

Partaking or differentiating? The effect of exchange, normalizing, and representational market practices in the healthcare market

The case of the lower back treatment niche



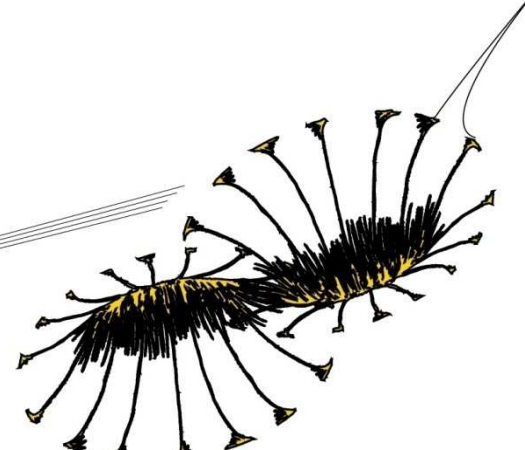
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Abstract

How does the change in the configuration of a market allow healthcare providers to perform new and innovative behavior? While the plurality of marketing literature assumes an economic perspective with rational customers, recent studies show that a complete view of the market requires a sociological and performative perspective, i.e. the market as a collection of activities. The purpose of this thesis is to complement this perspective with an extra dimension that creates a holistic overview of the changes in a market; time. We draw on qualitative research conducted in the niche market of lower back treatment, where actors are exposed to various changes such as new competition legislation and changing patient characteristics, leaving them to question their own possibility to differentiate. We analyze how the practices in this niche market have changed and how this influenced the configuration of the market over time. Our study reveals that several changes in practices have occurred over time, either because new practices were introduced or practices are performed in more diverse ways. We further found that the role of certain actors has altered with these practices. These findings suggest that the configuration of the market has changed over time and likely will change in the future, offering healthcare providers options to differentiate as behavior is not totally socially determined. We contribute to the existing literature interested in market practices and performativity studies, by adding a time dimension. We further build on work interested in agency and the relation between practice research and institutional theory.

Keywords: Economic sociology • market practices • performativity • healthcare niche

Introduction

Healthcare markets are continuously changing, illustrated by market reforms, regulations, and ways to stimulate competition (Annas, 1995; Hendriks, Spreeuwenberg, Rademakers, & Delnoij, 2009). Due to these changes, healthcare providers increasingly experience a need to adopt marketing practices which are deemed necessary to differentiate from competition (Naidu, Parvatiyar, Sheth, & Westgate, 1999). It's likely that marketing practices will keep gaining importance, as governments will keep cutting healthcare costs (Halbersma, van Manen, & Sauter, 2012). Different attitudes exist regarding the proper type of marketing for a healthcare provider. For example, Berkowitz (2010) suggests healthcare providers should adopt economically oriented and goods-based marketing models, such as the traditional 4P model of McCarthy (1964). These types of models define differentiation as differences in products and services between similar suppliers, coming forth out of

imperfections in both the supply and demand side of a market (Smith, 1956). Furthermore, they imply markets are static environments and its actors being rational and entirely self-interested, a notion that proved simplistic and inaccurate (see, for example, Heinrich et al, 2001). Despite governmental interference to reform healthcare markets, practices, norms and rules of behaviour are pervasive (Scott, 2000; Zucker, 1977) and this will likely constrain the possibilities for individual actors to differentiate their offerings from the rest. To decide on the degree of manoeuvrability, healthcare providers must therefore take into consideration the general and accepted practices and norms pertaining to the market. Hence, we equate the term differentiation to agency as described by Beckert (1999); the maneuverability a firm has to develop differentiated marketing practices and competitive advantage, in compliance with the urge to conform that prevails in a market. Beckert argues that institutions and institutional practices are both a constraining and requisite factor for strategic agency in the corresponding field. Institutions constrain behavior by setting expectations on how actors should act, thereby limiting degrees of freedom and at the extreme lead to firms that simply copy behaviors out of fear to violate institutional rules (DiMaggio & Powell, 1983). The likelihood of success of strategic agency diminishes with an increasing degree of institutionalization, as these fields will be more resistant to change (Beckert, 1999). Nevertheless, institutions enable agency because it allows actors to connect means-end relationships (Beckert, 1999). Fields in which institutions not (yet) exist exhibit uncertainty for actors, which troubles predictions on legitimacy and the future obtainment of resources. Strategic agency is therefore only possible in organizational fields that are at the minimum partially structured by social rules and norms. Dorado (2005) complements this theory with an algorithm to differentiate between different types of agency, depending upon the features of a particular organizational field. Hence, to conclude on the adequate type of agency, a characterization of the organizational field is prerequisite as this will reveal the opportunities to do so. Opportunities are then defined as *the likelihood that an organizational field will permit actors to identify and introduce a novel institutional combination and facilitate the mobilization of the resources required to make it enduring* (Dorado, 2005, p. 391). Based on the degree of institutionalization, she describes three degree fields with different opportunities. These are, from low to high respectively: Opportunity hazy, opportunity transparent, and opportunity opaque. Her model, however, doesn't include the notion of performativity; the fact that markets are not static objects but are created, sustained and influenced by actions of actors (MacKenzie, Muniesa, & Siu, 2007). To demonstrate how these dynamics work in a market, Kjellberg and Helgesson (2007) offer a sociological and performative perspective to describe markets as being constituted by three

different, yet interrelated market practice levels: exchange, normalizing and representational practices. This perspective on markets suggests that markets are continuously produced and reproduced through various practices by actors. Exchange practices include all the economic activities performed regarding the consummation of economic exchange, such as negotiating prices and distribution of goods. Normalizing practices are activities to guide and influence markets, with both formal and informal origins. Representational practices comprise all activities that provide information to describe and characterize markets, e.g. performing market research or calculating future healthcare costs. They furthermore describe different configurations of markets, for example a market mainly driven by exchange practices (i.e. industrial markets), or a combination of exchange and representational practices (i.e. a stock market). Because of its performative nature and its reliance on *homo sociologicus* rather than *homo economicus*, employing this model helps exposing institutionalized practices by revealing the degree of homogeneity between behavioural patterns in a given industry. Temporal elements proved to be of importance for institutions and the institutional process, as actors require time and space to perform activities that collectively create a market (Kaplan & Orlikowski, 2013; Lawrence, Winn, & Jennings, 2001). Furthermore, Emirbayer and Mische (1998) show how agency is a temporally embedded and social process. It is therefore, that we complement the model of Kjellberg and Helgesson (2007) with different time perspectives; the past, present and future forms of market configurations. Recently, changes in market practices such as changing patient attitudes or competition stimulating efforts, has created tension for actors and possibly changed the market configuration of the healthcare market. In this thesis, we study how the configuration of the market and the change over time therein influences the maneuverability of a firm. This is important because the healthcare market is increasingly becoming competitive, both urging healthcare providers to (re)act but also leaving them to guess regarding their options to differentiate. We intend to fill this gap by this study, therefore the main research question that guides our effort is: *To what extent is differentiation possible for a single healthcare provider, given the configuration of exchange, representational and normalizing practices in the healthcare market?* To account for the change over time, we add the following sub question: *How does the change over time in this configuration opens up for differentiation?*

We make several theoretical contributions with this study. First, we contribute to the growing body of literature regarding practice research and performativity studies grounded in economic sociology (Kjellberg & Helgesson, 2006, 2007; MacKenzie et al., 2007), but we

add a new perspective by involving different time dimensions (Ancona et al., 2000). Second, our work builds on previous work interested in institutional opportunities and human agency (Beckert, 1999; Dorado, 2005). Third, our findings enrich literature concerning the relationship between practices and institutional theory (Smets, Morris, & Greenwood, 2012). We further hope to offer practical contributions with our work, aiding managers by making choices regarding maneuverability according to market activities especially in the healthcare market.

We structured the remainder of the thesis as follows. In the next section a framework for understanding market practices in relation to institutionalization is depicted. We then describe the research methods. Next, separated market configurations on the three different time dimensions are described, in such a way that we can compare them in a final analysis to answer the research question. Lastly, we discuss our findings, give recommendations for further research and offer implications for managers.

Theory

The main framework used in this thesis to analyze the niche market of low back treatment is the model of Kjellberg and Helgesson (2007). Unlike economic models of markets, which assume that markets simply exist, they propose that markets are abstract entities that are created by activities of involved actors. Markets are therefore subject to performativity, i.e. the notion that economists and other actors constitute markets by describing it, rather than merely observing. Although differing in magnitude in the way they perform economics, the different types of performativity all imply that the use of economics have an effect on the economic process they portray (MacKenzie et al., 2007).

Market practices

The market as practices framework proposes that all activities can be categorized in three distinct, but interrelated groups. These activities are called market practices, defined by Kjellberg and Helgesson (2007, p. 141) as *all activities that contribute to constitute markets*. Their model is constructed of three interrelated market practices: Exchange, normalizing and representational practices. The following section will use the thesis of Kjellberg and Helgesson (2007) as guideline for exemplification of the three practices and their interdependencies, supplemented by specific examples found in other academic thesis. A

condensed overview of the three market practices with their definitions and examples is provided in table 1.

