CONTRACTING MODEL FOR LONG-TERM CARE

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Contracting model for long-term care

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I. Preface

Hereby, I present you the thesis “What contracting method could a buying organisation implement in a healthcare service triad”. This thesis finalises the master of Business Administration and my student days at the University of Twente. This research was conducted at Menzis, within the team of healthcare experts, during the period from January 2022 till July 2022. This research consists of contemplation of multiple theories and the effects on the mode of contracting long-term care. Together with the interviews and action research, this research aims to form a base for future contracting models in a healthcare service triad.

This assignment started with a broad research question on what could be a new form of contracting long-term care. Although I was familiar with healthcare contracting, the sheer complexity of Dutch long-term care made it clear that even though this research has come to an end, I have barely scratched the surface by exploring the subject of contracting long-term care. Despite this conclusion, I am grateful for selecting this topic, as it has taught me lessons on contracting in one of the most complex markets. These lessons will likely be of support in my future career as a professional purchaser.

I would like to take the opportunity to thank my supervisors Louise Knight and Frederik Vos of the University of Twente. They provided me with guidance and support, but foremost with the exceptional freedom of choice in this graduation project. Thence, this research feels like a finish to my study time at the University of Twente.

Additionally, I want to thank Menzis and my supervisors David Pruim and Nicole Poldervaart for the opportunity to research the topic of contracting long-term care. I want to thank them for having the patience and willingness to deal with someone completely new to this field. Besides, I want to thank them for facilitating the work sessions, which were of importance concerning the action research. At last, I want to thank all the respondents of the interviews and all the Menzis colleagues for their insights, feedback and support.

I hope you will enjoy the reading!

Sjoerd Pelle

II. Management summary

On the first of October 2020, the court of Den Haag decided that five Zorgkantoren (buying organisations) used invalid methods of reimbursing healthcare providers (Rechtbank Den Haag, 2020). Along with the expected cost growth of 2.8% per year (RIVM, 2020), it was the motive for Menzis to start this research on contracting models, that could assure affordable and available long-term care in the present and the future.

After establishing that the Dutch long-term healthcare market is complex, due to its imperfect market conditions, laws and legislations and conflicting interest. It became apparent that many factors affected the implementation of a contracting method, this resulted in the research question: *What contracting form could a buying organisation implement in a healthcare service triad?*

This research used the method of a literature review to understand the characteristics of the Dutch long-term healthcare market, as well as theories on contracting in a service triad. Experts interviews and action research were employed to provide insights into the interest of all three actors, buyer, supplier and client. Theory and practical insights jointly yielded a set of principles that could be used in a future contracting model.

Although the literature suggested that within a service triad, there would be contrasting interests between the actors (Sengupta et al., 2018). In practice based on the interviews, Menzis and most healthcare providers had the same goal, delivering excellent care and service to the client. Nevertheless, it is still important, to install an appropriate mode of contracting, to align the interest of all actors present in the service triad.

Although there is not one optimal form of contracting. This research recommends a contracting model which incorporates both the honorarium systematic and a form of outcome-based contracting through the use of KPIs. This model is complemented by a social contract, in which common norms, values and goals have been agreed upon. Together with collaboration between the buying organisation and supplier and selective contracting, this contracting model could secure affordable and available long-term care in the present and the future.

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1. Introduction

All citizens of the Netherlands have right on good quality healthcare. Healthcare organisations have to fulfil their duty of care. But this is becoming more and more difficult to realise, as there are problems in the healthcare sector such as a lack of skilled employees, a growing number of clients due to agedness (Menzis, 2019; Ministerie van Volksgezondheid, Welzijn en Sport, 2020) and increasing costs, which will grow from 18,1 billion in 2017 to 67 billion in 2060 (Ooms et al., 2021).

This research will focus on this challenge from the perspective of the buying organisation Menzis. Menzis is a major organisation in the Dutch healthcare sector. It operates as a health insurance company for 2.27 million inhabitants of the Netherlands. Furthermore, it is responsible for the long-term care of clients in the regions Groningen, Twente and Arnhem. This research will focus on the long-term care duty. In the Netherlands, a person can get a WLZ (Wet Langdurige Zorg) indication when he/she needs long-term healthcare, for instance, people with a disability, dementia, mental problems and more.

The role of Menzis is to provide the clients with healthcare that is of good quality. This structure can be defined as a service triad, which is an interplay between a buyer, supplier and client. Where the buyer contracts a healthcare supplier to deliver care directly to the client.

The current contracting model used by Menzis exist of a standard percentage of 92% of the NZA (Nederlandse Zorgautoriteit) tariff, plus a bonus of a maximum of 5,5%, if they fulfil certain requirements of the honorarium list (Menzis, 2019). This contracting model might not fit in the future as the court of Den Haag decided that five buying organisations used invalid methods of reimbursing healthcare providers (Rechtbank Den Haag, 2020). The court of Den Haag argued that the buying organisations could be seen as an public-law organisation, that due to the care duty and huge influence on regional healthcare policy, were bound by public procurement principles (Rechtbank Den Haag, 2020).

On account of the problems present in the Dutch healthcare sector, this research will examine if there are other forms of contracting that could promote the objectives of affordable and available long-term healthcare.

1.1. Research question

What contracting form could a buying organisation implement in a healthcare service triad?

Sub-questions:

1. What is a healthcare service triad?
2. How could a service triad add value for all actors?
3. What type of contracting could improve the overall performance?

1.2. Contributions

The contributions of this research are potentially significant for practice and theory on the future of long-term care in the Netherlands.

The practical contribution of this research is advice to the buying organisation Menzis, on how it could alter its contracting model. This research provides forms of contracting and remunerating suppliers in a healthcare service triad. Besides, it indicates forms of incentivizing suppliers to go the extra mile.

This research contributes to the theory of contracting in service triads. This research and its framework could be reproduced in future research with a focus on (long-term) healthcare or within another setting.

1.3. Context

1.3.1. Dutch healthcare sector

This chapter will discuss the Dutch healthcare sector. As it is complex and evolving, due to an ageing population. The consequence of this event is the growth of more and more elderly people who rely on any form of healthcare. Some of the biggest problems that the Dutch healthcare sector faces are a reducing labour force, increased healthcare expenditures and continuous tax pressure on the labour population (European Commission, 2018b; NPO, n.d.). Everyone in the Netherlands has the right to timely access to affordable, preventive and curative health care of good quality" (European Commission, 2018a).

First a little bit of background information. In 1968 the Dutch government implemented the Exceptional Medical Expenses Act (AWBZ). With this act, the Dutch government wanted to provide care to the general welfare state of the Netherlands. Every citizen of the Netherlands was insured under this act, not only elderly people but for all chronic care in principle, both home care and institutional care (Da Roit, 2012). Most responsibilities were held by the Dutch government, by organising and financing the care (Da Roit, 2012). In 2007 and 2015 the AWBZ was changed and resulted in the existing model where care in the Netherlands is organized through four laws, the 'Health Insurance Act' (ZVW), the 'Long-term Care Act' (WLZ), the 'Social Support Act' (WMO) and the 'Youth Act' (Jeugdzorg) (Ministerie van Volksgezondheid, 2016). As can be seen in figure 1, ZVW is the responsibility of insurance companies. The WLZ is the responsibility of buying organisations. The WMO and Youth act is the responsibility of municipalities in the Netherlands (Ministerie van Volksgezondheid, 2016).

The Dutch Healthcare spending is valued at approximately 91,5 billion euros. Of which on the ZVW 54,4 billion and on the WLZ 30 billion euros (Ministerie van Financiën, 2022). The ZVW is mainly focused on curing diseases and conditions, e.g. hospital care. Every citizen within the Netherlands has the right to ZVW, WLZ, WMO and Youthcare. The ZVW is privately arranged, where there are standard packages that include the most basic healthcare and citizens can take additional insurance at those private insurance companies, e.g. physiotherapy or dentist (Zorgwijzer, n.d.). These private insurance companies are controlled by the NZA on their performance on standards and requirements (Zorgwijzer, n.d.). The WMO concerns less urgent care and can be seen as a supporting role for people who need help in their day-to-day activities to improve their self-reliance (Uenk, 2019). Youthcare is a responsibility of municipalities and

is organised to help minors with problems like family and/or behavioural issues and mental health instability (Rijksoverheid, 2010).

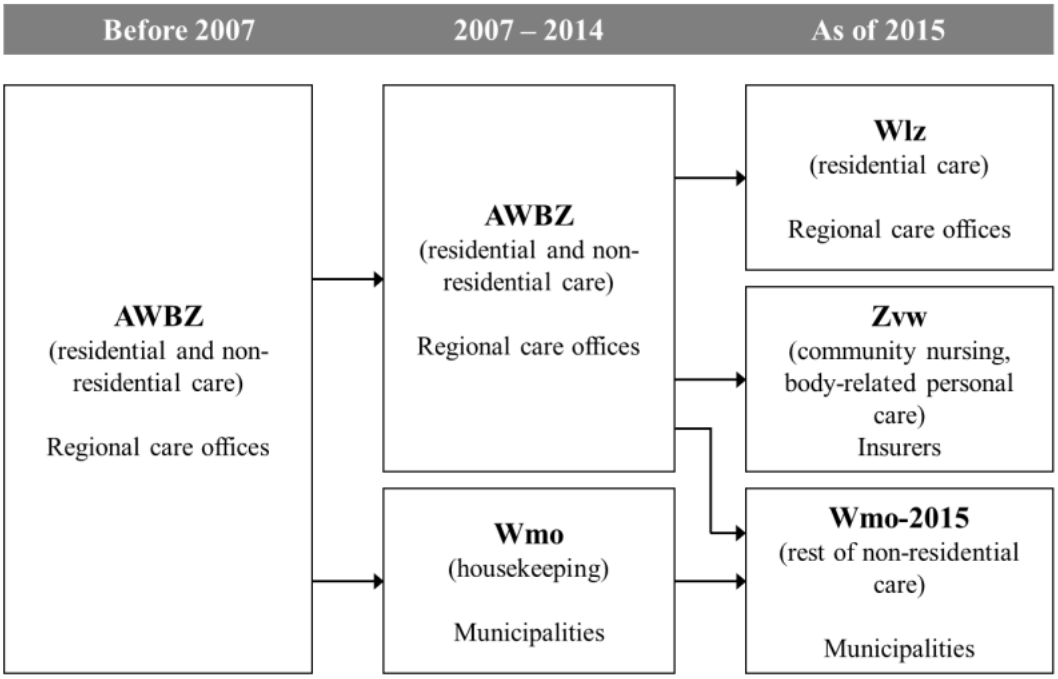

Figure 1: (Maarse & Jeurissen, 2016)

The WLZ focuses on long-term care, which is provided to the client 24/7. Before a client can make use of WLZ care he/she needs an indication from the 'Centrum Indicatiestelling Zorg' (CIZ). CIZ is an independent organization, financed by the Ministry of VWS, which judges if care is needed and to what extent (CIZ, 2022). The type of care and the intensity are expressed in the indication (CIZ, 2022). After this indication, a buying organisation (Menzis) receives the indication from CIZ and will start the process of healthcare allocation for the client.

The WLZ focuses on four primary types of healthcare, nursing care (V&V), mentally disabled care (VG), disabled care (LG) and mental healthcare (GGZ) (CIZ, n.d.). The buying organisations make arrangements with healthcare providers to place the client into one of the four sectors based on their indication. A client can also select his/her care and will request a certain budget from the buying organisation, this is in the form of a personal budget (PGB) (Ministerie van Algemene Zaken, 2014). The buying organisation must fulfil its "zorgplicht" duty of care assigned by the ministry of VWS (NZA, 2021) (ZN, n.d.). This means that the buying organisation has to fulfil the care that the client has the right to receive according to their CIZ indication. Furthermore, buying organisations have the responsibility to not exceed the budget they received from VWS (ZN, n.d.). Thirty-one regions within the Netherlands are divided amongst seven buying organisations. These buying organisations are acknowledged by

the Ministry of VWS to execute the WLZ in their appointed region. Menzis is responsible for three regions, Groningen, Twente and Arnhem. Other buying organisations are Zilveren Kruis (11 regions), VGZ (7 regions), CZ (6 regions), Zorg en Zekerheid (2 regions), DSW (1 region) and Salland (1 region (NZA, 2020).

1.3.2. The complexity of the WLZ sector

The buying organisations must provide sufficient healthcare to the clients with a long-term care indication, contemporaneously it should not cost excessive amounts of money and should be available and affordable for future clients (NZA, 2017). To fulfil this obligation each buying organisation receives a budget specified to the indications of the clients based in that region, this is allocated by the NZA after the ministry of health (VWS) has determined a budget (NZA, 2021).

In total has NZA 29,981 billion euros to divide amongst the buying organisation, of which is 26,550 billion can be divided in the usual way, 3,131 billion euros to pay for the personal budget (PGB) and 300 million euros to be used as "herverdelingsmiddelen", which are funds that are been used to counteract shortages (NZA, 2021).

The NZA calculates the maximum tariffs that buying organisations can pay to healthcare providers. Nevertheless, if all buying organisations would pay the maximum tariffs to the healthcare provider the budget would not be sufficient (NZA, 2021). Thence the court ruling explicitly states that buying organisation does not have to pay the NZA maximum tariff (Rechtbank Den Haag, 2020). The buying organisation estimate the costs involved with the long-term care and uses this calculation in the price agreements with the contracted healthcare providers, the price agreement is set as a percentage of the maximum NZA tariff (Menzis, 2019).

1.3.3. Current contracting model

This section will elaborate on the current procurement model of Menzis through an analysis of the purchasing framework WLZ 2019-2023 (Menzis, 2019). In this framework, Menzis explains its policy on remunerating and the organisational interests regarding WLZ care.

The contracted providers get a standard percentage of 92% of the NZA tariff. Above this selected percentage by Menzis, the healthcare provider can receive additional percentile points, up to 5,5 per cent if they meet certain requirements provided by Menzis. Through this method, Menzis wants to incentivize the healthcare providers to implement certain actions, e.g. learning places for students.

Besides, within the purchasing process, Menzis has some mechanisms that can be implemented to keep the costs within the budget. Menzis can adjust the financial compensation for all healthcare providers if they analyse that the current remuneration percentage per healthcare provider is not sufficient, through an unexpected increase of WLZ clients. Then Menzis will deduct a specific percentage for all healthcare providers per rate (Menzis, 2019).

The contracting model used by Menzis has a duration of five years, as Menzis wants to highlight the importance of strategic partnerships with its healthcare suppliers. The current model used by Menzis can be characterised as a fee-for-service (FFS) model, which is a payment model that pays the healthcare provider for each unit of services, such as a visit or surgical procedure.

FFS tends to promote overuse of the more expensive kinds of care, including surgery, often without the real need (Tulchinsky & Varavikova, 2014). FFS payment structures promote higher volumes of service delivery, as providers have an incentive to produce more healthcare service deliveries. Under the FFS model, the provider is at risk for the delivery of the service, not for the client's health outcomes or the total treatment costs (Conrad, 2015). This is especially so when the client is fully covered by health insurance and is therefore better able to pay for the service than the person without insurance. Some insurance systems require the participation of the user in the co-payment (Tulchinsky & Varavikova, 2014).

