, for instance, by always setting aside beds for their allies.

There has to be mentioned that combinations of these models are possible. For example, patients of the interviewed academic hospitals sometimes travel to other –specialized- hospitals to be operated on by another surgeon over there, but in some cases their own surgeon travels with them.

Seven hospital board members pronounced their expectation that hospital care would be offered in health networks in the future, with no separation between primary, secondary and tertiary care. Some hospitals are already working in chains or networks, or are planning to do so. Three hospitals said that they hoped they would become case managers of the patient; the patient 'arrives' in their hospital and they will take care of everything concerning care. In this position they will also negotiate with insurers about all types of care. One board member mentioned that he hoped that in the future the relationship with the insurer would be more focused on the long-term. Currently hospitals are negotiating every year with insurers about prices and volumes. Two hospitals were disappointed that it is not possible yet for an insurer to take over a hospital.

4.3.8 Caring is sharing: E-health

E-health will also play a role in this medical specialist focus of hospitals. Overall, board members seem not to see the benefits of telemedicine in the field of diagnosis, except for one. But they do see the benefits in the field of chronic patients and young patients (self-management). Also when it comes to second-opinions and data exchange between care providers, E-health can be of great value. One hospital also stated that they cannot ignore the existence of review sites, like zorg.independer.nl. On these sites medical specialists are assessed by patients, on the basis of this information, other patients can make a decision on which hospital or which doctor to go. Bottlenecks for digitization are the reliability of doctors on IT systems and the funding of IT systems, especially when GPs are performing medical specialist consultations using IT.

4.3.9 Fear for care and prevention
Trends that seem of minor importance are 'prevention' and 'fear for care'. Hospital board members did not name these trends as influential factors on which strategy decisions are based. Four hospitals board members did name the theme 'safety' in their top three of themes on their change agenda. Prevention seems to be shifted to the primary care. As a barrier towards the focus on prevention, or actually the focus on optimizing the chain, the current funding system is blamed. Currently, care providers are paid for every patient they treat, the longer the treatment, the more they get paid. This does not stimulate care providers to decrease the number of treatments and, related to that, to focus on prevention.

4.4 Deciding

Based on the different approaches and corresponding features described by Reitsma, Jansen, van der Werf, & van der Steenhoven (2004) the hospitals were spread over the approaches.

4.4.1 Directive
Two hospital board members seem to have the style of a directive leader, following a directive strategy. The goals are clear, take it or leave it. Rational choices were made and during the performance of the plans made, there is no room left for discussion. One board member openly admitted that he had difficulty with motivating people and that he let others to that. The other board member was more insecure about his role and eventually adopted this style, because letting his staff decide took too long. This board member has made use of soapboxes, so he will also fit in the style of tell & sell.

4.4.2 Tell & sell
Five hospital board members have given answers that fit the style of tell & sell. They told that they want to convince their staff. One hospital board member has worked with a reward system. Two hospital board members have worked with examples, to make the change more alive. People are allowed to think along; one hospital board member stated that his staff 'supported' the chosen course. Which means the staff did not actually participate in choosing the course. Another board member stated that he would like to learn how to release control, which could mean that he was not content with his style.

4.4.3 Negotiating
Eleven hospital board members seem to be negotiators. Looking at the characteristics of this style, this is plausible. Board members often deal with a small group, the chief doctors, which represent a larger group. Especially for non medical board members it is hard to mind the work of professionals. Therefore they can set a (non-medical) framework, which will be filled in by professionals.

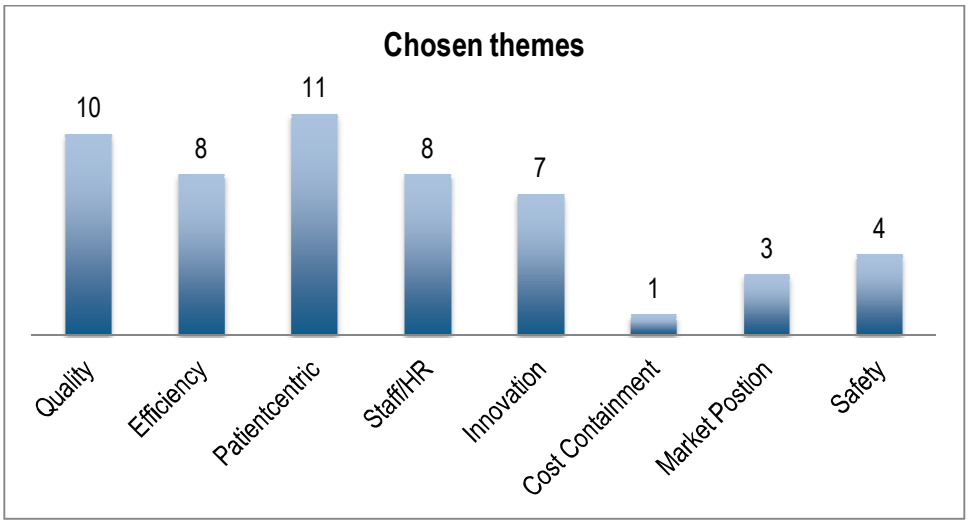
Seven out of the eleven board members literally described themselves and the role of the board of directors as creator of the framework. They provide the preconditions. Corresponding approaches that were named, are; creating an open culture, involving staff (also employees lower down the organization), deciding on themes, but let the professionals fill them in. The final goal is clear, but the means will be determined along the way. All new ideas can be put forward, as long as they meet the set preconditions. Change is supported, the people that seem good for the job, are put in the right place. It is about confidence; motivating people, but not controlling them.

4.4.4 Developing
Two hospital board members seem to have a developing approach. They are open to all new ideas and are a source of inspiration to others. The motivate their employees and purely direct on the process. There are no soapboxes and the hierarchy is described as an upside down pyramid; the professionals are on top and the board of directors is at the bottom. One board member said, that he asks his management team every week to come up with a new idea. Everybody is seen as a possible partner, therefore the size of the group is actually the whole network of a board member.

4.5 Acting

In this part of the research, there was looked at the themes the board members have chosen. For every theme some tools the board members use were discussed. Thereafter the eight steps of Kotter were reviewed, respectively steps towards successful effective leadership and errors in effective leadership. These steps were compared to what board members said about their role in the change process and which approaches and personal characteristics have contributed to their successes and failures.

Making use of the card-sort method the board members were asked for their top three of themes on their change agenda. After choosing the three themes, they were asked to give examples of how these head themes has been or will be expressed within the organization.



The theme that was chosen most is 'Patient Centric Care', followed closely by '(Transparency of) Quality'. 'Efficiency', 'Staff' and 'Innovation and Knowledge management' are ending in the mid-range and 'Safety', 'Market Position' and 'Cost Containment' are chosen least. Two hospitals board members chose for 'Collaboration', when that card was still an option. Two hospitals came up with other themes; 'Finance' and 'Cost-effectiveness'. One hospital only chose two themes.

According to the board members, if they did not choose a theme, this did not automatically mean the theme was of no importance to them. Some board members stated that, for instance in case of cost containment and efficiency, themes have been forced onto their agenda, due to political or legal reasons. In case of quality and safety, these themes were often seen as one or as preconditions. Sometimes themes were not chosen, because they are not a subject to change anymore. They are already as right as a nail, according to the board members.

It is obvious that for the future patient-centric care and quality will be of influence. For each theme the (most) mentioned means to direct or operate on a theme were written down.

4.5.1 Patient centric care

Patient centric care has two aspects; in terms of service and in terms of care. The current organizational structure with "maatschappen" will not be in line with treating patients demand-oriented. Four board members stated that they expect or hope the "maatschappen" will disappear. Some new structures were mentioned to create more (financial) commitment among medical specialists to the hospitals instead of to their "maatschap". Some examples of these commitments that were named are: partnerships, like law firms, or a structure with share holders. The problem with share holders is, that hospitals are prohibited to distribute profit. Six of the interviewed hospitals mentioned that they have been working with profit centres. To create more commitment

among their medical staff and more (cost) awareness. Patient centric care can be organized by creating a (multidisciplinary) team around the patient and around the disease. As mentioned previously, a couple of hospitals want to be case-manager for the patient. The patient will arrive in their hospital and they will take care of all things the patient need (for instance, home-help or rehabilitation).

Some hospitals are building more single rooms, to guarantee more privacy for the patient. New employees have been offered courses to be more patient friendly. A lot of patient satisfaction studies have been performed to constantly be aware of the image of the hospital among patients and to improve that image. A few hospitals are implementing 'PlaneTree'. Planetree is a holistic program that focuses on service. One hospital defined four types of patients (from empowered patients to obedient patients), to determine how to approach their clients and how they can offer each type of patient a customized treatment.

4.5.2 Quality

Hospital board members often see quality and safety as one theme. To improve quality and its transparency board members are trying to create an open culture, in which medical mistakes can be reported, discussed. As a result this will lead to proposals for improvement. Previously, this was unthinkable, according to some board members. Quality project teams have been set up and someone of the board is project manager of the team. Though, this can be difficult if they have no medical experience. One hospital has been trying to acquire a Joint Commission International accreditation, which is a high, international certification for quality. By implementing 'zorgpaden' (care paths) it is more transparent to the patient what will be happening in the hospital and if the treatment he/she receives is as it should be. Protocols and standardization will lead to routine and therefore quality. Yet, the medical specialists should still be challenged and want to be challenged for performing more complex treatments. Only performing routine procedures will not be satisfying. Therefore medical specialists will have to travel to other hospitals to perform complex treatments, to keep up to the mark.

4.5.3 Efficiency

Efficiency can be improved by optimizing processes, for instance by creating synergy in the back-office and setting up Shared Service Centres together with other hospitals. Efficiency also includes: optimizing patient logistics, standardizing, promoting the patient flow by working together with reactivation/rehabilitation centres and nursing homes. The use of E-health tools for chronic patients (telemonitoring) also contributes to improve efficiency, as cited by a board member: 'I do not want to see any persons in my hospital that do not necessarily have to be there'.

4.5.4 Staff

One hospital, located in an isolated area, has offered job mediation for partners of medical specialists to attract staff. This hospital has also offered education and training to their employees. Some hospitals stated that they are large enough or that innovative, that attracting employees is no problem. This assumes that attracting staff will be easier when a hospital can offer specialists enough challenging activities to broaden their horizon and to work on their personal development. One hospital gave their employees five extra days off, they are allowed to transfer them when they are 60+. To cite a hospital board member: 'The hospital is as good as the doctors that work there'. Recruiting employees can be difficult, but selecting them on patient friendliness and flexibility is even more difficult. Though, to improve the medical specialist care, it is necessary to have clear selection requirements for hiring new employees.

