Making use of stakeholders in the healthcare sector

Master Thesis

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Tilburg University
Jelle Schunselaar
928945

Supervisor: Dr. M.C.M van der Zouwen
Second reader: Drs. R. Pranger
Background Information

Details of student

Name: Jelle Schunselaar
ANR: 928 945

Names of the Tilburg University supervisors

Supervisor: Dr. M.C.M van der Zouwen
Second reader: Drs. R. Pranger

Master Thesis Circle: Interactive interventions for organizational change and learning

Title of the thesis: Making use of stakeholders in the healthcare sector

Research Question: What effects does involvement of external stakeholders have on the strategy development of a hospital?
Abstract

This research aims to investigate the effect of involvement of external stakeholders in the strategy development of hospitals. As hospitals are, partly, forced to deal with many external stakeholders, this research will explore what effect they have on the strategy development. This has led to the following research question:

“What effects does involvement of external stakeholders have on the strategy development of a hospital?”

The research question is developed upon already existing theory, but there is no sufficient knowledge how this is related to the healthcare sector, so a case study is chosen (Swanborn, 1996). The outcomes of differ greatly between the two cases. Both hospitals appointed the same key external stakeholders. However one hospital had different approach strategies to their external stakeholders, but except a few exceptions are not involved closely. This resulted in the minimum effect the stakeholders have on the development of the strategy. The other hospital was a cooperation. So dealing with the stakeholders was more or less implied as they were participants in the cooperation. Each stakeholder had the same goals and objectives. The incentives to collaborate and involve external parties had in both cases a financial nature and the ensuring of high quality care. The complete results and conclusions of the research will be discussed in this report.
Preface

This master thesis is the result of months hard working. The eventual thesis is a guideline of the research I have conducted will provide answer on the research question and will show the knowledge I have gained during my time at the Tilburg University. Of course the work and time spent on this thesis was not possible without the help and support of others.

Therefore I want to thank my supervisor Tonnie van der Zouwen, as she was always available, gave constructive criticism and always helped me by steering to the right direction and not to lose sight of the ultimate goal if I could not see the wood for trees. I also want to thank all members of the circle, all were supportive during this whole period, thanks for all the reading and the constructive comments. As well as Rob Pranger, he was very supportive and also flexible when needed.

Furthermore my thanks also go out to the interviewees, which made this research possible. Although everybody is anonymously treated, I want to thank them for taking time and patiently explaining everything to me.

And of course the persons who were not directly involved, but still supported me in several ways.

This thesis you are about to read was one with ups and downs, but I enjoyed writing it nevertheless. I hope that you as reader experience the same interest for the healthcare and stakeholder management as I did myself.
# Table of Contents

1. **Introduction** .......................................................................................................................... 7
   1.1 Research problem .................................................................................................................. 7
   1.2 Aim and research question .................................................................................................... 9
   1.3 Relevance ............................................................................................................................. 9
   1.4 Read directory ...................................................................................................................... 10
2. **Theoretical background** ......................................................................................................... 11
   2.1 Healthcare system ............................................................................................................... 11
   2.2 Stakeholders ....................................................................................................................... 14
   2.3 Stakeholder management ..................................................................................................... 19
   2.4 Strategy ................................................................................................................................ 22
3. **Methodology** .......................................................................................................................... 24
   3.1 Case study ............................................................................................................................ 24
   3.2 Units of observation and analysis ......................................................................................... 24
   3.3 What is studied? .................................................................................................................... 25
   3.4 What is done with it? ............................................................................................................. 25
   3.5 Why these hospitals? ............................................................................................................ 26
   3.6 About the quality .................................................................................................................. 26
4. **Results** .................................................................................................................................... 28
   4.1 The cases .............................................................................................................................. 28
   4.1.1 Case A ............................................................................................................................ 28
   4.1.2 Case B ............................................................................................................................ 29
   4.2 Results hospital A ................................................................................................................. 30
   4.3 Results hospital B ................................................................................................................. 36
5. **Conclusions** ............................................................................................................................ 40
6. **Discussion** ............................................................................................................................... 44
   6.1 Limitations ............................................................................................................................ 47
   6.2 Further research: what is next? ............................................................................................. 48
   6.3 Implications ............................................................................................................................ 48
   6.4 Reflections ............................................................................................................................. 49
7. **References** ................................................................................................................................ 50
8. **Appendices** ............................................................................................................................... 56
1. Introduction

