

Success factors for practice renunciation of general practitioners in the Netherlands

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In het hart van de gezondheidszorg.

“The young physician starts life with 20 drugs for each disease, and the old physician ends life with one drug for 20 diseases”.

Dr. William Osler, Canadian physician (1849-1919)

Preface

The aim of this thesis is to identify factors influencing practice renunciation of General Practitioners. The study is conducted at VvAA heretofore named the “Vereniging voor Arts en Automobilisten” (Association for doctor and motorists) located in Utrecht. This thesis is written as part of my graduation for the Master Business Administration at the University of Twente. In consultation with my supervisor, Arjen Schepen, influencing factors of practice renunciation and identification of success factors of practice reunification have been chosen as main topic. After qualitative (interviews) and quantitative (survey) research the research question: *“What are success factors for practice renunciation for General Practitioners in the Dutch healthcare sector?” could be answered.*

During my research phase my mentor always was willing to answer my questions and often gave direction to my research if I seemed to lose track. My first supervisor from the University of Twente Dr. Peter Schuur guided me throughout the whole writing process. Second supervisor MD. Wouter Keijser shared his (practical) knowledge and supported me mainly at the end of the writing process. I especially like to thank my supervisors Peter Schuur and Arjen Schepen for their excellent guidance and support during this process. Furthermore, I like to thank all interviewees and survey respondents for their participation. Without cooperation of these General Practitioners I would not have been able to complete this study.

In this report it is used as reference word for gender, it can interpreted as both his or her.

I would also like to thank my family and friends. Especially my girlfriend Linda who supported me during this writing process, since I certainly was not always the most cosy, laid-back, partner.

I also want to thank my colleagues at VvAA for the excellent collaboration, especially Irene Lensink and Lin Kiekebosch who helped me with identifying factors in the interviews and developing the questionnaire. Many colleagues offered me insights into potential issues of General Practitioners with this step in their career.

Douwe Willink

Utrecht, March 2017

Management summary

Within the current healthcare market, about 300 practice renunciations of general practitioners take place every year. The aim of this study is to identify critical success factor(s) and barriers for practice renunciation of general practitioners. Interviews and a literature search are conducted to identify influencing factors for practice renunciation. Twenty influencing factors are incorporated in a survey which was sent to GP's who are already retired and GP's who are $55 \leq$ and still working. By the use of this survey significant influencing factors and a critical success factor for practice renunciation were identified. The critical success factor for practice renunciation is "*Drafting of contracts (acquisition, partnership, cooperation agreements)*" which determinate 71.1% of the cases in the correct group. The other three significant influencing factors are "*Valuation of intangible assets*" "*Tax settlement for discontinuation of the practice of tax administration*" and "*After transfer, the former practice holder can remain working in practice as a HIDHA/Observer*".

Furthermore, regarding the importance of different factors, two "soft-factors" related to practice renunciation differed significantly between success and non-success group. "Soft factors" mean: Non financial or business incentives, examples are personal relation, trust, wellbeing of patients and personnel and the two differentiating factors were *identification if my successor will continue patient care the same way* and *if he is like-minded as me on business management*. These findings create opportunities for departing GP's who are planning to start with their practice renunciation soon, will be able to enhance their chances of success. The two factors "*Drafting of contracts...*" and "*Tax settlement for discontinuation...*" are also perceived as the main barriers in practice renunciation of all GP's.

The average age of retirement is shifting towards a higher age. The near-future retiring general practitioners are planning to renunciate their practice at the average age of 64.6 years ($SD \pm 2.4$) and start to orientate on practice renunciation around 59.5 years. In contrast, the already retired GP's ended their practice around 62.0 ($SD \pm 3.0$) and started their orientation at 59.9 ($SD \pm 2.6$). The majority of the GP's is not planning to work until their 67th. Most dominant reasons to stop early are: work pressure and exhaustion, family reasons, leisure, other interests and sufficient financial reserves built up. A suitable successor is identified when the owner is on average 61.0 years and comes largely from the general practitioners own network or was a former employee of the departing GP.

In conclusion: three influencing factors for successful practice renunciation are: *“Valuation of intangible assets”*, *“Tax settlement for discontinuation of the practice of tax administration”* and *“After transfer, the former practice holder can remain working in practice as a HIDHA/Observer”*. The critical success factor of practice renunciation of GPs in the Netherlands is *“Drafting of contracts (acquisition, partnership, cooperation agreements)”*.

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List of abbreviations

ANW	Evening night weekend
AIOS	Doctor in training to become a specialist
HAIOS	Doctor in training to become a GP
CSF	Critical Success Factor
FTE	Fulltime Equivalent
GP	General Practitioner
HAP	General Practitioner Center
HIA	Health Insurance Act
HIDHA	General practitioner employed at another GP
ICT	Information Communication Technology
M&A	Mergers and acquisitions
NHS	National Health Service
SD	Standard Deviation
SIF	Significant Influencing Factor
SPH	Pension Fund General Practitioners
UK	United Kingdom

Glossary of terms of the study

AOIS/HAIOS: GP in training

Care group: Cooperation of different GPs, who cooperate to offer appropriate care for patients.

Critical success Factor: A significant influencing factor with a high discriminating power, which greatly influences outcomes (1).

Due Diligence: Books examination. In mergers and acquisitions and in accountancy there is a specific meaning, namely (financial) books examination, often present in business takeovers.

Full-time equivalent, a unit of which the size of an employment or staffing levels can be expressed.

Goodwill (intangible assets): literally means benevolence and used in finance to describe that portion of the market value of a company which is not directly attributable to the assets and liabilities.

GP's center: Medical center from which physicians provide the attending urgent care in the region outside the normal practice times.

Health Insurance Act: On January 1, 2006 introduced legislation in which the mandatory health insurance scheme and the legislative basic package applicable to all residents in the Netherlands,

HIDHA: A GP which is employed by another GP.

Influencing Factors: Factor which could influence outcome of a process (20).

Non-successful: Not reaching your goal(s)

Observer: A GP hired by another GP .

Outsource: involves the contracting out of a business process and operational, and/or non-core functions to another party.

Partnership: Is one of the forms of an unincorporated company, which two or more persons or legal persons (members or partners) enter into a particular collaboration. The partners bring something in, with the aim of sharing the benefits arising therefrom.

Perceived success Factor: A factor which is perceived as very important.

Randstad: a string of towns in the west of the Netherlands. The Randstad is made up of four major cities, namely Amsterdam, Rotterdam, The Hague and Utrecht, and many medium and small cities which together form a metropolitan area.

Renunciation: The process of transfer of a practice or business from a departing owner towards a successor.

Significant Influencing Factor: Factor which significantly influences the outcome of a variable (4).

Soft-factors: Non financial or business incentives, examples are personal relation, trust, wellbeing of patients and personnel.

Stoppage profit: If a company is sold it is the difference between the actual value and the tax base value of the company. The difference consists for example of hidden reserves, fiscal reserves and goodwill. The strike profit income tax must be paid after deduction of a certain tax-free rules.

Successful : Reaching your goal(s)

1. Introduction

In the current Dutch healthcare sector four major players are present. The care recipient (consumer/insured patient), the care provider (medical professional/doctor), the health insurer and, pictured in the centre, the Government, who plays a directing role¹(figure 1).

An example of a healthcare provider is a doctor, which is researched in this study. During their medicine training they can choose to become a General Practitioner (GP). Medical students choose their specialism during their medical training, which takes six years. To become a GP, a basic-physician has to specialize for three more years. After graduation, a GP often starts as a practice observer (in Dutch: 'waarnemer') and 75% does so one year after graduation¹). Another option is to become employed at a GP's practice of another GP (HIDHA) (in Dutch: "Huisarts in Dienst Huisarts" (HIDHA). Five years after graduation 51% of GPs work as self-employed (entrepreneurial) GP¹. After multiple years of employment as an independent GP, a GP often quits practicing and likes to retire. If the GP is owner of a private practice, this practice will often be sold if the GP retires. This research focuses on these last years of practice and practice succession. This research is conducted from the GP's perspective, the healthcare provider, which is mentioned bottom left in figure 1.

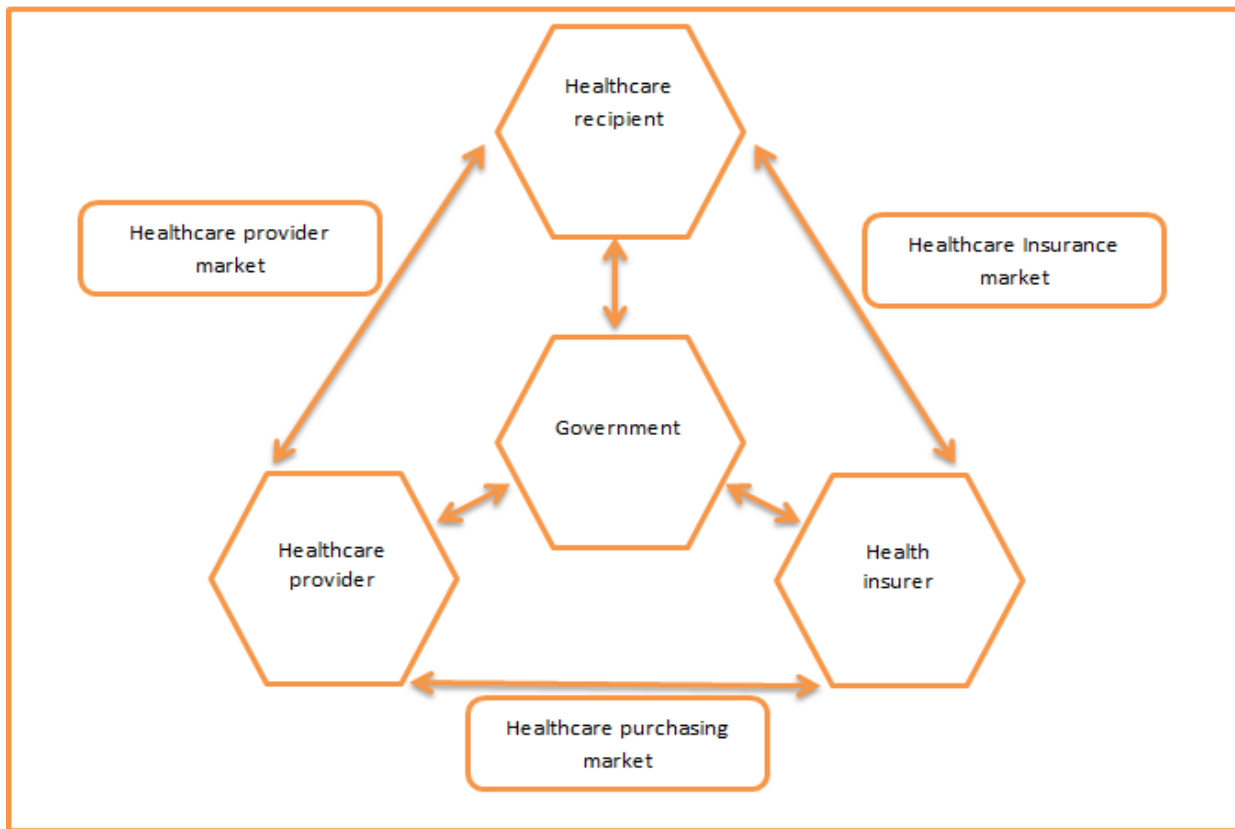


Figure 1. Dutch healthcare triangle (based on governmental document 27 855)¹

VvAA is an organization for healthcare professionals which assists and consults GPs in their professional work and career. A VvAA study identified that 78% of the GPs would like help/assistance in their practice quitting process². Although it has been demonstrated that this group of GPs would like to have help/assistance, it is not clear what kind of help these GPs would like to receive. Furthermore, possible differences in needs may exist between different GPs (pre-, post-retirement). At VvAA possibilities exist to contact GPs and identify needs and/or perceived barriers in the practice renunciation process. Currently 120.000 healthcare professionals are member of VvAA and 35% of them is between 55 and 65 years of age. Within the Netherlands 11.568 GPs are currently working of which about 8000 are self-employed

(70%)³, of all GP's 32% is older than 55⁴. About 10.000 of GPs are member of VvAA, which is a coverage of around 86% of all GPs. VvAA advises their renunciation GPs two-fold: they offer financial planning (approximately 100 cases per year) and they offer help with practice renunciation (approximately 150 cases per year). Every year about 300 acquisitions of practices take place in the Netherlands, also 30 new practices open each year³. This means that VvAA is currently present in 50% of GP's practice renunciation cases.

A practice renunciation consists of multiple phases; the orientation phase and the performance phase. The orientation phase often starts at about the age of 59 and raises questions as: "What are financial consequences of my retirement? When can I stop? Is my current practice saleable?" But also more existential questions are asked such as "How shall I fill my time after retirement? To what extent can I remain active within my current profession/practice?" In phase two, which often seems to start at the age of 64, the potential owner of the practice may start as an observer before he takes over. Also sometimes after renunciation, the leaving GP remains active (employed) for some period of time to assist the new owner and reduce working activity slowly.

Currently, there seems to be a mismatch regarding the leaving GP of the practice and the new owner of the practice. Settlers are mainly women, which want to work together with a partner in a duo or group practice³. While leavers are often men, solitary working and prefer renunciation of their practice to one successor³. Being an employed GP instead of owning a practice is rapidly growing in popularity as a result of feminization, and the trend of part-time working³. Despite attractiveness of practice management is put under pressure, because of increasing regulatory pressure and bureaucracy, it remains the dominant organization form of GP's in primary care³. Furthermore it remains unclear if goodwill should be asked by the transferring GP, and what factors influence possible earlier retirement of GPs in the Netherlands and what are consequences if this happens? This research will show what factors play a role in practice renunciation of GP's and what consequences will raise for future policy and VvAA.

2. Research design

In this chapter the research problem, relevance of the study and the objectives are described as well as the main research question and sub-questions.. In paragraph five the outline of the study is displayed.

2.1 Research problem

From earlier studies it is known that starting and retiring GPs would like assistance with their practice renunciation³. What type of help is necessary, how important different steps within the renunciation process are, and what subjects are leading is for the time being unclear. Also, possible differences between the already retired GPs and the pre-retirement GPs are unknown. What factors are perceived as important by GPs and what factors come forward from systematic analyses and study into this topic. VvAA is interested in possibilities in developing a model or integrated proposition, based on outcomes of systematic research, to assist in GP's practice renunciation.