4.5.5 Innovation and knowledge management

One hospital board member asked his management team weekly to come up with a 'Senseo'. This is a metaphor for an innovative idea which links two worlds. It is also about giving specialists space to come up with innovative ideas and seriously discuss them. Two hospital board members implemented so-called 'learn-experience years'. When a specialist comes with a good idea, a sort of trial will be set up for three years, after these years the idea will be evaluated. Thereafter it will be fully implemented or not. This is also a good way to cope with resistance.

Knowledge management can be worked on by implementing an EPR and by working together with other care providers. This will also lead to optimizing processes (a patient does not have to repeat its medical record over and over) and therefore it will contribute to efficiency. Knowledge management is as well about giving employees the opportunity to develop and to specialize (further).

4.5.6 Safety
Safety was partially explained at the theme 'quality'. To ensure safety in the hospital an open culture have to be created. Safety management systems need to be implemented. One hospital has been conducting mortality analysis to detect unnecessary mortality and speaking to medical specialists when a case of unnecessary mortality has been detected.

4.5.7 Market position
A better market position can be accomplished by growing. One hospital board member stated that he wants to grow faster than the market. Another way to achieve a better market position is by being competition ahead in terms of quality and service.

4.5.8 Cost containment
Cost containment was hardly chosen nor named as a theme. Probably, because cost containment is a theme, that is forced on the agenda by the government and insurers.

Handling these themes successful will depend on multiple factors. Kotter (2007) gave some tools, steps, to help leaders to be effective in leading change. There was looked at those steps and they were linked to the answers of the board members, to see if they follow these steps. Furthermore, there was looked at the personal characteristics of the board members, because they are also of influence in leading change.

1. *Establishing a Sense of Urgency*
   Two board members named this as important step. Though, they did not mention how they exactly establish a sense of urgency.

2. *Creating the Guiding Coalition*
   Of great importance, and also a challenge, was to motivate the medical staff. They have to be the guiding coalition, if they do not agree on a certain change, it will not happen. Two hospitals board members stated that it was important to take away uncertainty, because that creates resistance. Taking away uncertainty can be done by being clear about everyone's role and making the direction clear in which the hospital will be moving.

3. *Developing a Change Vision*
   Four hospital board members named translating the vision to all levels of the organization as a key to success. Keeping it simple. Sending all the information one receives as board member into the organization is not effective. A nurse cannot do anything about the costs of an DRG, this information has to be translated so that everyone can contribute in his/her own way.

4. *Communicating the Vision for Buy-in*
   Thirteen hospitals named communication as a key success factor, one board member even said: 'Communication is half of the work. '. Importance is also consistency, continuously carry out the vision on different manners.

5. *Empowering Broad-based Action*

This is also part of communication. Also thirteen hospitals mentioned putting forth (controversial) subjects as a key success factor. Like talking about the elimination of "maatschappen", talking about safety and creating an open culture in which anything can be said without starting to argue. Some board members also stimulate their staff to come up with new ideas, provided that they have to contribute to the needs of the patient.
Another success factor was giving employees space and responsibility, this was mentioned by eight board members. This helps to encourage people to undertake (untraditional) activities, actions and come up with ideas.

6. *Generating Short-term Wins*
   Four hospital board members named the generation of short-term wins as a success factor. They did this by setting frameworks, by practicing with small business parts and by doing and organizing things step by step.

7. *Never Letting Up*
   This was seen as a challenge named by four hospitals. Especially to hire, promote and develop employees that meet all the selection criteria. One hospital had a wide promotion and demotion policy to allocate every employee to the right place. Other hospitals were looking for high potentials and some hospitals were more rigorous in firing (and hiring) people.

8. *Incorporating Changes into the Culture*
   This is more about monitoring, how to measure the success and communicate it to the organization. Some hospital board members make use of 'soapboxes' (speeches) or are planning quarterly meetings with the profit centres to talk about their developments and how to improve. Six hospitals were talking about providing information/reporting to the organization about development. Nine hospitals were talking about operationalizing success, for instance by working with Key Performance Indicators (KPIs), so that everyone is constantly aware of how things are going in the organization and can anticipate on that. Other hospitals worked with surveys among employees and patients, to monitor the satisfaction.

Things like a dual board, giving examples to convince people and communicating the vision (the power of visualization) and prioritizing, what is of importance now and what later, what is worth arguing about and what not, were also named as a factor for success. One board member also said: 'Never fight with more than two "maatschappen" at the same time.'

The eight errors for effective leadership according to Kotter (2007):

1. *Not establishing a great sense of urgency*
   This was named by one hospital board member, he stated that is was important to recognize the urgency for change. He compared it to the orchestra on the quarter-deck of the Titanic, that kept playing, even when the ship was already sinking, the orchestra was still pretending everything was alright.

2. *Not creating a powerful enough guiding coalition*
3. *Lacking a vision*

4. *Under communicating the vision by a factor 10*
   This is linked to the importance of communication, thirteen board members stated that communication was, in a manner of, half of their work. This means, that if there is no communication, this will lead to failure. But this was not specifically named by the board members.

5. *Not removing obstacles to the new vision*
6. *Not systematically planning for and creating short-term wins*
7. *Declaring victory too soon*
8. *Not anchoring changes in the corporation's culture*

(Kotter, 2007)

An important failure factor, which was not mentioned by Kotter, but was mentioned by the board members, is that, as a board member, you should not be looking over the shoulders of the professionals. Professionals are trained and know what they are doing. Maybe this factor can be assigned to 'not creating a powerful enough guiding coalition'. When a board member is constantly telling its professionals what to do, there is no coalition, no support.
Though, it is remarkable that not many hospital board members named factors that might cause failure. Some named failures, but that are not the ones Kotter defines. Factors that might cause failure, according to the board members, are;

- Not knowing your market: who are your customers and what are their needs?;
- IT systems that do not answer the needs of the hospital;
- Working with formats, like recruitment assessments or Planetree
- Be a show-off, with an oversized car and an oversized boarding room

The personal characteristics of an effective leader in complex organizations were compared to the answers the board members gave when they were asked for their personal success and failure factors.

Motivation, loads of energy and a strong tendency towards taking charge (Kotter, 1988)(Yukl, 1989)
The energy certainly was mentioned. Eight hospitals stated that energy and perseverance are of great importance. Another board member stated, that as a board member you really have to like the job, because it takes a lot of time.

Knowledge of the industry and the organization (Kotter, 1988)
Here 'knowing the industry' comes back. That was mentioned by one board member as a failures; not knowing the market. Four hospital board members named it as a successful personal characteristic. Three hospital board members indicated that their medical background helps them to communicate with the medical staff. One board member indicated this as a challenge, because he did not had that background and found it difficult to assess quality.

Providing sufficient room for others (Kouzes and Posner, 1999)
Providing room, this already was mentioned. Eight hospitals saw this as a success factor.

Setting a good example (Kouzes and Posner, 1999)
Setting a good example was named by two hospital board members. As counterpart –a failure- was mentioned by four hospitals not to exaggerate, for example not to have an oversized car or board room.

Good internal and external relationships and interpersonal skills (Kotter, 1988), High power to ask questions and listen (Bennis and Nanus, 1986), Cheer a Stabbing (Kouzes and Posner, 1999) Coaching employees. Individual attention is vital. Leadership is aimed at changing or increasing the level of motivation and giving sense of people (Bass, 1990, Van Dijck, 1996)
Five board members said that it is important to have empathy, but no compassion. One board member stated: 'You should have more respect for the cleaning lady, than for the professional.'. It is important to show, as a board member, that you are committed and that you are willing to listen. A balance between the internal and external environment was also mentioned by two board members.

Personal values, such as integrity (Kotter, 1988)
One hospital board member named integrity as success factor.

Possess a vision (Bennis and Nanus, 1986), Inspiring a shared vision (Kouzes and Posner, 1999), Vision on further development of the organization. This creates a basis for trust and respect among colleagues (Bass, 1990, Van Dijck, 1996)
As stated in step four of Kotter (2007), creating and constantly communicating the shared vision is important. Thirteen hospitals named communication as a key success factor. One board member even said: 'Communication is half of the work. '. Consistency is also of importance, continuously carry out the same vision in different manners.

Coaching employees. Individual attention is vital. Leadership is aimed at changing or increasing the level of motivation and giving sense of people (Bass,1990, Van Dijck, 1996)
A direct approach was mentioned by the smaller hospitals as success factor. For the larger hospitals direct communication has been a challenge.

Two hospitals believe that it also has to do with talent, being a leader. Three hospitals mentioned that an effective leader should take risks now and then. Six respondents named being consistent as a personal factor for success.

The factors Yukl (1989) defines, were hardly mentioned. These are characteristics such as self-confidence, emotional maturity, stress tolerance, good attitude towards superiors, pragmatic, result oriented and thrill seeking. These features probably were not mentioned because they are too personal for the board members. The named features are still a bit casual, but the factors Yukl describes are more personal.

5. Conclusion & Discussion

The answers on the first interview question, “what should your hospital look like in 2016?”, were very diverse. Obvious is that every hospital wants to operate in a regional network and some academic hospitals also in a national network. The region will be bigger as care becomes more complex. One hospital was very specific and stated that in the future 30 to 40 hospital care organizations will be established. This does not mean that there will be 30 to 40 locations. There still can be about 100 locations, but care will be distributed in networks.

Hospital care organized in hospitals as we know them now, seems to belong to the past. Hospitals will start to work together with primary care and tertiary care organizations. Where the hospital begins and where it ends will not be clearly separated anymore. Patients will have to travel further, especially fort high risk treatments, because these will not be performed in every hospital. The same goes for professionals, a model was mentioned in which professionals were doing ‘routine’ procedures three days a week and were challenged two days a week by performing more complex procedures. This is the model in which the professionals visits the patient. Two other possible models mentioned by the board members for organizing hospital care are: the patient visits the professional and patients are referred.

Smaller hospitals are aiming a role as case manager. The patients will arrive in their hospital and they will take care of every part of the treatment process. They also want to negotiate with the insurer about all types of care that a patient needs.

Larger hospitals see themselves take over emergency care. It is less difficult for them to arrange capacity; enough personnel, to guarantee 24/7 accessibility. This process already has been started, two large hospitals in an isolated region see the more complex care shifting from the smaller hospitals to their hospitals.