1.1 Research problem

Organizations are more and more dependent on each other and the complexity where each organization has to deal with requires more involvement of stakeholders (Schruijer, 2006; Schruijer & Vansina, 2004). According to Freeman (1984) most firms understand the importance of the stakeholder and their pressure on the organization. However, to deal with all these stakeholders, there are different strategies (Jawahar & Mclaughlin, 2001). Making benefit of your stakeholders is a capacity of the organization according to the resource based view. This view is based on internal processes and routines that organizations have developed and managers use to profit from their environment (Miller & Shamsie, 1996; Gonzalez-Benito, 2005; Sharma, 2005). This theory can be combined with the Ecology theory, which concludes that organizations who are in fit with their environment survive while others fail (Astley, 1985).

From these two perspectives it can be concluded that stakeholders, as part of the environment of organizations, are very important. Overtime there are many definitions about stakeholders developed, however most are derived from Freeman’s definition: “any group or individual who can affect or is affected by the achievement of the firm’s objectives” (1984:25).

When organizations’ strategies fail it is often because key stakeholders were not involved by the decision makers (Bryson, 2003). While clients and employees are already often involved and valued the strategy making process (Zahra & Nielsen, 2002), there are many more important stakeholders.

Hospitals are an exceptional case when it comes to dealing with stakeholders. The environment they operate in is extremely complex, as they operate not in an entirely free market and have to deal with many regulations from the government. Because of that, hospitals have to deal with more complex situations and many stakeholders. A research published in a Dutch newspaper made it visible that there are more than 300 associations which represent the interest of all kind of parties alone besides all other organizations, and a billion Euros is involved (Volkskrant).\(^1\)

While the costs of the total health care increased with 55% between 1998 and 2003 (Hilten, Kleima, Langenberg & Wams, 2004), the government forced hospitals to economize 314 million euros\(^2\). Also competition between hospitals started to increase since the introduction of a new healthcare system in 2008 (NVZ, 2009). As the inclusion of stakeholders could be beneficial for the financial performance of hospitals, ignoring them could be a missed opportunity. This because the budgets of hospitals are decreasing and quality of healthcare must stay at the same level.

According to Wheeler and Sillanpaa (1998) the inclusion of stakeholders is already becoming the norm, in the development of strategies. They argue that listening and responding to stakeholders’ needs and beliefs is essential, not only for ethical reasons, but also for creating business strategy and improved collaborations between organizations (Wheeler & Sillanpaa, 1998). This research will explore what effect involving external stakeholders has on the development of a strategy. As involving external stakeholders leads to better financial performance, although this is less clear as it is with internal stakeholders (Berman, Wicks, Kotha & Jones, 1999). As the healthcare market is even more complex than regular markets, this research could provide insights in possible advantages of the inclusion of stakeholders and the effect they have on the development of a strategy.

\(^2\) Kamerbrief, appendix 1
1.2 Aim and research question

The goal of this research is to provide insight in what effects involvement of external stakeholders have on the strategy development of a hospital. In current literature, as stated in the introduction, there is already evidence that the inclusion of stakeholders is important because stakeholders are more dependent on each other (Wheeler & Sillanpaa, 1998; Schruijer & Vansina, 2004; Schruijer, 2006). Also, the financial performances increase (Berman, Wicks, Kotha & Jones; Jones & Wick, 1999). This thesis focuses on the healthcare sector and in particular general hospitals.

This leads to the following research question:

“What effects does involvement of external stakeholders have on the strategy development of a hospital?”

Sub questions:

1. Who are the key external stakeholders according to the hospitals researched?
2. How are external stakeholders involved?
3. Why do hospitals involve these stakeholders?
4. Why do the key external stakeholders collaborate?
5. What are the differences between the two hospitals examined?