While healthcare providers working on an FFS have stronger incentives, these incentives are often not aligned with the client's needs due to asymmetric information between the clients and providers (Kremer & Glennerster, 2011). Furthermore, clients are often not capable of deciding what good quality health care delivery is, this is a problem even in countries with strong regulatory systems. Sometimes healthcare providers give treatments that do not improve the overall health of the client in the short and long-term period. Healthcare providers in an FFS health care system also have no incentive to consider the consequences of treatment on others in the community, negative as well as positive. Many of the most cost-effective health approaches are preventive, these are underprovided as healthcare providers are not incentivized to deliver them (Kremer & Glennerster, 2011; Hunter et al., 2021). Some clients do not receive enough care in an FFS model, underuse of care is four times more present in the US compared to overuse of service delivery. This takes forms like limited access to healthcare, unaffordable treatments, and slow implementation of innovations (Hunter et al., 2021). Cost-related problems of the FFS model are associated with four primary problems. A lack of transparency in the healthcare service delivery and the associated payment structure. There is no accountability for healthcare outcomes in an FFS model. Provider pricing power is a major

drawback, the provider can make up its tariffs and thereby steering up the total cost of care. And last, huge administrative costs, as each separate service delivery is adjudged (Hunter et al., 2021).

Difference between the healthcare sector and private sector

Some aspects differentiate the healthcare sector from the private sector. Although both sectors can make money, this focus is sometimes overruled as client well-being is seen as more important (Boyne, 2002). Besides, the healthcare sector can be seen as an imperfect market and there are more monopolistic structures. When compared with many private markets this competition is more fierce for certain services and products and this requires that healthcare organisations often have to collaborate (Jones et al. 2013; Selviaridis & Spring, 2018; O'Flynn, 2019). Companies active in the healthcare sector have to deal with more formal procedures for decision-making and are therefore less flexible and more risk-averse relative to the private sector (Bozeman and Kingsley 1998). Due to these complexities, effective management of contracts in the healthcare sector makes it an interesting field of study.

2. Theoretical framework

Theories and methodologies employed

When conducting a literature review the use of different theories may lead to different interpretations of the findings. Therefore this research will review some theoretical perspectives used in service triads and purchasing literature, such as transaction cost economics, resource dependency theory, relational view, social exchange theory and agency theory on their applicability for this research.

Stakeholder theory

Stakeholder theory could provide this research with some insightful information on key stakeholders in the service triad. Based on Freeman (1984), stakeholder theory became a popular concept in management theory. Since Freeman's work, the stakeholder theory has been used to describe and analyse the relationship between organisations and society. A well-known definition of stakeholder theory by Buchholz and Rosenthal (2004) explains the concept as "those persons or institutions that have a stake, something to gain or lose as a result of the corporation's activities". Examples of stakeholders are consumers, governments, suppliers, competitors, communities, employees, and stockholders (Buchholz and Rosenthal 2004). The basic idea of stakeholder management is to take into consideration the interest and concerns of the primary stakeholders. To satisfy these crucial stakeholders' interests. It is the moral obligation of the company to strike a balance among the stakeholders' interests in directing the activities/operations of the firm (Buchholz and Rosenthal 2004).

Social network theory

The social network theory/social exchange theory focuses on the buyer-supplier interaction. This theory assumes that market exchanges between buying organisations and suppliers can involve economic and social outcomes. It provides a new perspective on opportunism and rejects the assumption of maximizing own gain. "Social capital theory, then, specifies a relation by distinguishing between structural, relational and cognitive forms of social capital "(Zijm et al., 2019). Within service triad literature the social network is widely used to capture the network aspects (Sengupta et al., 2018). Especially concerning the structural holes present in social networks. These gaps in connections provide opportunities for individuals who can bridge the gap and link the two disconnected networks together (Wynstra et al., 2014). This bridge position is central in Li & Choi (2009) *Triads in Services Outsourcing: Bridge, Bridge Decay and Bridge Transfer*.

Agency Theory

In service triad literature, Agency Theory is often used as it provides a theoretical basis for the effective designing of the client-provider contractual arrangements (Wynstra et al., 2014). It describes how the relationship between the principal and agent operates most efficiently (van der Valk & van Iwaarden, 2011). In the principal-agent problem, the interest of the principal differs from the interest of the agent (Jensen & Meckling, 1976). Service triads reflect a unique agency situation as they consist of three parties instead of two, which involve high information asymmetry and goal differences (Sengupta et al., 2018). The buying company is in a service agreement with the client and an agency agreement with the supplier. Furthermore, the supplier has to deal with two principals, the buying company and the client, each of which might have contrasting interests (van der Valk & van Iwaarden, 2011; Sengupta et al., 2018).

Agency Theory builds on specific assumptions about whether suppliers can be expected to act in the best interest of the end customers, or are likely to display opportunistic behaviour. First, regarding human nature, self-interest and bounded rationality and risk preferences (Broekhuis & Scholten, 2018). Second, interest differences between principal and agent may lead to information that is kept secret, resulting in information asymmetry. Third, organisation relates to the fact goal congruence between principal and agent reduces the risk of opportunistic subcontractor behaviour (van der Valk & van Iwaarden, 2011).

Justification of chosen theory

Within the service triad literature, there are two main theories used to describe the actors in a service triad. These can be defined as the Social network theory and the Agency theory (Sengupta et al., 2018). This research will use both of them, the social network theory and/or stakeholder theory to understand the needs and wants of all actors (Buchholz and Rosenthal 2004). Furthermore, this research will use the Agency Theory as it is used to design effective contracts and relationships between all three parties, that provide fair outcomes for the buying organisation, supplier and customer (Tate et al., 2010; Conrad, 2015).

This research will use the stakeholder theory of Buchholz and Rosenthal (2004), to clarify the relationships between the different stakeholders, as well as the primary interest of all three actors, buying organisation, supplier and client. It is important to understand the needs of all actors present in the service triad to establish satisfaction for all. Agency Theory is used as it provides a theoretical basis for the effective design of the principal-agent contract in this research (van der Valk & van Iwaarden, 2011; Wynstra et al., 2014).

2.1 What is a healthcare service triad?

Service triad literature is a relatively new topic, introduced by Li & Choi (2009). A service triad can be defined as a situation where a buying organisation contracts a supplier to deliver services directly to the buyers' customers. In this structure, all actors have a direct connection with each other (van der Valk & van Iwaarden, 2011).

2.1.1. Service triads

The health and social care market differ from traditional markets, both in structures of supply and demand. In traditional markets, the demand side is both customer and financer and the supply side is the producer and seller of the service (Lapré & van Montfort, 2001). In care markets, this process is more complicated as there is a third party that is organised to finance the market. This market can be described as a service triad, in which a buyer (Menzis) contracts with a supplier to deliver services directly to the buyer's customer (Lapré & van Montfort, 2001; Li & Choi, 2009) in which the supplier interacts with the buyers' customer (van Iwaarden & van der Valk, 2013).

Within the long-term care market, there are three kinds of parties active, the client, healthcare provider and the buyer (Menzis). A unique characteristic of the triadic structure is that all actors have a direct connection with the other two, these can be constant or intermittent (Li & Choi, 2009; Wynstra et al., 2014), besides there is a direct contact between subcontractors and customers which is a unique element of triads (van der Valk & van Iwaarden, 2011). The relationship structures of the three parties in the service triad are not constant, they change over time. First, there is a structural hole, where the end customer and healthcare provider have no contact and do not share information. Here the buying organisation serves as a bridge between the supplier and the client during the pre-contract (Sengupta et al., 2018). This bridge position, which is providing information and monitoring advantages, can ultimately shift to the supplier (Li & Choi, 2009; Uenk, 2019).

When the contract is in place, the service provision by the supplier starts and this creates a link between the end customer and supplier. In this phase, the buying organisation loses the bridge position to the supplier and therefore loses information benefits. Therefore, buying organisations should always monitor supplier performance to deal with agent opportunism (van der Valk & van Iwaarden, 2011). According to Li & Choi (2009) investing in communication with suppliers and customers will yield valuable information on how the supplier performs. This minimizes the possibility of opportunistic behaviour of the supplier and enables the buyer to better control the performance of the supplier.

Concluding, a service triad can be explained as a market where a buyer (principal) contracts with a supplier (agent) to deliver services directly to the buyer's customer (Lapré & van Montfort, 2001; Li & Choi, 2009). Within this setting there should be a form of monitoring supplier performance to deal with agent opportunism (van der Valk & van Iwaarden, 2011).

2.1.2. Contracting and monitoring in service triads

A topic that rarely has been studied in the context of inter-organisational service triads relates to the selection and use of contracts (Wynstra et al., 2014). Where the alignment between two parties can be difficult, the inclusion of a third party and its interest makes the contract process even more complicated (van der Valk & van Iwaarden, 2011; Wynstra et al., 2014). Organisational theories, particularly Agency Theory identify two main alternative types of contracting, behaviour-based contracting and performance-based contracting (Jensen & Meckling, 1976; Eisenhardt 1989). Agency Theory could be used to determine what type of contract will motivate suppliers to act in the best interest of the principals. The contract or Service Level Agreement between the buying organisation and the supplier should reflect the interests that the buying organisation needs to realise for the client (van der Valk & van Iwaarden, 2011; van Iwaarden & van der Valk, 2013). These formal contractual arrangements are negotiated upfront in the contracting phase, where parties build up their expectations that need to be satisfied after the contract is in place (van Iwaarden & van der Valk, 2013; Broekhuis & Scholten, 2018). In the contract management phase, contractual governance can help assure compliance with the agreements made between the buying organisation and the supplier (van Iwaarden & van der Valk, 2013). Through contracting all parties can coordinate and monitor roles and responsibilities, specification and operation of information sharing as well as decision-making and feedback processes (Broekhuis & Scholten, 2018).

Van der Valk & van Iwaarden (2011) and Broekhuis & Scholten (2018) argue that it is highly important to establish a social contract between buyer and supplier, as it steers the supplier toward the desired behaviour of the principals. Aligning all three parties in the triad through the right contract and monitoring is beneficial for the buyer, client and supplier. This is easier achieved through social contracts than legal arrangements. Furthermore, Broekhuis & Scholten (2018) concluded that buyers and suppliers in a service triad prefer flexibility, a cooperative attitude and a willingness to exchange information. This positively influences how the contract is perceived in terms of depth and completeness.

Concluding, it is important to establish formal contractual arrangements so all parties can coordinate and monitor roles and responsibilities after the contract is in place (Broekhuis &

Scholten, 2018). In addition the establishment of a social contract between buyer and supplier is beneficial, as it steers the supplier toward the desired behaviour of the principals (Van der Valk & van Iwaarden, 2011; Broekhuis & Scholten, 2018).

2.1.3. Incentivizing suppliers in service triads

Another method of aligning interest between the healthcare provider and the client is through incentivizing. Incentives are used to counter opportunistic behaviour and increase control over service quality (Uenk, 2019). These incentives should be included in a Service Level Agreement (SLA) where certain agreements could be written down which will motivate suppliers to act in their customers' interests (van der Valk & van Iwaarden, 2011; Broekhuis & Scholten, 2018) Healthcare providers could be incentivized to deliver better performance when client health benefits are linked with provider income (Conrad, 2015). Furthermore, continuous improvement should be rewarded incrementally to the healthcare provider, instead of all or none thresholds (Conrad, 2015).

Direct involvement by the buying organisation could provide a mix of trust and control in a supplier relationship (van Iwaarden & van der Valk, 2013). Jones et al. (2013) argued that "with the proper client protections, provider collaborations that incorporate incentives that reward efficiency and quality can be in the best interest of the client, provider, and payer". They propose a set of criteria that could make the healthcare sector more innovative, of higher quality and more accountable. Most healthcare sectors are reimbursed per diem per client, but this should change towards a method of rewarding healthcare providers for improved outcomes and client satisfaction, there should be a clear link between payment and service value (Jones et al., 2013).

Studies show that the complexity of services has a moderating effect on the relationships between incentives and supplier performance (Zou et al., 2019). This indicates that the more complex a service delivery gets, the greater the role and impact an incentive can have on good supplier performance. As services become more complex, the associated risk for buyers increases as well. Incentives come into play by aligning risk sharing between the parties and motivate them to act according to the contract and deliver better performances. Therefore, the incentive structure helps the buyer succeed in purchasing complex services (Zou et al., 2019).

Behavioural economics suggests that a penalty of a given size for not fulfilling the advanced health benefits or quality will more strongly encourage healthcare providers to deliver improved health outcomes/quality compared to an equally large reward (Conrad, 2015). This implies that

gains or losses increase the response of the provider. Besides, in theory, the incentive power of loss aversion is greater than that of reward-seeking (Conrad, 2015). Penalties should be introduced carefully alongside rewards to steer providers into an improved service delivery (Conrad & Perry, 2009; Van Herck et al., 2010). However, penalties should not be so large that they trigger a counterreaction among the providers in a direction, that they will replace the lost income by underperforming on different service deliveries or other hazardous behaviour (Conrad, 2015) O'Flynn (2019) proposed an incentive structure based on a relational perspective, where a supplier will react based on motivational drivers. The four motivators partially explain the behaviour of the agent. Whereas many outsourcing mindsets rely on views of human behaviour and therefore tend to rely on reward and sanction models as a model to exercise extrinsic motivations. However, they argue that human motivations are more diverse and a match of motivations and motivators is central to an effective relationship between buyer and supplier (O'Flynn, 2019).

Uenk (2019) analysed competition in the procurement of WMO. As it is like public procurement principles and a result of cutting budgets. Competition is in the form of tendering, where a health care provider can make an offer with a specified price and quality. This is assessed by the municipality and a provider is chosen (Uenk, 2019). " Other forms of competition in social care contracts can be introduced by awarding framework agreements without any guaranteed volume of turnover. Individual clients choose their care provider and this determines the contract value for care providers". In this market, healthcare providers compete with each other over individual clients. In combination with a switching possibility, this could result in a strong incentive for the healthcare provider to provide services of a good quality (Uenk, 2019).

Mechanisms that could promote better competition in the healthcare sector are improved symmetrical information on quality, outcomes and prices. As individuals are in a disadvantaged position about information. A health plan could offer publicly available information on prices, outcomes and quality (Conrad, 2015). Effective competition requires managing fairness of the healthcare plan and guidance towards unbiased risk selection (Conrad, 2015)

Risk management in service triads can largely be explained through the Agency Theory. It may help stipulate the contractual safeguards to minimize the risk of the buyer and client from opportunistic behaviour of the supplier (Wynstra et al., 2014). Perverse incentives could give rise to undesirable supplier behaviour (Wynstra et al., 2014). Furthermore, all parties must be transparent about their capabilities, aims and aspirations. If a party would make assumptions

about capabilities this could negatively affect the clients' needs (Wynstra et al., 2014; Broekhuis & Scholten, 2018). Both risks could diminish service quality delivery as well as reputational losses of the buying firm (Wynstra et al., 2014). Supplier risk could also be minimized through supplier quality management. Audits, evaluation, rating, improvement projects, certification and training. All could improve the quality of the delivered service (van Iwaarden & van der Valk, 2013).