The Northern region is probably more into E-health, because they are also organizing hospital care on the Wadden islands. Letting specialists go to the islands takes a lot of time and letting the patients come to the hospital also takes a lot of time, telemedicine can save that time. Overall, E-health has been seen as a tool to facilitate communication between health care providers, for instance, a multidisciplinary EPR.

The roles of the stake holders will change in the future, according to the board members. Currently, the insurer is insecure and does not (yet) have the instruments to assess quality. Some board members said that they would like to see the insurer as director in the future as against other board members, that called the insurer as needless and ‘shifter’ of money. The patient has been described as becoming more empowered, sometimes even greedy. They will have to travel in the future, especially for high complex, low volume care. The same goes for the professional, they will have to travel also. On the other side, the professional has to be more committed to the hospital. This now is done through profit centres and in the future it will probably be done by other financing structures, like share holders or partnerships. The “maatschappen” will belong to the past, also because a new generation, inter alia with part time working women, is emerging. The role of the supervisory board will also change, according to the greater part of the board members. Organizations will become larger, the role of the supervisory board will therefore become more complex. In addition to that, recently a new rule has determined, that people restricted to a certain amount of jobs. The supervisory board will become more a sparring partner. The external environment also expects more responsibility of the supervisory board.

The liquidation of the “maatschappen” is not a completely new topic. In my opinion, (older) professionals that work in “maatschappen” do not want to be in the pay of the hospital. First that generation should retire or there should occur a crisis situation, before all the ‘maatschappen’ will disappear.

All board members agreed on the statement that they are dealing with a change process. They described it as an incremental, continuous process. Actually this was quiet risky. When we started off with the study, was assumed

that hospital board members are in a change process. During the one and only soundboard meeting, one member was questioning this assumption. Luckily, during the interviews all the board members agreed on the statement that they are dealing with a change process.

The outlined vision, with the regional networks, will not be fully accomplished in 2016. The main reason to change now, and that also has speeded up the process, is the specialization agreement. The NMa, however, is slowing down mergers through rules and regulations. Organizations are not allowed to make agreements in advance, while this is necessary when care has to be distributed and concentrated evenly throughout the region. This also slows down the development of regional networks. The same goes for cross subsidizing, as long as there is not a better funding system, concentration and distribution will not evolve. Another reason to change the costing system is, that it has been an incentive for production, instead of an incentive for optimization of the chain.

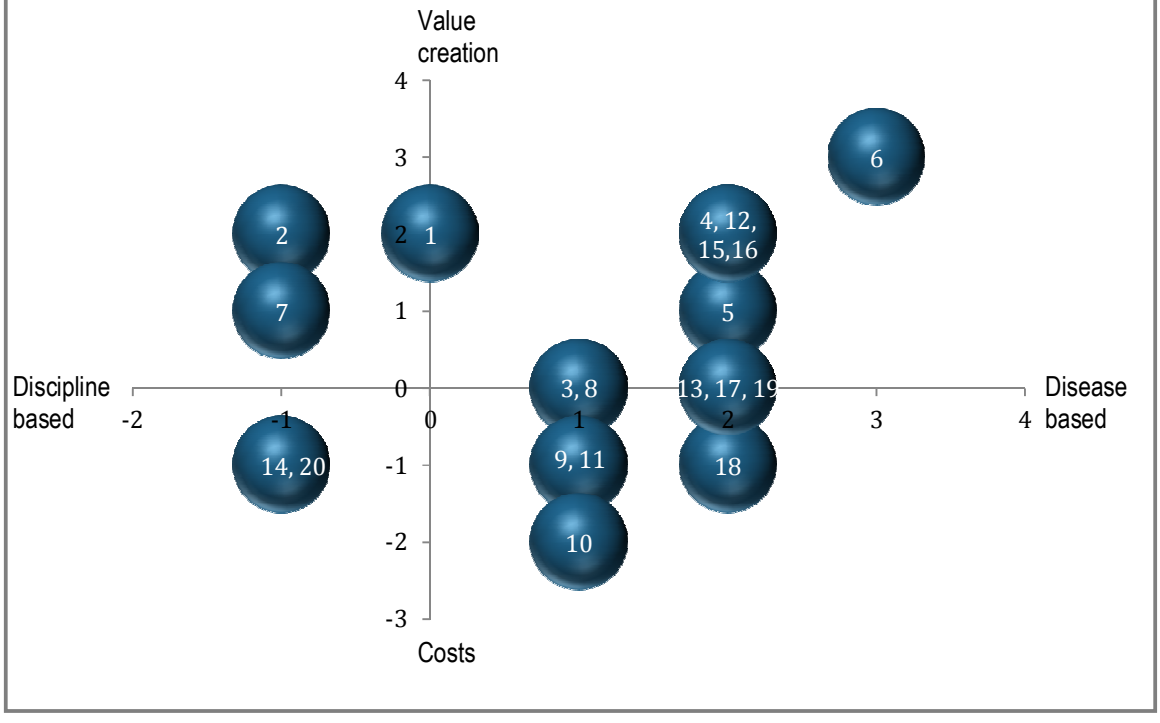
My personal opinion on the vision of the hospital board members is, that distribution and concentration may lead to more quality, but can also cause sky-high prices. If care is spread and there are only a few, or maybe even one, supplier(s), those will become price setters.

Based on the chosen themes, and further explanation, the hospitals were plotted in a scenario matrix. The most chosen themes were Patient-Centric Care, Quality and Transparency of Quality and Staff and Efficiency. A shortcoming of this study is, that during the first two interviews the card 'Collaboration', was still included in the card-sort method. After those two interviews we figured that every board member would chose this theme, but it actually is not a theme, not a goal, but a resource. In the schematic overview below is shown which themes the hospitals chose and an explanation that grounds their place in the matrix.

Hospital	Chosen themes	Explanation
1	Patient-Centric, Quality, Innovation	Specialization is of major importance, the chosen themes are pointing towards value creation. With innovation not only specialization was meant, but also service and sharing information towards patients.
2	Innovation, Patient-Centric, Staff	Hoping for the distribution of top referent care, themes that fit value creation.
3	Innovation, Safety, Staff	Insurance package is to extensive, focus on safety and staff.
4	Collaboration, Patient-Centric, Innovation	Collaborates with everyone, as long as it adds value for the patient, typical for value creation.
5	Staff, Patient-Centric, Other: cost efficacy	Patient is shopping without a wallet, insurance package is to extensive, more awareness. On the other hand, this hospital mentioned that they try to work according Michael Porter's principles.
6	Efficiency, Innovation, Patient-Centric	This hospital had a clear example of how value-creation and disease-based care look like; they defined patient types and adjusted the type of care on the situation.
7	Quality, Innovation, Efficiency	Is moving towards a high-complex, low volume care hospital, patient is empowered, staff is motivated to be more patient-centric.
8	Efficiency, Quality, Staff	Wants to have a directing role for the patient, is merging with another hospital.
9	Quality, Patient-Centric, Efficiency	All unprofitable activities are excluded. Concepts like Planetree are set aside, though they are trying to centre the needs of the patient (e.g. preferred dinnertime).
10	Staff, Other: Finance	Focus factory, only profitable activities are performed, professionals are asked to work performance-based.
11	Market position, Efficiency,	Staff is aware of the costs, are confronted with their KPI's, the patient

	Staff	receives complex care, EPR development
12	Patient-Centric, Safety, Staff	Care is organized around the patient , he/she can take charge from the beginning (transparent process)
13	Quality, Efficiency, Patient-Centric	Working 'lean', but also paying attention to innovation (like working in chains through E-health). Planning a collaboration across the region frontiers.
14	Collaboration, Quality, Cost Containment	Cost containment is a typical theme that fits in the current situation, though this hospital is working towards value creation; a merger is to be next, and there is close collaboration with the primary care.
15	Quality, Efficiency, Patient-Centric	A direct approach towards professionals; when there is a complaint of a patient, a professional is immediately notified. The patient is involved in the whole process. New plans have to meet three criteria: costs are controllable, benefits the patient and safety
16	Staff, Quality, Market Position	This hospital was built as 'hospital of the future', it is completely designed to serve the patient. Though, it is not clear if the patient is given treatment options.
17	Safety, Patient-Centric, Quality	Implemented PlaneTree, try to organize care based on demand. But also chose 'safety' as number 1 priority on the change agenda.
18	Safety, Patient-Centric, Quality	Also sees the disadvantages of concentration and distribution, working together to serve the patient better, but also to work more efficient ('smarter')
19	Quality, Safety, Patient-Centric	Working according a medical mall-program, every professionals is responsible for his own shop. But is also planning a collaboration with another hospital and a Webportal 2.0 is developed to give patients more control.
20	Efficiency, Innovation, Market position	Is struggling with internal issues and is not really focussing on the external environment; no collaboration is named or seen as a benefit. E-health is an interesting subject.

Figure 7: Hospitals plotted in the scenario matrix



Based on this distribution in the matrix, it can be said that hospital board members are moving towards disease-based care. Most hospitals are plotted in the scenario 'royal patient'. This was already noticeable when the themes were presented, because the themes most chosen are contributing to the royal patient scenario. Besides, the government, insurers and industry organizations seems to be directing on value creation, with the new specialization agreement to improve quality for the patient.

A lot of hospitals want provide patient centric care, but they seem not to know how to really implement it. It also depends on the type and size of hospital. An academic centre wants to distinguish itself based on the quality of their knowledge and the unique treatments they perform. An small size, general hospital will focus on the quality of their service, because the treatments they offer are not unique.

In terms of working on quality of service, the following examples were given:

- Define different patient categories and offer them a customized treatment
- Build (more) single rooms
- Patient friendliness courses and workshops
- Patient satisfaction surveys
- Implement PlaneTree

Patient-Centric Care in terms of quality of treatment:

- Organize care around the patient by working in multidisciplinary teams
- Make professionals more committed to the hospital instead of to their own discipline by using the medical mall model (profit centres)
- Quality can be improved through specialization and routine; distribution and concentration of care.