Table 1. Overview of market practices as proposed by Kjellberg and Helgesson, 2007

Type of practice	Definition	Example
Exchange practices	Concrete activities related to the consummation of individual economic exchanges	Specifying and presenting products, negotiating prices, advertising, distribution of goods
Normalizing practices	Activities that contribute to establish guidelines for how a market should be (re)shaped or work according to (some group of) actor(s)	Establishment of normative objectives (regulations), market reforms, specifying general rules of competition, shaping of voluntary standards
Representational practices	Activities that depict markets and/or how they work	Collection and processing of sales statistics

Exchange practices are all activities involved in the economic consummation of goods and services, such as supplier-customer meetings, prices negotiations and advertising, to mention a few. In addition, more general activities that contribute to construction of markets are included in this category. All exchange practices serve the purpose of (at least temporarily) stabilizing markets to aid economic consummation, such as the framing of resupplying office consumables by automated purchasing software (Andersson, Aspenberg, & Kjellberg, 2008). Further, material devices (e.g. supermarket shelves) and calculative processes assist in economic exchange and are therefore part of exchange practices.

Normalizing practices are all activities conducted by (groups of) actor(s) to establish (formal and informal) rules and norms to guide markets in certain directions. These agencies can either be market participants or third-parties not directly involved in the exchange process, such as governments or regulatory bodies. The norm forming process has three variations, which are all activities related to 1) market reform efforts, 2) general rule establishing and compliance, and 3) strategic planning and establishment of objectives by individual market actors. For example, Holm and Nielsen (2007) describe the sequence of normalizing practices of the Norwegian government, with the objective of protecting overfishing of the cod population by introducing transferable fishing quotas.

Representational practices are activities that describe the market and their mechanism, essential for development of images of markets. Since markets are conceptual and abstract entities consisting of activities of actors, representational activities are inevitable for the formation of a holistic overview of a market, by transcending and linking spatial and temporal elements of idiosyncratic exchanges. They thereby frame mental modes for actors, which function as an antecedent for business models (Nenonen & Storbacka, 2010). Examples of representation activities are collecting sales/marketing data, meetings to discuss market research and reporting about changes in the market.

Interdependent effects via translations

The three different market practices of the framework are linked and entangled in what are called 'translations'. To illustrate the connection between the three practices, Kjellberg and Helgesson (2007, p. 144) describe the example of customer segmentation. Possible steps for this activity are 1) designing a study based on the firms objectives, 2) selecting respondents through some sampling procedure, 3) surveying the resulting sample with instruments like questionnaires, 4) analysing the collected data using some technique for multi-variance analysis, and 5) developing profiles for each of the identified clusters.

The customer segmentation process, in itself a representational practice, is thus build up out of other smaller market practices. The customer segmentation can have impact on the strategy and decision-making of a company, may lead to new strategic objectives (normalizing practice). These new objectives can lead to new marketing efforts or new product offerings to customers (exchange practices). The three types of market practices are thus interrelated by strings of activities which can move back and forth between the three practices, as illustrated by figure 1. The different types of translations will be discussed in more detail in the following section.

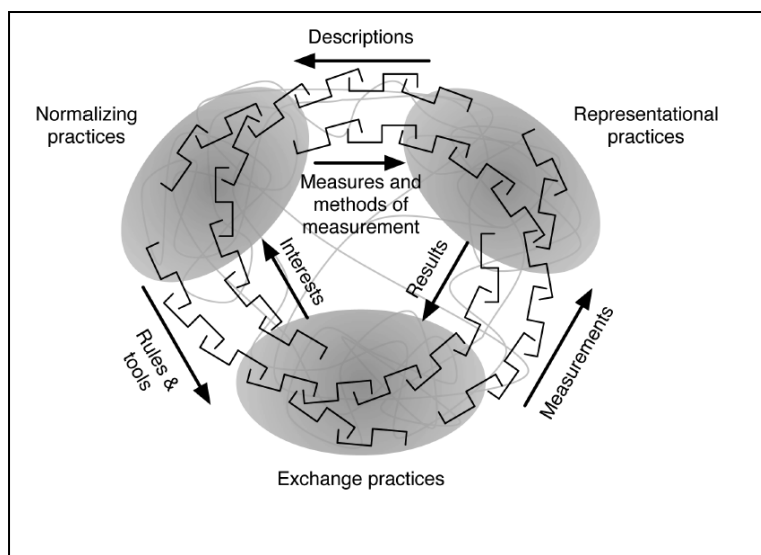


Figure 1. Types of translation between three types of market practices

Economic exchange and consumption is affected by normalizing practices in the form of both formal and informal rules. Illustrations of formal rules that influence exchanges include market reforms and anti-trust legislation, while the call for more environmental sustainability illustrates the informal standard setting. Representation activities affect exchange processes by displaying the result of actions of market participants, of which a prime example is the stock market (see, for example, MacKenzie, 2003).

New norms are created if situations in which norms are deemed necessary are represented, thereby proving the influence of representations on norms. An example provided by Kjellberg and Helgesson (2007) is one of a telecom firm, which is exempt from anti-trust laws (norms) because of the ideas of actors in the market that it would damage customers to have competition. Further, changes in exchange processes (e.g. rising costs, shifts in consumer demand) can cause various actors to ask for more / altered regulation. A prime example could be the ongoing embargo between Europe and Russia of certain products, leading European retailers to ask for exemptions of certain regulation.

To be able to communicate about markets, information regarding exchange activities is essential. Normalizing practices give rise to measures and methods of measurements, for example the introduction of and compliance to accounting standards. These norms provide clearance on the use of these measurement methods and therefore are enables actors to represent markets in a uniform manner.

Market configurations

Markets can be configured in many different ways, based on the combination of the presence and importance of the three market practice categories. As an example, Kjellberg and Helgesson describe four variations of market configurations. They argue that there is no reason to assume that not more possible configurations could exist, build up out of other quantities, importance and/or presence of the three market practices. Table 2 gives an overview of possible market configurations, with characterizing properties and examples.

Table 2. Examples of different market configurations

Configuration	Crucial practices categories	Description, symptoms	Example
1	Exchange	Exchange relationships rather than idiosyncratic exchanges	Industrial markets
2	Normalizing	Appears unstable and political due to rapid changes	Market in transition
3	Exchange, representational	Continuous translations between exchanges and images	Stock markets
4	Equal distribution of exchange, normalizing & representational	Stable markets with stable roles for actors	Food retail, electronics

Time dimensions

To complement the model of Kjellberg and Helgesson (2007) we did not merely describe the practices that are common in a market at this moment, but analyzed the practices on three different temporal perspectives; the past, present and future. We did this for several reasons. First, since the market as practices model assumes performativity, actors are able to influence the market. It is therefore not only interesting to see what the outcomes of their actions are, but it is rather necessary to achieve a holistic overview of the market. Since delays in reactions on performances of actors exist, more than one time dimension is needed to capture all practices that are present in the market in different time perspectives (Delmar, 2006). Second, Ancona et al. (2001) argue how temporal dimensions can add extra depth for the understanding of behavior in organization studies. They suggest that by using different time dimensions one is not only of describing change, but also the pace, duration, cycles, etc of the development over time. This provides a more complete view of the behaviors of actors and the field which they perform.

Current practices are related to past practices, but this relation can take various forms. Past practices can have enabled or altered present practices, have constrained or precluded

present practices, past practices can have intertwined into new practices, etc. We therefore need knowledge of past practices to be able to draw sensible conclusions on the present practices that are observed in a market. In the same way, current practices will influence future practices in a variety of ways, and therefore influence the composition of the organizational field. In accordance with performativity literature, this implies that the future of a field can be made by an actor, rather than merely observed and reacted upon.

Framework

In this part we will integrate the market configuration and the time dimensions to come to our theoretical framework. We study the three market configurations in this niche market; the past configuration, the present configuration and the future configuration. We employ the change over time in market configuration as the degree of institutionalization, i.e. indicating the maneuverability a firm has. We argue that when a field is strongly institutionalized, change is not or hardly possible. As the field leaves little room for improvisation, the market configuration should be the approximately the same over time. On the other hand, when large changes occurred and practices or practice categories have changed, the market configuration will appear dissimilar over time. In such a case, we can assume the field is not institutionalized or deinstitutionalized. The change in market configuration then enables us to conclude on the options for agency and differentiation, guided by guidelines of Dorado (2005). Figure 2 shows the theoretical framework applied in this thesis.

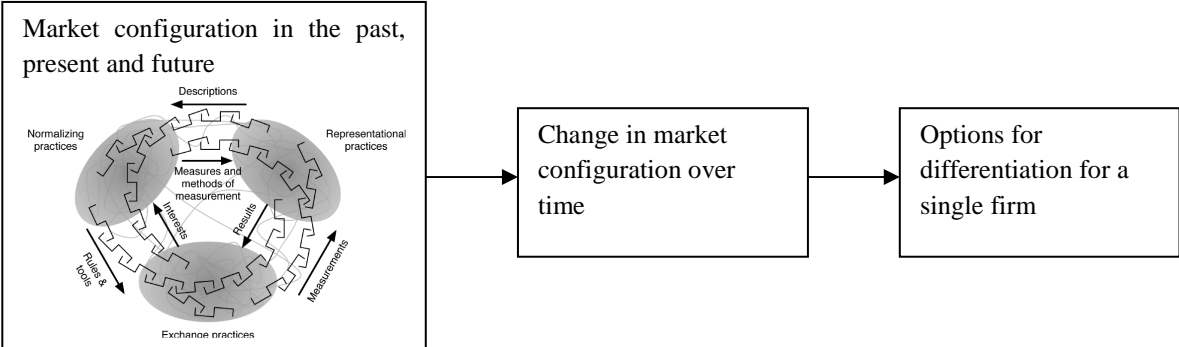


Figure 2. Theoretical framework

Method

As we are concerned with practices and behavioral patterns, we followed Lofland and Lofland's (2006) suggestion to use qualitative research. The research design is a case study (Babbie, 2007), which provides a unique way to develop theory about and understand phenomena by means of in-depth insight acquired in their corresponding fields (Miles & Huberman, 1994).