1.3 Relevance

The results of this research improve insight in what effects involvement of external stakeholders have on the strategy development of a hospital.

The scientific contribution of this research lies in the fact that until today hardly any research is done about involving stakeholders by hospitals and the effect they have on the strategy. This while the healthcare industry is very dynamic and complex and therefore would be suitable for inclusion of stakeholders. Because of this complexity and the highly regulated asymmetric market (further explained in the next chapter), this industry stands apart from other industries in which stakeholders are involved. Furthermore, this research provides an answer how hospitals use the current existing theories about the inclusion of stakeholders and the affect the stakeholders have on the strategy development. Thus this research can contribute to already existing knowledge about stakeholder management and strategy development.
The practical contribution of this research is a comparison between two hospitals. With the commercializing of the healthcare industry, it is relevant for hospitals to get an overview what the effect involved stakeholders have on their strategies. This thesis can provide different perspectives for hospitals of the inclusion of stakeholders and effects it has on the strategy.

1.4 Read directory

In the next chapter the theoretical framework of this research will be described, it will show how literature is examined and compared. It will explain what is to be studied and what not. The construction of the research, techniques of data collection and analysis can be found in chapter three and will be justified in this chapter as well as how it meets the quality criteria. Further on in the paper are the results and the associated conclusions which will clearly answer the research question. Chapter six will exists of discussion and the limitations of our research will be reflected.
2. Theoretical background
In this chapter I elaborated the definitions of the concepts used in the research question. The concepts stakeholders, stakeholder management and strategy are explained, it will provide insights in how these concepts are applied in this research. I also explain more about the Dutch healthcare system, this is necessary to place everything in the right context.

2.1 Healthcare system
In order to fully understand this research, a sufficient knowledge about the Dutch healthcare system and healthcare market is necessary. In my thesis I do not go into detail on the financial side, as financing hospitals is rather a specific part where a high degree of knowledge is required. I only briefly explain how the healthcare is organized and the most important changes in the system from the past.

The Dutch healthcare market is an asymmetric market. Stakeholders have to deal with each other in another way then in other industries. The market can be analyzed on micro, meso and macro level. Macro level would be the complete healthcare industry, micro level particular departments or phenomenon within an organization. As my research focuses on the strategies of hospitals I focused on the meso level, which focuses on the organizations within the industries.

One of the consequences according to Jeurissen (2005) of the asymmetric market is that the care recipients usually have less knowledge than the providers, because of that the liberation of the market would not result automatically into more efficiency.

Three players
In the Dutch healthcare there are three players, which are important for the structure. Financing the market (1) healthcare insurance companies, (2) care recipients and (3) care providers, e.g. hospitals.

Care recipients are in this case policyholders and dependent, which could get care needs. The care providers have to adjust their care on the demands and needs of the care recipients. Different from normal industries and markets, is the third party: health insurance companies. According to the Rijksinstituut voor de Volksgezondheid en Zorg (RIVM, 2008) the third party is essential in order to assure quality, accessibility and affordability which is public interest. Besides the healthcare insurance companies assists the care recipients, as care is often
non transparent due the complexity of the care. The care recipients are not able to develop sufficient countervailing power relative to the care providers.

Figure 1 shows the structure of the Dutch healthcare market. Lapré and Van Montfort (1999) distinguished three submarkets; the healthcare providing market, the healthcare contracting market and the healthcare insurance market. The government monitors and creates preconditions for all actors on the markets, and has therefore a big influence on the functioning of these markets.

As my research focuses on the use of external stakeholders for developing strategies of hospitals (care providers), I only look at the healthcare providing and the healthcare contracting market. Although all markets are connected closely to each other, as the health contracting market and insurance market are derived from the healthcare providing market, as healthcare is the actual delivery (Putters en Frissen, 2006).

**Healthcare providing market**

In this market there is interaction between the care recipients and the care providers. Instead of a collective market, this market is characterized by its individuality and therefore it is an individual market (Lapré & Van Montfort 1999). There is extensive regulation from the
government according to quality legislation, legislation of rights of care recipients as well as it governs ethical issues (Maarse, 2001).