2.2 Relevance of the study

This study is undertaken to contribute to the knowhow of practice termination or transmission of GPs, which is an important subject in the current aging population of healthcare professionals⁴. Especially because the healthcare market has recently (2006) become a managed competitive market, which made autonomous healthcare professionals (including GPs) mandatory entrepreneurs. Also, healthcare professionals have indicated that questions regarding practice termination remain. An example is: "What can I add to the process myself and what activities should I outsource?" Examples of questions asked by VvAA are: "How could practice renunciation be standardized and then deployed? What are legal restrictions for practice renunciation? What are the needs and barriers in the GP's perception of practice termination process? What factors influence successful practice termination or transfer and how important are these factors?"

2.3 Objectives of the study

Objective of this study is to understand the needs of GPs regarding practice termination or transmission (renunciation) and to identify possibilities for the VvAA to fulfil these needs. Outcome of the study can be a product, a model, or any other instrument to help GPs with their choices and process of terminating and transferring their practice. Perhaps GPs who prepare their renunciation focus on irrelevant factors, or some need help in new fields of renunciation of their practice, which are currently unnoticed.

2.4 Research questions

Main question:

What are success factors for practice renunciation of General Practitioners in the Dutch healthcare sector?

Sub-questions:

- a) Which factors influence practice renunciation?
- b) What are critical success factors regarding practice renunciation?
- c) Which barriers do general practitioners encounter regarding practice renunciation?
- d) What are differences between GPs who already renounced their practice and those who are expected to renunciate their practice in future years?
- e) What can VvAA do for GP's in the context of practice renunciation?

2.5 Outline of the study

Now the practice renunciation and healthcare market are introduced in chapter three the methods of this study are described. Followed by a literature search in chapter four, which described the GP's healthcare market comprehensively and the business steps for mergers and acquisitions and psychosocial barriers for retirement. In chapter five the results of the different analyses are mentioned, followed by the conclusion in chapter six. The results are discussed in chapter seven. In chapter recommendations for GPs, VvAA and further studies are mentioned.

3. Methods

This study contains a qualitative (start) part and a quantitative part, in which pre- and post retirement GPs participated. The qualitative study consisted of a literature search and interviews with retired GPs. From these 20 influencing factors were extracted. These 20 influencing factors were analysed with a Chi²-test to identify significant influencing factors (SIF) and perceived success factors (PSFs). These SIFs were analysed in a discriminant analyses and discriminant analyses step-by-step to identify the critical success factor (CSF). Also differences in importance between both groups (pre-post-retirement) of GPs were identified by using a Chi²-test. In chapter 3.1 the research design and methods are further elaborated on. In paragraph 3.2 data collection techniques are mentioned and in 3.3 sampling techniques are explained. Last in paragraph 3.4 data analysis and interpretation is described.

3.1 Research design and methods

The methodology of this research consists of a qualitative and quantitative part with semi-structured interviews and a survey. Via VvAA contacts, five GPs who recently have renounced their practice are contacted (summary in appendix XI). Those are interviewed in a semi-structured way, to identify their motives, needs, considerations, perceived barriers and effects of their practice termination or transmission and to identify factors which influence the renunciation process (top oval in figure 2). In addition to this, a literature search is conducted to identify possible other related factors. The 'expert' interviews with GPs are transcribed and analysed via a seven step process to extract and sort the data.

Next, based on the qualitative identified outcomes and the literature search an online survey is developed and, after a short pilot study, sent by email, via the VvAA member panel (in Dutch: "ledenpanel") to GP's who recently renounced their practice (post-retirement) and to GPs who are expected to renounce in future years (age 55 and older named: pre-retirement). The survey includes several questions regarding success factors and barriers that may influence the renunciation process. Finally, measured success factors and barriers regarding the renunciation

process are described. The dependent variable is the success of the practice renunciation, whereas factors influencing the renunciation are independent variables (influencing factors). With data from the survey and further calculations the value of all independent variables (influencing factors) and dependent variables (success) are measured. Furthermore the influence of the independent variables on the dependent variable is measured and calculated (figure 2). Also differences between GPs who already conducted practice renunciation and GP's who have to start this process will become visible.

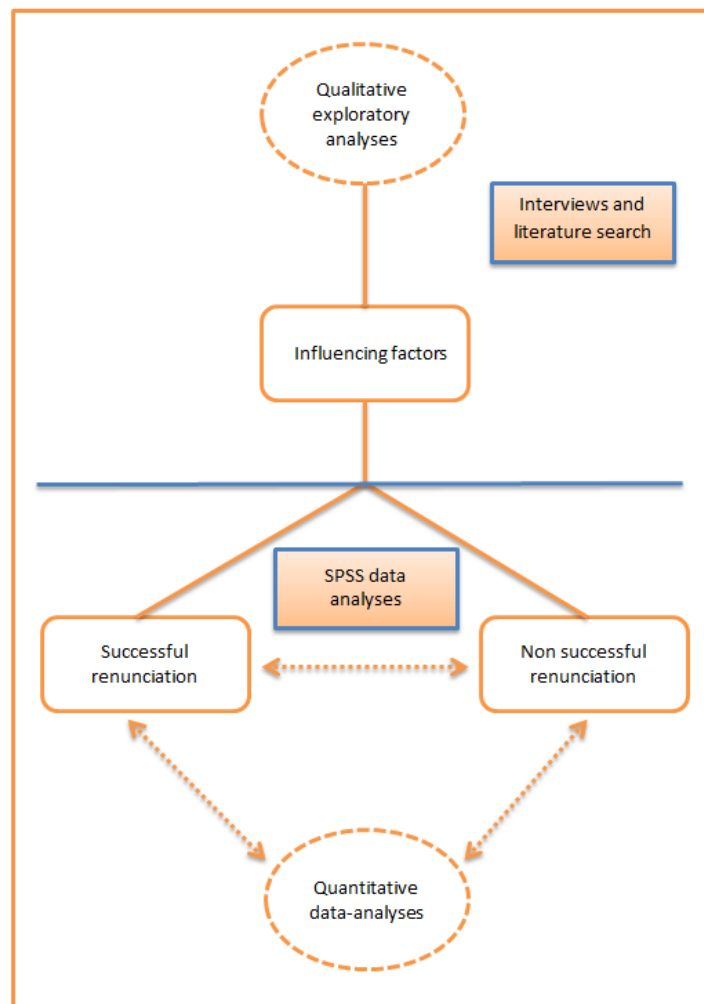


Figure 2 Overview of study design

3.2 Data collection techniques

Data are collected from several information sources. First the interviews and literature search were conducted (around the same time) to complement each other to create as much relevant knowledge as possible.

Interview: Interviews with five GPs who recently renounced their practice were conducted to identify success factors and barriers of renunciation. Interviews were semi structured, recorded, transcribed and analysed⁴². Interviews are known to provide in-depth information applying to participants' experiences and viewpoints of a particular topic⁴². Via VvAA these GPs were contacted to ask whether they would like to participate in an (anonymous) interview. These interviews were conducted in Dutch and in the GP's office or at the VvAA office.

Literature study: To add scientific knowledge and theory to this “practical problem” several scientific internet databases were used, such as Scholar, PubMed, Web of Science and Scopus. Search terms used are: Practice renunciation, practice transfer, business transfer, succession and retirement of GP's. Snowballing of sources is used multiple times. Also “grey literature” was used, especially from (Dutch) organizations which assist in renunciation of a (medical) practice, such as professional organizations and medical consultancy firms i.e. NIVEL. Incorporating grey literature reduces publication bias⁴⁰.

Pre-test: The goal of a pre-test is to test the data gathering instrument. Six GPs were asked to participate in this pre-test. After pre-test the questionnaire was send to the “VvAA member panel”, in which 412 GPs were eligible for an questionnaire invitation. A pre-test protects the survey against errors such as ambiguous questions⁴¹.

Survey: After the interviews and literature research were conducted possible success factors and barriers which influence the renunciation process were identified. This information is used to develop a survey, which is sent to retired, and pre-retired GPs. A survey is considered the best method to identify data to describe a large population⁴¹. The survey included questions about frequencies and importance of several factors. Next, data is analysed and post-retirees are divided into two groups, successful and unsuccessful renunciation of practices.

Furthermore, differences between retired and pre-retirement groups were identified. However success seems a vague term in business literature it is interchangeable with the term 'performance', which both in general mean the achievement of something attempted, desired, or planned³³. In general success means: *"A good outcome or result or something that ends well"*³⁴. A critical success factor is a factor that influences this possible success: *"Those things that must be done if a company is to be successful"*³⁵.

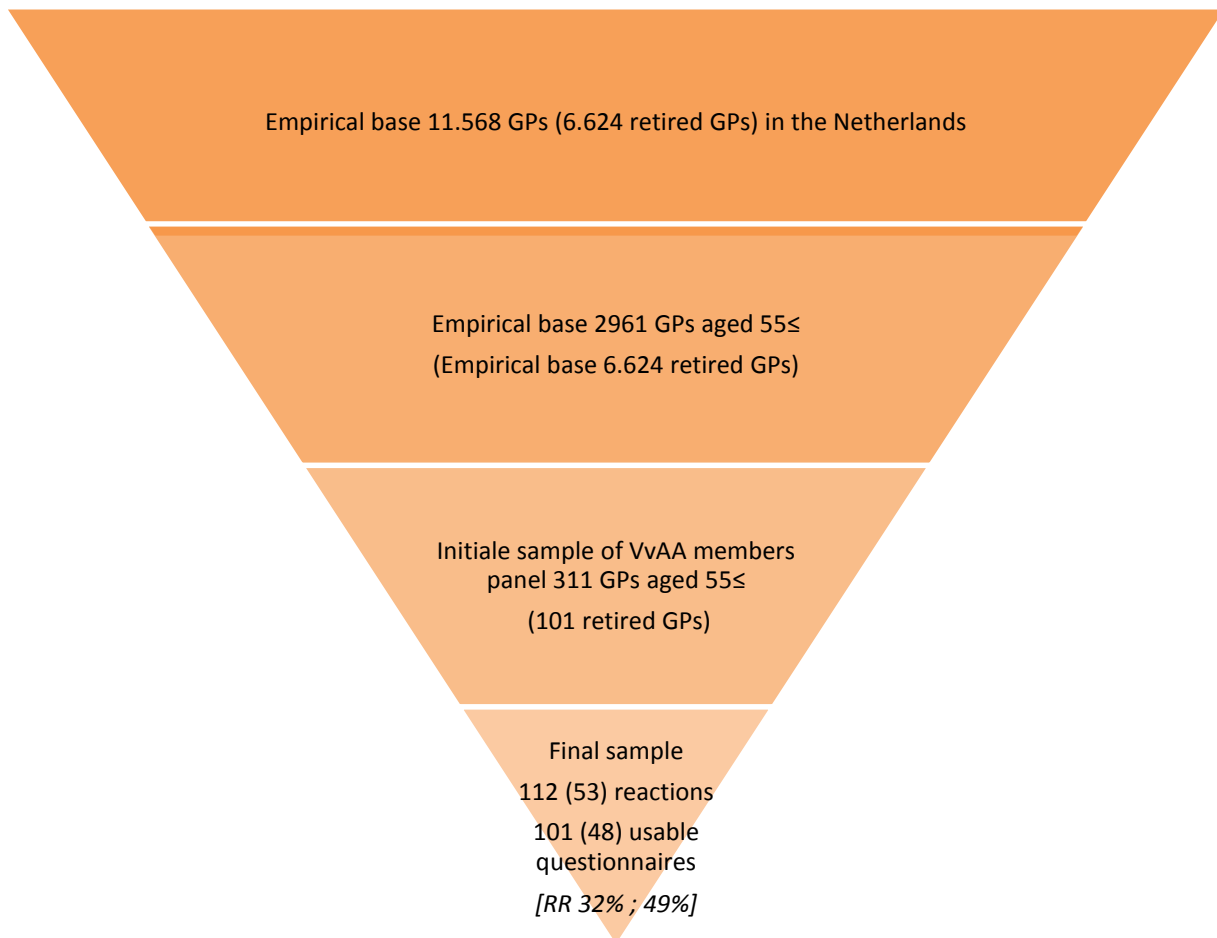


Figure 3 Flowchart of pre-retirement GPs respondents^{4,22}

3.3 Sampling and data-analysing techniques

For the qualitative research, purposive sampling is used. GPs are approached via the VvAA network ("Ledenpanel"; 412 GPs invited), and the responding GPs are included in the study. No specific selections of GPs were made, except for age and being a retired GP.

The quantitative part of the research exists of a survey, which was sent to GP's. GP's were asked their perception of the importance of different postulated factors for the success of renunciation of their practice and whether the factor was noticed by the GP. Also the success of the renunciation (dependent variable) was measured for every GP. This way it is possible to statistically analyse the influence of the factors on the perceived success of the GP in the renunciation process. The perceived success rate was for example measured by rating the GP's renunciation outcomes. The statistical analyses are conducted with a Chi²-tests to identify which independent variables affect the successful or non-successful renunciation processes. A discriminant analysis is used to identify how much of the GPs could be predicted correctly in their status of success based on the presence of influencing factors. This way it was possible to analyse the estimation of the GPs in the success of their renunciation. Asked is the importance of influencing factor and comparing these with the presence of these success factors. Next, via an univariate or multivariate statistical analyses it was possible to identify if GP can estimate important factors. Furthermore insight in goodwill and succession issues are acquired by the questionnaire.

3.4 Scientific accountability

This research used a certain degree of method triangulation as a result of combining qualitative and quantitative reserach⁴⁰. Findings arising from using multiple methods and data sources are more likely to be valid⁴⁰. Qualitative data is gathered via semi-structured interviews that are recorded and verbatim transcribed⁴². After transcribing first open encoding, followed by axial encoding and selective encoding, the results are analysed and compared with the initial survey ideas⁴³. The survey was adapted where necessary and next results were gathered. A survey is likely the best method for collecting data to describe a large population such as GPs in the

Netherlands⁴¹. Furthermore problems regarding representativeness are likely to be minimized by using an online survey⁴¹. Outcomes are used as raw data that are structured and analysed with SPSS. The data analyses is conducted with SPSS, the tests that are used for the analyses is Chi², Univariate and Multivariate analyses and a Discriminant analysis were used.

4. Literature review

This chapter adds relevant literature to information (influencing factors) identified in the interviews. Furthermore it also shows a short review of steps in renunciation in businesses, this will show which steps are often outsourced and so possible barriers for practice renunciation. First relevant literature regarding GP's in general is described, followed by information regarding the process of business renunciation and the advices VvAA offers the GP market. Third, the subject of goodwill in the GP market is described. Last psychosocial barriers for retirement in business succession is described.