As unit of analysis, we focus on the niche market of low back treatment in the Netherlands. Diverse changes in last decade have changed this field, such as the allowance of private hospitals in 2006 to promote competition and increase quality (De Grave & Barendregt, 2007). This has increased the number of firms in the market, as previously only hospitals were allowed to furnish specialised care. The players in this market compete on different levels, being primary, secondary and (optionally) tertiary care. The first level, primary care, consists of (para) medical healthcare providers that act as first consultation point and approachable without restrictions. Physiotherapists, chiropractors and general physicians are typical actors in the field of primary care. Secondary care is healthcare which is not accessible without referral of a primary care physician and is typically more specialized. Due to governmental competition promoting activities and new legislation concerning private hospitals, public hospitals have seen an increase in competition in this market. Tertiary healthcare in the Netherlands consists mostly of academic hospitals, offering very specialized and advanced medical investigation and treatment opportunities. Patients are not accepted in this care system without referral from a primary or secondary care provider. For this study, we primarily focus on the secondary healthcare level for the lower back diagnosis and treatment.

As representatives for the practices in this niche market, different stakeholders in this market were identified. According to Brugha and Varvasovszky (2000), two types of stakeholders exist in the healthcare industry: primary stakeholders that are needed for survival, secondary stakeholders that are not needed for survival. Since secondary stakeholders can be basically everyone (Freeman, 2010), only primary stakeholders are included. Because different stakeholder provide different resources and therefore aid in different ways in the firm's survival, practices of several primary stakeholder groups were analyzed (Freeman, Wicks, & Parmar, 2004). Table 3 provides an overview of the different stakeholders and a justification for the reason they were interviewed.

Table 3. Overview of stakeholders

Type of stakeholder	Reason for selection of stakeholder	Number of interviews
Manager of private hospital	Directors	1
Patients	Receive care and thereby provide declarable activities	4
Purchasers of health insurance firms	Provide revenue stream by contracting activities	3
Physicians & medical specialists	Conduct day-to-day business & critical knowledge source	4
General practitioners (GP)	Most important referral agents	4

The qualitative data analysis procedure of Miles and Huberman (1994) was used, which consist of four different, yet interrelated phases: Data collection, data reduction, data display, verifying and conclusion drawing. For data collection, we used semi-structured interviews that were created to gain in-depth insights. The use of this type of interviews is based on the research goal, i.e. to gain a deep understanding of the marketing practices and their change over time. The interview questions were based on the three different market practices of Kjellberg and Helgesson (2007) and were adjusted for the types of stakeholders and their practices in the market. For every practice the respondent was asked how the current situation is, how it has changed compared to the past, and in which way he thinks it will change in the future. In total we used four different interview scripts. Using semi-structured interviews with mainly open questions further ensures enough flexibility and offers the possibility to ask further when uncertainties arise. All the interviews were recorded and notes were taken during the interviews, to check if every question has been answered (Opdenakker, 2006). To improve the reliability we triangulated the findings of our interviews with other secondary data sources (Mathison, 1988). We amassed combined information from different sources such as the website of the Dutch healthcare regulatory body (NZa, Dutch Health Authority), paper and online versions of medical professional journals such as *Medisch Contact*, and *De Zorg*, a magazine of collective organization for employers and employees in the healthcare industry.

The data reduction phase of Miles and Huberman (1994) is a process where the qualitative data is reduced and organized into manageable pieces, making it workable for analysis. All of the interviews were recorded and transcribed verbatim. After that, we analysed the data with the help of Atlas TI 7.0, offering the opportunity to code the

transcribed fragments. We were interested in two different dimensions of the observed niche market; the market practices of actors and the change over time. Therefore, in the analytical process, we draw on suggestions of Kaplan and Orlikowski (2013) and used two rounds of open coding.

The first round of coding was concentrated on the different market practices of actors. We were especially interested in the way this practices shape the market and what mutual influences between the different practices and practice categories exist. Special attention was given to the homogeneity in practices, for which we both compared inter- and intragroup differences. A second round of coding focused on the temporal change in the market practices. We searched for patterns and explanations in the change over time of activities, such as the way practices arise, evolve or merge, or extinct. This analysis was done both between and within different actor groups. Special attention was given to the future directions, as this can have implications for the conclusion on the type of agency. To increase inter-rater reliability and prevent psychological biases, the transcripts of the interviews were inspected by and discussed with other researchers, such as fellow students, until consensus was reached.

The display phase was guided by narrative text based on the most prominent patterns that were found. This was aided by a table based on the different practices and their changes over time with characterizing quotes. Since all the interviews were conducted in Dutch, the citations were translated to English and checked by another researcher until consensus was reached. This let us draw and confirm conclusions on the findings, which we continuously did based on newly acquired results. This enabled us to answer and conclude on the research question.

Results

This chapter will comprise the most prominent and characterizing activities of actors in this niche market, subdivided into the three different time dimensions: Past, present and future. Since future perspectives are merely expectations, we compare the interview data with secondary data sources for triangulation when possible. We use the term medics as a reference to group all the medical participants in this study, such as medical specialists, specialized physiotherapists and GP's. Table 4, 5 and 6 illustrate characterizing quotes we encountered during this study, to which we refer in the text when this gives more insight.

Table 4. Market practices in the past

Categories	Practices	Illustrative quote
Exchange practices	Logistical optimization, debureaucratization	<i>“In the past, a public hospital was like a holy setting. You can see cracks forming there, and see private hospitals coming up now. “ (Medical specialist) “The problem was that public hospitals were institutions that existed for a long time and with a certain monopoly because they didn’t had any competition. Everything was controlled by the Ministry, also the health insurers were largely controlled by the Ministry.” (Medical director)</i>
	Referring activities	<i>“What I see at my colleagues, the loyalty to the secondary care, e.g. ‘I always send my patients to a specific medical specialist because I know that person despite of some negative stories I heard about him’. I’m not doing that anymore. I follow my own plan.” (GP)</i>
	(Selective) purchasing activities	<i>“In the past all health purchasing was organized in such a way, that the largest health insurer in a certain region negotiated with all healthcare providers in that region. Currently, everyone is responsible for its own procurement and each health insurer for itself in the whole Netherlands. That’s why we are more able to differentiate ourselves now.” (Health purchaser)</i>
	Marketing activities	<i>“I think it’s really old-fashioned that it [marketing practices] wasn’t allowed, if you want a market mechanism to work, you need people to present themselves.” (Medical specialist) “We were not allowed to perform any kind of marketing activity.” (Medical specialist)</i>
	Information acquirement by patients	<i>“Previously, patients were sent to any hospital without protest. ... Nowadays, they search information and select in advance.” (GP) “Maybe I would have listened to my GP [instead of searched the internet]” (Patient)</i>
Normalizing practices	Competition stimulation	<i>“Before 2006 it was pointless [to explore entrepreneurial opportunities], I got my fixed fee for each patient and that was it. So why should I do more than the regular things?” (GP)</i>
	Protocolled working and risk hedging	<i>“I have less freedom nowadays, but the freedom I had in the past was too big in my opinion.” (GP) “We did have fewer rules indeed. I mean, especially in the rural areas you just did what you could, you were on your own. There were more opportunities to give your own opinion and act on it.” (GP)</i>
	Administrative pressure / change initiatives	<i>“I think there are more rules now compared to the past” (Patient)</i>
	Patient assertiveness / personal responsibility	<i>“I’ve been a physician’s assistant myself, and taken your own initiatives regarding healthcare has become more important.” (Patient) “I would have listened to my GP and waited for him to give me a referral.” (Patient)</i>
Representational practices	Transparency, quality and benchmarking	<i>“One of the things that has really changed ... is the accountability, the transparency. I think that will gain in importance coming years.” (Manager of private hospital) “And how can we reward healthcare providers that deliver higher quality care? Those kinds of questions are more extensively discussed compared to the past.” (Health purchaser)</i>
	Attitude towards private hospitals	<i>“In the starting phase, private hospitals were seen by many (especially GPs) as the cherry pickers of the healthcare industry, as those who enriched themselves.” (Manager of private hospital)</i>
	Influence of media	<i>“You would expect a large influence of media on healthcare, but in reality it doesn’t. ... I think the influence is smaller now compared to the past, because of our restricted freedom caused by prescription policies imposed by health insurers. ... Media articles have less effect, because we won’t go along with patients’ requests. ” (GP) “I think there is more [imaging] now because of the media [compared to the past]” (Patient)</i>

Practices in the past

Exchange practices

The most important exchange practice in this market, to which every other practice is linked, is the diagnosis, treatment and relapse prevention of lower back problems. As shown in table 4, in the past, the secondary lower back treatment market was characterized and dominated by public hospitals with bureaucratic structures and logistical problems such as waiting lists up to six months. There was no real lower back treatment niche, as no actors were particularly focusing on lower back problem. Patients with lower back illnesses did go to a public hospital, where doctors are more likely to think in a silo mentality because of a mono-disciplinary approach, because public hospitals apply a general focus on many medical disciplines, rather than specializing in one area. This leads to frequent referring of patients within the company to another specialist when a physician finds out that he can't help them. Some of the patients have visited public hospitals for many times, being referred from one medical specialist to another, without any effective diagnoses or treatment. This is experienced as not being taken seriously, which fosters frustration and sadness.