*Healthcare contracting market*

In this market the healthcare insurance companies and the care providers are active. Insurance company’s buys care for care recipients. Besides the purchase of care, insurance companies come to agreements with the care providers about the purchase of care. However the agreement can only be applied on a certain segment, which is given free by the government to negotiate about. Due the agreements with care providers about price, organization and the content of the care providing, insurance companies are according to Lapré et al (2001) able to prevent induced needs and supply induced and reduce variation in care provision.

*The development of the market*

Regulated market in the healthcare goes back to 1987 where Commission Dekker researched how the healthcare industry in the Netherlands could be improved. Regulated competition must provide the balance between solidarity and competition among the actors in the sector. The government stimulates the demand and providing parties and regulates the possibilities of the contractors, the health insurance companies (Schut, 2003). Since 2002 the accent of policy within healthcare shifted more towards profit and commerce (VWS, 2002).

*The consequences so far*

Because of all kind of new regulations made by the government, a lot have changed for stakeholders of hospitals. As licenses for hospitals are changed, the demand side also changed. Insurance companies are no longer obligated to contract each hospital, according to Kwartel (2003), is it most likely that insurance companies provide „preferred provider’ insurances.

These preferred providers can only be applied for certain treatments. Treatments are divided in so called „diagnose behandel combinatie’ (dbc) A and B segments, while the A segment is nationally determined, and therefore the prices in each hospital for these treatments are equal, prices asked by the hospitals for treatments in the B segment are determined by hospitals itself.
Next year, 2012, 70% of the DBC will be free negotiable\(^3\). Current numbers only go back to 2009, where only 34% of the treatments were freely negotiable. In figure 2, you can see how important the B segment is becoming for hospitals and their stakeholders. Hospitals have to focus more on quality and costs of the treatments, as health insurance companies will only contract the qualitative best treatments against the right price, however there are still doubts of this freely negotiating would lead to more efficiency (Huijnen & Van der Schors, 2005). This table shows us that cost reduction within hospitals is becoming more important, as the B segment is only increasing and thus competition among the hospitals will increase.

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**2.2 Stakeholders**

There are a lot of definitions of the concept „stakeholder”. The definition of Freeman is one of them: “any group or individual who can affect or is affected by the achievement of the firm’s objectives” (1984: p.46). It is a very broad definition and Freeman one of the most cited authors. In many studies this definition is narrowed down, because according to the definition

of Freeman too many people and parties can be seen as stakeholder (Mitchel et al., 1997). In my study I also use the definition of Freeman’s as starting point, but I have elaborated this definition further with the help of several studies and the stakeholder theory.

The stakeholder theory explains and predicts how organizations are influenced by stakeholders and how the organization influences the stakeholders, with this theory management would be able to strategically involve managing stakeholders (Frooman, 1999).

Donaldson and Preston (1995) came up with two distinct perspectives according to the stakeholder theory: the normative and the instrumental view. The normative perspective sees all stakeholders as having intrinsic value, according to the stakeholder theory an organization deals with and manage stakeholders on the ground of moral principles (Berman, Wicks, Kotha & Jones; Frooman, 1999). The instrumental view considers stakeholders important as contributing to their needs would be profitable, good management of stakeholders can lead to maximizing profit (Berman, Wicks, Kotha & Jones; Frooman, 1999). When the normative assumes the organization or its stakeholders should not exist only to serve it own ends, in opposite to the instrumental view which focus primarily on the benefit of the organization (Berman, Wicks, Kotha & Jones; Jones & Wick, 1999).

Research of Clarkson (1995) however showed results that managers nowadays are not only responsible for profit, and maximizing returns to shareholders at the expenses of other important stakeholders. Results show that managers are now responsible to meet the needs of stakeholders (Clarkson 1995).

In the studies above there is no distinction made between different kinds of stakeholders. Berman, Wicks, Kotha and Jones (1999) consider the following relations as most important: employees, natural environment, diversity, customer/product safety and community. From these relationships stakeholders can be derived, but it does not provide a clear overview. Donaldson and Preston (1995) argue that the variety of relationships with stakeholders does not lead to clarification but is more confusing.