Concluding, the primary role of incentives is to align the interests of the principal and agent. Incentives help aligning risk sharing between the parties and motivate them to act according to the contract and deliver better performances (Zou et al., 2019). These incentives can be positive in the form of a gain (bonus) or negative in the form of a loss (penalty). Competition in healthcare markets might be a useful incentive although it requires managing fairness and guidance towards unbiased risk selection (Conrad, 2015)

2.2. How could a service triad add value for all actors?

This chapter will discuss how a buying organisation can create a setting wherein all actors active in the service triad perceive the system as valuable. Based on the stakeholder theory of Buchholz and Rosenthal (2004), this research will clarify the relationships between the different stakeholders as well as their primary interests. This is complemented by the service-dominant logic (SDL) as it can be used to explain how actors in a system can be sources of value creation, by integrating resources coordinated through the service exchange (Storbacka et al., 2016).

2.2.1. Interest buying organisation

The main interest of Menzis is to guarantee long-term care in the present and in the future which is of good quality and thereby fulfils the clients' care request. Secondary interests are reducing the cost of care, as well as improving the total quality of care. Purchasing can have secondary interests such as improving employment conditions, industry strengthening, regional involvement, diversity, innovation and sustainability (Telgen et al, 2007; PPRC, 2022a). This interest of Menzis on its WLZ policy can be summarized as a focus on three main themes (Menzis, 2021):

· Improving the perceived quality of care and well-being of the client.

· Improvement of care, together with healthcare providers and clients.

· Realising suitable care for clients as fast as possible, to save costs.

Primary interest of Menzis is to deliver appropriate care for all long-term care clients. This should be in line with the procurement rules as the court of Den Haag argued in October 2020 that the model used by five buying organisations was invalid (Rechtbank Den Haag, 2020). Menzis was excluded as they used long-term contracts, whereas the five sentenced buying organisations used contracts with a duration of one year. The judge acknowledged that buying organisations can offer a lower tariff than the one set by NZA, with the prerequisite that the tariff is properly explained and arguments are provided which explain why the tariff is reasonable (Rechtbank Den Haag, 2020).

The decision of the judge gave some direction towards what kind of contracting model should be used as the court indicated that institutions such as buying organisations are obligated to act according to the procurement principles "aanbestedingsbeginselen'' and can therefore be seen as public law organisations (Rechtbank Den Haag, 2020), such as a municipality, hospital or university. Although the buying organisations have to follow the public procurement principles it is not obligated to pay a price that is cost-effective for all providing organisations (Rechtbank Den Haag, 2020), healthy management is the responsibility of the provider (VNG, 2017).

On that account, this section will highlight how a public law firm has to respect the tender law as it might provide Menzis direction in its procurement of long-term healthcare. If an organisation fulfils the following criteria it will be seen as a public law organisation. First, the organisation has a specific goal, fulfilling the needs of common interest. Second, the organisation should be a legal personality, in which it is financed by a state, province, municipality or other public law organisation or it is supervised by a contracting service (Pianoo, n.d.-a). The court of Den Haag decided that buying organisations should be recognized as a public law institution and therefore should act according to the tender law and its principles. These principles "aanbestedingsbeginselen'', are composed of five main aspects:

- Non-discriminatory: Public law organisations should provide equal opportunities to all companies that want to enrol in a task (Ministerie van Economische Zaken, 2017).
- Equal treatment: Public law organisations should treat all companies that can fulfil the requirements of the task equally (Ministerie van Economische Zaken, 2017).
- Transparency: Public law organisations should provide clear-cut information to all companies (Ministerie van Economische Zaken, 2017).
- Proportionality: Public law organisations should put in place requirements that are in proportional relationship to the contracting (Ministerie van Economische Zaken, 2017).

- Should not contravene competition: Public law organisations should not hinder competition by designing tasks that prejudice/benefit certain companies (Jengibarjan, 2021).

Concluding, based on the literature the primary interest of the buying organisation can be defined as guaranteeing long-term care in the present and the future which is of good quality and thereby fulfils the clients' care request. Secondary interests relate to cost efficiencies and the improvement of the long-term care sector.

2.2.2. Interest supplier

Based on the Agency Theory, the interest of the principal differs from the interest of the agent (Jensen & Meckling, 1976). Within the service triad, there are two principals, the buying organisation and its end-customer/client. The agent in this triad is the healthcare supplier. Given the self-interest of the agent, it may or may not have behave as agreed. The agency problem arises because the principal and the agent have different goals and/or the principal cannot determine if the agent has behaved according to the contract (Eisenhardt, 1989

The basic logic is that an individual provider wants to maximize a combination of income and client health benefits. These are both influenced by the quantity of service delivery and the quality of the service (Conrad, 2015). Based on the assumptions of the Agency Theory one could assume that the interests between the buying organisations and supplier differ.

Based on the literature review, primarily Agency theory, this research concludes that the interest of the healthcare supplier is to maximize its gain (Jensen & Meckling, 1976). A thorough understanding of the interests of the healthcare supplier can not be retrieved from the literature review and therefore need to be answered through expert interviews and other forms of data collection.

2.2.3. Interest client

As mentioned before, service triad literature is a relatively new topic and there is not much theoretical work done on healthcare contracting in a service triad. Therefore this section will discuss potential methods of improving the total quality of healthcare service delivery.

Fundamental in this research is to understand what are the interests of the clients. “Value in health care is measured by the outcomes achieved and value for consumers, also increasingly includes the quality of the client-family experience and interpersonal interactions. (Clark, 2018). Conrad (2015) defines value as the maximum health benefit at a minimum cost, better value is a combination of improved health outcomes, clinical quality, better client experience

and a reduced amount of cost associated with the total care delivery. Service quality measurement can be difficult due to the special characteristics of service delivery, e.g. intangibility and personal interaction (Lemon & Verhoef, 2016). An example of service quality measurement tools is the quality framework from the Leyden Academy (2019) which incorporates the well-being demands of clients, family members and nurses/practitioners. The primary focus is on the well-being of the client through caring instead of curing. The findings of this research were, that if the relationship between the client and practitioner improves the well-being of the client also increases, which is the primary interest of healthcare (Leyden Academy, 2019).

Aggarwal et al. (2019) argue that quality is the totality of features and characteristics of care. They argue that the quality of service provided to clients is highly crucial and if possible should be prevented. Furthermore, it should be continuous improved and outcome-based guided by the clients' needs. They perceive a healthcare system of good quality when it is accessible, appropriate, available, affordable, effective, efficient, integrated, safe and client-related (Aggarwal et al., 2019). The ultimate goal of quality assurance programs is high client satisfaction, which requires client-centred care and compliance with standards and protocols. Furthermore, shared decision-making could improve client satisfaction in a mode where practitioners and clients make decisions together using the best information available (Aggarwal et al., 2019).

In line with the findings of Leyden Academy (2019), Stolk-Vos (2022) argues that the quality of healthcare perceived by the client exist of different parameters. Stolk-Vos (2022) found five main themes that affect the perceived quality of the clients with chronic uveitis: disease symptoms and treatment, diagnosis and treatment process, impact on daily functioning, emotional impact, and treatment success factors. Furthermore, Stolk-Vos (2022) found that a trained coordinator could help in improving the accessibility, the interdisciplinary monitoring of disease activities, ensuring timely and accurate referral and the management of in-between visits questions. Also providing information and clear communication could help minimize the uncertainty clients experience about short- and long-term disease outcomes. And last Stolk-Vos (2022) suggests that better alignment with clients about the risks and benefits of specific types of medication could provide the clients with more control and understanding of their treatment.

Concluding, based on the different views on quality in healthcare service delivery, quality can be seen as the totality of features and characteristics of care that bears on its ability to satisfy given needs (Aggarwal et al., 2019). The central needs are focused on the well-being of the

client, family members and healthcare personnel, focusing on caring instead of curing (Leyden Academy, 2019). A good quality healthcare system incorporates the needs of all parties involved, the client, the supplier and the buying organisation. Therefore, information on all three parties is needed to establish a complete understanding of the needs of the clients, healthcare providers and Menzis. This information will be gathered through the interviews with client experts, purchasers and policy makers.

2.3. Contracting in the healthcare sector?

2.3.1. Contractual theory

Contractual theory helps in explaining the functionality of a contract and its associated challenges and opportunities. Fundamental in contractual models is the inclusion of incentives for service providers. A contract is put in place when a principal desires an outcome, which is delivered by an agent. All contracts carry the risk that the agent will act in their interests rather than those of the principal. By focussing on the outcome, the principal expects the agent to behave according to the contract. It is expected that opportunistic agent behaviour such as withholding information, shirking, failing to fulfil promises will be minimised (Sanderson et al., 2017). Characteristics of the services and the service market can make the use of incentives difficult (Sanderson et al., 2017). Asymmetries can affect the contracting of services and therefore can increase transactional costs between principal and agent (Sanderson et al., 2017). Transaction costs consist of the costs of negotiating, specifying and drafting a contract and monitoring costs (Sanderson et al., 2017). From a relational view perspective, trust, flexibility, solidarity and reciprocity can help sustain a contractual relationship. Especially trust is associated with a mechanism of managing risk (Sanderson et al., 2017).

Relational contracting

The role of contractual and relational governance has received much attention from service procurement literature. Literature and empirical studies have shown that companies must have appropriate contractual and relational capabilities to write, interpret and manage complex service contracts (Zou et al., 2019). Relational governance consists of frequent review meetings between the buying organisation and the service providers. Changing service specifications during the contract period. And revising the contract if it is necessary for the buying organisation and/or supplying firm (Zou et al., 2019).

The relational approach has been linked with complex problems. It is argued that due to the complexity these relationships between buyer and seller require more integration and

connection. Getting relational means rethinking the relationship and organisational forms. This trend in policy change is present in the governments of the UK and Australia, which perceive the outsourcing perspective as a poor fit. An approach with higher levels of cooperation and mutual interest could foster a long-term strategic relationship (O'Flynn, 2019).

Most companies understand that their suppliers are critical partners in lowering total costs, increasing quality, and driving innovation, but when the contracting phase begins the management turns into an adversarial mindset and focus on a transactional contracting approach (Frydlinger et al., 2019). Many contractual clauses are implemented which harm flexibility and foster negative behaviours that affect the relationship between the two parties. Frydlinger et al. (2019) propose a different approach, a formal relational contract with the focus on win-win. This approach is similar to the vested methodology which focuses on "a formal relational contract that specifies mutual goals and establishes governance structures to keep the parties' expectations and interests aligned over the long-term" (Frydlinger et al., 2019). This relational contract is designed to foster trust and collaboration among the parties, which is useful in complex situations, in which it is difficult to assess the what-if scenario (Frydlinger et al., 2019). This vested methodology is explained by Vitasek et al. (2010) in their book *Vested outsourcing, five rules that will transform outsourcing.*

2.3.2. Contracting forms

Outcome-based contracting

Outcome-based contracting or, Value-Based Health Care (VBHC) is a theory developed by Porter (2008), where he describes how the healthcare system should be changed in the United States of America. He perceived the US healthcare system as profit-driven, with a high incentive to produce. He came up with four essential principles that would positively impact the healthcare system in the US. Although his research is focused on hospital care, it provides some interesting insights.

- A high-value system can only work if the client value is seen as the primary goal. Improving value can be seen as an increased outcome per unit of cost. Minimizing/reducing cost ultimately lead to higher cost in the long run as smart investments are postponed.
- Care should be organized around the way value is created. Value is created in the total care of a client's medical condition and his/her full cycle of care.

- VBHC requires a method of measuring value. Without measuring outcomes and costs at the medical condition level, it is difficult to improve, even with the best of intentions.
- Contracting/payments should be linked with value creation for the client.

Porter (2008) argues that competition in health care should focus on matching clients to providers who produce the best outcomes. Value-based purchasing (VBP) is designed to stimulate better clinical outcomes and improved client experiences during treatment. Improved quality benefits all, it reduces the overall cost and it identifies healthcare problems before they can harm the client (Aggarwal et al., 2019). This change puts enormous pressure on hospitals, as VBP creates a competitive environment in which hospitals must compete with each other on their ability to effectively and efficiently cater to and satisfy the increasingly complex demands of clients (Bradley et al., 2018).

This pressures the providers to specialise their teams in a field of expertise. When a healthcare provider sees volume and experience in a medical condition, it can afford to cover most of the care cycle to allow optimization of overall care. With scale and experience, a provider can afford dedicated facilities tailored to a specific job, which can be done efficiently and effectively. VBHC requires a measurement tool to reimburse the healthcare providers. First-tier outcomes have to do with the health status. Second-tier outcomes relate to the client experience. Third-tier outcomes involve sustainability issues and relate to the consequences of the treatment.

Van der Valk & van Iwaarden (2011) propose that an outcome-based contract is more likely to lead the agent (healthcare provider) to behave in the interests of the principal (buying organisation and client). Outcome-based contracts build on measurable effects (Eisenhardt, 1989). When the principal is more interested in the process of the service and outcome interests are difficult to measure, behavioural contracting should be used (Eisenhardt, 1989; Uenk, 2019). Broekhuis and Scholten (2018) recommend buying organisations include both performance and behavioural-based contractual terms that relate to the customer experience when contracting in a service triad. In outcome-based contracts, indicators that are more controllable and relatively cheaper should be more important in the payment structure (Conrad, 2015), such as client experience and clinical quality (process). Furthermore, clinical evidence shows a strong link between the process and health outcomes (Conrad, 2015).

One way of assessing how a client perceives a healthcare delivery is through the measurement of client satisfaction. Measuring satisfaction also serves as a mode of quality improvement and quality audit. It is essential to realize the clients' needs and collect information on the clients' perspectives on service delivery to further improve care management and promote the service quality of given healthcare providers (Rivers & Glover, 2008). The major concern regarding the use of client satisfaction to measure representative service quality is those health organisations and/or buying organisations, view the clients' evaluation as incorrect or biased (Rivers & Glover, 2008).

Although the work of Porter (2008) on Value-based Healthcare (VBHC) has been a subject of interest in many types of research, it does not provide a practical tool which can be implemented in a healthcare setting to obtain the interest of maximum client value. van Veghel et al. (2018) propose such a model in which they define a new reimbursement approach in which the quality of the care is remunerated instead of the volume. They noticed that a pay-for-performance model should replace a pay-for-service approach. This Dutch research integrated many of the core principles of Porter's work. Results of their study indicated that the aligned outcome-based model had a positive effect on shared targets, inter-organisational trust and client value. Along with the principle of Porter, the improved delivery of care has been remunerated, according to the contract, with a financial incentive.

The model of van Veghel et al. (2018) introduces client-relevant outcomes, it applies to all selected outcome measures, including short-term and long-term outcome measures. By remunerating a healthcare provider in the short-term and long-term, this model pressures healthcare providers to take accountability for the well-being of the clients in the entire care delivery chain.

To implement an outcome-based remunerating model it is crucial to be transparent with all involved actors, buying organisations, suppliers and clients. The input for the measured outcomes should be based on scientific knowledge and/or customers' needs.