To visit a healthcare provider in secondary care, patients need a referral of primary healthcare providers such as GPs. However, GPs always try to treat patients themselves when possible, for example with rest and medication, or by referring to a primary healthcare provider such as a physiotherapist. Referring also happens when a GP does not have a clear idea of the disease and would like more diagnostics from a medical specialist. Referring to secondary healthcare is most likely when symptoms are not cured or have worsened during treatment in primary care. In the past, GPs had more freedom and chose which follow-up treatment was more favorable for the patient. Their referral decisions were guided by the habit of referring to specific medical specialists because of personal relationships, as illustrated by a quote of a GP in table 4. Further, their decisions were influenced by success stories of other patients, but these were rare as patients mainly did what the GP advised.

In this niche market, most patients do not pay directly to a healthcare provider. Rather, healthcare providers can declare the majority of the costs at health insurance firms, as explained to us by a health purchaser. In the past, the biggest insurer in a particular region contracted the regional facilities for itself and all other insurers, using the representation model. As an effect, every insurer paid the same price to a certain healthcare provider, leaving no options for differentiation for a single insurer.

Marketing practices other than word-of-mouth were absent, for two reasons. As illustrated by a medical specialist, the first reason was that hospitals were prohibited to do marketing, both out of legislation and institutionalized medical norms. Second, there was no necessity to do engage in marketing practices since every hospital has its own regional monopoly, and was therefore ensured of enough patients.

Patients were much less able to search extensively for information on healthcare providers since most healthcare providers didn't have a website and comparison sites were not yet available. Therefore, the role of the GP was more influential as they decided for a patient where they need to go to. A patient commented that maybe the past, when she wasn't able to search for information on the internet, she would have listened to her GP. GPs note that patients almost invariably acted on their advice and seldom a patient asked for a referral of his choice, as an effect of word-of-mouth.

Normalizing practices

Before 2006, the Dutch healthcare sector was an established field with intensive interaction between participants, but without competition. The Dutch Ministry of Health, Welfare and Sport was responsible for all the activities in the healthcare sector, and collaborated intensively with hospitals and health insurers. As indicated by a GP, rather than being paid based on actual performed transactions, healthcare providers were paid a fixed amount of money, in the form of a yearly fee per patient or a guaranteed contract price. It is therefore, that there was no reason to be innovative, as the financial motive to do so was absent. Furthermore, because of this payment system, patients could get limitless care and 'shop' to every hospital they want, increasing the total costs of healthcare.

Medics felt no administrative or organizational pressure in the past, as declaring activities at health insurers were smoother for them. Each medic further worked with a protocol; an algorithm based on scientific research that decides the subsequent step in the medical process. As each type of illness has a medical protocol, GPs deal with a lot of different protocols, while medical specialists such as neurologists are generally only are concerned with one or two protocols. In the past, medics had more freedom to deviate from these protocols without problems as physicians were more inclined to act on their gut-feeling. Furthermore, the doctor role was more authoritative, as for example illustrated by the fact that medical errors did not end in lawsuits.

Historically, patient characteristics were sociologically different. Participants describe the patient in the past as more obedient and having less options to participate in the decision making process. This was an effect of large information and authority symmetries between the doctor and the patient, which led to doctors making all medical decisions. However, patients were less assertive, but were also less willing to travel further for healthcare or pay personal contributions for premium types of care.

Representational practices

As shown in table 4, quality indicators for healthcare operations were absent in the past, as no real need to differentiate between different healthcare providers existed. Research was done by scientific groups, but their mere goal was to show the effectiveness of certain treatments, rather than being able to compare different healthcare providers. Since the healthcare sector was not considered a market and all the costs were paid by the Ministry, measurement and calculative devices were not needed.

In the past, a negative attitude towards private hospitals existed. When the private hospitals were introduced in 2006, they were seen by some actors as ‘cherry pickers’; firms that enriched themselves. Especially GPs were initially reticent to refer to these new firms. Furthermore, a medical specialist explained how public hospitals were at first also critical towards private hospitals. They claimed that private hospitals merely did predictable care that could be planned in advance, but that public hospitals were responsible for the emergency cases in the middle of the night.

Different opinions exist on the influence of media on the healthcare sector. Some actors argue that the influence was bigger in the past because doctors had more freedom to for example prescribe different types of medication. A patient thinks the current influence of the media is larger because more healthcare related issues are discussed in the media. The media, however, did not really form an image of the market but rather carries out case studies on the healthcare sector, such as medical blunders.

Table 5. Market practices in the present

Categories	Practices	Illustrative quote
Exchange practices	Logistical optimization, debureaucratization	<i>“It’s just hard to organize this in a public hospital. ... That’s our strength, we got everything under one roof.” (Medical specialist)</i> <i>“You have to position yourself in the market: ‘I’m doing special practices’. And when you’re good at it, it will attract patients.” (GP)</i>
	Referring activities	<i>“They starting to refer to us increasingly, due to good reporting they are becoming enthusiastic, it’s all word-of-mouth. Then a doctor [GP] thinks: I’ve seen this treatment working for patients four, five, six times, so I’m going to refer for a seventh time. But it’s a slow process.” (Medical specialist)</i>
	(Selective) purchasing activities	<i>Academic hospitals are doing complicated healthcare, so it’s reasonable they ask a higher price. Private hospitals are very specialized and are therefore able to arrange their processes efficiently, so that’s why we expect a lower price, at least compared to other hospitals. So we compare and benchmark the different tenders, and ask ourselves the question: ‘Is it reasonable and in line with other healthcare providers what they ask?’ But there is always room for negotiation. (Health purchaser)</i>
	Marketing activities	<i>We don’t do many activities regarding PR and media, it’s all word-of-mouth. Not with large advertisements or in telephone guides or what have you. (Medical specialist)</i>
	Information acquiring by patients	<i>“I really look for reviews, I Googled [name company] to see if there were complaints and how experiences of other patients were. That’s very important to me.” (Patient)</i>
Normalizing practices	Competition stimulation	<i>“Suddenly I could participate in secondary care, which previously only was allowed for public hospitals. Then I started this clinic and I had my own private MRI and X-ray room.” (Medical director)</i> <i>“I’m pro competition, because in the end it will lead to cost cutting. It only did not lead to that yet.” (Patient)</i>
	Protocolled working and risk hedging	<i>“Well, there is actually only one rule: ‘You’re a doctor and you are trained in medicine, surgery and obstetrics. ... You do what you are able to, but what you can’t do (anymore), you shouldn’t do.” (GP)</i>
	Administrative pressure / change initiatives	<i>“Sometimes, when an incidental success causing the elimination of one form, we will get a new one within a month.” (GP)</i> <i>“It is becoming a too big part of my job. A lot of medics share that opinion; we just want to work with patients, and nowadays there is too much administrative and political burden connected with it.” (GP)</i>
	Patient assertiveness / personal responsibility	<i>“My GP didn’t agree with me, absolutely not. Then I said: ‘Well, you don’t have to give me that referral, I’m going anyway.’ (Patient)</i> <i>“Well there are doctors who say: ‘I do not perform surgery on you, nowhere did you proof that you did something to your problem yourself.’ (Medical specialist)</i>
Representational practices	Transparency, quality and benchmarking	<i>“Up till date, we can’t assess it objectively, as there are no objective criteria. The healthcare in the Netherlands is in general good, but we just don’t know wat the best players are yet. That make’s it difficult to differentiate on that.” (Health purchaser)</i>
	Attitude towards private hospitals	<i>“The commercialization of healthcare is not always good, but it made this kind of clinics possible, which is amazing. Because clinics where medical specialties are centralized, is a real gain in my opinion.” (Patient)</i>
	Meetings with managers and physicians	<i>“I don’t see other physicians to talk about it [the healthcare market], but I meet them and 9 out of 10 times we speak naturally about it. (Medical specialist)</i> <i>“I’m involved in all kind of activities: I’m in quality committees and supervisory bodies, I’m in different management positions, I teach at a number of universities, I contact doctors and directors of hospitals, so that’s how I stay informed.” (Manager of private hospital)</i>
	Influence of media	<i>“I think the influence is quite large. But I doubt if it is always elaborated in the right way.” (Patient)</i> <i>“The influence is large. It’s a popular subject due to all changes, politics, health insurers; a lot of things are going in the healthcare sector. What you write and how you write, is very important.” (GP)</i>

Practices in the present

Exchange practices

Recently, entrepreneurial firms started changing this field by activities characterized as logistical optimization, debureaucratization, and employing a multidisciplinary approach to lower back problems. These firms apply the same technology and knowledge as public hospitals, but let different medical specialists focus on lower back pain, rather than on their medical specialty. Because lower back pain can have an abundance of causes and therefore requires an integrated medical investigation, these entrepreneurial healthcare providers typically achieve better results compared to public hospitals. This focus on illnesses by smaller firms is also seen in for example eye-care and dermatology, where higher quality care is delivered for a lower price with less logistical burden. These small healthcare providers increasingly form a competitor for the established public hospitals with previous regional monopolies. We documented an increased need for specializing activities of healthcare providers, mentioned by various actors. For an illustration, see table 5.