4.1 General practitioners market

One year after graduation majority of GPs are working as a freelancer, five years later majority of GPs is independent and own their own practice¹. Most of the settlers take over existing practices of GPs who want to retire³. In 2015 about 300 practice takeovers took place, 327 GPs started as independent GP against 297 GPs who ended their practices, the number of GPs looking for a practice remains constant at about 485 GPs³. Reasons for retirement of GPs are investigated comprehensively. Main reasons for GPs in England and Scotland for retirement are: increased age, job dissatisfaction, having no children under 18 years of age and having an ethnic minority status⁵. Factors influencing a higher job satisfaction are: serving populations with low deprivation, being young and white, and working fewer hours (part-time)⁵. Another study identified retirement intentions for older Australian GPs and their reasons for earlier retirement: Work pressure, exhaustion and burnout were mentioned, together with poor job satisfaction and disillusionment with the medical system or medicare⁶. What stands out is that in both studies women are more likely to continue working to an older age than men⁷.

Also factors within the healthcare market for GPs can play a role in the retirement process. On 1st of January 2015 11.568 GPs and 5.045 practices of GPs existed in the Netherlands^{4,8}. From these 11.568 GPs about 70% is freely established (including pharmaceutical holding GPs, figure 4)⁴. Since 2006, with the new HIA (Health Insurance Act) GP's market changed, managed competition between GPs was introduced and market of GP practice takeovers emerged. With this new law, tasks of GPs changed, a GP practice owner became an entrepreneur. Administrative and process orientated tasks instead of solely patient care emerged⁹. Despite

this new tasks the GP remained an important link within the Dutch healthcare system. The GP has a coordinating and gate-keeper function with focus on patient care⁴. Healthcare expenditures on GP's care were about 2.68 billion in 2013, which is about 2.9% of the Dutch healthcare expenditures⁴. A volume growth of 1-3% is expected in future years, which will result in a positive perspective for the GP's market⁴. As a result the level of business transfers (practice renunciations) will grow⁴. This growth will result in regional differences and in some regions to shortages of GPs (figure 5)⁴. In cities enough GP's are present, whereas in the edges of the Netherlands the GP density is expected to keep declining. Average GP density is 4.3 FTE per 10,000 residents⁴. What factors influence the establishment behaviour of new GPs has been investigated. Employment for partner, nearness of friends and family are most dominant identified factors¹³. Furthermore incentives to settle in less popular regions were the starting of training dependences for GPs in these regions and financial and facility support for new GPs¹³.

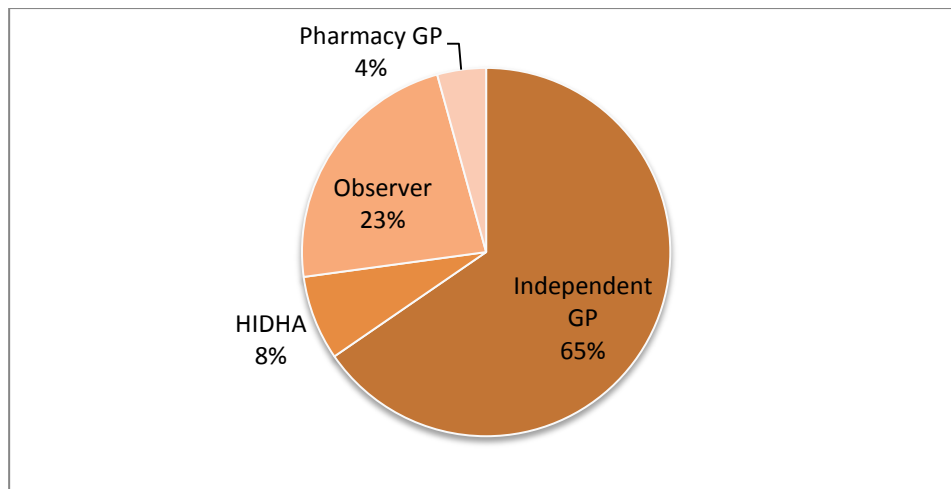


Figure 4. Segmentation of practicing GP's⁴

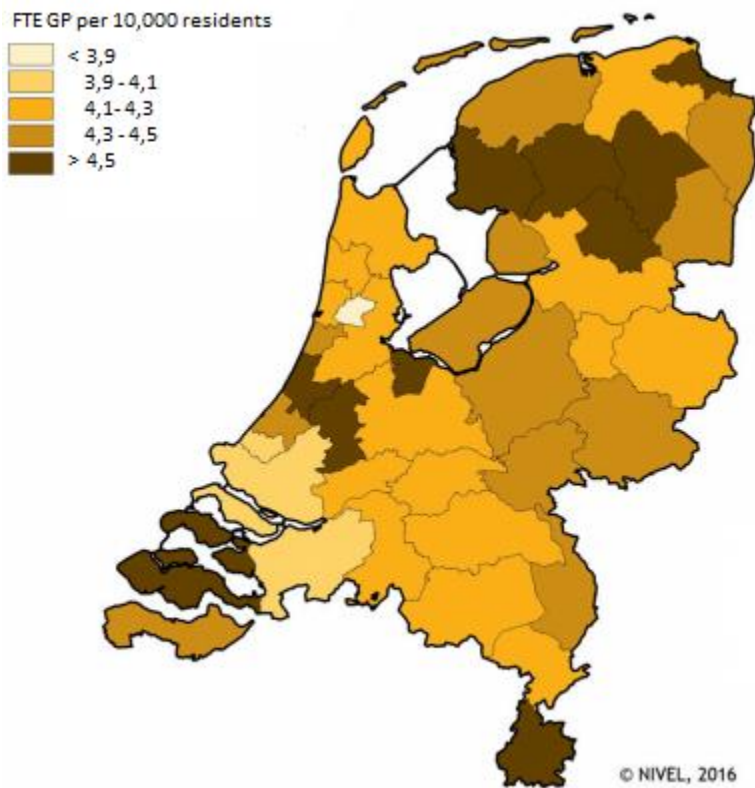


Figure 5. GP's density (level of FTE GP per 10.000 residents) to region (2015)¹⁹

The characteristics of new GPs has changed in recent years. The majority of settlers is women, who want to takeover a duo practice, prefer to work part-time and do not want to take over a practice at home³. Whereas retirees are most often men, working solitary and want to transfer their practice (which is often a practice at home) towards one successor³. This mismatch seems an evident problem in the current GP's practice renunciation market. Young GPs often appreciate their leisure time and want a good private-working balance³. The current market is dominated by practice owning GPs, however more starting GPs who want to settle are present then older GPs who want to transmit their practice³. Although as a consequence of ageing within the healthcare market, more GPs offer their practice in the market, it is expected that in future years practice settlers will become more dominant³. As a consequence of the high amount of women within medical studies, feminization of the GP's market will continue (figure 6)⁴. Figure 6 visualizes the age distribution of GP's which shows more men in ageing segments and more women as entrants.

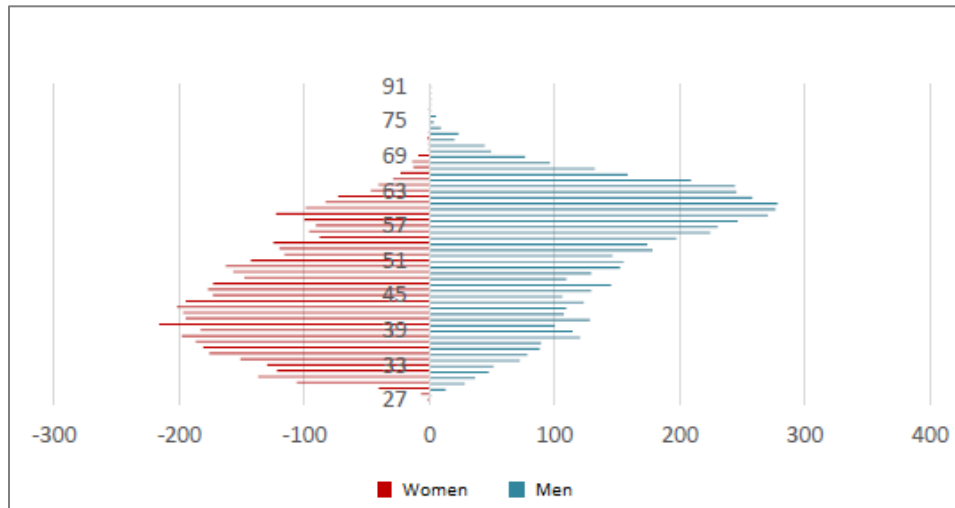


Figure 6. Age distribution of GP's (negative values of women are absolute) (2015)³

Furthermore, looking at the current market, shifts in types of practice are taken place. As mentioned earlier, entrants prefer group practices, and dislike practices at home. The current distribution of practices is mentioned in figure 7.

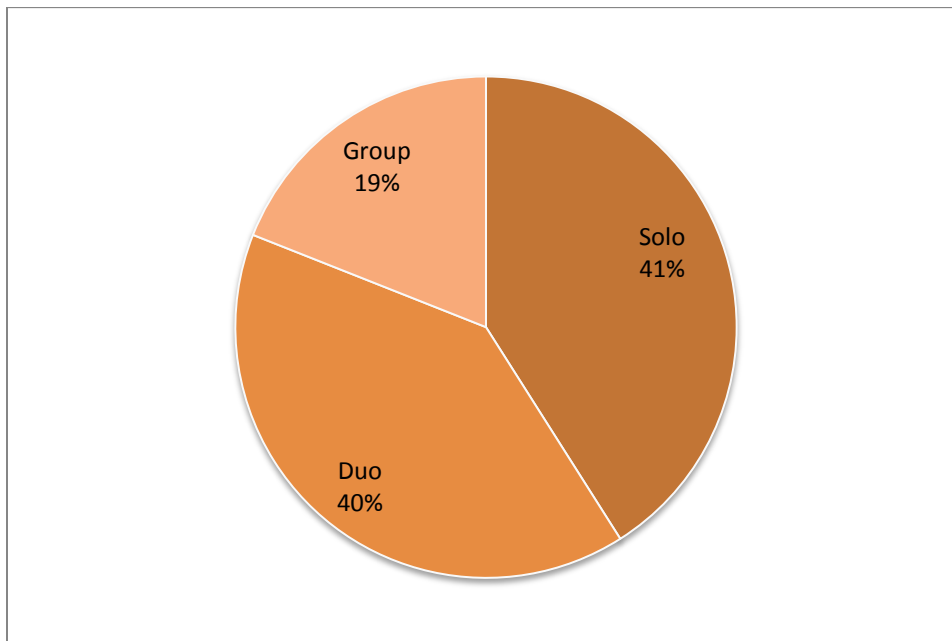


Figure 7. Segmentation of GP's practices (2015)⁴

4.2 Business renunciation and VvAA

Renunciation of a GP's practice can be compared with a business transition. What steps are present at successful business transitions is often studied. Business transition can be divided into four phases and multiple steps, mentioned in figure 8^{10,18}. In literature several different steps and systems are present for Mergers and Acquisitions (M&A)/business transactions. Figure 8 is an aggregation of several business sources towards the steps of practice renunciation at GPs^{10,18}. However, not all business transaction aspects are present in GP's practice renunciation. Examples of steps that are missing are: A confidentiality agreement, a letter of intent and Due Diligence (books examination). The first two do not seem present as a result of high level of trust between the GP and its successor, the third seems absent due to the fact that a GP in general offers a service and does not have products in stock. Also differences appear because GP's practices are often smaller than businesses that will be transitioned). Furthermore, GP's practices aren't publicly traded (listed) which results in less sensitive secret information and less steps necessary to protect this (sensitive) information.

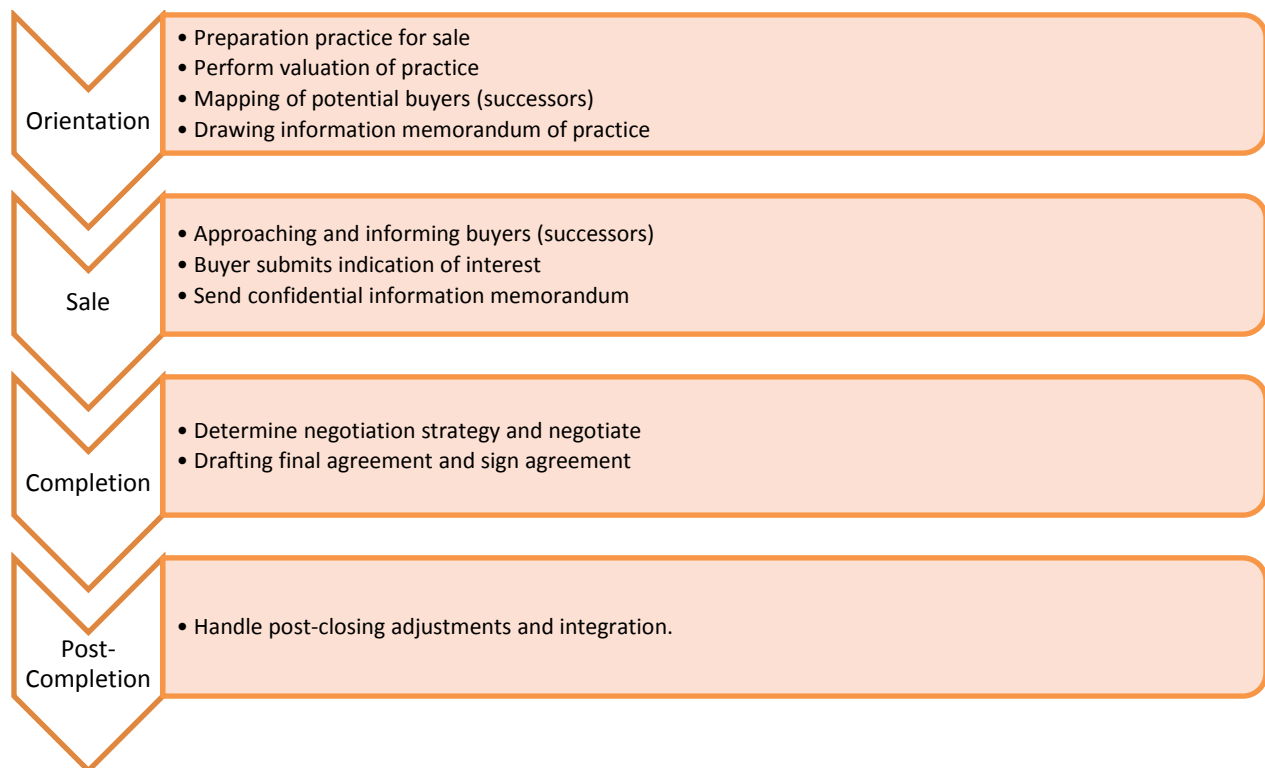


Figure 8. Steps of business transition^{10,18}

Practice renunciation differs undoubtedly from business transmission. However this framework can be used as a base for identifying success factors of practice renunciation. VvAA offers help in practice renunciation, both for settlers as for retirees. VvAA offers a four step model for practice renunciation¹¹.