Customer choice model

A potential instrument that could allow competition in healthcare is the "persoonsvolgende bekostigingsmethodiek" Menzis has incorporated this policy in its purchasing framework (Menzis, 2019), it can be seen as a sort of customer choice model which is implemented in Danish long-term care. The Danish government implemented the customer choice model to create competitiveness among healthcare providers, not on basis of price, but on the quality of

care (Kruse et al., 2021 p.52) or non-price aspects (Goddard, 2015). Under customer choice models, service users choose from a list of providers assembled by the local authority, on the assumption that competition for users will drive quality improvement among providers (Bertelsen & Rostgaard, 2013). This mechanism can only work in competitive care sectors where clients have a direct choice of provider (Goddard, 2015). Within the Danish model, the healthcare providers are monitored on their competencies, instead of extra administration (Kruse et al., 2021 p.66). This framework provided by Bertelsen & Rostgaard (2013) opens up the discussion on the customer choice and its effect on the objective of affordability and availability of long-term care.

Although customer choice models could provide beneficial value for individual clients. It might be excluded from a variety of contracting models because of contradicting elements. As clients are not asked to select based on strategic decisions, because they lack the expertise to gauge quality and efficiency. Instead, they look at observable issues such as waiting times, convenience, and the particular procedures they require (Greer et al., 2020). Furthermore, clients are often not capable of deciding what good quality health care delivery is, this is a problem even in countries with strong regulatory systems (Kremer & Glennerster, 2011). " Perhaps the limited choice is more appropriate and acceptable than numerous choices. In other words, addressing the needs of an individual on a one-to-one basis will ultimately benefit or disadvantage the individual or society as a whole" (Zolkefli, 2017).

Performance-based contracting

Outcome-based contracting or performance-based contracting has been debate in this research on its effectiveness and suitability within the healthcare market. Outcome-based contracting can be differentiated from other contracting types, because of its focus on aligning goals and incentives across the whole supply chain. It works by increased risks and rewards for suppliers as performance achievement is related to financial bonuses and penalties, with an emphasis on the co-production of outcomes through customer/supplier interactions (Sanderson et al., 2017).

Performance-based contracting (PBC) is an attempt to move human service contracting away from its historical reliance on input and process design specifications towards a favour of output, quality and outcome performance and leaving the process up to the supplier (Martin, 2005). PBC appears to accomplish its interest and thereby changing the behaviour of contractors to focus on performance due to incentives linked with the performance (Selviaridis & Norrman, 2014). These contract forms can involve outputs but do not require that contractor compensation is only linked with performance (Martin, 2005; Selviaridis & Wynstra, 2014).

PBC can only work if the outcomes are measurable (van der Valk & van Iwaarden 2011). When the measurability increases, the attractiveness of the PBC model also improves (Selviaridis & Norrman 2014). Performance is seen as a vital dimension of PBC together with incentives and risks. This requires an extensive measurement, reporting and evaluation of the performance when designing and managing PBC (Selviaridis & Wynstra, 2014).

Benefits of PBC include increased efficiency, improved spending accountability, innovation, budget flexibility and value for money (Selviaridis & Wynstra, 2014). From the supplier's perspective, the PBC benefits are connected to a better understanding of the expectations (Selviaridis & Wynstra 2014). The more the incentive system is related to performance, the more accurate and precise data of performance should be monitored (Martin 2005) Although this might be difficult and costly (Selviaridis & Norrman, 2014). Here, IT can be seen as a great tool for data collection and performance measurement systems (Selviaridis & Norrman 2014). Coordinators should invest in accurate information systems and develop capabilities and skills in collecting and analysing service data as well as measuring service supply chain performance (Selviaridis & Norrman, 2014).

A criticism of PBC is that it leads to "cherry picking". Suppliers will focus on clients that are the easiest to serve and will avoid those clients that are the hardest to serve, due to financial reasons (Martin, 2005). Furthermore, buyers and suppliers can also struggle to align interests, especially in triadic relationships, where buying organisations tend to think about what end customers want instead of asking them, which further leads to contradicting expectations (van der Valk & van Iwaarden 2011).

Population-based contracting

Population-based contracting in healthcare markets involves a risk-bearing party such as a healthcare provider group, a hospital or another payer, which administers the contract and assumes the risk for contractually defined services. These contracts can be structured in many ways about their reimbursement. The healthcare service provider can receive a specified remuneration per member per month, or periodically receive an agreed-upon percentage (Jacofsky, 2017).

The population-based contracting model is assumed to have stronger effects on the interest of cost-reduction compared with bundled payments as providers bear the risks to the population's health. Population-based contracting prevents the fundamental problem that exists both in FFS contracting and bundled payment models, namely the production incentive (Jacofsky, 2017).

"Of all the contracting varieties, population health management is the largest paradigm shift with the largest upside if managed well" (Jacofsky, 2017). From a healthcare provider perspective, cost reductions are achieved in the most successful mode through early detection and prevention programmes. A major problem in population-based contracting as well as bundled payments is the incentive to withhold care from clients that are more likely to be on the higher levels of cost, also known as 'cherry picking' (Jacofsky, 2017).

Summary of contracting forms

Contracting forms	Definition	Benefits	Drawbacks
Fee-for-service (FFS)	The fee-for-service model is a payment model that pays the healthcare provider for each unit of service	The model is easy to understand and implement.	FFS payment structures promote higher volumes of service delivery and do not focus on client health outcomes. Furthermore, many of the most cost-effective health approaches are preventive, these are underprovided.
Value-based Healthcare	Contracting and incentives are linked with be linked with value creation (outcomes) for the client, in VBHC/outcome based contracting.	An outcome-based contract is more likely to lead the agent (healthcare provider) to behave in the interests of the principal	The model does not provide a practical tool. Furthermore, outcomes are difficult to measure in the long-term healthcare market.
Customer choice model (CCM)	Under CCM, service users choose from a list of providers, on the assumption that competition for users will drive quality improvement among providers.	Competition based on the quality of care could provide beneficial value for individual clients, with a focus on monitoring competencies, instead of extra administration.	Can only work in competitive care sectors where clients have a direct choice. Besides, clients are often not capable of deciding what good quality health care delivery is.
Performance-based contracting (PBC)	Performance-based contracting (PBC) is an attempt to move human service contracting towards a favour of output, quality and outcome performance and leaving the process up to the supplier.	PBC changes the behaviour of contractors to focus on performance due to the linked financial incentives and penalties. It can have a positive effect on increased efficiency, improved spending accountability, innovation, budget flexibility and value for money.	PBC can only work if the outcomes are measurable. Aligning interest might be difficult and suppliers will focus on clients that are the easiest to serve "cherry picking".

Population-based contracting	Within population based contracting the healthcare service provider receives a specified remuneration per member per month, or periodically receive an agreed-upon percentage	The healthcare service provider bears all the risks. Which has a strong effect on the interest of cost reduction and the production incentive.	A major problem is the incentive to withhold care from clients that are more likely to be on the higher levels of cost.

2.3.3. Mechanism

Competition in healthcare markets

One of the most intensely debated topics in healthcare markets is the role of competition (Goddard, 2015). Competition can add value as healthcare providers compete with each other to deliver maximum value for each euro spent (Porter 2008; Westra et al., 2017). In ‘’perfect’’ markets where buyer and supplier meet in an exchange relationship, there can be competition based on price and quality. Healthcare markets can be characterised as ‘’imperfect’’ markets and therefore many argue that the market should be regulated (Goddard, 2015). This research will discuss competition based on non-price aspects of care such as quality, as a race to the bottom through cost competition is seen as unwanted by all parties (VNG, 2017; Uenk, 2019). Competition based on price can lower price-cost margins, which can in turn reduce suppliers' incentives to provide high quality to attract additional clients (Katz, 2013). Goddard (2015) observed that in markets where a price/tariff is fixed by a regulator the main competition focus is based on quality and non-price aspects of the service (Goddard, 2015).

This view on quality competition is shared by Porter (2008) in his value-based health care (VBHC) he argues that competition in health care should focus on matching clients to providers who produce the best outcomes. He argues that the client is in the best position to determine what is quality to him/her and how it is established in his/her full cycle of care, although this could be doubted. Furthermore, he argues that reducing cost ultimately lead to higher cost in the long run as smart investments are postponed to someone else responsibility. Reducing cost is in itself not a bad thing, but it should not impoverish the quality of the care, as a race to the bottom is seen as unwanted by all parties (VNG, 2017; Uenk, 2019). And lastly, contracts with healthcare providers should be linked with the value creation for the client (Porter, 2008).

Duration of the contract?

The selection of a contract and its duration is a crucial phase in contract development. The problem has generally been discussed in terms of a trade-off between the flexibility offered by short-term contracts and the price uncertainty reduction achievable by using long-term contracts

(Johnsen et al., 2021). In changing markets where technology evolves fast, a buyer will likely implement short-term contracts to get the best price possible from its supply base (Merckx & Chaturvedi, 2020). However, short-term contracts might not incentivize the supplier to make investments that can reduce its production cost. Conversely a longer-term contract is a better mode to incentivize the supplier to invest in cost reduction strategies as it is assured of future business. Hart et al. (2015) add that long-term contracts are efficient when parties make relationship-specific investments that affect their own (financial) performance. Merckx & Chaturvedi (2020) investigated within a reverse auction or Dutch auction setting if short-term contracts or long-term contracts were in the better interest of the buying organisation. They found that a buyer typically favours long-term contracts when the supply base is small. On the contrary, for larger supply bases the buyer is in a better position to leverage competition through short-term contracts. Their research came with two implications; the issues of contract length and supply base size are interrelated and the investment dimension should be incorporated in the joint decision of the contract length and the supply base size (Merckx & Chaturvedi, 2020). Johnsen et al. (2021) found that long-term contracts seem to be more robust than short-term contracts because supplier commitment will likely be higher. This commitment comes in the form that buyers reveal their true cost types and this reduces the likelihood of contract rejections in later periods. While there may be other elements that influence the choice of the contract type the study of Johnsen et al. (2021) suggests that using long-term contracts could also reduce coordination problems and fairness issues that negatively affect the effectiveness of contracts.

Hart et al. (2015) propose another form of duration, a continuing contract is a contract which uses the first period contract as a reference point and this can sometimes be a useful compromise between a long-term contract and a short-term contract. This contract type will perform relatively well in markets that are not due to big changes, this implies for the healthcare market. In a continuous contract parties will act in good faith and will apply the notions of fair dealing.

Supply base alignment and cooperation

Alignment of supply bases can have a positive effect on the performance and relationship between supplier and buying organisation. Alignment can be achieved through integrating processes, collaborating and sharing information and making performance the main priority by translating them into specific interests and measures. Supply base performances can only occur by aligning supply chain members through incentives. That is where contracts can have an impact on the relationship between the buying organisation and the supplying firm (Selviaridis & Spring, 2018). Buyers could use pay-for-performance/outcome-based contracts to align the

suppliers' compensation with the required outcomes and therefore increase the likelihood that a supplier will act according to the wishes of the buying organisation. These incentives can take various forms e.g. a bonus/malus or a gain-/pain-share mechanism (Selviaridis & Spring, 2018).

These mechanisms can affect the counterparts' ability to learn about each other exchange perceptions and behavioural responses (Selviaridis & Spring, 2018). A contractual provision such as outcome-based contracting can be framed as a gain, a bonus/reward, which is likely to promote creativity, flexibility and a collaborative relationship. Alternatively, it can be framed as a loss, or financial penalty, which can induce careful behaviour, close monitoring and an arm's-length relationship (Selviaridis & Spring, 2018). O'Flynn, (2019) proposes other forms of coordination. Supervision relies on instructions. Classical contracting relies on incentives and competition. And negotiation relies on flexible agreements. Relationships are often dynamic and therefore they might change over time or in response to behaviour (O'Flynn, 2019). Therefore, continuous learning and communication are important to trigger re-framing of provisions to stimulate positive responses and foster collaboration among the actors (Selviaridis & Spring, 2018; O'Flynn, 2019).

Critical in developing relationships between actors is the development of high levels of trust among the stakeholders in the network. This improved trust will foster a better flow of information and help in the creation of a contestable environment where actors can move away from overly legalistic contracts towards a form of contract with more autonomy and accountability for the delivery of services (Migone, 2018).

Shared savings

Several countries have introduced a gatekeeping system to manage the increased demand of costs associated with healthcare. Current payment models do not provide the additional resources necessary for maintaining a client-centred perspective, nor do they incentivize care providers to act upon their role of managing costs and quality (Hayen et al., 2015). "Incorporating a shared savings program does reward taking accountability for overall costs and quality results, and could thereby improve the sustainability of the primary care setting" (Hayen et al., 2015). Shared savings are especially useful in the Dutch case of long-term care as clients enrol for a longer period, thereby the healthcare provider will have a long-term perspective on shared savings. The healthcare provider will not cut the edges in the short term when it knows that costs may occur in the longer term. Hayen et al. (2015) came up with a shared savings model that incorporated quality measures as well as cost savings. A healthcare

provider is responsible for providing good quality, which is measured in four aspects, client satisfaction, chronic care, drug prescription behaviour and practice management. The healthcare provider is assessed on a scale from 0% (worst) to 100% (best). In case a provider scores 70%, it will receive 70% of the sharing rate of savings (Hayen et al., 2015). For instance, a cost saving of 5% will result in a shared saving of 3.5% for the healthcare provider.

By sharing in potential total cost savings, the payer intends to prevent providers' from overtreating and overprescribing healthcare. The strength of the incentive increases when the provider expects a higher share of cost savings (Weitzman, 1980) and when it achieves the saving. A higher sharing ratio creates more incentive for the provider to reduce costs. But it also makes the contractor bear more risk, requiring a greater fixed fee or standard payment, as compensation for bearing the risk (Weitzman, 1980). These shared savings models could be one-sided only savings, with no downside risk for providers. Or two-sided with both shared savings and shared downside risk (Conrad, 2015).

Selective contracting

Within the Dutch healthcare setting, the government chose regulated competition where healthcare insurers were allowed to select hospitals based on quality and price. Furthermore, they were allowed to negotiate volumes and prices with the selected hospitals. The Dutch government believed that this would ensure better universal access to affordable care of good quality. One aspect of this decision was that selective contracting would stimulate efficiency, effectiveness, innovation and would reduce overcapacity (Ineveld et al., 2018).

The aim of selective contracting is to stimulate competition between care providers, with the effect that only the best providers will be present in the business. There are certain options that a care provider can take, comply and stop the treatments if they do not reach the threshold volume. Enlarge their volume through increasing market share or cooperation with other care providers. Ineveld et al. (2018) discovered that most care providers chose the option to cooperate with other care providers and by this method, they would fulfil the volume requirements. These initiatives resulted in increased coordination among the care providers in several ways: expanding cooperation into other treatments and disciplines, deepening their agreement by guidelines and protocols, and formalizing their agreements into contracts (Ineveld et al., 2018). Although the government assumed that selective contracting would stimulate competition, more efficiency, effectiveness, innovation. This did not occur and led to a

strengthened strategic position of the care providers, who choose to negotiate with each other in a clear win-win spirit in their network (Ineveld et al., 2018).