Hospital board members often see quality and safety as one theme. To improve quality and its transparency board members are trying to:

- Create an open culture, in which medical mistakes can be reported, discussed.
- Set up a quality project team with a board member as project manager
- Acquire a Joint Commission International accreditation
- Implement 'zorgpaden' (care paths), to make care more transparent for the patient
- Protocols and standardization will lead to routine and therefore quality (practice makes perfect)

Efficiency can be improved through optimizing processes, for instance by:

- Creating synergy in the back-office and setting up Shared Service Centres
- Optimizing patient logistics, standardizing, promoting the patient flow by working together with reactivation/rehabilitation centres and nursing homes
- Using E-health tools for chronic patients (telemonitoring), more responsibility for the patient

A hospital is as good, as the doctors that work there. Staff is about recruitment and selection, but also about employee engagement. Some hospitals stated that they are that large or that innovative, that recruiting employees is no problem. Because they can give employees the opportunity to develop themselves. Several options were mentioned for working on this theme:

- Job mediation for partners of medical specialists to attract staff
- Select on patient friendliness and flexibility
- Give employees five extra days off and allow them to transfer them when they are 60+
- Create an environment in which professionals can learn and develop

A successful strategy will partly depend on the composition of the board (Moen, Ansems, & Hanse, 2000). A recommendation would be to have a non medical and a medical person in the board. For someone with a medical background it seems to be easier to start a discussion with the medical staff. The other person, with a financial or executive background, can guard and steer the process. One hospital board member compared it to an opera house, which has an artistic and a financial director. According to hospitals in the rural areas, for example Friesland and Limburg, a board member should have a connection with the region, according to the board members. This seems to be of less of importance in the "Randstad" (metropolitan areas).

Concerning the strategy; there is no one size, fits all. It depends on the region, type of hospital, type of patients, staff et cetera. No specific strategy was defined. Besides, it was difficult to come to distinct approaches, because this is not really a task of a board member. It would have been better to also interview a change manager to find out what kind of policies and projects are implemented and started in the organization. Though, the strategy style that was adopted most, is the negotiating style. In the negotiating style the board is not controlling the content, but the process. They are the creators of the framework. The professionals decide on the content and fill in the framework. Opportunities and proposals come by and board members decide if they stay within the limits of the framework.

Significant success factors for every hospital seem to be:

- Communication; share the vision, be visible, be approachable. Listen to employees, take their problem serious and show that you are interested. Be clear about the goals and how to reach them. Create a framework to support professionals to accomplish the goals that are set, but do not interfere.
- Enter into a discussion; dare to confront the medical staff. Put on the table sensitive issues.
- Leave space for professionals to come up with new ideas, but also with critique. Create an open and transparent culture. For professionals to report calamities and for patients to choose. Be clear to patients about what they can expect. Leaving space also is a sign of showing confidence.
- Visualize, use tangible examples and anecdotes. Show images. Create an inviting prospect.
- Crisis. If a new board member takes control during a crisis situation, he/she will be able to show all his/her skills. Especially when multiple interim-directors made a mess of the hospital the last years.

Positive personal characteristics of an effective leader are:

- Motivate people. Have endurance, persevere; change management in a hospital is like marathon running.
- Setting an example, be a role model
- Know when to be opportunistic and when to be consistent
- Adopt a personal, direct approach. Have respect for the professionals, but do not pity on them.

Hospital board members did not name many factors that contribute to failure. Maybe that can be considered as a factor that contributes to failure. The model of Lindgren and Bandhold (2003) stated that it is important to know the strengths and weaknesses of the organization (and of yourself). Although, there was not explicitly asked for factors that will lead to failure. Errors that hospital board member came up with are:

- Interfere. Look constantly over the shoulders of the professionals.
- Be a show-off. For instance, driving an oversized car and having an oversized office and private meeting room. Brag about successes that have not been achieved yet.

During the interviews it became obvious that I could categorize some board members as leaders and some as managers. The leaders were very visionary, innovative, used a lot of metaphorical language and one-liners and did not really have plan to monitor their actions. The managers, on the other hand, were more rational, controlling and calm. When I was talking to my colleagues after the interviews, we sometimes also discussed the former board member. Most of the time the former board member was a completely different person, in terms of

leaders and managers, than the present board member. It seems to look like a cycle; first a leader directs the organizations, with all his innovative ideas, but without structure, than the manager comes and leads those ideas into smooth channels. This can also make a difference in leadership style, chosen themes and success factors.

Performing a master assignment commissioned by a company, can be a restriction and an enrichment. Different interests are involved and there is only one person defending the interests of the master thesis, which is the master student. On the other hand it would not be possible to interview that many hospital board members, or maybe even one hospital board member, as (just) a master student alone.

A difficulty was, that there was not made use of a voice-recorder. Because the assumption was, that this would restrict the hospital board member from speaking freely. This meant I, as the minutes secretary, had to rely heavily on my notebook and that a hospital board member was in the position to adjust the final report.

Besides, even an in depth interview of one and a half hour is too short to really go in depth. Sometimes one topic was talked about a lot, but then the other topics did not came to their right. The interviews were also performed by several persons, which makes it harder to quantify and generalize. Everyone asked the questions in a slightly different manner, through which board members did not always interpret a question as it was meant.

Fourth, a lot of hospital boards consist of more than one board members, while we were only talking to one of them. Often the tasks are divided over the board members, so a possibility is that the interviewed board member knew a lot about his/her tasks, but not about the tasks of his/her colleague. Board members with a non-medical background often have a business administration or accountancy background, which shines through in their strategy and chosen themes. They often are more focusing on costs, market share and volumes . Board members with a medical background –probably automatically- were talking about the patient. Furthermore, hospitals are subject to the external environment. The course the hospital board members take, also depends on rules and regulations and on other actors (such as other hospitals in case of a merger).

The selection of the samples was a bit biased through the relations that Capgemini has and the persons they would like to talk to. In the first place was looked at the distribution of the hospitals throughout the country. Then was looked at the hospitals on the list that were easy to contact. Thereafter the interviewing was started. After about fifteen interviews the sample was evaluated; the sample should represent the hospitals in the Netherlands. On the basis of that evaluation other hospitals were added to the list, invited and interviewed.

Finally, researching and writing a thesis when you are inexperienced in a certain field, is hard. Especially when you only have six months to become a, sort of, expert in the field. It was tough for me to determine what was revolutionary in hospital care and what was as old as the hills. Also because it seems to be a reserved world. As was shown when talking about personal characteristics, board members do not like to show their hand. When I would have had more time, I would study each scenario further and defined more detailed strategies for every scenario. Maybe I also would have chosen a theoretical framework that supports the research better, because literature did not define and explain the TAIDA model very broadly, which makes it less transparent and reliable. It also was more a method, a model, instead of a theory. It may be better to apply on one organization, instead of all kinds of hospitals.

Recommendations for further research would be:

- Choose another theoretical framework
- Analyse and specifically define every scenario and every strategy
- Directly select a sample that represents the Netherlands
- Appoint one single interviewer
- Interview multiple persons in a hospital, among others one that is responsible for change processes or defining the strategy (e.g. a change manager)

- Cut down on the number of topics discussed in the interviews. Talk with different persons about different topics.

Recommendations, in short, for hospital board members that want to move towards the royal patient scenario are:

- Focus on patient-centric care and quality, as a result an improvement in efficiency will occur
- Staff is of major importance. Without qualified staff, there is no clinical activity.
- How to work on those themes? See paragraph 4.5.
- Adopt a negotiating strategy; be the creator of the framework. Let the professionals decide on the content.
- Communicate. Share the vision, set clear goal(s), set an example, be visible, be reachable, be committed.

And a final advice, not only to the board members, but also to students, researchers and consultants:
"Never give in, never give in, never; never; never; never - in nothing, great or small, large or petty - never give in except to convictions of honor and good sense" (Winston Churchill, 1941)

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Appendix A: Literature overview trends & scenario's

Author & Title	Trends	Scenarios
(Blank & Wats, 2009) Aanbod ziekenhuiszorg 2020		• Shutdown cross subsidization and market power: pressure on productivity and efficiency, big top clinical hospitals cannot maintain their position. Larger number of small hospitals with optimal scale. Large academic centers rationalize, it's too expensive for them to use costly infrastructure for low complex care. They are going to specialize in product leadership, even at the European level. The highly complex care at academic hospitals, large amount with relatively small size. These do not necessarily have a "real" academic status. • No shutdown of market power + cross-subsidization: current number of academic centers approximately remains. All current predominantly small general hospitals are swallowed and there is a large number of top clinical hospitals. • Shutdown cross subsidy: disappearing basic hospitals. Only the top clinical hospitals and teaching hospitals remain. Relative earnings of the top clinical hospitals are at the expense of teaching hospitals. The academic centers are significantly more sensitive to this situation because they have more opportunities for cross-subsidization. However, this is the least likely alternative. • Turn off market power: academic centers remain in their present form, their numbers are increasing. The increase is not from the founding of new teaching hospitals, but from a number of top clinical hospitals by increasing their training and research will also be able to benefit from cross-subsidies. The other top clinical hospitals get into trouble. Their inefficient scale will play tricks on them and they will be transformed into or replaced by more efficient base hospital.

(BS Health Consultancy, 2009) Onderzoek naar de toekomstscenario's van de ziekenhuismarkt	• Liberalization of the health care market • Aging population • Enhancing consumer empowerment • Increased health-conscious lifestyle and focus on prevention • Organizational structure of care to target groups / diseases • More focus on pay-for-performance • Further collaboration between health insurers and hospitals • Concentration of the hospital supply • Specialization and differentiation of care from hospitals • Greater focus on service aspects, customer focus • Digitization and technological innovations in care • Scarcity of labor • Low economic growth • Development of diagnostic technology • Internationalization of Healthcare • Changing the position of specialist, new governance models • Commercialization of health care demand • Higher financial risk on investments	• "Conglomeration": health insurers have selected the best providers and make them part of 'care conglomerates. The insurance companies set high standards with regard to price, quality and service. The care conglomerates are a combination of providers, which operate independently and individually. Hospitals are organized into specialties. • "Concern Formation": partnership of hospitals with a health insurer. There is one organization in which the care provider is used that is most suited to treat patients effectively and efficiently. Hospitals are centers where complex operations are possible for different target groups. The purpose of a concern is to offer a product for the same or lower cost that leads to a higher life expectancy and health gains. • "integrated care": a customer-supplier relationship between health insurers and hospitals. It is not allowed for insurers to have an interest in a health care provider. The health insurance buy health care provision for different groups in so-called "chain-care groups, including both primary care providers and hospitals, that are involved in a more extensive cooperation with each other. • "Every man for himself": competition among hospitals in price, quality and service. In this scenario healthcare providers are operating as individual providers organized into specialties. For survival target teaching hospitals are more complex treatments. General hospitals in the Randstad are trying to specialize in basic care.
(Idenburg & Schaik, 2010) Diagnose 2025	• Caring is sharing: more transparency in knowledge and skills; • Younique: more differentiation in health care consumer; • Power to the patient: more do-it-yourself care; • The sky's the limit: higher expectations of quality care and experience; • Afraid of care: by anxious insecurity and complexity; • Healthy Grey Netherlands: vital living longer; • Everyone is patient, often chronic; • Googleritis: digitization of consumer-care interaction; • Care without borders: globalization of health; • Being healthy is a choice: pay more attention to lifestyle; • Prevention: to prevent higher priority; • Greener: towards sustainable care; • Saving lives, saving costs: reification, market and entrepreneurship; • Who cares for me ...?: More demand and less supply of labor; • Switching: redesign of the care chain; • Check please: more demand, more costs .....;	• Virus Scenario: Most of the expenditures are on healthcare, emphasis on prevention, accountability lies by government • Chronic Illness scenario: simple, little solidarity, disappointing growth private healthcare companies, hospitals franchise chains, four major insurers • Rupture Scenario: liberalization, breaking with the government, have and have nots, growth in private healthcare businesses, all at additional costs.