- A. Timeline
- B. Financial considerations
- C. Legal agreements
- D. Practical issues

Multiple factors are included within this advice. First the practice is evaluated (global description of the practice and comparing with average practice/benchmark) and profiled (composing a sales memorandum), contractual duties are mapped and a successor's profile is drawn. The successor can be a already known HIDHA or observer, colleague at HAP (in Dutch: Huisartsenpost) (GP's-centre), or a partner of the current partnership (in Dutch: maatschap)¹¹. Second, financial considerations will be mapped. First, personal financial situation, retirement, AOW pension, and equity will be evaluated (financial planning). Also value of the practice will be mapped. Including inventory, instruments and renovations¹¹. Furthermore intangible assets (goodwill) and real-estate are calculated and included in the evaluation. Goodwill is a very sensitive, yet important subject with great impact on GPs practices market and renunciations. As a consequence of this high impact goodwill will be further elaborated later in this chapter in it's own paragraph. Real-estate, especially practices at home, can lead to complex situations in the renunciation process, as a result of the private and business interpenetration.

Furthermore legal agreements which need to be respected; what does the contract say, or what is missing? What happens with personal, acquisition and payment method?¹¹ Does the contract beholds a relationship clause or a perpetual clause, and what are consequences of these clauses? Last are practical issues, which behold timely denounce of agreements, introduction track of successor and insurances which needs to be stopped or adapted¹¹. These are all steps a practice quitter needs to take into account. Some steps are mandatory, some steps can be conducted by GP themselves, sometimes an external adviser seems a good alternative. It is mentioned that practice transition also has an emotional load and to deal with this properly, an

external adviser is often hired³. Although it is currently unclear which factors influence the outcome of practice renunciation most, and how they effect the renunciation, VvAA uses several advising pillars:¹¹:

- Selection of successor
- Finances of practice
- Consequences for staff
- Pension & Annuity
- Tax aspects
- Legal Aspects
- Practical line of business

4.3 General practitioners and goodwill

Goodwill is *the difference between the sale value of the separate property of the practice and the final sales price of the practice in total*¹⁵. Whether goodwill should be asked is a sensitive question in the current healthcare market, although recently minister Schippers (Minister of Health) stated that goodwill cannot be forbidden based on economic or legal restrictions¹². Goodwill is payed in 30-40% of the practice renunciation and is increasingly present¹⁴. Usually goodwill levels vary between 20.000 and 100.000 euro^{12,15}. Goodwill is a sensitive subject and relevant (quantitative) data misses, most studies regarding this subject are based on qualitative research and a knowledge and research gap is present.

In 1973 the collective pension fund for GPs was established, which reduced the importance of goodwill (as retirement provision) for GPs. In 1987 the goodwill fund was started, where GPs could reclaim their goodwill. If payed-out by the fund, a GP was forbidden to ask goodwill at the moment of practice renunciation. Goodwill pay-out via the goodwill fund remained present until 2002¹⁶. With the new HIA in 2006 the prohibition for asking goodwill was stopped¹⁶. Goodwill started to resurface around 2007 with more commercial parties who want to takeover GP's practices, they offered high levels of goodwill for GP's practices¹⁵. Recently it was identified that leaving GPs are asking goodwill more frequent again^{15,16}. Also the higher level of new entrants (new GPs) can be seen as an influencing factor¹⁵. With more new entrants, more demand for practices arises, while the level of retiring GPs remains the same, which stimulates the

development of goodwill¹⁵. Although the upcoming retirement of the relatively large “baby boom” generation could recalibrate this balance¹⁵. It is assumed that presence of goodwill is location dependent; with a important part in the “Randstad” region (Western part of the Netherland with big cities)¹⁵. Outside of the “Randstad” goodwill is less present¹⁵. It is assumed that the high level of observers in the Randstad stimulates goodwill in this region¹⁵. Also most of the GPs training institutes are in the this region of the Netherlands (appendix III), which could be a factor influencing the higher demand of GP’s practices for starters^{15,17}. In these cities more observers are present which could lead to a higher demand for GP practices¹⁵.

An objective way of calculating the level of goodwill remains absent, although multiple provisions are present. The level of goodwill asked is often influenced by six factors: Location, earning capacity, state of practice, recent investments, personal preferences and formation of chains¹⁵. However it is described that for a successful practice renunciation often other than economic factors play a major role, such as a fitting successor with the same norms and values as its predecessor (“soft-factors”) ¹⁵. Two positive and two negative effects of goodwill on the quality of GP care are identified. The first risk is the selection of the successor. Goodwill could affect the renunciation process, succession could become more influenced by financial factors than by qualitative (care) factors (most paying successor versus best GP successor)¹⁵. Second, more chains of GP’s could emerge, if these commercial businesses aren’t capable of earning their investment (goodwill) back, experts expect cuts on quality of GP care¹⁵. Also two positive effects of goodwill are identified. First, the continued investment policy of GPs, also at the end of their career¹⁵. Second, a contribution to the availability of GP care in the edges of the Netherlands¹⁵. Due to the assumption that outside the “Randstad” goodwill is hardly present, regions outside the “Randstad” could be more attractive due to absence of goodwill for a starting GP. If goodwill was not present, these areas could possibly become more subordinated.

4.4 Psychosocial barriers for retirement

Renunciation can be perceived as a form of grief. A long period of working will be finished either gradually or at once by retirement. In this paragraph renunciation will be reviewed from the perspective of “grief”.

In 1973 Kübler Ross identified seven phases of grief based on the first time a patient is informed about a terminal illness⁴⁴. Her book is cited more than 10.000 times and her model is also used as a basis for change management⁴⁵(appendix X). The transition or change from owner(ship) can be seen as a important step for a business owner or GP who is renouncing its practice. Because of a lack of literature regarding influencing factors for retirement of GPs, literature regarding (family) business transfer is used to study psychosocial factors regarding business/practice succession. Despite the fact that a business owner seems to differ greatly from a GP, similarities exist: Both are for example entrepreneur, however differences are present as well especially as a result of the presence of medical ethics a GP is involved with.

In business succession several factors play an important role such as legal, financial and fiscal components but also barriers against succession and managing the process of succession exist⁴⁶. Several barriers and psychosocial factors influence succession, which may be especially important for the departing owner. For every owner one aspect is certain: “*Eventually every owner leaves his business*”⁴⁷. Detaching or loss of a business, is seen as an extraordinary event, especially because it mostly only takes place once in a lifetime⁴⁸. Succession is often seen as an emotional event, and most owners experience it as difficult “to let go”^{49,50}. Adapting to these barriers by coping with them could positively influence the departing owners to move on to their next phase of their life. Perhaps it could influence a smoother succession and prevent reaching a depression phase in the Kübler Ross curve (appendix X).

In literature eight physiological barriers of business transfer are identified. Weesie and van Teeffelen (2014) mentioned that a large group of entrepreneurs deals with issues with their intangible assets of the business and identified the four most common psychological barriers, which are⁵¹:

- I. Role changes and degradation of power

- II. Succession planning
- III. Problems in letting go
- IV. Distrust in the successor

The role change and degradation of power are evident, owners of businesses have public recognition with their position at the top⁵². They lose a degree of gratification with the loss of public exposure and public contact and lose influence, power attention and possible admiration⁵². Succession planning is the second barrier which is investigated thoroughly. Four factors that influence succession planning negatively are: Costs, other work demands, overcoming resistance and need for performance management⁵³. The third factor is taking distance, which is influenced by other co-factors, such as the feeling of responsibility⁵². A business owner feels responsible for the well-being of his/her employees, perhaps a GP feels, next to responsibility for it's personnel, also responsible for his/her patients. Fourth factor is distrust in the successor, which often is also seen as a co-factor of the barrier of letting go⁵². This is underlined by the finding of Levinson (1974) which identified that many business founders selected successors who were bound to fail⁵⁴. Next to identification of barriers, Weesie and van Teeffelen (2014) also identified the four most common coping strategies of business transfers. These coping strategies are mainly identified as problem and emotional based strategies which are⁵¹:

- i. Focus on venting emotions
- ii. Make use of instrumental support
- iii. Active coping
- iv. Planning

The first coping strategy is often present in social environments such as close friends and family, but venting emotions is not open for discussion in every social environment⁵⁵. Second is making use of instrumental support. An example of this coping mechanism is the help of experts⁵¹. Experts seem to fill in a knowledge gap and could provide mental support next to the standard social environment (Accountants are often first asked for support)⁵¹. Often the accountant is known with the entrepreneur and the business for a long time, which could explain this "first line of support". Active coping is the third factor which is related to the business transfer⁵¹. This seems only present when the departing owner passed the denial phase of the

Kübler Ross curve. Fourth and last factor is 'planning', which is remarkable as planning also can be a barrier. To overcome the barrier of planning, a rational solution could be planning itself⁵¹. *Almost half of our adult lives is spent in experiencing developmental transitions*⁵⁷. Any feeling of loss or grief as a result of transition must be resolved, if the individual wants to move forward beyond the transition⁵⁸. This means perceiving the transition in a new perspective and developing new skills for negotiating the dangerous shift from being an owner towards being retired⁵⁸.

What after retirement? The old owner stops working and things will change. Especially the relinquishing power is difficult for retiring business owners. The public recognition which accompanied their function has been a great dimension in their lives⁵². There may feel deprived at retirement of essential inputs; identification with an institution (of power), influence over individuals, finances and the community⁵².

Many leaders/owners explore difficulties in letting go at the end of their career. Kets de Vries (2003) describes three psychosocial processes that affect retirement⁵². These three events together are defined as *The Retirement Syndrome*, which include five underlying changes: Loss of status, recognition, income, physical aging and emotional stress, which are all connotations of taking distance and letting go and can be perceived as negative⁵². People who reach the top at a relatively early age, and have a long tenure are often struck hardest by this syndrome. The first of three events is the *experience of nothingness* which is experienced by many formal owners of businesses in the absence of work⁵². The loss of work (a critical activity), loss of public exposure and public contact and loss of influencing power, attention and admiration can even lead to depression⁵². Second is the *Talion principle* which is a subliminal fear of reprisals. Being an owner of a business, or a GP, involves making difficult decisions which affect life of others. The unconscious belief in the *Talion principle* files up in their memory bank and retirees expect retaliation. Last is *The Edifice Complex* which is the need to leave behind a legacy⁵². They see their (good named) business as their legacy, and are anxious that their successor will destroy this legacy. As a reaction they hold on to power for as long as possible⁵².

5. Results

First the response rate is described in paragraph 5.1. Next in chapter 5.2 descriptive statistics of the respondents are discussed, followed by results in 5.3 per GP age group (pre and post-retirement GPs). In chapter 5.4 the significant influencing factors are identified. Chapter 5.5 contains the critical success factors and 5.6 the perceived success factors. In chapter 5.7 perceived differences between both groups of GPs are analysed.

5.1 Response rate

The response rate for the total invited group of GP's was 49% (n = 53) for the retired GPs and 32% (n = 101) for the active GPs. All together 167 GPs responded to the questionnaire, with 154 finished questionnaires. From the perspective of population and GP density (figure 4) it is identified that the GP density in "de Randstad" is almost equal as in the rest of the country (with a high density peak around Amsterdam). The "Randstad" has about 7.1 million inhabitants, which is (based on a total of 17 million) about 42% of the Dutch population. Within the survey 25.5% and 39.3% of the respondents live within "de Randstad".

5.2 Descriptive statistics

It took the respondents on average 12.41 minutes (post-retired GPs) and 05.41 minutes for the active GPs (pre-retired) to fill in the questionnaire. Within the retired group, 94% of the respondents were men. Within the active GPs group 77% was men. The average age of the retired respondents was 70.7 years with a maximum of 87 and minimum of 61 years of age (SD \pm 4.8 years). In the active GP group (pre-retirement) the average age was 64.6 with a minimum of 60 and a maximum of 72 (SD \pm 2.4 years). Types of practice are divided in solo, duo and group practices (figure 9 and 10).

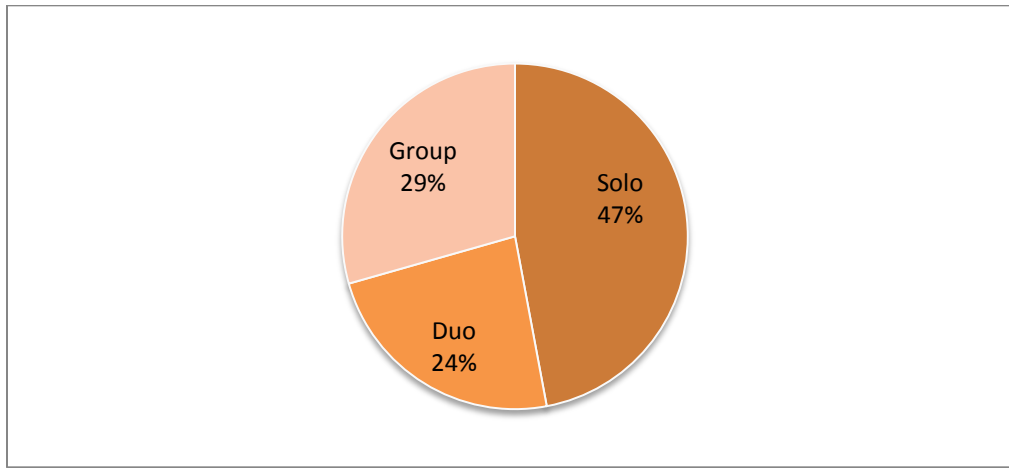


Figure 9 Segmentation of practices of retired GPs.