Bundled payments

The fee-for-service model is the most used remuneration model in health care markets. But due to the lack of incentives to improve quality, it can result in overtreatment, waste, and avoidable complications. Although scientific evidence on bundled payments is limited it provides a perspective on remunerating suppliers with the aimed effect of such contracts on cost containment and quality improvement (Steenhuis et al., 2020). A bundled payment can be viewed as a periodic lump-sum payment for a range of services delivered by one or more providers with a focus on outcomes. These bundled payment models can be expanded with shared savings and/or shared-risk components. The strength of a bundled payment model is the shift in financial and clinical accountability from the buying organisation to the single provider (Conrad, 2015). Through this shift, the providing organisation is incentivized to coordinate all the care across the total cycle of care and therefore it will limit the amount spent on services, deliver appropriate care, and further align their interests with the payer's interests, with the possibility to provide it in different ways due to the increased flexibility (Steenhuis et al., 2020). This requires extensive collaboration among the payer and provider as well as amongst the providers, with a focus on the clients' full care cycle. Limitations of the bundled payment model are privacy issues regarding information sharing, difficulties regarding criteria definition and opportunistic behaviour (Steenhuis et al., 2020), as well as issues about accountability in unforeseen complications (Conrad, 2015). Implementing the bundled-payment model has proven to be difficult due to its conceptual limitations (Conrad, 2015).

Collaborative KPI

To address problems associated with principal-agent relationships Akkermans et al. (2019) came up with a type of buyer-supplier contract that would minimise behavioural uncertainty and moral hazard. They propose a collaborative KPI contract that addresses the challenge in a buyer-supplier process by accounting for the performance of both actors, buying organisation and supplying organisation. The model provides two main advantages. "First, by defining, incentivizing, and measuring the quality of processes at both the supplier and the buyer, collaborative KPIs can resolve the predicament of implementing performance-based contracts" (Akkermans et al., 2019). Second, identifying the service together helps the buying and supplying organisations to understand each other's interdependency and therefore promote collaboration by focusing on the performance outcomes of the supplier as well as the buying

organisation. Together with contracts, trust, and relational norms they jointly reduce opportunistic behaviour and enhance relationship performance and satisfaction (Akkermans et al., 2019). For supplying firms, mutually agreed KPI can decrease the perceived risk (Selviaridis & Norrman 2014).

Akkermans et al. (2019) have designed the collaborative KPI contracting approach, as a process for developing buyer-supplier relationship performance indicators that promote collaboration by focusing on outcomes. That measures supplier and customer performance and which are defined in a collaborative process. The following four mechanisms collectively explain the successful implementation of this service outsourcing contract.

- Stakeholders on both sides showed a genuine willingness to engage in the new process.
- At the operational level, systemic thinking and modelling facilitated integral process understanding.
- The collaborative design fostered consensus and commitment by both parties.
- Incentives were linked through collaborative KPIs.

Summary mechanisms

Mechanism	Benefits	Drawbacks
Incentives	Healthcare providers could be incentivized to deliver better care, with lower associated costs. Incentives help align risk-sharing between the buyer and supplier and motivate them to act according to the contract and perform better.	Incentives structures should be designed so that negative incentives and ‘cherry picking’ of easier clients can not be occurring. Not all agents act upon financial incentives.
Competition (incentive)	Competition can add value as healthcare providers compete with each other to deliver maximum value for each euro spent. This stimulus could work in markets where a price/tariff is fixed by a regulator, the main competition focus is based on quality.	In ‘’perfect’’ markets where buyer and supplier meet in an exchange relationship, there can be competition based on price and quality. The Dutch healthcare market can be characterised as an imperfect market.
Current model	This contracting mechanism uses the honorarium list to provide incentives to healthcare providers to improve the overall quality of provided care to the client.	Some problems with regards to its applicability and flexibility in the future.
Duration of contract	In changing markets where technology evolves fast, a buyer will likely implement short-term contracts to get the best price possible from its supply base. A longer-term contract is a better mode to incentivize the supplier to invest in cost reduction strategies as it is assured of future business. And also reduces coordination problems and fairness issues that negatively affect the effectiveness of contracts.	Short-term contracts might not incentivize the supplier to make investments that can reduce its production cost. Long-term contracts might be inflexible and create lock-in situations.

Supply chain alignment and cooperation	Alignment of supply chains can have a positive effect on the performance and relationship between supplier and buying organisation. Through integrating processes, collaborating, sharing information and prioritizing performance	Supply chain performances can only occur by aligning supply chain members through incentives. Through a bonus/malus or a gain-/pain-share mechanism High levels of trust are required
Shared savings	Incorporating a shared savings program does reward taking accountability for overall costs and quality results. Especially useful in the long-term care as the healthcare provider will have a long-term perspective on shared savings.	The contractor bears more risk and will therefore require a greater fixed fee, as compensation for bearing the risk.
Selective contracting	Selective contracting could stimulate efficiency, effectiveness, innovation, cooperation and could reduce overcapacity.	Some healthcare providers got a better strategic position in the market, negative effect on competition.
Bundled payments	The strength of a bundled payment model is that it shifts accountability from the buying organisation to a single provider who is incentivized to coordinate the total cycle of care and therefore will limit the amount spent on services.	It requires extensive collaboration among the payer and provider as well as issues regarding information sharing, quality criteria definition and opportunistic behaviour.
Collaborative KPI	The collaborative KPI develops buyer supplier relationship aiming on collaboration by focusing on outcomes from both parties.	Both stakeholders have to show a genuine willingness to engage in this novel and high-risk process.

3. Research design

This research will use three types of methods to answer the research question. It will use a literature review, expert interviews and action research. The method of literature review was chosen to refine and frame the research question. The literature review establishes familiarity with the current research on the Dutch healthcare, service triads and contracting. The method of experts interviews was used as "It provides exclusive insights into expert knowledge" (Monke, 2007). The expert interview is a frequently used method in empirical social research with the aim of discovering a person's insider knowledge (Monke, 2007). Action research was selected as a research methods as it aims to provide the organisation with reliable and valid data about the topic (Ørngreen & Levinsen, 2017).

3.1. Literature review

The method of a literature review will be used to analyse the Dutch healthcare sector and the current contracting policy used by the buying organisations. This will be done through an analysis of empirical and academic literature. The empirical analysis will contain a review of (internal) policy documents of Menzis with the primary role of establishing an understanding of the status quo of the Dutch healthcare sector. Part of this analysis is the survey of Menzis on the assessment on the current contracting model by the healthcare suppliers. This survey existed already and contains qualitative and quantitative data on the assessment on the current model used by Menzis. Within this assessment the healthcare providers provided potential improvement points and they addressed their needs and wishes.

The academic literature will be found through the Scopus platform, as it reveals peer-reviewed articles of potentially relevant journals. Those journals were scanned and relevant articles were examined and processed in this research. Topics of the journals were policies used by buying organisations in the Netherlands as well as abroad. These buying organisations can be active in the healthcare sector as well as in other (public law) domains. These published materials can provide an examination of recent or current literature. In addition this literature review provided new insights and sources through the snowball method. This literature covers wide range of subjects at various levels of completeness and comprehensiveness (Grant & Booth, 2009). The strength of a literature review is that it can be done relatively quickly compared to a systematic literature review for instance. A weakness linked to that characteristic is that because of the shortened time quality assessment the risk of using biased or poor-quality studies increases (Grant & Booth, 2009).

Step 1: Inclusion criteria: The inclusion criteria and the various keywords were identified to search and select the relevant articles from Scopus. Keywords included *service triads, agency theory and the healthcare sector.* Database filters were used to exclude journals that were not relevant and accessible. Only research articles that were published from 2009 till now were considered relevant as the starting year because service triads and related issues were introduced during this year by Li and Choi (2009).

Step 2: Selection based on the title and abstract. Titles and abstracts were reviewed to eliminate articles that did not focus on contract management in a (healthcare) service triad.

Step 3: Selection based on full text. In the last step, this research refined a list of selected articles after reading the full text. Then, this research used a backward tracking approach to check if previous work done could elaborate on service triads in the healthcare sector. In total the three-step procedure yielded 26 articles of which five were useful to establish a foundation of service triads in this research (van der Valk & van Iwaarden, 2011; van Iwaarden & van der Valk, 2013; Wynstra et al., 2014; Sengupta et al., 2018; Broekhuis & Scholten, 2018)

3.2. Expert interviews

This research will use expert interviews to provide answers to two different sub-questions. First, interviews will be used to understand what the interests of the buying organisation, supplier and client are and this will be discussed in sub-question two: *How could a service triad add value for all actors?* Second, this research will use expert interviews as a mode to discuss contracting methods and mechanisms that have been presented in the literature review and sub-question three: *What type of contracting could improve the overall performance?* As these proposed contracting types can be new to the field of healthcare purchasing there might be crucial information that could hinder the application of such a contracting form. Therefore expert interviews are used to examine if the proposed contracting principles/concepts could be implemented. Furthermore, the experts could provide new insights that could improve the relevance of this research as experts know specific operations, laws, routines and have subjective interpretations of relevance and beliefs (van den Audenhove, 2011). As this research focuses on the service triad network it will use interviews to get information from a variety of stakeholders; buying organisations, providers and client interests. The participants were specifically approached and chosen through the non-probability sampling method, which implies that not all members of the population had an equal chance to be involved in the sample (Babbie, 2016). The chosen sampling method is acceptable as not all members of the population

have an acceptable knowledge of the Dutch healthcare sector and/or long-term care sector (Babbie, 2016).

Research population

- Six purchasers/contractors
- Five policy makers
- Three client experts/supporters
- Two project managers
- One data analyst
- One Financial expert
- One IT specialist

The function of the interviews

Sub-question two will be partly analysed through interviewees that could explain what the interests of one-or-more actors in the service triad are. Based on the Agency Theory this research assumes that each actor has a different interest. Therefore it is wise to conduct (small) research on the interests of the actors to verify or break down this assumption, this could be in the form of an interview and/or existing data on the actor's interest.

Sub-question three will be partly analysed through interviewees that could explain the potential opportunities and challenges associated with (new) forms of contracting in the healthcare sector. This will be done by interviewing experts at Menzis, the relevance of these interviews is to extend knowledge on implementing new forms of contracting types.

Sub-question two and three could partly be explained through a literature review. Yet, information on the subject is too limited to answer the questions specifically aimed at the healthcare sector. This requires knowledge which is accessible through performing interviews with healthcare/contracting experts, who work with the material daily. Without the interviews the findings of this research will be too general and therefore not relevant for a buying organisation, operating in a healthcare service triad.

Interview protocol

To gain an understanding of the interviews, this section will explain the interview protocol. For a thoroughgoing understanding of all interview questions see Appendix A and B. First of all, there were two general questions:

- What is your position/role in relation to the company's organizational structure?
- What does your job entail?

From here, the following questions were asked with regards to the stakeholder interest, buyer, supplier and clients perspective:

- How much influence does the stakeholder have?
- What exactly is the stakeholder's interest?
- What do they need?

With regards to the relationship and structure of the market:

- Can you briefly describe the service supply chain (i.e. customer, provider and key sub-contractors)?
- Can you briefly provide an overview of customer/supplier relationship in focus?
- What are the main issues/challenges you face regarding the management of the business relationship?

With regards to the design of the contract:

- How is “customer value” defined?
- How is performance defined in the customer/supplier contract in terms of service outputs/outcomes (e.g. KPIs/SLAs)?
- How is financial and operational risk allocated in this specific customer/supplier contract?
- What is the payment mechanism/model included in the customer/supplier contract and why is it included?
- Does the payment mechanism include bonus/penalty payments? If yes, how are these linked to performance?
- What is the duration of the contract?

With respect to contract management:

- How are key “outputs”/“outcomes” measured and managed?
- How is performance evaluated and reported?
- How does the payment/incentive structure impact on customer/supplier behaviour?
- Have you adjusted the payment scheme and associated incentives?
- What are the key challenges and problems in managing the customer/supplier contract?
- What is the role of trust and collaboration facing the formal contract in managing the business relationship?

Final questions:

- Access to complementary documents?

- Suggestions for other interviewees and/or research issues?
- Is it okay to come back for further questions?

The utilisation of the interview

To ensure that this research and the interviews meet the ethical standards of the BMS faculty, ethical approval was completed in advance. Interviews had a duration of approximately 45 minutes. Nineteen interviews were conducted until saturation occurred at the seventeenth interview. Saturation is the moment in which no further themes occur in the data, or new information gets (Guest et al., 2006). All interviews will be recorded and transcribed (Amber script) with the approval of the interviewees, afterwards, they have been made anonymous and coded with ATLAS.. As this research was coded by one person through ATLAS, there could be researcher bias. To counteract this bias, the data has been coded twice, to increase the credibility and confirmability of the research. The approach of Krefting (1991) was used, which uses a minimum of two weeks intervals after which the data should be coded over again. This research uses the approach developed by Braun and Clarke (2006).

- Familiarization: getting familiar with the data which is worked with.
- Coding: highlighting sections of the text on their content.
- Themes: selecting different codes to a theme to identify patterns.
- Reviewing themes: checking if everything is accurate and themed.
- Define themes: give each theme a name/colour.
- Writing: write the report.

The six-phase method of Braun and Clarke (2006) requires an extensive engagement of the researcher as themes have to be defined. A theme is " an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations" (DeSantis & Ugarriza, 2000). Or are features of participants' particular perceptions and/or experiences that the researcher sees as relevant to the research question (University of Huddersfield, n.d.). Themes can be defined in advance, based on a conceptual framework, or afterwards after conducting the interviews. This is in line with the work of Braun and Clarke (2006) who indicate that in thematic analysis new themes can be unfolded, while some themes have already been disclosed in the literature review and/or conceptual framework.

The thematic analysis has revealed eighteen initial codes. After organising the codes through inter alia merging similar and deleting irrelevant codes, which were then assigned to fiveteen overreaching categories of codes.

Initial codes	Mentioned	Categories
Collaboration	24	✓
Current policy	22	✓
Customer-choice model	7	
Domain-transcending	15	✓
Flexibility	13	✓
Idea/interpretation	11	
Incentives	22	✓
Information	18	✓
Duration	10	✓
Interest buying organisation	8	✓
Interest healthcare supplier	9	✓
Outcome-based	20	✓
Patient value	18	✓
Penalty	5	
Relational contracting	17	✓
Risk	19	✓
Selective contracting	11	✓
Volume-bundling/ population based contracting	12	✓

This research follows a qualitative mode, which can be defined as an "iterative process in which improved understanding of the scientific community is achieved by making new significant distinctions resulting from getting closer to the phenomenon studied" (Aspers & Corte, 2019,). Qualitative research can be characterised as being compromised of non-numeric data, whereas quantitative data uses numeric data. As this research has an exploratory character, interviews can quickly become haphazard and irrelevant. Therefore the interviews will be semi-structured, with an advanced made list of questions and the list of possible intervention methods. Within the interviews, there will be room for a contribution of the interviewee and his/her point of view on the different intervention methods.