Another way to classify stakeholders, is by making use of different levels of stakeholder theory. According to the different levels of stakeholder theory (strategic level, multiple trustee approach and „new synthesis”), also stakeholders can be categorized (Goodpaster, 1991).

The first logical distinction made should be separating key stakeholders and non key stakeholders (Salam & Noguchi, 2006). According to Salam and Noguchi (2006), key
stakeholders are those who can successfully influence the successes of the projects. This can also be seen as dividing into primary and secondary stakeholders (Hillman & Keim, 2004). According to Savage et al. (1991) primary stakeholders do have an official relationship with the organization while secondary stakeholders can influence or can be influenced by the organization but do not have a formal relationship with the organization. Another logical categorizing step would be dividing into internal and external stakeholders, although some stakeholders are not classifiable in this way (Savage et al, 1991).

Wheeler and Sillanpaa (1998) divided the stakeholders based on primarily and secondary stakeholders, as Clarkson (1995) does as well. The model Wheeler and Sillanpaa is based on these stakeholders and further elaborated with primary and secondary non-social stakeholders. See figure 3.

Figure 3, Stakeholders according to Wheeler and Sillanpaa (1998)

Between the organization and the primary stakeholders there is a high level of interdependence, as they are necessary for the organization to function (Clarkson, 1995). Secondary stakeholders are according to Clarkson (1995) influenced or can influence the organization, but are not necessary to involve in order to survive.
Something missing in the model of Wheeler and Sillanpaa (1998) is however the distinction between market and non-market stakeholders, which is made by Stevens et al. (2005). Because of the transactions involved by market stakeholders, they can influence directly the other organization, they also can threat to exit the relationship and collaborate with a competitor (Hill & Jones, 1992).

As there is already a lot of literature about internal stakeholders and even evidence that involving them in the forming of the strategy results in better financial performance (Pfeffer, 1994; Youndt, Snell, Dean & Lepak, 1996). I focused on external stakeholders, as their contribution towards a better strategy is rather unknown and therefore more interesting (Berman, Wicks, Kotha & Jones 1999; Frooman, 1999). Although Altman assumes that involving the community, as external stakeholders, leads to fit a broader strategy. Also Berman, Wicks, Kotha and Jones found evidence that involving external actors leads to a better financial performance, although this is less clear as it is with internal stakeholders, see figure 4 (1999).

![Stakeholder Relationships](image)

**Figure 4, influence stakeholders on financial performance (Berman, Wicks, Kotha and Jones, 1999)**

The definition of external stakeholder is very broad, this is narrowed down with the use of the distinction of market and non-market stakeholders. As for example I did not involve the government and local authorities because they do not have direct interest in the strategies of hospitals.

However, because of the complex environment and regulations in which hospitals operate I cannot divide external stakeholders in primary and secondary, as Clarkson (1995) did for normal organizations. For example there are certain rules about what kind of surgeries must be done, for what area the hospital is responsible and how they are financed. The Dutch healthcare authority (NZa) provides on yearly basis each hospital with a budget, this budget is based on the number of citizens within the area, number of beds of the hospital and the expected „production’ of the hospital. The hospitals do not have direct access to this budget, they have to send bills to health insurance companies, other hospitals and clients in order to
receive their budget (Wet marktordening gezondheidszorg)\textsuperscript{4}. Because of these reasons I focused on general external stakeholders which are involved in developing the strategy of the hospitals.

\textit{Attributes}

Besides the typologies, each stakeholder can be further classified based on the attributes power, legitimacy and urgency (Frooman, 1999; Mitchell et al., 1997). With these three attributes the importance of the stakeholder can be measured, known as the stakeholder salience. Based on these three attributes Mitchell came up with figure.

Power consists of three types according to Etzioni (1964): coercive, utilitarian and normative power. Coercive power is based on the resources of physical power and therefore not applicable in this setting. Utilitarian and normative power is based on financial and symbolic resources. These types of power are present in a lot of stakeholders.