	• One-to-one: targeted treatment with medical technology.	
(Lucht & Polder, 2010) Volksgezondheid Toekomstverkenning 2010	• Life expectancy increases • Reduced mortality risks • Care supply more specialized and more intensive • Care volume increases • Care expenditures increase • More chronic illnesses and care-related infectious diseases • More outpatient care • Multidisciplinary and patient-centered care • Emerging medical technology • Focus on prevention	
(Mierden, 2010) Toekomstscenario's zorginstellingen		• The efficiency dependence model, which is characterized by an internal focus on efficiency and a relative dependence on health insurance. • The open innovation structure, this is constantly looking for new innovations in health care institutions, with strategic partners in the industry. • The cost squeeze model: herein are organizations only focusing on costs and reactive Executive guidelines set by health insurers. • The HMO collaboration model, this model there are patient-and efficiency-oriented cooperation between hospitals and insurers. • Strategic value creation model, this model provides strong and broad orientation in value from several strategic options. The strategic focus and implementation determine the policy.
(MinVWS, 2007) Niet van later zorg	• Increasing demand for care (more GP contacts) • Higher care expenditures • Medical technological developments (more medication usage) • More people with chronic illnesses • From inpatient (nursing & caring) to outpatient care (home care) • Staff shortages	• Collective prosperity: government responsibility, economic growth, focusing on prevention • Sharing: gloomy but solidarity, stripped AWBZ and basic insurance, nothing to choose • Selective growth: individual responsibility, some areas flourish, others remain behind, have and have nots • choice rich perspective: individual responsibility, hedonistic, materialistic and liberal lifestyle.

(Raad voor de Volksgezondheid en Zorg, 2010) Perspectief op gezondheid 20/20	• No room for growth in healthcare expenditures • Changing demand for care • Increasing opportunities for diagnosis, treatment and care • Citizens have more demands • Shortage of health workers • More responsibility to individuals (from illness and care to health and behavior) • Prevention • More teamwork, also with the patient	
(Schimpff, 2008) The hospital of the future	• Customer Tailored Medicine [Personalized Medicine] • Greater Emphasis on Prevention • Marked Advancement in Repair, Restoration and Replacement of Organs, Tissues, Cells • Fully Digitized Medical Information with Instant Access, Anytime, Anyplace • Safety and Quality Profoundly Improved • Initial Steps to Realistically Address Rapidly Rising Costs	
(Tillaard & Brake, 2011) Zorg & ICT 2020	• Direct government intervention is declining, influence remains, including through insurance companies. More controlling by mechanisms > more market dynamics • There are new parties, large specializes companies and smaller companies. • Social Interaction Platform: decisions of the patient are at the center of the main. Moreover, the mobile internet becomes greater than the fixed Internet from the PC. • Around 2020 the patient really becomes empowered in a transparent communication environment that government, providers and insurers forces to behave on an equal footing with the buyers regarding care and healing. Personal health records (PHR), health and welfare will become increasingly self-managed and more attention is needed for those who are computer illiterate. • Growing gap between digital and computer illiterates are examples of active threats. • Inadequate organizational structure and financing of care, slow adoption of (ICT) innovations and the unclear role of interest groups when the patient take control over their own destiny.	• Beer represents the great power of healthcare by the government with little momentum. • Elephant stands for large private-led care. • Beavers represent local small-scale care. • Wildebeest represents small-scale dynamic care.

(Wanless, 2002) Securing our future health: taking a long-term view	• commitments already made to improve the quality of the health service and its consistency • changing patient and public expectations. • advances in medical technologies • changing health needs of the population • prices have historically risen faster than the general level of inflation • The level of productivity improvement which can be achieved.	• *Solid progress* – people become more engaged in relation to their health. Life expectancy rises considerably, health status improves and people have confidence in the primary care system and use it more appropriately. The health service becomes more responsive, with high rates of technology uptake, extensive use of ICT and more efficient use of resources; • *Slow uptake* – there is no change in the level of public engagement. Life expectancy rises, but by the smallest amount in all three scenarios. The health status of the population is constant or deteriorates. The health service is relatively unresponsive with low rates of technology uptake and low productivity. • *Fully engaged* – levels of public engagement in relation to their health are high. Life expectancy increases go beyond current forecasts, health status improves dramatically and people are confident in the health system and demand high quality care. The health service is responsive with high rates of technology uptake, particularly in relation to disease prevention. Use of resources is more efficient.
(Wyke, 2011) The future of health care in Europe	• Healthcare spending will continue to rise, not only because of inflationary drivers, but because of growing recognition by policymakers that improved health is linked with greater national wealth. • Keeping the universal healthcare model will require rationing of services and consolidation of healthcare facilities, as public resources fall short of demand. • General physicians will become more important as gatekeepers to the system and as coordinators of treatment for patients with multiple health issues. • More effective preventive measures and fundamental lifestyle changes will be promoted to encourage healthy behavior. • European governments will need to find a way to improve collection and transparency of health data in order to prioritize investment decisions. • Patients will need to take more responsibility for their own health, treatment and care. Governments will have to tackle bureaucracy and liberalize rules that restrict the roles of healthcare professionals and artificially raise the cost of medical research.	• Technology triumphs and cures chronic disease, while e-health takes a prominent role in the management of healthcare; • European nations join forces to create a single pan-European healthcare system; • Preventive medicine takes precedence over treating the sick; • European healthcare systems focus on vulnerable members of society; • European nations privatize all of healthcare, including its funding.

(Zajac, 2003) The public hospital of the future	A useful framework for assessing and planning change is provided by the six specific aims for improvement in healthcare recommended by the US Institute of Medicine. Healthcare should be: • Safe — avoiding injury from the care; • Effective — providing evidence-based services; • Patient-centered — providing care responsive to patient preference; • Timely — reducing waits and sometimes harmful delays; • Efficient — avoiding waste; and • Equitable — providing care that does not vary in quality because of patient characteristics (sex, ethnicity, socioeconomic status).

Appendix B: Interviewscript

Interviewscript Zorgtransformaties

t.b.v. interviews over de veranderagenda, veranderstrategie en –aanpak van ziekenhuizen

Voorbereiding interview

De volgende zaken zijn van belang in de voorbereiding van het interview:

- Doorlezen en high-lights noteren van het meerjarenplan van de ziekenhuisbestuurder en dit rondsturen aan alle interviewers. Dit gebeurt door degene die ook het verslag maakt, Sjoerd, Léonie, Margoleen of Carlijn.
- Doorlezen van dit interviewscript door alle interviewers;
- Meenemen kaarten met thema's t.b.v. vraag 4;
- Duidelijke rolverdeling afspreken.

Noot voor de interviewers: Gebruik van het interviewscript en introductie

Dit script is bedoeld als handleiding voor tijdens de interviews.

Elk interview wordt afgenomen door minimaal twee collega's. De volgende rolverdeling wordt aangehouden:

- De eerste persoon stelt in principe de vragen en zorgt voor een goed verloop (relatie, proces en inhoud) van het interview
- De tweede persoon legt de antwoorden tijdens het interview vast mede aan de hand van dit script en stelt indien nodig de verdiepingsvragen. Achteraf werkt deze persoon het interview uit in een gedetailleerd verslag.
- In geval er een derde persoon bij het gesprek is, dan kan ervoor gekozen worden om de verschillende hoofdvragen (thema's) te verdelen.

Op pagina 3 start een vragenlijst met daarin **vijf hoofdvragen**. Onder elke hoofdvraag is een aantal subvragen geformuleerd om het antwoord te kunnen 'vinden'/ richting te kunnen geven aan het gesprek. Bij een aantal vragen staat een aantal antwoordcategorieën opgenomen. Deze zijn voor de interviewers (de scribe) als achtergrondinformatie. Het is niet de bedoeling deze keuzes te noemen in het gesprek, omdat de geïnterviewde mogelijk niet begrijpt wat hier wordt bedoeld. Het is wél de bedoeling om op basis van de vragen te kijken in welke categorie het antwoord valt/ zou kunnen vallen.

<u>Doel en opzet van het onderzoek</u>

Capgemini Consulting – het cluster Gezondheidszorg – voert een kwalitatief onderzoek uit naar de veranderagenda, veranderstrategie en -aanpak van ziekenhuizen/bestuurders. Het doel is om inzicht te krijgen in de wijze waarop ziekenhuisbestuurders denken dat zij kunnen veranderen naar toekomstbestendige zorgorganisaties.

Toegevoegde waarde onderzoek:

- Wij zien een grote turbulentie/ beweging/dynamiek in de markt;
- Hoe kijkt u daar als bestuurder strategisch en in de aanpak naar? (Wat betekent dit voor de strategie en de veranderaanpak zelf?)
- Dit onderzoek is kwalitatief. De uitkomsten geven wij terug aan andere bestuurders en dient ter inspiratie van bestuurders bij het veranderen; resultaten worden breed gedeeld.

Onderzoeksopzet:

- Naast literatuuronderzoek, interviews met 20-25 ziekenhuisbestuurders door heel Nederland in juni t/m augustus 2011;
- Uitkomsten interviews in publicatie. De bestuurder ontvangt uiteraard ook een exemplaar;
- Landelijk congres van Zorgvisie (17 november 2011): bevindingen breed gedeeld;
- Nationaal onderzoek met internationaal perspectief; onze collega's in Zweden, UK, Denemarken, Duitsland, Frankrijk voeren een vergelijkbaar onderzoek uit.