3.3. Action research

This research will make use of a form of action research to answer sub-question three: *What type of contracting could improve the overall performance?* Action research can be defined as "an arrangement whereby a group of people learn, acquire new knowledge, perform creative problem-solving, or innovate about a domain-specific issue" (Ørngreen & Levinsen, 2017). This form of data collection adds value to this research as the sessions are conducted by experts within the domain, and they promote genuine participation. The goal of the action research is to create an outcome, e.g. generation of new insights, suggestions, or redesigns of a product, process, or innovation (Ørngreen & Levinsen, 2017). "Action research combines theory

(researchers) and practice (practitioners) through change and reflection in an immediate problematic situation" (Avison et al., 1999). In the process of action research, the researcher tries out a theory with the practitioners and gains feedback from the experience. This iterative process adds value to the theory and practices each time when it is executed

The role of the researcher is to actively provide theoretical advice to the practitioners and thereby gain relevant discussions and reflections on the problem (Avison et al., 1999). Within the action research, the scientist will exercise multiple roles following the guidelines of Wittmayer & Schäpke (2014). Primarily focused on the action issues, where the scientist facilitates the process and participates in the process and experiments. Furthermore, the scientist supports in policy formulation and observes, reflects and analyse the actions.

The composition of the action research team is kept small to allow everyone personal attention and the chance to be heard. The list of participants mentioned below includes experts from the host organisation Menzis and different domains of expertise.

- Project manager: responsible for managing the development of innovative projects, such as the creation of new contracting policy.
- Contracting expert: responsible for contracting and monitoring of healthcare suppliers.
- Financial expert: responsible for the financial affairs with healthcare suppliers and other organisations such as the NZA.
- Juridical expert: responsible for all legal matters of Menzis. This domain of expertise is useful with respect to the public procurement principles and tender law.
- Policy expert: responsible for the creation of new policy on long-term care contracting.
- Client representative: responsible for daily contact with clients, therefore knows much on the needs of the long-term care clients.

Using action research as a research methodology is an especially useful approach, in studies that are emerging and unpredictable (Ørngreen & Levinsen, 2017). Action research aims to provide the organisation with reliable and valid data about the domain in question. Moreover, action research could also be used as a qualitative segment of a mixed-method research design, which is usually accomplished through interviews (Ahmed & Asraf, 2018). The relevance of the use of multiple modes of data collection can be explained through the concept of triangulation. Triangulation is a method used to increase the credibility and validity of the research findings (Noble & Heale, 2019). Credibility refers to how believable the study is and

validity relates to the extent to which a study accurately reflects the concept being investigated (Noble & Heale, 2019).

Memo

When conducting action research, researchers should explain their approach and its application. The research will be evaluated on its ability to explain the practices occurring in the research setting. Therefore documentation of the research process is critical (Avison et al., 1999). This research will make use of the method of memos. Memo writing is an analytical process that is essential in ensuring quality in grounded theory (Chun Tie et al., 2019). Memos are little storehouses of ideas generated and documented in the interaction with the data, they provide detailed records of the researchers' thoughts, feelings and intuitive contemplations (Chun Tie et al., 2019). Memos can be summarized as informal analytical notes about the data (Chun Tie et al., 2019). Through the process of memo writing the researcher analytically interprets the data, discovers relationships, and develops theories about these patterns (Hull, 2014; Chun Tie et al., 2019).

4. Results

This chapter will describe the results from the sub-questions one, two and three. Sub-question one: *what is a healthcare service triad?* has been analysed and answered in the literature review. To make the findings of sub-question one comprehensible for readers who have not looked at the literature review, a small conclusion has been added in this chapter.

Sub-questions two and three have been examined through the interviews and the action research at Menzis. The interview sessions have been recorded, transcribed and coded. The action research has been documented through memo writing. The findings of both data collection methods will be highlighted in this section.

4.1. What is a healthcare service triad?

The answer to sub-question one is provided in the theoretical framework. The summary below is created to provide a concrete answer.

The healthcare market is different from traditional markets, both in structures of supply and demand. In traditional markets, the demand side is both customer and financer and the supply side is the producer and seller of the service. In healthcare markets, this process is more complicated as there is a third party that is organised to finance the market. This market can be described as a service triad, in which a buyer contracts with a supplier to deliver services directly to the buyer's customer. In triads, buying companies are dependent on the performance of the supplier, who controls the service delivery. Therefore, the buyer needs to take certain measures to ensure that the service delivery is provided in an appropriate mode. Frequently, Agency theory is used to evaluate the design of effective contracts and relationships between all three parties. These contracts should provide fair outcomes for the buying organisation, supplier and client. The main assumptions of the Agency Theory are human nature, self-interest and bounded rationality. Service triads reflect a unique agency situation as they consist of three parties instead of two, which involve high information asymmetry and goal differences, e.g. the supplier has to deal with two principals, the buying company and the client, each of which might have contrasting interests. Concerning contracting, Agency Theory could be used to determine what type of contract will motivate healthcare suppliers to act in the best interest of the principals. Formal contractual agreements can coordinate and monitor the roles and responsibilities, as well as other organisational processes. Meanwhile, social contracts might help in aligning all three parties in the triad through the right contract and desired behaviour.

Aligning interest is commonly done through installing incentives, which are used to counter opportunistic behaviour and increase control over the service quality.

Concluding, a healthcare service triad is an interplay between a buyer, supplier and client. Where the buyer contracts a healthcare supplier to deliver care directly to the client.

4.2. How could a service triad add value for all actors?

This section will highlight how a service triad can add value to all actors present in the system. These views have been derived from the interviews with experts at Menzis, such as policymakers, client panel experts, client supporters and (senior) purchasers. Alongside the surveys of the healthcare providers, this section will provide a view of the interests of all three actors present in the healthcare service triad.

4.2.1. Healthcare provider

Although Agency Theory assumes that the interest of the different actors differs from each other. Most respondents, especially purchasers, indicate that the buying organisations have the same goals as the healthcare provider most of the time. But there were differences between the motivations of different healthcare providers, some are more focussed on the internal motivation, delivering excellent care for their clients, concerning the budget. Others were more focused on external motivations, e.g. making as much profit as possible. Overlap in interests of many healthcare providers and Menzis is a preference for a long-term contract to assure that the agreements are respected now and in the future. Menzis surveyed the healthcare providers and found the following results for their current policy.

Concerning the contracting model, healthcare suppliers provided the following suggestions:

- They would like to see a policy which fits more appropriately to the present day. For instance due to the COVID-19.
- More attention to the differences between providers, the honorarium list makes no differentiation between the healthcare providers and all are treated the same.
- The honorarium list should have fewer items and some of these items should be updated as they do not incentivize anymore, e.g. a digital client dossier has become the standard but it is still remunerated.
- Menzis should have more notice for the GGZ (mental healthcare).
- The healthcare suppliers would like to see more collaboration with Menzis, this collaboration should change and innovate the long-term care in the region.
- This collaboration would also be domain transcending, e.g. with municipalities.

- Extra money for innovation and development of healthcare providers.
- A common approach to dealing with labour shortages, as this is a primary problem in the sector, especially staff turnover.
- Facilitating a learning network in the region where suppliers and Menzis can share best practices to improve the overall performance.

Concerning the current policy, the healthcare providers want fewer items on the honorarium list and these items should be more up-to-date. Furthermore, the healthcare providers would like to see more differentiation in attention and approach to the variability of the healthcare providers (size, type of care). These suggestions indicate that providers would like to collaborate more with Menzis, both in financing as in change and innovation management. Change and innovation should be financed more according to the healthcare providers. And at last common learning and dealing with labour shortage problems are suggested for implementation. The interviews with experts at Menzis provided a similar view on the relationship between the healthcare provider and Menzis. The points of improvement mentioned in the survey were similar to the points mentioned by the interviewees.

Concluding generally, healthcare providers are content with the current model but would like to see some changes for the honorarium items and differentiation between healthcare providers.

4.2.2. Client

The interest of the client is the most difficult interest to understand for the buying organisations. But the general view of the interviewees was that the client values his/her total cycle of care through different criteria. Some have a focus on the location of the care, is it close to home, others highlight the quality of the care and make their decision on these parameters. Therefore, there is not a general interest for all clients, the interest is specifically bound to a client before the treatment has started. That makes it extremely difficult to use these sets of data to form policy. After the contract is in place the “bridge position”, which is linked with information and monitoring advantages, shifts from the buying organisation to the supplier and therefore the buying organisation loses information benefits. Not all healthcare providers are willing to share this information. Besides, the legislation makes it difficult to get information from some client groups, like PGB. Furthermore, some sources of information are not reliable and can therefore not be used as input for performance management.

Although this is difficult for Menzis as a buying organisation, the interviewees mentioned that they have installed certain mechanisms such as a customer journey, client supporters, client counsel and client surveys. Interviewees mentioned that these forms of data collection could be

more digitalised to have more effect. These various sources of information are translated into the policy creation of themes.

Based on the interviews there is a consensus within Menzis on the definition of client value. “Client value is interpreted differently among different stakeholders” a client views value differently compared to a practitioner or the buying organisation. Although this difference, there is a general shift in the view on client value. The client value used to be monitored through measurement of outcomes, for instance, is a certain wound taken care of or is someone healed from a certain illness. Nowadays, client value is more and more centred on the well-being of the client, the human aspects become more important in the total cycle of care. Examples of this well-being are: the mode of treatment, are clients incorporated in the decision-making process. Besides, providing information to the client on the treatment has a positive effect on the perceived involvement of the client-healthcare provider relationship.

Although interviewees argued that it would be interesting to incorporate client value parameters in the remuneration of healthcare providers, it is difficult to implement it. Because the opinions of clients are difficult to validate and might not be reliable. For instance, a client in Groningen might have a different view on the same type and quality of healthcare, in comparison with a client living in Twente. Two questions arise, first how will a buying organisation implement such parameters in its remuneration and second would it be reliable and thereby add value to the total cycle of care. These two questions mentioned by the interviewees indicate that it is difficult to implement client value in a remunerating model. “Customer satisfaction could be measured and implemented, but it does not touch the parameter of quality of care”.

Concluding, within Menzis there is a consensus on the definition of client value, but there is no consensus on the use of such a parameter in a remunerating model.

4.2.3. Buying organisation

The main interest of Menzis is to guarantee long-term care in the present and in the future which is of good quality and thereby fulfils the clients' care requests. Interviewees mention that it is important to deliver “appropriate care” that fulfils the clients' needs without costing society too much money. As the costs of long-term care are increasing at a rapid pace. An interviewee mentioned that in 2018 the costs were 2.5 billion euros and in 2022 the costs had increased to 4 billion euros. Although these costs are paid by the ministry of healthcare, Menzis is responsible for the budget and the quality of the care. These costs will increase in the future

according to the interviewees and therefore Menzis should make decisions on the delivery of the care.

A potential tool which could improve the performance of Menzis and the healthcare providers is the type of contract and relationship. An interviewee mentioned that “healthcare providers are the means to fulfil the needs of the end customer, the clients”. Furthermore, some interviewees mention that Menzis and the healthcare provider should collaborate more on common problems like labour shortages, complex cases and information sharing. Other interviewees, especially purchasers, mention that they would like to have more control over the choice of the healthcare providers they want to work with. Especially for the complex cases with low volumes, where they would like to contract only one or two healthcare providers. A purchaser mentioned that he/she feels to be more in an intermediary role than as a purchaser. They argue that the overall performance could be improved if they could control the contracting process more in the tender.

Concluding, the interest of Menzis is to provide appropriate care to its clients now and in the future. Interviewees mention the challenges, but there lacks a general approach to deal with the problems.

Conclusion on overall buyer, supplier and client view.

Although assumed by the Agency Theory, the interest of the principals and agent does not differ in most cases. The buyer and supplier both have the same goal in mind, delivering proper care to the long-term care clients. Thence, the assumptions of the Agency Theory could be rejected.

4.3. What type of contracting could improve the overall performance?

This section will provide advice to the host organisation Menzis. In which it respects the characteristics of the market and the interests of the different actors mentioned in sub-question one and two. This section will be explained through the analysis of the interviewees and action research. First of all, this section will analyse the current model used as a starting point. Then it will discuss the other codes mentioned in the interviews and the outcomes of the action research sessions.

Current model

The current model used by Menzis is a great starting point as it indicates what works well and what does not functions in the Dutch healthcare market. All interviewees argued that one could

not speak of a well-functioning market and that the Dutch healthcare market can be seen as an imperfect market. This has implications for the design and management of a contract with a healthcare supplier. Although an imperfect market may indicate that it is difficult to operate in, interviewees proposed that this was not the case as Menzis is the only player active in their role. As they need all supplies of healthcare services, they view their suppliers as critical in the delivery of good quality long-term healthcare.

The main positive attributes linked with the current model are the long-term duration of the contracts of five years and the honorary list. The long-term duration provides ease of mind for the suppliers and creates strong partnership relations. This stability for suppliers provides them room to innovate and invest in their organisation, as well as the relationship with Menzis and other organisations. Menzis had the idea to create councils where organisations could discuss difficult cases and common problems, all in line with strategic partnerships.

Another positive element of the current model mentioned was the honorary list. The interviewees mentioned that the use of an honorary list incentivized the healthcare suppliers to provide better care services, as well as innovate and invest in their organisation. By linking performance with a financial bonus, some interviewees argued that the suppliers were willing to go the extra mile for their clients.

On the other hand, the long-term duration of the contracts does have negative implications on the flexibility that Menzis can exercise. This attribute was mostly linked with the honorary list, which was outdated after two/three years for some organisations. Others indicated that it was a financial consideration if a specific honorary item would be interesting for the organisation. Especially for smaller and/or extramural organisations, it was not interesting and/or achievable, as the honorary list was more focused on intramural healthcare. This indicates that the honorary list is not operational for all organisations and therefore does not provide the desired result.

Concluding, the long-term contracts with the honorary list is viewed by the interviewees as a positive matter. In general, they incentivize the healthcare suppliers to go the extra mile. But due to the long-term nature of the contracts, they are being seen as inflexible and therefore outdated after some years.

Collaboration

A theme mentioned often in the interviews was collaboration or strategic partnerships. As mentioned under the current model section, the healthcare market can be seen as imperfect. Due to common problems like labour shortages, increasing costs and rising demand it is even more

important for Menzis to collaborate with its suppliers to achieve its interest of affordable and available long-term healthcare.

The interviewees argue that it is important to collaborate more in the future and some see Menzis as the ideal actor to facilitate and mediate the collaboration with and among the different healthcare suppliers. For instance, through meetings where issues can be discussed. As an illustration, some healthcare suppliers in Twente and Groningen have agreed to arrange night care together, instead of four cars driving a night shift this is minimized to one and thereby reduces costs and work pressure for their personnel.

A potential instrument that could foster collaboration, even more, is the establishment of incentives focused on collaboration among healthcare suppliers. If Menzis could remunerate specific types of care or services collectively, e.g. night shifts or artificial respiration, then this could affect the likelihood that suppliers will collaborate. This characteristic is not present in the current model that remunerates all suppliers individually from each other. A potential solution could be the use of a collective lump-sum payment where suppliers could work together to deliver care. In such a scenario, Menzis could be open towards the supplier and help them in achieving their goals. This process innovation requires investments and operating room for the healthcare suppliers.