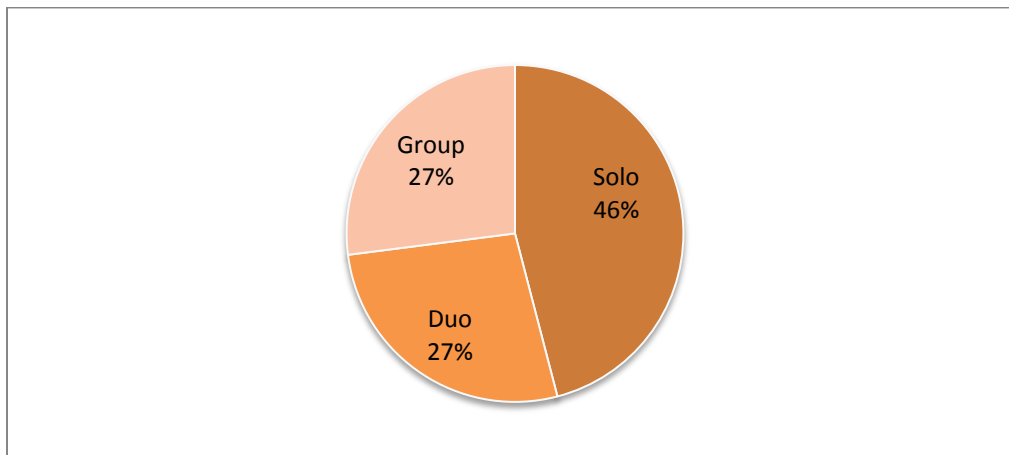


Figure 10 Segmentation of practices of active GPs (Pre-retirement group).

Furthermore, identification of location is analysed. Based on postal code 25.5% of the retired GP's are located in the central-western part of the Netherlands, consisting primarily of the four largest Dutch cities (Amsterdam, Rotterdam, The Hague and Utrecht) and their surrounding areas ("Randstad") while in the active GP group 32.3% of the GP's are located in the "Randstad".

As mentioned before in the Netherlands 11.568 GPs are active, 70% of them is entrepreneur and is (co)-owner of a practice⁴. In the respondent groups of GP's with a group practice are overrepresented while duo practices are underrepresented and solo practices are slightly

overrepresented. Already in 2015 Nivel already mentioned the growing popularity of groups and duo practices¹⁹. In the perspective of age distribution currently about 32% of the active GPs is older than 55 years of age⁴. As depicted in figure 5, the number of female GPs has increased in recent decades.

Primary and secondary outcome measures

Level of success is used as the primary outcome variable. This variable can possibly be influenced by other factors, which are included in the survey. These exogenous factors could influence the level of success. The relation between the outcome and possible influencing factors are identified by a Chi² test (P-values in table 1).

	Goodwill start	Goodwill stop (plan)	Randstad	Succes	Practice type	Gender
Goodwill start		0.37	0.73	0.16	0.33	0**
Goodwill stop (plan)	0.14/0.06*		0.54	0.88	0.61	0.77
Randstad	0.40	0,57		0.73	0.73	0.42
Succes	*	*	*		0.16	0.19
Practice type	0.92	0.03	0.13	*		0.16
Gender	0.02	0.11	0.92	*	0.08	

Table 1 Influence of exogenous factors on each other (grey = pre-retirement & brown = post-retirement group of GPs)

* Two answer options analysed (both non significant)

** Women shortage makes outcome non valid

Level of success is not influenced by any of the exogenous factors, except for two factors. It is identified that in group of active(pre-retirement) GPs, the type of practice does significantly influence the (intended) presence of goodwill at practice stop for pre-retirement GPs. Second it is demonstrated that gender has influenced the occurrence of goodwill in the past, when the GP started its practice.

5.3 Results for pre-retirement and post-retirement groups separated

In chapter 5.3.1. results of the retired GPs and in chapter 5.3.2. the results of the active GPs will

be described.

5.3.1. Post-retirement GPs

The retired GPs renounced their practice on a mean age of 62.0 years (SD \pm 3.0), with a minimum of 50 and a maximum of 67. They started to orientate on their practice renunciation at a mean age of 59.9 (SD \pm 2.6) and initially wanted to renounce their practice at 62.3 years of age (SD \pm 2.9) (Appendix VII and IX). 82% of the retired GPs didn't work to their AOW-age, or the "general retirement law-age". Most dominant reasons to quit practicing are declining job satisfaction, health reasons, family reasons, leisure and other interests, and lastly sufficient financial reserves built up (figure 11).

Retired GPs have found their successor mainly when he or she was working as a HIDHA/medical observer in the GP's practice (30.4%) (figure 12). 56.5% of the retired GPs mentioned that their successor first was employed as HIDHA/Observer. 30.4% of the retired GPs mentioned that they remained active as a HIDHA/Observer after practice renunciation, with an average of 19.9 hours a week (SD 9.5). Of the retired GPs, 10% started their own practice. Regarding the practice renunciation process, 15.9% mentioned that their renunciation process had stopped and they needed to search for a new successor.

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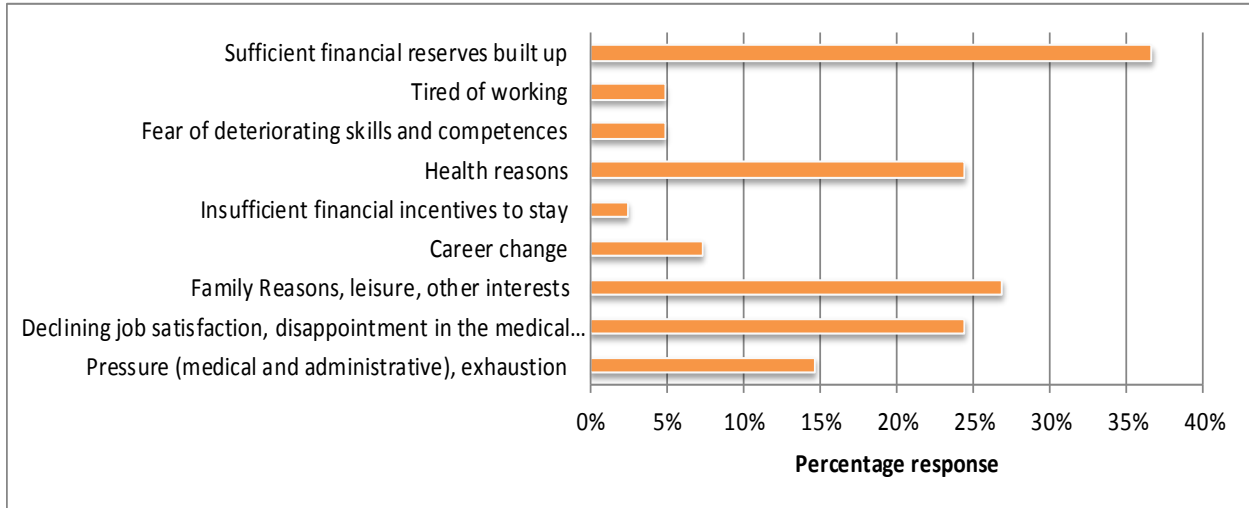


Figure 11 Reasons for retired GPs to stop practicing before “AOW-age”

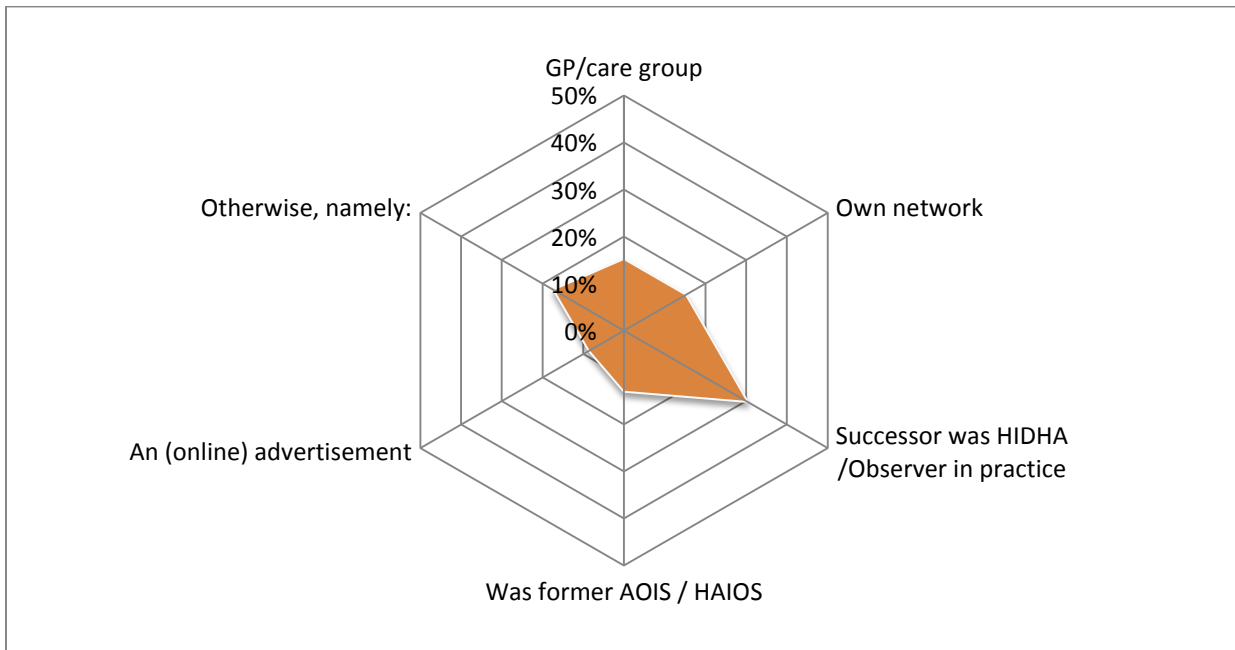


Figure 12 Origin of successor for retired GPs

5.3.2. Pre-retirement GPs

First, active GPs are planning to renunciate their practice on an average age of 64.6 years (SD ± 2.4), with a minimum of 60 and maximum of 72 years (Appendix VII and IX). 54.6% of the pre-retired GPs mentioned they had planned not to continue to work until their AOW-age. While 15.5% didn't know if they wanted to remain working until their AOW-age, and only 30.0% mentioned they had planned to remain working until this age. Most dominant reasons to stop before the AOW-age were work pressure and exhaustion, family reasons, leisure and other interests and third, sufficient financial reserves built up. 50.5% of the pre-retirement GPs already have identified their successor (figure 13). The successor is often coming from the GPs own network or is HIDHA/Observer in the GP's practice both 45.8% (figure 14). On the question whether a successor first needs to be employed as a HIDHA/Observer before practice renunciation will be started, 43.5% answered yes, 16.3% answered no and 40.2% did not know this yet. One third of the retiring GPs wants to remain active as a HIDHA/Observer after practice renunciation, with an average of 17.4 hours a week (SD ± 7.1). Within the pre-retirement group, 12.7% started their own practice.

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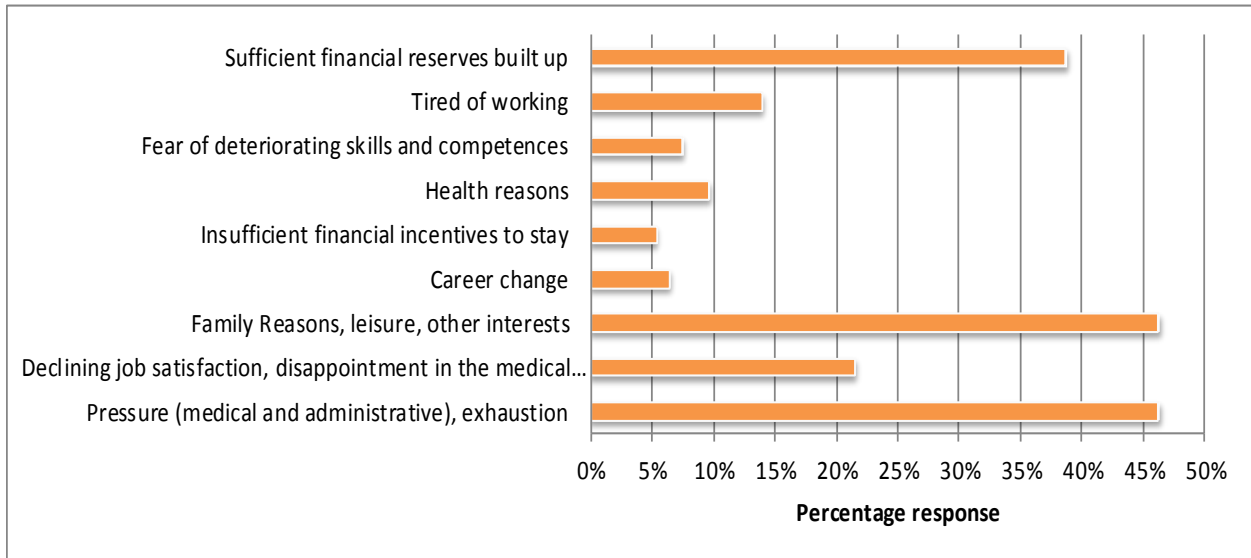


Figure 13 Reasons for pre-retirement GPs planning to stop practicing before “AOW-age”

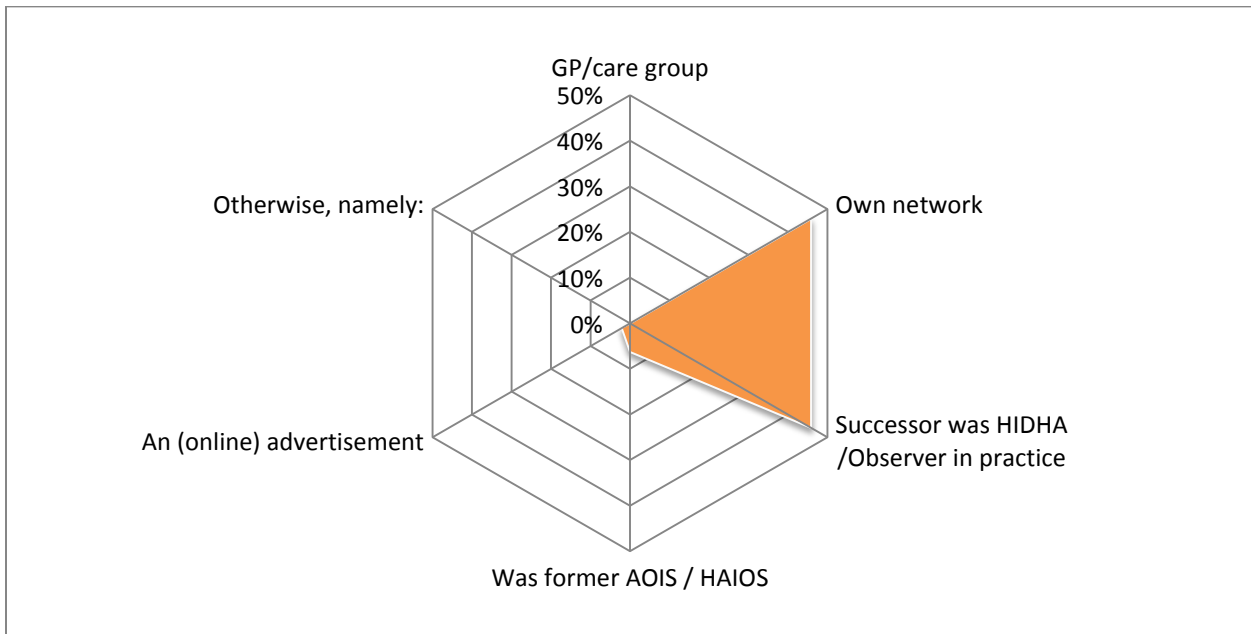


Figure 14 Origin of successor for pre-retirement GPs (if successor is already present)

5.4 Identification of significant influencing factors

To identify significant influencing factors (SIF) a Chi²-test is conducted (appendix VI). Based on the success it was possible to divide the retired GPs in two groups. GPs with successful and non successful practice renunciation. The 20 start (influencing) factors were analysed and a Chi²-test was used to identify significant influence of a factor on the success of the practice renunciation. It was possible to identify four significant influencing factors. Significance was set at $p < 0.05$, the higher the rank (and significance) the higher the influence on success.