Compared to the past, we observed changes in the referral practice of GPs, with two reasons. While some of the GPs still habitually refer to specific medical specialists because of close relations, others try to be more objective or are less loyal to the secondary care compared to the past. Especially success stories of patients at for example new innovative private hospitals have the ability to alter referral practices of GPs, as noted by medical specialist. The second reason for changes in referring are changed insurance policies. When patients are not able to declare certain treatments with their health insurer, they are inclined to ask for another treatment, in which GP generally go along.

Large shifts have occurred in the way this procurement process takes place last years. Since the introduction of competition in the healthcare sector, every insurer is now responsible for their own care procurement in every region, giving more options to negotiate harder or make different deals. Health purchaser's main purpose is to have national coverage, enabling policyholders to visit health care providers throughout the whole country. Procurement has to be fair for all healthcare providers, thus private and public hospitals are granted the same rights. The purchasing process is further based on two main pillars: Price and quality. Logically, these two are linked in a linear fashion, i.e. care with a higher degree of difficulty gets a larger compensation. Till date, the quality of care is hard to determine, as no real quality indicators are set yet. They therefore mostly rely on price, national coverage

and volume purchased. As policy holders increasingly select their health insurer on the monthly paid premium, health insurers experience an increase in financial pressure placed upon them. As a way to mitigate costs and be competitive, a health purchaser mentioned he recently started with selectively purchasing care, which comprises purchasing care at only few healthcare providers based on specific criteria such as price or quality. By contracting only the best facilities, they hope to prevent excessive costs of for example reconstructive surgery. Two of the health purchasers we interviewed are already started with selective purchasing. Patients have mixed feelings regarded selective purchasing, as their freedom to choose a physician of choice diminishes. On the other hand, they regard contracted facilities to be of good quality, because they feel health insurers would not contract underperforming healthcare providers.

A notable aspect of this niche market is the absence of marketing activities by healthcare providers, which we observed in the past but prevails till date, as remarked by a medical specialist. The fact that they currently solely rely on word-of-mouth marketing activities of patients has two main reasons. The main reason for this is that marketing still is against ethical and professional norms of medics. However, in other sectors of healthcare (e.g. dentistry, eye-care) violation of these norms increasingly occur without real consequences. We furthermore observed a shift in this attitude, such as medics who progressively reject the ethical norm that marketing is prohibited, as market mechanism requires providers of goods to present themselves. The second explanation, coming from a medical specialist, is that marketing or PR is not needed because patients with complicated lower back pain unfortunately will not be treated properly in a public hospital because of its silo mentality. They will therefore ultimately end up in a more specialized private hospital.

Patients are positive about a possible increase in marketing activities by healthcare providers, as this would ease their search for information. We documented how patients increasingly search the internet for information regarding healthcare, as illustrated by a quote of a patient, shown in table 5. Information technology and increased connectivity enable them to collect information and reviews of lower back healthcare providers. Patients increasingly propose own initiatives for referrals based on findings on the internet, which most GPs consider a good development. Rather than relying on the advice of GPs or medical specialists, especially reviews of other patients are progressively regarded as a reliable source of information. Most participants expect patients will rely on the internet more in the future as a source of reliable information.

Normalizing practices

In 2006, the Dutch government introduced a market mechanism in the entire healthcare sector. The goal was a decrease in costs by stimulating competition on two levels; the health insurers and the healthcare providers. The Dutch government started licensing firms other than public hospitals for provision of medical specialist care in secondary healthcare. Furthermore, the reform of the healthcare insurance system gave health insurers more freedom to choose to contract healthcare providers. As illustrated in table 5, a medical director mentioned that this new legislation has opened up for entrepreneurial opportunities for him, being enabled to deliver new types of care. All participants of this study are positive about the new competition legislation because it opens possibilities for new entrepreneurial opportunities. Competition further has the ability to promote lower price and higher quality. They note, however, that up till now it didn't help cutting costs as compensations are declining, and insurance premiums and personal contributions keep rising annually. Furthermore, there is still resistance towards the idea of market mechanism by some actors, illustrated by medics who observe the field of lower back treatment not as a market, because in their opinion no real competition exists. Other similar players in the field are seen as companions, but the relationship cannot be described as a real collaboration because of the sequential nature of the referral practice. Once a patient is referred, a letter to the new therapist/diagnostician is sent and then the current intervention ends. Differences in images of competition exist between primary and secondary care, with primary care being observed as very competitive market.

Medics agree that the healthcare niche of lower back treatment does not differ from healthcare in general regarding medical autonomy and medical regulation. Although medics need to adhere to a lot of medical rules, they are not perceived as negative because these rules are justifiable, act as guidance and are the consequence of scientific research. However, deviation from the protocol has to be recorded rigorously as a form of risk hedging, since medical failures are increasingly judged in court or by disciplinary committees. Medics and patients are afraid the Dutch system will turn into an American system where suing will become normal.

Compared to the past, most actors (except patients) in this niche market experienced an increase in administrative activities and pressure as more activities have to be registered to receive compensation from the health insurer. Especially medics perceive this disturbing, as

they would like to spend their time on care rather than administrative and organizational activities, as illustrated by a GP in table 5. Medics feel healthcare providers have an abundance of administrative and declarative protocols to adhere to, which interferes with a smooth administration process. What they furthermore find disturbing, is the feeling that healthcare providers increasingly have to prove they are not fraudulent with their declarations. Although unknown to most medics, initiatives to change the administrative burden are organized by occupational groups such as the LHV (*Landelijke Huisartsen Vereniging*, National GP Association). Their efforts, however, are limited in their effectiveness as requests for less administrative regulation are seldom accepted. An initiative started by ZKN (*Zelfstandige Klinieken Nederland*, Independent Clinics Netherlands) had more success, as newly introduced regulation forces health insurers to treat public and private hospitals equal regarding purchasing activities. It is striking though, that we also encountered participants who think administrative pressure decreased for healthcare providers last years. Most participants mention a growing criticism to the bureaucracy and administrative pressure in the healthcare industry.

Several medics explain how the patient as an actor has changed compared to the past. Currently, changing societal norms has led patients to become increasingly assertive, as illustrated by the observations of doctors that patients are becoming more demanding. Patients do progressively feel more responsible to make sure they receive the best care possible, exemplified as willingness to pay higher personal contributions and travel further for top quality healthcare. Especially in private hospitals, where personal contributions are common, patients expect premium service. GPs also note that patients are more inclined to ask for referrals of their own preference, rather than take the advice of the physician. While medics differ in their attitudes regarding more assertive patients, they jointly consider it a positive development that patients are more interested in their medical situations. Another trend that intertwines with patient assertiveness is the hardening of the healthcare culture. Participants increasingly think that patients have to contribute to the solution themselves, such as losing weight or quitting smoking/drinking alcohol. Obese patients are increasingly rejected for surgery, as doctors feel patients need to take their responsibility regarding their health. This is yet another form of risk hedging as performing surgery on obese patients entails more risk. Both the increased patient assertiveness and responsibility are depicted with typical quotes in table 5.

Representational practices

All medics, the manager and the health purchasers we interviewed mentioned an increased demand for transparency and quality, showing the current lack of information about medical quality and effectiveness in this field. An insightful quote regarding this was given by a health purchaser and is shown in table 5. The lower back treatment niche currently has two types of quality indicators that can be used, i.e. process indicators and outcome indicators. Process indicators are easy to define and measure; examples include the presence of a safety management system and meeting criteria for hygiene requirements. Process indicators do not, however, ensure an effective treatment. Treatment outcomes, patient satisfaction and pain reduction are therefore outcome indicators, which are harder to measure because of various reasons such as the time interval between the first and second measurement. Furthermore, as many participants noted, it is rather difficult to determine what the right type quality indicators are. Although different scientific medical groups are conducting scientific research to establish indicators, a lot of disagreement within those groups hinders rapid progress.

A manager of a private hospital explained they already started doing their own scientific research. Patients are requested to fill out online questionnaires regarding their physical complaints and progress on three different measurement points, which is then used to show effectiveness of treatments to for example health insurers. Other research projects concern PhD projects and RCTs, exploring the effectiveness of new, innovative treatments such as injects in the spine for lower back problems. The goal is to proof their effectiveness, with the ultimate goal being persuading the NZa to oblige health insurers to cover the costs of the treatment.

Although not completely disappeared, as an effect of word-of-mouth of good patient experience and treatment effectiveness, the negative status towards private hospitals is diminishing. An observation made by a medical specialist (that is shown in table 5) is that private hospitals are upcoming in the so called the 1,5 level care, combining general primary healthcare with specialized medical knowledge. Because these firms typically focus on one type of illness rather than an area of specialty, they acquire critical knowledge and are seen as experts in the field. This change is recognized throughout the whole healthcare industry, such as lower back specialists, dermatology clinics, and private diabetes hospitals. Especially patients are very enthusiastic of specialized clinics, as some of them had unpleasant experiences in public hospitals because of its silo mentality. GPs are also more inclined to

refer to private hospitals for their logistical advantages and customer friendliness, but only after they received multiple positive feedbacks from other patients.

Meetings arranged to discuss matters regarding the healthcare market are uncommon in this healthcare niche. However, when physicians gather to discuss operational or patient-related matters, market-related issues automatically are discussed. The manager we interviewed is the only participant who meets with other managers or medics to deliberately discuss the healthcare market. She tries to stay informed via different associations, such as universities, management boards, etc.