<u>Introductie interviewers en rolverdeling</u>

Dit onderzoek biedt een goede gelegenheid voor een kennismaking tussen GHZ en de bestuurder. Bij de introductie van de interviewers dienen twee toelichtingen aan bod te komen:

1. **Wie zitten er voor de bestuurder en in welke rol**? *Stel jezelf voor.*
2. **Wie is de GHZ?**
   - Gezondheidszorg: 40 – 50 consultants, met groot aandachtsgebied en brede focus.
   - Achtergrond loopt uiteen van artsen, apothekers en een psychologe tot experts in bekostiging & beleid en beheer en ICT in de zorg. Daarnaast ook econometristen.
   - Eén van de grootste consultancy partijen in Nederland, ook in de zorg

Procedure: Opbouw van het interview en focus

Het interview bestaat uit drie onderdelen:
1. De organisatie in 2016 (visie en ambitie)
2. De verandering (transitie)
3. De strategie van de aanpak van de verandering

Dit is tevens de kapstok voor het interview, de vragen zijn in deze drie categorieën onderverdeeld. Het interview duurt circa 1 tot 1,5 uur.

Focus voor de interviewers:
- Toekomstbestendigheid, 2016[4]
- Repertoire strategie en leiderschap
- Persoonlijke ervaringen bestuurders; successen, afwegingen, lessons learned (quotes noteren!)

Categorie A: (beschrijving van) de organisatie in 2016

Vraag 1: Waar staat uw ziekenhuis in 2016 en hoe ziet uw organisatie er op dat moment uit (kenmerken)?

a. Waar bent u straks dan van? Wie kunnen er dan terecht bij u(w organisatie) en voor wat?
b. En welke visie en ambitie zitten hierachter?
c. Op welke ontwikkelingen in de zorg speelt deze verandering in?
   - Veranderingen in de algemene omgeving, bijvoorbeeld verandering positie patiënt, overheidsbeleid etc.
   - Veranderingen in de markt en concurrentieverhoudingen
   - Veranderingen van de organisatie zelf (changes in people)
   - Eerdere ervaringen met veranderingen in de organisatie
d. Indien er sprake is van een herinrichting/verandering van de organisatievorm/structuur: Wat is het doel dat met deze herinrichting (= middel) wordt bereikt?

Note voor de interviewers:We willen hier ook weten vanuit welke gedachte deze keuze voor de organisatie is gemaakt (waarom?)
Note voor de interviewers: we willen hier graag weten wat de organisatievorm is en of er een herinrichting van de organisatie gaat plaatsvinden (o.a.). Kortom is er sprake van:

- **Differentiatie:** Bij differentiatie in de bedrijfseconomie stoot een bedrijf een activiteit in de bedrijfskolom af. Het tegenovergestelde is integratie waarbij een bedrijf een extra activiteit uit de bedrijfskolom gaat uitvoeren. Bij differentiatie wordt de bedrijfskolom langer, bij integratie wordt de bedrijfskolom korter.
  - Functiedifferentiatie: is het creëren van nieuwe functies met eigen taken, bevoegdheden en verantwoordelijkheden.
  - Afstoten

[4] Toekomstbestendige zorgorganisaties zijn organisaties die kunnen inspelen op de veranderende eisen vanuit de samenleving, zoals een krapper wordende arbeidsmarkt, financiële en economische druk, en het daarmee samenhangende overheidsbeleid

- Anders
    - Nieuw sturingsmodel
    - Herontwerp processen
- **Verticale integratie:** Hiermee doelen we op samenwerking tussen organisaties die op een ander niveau van de markt werkzaam zijn.
    - Netwerk:
    - Ketenzorg:
- **Horizontale integratie**: Een samenwerking (concentratie) is "horizontaal" van aard indien een overeenkomst wordt gesloten of aan onderling afgestemde feitelijke gedragingen wordt deelgenomen tussen ondernemingen die op hetzelfde niveau of dezelfde niveaus van de markt werkzaam zijn
    - **Fusie**
    - **Overname:** Bij een overname verkrijgt een onderneming zeggenschap over een andere onderneming, bijvoorbeeld door het kopen van een pakket aandelen of activa6
    - **Alliantie:** Vrijwillige, evolutionaire en flexibele organisatievormen tussen twee of meer organisaties om zowel gezamenlijke als individuele doelstellingen te verwezenlijken waarbij producten, diensten, en technologieën worden uitgewisseld, gedeeld, of gezamenlijk ontwikkeld met het behoud van de eigen identiteit.
        - **Joint venture:** Een joint venture is een gemeenschappelijke onderneming die onder leiding staat van twee of meer bestaande ondernemingen.
    - **Contracten:** contracten omvatten de samenwerkingsverbanden die gebaseerd zijn op contracten /overeenkomsten.
        - Bijv. shared service center

Vraag 2: Wat betekent dit voor:

a. De professional (medewerkers):
b. De patiënt
c. De raad van toezicht
d. De verzekeraars

Vraag 3: Hoe groot is nu de stap (verandering) die u moet maken, denkend in termen van omvang en impact?

- Ziet u het als een fundamentele verandering?
- Is deze verandering anders dan voorheen?
- Hoe zou u deze verandering willen typeren?
    - Evolutie
    - Revolutie
    - Adaptatie
    - Reconstructie

Table 1 Types of change

		Extent of change	
		Transformation	Realignment
Speed of change	Incremental	*Evolution*: Transformational change implemented gradually through interrelated initiatives; likely to be proactive change undertaken in anticipation of the need for future change	*Adaptation*: Change undertaken to realign the way in which the organisation operates, implemented in a series of steps
	Big bang	*Revolution*: Transformational change that occurs via simultaneous initiatives on many fronts; more likely to be forced and reactive because of the changing competitive conditions that the organisation is facing	*Reconstruction*: Change undertaken to realign the way in which the organisation operates, with many initiatives implemented simultaneously; often forced and reactive because of a changing competitive context

Categorie B: beschrijving van de verandering

Vraag 4: Wat moet er gebeuren om tot de organisatie in 2016 te komen? Wat zijn de thema's op uw veranderagenda?

Note voor de interviewers: we vragen de bestuurder om deze vraag te beantwoorden aan de hand van een aantal thema-kaarten (volgens de zogenaamde 'card-sort methode'). Op basis van een set kaarten met daarop verschillende thema's afgebeeld vragen de bestuurder een keuze te maken in de thema's die tijdens de verandering worden aangepakt. Vervolgens vragen we de kaarten naar prioriteit (belangrijkste bovenaan) op volgorde te leggen.

a. Wat zijn de thema's/doelen op uw veranderagenda?
b. Welke onderwerpen hebben volgens u prioriteit? (top 3 van de thema's)
c. Waarom kiest u voor deze thema's?
d. Op welke wijze worden de (top 3) thema's aangepakt? De vraag is *wat* gaan zorgaanbieders doen om deze doelen te bereiken? Denk daarbij aan Lean-concept, IT-toepassingen etc. zie beschrijving van onze HT-proposities.
e. Hoe ziet uw persoonlijke veranderagenda eruit?
f. Wat heeft u (tot nu toe) persoonlijk van veranderingen in uw organisatie geleerd?
g. Wat ervaart u als kritische succesfactoren? Waarom?
h. Wat ervaart u als de faalfactoren? Waarom?

Tip: Loop de top 3 kaarten één voor één langs en vraag naar concrete voorbeelden.

Categorie C: beschrijving van de veranderstrategie- en aanpak

Vraag 5: Hoe ziet de veranderstrategie er uit?
a. Wat vraagt deze veranderstrategie van u als leider?
b. Waar zit voor u de uitdaging in?

Noot voor de interviewers: aan aspecten binnen de veranderstrategie moet je denken aan (en doorvragen):
- **Aansturing**: top down-benadering (directief/ centrale regie) of bottom up-benadering (minder directief)
- **Instrumenten**: Teambuilding, coaching, Problem solving, werken aan commitment, Herontwerpen van structuren en processen

Verdiepingsvragen:
a. Waarom is voor deze strategie gekozen?
b. Welke stappen/fases worden gezet om de verandering te realiseren?

c. Hoe organiseert u de verandering?
    - Initiatie van de verandering: hoe wordt/is gestart?
    - Projectorganisatie: hoe is deze opgezet? (verdeling verantwoordelijkheden)
    - Hoe stuurt u de verandering?
        - Beheercyclus
        - Verandercyclus
        - Leercyclus
    - Hoe wordt de verandering begeleidt?

d. Welke interventies[5] past u toe/ gaat u toepassen?
    - Voor voorbeelden van interventies/ activiteiten zie bijlage 2

e. Wat ziet u als essentiële randvoorwaarden/kritische succesfactoren?

Afronding van het interview

De interviewers ronden het gesprek af met de volgende opmerkingen/vragen:

- Bedanken voor tijd en bijdrage;
- Een verslag van dit interview sturen we u toe;
- De resultaten van deze interviews leiden tot een publicatie. Deze sturen we u uiteraard toe;
- Mogen we als naslagwerk ook uw beleidsplan ontvangen?
- Mogen we u citeren?

[5] Interventies definiëren we als één of een serie geplande veranderactiviteiten die erop gericht zijn het functioneren en de effectiviteit van de organisatie te vergroten.

- Het betreft een **activiteit** of een serie van activiteiten.
- Het betreft (veelal geplande) veranderingen. Interventies worden door een verandermanager gebruikt om de organisatie en vooral het **gedrag van mensen te beïnvloeden**.
- Het betreft **effectiviteit**. Interventies zijn erop gericht om resultaat te hebben.

Appendix C: Enclosure interviewscript

Naam respondent: **Datum:**

In deze bijlage staan verdiepingsvragen en antwoordcategorieën genoemd voor tijdens het interview. Dit interviewscript is gemaakt om duidelijkheid te geven aan interviewers waar zij de focus moeten leggen en naar welke antwoorden we op zoek zijn. Daarnaast is het bedoeld om een vertaling te kunnen maken van de antwoorden van bestuurders naar de resultaten en om deze resultaten vergelijkbaar te kunnen maken.