Table 2 Significant influencing factors for practice renunciation success between success and non-success groups

Number	Variable	Absent successfull GPs	Absent Non successfull GPs	Significance (Chi2-test)
1	Drafting contracts (acquisition, partnership, cooperation agreements)	2.1%	12.5%	0.02
2	Valuation of intangible assets (goodwill calculation)	41.7%	29.9%	0.03
3	Tax settlement for discontinuation of the practice of the Tax Administration (calculation of the stoppage profit)	10.4%	2.1%	0.03
4	After transfer, the former practice holder can remain working (part-time) in practice as a HIDHA/Observer	50.0%	37.0%	0.04

Three answer options for each variable were present; the variable factor was absent, present and mainly conducted myself, or present and mainly outsourced (table 2). The 20 variables were analysed based on two answer options, presence or absence (table 3) and mainly conducted myself or mainly outsourced (table 4). The four identified factors in table 2 also emerged in these analyses. Within tables three and four the non-significant answer option is left out of the analyses.

Table 3 Presence versus absence analyses of influencing factors on successful renunciation

Number	Variable	Absent successfull GPs	Absent Non successfull GPs	Present succes	Present non succes	Significance (Chi2-test)
1	Drafting contracts (acquisition, partnership, cooperation agreements)	2.1%	12.5%	60.4%	25.0%	0.00
4	After transfer, the former practice holder can remain working (part-time) in practice as a HIDHA/Observer	50.0%	37.0%	13.0%	0.0%	0.04

Table 4 Outsourced versus self-conducted analyses of influencing factors on successful renunciation

Number	Variable	Mainly self successful GPs	Mainly self Non successful GPs	Mainly outsourced successful GPs	Mainly outsourced non successful GPs	Significance (Chi2-test)
2	Valuation of intangible assets (goodwill calculation)	14.3%	28.6%	57.1%	0.0%	0.00
3	Tax settlement for discontinuation of the practice of the Tax Administration (calculation of the stoppage profit)	2.4%	11.9%	57.1%	28.6%	0.02

Furthermore barriers are identified by analysing the twenty influencing factors. If an influencing factor is more present (50%<) (more than absent) and is more outsourced than conducted by the GP itself, a factor is identified as a barrier for practice renunciation. Two factors are identified as barriers. First *Tax settlement for discontinuation of the practice of the tax administration (calculation of the quitting profit)* and second *Drafting contracts (acquisition, partnership, cooperation agreements)*. With respectively 88% and 85% presence and 75% and 67% outsourced levels for both barriers.

5.5 Identification of critical success factors

Critical success factors (CSF) are identified by using a discriminant analysis (statistic accountability appendix IV). The four in paragraph 5.4 identified significant influencing factors (SIF) are used as input in the discriminant analyses. A discriminant analysis shows the percentage of the cases which are divided in the correct group based on a certain criterion. In this study success or non-success are the populations where the criteria to divide them in are the influencing factors. The discriminant analyses show that 79.1% of the cases can be divided into the correct group, based on the four SIF's. The discriminant analyses is significant with $p = 0.01$.

Next a discriminant analyses step by step is conducted. A discriminant analyses step by step shows the most dividing SIF's. It is identified that the step of *Drafting contracts (acquisition, partnership, cooperation agreements)* can identify 71.1% of the cases in the correct group. Which mean that if deducted, (79.1% - 71.1%) the other three SIFs only divide another 8.0% in the correct group. This means that *Drafting contracts (acquisition, partnership, cooperation agreements)* is the only Critical Success Factors (CSF) for success in practice renunciation.

5.6 Identification of perceived success factors

To identify perceived success factors the importance of the influencing factors was used to conduct a Chi²-test. Two of the twenty influencing factors significantly differed between the success and non-success group. The importance of the different influencing factors is mentioned in appendix VIII; the ranking of these factors is conducted in a similar way as the ranking in appendix V. The two significantly differentiating factors are:

Table 5 Significant differing perceived success factors between success and non-success groups

Number	Variable	Significance (Chi2-test)	Success score	Non-success score
1	Identification if my successor will continue patient care in the same way	0.02	1.242	0.249
2	Identification if my successor is like-minded as me on business management	0.04	0.656	- 0.267

The five factors perceived a most important are the same factors as put forward in the success and non success group (in orange). First the scores and ranks of the success group are described (table 6) and in table 7 the highest ranked factors for the non-success group are described.

Table 6 Top 5 ranked perceived important factors for the success group

Number	Score	Factor
1	1.35	Identification if my successor is a suitable candidate
2	1.33	The capabilities of the SPH pension evaluated and then made choices. (Earlier or later retirement, part-time retirement, conversion or not, market exchanges of pension)
3	1.30	Drafting contracts (acquisition, partnership, cooperation agreements)
4	1.24	Identification if my successor will continue patient care in the same way
5	1.23	Calculate when and if I can stop my practice (financial planning; own funds, annuities, mortgage repayment, etc.)

Table 7 Top 5 ranked perceived important factors for the non-success group

Number	Score	Factor
1	1.19	The capabilities of the SPH pension evaluated and then made choices. (Earlier or later retirement, part-time retirement, conversion or not, market exchanges of pension)
2	0.88	Calculate when and if I can stop my practice (financial planning; own funds, annuities, mortgage repayment, etc.)
3	0.81	Tax settlement for discontinuation of the practice of the Tax Administration (calculation of the stoppage profit)
4	0.65	Identification if my successor is a suitable candidate
5	0.56	Transfer / change of insurance (professional liability, legal assistance, inventory, business interruption, disability, stalling)

5.7 Analysing perceived differences between pre- and post-retirement groups of General Practitioners

Next to differences between the success and non-success group also differences in importance ranking between the pre- and postretirement group can be calculated. This is analysed by using a Chi²-test on the importance ranking of the influencing factors. Six of the 20 influencing factors were identified as differing significantly (statistic accountability Appendix V).

Table 8 Significant differing influencing factors between pre- and post-retirement groups of GPs

Number	Significance	Factor
1.	P = 0.00	Asking of intangible assets (goodwill) at practice renunciation
2.	P = 0.00	Temporary association of the successor before the practice is fully transferred
3.	P = 0.01	After practice renunciation, the former practice holder keeps working (part-time) in practice as HIDHA/Observer
4.	P = 0.02	Valuation of intangible assets (goodwill calculation)
5.	P = 0.02	Actively seek potential successor
6.	P = 0.04	Determining acquisition value of entire practice

The five perceived most important factors for GPs are the similar for retired GP's ad active GP's. Although differences in ranking appear between both groups. The five most important

factors are visualized in table 9 (those in grey differ significantly between both groups) full table in Appendix V.

Table 9 Five perceived most important influencing factors for pre and post-retirement groups.

Rank Pre-retirement	Rank Post-retirement		Score pre	Score post
3	5	Actively seek potential successor	1.05	0.91
1	3	Identification if my successor is a suitable candidate	1.19	1.09
5	2	Calculate when and if I can stop my practice (financial planning; own funds, annuities, mortgage repayment, etc.)	0.99	1.11
4	1	The capabilities of the SPH pension evaluated and then made choices. (Earlier or later retirement, part-time retirement, conversion or not, market exchanges of pension)	1.03	1.28
2	4	Drafting contracts (acquisition, partnership, cooperation agreements)	1.07	1.04

6. Conclusion

The aim of this research was to identify success factors for practice renunciation of General Practitioners in the Dutch healthcare sector. Twenty different factors were identified as possible influencing factors of practice renunciation. Four of these factors significantly influenced the outcomes of practice renunciation:

- Drafting contracts (acquisition, partnership, cooperation agreements)
- Valuation of intangible assets (goodwill calculation)
- Tax settlement for discontinuation of the practice of tax administration (calculation of stoppage profit)
- After transfer, the former practice holder can remain working (part-time) in practice as a HIDHA/Observer

Of these, the first SIF has the highest discriminating power, the critical success factor for practice renunciation is the *drafting of contracts (acquisition, partnership, cooperation agreements)*. This is the most important success factor for practice renunciation of GPs in the Netherlands.

Barriers for practice renunciation are factors who are as well mainly (50%<) present as mainly outsourced. Two factors that are identified for practice renunciation are:

- Tax settlement for discontinuation of the practice of the tax administration (calculation of the stoppage profit)
- Drafting contracts (acquisition, partnership, cooperation agreements)

Two factors differ significantly between the success and non-success group regarding their perceived importance, both factors are scored significantly more important by the successful group: *Identification if my successor will continue patient care the same way as I do* ($p = 0.02$) and *Identification if my successor is like-minded regarding business management* ($p = 0.04$).

Six factors are identified as significantly differing factors between the pre- and post-retirement group. One of these is also ranked as important by both groups, which is *actively seeking a potential successor*, which the retired GPs rank significantly lower than the pre-retirement group. Despite this difference, both groups score the same five factors as very important.

7. Discussion

The primary outcomes of the study will be discussed in this chapter. Paragraph one till four regard general discussion regarding GPs. Paragraph five till eight discuss the influencing and critical success factors regarding renunciation in GPs. In paragraph one the average retirement age and factors that influence an early retirement age of GPs are discussed. In chapter 7.3 factors which are related to the identification of the successor are described. In chapter 7.4 psychosocial barriers for retirement in GPs are discussed. Furthermore, in chapter 7.5 the factors that significantly influence the success of practice renunciation are described and discussed, followed by the perceived differentiating factors between the successful and non-successful GPs in paragraph 7.6 In chapter 7.7 the perceived differences between the pre- and post-retirement group are discussed. Chapter seven ends with a discussion regarding goodwill and which factors influence the presence of goodwill. This chapter contains a critical reflection of the results of chapter five.

7.1 Primary outcomes

Outcomes of the primary analyses show differences between the respondent group and the total market of GPs. First, males are overrepresented in the respondent group (82.4%), which is similar in the GPs market (figure 6). This uneven distribution between males and females is the result of an uneven distribution between male and female students in the fifties. The included GPs in this study are 55 years and older, which means that they started with their study medicine about 35 years or longer ago. In those decades opportunities for females to participate in academic education started to increase, but at that time females were only a small part of the university students, also in medical studies²⁶. This could also explain the low level of women in both respondent groups, which is strengthened by figure 5 which shows low numbers of female GPs in higher age groups.

Second, the distribution of types of practices represented are skewed. Figure 7 shows the distribution in the Netherlands the respondent groups shows more solo and duo practices and groups practices are underrepresented. The difference could be explained by the time passed. Data refer to year 2015 (figure 7). However, the difference seems more a result of the sample composition and response bias. Due to the fact that the touted groups were selected based on

age, the average age of the respondent groups differs from the average age of all GPs in the Netherlands. Considering the types of practices, the group practice is relatively more present in this sample compared to the amount of group practices in the Netherlands. It is possible that non-response bias is present. Non-response bias can occur if the answers of the respondent group differ from potential answers of the group that did not participate in the study²¹. People who actually are in the process of renunciation or people who perceive it an important subject might have reacted more often on the invitation and might be overrepresented in the sample. Last “Randstad” is slightly underrepresented, which could lead to shifted outcomes in the framework of the goodwill question.

7.2 Retirement age and factors that influence early retirement

The retirement age and the assessed retirement age of the pre-retirement group differed. Recall: retired GPs on average retired at age of 62.0 and the pre-retirement group prefers to retire at the age of 64.6. In 2001 the average retirement age was 56.5 years, in 2011 it was 58.8 years. It seems to increase gradually. Although it was described that GPs often renunciate their practice at age of 58.8 in 2011, they often remain working as a doctor for insurers or as manager in a medical organisation²⁷. Literature shows that retirement age has increased as a consequence of increasing number of assistants for a GP, which makes the job less heavy. Also cooperation with “Huisartsenposten” “GP’s centres” has reduced the workload for GPs^{26,27}.