The definition of legitimacy used by Boonstra (1999) and Mitchell et al. (1997) is originally from Suchman:

\begin{quote}
\textquote{a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definition} (1995: 574).
\end{quote}

According to Mitchell et al. (1997) legitimacy and power can be independent of each other, however if the stakeholder has both, it has more authority over the organization.

Urgency, Mitchell et al. referred to urgency as: “the degree to which stakeholder claims call for immediate attention” (1997:867). This third attribute causes a more dynamic nature in the typology (Mitchell et al., 1997).

\textsuperscript{4} Retrieved from: http://wetten.overheid.nl/BWBR0020078/geldigheidsdatum\_11-01-2011
2.3 Stakeholder management

A tool for managing stakeholders, as part of strategic management is stakeholder management (SM) (Langtry, 1994). According to Post, Sauter-Sach and Preston (2002) maintaining relationships is considered important as managing the stakeholders is essential for successes of organizations, so mutual benefit would be meaningful as organizational wealth can be created or destroyed by these stakeholders. Stakeholders may voluntarily or not, bear some risk if the organization tries to create more value for its own organization, but the stakeholders also benefit or can be affected thereby (Clarkson, 1995; Schneider, 2002).

Besides creating successes, the relationships also make it possible to cope with uncertainties and unstable environments (Leana and Sousseau, 2000). The contribution of these relationships in shaping vision, supporting and executing the plans asks for managing and reaching consensus among the key stakeholders, it is about what should be done and how (Savage et al., 1991).

There are in the current literature two approaches: instrumental stakeholder management and the normative approach. For the instrumental approach stakeholder are used for strategic goals, and is about how the organization can be affected by its stakeholders. The normative approach does not only look to stakeholders who can affect the organization, but also take into account those who get affected by the organization. Besides these two approaches an
organization can also choose to exclude the stakeholders and so these organizations do not have a SM approach. For the options see figure 6.

<table>
<thead>
<tr>
<th>SM approach</th>
<th>Considered Groups</th>
<th>Definition</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Only stakeholders</td>
<td>Provides financial resources</td>
<td>By resource provision</td>
</tr>
<tr>
<td>Instrumental</td>
<td>Shareholders and others who can affect</td>
<td>Can affect or is affected (with stress on the former)</td>
<td>By effect on the reaching of strategic objectives</td>
</tr>
<tr>
<td>Normative</td>
<td>All stakeholders with a moral claim</td>
<td>Can affect or is affected (with stress on the latter)</td>
<td>None, all stakeholders are equally important</td>
</tr>
</tbody>
</table>

Figure 6, Stakeholder Management Approaches, derived from Berman et al. (1999)

Results of Berman et al. (1999) showed that instrumental approach is positively related to the financial performances of an organization, unlike the normative approach which has no effect. When Berman et al. (1999) describes two main approaches, Savage et al. (1991) divides the stakeholders into four groups as he recommends for each group a different strategy based on the potential of threat or cooperation among the stakeholders. In figure X, there is a matrix of these threats and cooperation which lead to different kinds of stakeholders which each has their own strategy (Savage et al., 1991).

Figure 7, Stakeholder Management Strategies (Savage et al., 1991)

**Supportive Stakeholders**

Stakeholders with no or little potential for threat and high potential for cooperation are supportive stakeholders. They could be important for achieving goals and objectives of the
organization, and are because of the lack in threat a desired partner. Examples of these stakeholders are employees, suppliers and local community NGO’s (Savage et al., 1991).

There is a big potential in this group, therefore it is important for managers to involve these parties in important issues of the organization. Participation of these stakeholders in decision making processes should be sought as cooperation with these stakeholders could solve problems and provide organizations with a competitive advantage. According to Savage et al. (1991) middle management should be authorized to make use of these stakeholders, using participative management skills.

*Marginal Stakeholders*

Parties which are not likely to cooperate with and could not be a threat for the organization still can have a stake in organization and therefore decisions of the organization. Potential of cooperation or threat could increase in the future if their stakes in the organization increases for examples by new laws or a changing environment. Savage et al. (1991) mention stakeholders as stockholders and consumer interest groups.