Gebruik van dit script:
Elk interview wordt afgenomen door minimaal twee personen. De rolverdeling is als volgt:

- De eerste persoon stelt in principe de vragen en zorgt voor een goed verloop (relatie, proces en inhoud) van het interview
- De tweede persoon legt de antwoorden tijdens het interview vast mede aan de hand van dit script en stelt indien nodig de verdiepingsvragen. Achteraf werkt deze persoon het interview uit in een gedetailleerd verslag.

Verder…

- Leiderschap wordt in de publieke sector als dé belangrijkste succesfactor genoemd als het om veranderingen/transformaties gaat. Er is daarom gekozen dit thema in het onderzoek te betrekken. Er zijn geen expliciete vragen hierover opgenomen, maar moet in feite als rode draad door het gesprek heen lopen. Stel dus voortdurend de vraag. Wat betekent dit voor u als leider? Waar moet u rekening mee houden? Wat ervaart u als lastig? Waar zit voor u de grootste uitdaging voor u als persoon. Etc.
- Lessons learned: we willen de uiteindelijke publicatie 'kleur geven' en verlevendigen door voorbeelden op te nemen of quotes. Hiervoor is het van belang dat bij de vragen ook naar de ervaringen van bestuurders wordt gevraagd. Bij dergelijke vragen kun je denken aan:
    - Wat werkte wel, wat werkte niet?
    - Wat zou u een volgende keer anders doen?
    - Waar was u echt trots op?
    - Wat zijn/ waren de succesfactoren?
    - Wat zijn/ waren de faalfactoren?
    - Welke good-practice heeft u al bereikt?

Welke vragen willen we beantwoord hebben aan het einde van het gesprek?

Categorie A: beschrijving van de organisatie in 2016

1. Waar ziet de bestuurder de organisatie in 2016 staan?

We willen hier graag weten wat de organisatievorm is en of er een herinrichting van de organisatie gaat plaatsvinden (oa). Kortom is er sprake van:

- Horizontale integratie:
    - *Fusie*
    - *Overname*
    - *Alliantie*
        - *Joint venture*
    - *Contracten*
        - *Bijv. shared service center*
- *Verticale integratie*
    - *Netwerk*
    - *Ketenzorg*
- *Differentiatie*
    - *Functiedifferentiatie*
    - *Afstoten*
- *Anders*
    - *Nieuw sturingsmodel*

- *Herontwerpprocessen*

Graag aanpassen wat van toepassing is. Een toelichting op deze concepten staat in de beschrijving 'organisatievormen ziekenhuizen'.
We willen hier verder weten vanuit welke gedachte deze keuze voor de organisatie is gemaakt (waarom?):

- Indien er sprake is van een herinrichting/verandering van de organisatie: Wat is het doel dat met deze herinrichting (middel) wordt bereikt?
- En welke visie en ambitie zitten hierachter?
- Op welke ontwikkelingen in de zorg speelt deze verandering in?
  - Veranderingen in de algemene omgeving (environmental)
    - Positie patiënt verandert
    - Opvattingen in de samenleving veranderen
    - Overheidsbeleid: kortingen, prestatiebekostiging
  - Veranderingen in de markt en concurrentieverhoudingen
    - Toenemende vraag
      - Vergrijzing in de regio
      - Professionele ontwikkelingen
  - Veranderingen van de organisatie zelf (changes in people)
  - Eerdere ervaringen met veranderingen in de organisatie

Wat zeggen stakeholders *in 2016* over uw organisatie? (waar uit zich dat in voor):

- De professional (medewerkers):
  - Andere contracten
  - Betere werkomgeving
- De patiënt
  - Snel geholpen, geen wachtlijst
  - Kwaliteit behandeling
  - Goede informatie
  - Zorg dichtbij
  - Toegankelijkheid: 24/7 zorg
- De raad van toezicht
- De verzekeraars
  - Lage kosten
  - Goede kwaliteit
  - Openbare informatie

Categorie B: beschrijving van de verandering

Waar staat uw organisatie anno 2011 en wat moet er gebeuren om hier (de organisatie 2016 zoals beschreven in vraag 1) te komen? (inhoudelijke beschrijving van de verandering)

Hoe ziet uw (verander)agenda eruit?

a. Wat zijn de top 3 *doelen* die u wilt bereiken?
   - Kwaliteit
   - Patiëntgerichtheid/verbeterde dienstverlening
   - Veiligheid
   - Marktpositie
   - Efficiënte bedrijfsvoering
   - Kostenreductie
   - Innovatie en kennisontwikkeling[6]
   - Anders, namelijk…
b. Waarom is gekozen voor deze doelen?
c. Welke doelen hebben prioriteit? (top 3 van de thema's)

[6] Hieronder valt ook onderwijs

d. Op welke wijze worden de (top 3) doelen aangepakt? De vraag is *wat* gaan zorgaanbieders doen om deze doelen te bereiken? Denk daarbij aan Lean-concept, IT-toepassingen etc. zie beschrijving van onze HT-proposal.

Deze laatste vraag is van belang om een vergelijking te kunnen maken met onze aanpakken.

Categorie C: beschrijving van de veranderaanpak – proces

2. Bent u al gestart met de verandering van de organisatie?
   c. Indien ja, wat is de strategie van de verandering?
   d. Indien nee, heeft u al een strategie gemaakt?

3. Hoe ziet de veranderstrategie eruit?

Aan aspecten binnen de veranderstrategie moet je denken aan (en doorvragen):

- Visie: verbeteren (het geleidelijk, fasegewijs ontwikkelen van de organisatie) óf vernieuwen (het fundamenteel en snel aanpassen van de organisatie)
- Aansturing: top down-benadering (directief/ centrale regie) of bottom up-benadering (minder directief)
- Snelheid: stapje voor stapje (langdurig), big bang (relatief kort proces)
- Instrumenten: Teambuilding, coaching, Problem solving, werken aan commitment, Herontwerpen van structuren en processen

Vragen die verder ter verdieping dienen te worden beantwoord in het gesprek en op doorgevraagd kan worden:

e. Waarom is voor deze aanpak gekozen?
f. Welke stappen/fases worden gezet om de verandering te realiseren?
g. Hoe organiseert u de verandering?
   - Initiatie van de verandering: hoe wordt/is gestart?
   - Projectorganisatie: hoe is deze opgezet? (verdeling verantwoordelijkheden)
   - Hoe stuurt u de verandering?
     - Beheercyclus
     - Verandercyclus
     - Leercyclus
   - Hoe wordt de verandering begeleidt?

h. Welke interventies[7] past u toe/ gaat u toepassen?
   - Voor voorbeelden van interventies/ activiteiten zie bijlage 2

i. Wat ziet u als essentiële randvoorwaarden/kritische succesfactoren?

[7] Interventies definiëren we als één of een serie geplande veranderactiviteiten die erop gericht zijn het functioneren en de effectiviteit van de organisatie te vergroten.

- Het betreft een **activiteit** of een serie van activiteiten.
- Het betreft (veelal geplande) veranderingen. Interventies worden door een verandermanager gebruikt om de organisatie en vooral het **gedrag van mensen te beïnvloeden**.
- Het betreft **effectiviteit**. Interventies zijn erop gericht om resultaat te hebben.

Appendix D: Card-sort method

Patiëntgerichtheid

Kwaliteit en transparantie van zorg

Veiligheid

Marktpositie

Efficiëntie

Samenwerken

Kostenreductie

Innovatie & Kennisontwikkeling en -deling

Medewerkers

Ander thema

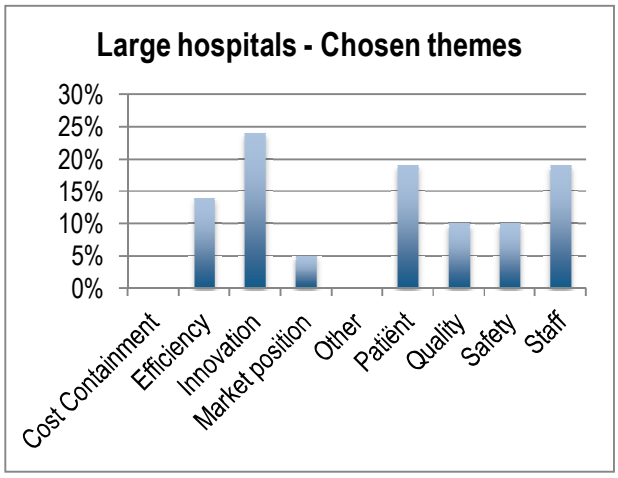
Appendix E: Overview other data analysis

	gender	Region	education	Type	Size	theme 1	theme 2	theme 3	Style
1	m	W	M	A	L	Patiënt	Quality	Innovation	Negotiate
2	m	S	M	A	L	Innovation	Patiënt	Staff/HR	Tell & Sell
3	m	S	Nm/?	T	L	Innovation	Safety	Staff/HR	Negotiate
4	M	N	M	G	M	Collaboration	Patient	Innovation	Developing
5	m	S	Nm/E	T	M	HR/Staff	Patiënt	Other: Cost effectivity	Developing
6	m	E	Nm/?	T	L	Efficiency	Innovation	Patiënt-centric	Negotiate
7	M	S	M	T	L	Quality	Innovation	Efficiency	Negotiate
8	M	N	Nm/E	G	M	Efficiency	Quality	Staff/HR	Negotiate
9	m	W	Nm/F	G	S	Quality	Patiënt	Efficiency	Tell & Sell
10	M	E	M	G	S	Staff/HR	Other: Finance		Directive
11	f	E	Nm/F	T	L	Market position	Efficiency	Staff/HR	Tell & Sell
12	f	S	Nm/E	T	L	Patiënt	Safety	Staff/HR	Negotiate
13	M	N	NM/F	T	M	Quality	Efficiency	Patient	Tell & Sell
14	M	N	Nm/.F	T	M	Collaboration	Quality	cost containment	Negotiate
15	m	N	Nm/F	G	S	Quality	Efficiency	Patiënt-centric	Negotiate
16	M	S	Nm/E	O	M	Staff/HR	Quality	Market position	Negotiate
17	m	W	Nm/E	G	M	Safety	Patiënt	Quality	Negotiate
18	m	W	Nm/F	T	M	Safety	Patiënt	Quality	Negotiate
19	m	E	Nm/F	G	S	Quality	Safety	Patient	Tell & Sell
20	m	E	Nm/F	O	M	Efficiency	Innovation	Market position	Directive