Recall: In retired group only 18.0% of the GPs continued to work until “AOW-age”. Of the pre-retirement group 30.0% mentioned to continue working until “AOW-age”, which is lower than GPs in research conducted in Australia (63%)⁶ and comparable with similar research conducted in the UK (<25%)⁷. Just over half of the GPs in the survey mentioned to plan to retire before the “AOW-age” which is a higher percentage than mentioned in other studies^{5,23}. In the UK (NHS), the retirement age of a GP is 60 years and in Australia this is 65 years. The retirement age in the Netherlands used to be 65 years, but in 2013 this is increased to the age of 67 in 2021²⁸. Based on these age differences outcomes of the Australian research can be best compared with this Dutch research outcomes. The group of GPs who do not want to work until their retirement gave. Two important reasons for wanting to retire early. First, pressure of work (medical and administrative), exhaustion and burn-out are identified in this study as well as in other studies^{5,6,24}. Second, family reasons, leisure time and other interests are also identified in

this and in other studies^{5,6,24}. Other factors seem to be more dominant in other countries than in the Netherlands, especially diminished job satisfaction and disappointment in the medical system^{5,6,24}. Older GPs often perceive changes as difficult, partly because the current medical practice is developing quickly and is different from what they have learned in the past²⁴. Despite this, only 7,5% mentioned to have problems with fear of deteriorating skills and competences, which corresponds with outcomes of other studies⁶. If the Netherlands would ever have a lack of GPs, earlier research in the UK identified that increasing the retention rate of older GPs is more cost effective than training new GPs²⁵. A remarkable difference between the pre and post-retirement GPs is the high presence of “Pressure (medical and administrative) exhaustion” which is about three times higher in the pre-retirement group. This could be a result of the new HIA of 2006, which obliged GPs to carry out more administrative tasks (often imposed by the health insurer), which is currently a major issue of discussion in healthcare³⁶. Policy should focus on lowering medical and administrative pressure and exhaustion and stress of older GPs. Perhaps a release of medical pressure can be realized by shifting of “ANW-shifts” (evening, night and weekend shifts) towards other, younger, GP age groups. Although reduction of working load and shifts of older GPs, this will always remain a temporary solution. Change of these ANW-shifts probably will only shift the working pressure towards another, younger, age group of GPs.

7.3 Identification and settlement of the successor

The majority of the successors of GPs comes from the network of the renouncing GP. Young GPs often start, after they have finished their study, as a HIDHA/Observer before they start their own practice³. As a consequence of this development, often the GP that plan to stop working, already has an idea of possible successors, namely a HIDHA/Observer who already is known in the practice. Second, more cooperation between different GPs is obliged with the new health insurance act (HIA). More cooperation means more contact between different GPs which could declare the high level of successors coming from the GPs own network. One of the findings is that only a small percentage of the successors was identified via an (online) advertisement. It can be concluded that GPs often identify their successor in their own network and do not to “actively search” for a possible successor. This can also be influenced by the higher level of GPs who want to settle versus the quitters³. Most obvious explanation is that a GP prefers a successor who he already knows and trusts. However, the other 50% of the pre-retirement GPs

who have not identified their successor yet could be responsible for the difference between the post and pre-retirement groups. GPs who doesn't have identified their successor yet at the moment they start to orientate on their practice renunciation will probably search for a possible successor external via (online) advertisements and will ask in care groups more (start to actively search for successor). This could explain the difference between the pre- and post-retirement groups.

Multiple studies identified wishes of starting GPs. It was identified that region opportunities had influence on preferable place of settling. Most important regional reasons were, employment opportunities for partner and closeness of friends and family¹³. Stimulating factors to settle at less popular regions are: Starting education dependences in these regions and to facilitate support for practice renunciation in these regions¹³. All four countryside corners are less popular regions than the centre of the Netherlands¹³. Furthermore as mentioned before and endorsed by the results of this study, departing GPs are often men with a solo practice who want to renunciate their practice to one successor³. While majority of the successors is women, wishing to takeover a group or duo practice³. From GPs searching for a practice 60.5% of the men want to work part-time versus 87.9% of the women³⁷. Taking into account that about 70% of the GPs in education are women (active as GP in total is only 36%), it is clear that a FTE problem will arise. Also men in education to become a GP want to work on average 0.86 FTE while women want to work on average 0.57 FTE³⁸. Perhaps one male soloist can be taken over by two starting feminine GPs, however a FTE mismatch seems to remain present. In earlier research both the departing as successor GPs mentioned the importance of preparation and obtaining advice essential at practice renunciation³. Departing GPs often use support and advise in the negotiation process and for tuning of private and business interests³. While starters are looking for any information, and mention they have simply do not have enough information for conducting a good practice renunciation³. They mention to need additional advise on "how in general things are done" but also for financial advise and tuning of private and business interests³. Similar to results of this study, also about a quart of starting GPs has fundamental problems with asking/ paying goodwill³. It can be concluded that there is a need for advise for practice renunciation in as well the starting as departing GP group. This support seems able to have a positive influence on settlement of new GPs in less popular regions.

7.4 Psychosocial retirement barriers for general practitioners

As mentioned in paragraph 4.4 business owners can feel several barriers for retirement. These can be financial, fiscal, legal but also psychosocial⁴⁶. Perhaps some of the psychosocial barriers felt by business owners can also be experienced by GPs, although this remains an assumption. However, grief is felt in all kind of different processes of resigning or 'saying goodbye'.

First, the role change and degradation of power. It is assumed that especially in small towns, where every citizen has it's own role, a degradation of power is more present. As a worker they did get a constant affirmation of their importance as an individual, after retirement this function declines. In big cities this degradation of power is expected to be lower as a result of a greater population and more anonymity. The second problem is succession planning, which has four barriers, of which is psychosocial; which is overcoming resistance⁵³. To overcome resistance in succession planning three general (external) coping strategies are mentioned. Next to technical and supportive consultation, preparing the family about possible emotional difficulties will help to reduce resistance to succession⁵⁹. Second, helping the entrepreneur to become self-aware of its own actions and third to encourage the entrepreneur to move away from one venture and towards another⁵⁶. For GPs this last coping strategy could mean to start working in another practice or function, as an observer, board function or for example or as an insurance practitioner. This is supported by the results of this study, which identified that about one third of the GPs remained or plan to remain working as a GP after retirement. This can also be an way of "preventing taking distance or "letting go". A discussion regarding this subject is the "remaining of working within the practice" (significant influencing factor of successful practice renunciation), which can negatively influence the process of "letting go" or working at another practice of function²⁷ to take more distance. The third problem is "taking distance and "letting go" seems also present in GPs. GPs have taken an medical oat. With this oat they feel themselves responsible, not only responsible for their personal (and their families) as a business owner but also responsible for their "herd" of patients. This high level of responsibility could increase the problem of taking distance. An interesting finding is that the retired GP group shares this vision of dealing with patients as more important than dealing with the staff, while in the pre-retired group this is other way around (recall appendix V). Perhaps after retirement the feeling of responsibility for the staff reduces because the expectancy they will be able to cope,

while the feeling of responsibility for patients seems to remain. Furthermore regarding the problem of “taking more distance” it is identified that the pre-retirement group scores a higher mean on the importance of fifteen factors compared to the post-retirement group. This higher score on importance for pre-retired GPs could indicate that retired GPs are further in their process of taking distance, which is a healthy development in the process. The fourth common psychosocial barrier is a lack of trust in the successor. This study identified that in about (recall) 15% of the renunciations the first successor was not the final successor. However GPs all underline the importance of identification of a suitable successor as very important (recall: importance rank 1 and 3). Having a competent successor that fits in the practice, is a very important factor for GPs.

Another barrier which could influence practice renunciation is the presence of the *retiring syndrome*. People who reach their top at a relative early age, with a long tenure are often struck hardest by the *retiring syndrome*⁵². GPs often buy their practice in their mid thirties and remain working for about 30 years. Perhaps they may experience it as difficult as well, but often will be able to cope. The importance of a suitable successor can be intertwined with one of the events of the *retiring syndrome*, namely *the edifice complex*; leaving behind a legacy⁵². The legacy of a GP is often its practice, the departing GP wants a successor to take good care of its practice but also his patients and personnel after retirement. To reduce distrust in the successor, GPs probably prefer to find a successor which they already know and trust, which is underpinned by the high percentage of successors coming from the departing GPs own network and former employees. After retirement, the loss of critical activity (work), public exposure and contact (with patients) will probably be experienced by GPs as well. The so called *experience of nothing* may differ between GPs who work in a big city versus those who work in a small village. Especially the public exposure will probably differ between GPs who work in city and rural practices. To “*remain active as a Hidha/Observer*” could be a coping mechanism to reduce the *experience of nothing*. The third factor within the retiring syndrome is the *Talion principle*, a subliminal fear of reprisals⁵². In the perspective of GPs this seems a possible occurring event, for example by dissatisfied patients or mistakes in diagnoses of the past. These “wrong choices” have negatively influenced people in the past, which could subconscious lead to a fear of reprisals.

Several issues are addressed, what may be real threats for a successful business transition. First, the departing GP needs to be (emotional and psychosocially) ready and barriers for renunciation should be reduced and or eliminated. Business succession requires a continuous investment of time, resources and support from the owner, and legal and financial advise from experts⁴⁶. If the GP does not seem ready for his/her retirement, the real process of succession will not (yet) take place. Second important factor is the financial planning, whether or not it is possible to retire at the moment the GP wants it. The question is if he/she has enough capital to retire? This item is scored as very important by both groups of GPs (recall: importance rank 5 and 2). Furthermore, finding an successor is an issue, but also identifying whether the successor is a suitable candidate (recall respectively: importance rank 3 and 5 and importance rank 1 and 3). Finally, the process of practice renunciation itself is important, which is the focus of this research. Within practice renunciation the absence of contracts can prelude unsuccessful practice renunciation. Furthermore, not outsourcing a goodwill valuation and a tax settlement can negatively influence a successful practice renunciation. Figure 15 shows the main ingredients for a successful practice renunciation. Sometimes step three, *the identification of a suitable successor* is not present at the start of the renunciation process. This is obviously an essential step for a successful practice renunciation.

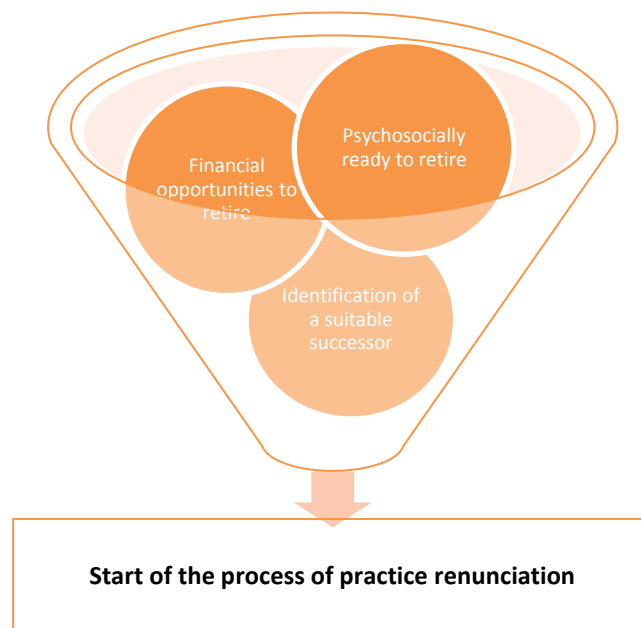


Figure 155 Three step model towards practice renunciation

7.5 Statistically influencing factors

Four factors were identified as influencing the outcomes of practice renunciation significantly. By conducting the discriminant analyses it was identified that one of these factors is responsible for the division of 71.1% of the cases in the correct group. This is the critical success factor of practice renunciation by GPs in the Netherlands. The first two of four significantly influencing factors differed based on presence of *“Drafting contracts”*. This implies that GPs who do not draft contracts are less successful in their practice renunciation. This might be a result of problems that emerge after the practice renunciation. By drafting contracts these problems or disagreements which emerge afterwards possibly can be reduced. Contracts are used to establish and capture good agreements. If contracts are missing, and afterwards problems arise, negative outcomes may develop. If a contract is drafted correctly and problems arise, both parties can rely on the contract. This factor is the most important factor in practice renunciation. Besides this, GPs who experienced a successful renunciation, also categorize this factor as very important: rank 3 (table 6). The GPs who did not renounce successfully, did not estimate the level of importance of this factor correctly. The non-successful GPs did not rank this factor within the five most important influencing factors. This underpins the finding that this is an important influencing factor which is underestimated by the non-successful GPs (Appendix VIII).

“After transfer, the former practice holder can remain working in practice as a HIDHA/Observer” is a factor which implicates that being able to remain working as a GP seems to increase the chance of a successful practice renunciation. This factor, as well as other factors, should explicitly be discussed and agreed upon with the successor of the departing GP. Perhaps this gradually departing of the GP can prevent problems, which might arise if the departing GP stops at once. The departing GP may assist the new GP in a positive way with the process of becoming independent. All involved parties should be well informed about the transition from the “old” boss/owner to the new GP in charge. Only in a small percentage of the practice renunciation cases this occurs, while it increases the chance of success. Although this factor is statically significant in the discriminant analyses, it is categorized as not very important by the GPs; they ranked it very low at the twentieth place in both groups of GPs (Appendix VIII). This is an underestimated factor in practice renunciation, despite the low occurrence level.

The second two significantly differing influencing based on execution mainly by GPs themselves versus outsourced is: *“Valuation of intangible assets”*. Goodwill is perceived as overvalue of the practice¹⁵. The GP’s who renounced successfully and those who did not differ concerning the calculation level of goodwill. Within the success group about four times more GPs outsourced the goodwill calculation compared to the non-success group (table 4). Calculation of the goodwill is a complex matter, for which different calculation systems and factors can be used¹⁵. It seems clear that outsourcing the goodwill calculation can positively influence the success of a practice renunciation. If GP’s are in negotiation with their possible successor, sensitive subjects as presence and/or level of goodwill can influence the mutual feelings of trust between successor and GP that departs, especially if these differ greatly in opinion. By (both) outsourcing the calculation of goodwill, a more objective goodwill level will be established and negotiation may occur smoother. The importance of this factor is underestimated by the GPs. What stands out is that successful GPs score the importance of this factor lower than the non-successful group. This negative score can be the result of the “absence” of goodwill. If a GP did not ask goodwill, these cases were excluded from in the analyses about “self-conducted” versus “Outsourced”. However this group did score the importance of this factor, which would logically decrease the importance of this factor. If goodwill was absent for a GP, he will probably score this factor also low in importance.

The number of successful GPs who outsourced *“Tax settlement for discontinuation of the practice of the tax administration”* this and those who conducted it themselves categorized this factor almost 10 higher in importance than for the non-successful group. It seems clear that both groups mostly outsource this step, although in the non-successful group a lot of people still (try to) conduct this themselves. The tax administration of the Netherlands advises people to get advised by a professional: *“Calculating the stoppage profit is very complicated. Therefore it is wise to get advise.”*²⁹ This advise is not only important for GPs but for all entrepreneurs. Taking into account that the majority of the GPs is not economically or fiscally educated, outsourcing this factor seems to be a wise step. Both groups of the GPs recognize this factor as very important, although the successful GPs do not rank it in their top five most important factors (Appendix VIII). If this factor is conducted wrong the tax administration of the Netherlands can fine the departing GP.