Part of the success of the collaboration is the relationship between the healthcare supplier and Menzis and the relationship between healthcare suppliers. Based on the interviews, suppliers argue that Menzis could provide them with the room to collaborate and implement new ideas. This requires relational contracting with the current actors, but the actors could also collaborate with non-specialistic care parties such as municipalities, domain-transcending.

Overall, the interviewees argue that it is in the vital interest of Menzis and the healthcare suppliers to not only look at their own internal processes but to collaborate to keep the long-term care viable in the future.

Relational contracting

Although the concept of relational contracting was already used in this chapter, it is essential to highlight as the interviewees argued that it was important to them to have (strategic) partnerships with the suppliers. Essential in relational contracting is to listen carefully to the problems of the counterparty, even though they might oppose the interests of Menzis.

The long-term relationship between Menzis and the healthcare suppliers positively affects this relationship according to the interviewees. This affects trust in competence and intentions of both parties, buying organisation and supplying organisation. This improved trust in competence and intention is essential in the desired partnership relation. On the other hand, some interviewees mentioned that the level of trust among the healthcare suppliers and Menzis is low. And that there is an organisational culture in which people are likely to dig in due to mistrust. To counteract this Menzis is active in its relational management through locational visits by purchasers, where they discuss potential issues and opportunities that could affect the performance of both actors.

This relational contracting is linked with social contracting and could be an essential part of the success of Menzis its performance. Social contracting theory focuses on the buyer-supplier interaction. This theory assumes that market exchanges between buying organisations and suppliers can involve economic and social outcomes. It provides a new perspective on opportunism and rejects the assumption of maximizing own gain.

Concluding, relational contracting could help all actors in the formation of a workable contract that is based on high levels of trust, collaboration and shared visions and norms.

Incentives and penalties

Incentives are often used in a principal-agent relation where the principal wants to align interests. Aligning interest is commonly done through installing incentives, which are used to counter opportunistic behaviour and increase control over the service quality (Uenk, 2019).

The current model of Menzis, has a method of incentivizing the healthcare supplier through the honorary item list. Although its functionality and effect is discussed in the previous section, the idea and logic of such a mechanism fall under the category of incentivizing. To sum up its effect "The purchasing policy of 2018-2023 has made a big step in rewarding healthcare suppliers through the honorary list, which differentiates suppliers based on extra service quality delivery". Interviewees argued that another type of incentive that could be used is a shared savings model, with or without a penalty. A stimulus, negative or positive, could be in the form of financial reward/punishment, higher tariff and/or more volume, and or social outcomes, reputational loss or gains.

Based on the interview session, most interviewees do not favour the use of penalties. Publication of a penalty does not come through as nice as a bonus and therefore might harm the relationship with the supplier. On the other hand, a respondent from the financial department

mentioned that the current situation was peculiar. Because, when total costs exceeded the pre-agreed amount there was no financial risk involved for the supplier and the buying organisation would remunerate the additional costs. The respondent defined this situation as “a regulation without a budgetary ceiling” and argued that this underperformance should not be the responsibility and burden of Menzis.

Although some interviewees argued that the “persoonsvolgende bekostigingsmethodiek”, a type of customer choice model, would theoretically have a positive effect on the service delivery, practice shows that due to the imperfect nature of the market it does not function as intended. “A customer choice model only works in a market where there is more supply than demand” and interviewees indicate that freedom of choice can not be granted, but options between healthcare suppliers could be provided to clients.

Concluding, all interviewees argue that incentives should be integrated into a contracting model and mention that a stimulus or bonus will have a positive effect on the behaviour of the healthcare provider. The use of a penalty, due to underperformance is not favoured.

Flexibility and duration

This section discusses the duration of the contract and the ability to change the contract over time. Based on the interviews, it was mentioned that Menzis can not change the contract during the ongoing period. Due to the procurement principles, which have to be followed as Menzis is viewed as a public law organisation. Therefore this section will highlight the consideration of the positive attributes of a long-term contract and the ability to change the contract and flexibility.

Positive characteristics of a long-term contract. First, it provides ease of mind for the supplier, because the organisation is assured of work for a pre-defined period. Second, contractual procedures take a substantial time for the healthcare supplier, which can not be used effectively in its healthcare service delivery. Third, the contractual procedures take a lot of time for Menzis to analyse and process, by implementing a long-term contract Menzis can save itself from much administrative work.

The main drawback of a long-term contract is that the buying organisation, Menzis, has no option to change the contract during the contract period. For instance, many interviewees argued that they would like to see some items replaced by more innovative items. For instance an item such as the option for guests to sleep over was rarely used by families of clients, but it was remunerated for five years and it accounted for a bonus of 0,2%.

Flexibility can also be interpreted in the after-contractual phase. Interviewees mention that healthcare suppliers would like to have flexibility in their choice, in how to innovate and organise in the near healthcare future. However, these same suppliers indicate that they would like that Menzis would facilitate and guide this process. A potential solution might be the functional specification, which is a formal document used to describe a service's intended capabilities, appearance, and interactions with the end-users.

Concluding, due to the legal nature of the contracts it is not possible to change items/arrangements during the contractual period. Therefore, Menzis should make a choice between the level of flexibility or influence they want to exert or the benefits of a long-term contract.

Information and domain-transcending

The flow of information is important in long-term care but is often stopped due to laws and regulations on privacy. Therefore, the flow of information is not ideal besides the level of transparency and information sharing could be better from both sides. Furthermore, the use of data in the healthcare sector is “almost nihil compared with other sectors” interviewees argue that the usage of electronic data could make the sector more efficient.

Concerning other domains such as the WMO, there is no communication with the WLZ. As the WMO is the precursor of the WLZ for many clients, it would be useful to understand what, who and how big the stream of new clients is. This domain-transcending flow of information could help, but is restricted due to laws and regulations on privacy. This situation is also present between the WLZ and ZVW.

Some interviewees suggest that the WLZ could collaborate more with the WMO and ZVW. To prevent clients from going from the WMO or ZVW to the WLZ. They argue that society should focus on keeping the society as healthy as possible and thereby prevent people going to one of the highest cost-class of healthcare. “Healthcare is a social problem, not one of Menzis, a municipality, or government, all actors should collaborate and discuss how to solve this societal issue”.

Concluding, the flow of information in the long-term care sector is not optimal due to laws and regulations. If this could be improved, interviewees think that it could solve some problems. Furthermore, the communication and collaboration between the different domains could be a useful approach to keep healthcare affordable and available in the future.

Risk

During the interviews, it became clear that Menzis and its employees find it difficult to deal with risks associated with contracting and managing the healthcare suppliers. On the one hand, Menzis wants to promote the partnership relation it has with its (key) suppliers. On the other hand, Menzis finds it difficult to be strict and pragmatic, when costs exceed the pre-defined amount. Interviewees mentioned that there is not a cost limit for extra care and that the healthcare suppliers are not risk-bearing in such a situation. “When a healthcare supplier makes money on its client group, then profit is for the organisation only. But when a supplier makes a deficit due to extra care the costs are for Menzis”. Interviewees argued that not all risk should lie at Menzis, or an individual healthcare supplier.

Concluding, Menzis finds it difficult to deal with risks associated with the management of the contract and relationship with healthcare suppliers.

Outcome-based contracting

Outcome-based contracting, value-based contracting or VBHC, focuses on the outputs of the service delivery and does not fully specify how the supplier should deliver the service. The theory was often mentioned in the interviews, with a wide range of options. Some interviewees were convinced that it could stimulate innovation, this is in line with the beliefs of the participants of the action research. Others were more critical and thought that it could not be implemented, managed and monitored due to the nature of long-term healthcare “clients in the long-term care due not leave or get better, so what relevant outcome should you measure and remunerate”.

Essential element of outcome-based contracting is to use Key Performance Indicators (KPI), these are used to measure if the supplier has delivered healthcare of a good quality, for instance the total cycle of care. A drawback of the long-term care setting is that people in the WLZ will never leave, only when they die. Therefore, it is extremely difficult to assess if the outcomes are acceptable, or not. Besides, not all long-term care clients are capable and reliable to assess their experienced healthcare. Also, not all people grade their service delivery the same and this affects how the organisations will be remunerated. Let alone regional differences, someone in Groningen might evaluate healthcare different from Twente or Gelderland.

There was a success story to the outcome-based theory, except this focused on hospital care. This illustrated that value-based healthcare could work, if outcomes, clinical and client reported outcome measures (proms), are measurable. Then this theory could work and provide better

clinical outcomes, as well as improved efficiency and cost reductions. Examples of healthcare sectors that are suited for value-based healthcare are orthopaedic care and ophthalmology, for instance, cataract surgery.

In addition to measuring outcomes, the shift from traditional fee-for-service remuneration (p*q) requires organisational change from both parties, buying organisation and the supplier. Some organisations in the Dutch healthcare change very slowly and thereby do not innovate quickly or not at all. A policy maker and purchaser mentioned that this slow rate of innovation is partly due to the risk-averse behaviour of healthcare suppliers as they expect to lose revenue when a new form of outcome-based contracting would be implemented.

During the sessions of the action research, the concept of free proposals was mentioned and discussed. A free proposal is a form of contracting where the buying organisation does not specify the how (process), but only specifies the outcomes of the service delivery. Through this method, the buying organisation provides the healthcare supplier with the option to design the process with full creativity and flexibility. By specifying the outcomes, the buying organisation can steer towards desired goals, such as (domain transcending) collaboration.

Concluding, although value-based contracting might be a “dream scenario” according to interviewees, Its applicability to the long-term care sector in the Netherlands might be difficult especially, because solid outcomes can not be measured adequate.

Selective contracting

This study looked at the concept of selective contracting. Which aims to stimulate competition between care providers, with the effect that only the best providers will be present in the sector. There are certain options that a care provider can take, comply and stop the treatments if they do not reach the threshold volume. Enlarge their volume through increasing market share or cooperation with other care providers.

Interviewees at Menzis agreed that it could be useful to select only a couple of suppliers for complex cases with low volumes, for instance, Huntington or Korsakov. These cases are too complex and the volume is too low to exercise market competition. Therefore, they propose that these selective cases should be tendered with a steered approach, e.g. interviewees would like to select based on the knowledge, competence and experience of the healthcare supplier. Interviewees mentioned some benefits and drawbacks of this approach. First of all, the total quality of care would likely be higher due to the clustering of experience, which positively affects the client. Second, as volume is bundled the supplier is guaranteed of a higher amount

of clients and can therefore scale up. And third, as there are only a view suppliers, the buying organisation can better monitor the performance of the supplier. A drawback is the possibility of cherry picking by suppliers, which should be prevented by the buying organisation.

Concluding, selective contracting could be useful for certain types of care, especially high complex low volume cases.

Population-based contracting

The interviewees mentioned a contracting mechanism similar to population-based contracting where regions would be divided among healthcare suppliers. To refresh, population-based contracting is a concept where a healthcare service provider receives a specified amount per member per month and thereby bears all the risks. And thereby has strong effects on the interest of cost reduction and the production incentive.

During the interviews, the respondents used a similar illustration of a flat where four different cars of healthcare organisations were parked in front. They argued that such a situation was common in Groningen, Twente and Gelderland and that prevented the organisations from working in an efficient mode. They suggested that these regions/neighbourhoods could be divided among the healthcare suppliers to limit travel time.

Although this concept could be useful, there is one main drawback associated. This drawback is cherry picking, which is the incentive to withhold care from clients that are more likely to be on the higher levels of cost. Furthermore, this type of contracting could harm the market competition installed in the Dutch healthcare market and relates to the issues of market partitioning. On the other hand, there are already pilots, in which different healthcare suppliers collaborate and take care of night care together.

Concluding, population-based contracting could be useful in making the healthcare sector more efficient. Its application in the current setting can be difficult due to the competitive design of the healthcare market.

4.4. Summary of results

This section will briefly summarize the findings of sub-question one, two and three, based on the literature review, expert interviews and action research.

A healthcare service triad can be defined as an interplay between a buyer, supplier and client. Where the buyer contracts a supplier to deliver care directly to the client. In this setting, the healthcare supplier has to deal with two principals, the buying organisation and the client. The

Dutch healthcare sector can be characterized as a healthcare service triad as many of the phenomena originating in the literature exist in practice. For instance, the “bridge position”, with information and monitoring advantages, exists in the Dutch healthcare service triad. Besides this bridge position shifts from the buying organisation to the supplier and therefore the buying organisation loses this advantage.

Based on the Agency Theory, which is often used in combination with the service triad literature, one might assume that there is high information asymmetry and goal differences. Within the Dutch healthcare service triad, there is high information asymmetry, due to privacy laws and regulations. Together with the shift of the bridge position, it results in an imbalance of information. The second assumption of the Agency Theory, goal/interest differences is not supported by this research as the findings of sub-question two were that the interests of the actors are often similar and do not differ, in other words, the buyer and supplier both have the same goal in mind, delivering proper care to the long-term care clients. Thence, the assumptions of the Agency Theory could be rejected.

After the concept of a healthcare service triad was discussed and the interest of all three actors was mentioned. This research examined how contracting could improve the overall performance. First, this research analysed the current contracting model based on policy documents, a survey and interviews. Second, this research used the literature review as input for the interviews and action research on possible new forms of a contracting model.

The current contracting model has positive and negative attributes according to the experts of Menzis and respondents of the survey. There are two main addressed points. The duration of the contract and the honorarium list. Both Menzis and the healthcare suppliers indicate that they like a long-term contract because it provides ease of mind and it promotes the strategic partnership, they both favour. Likewise, both Menzis and the healthcare suppliers indicate that the honorarium list can be a useful tool, to incentivize and differentiate based on quality.

Although these two points have been mentioned positively, there are comments on them as well. The respondents of the survey and purchasing experts of Menzis indicate that the honorarium list is outdated due to its longer contractual duration. The buying organisation and supplier would both prefer more flexibility in adjusting the items on the honorarium list. For instance, an item such as the option for family/guests to sleep over at clients was rarely, but it was remunerated for five years and it accounted for a bonus of 0,2%.

Concerning the future, both parties would like to see more collaboration, with each other, but also with municipalities and other domain-transcending organisations. This is partially translated into the request to work together in a strategic partnership with improved levels of trust in competence and intention. Concerning the incentives, there is consensus within Menzis that a form of stimulus should be implemented in a new contracting model, but exactly which form of an incentive is unclear. Most purchasers favour the honorarium list as they perceive it as a great tool to differentiate among the different healthcare suppliers based on the quality of the care and it incentivizes the healthcare suppliers to improve their service delivery. Some policy makers would like to implement a different form of incentives, which has similarities with outcome-based contracting models. These policy makers would like to implement a free proposal, which is a form of contracting where the buying organisation does not specify the how (process), but only specifies the outcomes of the service delivery and thereby provides the flexibility to the supplier to innovate and improve its internal processes. Most purchasers/contractors do not favour such a form of contracting as they think that it will likely increase their monitoring role, likewise the evaluation of the free proposals and outcomes might result in problems after the contract is in place. Furthermore, the purchasers think that Menzis will lose its ability to steer the healthcare suppliers in the desired direction, which could be controlled through an honorarium list.