Participants differ in their attitude regarding the influence of the media. Medics remark that biased articles having large societal effects, focusing on exaggerated minor details of little medical importance. Only a few participants mention the media having a small effect, or having no effect at all. Although patients ask for the new medication seen on for example the internet, this doesn't affect GP's daily practices because of restrictions in their protocol, such as obligatory prescription policies. The majority of participants think the media is quite influential and see an increase in media coverage on health related issues. Still, the media does not actually make an image of the market but rather discusses anecdotal cases. A patient noted that she realizes that every company probably has dissatisfied customers, but she considers one negative criticism to be more impactful than a positive review. Health purchasers also mention a large influence of the media on their practices, for example when a policy holder goes to the media with an issue regarding a declaration.

Table 6. Market practices in the future

Categories	Practices	Illustrative quote
Exchange practices	Logistical optimization, debureaucratization	<i>“I think public hospitals will be stripped a little further. ... The only service they will keep providing is the typical hospital care, like COPD, cancer, ... that’s real hospital care.” (Medical director)</i> <i>“I believe that a healthcare provider should take all they can get on their area of expertise, and should have access to all relevant information ... They have to professionalize in their best practice and not offer a whole spectrum, just to attract every possible customer.” (Patient)</i>
	Referring activities	<i>“It’s going to be stricter, insurers get more power and they will determine who will treat the patients.” (GP)</i>
	(Selective) purchasing activities	<i>“The conversations are always the same, so I can image we are maybe going to apply multi-year contracts with healthcare providers, when we reach consensus about the level of quality.” (Health purchaser)</i> <i>“I think more care will be purchased selectively, but that a lot of patients are not going to accept that. And then it will be reversed to a great extend.” (Manager of private hospital)</i>
	Marketing activities	<i>“I think it only will increase and that we’ll move towards the American model. ... Of course we’re very sensitive for it, I think we will move in that direction in the Netherlands too.” (Patient)</i>
	Information acquirement by patients	<i>“Patients will become more assertive and better informed, don’t forget that. We live in an information society. We got the internet, where you can find everything. That will foster another type of patient.” (GP)</i>
Normalizing practices	Competition stimulation	<i>“Well, that implies that I’m going to look somewhat different to colleagues, the feeling of ‘us’ will become more like ‘you and me’. That’s a big change.” (GP)</i> <i>“I think competition will increase, like these private clinics ... The propositions will become more comprehensive, which will even further increase competition. But that in itself is not bad, competition keeps you sharp.” (Patient)</i>
	Protocolled working and risk hedging	<i>“It’s going to be stricter in the future. The field of medicine will become very protocolled, like ‘you’re going to do this, and motivate when you deviate.’ And motivate it appropriately, otherwise you shouldn’t do it.” (GP)</i>
	Administrative pressure / change initiatives	<i>“I hope it will decrease, and I hope digitalization can help with that.” (Patient)</i> <i>“If it’s up to the government, it will only increase.” (Patient)</i>
	Patient assertiveness / personal responsibility	<i>“Patients will become more assertive and better informed, don’t forget that. We live in an information society. We got the internet, where you can find everything. That will foster another type of patient.” (GP)</i>
Representational practices	Transparency, quality and benchmarking	<i>“You can imagine that when quality indicators will become available ... we can request them at all healthcare providers and make a choice based on that, but we have to be clear about our ranking and calculative method then.” (Health purchaser)</i>
	Attitude towards private hospitals	<i>“I can image when this kind of clinics are going to be successful, maybe the attitude towards public hospitals in general will change.” (Patient)</i>
	Influence of media	<i>“Physicians probably have to pay more attention, it will be tighter. There are more stories in the media about things that went wrong in hospitals, and also because of the commercialization of healthcare, I think it’s good to for a hospital to be well prepared. There will be less room for leaving things out of account.” (Patient)</i> <i>“I think the influence of the media will increase and that we will move toward the American model. ... I’ve been there a few times, and they have commercials for all kind of medical stuff. We are very sensitive for it, so I think we will move in that direction in the Netherlands too.” (Patient)</i>

Practices in the future

Exchange practices

The upcoming of private hospitals has changed the niche market of the lower back treatment. Since these firms achieve good results and are seen as customer friendly, some of the participants think public hospitals will be less influential in the future, especially because private hospitals are becoming more specialized in certain types of illnesses. Most of the participants agree that public hospitals will remain, but some actors think public hospitals will go bankrupt or only stay for typical hospital care such as diagnosis and treatment of cancer or COPD, as illustrated in table 6. It is striking that especially patients mention the need to specialize in one area of illness for survival; they feel medical services should not be viewed as a commodity, but should be customizable to a specific patient's needs. Health purchasers are more reserved about the future of public hospitals. Although private hospitals might deliver qualitatively better care, public hospitals can leverage the other types of care they provide to persuade an insurance firm to buy specific types of care merely from them. Till date, they see private hospitals as a welcome addition to public hospitals, rather than substitutes. All actor groups agree that the healthcare industry is moving towards a market-driven model, where specialization will be necessary for survival, as it is a means to become and stay competitive.

GPs have different attitudes towards the way they see changes in referral policy in the near future. While some mention that there will be no changes in their referral policy, some think it will be more protocolled, with less room for own interpretation and autonomy. Other options are also mentioned. Table 6 illustrates the perception of a GP, who mentioned that health insurers possibly will decide where to send a patient to, either directly or via selective purchasing. Both these outcomes constrain the freedom and autonomy of GPs.

Most participants mention that selective purchasing will become a normal way of purchasing health care, at least comparable to purchasing based on coverage. Medics and GPs differ in their attitude towards selective procurement of care, but all expect an increase in this market stimulating mechanism. However, some participants expect patients might not accept selective purchasing on a large scale, which could lead to revoke the selective procurement of care. Apart from selective purchasing of care, other options for future purchasing activities are multi-year contracts between insurers and healthcare providers.

Patients expect marketing activities of healthcare providers to increase, as this is already increasingly observed in other fields of the healthcare market. Furthermore, some medics explained that they also expect an increase in marketing activities in the healthcare sector, which is needed for comparison between different suppliers. However, some medics are reticent on their opinions regarding marketing in the future, possibly because of the conflict with their ethical norms.

As information technology progressively interconnects patients with each other, the common opinion is that the internet will become increasingly important for patients to base their decision for a healthcare provider on. As a GP noted, as shown in table 6, patients will be better educated and probably more assertive, which will change the general patient characteristics.

Normalizing practices

Future perspectives are an increase in competition, mostly because of private hospitals' logistical and multidisciplinary advantages combined with more selective purchasing. Furthermore, although market mechanism and competition ensure everybody tries to deliver the best care possible; some medics fear this will negatively affect their mutual relationships in the future, as illustrated by a GP. Although patients agree that market mechanism can have possible effects, they hope that customer advocacy remains in the future, i.e. financial incentives should not overrule the best possible care for a patient; even if that means a healthcare provider needs to refer the patient to another healthcare provider. Attitudes regarding competition differ both between and within actor groups. Although competition has the ability to reduce costs and increase quality, it will also threaten various businesses to go out of existence. This threat is especially mentioned by GPs, possibly because they do not have competition in their own field yet and are therefore not accustomed to the concept of rivalry.

The common attitude of medics towards the future regarding their protocol is that medical scientific research will refine the algorithm, and therefore leave both less room for maneuverability and a smaller error margin for medics. This will make risk hedging activities more important, since most participants expect an increase in legal medical cases. Patients are positive about the growing number of medical rules and hope this development maintains in the future, to ensure the best care possible and minimize the risk of medical failure. Some participants mention that the innovations in IT and the digitalization of healthcare systems and

services have the opportunity to minimize administrative pressures and avoid unnecessary bureaucracy (see table 6).

The sociological change of patients, who are observed as becoming more assertive, will probably continue in the future. All medical personnel and health purchasers agree that patients will become more influential in the future, when the market mechanism will function efficiently, as they then are able to influence healthcare providers by deliberately choosing.

Representational practices

The common future perspective is that quality measures will be developed to compare and differentiate between healthcare providers. Medics mention that quality will be the main factor they will be judged on in the future. This is consistent with the attitude of health purchasers, who agree on the fact that when quality indicators become available in the future, selective purchasing will be increased, as this facilitates their benchmarking activities and reinforces their negotiation position. For an illustration by a health purchaser, see table 6. This is in line with various articles we found on the website of the NZa, which supervises various quality indicator development committees and advises the Dutch government to facilitate selective purchasing to economize.

Participants expect private hospitals to be more accepted in the future, especially if they continue to stay customer friendly and achieve high treatment results. This could also be an effect of less public hospitals, as professionals forecast a decrease of 90% in public hospitals within fifteen years because they are inefficiently organized. Likewise, a patient mentioned that the attitude towards public hospitals can negatively change when private hospitals will keep delivering high quality care with less logistical problems, such as unnecessary long waiting lists.

Participants think especially social media will gain in influence, because reviews of fellow sufferers are seen as the most reliable source of information. Furthermore, they think that health providers need to make sure they operate correctly, as concealment of medical failures will be harder due to the growing interconnectivity. These medical failures will also be punished more severely. The media likely will also play a larger role in the marketing practices, as some participants think the Dutch healthcare sector will resemble the American healthcare market, where advertisements for various treatments and pills are common on for example TV, as illustrated by a patient in table 6.