7.6 Perceived differences between successful and non-successful General Practitioners

First, successful GPs rank the importance of eighteen out of twenty factors higher than the non-success group. The two factors who were rated lower had a negative value in both groups. Perhaps the GPs who were less successful didn't care as much about their renunciation in general than the successful group did.

Two factors were analysed as being perceived significantly different between the success and non-success group. Recall: The non-success group scores the first factor at 0.25 versus 1.24 for the successful GPs. This first factor is "*Identification if my successor will continue patient care in the same way as I do*". Which is number four for the success group and not ranked in top five for the non-success group. Second, the non-success group scores this second factor negative (-0.27), while the success group scores this factor at (0.66) (appendix VIII). The second factor is "*Identification if my successor is like-minded as me on business management*". These are examples of "soft-factors" in which GP renunciation differs from business transactions to external parties³⁹. In pure business transfers to external parties it is seen as a benefit, that former owners/boss are less involved with his former business and clients³⁹, while in contrast, in GPs practice renunciation this involvement seems important. The difference between the successful and non-successful GPs is evident. Two reasons could be underlying this difference, first the departing GP is more concerned with his practice, successor and above all his patients, so he thinks this is very important. Second, often GPs live close to their practices. If the retired GP runs into one of its old patients and that patient is dissatisfied with the successor, the old GP may feel more negative about the renunciation.

Differences in scores may stem mainly from "neutral" scores by the non-success group versus "important" by the success group. So, some kind of interest in the business management and patient care of the successor seems important for successful practice renunciation.

Looking at the ranked five most important perceived factors per group (table 6 and 7), three factors are mentioned in both groups within the top 5. The success group ranked "*Identification if my successor is a suitable candidate*" highest were the non-successful group ranked this as number four. Again a "soft fact" which is ranked as important which again shows that GPs think the quality of their successor is important and not just "sell" their practice based solely on

business factors (financial incentives).

The second most important factor for the successful group is: "*The capabilities of the SPH pension evaluated and then made choices*", which has rank 1 in the non-success group. The SPH pension is built upon four pillars, which all can influence the level and dispersion of the pension over the years³⁰. After retirement SPH pension often is the main income of a GP, which directly explains why this factor is ranked as very important.

The third most important factor for the successful group is: "*Drafting contracts*", which is the critical success factor for practice renunciation. The non-success group did not recognize this as very important. It is not mentioned in the top 5 of most important perceived success factors by them. This could explain why this group is less successful in several ways. First, in the non-success group this factor is significantly more absent than in the successful group. Second, the non-success group doesn't recognize the importance of this factor as much as the success group (importance score 0.56 versus 1.30). So, to improve practice renunciation for GPs, it's not only necessary to draft contracts more often (creating presence of contracts), but also to emphasize the importance of this factor, so that GPs will focus on this factor and will not ignore this factor.

The fourth important factor for the success group is to "*Calculate when and if I can stop my practice*", which is ranked number 2 in the non-success group. This factor has to do with financial planning of a GP. Calculations about income, possession, expenditures and future plans are often conducted by professionals who are specialized in finance. This report shows a GP when he (financially) is able to stop his practice. This is not a "soft-factor" but a real business and financial driven decision and moment. GPs are often not educated about this subject and have indistinctness about the moment that they are financially able to quit practicing. This factor is interrelated with the SPH-pension, income after retirement, which is clearly very important for the departing GP.

The non-success group had two other factors in their top five. First the "*Tax settlement for discontinuation of the practice for the tax administration*". Which is striking, because this factor is present far more in the successful group than in the non-successful group (table 4). However, the ranking of this factor is higher in the non-success group, the score of this factor in the success group is higher than in the non-success group (0.97 versus 0.81). However the

successful groups scored other factors such high that this factor wasn't a top five factor for the success group. Which substantiated the earlier made assumption that the non-success group generally scores the renunciation as less important.

The second factor which the non-success ranked in their top five, while this factor was absent in the top five of the success group was: "*The transfer/change of insurances*". Again the overall score was in favour of the success group, although because of general lower score of the non-successful GPs this is ranked in their top five. This seems to have no significant influence on the level of success in practice renunciation outcome, much focus of GPs on this factor does not seem a good predictor of a successful practice renunciation. Transfer of these insurances seem more side issues which need to be checked but do not seem to influence the practice renunciation process strongly.

7.7 Perceived differences between pre- and post-retirement group

Between the pre- and post-retirement groups the importance of the different factors is also analysed. The significantly differentiating factors are mentioned in chapter results table 8 and table 9 and appendix V. To discuss the six factors they can be divided into two themes. First the theme of practice value and second the theme of practice succession.

Valuation of practice

The first factor that stands out is "*Asking of intangible assets at practice renunciation*". The pre-retirement groups score significantly higher on importance of this factor. This difference can be explained by the "Goodwill fund" which is more absent in the pre- than the post-retirement group¹⁶. As a consequence of the disappearance of the goodwill fund, more GPs are legally allowed to ask goodwill. This higher level of GPs allowed to ask goodwill probably automatically rises importance of this factor for the pre-group versus the post-group. Factor four "*Valuation of intangible assets (calculation of goodwill)*" can be explained the same as this first factor, more importance in the pre-retirement group as a result of the disappearing effects of the goodwill fund. Factor six "*Determining acquisition value of entire practice*" also belongs to the theme of practice value, again the pre-retirement group scores this factor significantly higher than the post-retirement group. It can be concluded that pre-retirement GPs are more interested and concerned with valuation of their practice than their predecessors from some years ago. Which

seems a clear result of the changing environment regarding goodwill and the goodwill fund¹⁵.

Succession of practice

The second significant perceived factor is "*Temporary association of the successor before the practice is fully transferred*", which both groups do not value as very important, although the pre-retirement group seems neutral about this factor while the post-retirement group scores this negatively. This could indicate that the pre-retirement group is more aware or busy with "soft-factors", such as temporary association. The third significant perceived factor is in the same theme as number two, "*After practice renunciation, the former practice holder keeps working in practice as HIDHA/Observer*". Both groups see this as a negative factor, although the post-retirement group is more negative. Combination of factor two and three shows that an intertwined practice renunciation is not very popular, although slow resign of the older GP can perhaps positively influence the success of practice renunciation (table 2). Factor five "*Actively seek potential successor*" is significantly scored higher in the pre-retirement group, which underlines the assumption that the near future retiring GPs are more concerned with their successor and practice after renunciation than the post-retirement group. Perhaps these near future retiring GPs are also more interested in the "soft-factors" regarding their successor and a good transfer of their practice, including their patients.

Altogether it can be concluded that pre-retirement GPs seem more concerned with their future practice renunciation than post-retirement GPs with their past renunciation. Which can be a result of a changing environment of practice renunciation but also with time. Some years after practice renunciation, a GP probably is less concerned with its in the past conducted practice renunciation in general.

Despite the differences between both groups in the height of the scores, they rank the same five factors as most important. (The importance scores of the pre-retirement group remain higher than those of the post-retirement group). It can be concluded that from the GP's perspective these five factors are the most important factors for practice renunciation. Two of them consider themes of finance and income after retirement (*SPH capabilities and the moment to stop practicing*). Two factors consider the theme of successor (*actively seek and check of suitability*

of candidate). The fifth important factor according to the GPs (rank 2 and 4) is “*Drafting contracts (acquisition, partnership, cooperation agreements)*”. This is the critical success factor of practice renunciation of GPs in the Netherlands. GPs seem quite aware of the importance of this (statically) important factor. Despite this observed importance, in about 15% of the practice renunciations this very important step remains absent.

7.8 Goodwill

Paragraph empty concerning confidential information.

8. Recommendations

In this chapter first recommendations for GPs in general are given and which steps for GPs in practice renunciation are necessary. In paragraph 8.2 recommendations for VvAA are described. The first three recommendations are general VvAA recommendations and the next recommendations are applicable on the “proposition practice renunciation”. Last in chapter 8.3 limitations of this study and recommendations for future research are described.

8.1 Recommendations for General Practitioners

The following steps should always be present at practice renunciation to gain a higher chance of successful practice renunciation: **The drafting of acquisition, partnership and cooperation contracts.** By juridical capturing the agreements between both parties the chance of success is increased. The advice is to draft contracts at every practice renunciation. Furthermore if **the possibility for the former practice holder to remain (part-time) working as employer in the practice** is present, the chance of successful practice renunciation will increase. This last advice needs to be discussed comprehensively with the successor and should not be a one-sided requirement of the departing GP.

It is recommended that the following two steps are present and outsourced to gain a higher chance of successful practice renunciation:

First, the **valuation of intangible assets**, which beholds the goodwill calculation, should be outsourced. This way, a more objective calculation is expected and the working relation between the departing GP and his successor will probably be less sensitive if proposed levels of goodwill differ. Also, calculation mistakes will occur less frequent, and the calculated goodwill will probably be a fair amount for the practice.

Second, the **tax settlement for discontinuation of the practice of the tax administration**, which beholds the calculation of the stoppage profit should be outsourced. If this is conducted by GPs themselves, mistakes can be made easily, because of the complicated calculations of stoppage profits. Such (calculation) mistakes can cause problems with the tax administration and even may result into fines for the retiring GP.

Next recommendation for GPs is to start with their orientation on proposed renunciation on time.

Which means that in their late fifties (age 56-58) a GP should start to identify the moment he or she is able to quit practicing (financial planning) in order to avoid negative surprises. With this financial planning in combination with the conceived moment, the GP that wants to transfer its practice is able to formulate a timeline. (*Benchmark near future retiring GPs information: Orientation start average 59.5 years; suitable successor average 61.0 years; Planned practice renunciation 64.6 years*)(chapter 5.3 and appendix VII).

Last recommendation for retiring GPs is to accept the importance of (corresponding) vision of its successor regarding patient care and business management in the practice. If the importance of these “soft-factors” is recognized, identified and analysed, outcome of practice renunciation will probably be influenced positively.

8.2 Recommendations for VvAA

In general VvAA will be able to help GPs with the identified barriers and promote the success factors where possible. Furthermore, VvAA can publish the results of this study. First VvAA consultants can take notice of the results and they might want to adapt their “practice ending proposition” and advises. Next, the GPs could be informed through a publication in the monthly magazine of VvAA and at their “almost retiring as a GP events”.

The first recommendation for VvAA is to develop a tool to identify the match between the departing GP and its successor. This tool should be used to identify the vision of both GPs regarding different subjects of practice renunciation. This tool can identify if a (potential) successor is a suitable candidate. Sensitive themes as attitude towards goodwill can be identified and future problems in practice renunciation can be identified and prevented early in the renunciation process.

The second recommendation is to spread the knowledge regarding the identified significant influencing factors of successful practice renunciation within VvAA, internally. With these factors the consultants can advise GPs more specific, which increases the chance that their practice renunciation develops successfully. Off course all other relevant information regarding practice renunciation identified in this study, should be disseminated within VvAA.

The third recommendation is to use the five identified most important perceived influencing factors in the marketing department of VvAA's proposition for practice renunciation. These are the five factors which the GPs score as "very important" by which marketing can parading with these factors. These factors will appeal to the GPs and acquisition can be improved.

This study focusses mainly on the process of practice renunciation. As in figure 15 is depicted, three phases before the real process of renunciation starts, are important to take into account. VvAA currently has a service for the financial planning and another recommendation one is aimed towards improving the successor evaluation. For the first step, evaluation of psychosocial readiness for practice renunciation of GPs, VvAA has no services yet. Perhaps developing a service/tool to identify readiness for practice renunciation (like the successor footprint) is recommended. This tool should not only evaluate the GPs own readiness but should also be able to identify psychosocial barriers for practice renunciation for the individual who starts the process of renunciation. With it VvAA perhaps can become "first supporter" instead of the accountant.

The following recommendations are applicable and aim to improve the proposition practice renunciation of VvAA. First, the age at which the proposition starts, should be shifted from 55 till 58 years of age. Second, in step one of the proposition (financial planning) the SPH pension possibilities and choices advise should become more extensive enlarged, so that marketing can include this in their communication. Third, if help is offered in searching a successor this should only be offered in step one of the proposition. In later steps only analyses of the suitability of the successor candidate seems relevant.

The last recommendation for VvAA regards proposition building in general. VvAA currently builds propositions for new business based on two inputs: First, input from the consultants (practice) and second by conducting interviews with customers. Last recommendation is to first check retrieved insights with an (online) questionnaire before starting to build new business propositions, provided that relevant quantitative data is missing.

8.3 Limitations of the study and future research

The overrepresentation of group practices, the small underrepresentation of GP's who work in the 'Randstad' and 'non-response bias have been described in paragraph 7.1 on possible bias. The study group (N = 167) is relatively small which limits the degree of generalization of the results. The response rates for both groups of GPs was 32.0% and 49.0% and could probably have been increased by sending a third reminder. Furthermore, the subject of the study might not appeal to all GPs. GPs have a busy (working) life which might have influenced the response rate in the pre-retirement group, while post-retirement GPs are assumed to have more free time. Also perhaps GP's at age 55 aren't interested in their practice renunciation yet. Furthermore, the ranking of level of success by reporting (1-10) is a frequently used measurement, although whether it covers the term "Success" remains unclear.

Last limitation is the lack of theoretical models and literature regarding the process of practice renunciation. This problem was solved by the use of business-renunciation theory with practical information from healthcare studies. This combination forms the basis for theory development of practice renunciation for GPs.

First recommendation is to develop better measure for the construct "Success". Perhaps clustered multiple survey questions can be used to identify a better "Success" construct.

Second, as mentioned above, literature and theory regarding practice renunciation in GPs is missing. With different healthcare systems in different countries, practice renunciation might differ between countries. To build a better theoretical framework regarding practice renunciation in the Netherlands, more studies into practice renunciation in the Dutch healthcare system should be conducted. These studies can support advisers and consultants who assist GPs in their renunciation process. Also, such studies can clarify the practice renunciation process for GPs as well. To gain more generalizable results a larger study group is recommended.

Third, this study focusses on practice renunciation of GPs. Similar studies that include other healthcare professionals (dentists, paramedics, medical specialists) will help to better understanding the process of renunciation in general. Also, segmentation between GPs, i.e.

soloists and partnership GPs, should be further investigated.

Fourth, It is recommended to further study the transition of GPs regarding practice renunciation and the psychosocial barriers they might experience before actual retirement. This research used literature from business owners, but what are specific psychosocial barriers for GPs to retire? This could be an interesting topic for further research. How GPs can cope with these barriers and after retirement, whether and how aftercare should be provided, could further researched.

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