With regards to selective- and population-based contracting models, respondents think that these might be useful for specific target groups, e.g. clients with Korsakov or dementia

Concluding, the Dutch long-term care market can be characterized as a service triad in which the interest of the different actors does not differ in most cases. Both Menzis and the healthcare suppliers understand their role in providing affordable and available long-term care, but there is no consensus on the choice of a future contracting model.

5. Discussion and conclusion

5.1. Conclusion

This research addressed the contracting process of long-term care in the Netherlands, from the perspective of the buying organisation without nullifying the interest of the healthcare providers and client. This process was examined through the research question: *What contracting form could a buying organisation implement in a healthcare service triad?* To answer this question a qualitative study is executed, consisting of expert interviews and action research.

First of all, this research focused on the setting of the long-term care in the Netherlands, which could be characterized as a service triad, consisting of three actors, the buying organisation, the healthcare provider and the client (Lapré & van Montfort, 2001). The bridge position mentioned by Li & Choi (2009), shifts from Menzis to the supplier and therefore information and monitoring advantages shift to the supplier (Li & Choi, 2009; Uenk, 2019). The buying organisation, is dependent on the performance of the healthcare provider and therefore has to control and monitor this through an appropriate mode (van der Valk & van Iwaarden, 2011). Within a service triad, it is assumed that there are contrasting interests (Sengupta et al., 2018), these have to be controlled through effective contracts and relationships that provide fair outcomes for all three actors (Tate et al., 2010; Conrad, 2015).

Second, this research shed light on the different interests of the three actors present in the healthcare service triad. Service triads reflect a unique agency situation as they consist of three actors, in which the healthcare provider has to deal with two principals, of which each might have contrasting interests (van der Valk & van Iwaarden, 2011; Sengupta et al., 2018). A good quality healthcare system incorporates the needs of all parties involved, the client, the supplier and the buying organisation (Leyden Academy, 2019). Although the Agency Theory might suggest that the interest of the three parties differ. In practice, Menzis and most healthcare providers have the same goal, delivering excellent care and service to the client. Thence, the assumptions of the Agency Theory could be rejected in most cases.

Thirdly, contracting models and mechanisms were discussed in this research. As mentioned in theory, it is important to install an appropriate mode of contracting to align the interest of all actors present in the service triad. When deciding upon a new form of remunerating it is important to understand the effect of certain mechanisms on the relationship between the buying organisation and the healthcare supplier. Relational contracting and incentives have a positive effect on the relationship and behaviour of both actors. The long-term duration of contracts is

favoured by suppliers but hinders the flexibility of the buying organisation. Selective-, outcome-based- and population-based contracting might be useful for specific target groups. And last (domain-transcending) collaboration might provide solutions to mutual problems and help the flow of information between the actors involved in the Dutch healthcare sector.

The conclusion of this research and its research question is that there is not one optimal form of contracting linked with the Dutch long-term healthcare sector. However, the theory and findings provide principles that could be used to establish a well-functioning contract that respects the interest of all three parties active in the healthcare service triad. These principles, along with the findings of the interviews and action research have been processed into possible contracting models, these are mentioned in the practical implications.

5.2. Limitations

The findings of this study have to be seen in the light of some limitations, the first limitation is the lack of previous studies in the field of contracting long-term care. The second limitation concerns the limited access to data, from the perspective of the client and healthcare supplier, this could result in a selection bias. The third limitation is researcher bias, as there was only one coder, who viewed and coded the interviews and action research. These are the three major limitations in this study that could be addressed in future research to make similar research less viable to biases.

The first limitation, the lack of previous studies affected this research as there was no foundation of academic literature on long-term healthcare. The only link between the service triad literature and (health) care contracting was done by Uenk (2019) with his work *commissioning of WMO*. This research counteracted this limitation through an explorative research, in which it accepted academic and empirical work from different sectors, such as public law organisations, municipalities and hospitals, governments and private companies. Although sometimes not completely suited to the situation of the long-term healthcare market, these academic studies and empirical articles have shed a light on contracting in a service triad.

The second limitation is the limited access to data from the perspective of clients and healthcare suppliers. Starting with clients, due to ethical issues it was not an option to approach clients for their opinion on the contracting process of Menzis and how they viewed client values. Although their view might be interesting for this or future research, approaching clients in the long-term care sector was restricted as there could be possible risks associated with it. Besides, not all

long-term care clients can be viewed as reliable sources of information, e.g. clients with dementia. Concerning the healthcare providers, these have not been approached to participate in this research due to the restricted time available for this research. There is not one generic healthcare supplier and to establish a representative view of an average healthcare supplier it would require a broad set of interviews with many different healthcare suppliers. The feedback surveys of the healthcare suppliers along with the interviews were acceptable to create a perspective of the healthcare supplier.

Although these two groups have not been participating in this research, their perspectives on contracting and the interplay between the organisations/individuals have been examined through a careful selection of the experts at Menzis.

To investigate the perspective of the client on his/her treatment and what he/she thinks is important questions have been asked specifically to client supporters working at Menzis, and experts who fill in a position at client panels. Alongside observations of client surveys and customer journeys. All these sources combined provide a comprehensible view of the needs and wishes of general long-term care clients.

To explore the perspective of the healthcare suppliers, this research approached (senior) purchasers who have a deep understanding of the needs of this actor. As they have daily contact with this party, the purchasers have an understanding of the problems and challenges they face, as well as the needs and opportunities they come across. Together with the (feedback) surveys of the healthcare providers, these sources combine a complete overview of the perspective of the healthcare providers. Within this view, there is differentiation among the healthcare providers, as there is a difference between the needs and wishes of the different types of healthcare suppliers.

The third bias is the researcher bias, which occurred as there was only one coder who viewed the interviews. Therefore the analysis might be biased to some extent. To counteract this bias, the data has been coded twice, to increase the credibility and confirmability of the research. The approach of Krefting (1991) was used, which uses a minimum of two weeks intervals after which the data should be coded over again. The codes have been established based on the principles developed by Braun and Clarke (2006). This method of coding resulted in a reduction on the amount of codes used. Concerning the action research, memo’s have been used to capture the researcher's reflexivity and personal thoughts

There is one constrain of this research, the choice of the theoretical framework. As this research used the perspective of the Agency theory in combination with the service triad literature as it assumed that some, not all, actors would have conflicting interests. This was the basis for this research, but gradually during the interviews, it became apparent that the interest of the different actors was not always conflicting. Respondents argued that most healthcare suppliers and the buying organisation had the same goals in mind. Especially larger organisations see that they have a societal duty in providing healthcare of good quality and a cost-controlling duty, to prevent the costs from overflowing. Some suppliers are more focused on their own internal process and would likely pursue profit over the wellbeing of their clients. A financial expert mentioned "making profit is not wrong, but making a profit of 30-40% over social funds is wrong in my opinion".

5.3. Future research

This research started with the question: *What contracting form could a buying organisation implement in a healthcare service triad?* This research was executed to form advice to the host organisation, Menzis. Future studies could fruitfully explore this study further by building upon the findings of this research, assessing the limitations, constructing this research in a new context and expanding the theoretical framework which is used.

Building upon the findings of this research could improve the quality of this research. At the moment, Menzis is still developing its purchasing policy for the term 2024. As this process is continuing, it might be interesting to follow this process. Especially with regards to the data collection method of action research, as there will be more sessions.

Future research could integrate other parties involved in its sample size, such as the healthcare suppliers and/or other experts, through interviews and other forms of data collection. Future studies could improve the validity and reliability of this research by integrating them into future work. As mentioned before, clients could/should not be used as respondents, but organisations like ZN, NZA and Leyden Academy might be useful sources of information.

Constructing this research in another context might provide different conclusions and implications. For instance, due to cultural or geographical differences. There is a paper by Kruse et al. (2021) on the differences between healthcare markets in different countries, Japan, Denmark, England and the Netherlands. This paper highlights how different markets react to different incentives, competition and more. It could be a useful guide toward similar research in a different setting, context, location and/or culture.

Future research could examine if the theoretical framework used in this research does cover the whole setting of the Dutch long-term healthcare sector. This study used the Agency Theory in combination with the service triad literature. A theory that might contradict the assumptions of the Agency theory could come to different conclusions. This link could be checked in future research, where the scientist could combine the service triad literature with a different one, such as social network theory, service-dominant logic and the stakeholder theory.

5.4. Practical implications

This section will discuss the practical implications of this research. As mentioned in the conclusion, there is not one optimal form of contracting and it is dependent upon different factors. Therefore, this section will discuss three types of contracting models, one involves incremental changes, a second involves a moderate change and the last involves a more radical change compared to the current model. All models have been derived from the literature review and complemented by the perspectives of the participants of the interviews and action research.

General points

Essential in all three practical advices, is the inclusion of a social contract. A social contract is an agreement between the buyer and supplier, in which common norms, values and goals have been agreed upon. Thereby it steers the supplier towards the desired behaviour of the principals. Aligning all three parties in the triad through the right contract and monitoring is beneficial for the buyer, client and supplier. This is easier achieved through social contracts than legal arrangements (Van der Valk & van Iwaarden, 2011; Broekhuis & Scholten, 2018).

Furthermore, selective contracting could be integrated into all three types of contracting. Selective contracting could be used to select a certain amount of healthcare suppliers to deliver specialistic, high complex and low volume healthcare, e.g. Huntington or Korsakov. Thereby, the knowledge and experience will be clustered and not splintered. This will have an expected positive effect on the quality and efficaciousness of long-term healthcare.

Collaboration between the different organisations and domains is a topic often mentioned during the interviews and action research. Within these sessions, the participants argued that collaboration between healthcare organisations themselves and Menzis could provide valuable improvements. Likewise, domain transcending collaboration with municipalities could improve the flow of information and perhaps could reduce the costs of the long-term care sector, “could money of the WLZ be invested in the WMO with the aim to decrease the costs in the long-term care”. As the long-term care sector is the most expensive type of care, preventing or reducing this increase could have a positive effect on the total

expenses of care for all sectors within the Netherlands. Therefore, collaboration could have a positive effect and could be integrated into a more decisive role.

1. Incremental change

Within this advice, Menzis does not change much on its current model. Therefore, it will still use the honorarium systematic. Thereby, it can differentiate among the different healthcare suppliers. Nevertheless, Menzis could make some changes with regards to the type of healthcare supplier and the related honorarium, in other words, the honorarium might be different for intramural and extramural, big organisations and small healthcare suppliers. Thereby, the honorarium fits better and will incentivize the suppliers to go the extra mile. A bit of advice concerning this choice is to use contracts with a duration of two or three years. By this, Menzis can update the contract and make the honorarium items more up-to-date and thereby incentivize the healthcare providers.

The benefits of this choice are the familiarity with this model, both for Menzis and for the healthcare supplier. Contemporaneously, through the honorarium list Menzis can steer the healthcare supplier in a desirable direction. In addition, this model is expected to be the least administrative for Menzis and the healthcare supplier as it is rather framed.

The drawback of this choice is that it is not that innovative, Menzis and the healthcare supplier will do business as usual. Likewise, it will not provide flexibility for the healthcare suppliers to change their processes, something they ask for, based on the interviews.

2. Moderate change

With regards to this advice, Menzis will partially change its contracting model and will integrate some new elements. The honorarium list will still be in place and will be supplemented by a form of outcome-based contracting. This form of outcome-based contracting will be in the form of KPIs that will be designed through dialogue with an expert at Menzis and the healthcare supplier. This form of contracting is new for the buyer and the supplier and this requires that the KPIs should be SMART, specific, measurable, achievable, relevant and time-bound. These KPIs should be remunerated if they have been achieved. By keeping the honorarium systematic, Menzis can differentiate between healthcare suppliers which is important according to the interviewees. And integrating this form of outcome-based contracting can provide the healthcare suppliers with the possibility to innovate and tackle problems through an upfront agreed approach. This choice of contracting requires a longer-term duration as both organisations make investments, that have to be accrued.

The main benefit of this approach is that it incorporates the wants of most stakeholders within Menzis and at the healthcare suppliers. Purchasers at Menzis want to differentiate among healthcare suppliers, as they perceive quality differences and policy makers are more in favour of outcome-based contracting, as they would like to incentivize the supplier to innovate. By integrating them both in this model, Menzis can steer and differentiate and it can provide healthcare suppliers with flexibility and room to innovate. By agreeing upon the KPIs together upfront in dialogue, Menzis can view if the KPIs are SMART and add value to the contract and its performance.

The drawback of this approach is that it requires more monitoring by Menzis and thereby adds more administrative burden to the buying organisation and healthcare supplier. Furthermore, there might be problems in defining the KPIs based on the SMART approach. Perchance, the judgment of Menzis or an independent organisation might provide problems in reviewing the KPIs and to what extent the KPIs have been relevant and achieved.

3. Radical change

This advice is the most innovative option, in which most components of the current model will be replaced. This model will replace the honorarium systematic with an outcome-based contracting model which uses a free proposal. A free proposal can be defined as a plan or suggestion, put forward for consideration by the buying organisation. In such a free proposal, the outcomes of the service delivery are important, not the processes. This provides the healthcare supplier with much flexibility and room to innovate its processes. The outcomes have to be SMART to successfully use such a contracting model. Within such a contracting model the outcomes should be linked with KPIs which act as parameters, who in turn, if met should be remunerated in the form of a bonus and/or penalty.

The benefits of this contracting model are improved flexibility for the healthcare supplier, as well as the ability to innovate in its processes and make the necessary investments. Such a contracting model changes the mindset of the healthcare supplier from a volume-focused perspective, p*q, to a more total cost of care mindset. This will affect how an organisation looks at its internal processes and will likely result in cost reductions.

The drawbacks of this contracting model are the increased administrative burdens for both Menzis and the healthcare suppliers, who have to monitor the performance, to receive the remuneration linked with the KPIs. Likewise, the evaluation of free proposals and or the outcomes/parameters are not always black and white and this could result in problems after the

contract is in place. Furthermore, as a buying organisation, when choosing a free proposal/outcome-based contracting model Menzis loses its ability to steer the healthcare suppliers in the desired direction.

Final recommendation

This research would strongly advise selecting the second option, the moderate change, as it fulfils the needs of most internal stakeholders of Menzis and the healthcare suppliers.

On the one hand, healthcare suppliers would like to have some flexibility and room to innovate, this will be facilitated through the outcome-based nature of the KPIs. On the other hand, they would like Menzis to facilitate this change and help them in this process, this will be done through the use of the honorarium systematic. Therefore, this research expects that the second option will fulfil the needs and wishes of the healthcare suppliers.

Based on the interviews and action research, it became clear that there is no internal consensus on the policy for 2024. Therefore, this research expects that the second option will likely lead to more satisfaction for purchasers, policymakers and client experts. Through this method of contracting, the purchasers can differentiate among the healthcare suppliers and stimulate them to innovate and improve through the outcome-based contracting method of KPIs. Along with the long-term duration of the contract, this research expects that the buyer, supplier and client will be content with this contracting model and will have positive effects on the affordability and availability of long-term care in the present and the future.

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