Niche market analysis

In this chapter we analyze the changes we observed in the niche market of the lower back treatment. We first analyze changes in the role and importance of different actors, followed by shifts in the market practice categories we observed. We then finish with the change in market configuration over time, enabling us to conclude on the research question.

Change in actor roles

Since the introduction of the competition legislation, health purchasers of insurance firms have gotten more buying power, which enhanced their negotiation position. Especially since selective purchasing became lawful, they are able to negotiate more resolutely with healthcare providers. Expectations are that health care insurers will have more normalizing practices in the future, determining different policies to which healthcare providers need to adhere to. It is therefore that all actor groups, including the purchasers themselves, mention that the influential capacity of health insurers has strongly grown and likely will inflate further in the future.

Another actor group that has gained in power relative to the other groups is the patient. Information technology has enabled them to make informed choices, a process which we interpret as the beginning of a transformation from a compliant patient to an empowered customer. This new position in the market has important implications for all other actor groups, but especially healthcare providers and health insurers. Both these groups feel the need to be more customer-focused in the future, because patients are now in the position to influence their existence because of their ability to differentiate between healthcare providers and health insurers.

Finally, our results further suggest that as an effect of more assertive patients and selective purchasing, the role of the GP is slowly transforming from a medical authority to an approving and advising intermediary. Rather than unilaterally deciding where to send a patient, GPs are increasingly asked for a referral of the patient's choice. Further, the GPs in this study also noticed that insurance policies begin to influence their referral options, as patients do not get every treatment declared from their health insurer. Although their role is changing, patients are still sensitive for the advice of their GP. Our results indicate that a GP is most likely to refer to a private hospital when other patients have had positive experiences.

This process resembles the process of institutional partaking, which is described as incremental changes over time, not traceable to the actions of a single actor.

Change in practice categories over time

In the past, intensive exchange practices were observed, for example the referral relations between healthcare providers. These relations should be viewed as ongoing exchange relations, rather than idiosyncratic economic exchanges. Many of these exchange practices were fixed and leave little room for maneuverability or improvisation, illustrated by for example the ‘one-size-fits-all’ purchasing method. The field was dominated by large public hospitals, something that changed in the present. We currently documented a field in which small healthcare providers are competing with large public hospitals successfully, because of their specializing efforts. Further changes are seen in the referral practices of GPs and the way of purchasing by health insurers, such as selective purchasing. Moreover, a new practice was observed, i.e. the information acquiring activities of the patient. The common perspective is that these practices will further change in the future and will make the market more competitive: Selective purchasing on larger scale, further specialization of healthcare providers and other referral policies of GPs. In addition, marketing practices may become more general and important. We can conclude that exchange practices have vastly changed, since a variety of distinct options currently exist to perform a certain practice.

Normalizing practices in the past focused on voluntary medical norms of physicians, such as the prohibition of marketing. There were fewer rules for medical operations and the referral of patients, as both GPs and medical specialists had more freedom. There were no rules or efforts to guide or transform markets. The NZa together with the Dutch government introduced competition in the field, making the present field more competitive as more financial motives to differentiate and innovate exist. The protocolled working of medics has become stricter, as did the administrative pressures healthcare providers need to adhere to. A new norm forming group is the patient, who has become more individualized and therefore more assertive, as a result of societal changes. The expectation in this field is that these societal changes will endure, further increasing patient assertiveness. Moreover, since the costs of healthcare are not decreasing fast enough, the Dutch Ministry together with the NZa will probably introduce further financial motives and pressures to stimulate competition. We conclude that normalizing practices have changed: Whereas in the past only informal norms

and medical rules existed, they are now complimented with more assertive patients and competition legislation in the present and future.

Representational practices, in the form of calculating activities on the services, their quality and thereby a classification were absent in the past. The view on private hospitals was mainly negative, seeing them as firms who mainly enriched themselves. There is no coherent opinion the historical influence of the media on this healthcare niche. In the present time, we observe different representational practices, largely focused on disclosing the effectiveness of healthcare providers. These indicators are not developed yet, but activities to examine the proper measures are present. The negative attitude of private hospitals is diminishing and probably will disappear, as an effect of time and trial-and-error for the actors in the field. The current influence of the media is predominantly assessed as large, which is expected to expand in the future. Particularly new forms of media, such as social media, are expected to gain in powerfulness. We foresee a growth in representational practices when quality indicators are developed and healthcare providers can be judged on their treatment outcomes. Table 7 gives a short summary of the changes in practice categories.

Table 7. Changes in practice categories over time

Dimension	Exchange	Normalizing	Representational
Past	Fixed practices in taken-for-granted style, solely public hospitals	Merely medical rules and informal norms	Largely absent, minor influence of the media
Present	Private and public hospitals, changes in referral policy, information searching by patients	Medical rules, informal norms, competition stimulation, more protocolled working	Development of quality indicators, more influence of the media, changing attitude towards private hospitals
Future	Less public hospitals/more private hospitals, more information acquiring, potentially marketing	Medical rules, informal norms, intense competition stimulation, firmly protocolized working	Calculating efforts by means of quality indicators, larger role of media, neutral/positive attitude towards private hospitals

Change in market configuration

The market configuration in the past was for the most part exchange based, in the form of taken-for granted exchange practices with no room for maneuverability. Normalizing practices played a small role in the form of medical norms, both regarding marketing and

medical interventions, but not in efforts to guide a market as it could not be considered a market. Representational activities played a small role, as the only influence came from the media and there was little interest and necessity to perform calculations on the market.

We argue that the lower back treatment niche is an effect of changing practices, as this niche is only made possible by the competition legislation in 2006. Therefore, in the present market configuration, exchange practices and normalizing practices have become equally important. Medical rules and informal norms are still present but in the current configuration, other normalizing practices such as competition stimulation also begun playing a role and radically influenced the field and its actors. Representational practices still play a minor role, as market measuring and imaging activities are not yet possible because of the absence of quality indicators. Therefore, the only representational practices are the media and conducting scientific research to define the right measurement devices. The market configuration has also changed due to the shift in actor roles, making the practices of certain actor groups relatively more important.

Different attitudes towards the future exist, although we can assume that competitiveness will increase as representational practices will become equally important as other market practice categories. Calculations on health services will become more important, as actors want to make more informed choices. Furthermore, we can assume the role of the patients and their activities will grow in importance, as they will transform to educated and conscious customers. On the other hand, medical and insurance rules can be tightened, leaving less room for healthcare providers and health purchasers. Further competition legislation or economizing is also a possibility in this market. We expect the market configuration to distribute the three market practice categories evenly, as it moves towards a more competitive market with less information asymmetries and more powerful patients. Figure 3 represents the change over time in this field. To the extent qualitative data can be quantified, this images attempts to illustrate the change in the market configuration.

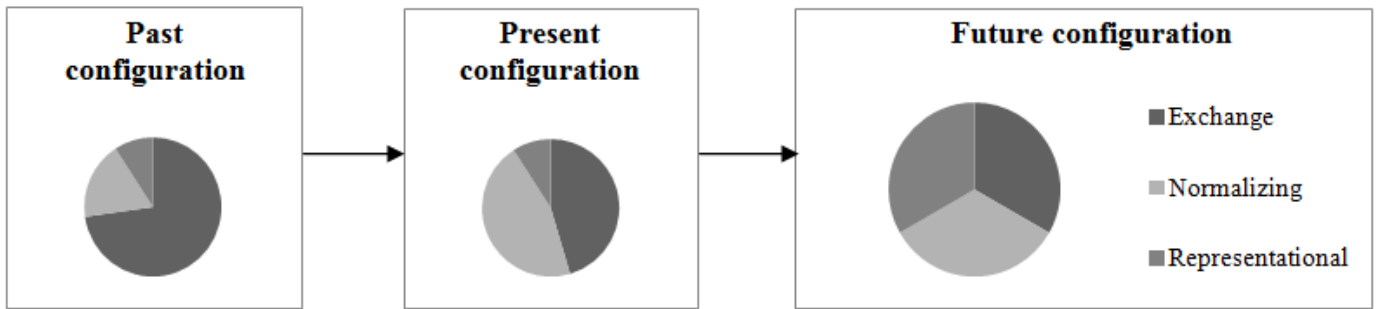


Figure 3. Image of change in market configuration

Conclusion

The past market configuration mainly existed of exchange practices with limited freedom to maneuver and had a very static character. We argue that the market's configuration in the past was therefore strongly institutionalized with hardly any opportunities to change. When comparing the present market configuration to the past composition, we observe changes in the configuration of the market, such as newly introduced practices and changing actor roles. As social pressures are not able to prevent the altering of market configuration, these findings suggest behaviour is not totally socially determined, as this implies a modification of practices. Furthermore, the changes in the practices signify the room for improvisation with regard to behaviour of actors. However, we also found persisting norms and practices that changed rather slowly, or did not change at all. We therefore argue that the practices that persisted change are very strong internalized habits or beliefs. As we found evidence for both evidence for low institutionalization and strong institutionalization, it leaves us to conclude the studied field is moderately institutionalized, or described as opportunity transparent. In the future configuration, we expect more diversified practices and by different actors with other roles compared to the present. These new practices will be evenly distributed over the three market practice categories, giving more freedom to differentiate as this produces more freedom to maneuver. Hence, we argue that the organizational field of the healthcare industry in the future will also be opportunity transparent.