Legend

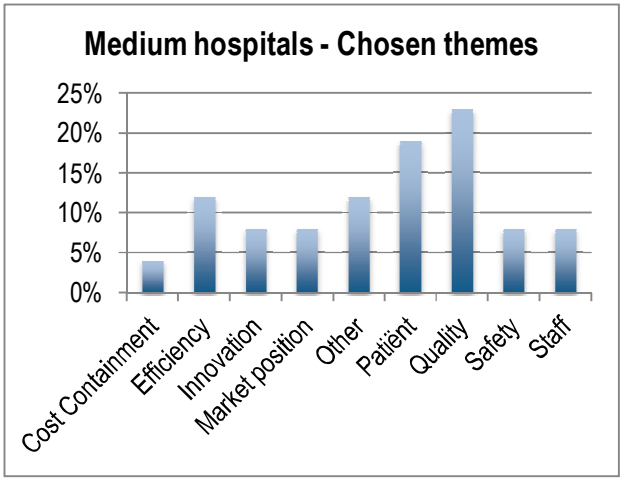
Gender:	Male (M) / Female (F)
Region:	North (N): Groningen, Friesland, Drenthe East (E): Overijssel, Gelderland, Utrecht, Flevoland West (W): Noord-Holland, Zuid-Holland, Zeeland South (S): Brabant, Limburg
Type:	Academic (A), General (G), Topclinical (T), Other (O)
Size:	Small (S), Medium (M), Large (L)
Education:	Medical (M) / Not medical (NM), in case of NM, experience in: CEO (E) / CFO (F)

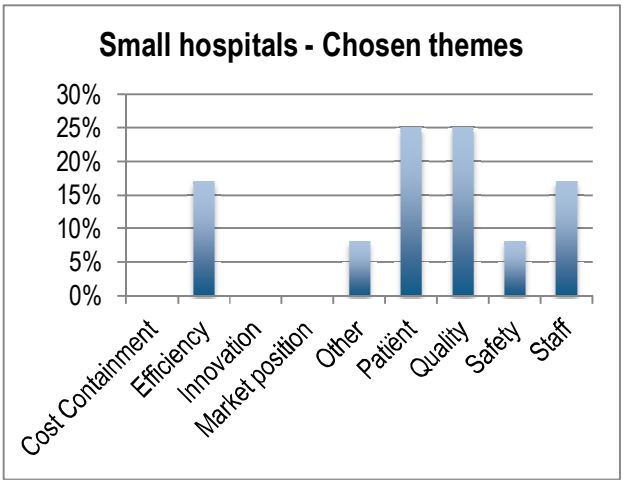
Large hospitals often choose for the theme 'innovation and knowledge management', while small hospitals rather choose 'patient-centric'. This can be explained because the interviewed large hospitals consist of five top clinical and two academic hospitals. They are more likely to differentiate on innovation, because there are not a lot of hospitals with the same (sub)specialties. The more they innovate, the more they are able to specialize, the more unique they are (and can create a monopoly or oligopoly position for themselves). On the other hand, the interviewed small hospitals consist of four general hospitals. They have to compete and because they are not able to compete on their specialties –they provide basic care-, they have to compete on other things, like patient- centric care and service.

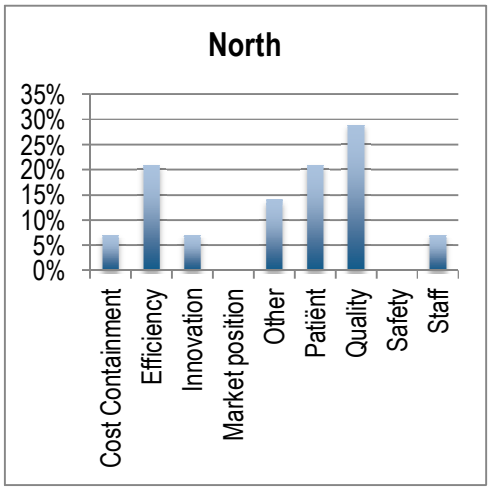


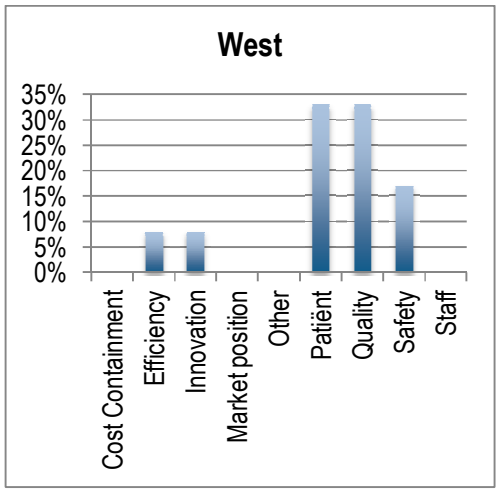
Remarkable is, that especially hospitals in the west of the Netherlands focus on patient safety and quality. This can be explained in terms of market tightness, but it is also possible, because only three hospitals in the west are interviewed and two of them are general hospitals.

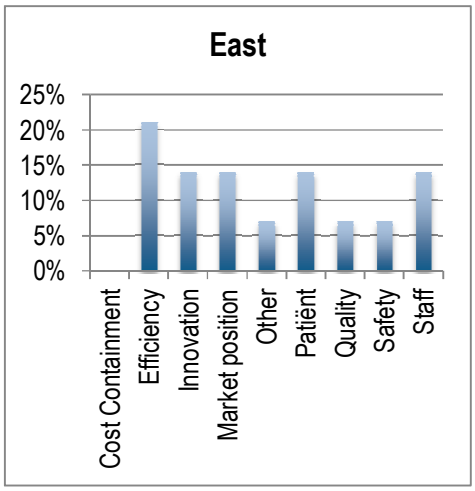
Hospitals in the east of the Netherlands often choose for the theme 'efficiency'. It may be that the underlying reason for this decision is, that seven out of ten board members over there has a financial background.

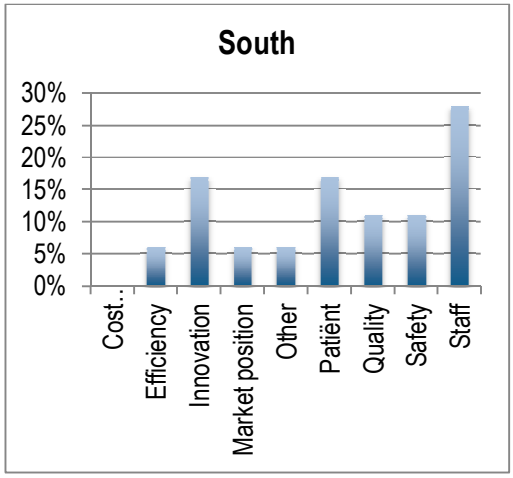












Type	North	East	West	South	Total
Other		1		1	2
General	3	2	2		7
Topclinical	2	2		4	8
Academic			1	1	2
Total	5	5	3	6	19

Background	North	East	West	South	Total
M	1	1	1	2	5
NM/E	1		1	4	6
NM/F	3	4	1		8
Total	5	5	3	6	19

Type	large	small	medium	Total
Other			2	2
General		4	3	7
Topclinical	5		3	8
Academic	2			2
Total	7	4	8	19

Appendix F: Planning

Week	What	Comments
15	Start up, literature study	
16	April 18th: Meeting with Hindrik Vondeling & Robert Stegwee @ UT Literature study, writing proposal	From April 18th till June 6th following the course Leadership, Organizational Change and Consultancy at the University of Twente
17	April 27th: Meeting steering group April 29th: Meeting with Robert Stegwee, Carlijn Nobels & Leonie van Rijk @ Cap Literature study, writing proposal	April 25th : Easter
18	Hand in research proposal @ UT Literature study, writing proposal	May 2nd: LOCC May 4th: MCL with Ronald Teeuw Meeting everybody
19	Adjust research proposal	May 9th: LOCC May 12th: Present research proposal @ UT
20	May 16th: Meeting with Hindrik Vondeling, Henk Bijker, conference call Robert Stegwee Introducing new theory; TAIDA model	May 16th: LOCC May 19th: Kentalis with Ingrid Thuis
21	May 25th: Discussion about interview questions Defining concepts used in interviews	May 23rd: LOCC May 24th: MCL with Ronald Teeuw
22	May 30th: Conference call steering group June 1st: Meeting with Robert Stegwee	May 30th: LOCC May 31st: Review proposals @ UT June 2nd & 3rd: Ascension
23	Planning interviews	June 6th: LOCC June 10th: Cluster outing
24	June 16th: Meeting soundboard Planning interviews	June 13th: Pentecost
25	Adjustment interview questions/research. June 21st: Briefing interviewers	
26	June 28th: Interview MCL	
27	July 5th: Interview Antonius Sneek July 8th: Meeting Hindrik Vondeling	July 6th: preparation Innovate July 7th: Innovate
28	July 15th: Meeting with Henk Bijker	
29	July 19th: Interview Rabobank	July 18th: Innovate July 22nd: Vacation
30	July 27th: Interview Tjongerschans July 28th: Interview Orbis Concern July 29th: Discussion publication	July 25th: Kentalis
31	August 1st: Interview Catharina August 2nd: Interview Dutch Insurers August 4th: Interview IJsselmeerziekenhuizen	Data analysis will take place during the data collection
32	August 8th: Interview AMC August 8th: Meeting Project Team August 9th: Interview ZGT	August 10th: Kentalis workshop August 12th: Half day off

	August 9th: Interview Amphia August 10th: Interview Diaconessenhuis August 11th: Interview CWZ August 11th: Interview Isala	
33	August 15th: Meeting; data analysis August 16th: Interview Antonius Nieuwegein August 17th: Interview Atrium August 18th: Interview Nij Smellinghe August 19th: Interview Rivas	August 19th: Half day off
34	August 23rd: Interview St Jansdal August 24th: Interview Martini August 25th: Interview AZM August 26th: Interview Jeroen Bosch August 26th: Interview Sint Franciscus	August 22nd: half day off Augusts 25th: half day off
35	September 2nd: Meeting Project Team Data analysis & writing last chapters	
36	Data analysis & writing last chapters	September 9th: Half day off
37	Data analysis & writing last chapters September 14th: thesis to exam commission	Vacation: 15 – 22 September
38	September 23rd: meeting soundboard	Vacation: 15 – 22 September
39	September 26th: meeting exam commission Rewriting Handing in thesis @ BOZ	
40	October 7th: handing in final version examn commission	
41	October 14th: presenting GHZ?	
42	October 21th: Graduating	
45-46		November 17th: Congress & Publication