Dorado (2005) describes two options for agency in opportunity transparent fields/markets: Passive partaking and active institutional entrepreneurship. Changes in this the lower back treatment niche necessitate new practices, but the current institutional arrangements lag in time behind the developments. To keep up with the pace of recent

developments, an active approach is needed to stay ahead of competitors. Changes in organizational fields (as observed in this thesis) can affect the temporal orientation of actors (Emirbayer & Mische, 1998). For successful change in organizational fields in an attempt to become and stay competitive, a single firm that is willing to differentiate should have a strategic (i.e. future oriented) temporal orientation. Subsequently, support of subsidiary actors and sponsors should be gained, followed by a process of persuading important institutional actors of the necessity of change. Healthcare providers with a desire to differentiate should therefore gain support of and convince the most important actors in their field, currently patients and health insurers.

Discussion

In this thesis, we studied the options a single healthcare provider has to differentiate their offering and practices, determined by the configuration of the market and the change over time therein. We moved away from the ‘atomistic’ rational type of actor, and moved toward a ‘pragmatic’ and social view of markets and organizational fields. Whereas economists possibly under-socialize and over-rationalize individuals, sociologists are at risk of over-socializing individual efforts by perceiving behavior as totally determined by social norms and taken-for-granted practices. To overcome this limitation, we studied practices of multiple actor groups and the change of their practices over time, both on micro (psychological and individual) and macro (societal) level. Our study showed how market practices and roles of actors can evolve over time, thereby influencing the market’s configuration. We furthermore complement the model of Kjellberg and Helgesson (2007) with a new market configuration; a market based on mainly normalizing and exchange practices. To gain a comprehensive insight in a market, the model of Kjellberg and Helgesson should be supplemented with a change over time element so that different configurations of three practices can be captured and related to market outcomes. Furthermore, we found evidence that it is important to differentiate between the different components of normalizing practices, as the historical image of this niche market was dominated by informal norms and medical rules. Only after the introduction of competition legislation, the field drastically changed. Informal norms, medical rules and competition legislation are, however, all parts of normalizing practices. As a result, a far-reaching analysis should differentiate between the different components of normalizing practices. We also found several elements that changed over time in the studied market, such as new legislation, new actors (or changing actor roles) and new relations among actors. All these motions have the capacity to change institutional

arrangements in the field of healthcare (Scott, 2000; Smets et al. (2012), and thus the configuration of a market. Furthermore, we documented how innovative practices are capable of changing fields, such as the debureaucratization and logistical optimization by healthcare entrepreneurs. We thereby validate findings of Smets et al. (2012), how describe this process as situated improvising, i.e. practically coping with novel complexities. We further found that status in a field can change and influence the capabilities of actors, supported by a thesis of Phillips and Zuckerman (2001). Their findings suggest that only middle-status players feel the need to act according to institutionalized norms and rules. High-status players have the reputational capital to deviate from the norm, while low-status players do whatever it takes to survive, whether legitimate or not. We therefore suggest adding a status component to the model of Kjellberg and Helgesson (2007) and general institutional theory, increasing its suitability to describe markets and organizational fields.

In our study, representational activities are largely absent as no congruent measurement method exists yet. This notion contravenes with the suggestions of Callon and Muniesa (2005), who argue that the calculative efforts are inherent to a market. A market is then seen as a socio-technical mechanism to compare goods, their quality and a result (e.g. price or classification). Services can be compared on the basis of availability, but the quality is not yet calculable as an effect of the absence of valid measurement devices. Therefore classifications cannot be categorized, impairing choice possibilities for actors, as they cannot base their decisions on representative and comparable information. Calculations and representations of markets further help a firm with its market orientation (Ruiz, 2012). However, instead of firms being market-driven as classical market orientation literature suggests, the market as practices perspective sees firms as intertwined with the market. This implies that firms are not merely reacting on markets, but are able to influence them.

We used a socio-economic perspective combined with a performative approach to describe the niche market of lower back treatment, as the classical and popular models do not take into account social practices and therefore inadequately describe markets. Furthermore, as these theories are embedded in goods-dominant thinking, they assume value is created by healthcare providers, rather than by interplay of the healthcare provider and the patient (Nordgren, 2009). Following service-dominant logic (e.g. Vargo & Lusch, 2004), thereby assuming value is created by the patient, economies of scale/scope do not have a large impact on the competitive edge of a healthcare provider. Our findings reveal that healthcare providers with specific knowledge or skills are more likely to become (and stay) competitive, a notion

supported by Stabell and Fjeldstad (1998). They argue that service firms such as healthcare providers build competitive advantage out of specialized knowledge and a good reputation. This is in accordance with the prediction of participants that public hospitals will go bankrupt when they refuse to specialize. We therefore argue that when the market mechanism will work more efficient in the healthcare sector, differentiation is not only possible and advantageous, but rather necessary.

Our results suggest varying changes will be introduced and will disrupt the healthcare industry in the Netherlands in the coming years. Especially for general public hospitals without specialized departments or services, the future is highly uncertain. As such disruptions may continue to arise; they will likely cause a breakdown of the taken-for-granted practices of healthcare providers which may lead them to reconsider the structure of their activities, potentially with new perspectives on practice innovation (Loohuis & Ehrenhard, 2014; Loohuis, 2015). Although practice breakdowns may produce an uncomfortable sensation, we suggest that healthcare providers should use these moments to innovate, in order to keep up with the developments in the healthcare sector.

Suggestions for further research

A shift in academic thinking from ‘nouns to verbs’ is not exclusively observed in the discipline of marketing theory. The related field of organizing and strategizing experienced a similar shift in thinking, seeing strategy as something a firm and its actors do, rather than an entity that a firm has/owns (Whittington, 2006). There is considerable overlap between strategic and marketing practices, as for example strategic planning and establishment of objectives is a component of normalizing practices (Kjellberg & Helgesson, 2007). However, we can assume that these strategy practices can be further subdivided. For example, Whittington, Molloy, Mayer, and Smith (2006) describe different strategic practices such as strategy workshops, project management of strategic initiatives, and creation of artifacts to communicate change. To our knowledge, however, the mutually influencing relationship between strategic practices and the three market practices is scarcely studied. It is therefore interesting for future research to investigate in which manner strategic practices influence the market practices of a firm (and, consequentially, its market).

Our findings indicate that both patients and physicians are becoming more individual, as an effect of the individualization of Western societies, a subject studied by many scholars (e.g. Veenhoven, 1999). As this possibly suggests that actors are becoming less sensible for

social rules, it is interesting to study how the individualization of societies influences social relationships (Granovetter, 1985) and (adherence to) institutional rules (DiMaggio & Powell, 1983).

We observed the process of marketization, i.e. the deployment of a market mechanism in an established field, such as public sectors that get privatized. Our findings support the claim of D'Antone and Spencer (2014) that marketization in such sectors is an immense challenge and a rather slow process. Furthermore, scholars mention both ethical and practical problems for a market mechanism in the healthcare industry. Because of the patient-health insurer configuration in the healthcare industry, patients do not have the same negotiation power as a normal 'buyer' (Grit, Van de Bovenkamp, Bal, & Centrum, 2008). Moreover, a desperate patient will in all likelihood just visit every healthcare provider possible, working against the market mechanism (Heubel, 2000). However, although considered of marginal institutional influence, customers can catalyze changes in an organizational field (Ansari & Philips, 2011). Future research should therefore aim to investigate to which extent a patient can be assumed a customer, and what this implies for market(ing) theory and the degree of institutionalization in a field.

Managerial implications

The findings of our study also have important implications for practicing managers. Our findings suggest that market configurations can alter over time, opening up opportunities for differentiation. Following the performativity assumption, actors should be aware of the fact that they are not in a market, but they rather are a (part of) the market. They construct this market together with other participants by performing different, but nonetheless important activities. Therefore, to differentiate, the practices of other actor groups should be integrated into the differentiating efforts. We provide the following guidelines for healthcare providers to achieve differentiation.

We did not find evidence that normalizing practices can be influenced by a single healthcare provider. Private hospitals were, however, able to change the negative attitude towards them because they achieved good results and scored high on patient satisfaction. This implies that healthcare providers are, as opposed to normalizing practices, able to change representational practices. Since the availability and quality of information is of increasing importance as the field still exhibits information asymmetries, optimal decision making is

hindered, not only for patients but also for health purchasers. It therefore appears crucial for healthcare providers to guarantee the availability of positive yet reliable information.

Practically, this boils down to two main recommendations. First, our findings indicate that patients have become more assertive and will execute information acquiring activities and these developments likely will continue in the future. Therefore, we suggest that the information acquiring activities of patients should be facilitated by, for example, search engine optimization or marketing campaigns. Thereby, the likelihood with which patients will encounter this information and ultimately include it in their decision making can be greatly increased. Second, since the main marketing vehicle currently still is word-of-mouth marketing, healthcare providers should also focus on internal marketing in the form of making first line physicians aware of their roles as company ambassadors as they have the most customer contact.

Another reason why information has become more important is the fact that health purchasers are interested in selective purchasing of high quality care. As our results indicate that selective purchasing will increasingly be implemented, healthcare providers are strongly recommended to give transparency on their results by measuring its treatment effectiveness. Furthermore, they can support the benchmarking activities by jointly researching appropriate quality indicators. As our findings further reveal, specializing in a certain area will likely ensure high quality treatment, which aids in the selective purchasing process as specialized healthcare providers add extra value compared to generalists.

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