The strategy that fits for this group would be monitoring. If the main interests of each stakeholder is identified, the organization can involve these interests in the decision making process. If a decision influences or is influenced by one of these stakeholders, the organization can choose to increase the support of these stakeholders.

*Non supportive Stakeholders*

The most difficult stakeholders to manage are the non supportive stakeholders. There could not be collaborated with, but there is a high risk they could interfere in achieving goals and objectives of the organization. Stakeholders in this category are competitors, but also the government who can influence the market. Managing these stakeholders is very strategic, as it involves marketing and strategic notions (Savage et al., 1991).

The strategy which is suggested for this group would be defensive. But an important part of managing these stakeholders is making them shift towards another type of stakeholder. Although it is difficult, in some cases impossible, if collaborating with a stakeholder it becomes a mixed blessing stakeholder (Savage et al., 1991).
stakeholders, which is the case in non-supportive stakeholders, must be reduced according to a defensive strategy (Kotter, 1979).

**Mixed Blessing Stakeholders**

The last category stakeholders could be a big threat as well as an opportunity to cooperate, therefore have an important role for the organization. Examples of these stakeholders are experts within the organization and companies with complementing products (Savage et al., 1991).

According to Savage et al. (1991) a collaborative strategy should be applied. Joint ventures and mergers are some forms of collaborations. When collaborating with these stakeholders it is more unlikely that these organizations become a threat for the organization. But when these stakeholders are not managed in the right way, they can become non-supportive stakeholders. However, if managed in the right way, it is possible that the mixed blessing stakeholders become supportive stakeholders (Savage et al., 1991).

Due to the asymmetric market and many regulations, the examples made by Savage et al. (1991) will not always be corresponding with the stakeholders for hospitals. Still, the matrix would be a proper way of defining the stakeholders as it is in combination with the approaches of Berman et al. (1999) very complete and provides the opportunity to directly combine stakeholders and strategy.

### 2.4 Strategy

Strategy is an old and very broad concept, one of the most cited and influenced authors Chandler (1962) defined strategy as followed: the determination of the basic long-term goals and objectives of an enterprise, and the adoption of courses of action and the allocation of resources necessary for carrying out these goals” (p. 13). Another influential author, Henry Mintzberg (1978) translated this definition in his words as: “(a) explicit, (b) developed consciously and purposefully, and (c) made in advance of the specific decisions to which it applies. In common terminology, a strategy is a plan” (p. 935).

According to Porter (1996) there are three strategy principles: (1) the creation of a unique and valuable position, involving a different set of activities, (2) considerations in competing, to choose what not to do, (3) creating a fit between the organizations’ activities.
The authors, discussed above, agree that the strategy should lead to gaining competitive advantage.

All are convinced, it is about gaining a competitive advantage. The creation, production, sales and delivery of a product or a service are the basics of competitive advantage (Porter, 1996). With strategic positioning organizations try to create sustainable competitive advantage by keeping what is distinctive about the organization. This can be done by performing the same activities as competitors in other ways, or perform different activities (Porter, 1996). Collis and Rukstad (2008) found that the paper of Porter did not provide answer to the question of how to describe the strategy of an organization. Strategy can be divided into three parts (Collis and Rukstad, 2008), the first part is the objective. Here there is defined what the strategy is designed to achieve, the objective of the organization. Secondly the domain or scope must be defined. Finally the means must be described, how the organization is going to achieve its objective. Collis and Rukstad (2008) claim: “Your competitive advantage is the essence of your strategy: What your business will do differently from or better than others defines the all-important means by which you will achieve your stated objective.” (p. 3). The organizations propositions, why to choose for your products or services, are complementary to the competitive advantage. In the figure 1.3 below, there is a visualization of the statements of company in a hierarchic way.

![Diagram of strategy elements]

**Figure 8.3, Strategy elements according to Collis and Rukstad (2008)**

For my research I examined strategy documents regarding these three topics, from Collis and Rukstad.
3. Methodology

To obtain a proper answer to the research question, the research must follow a certain methodology. Here I describe the research design of this study, justify the methodological decision concerning data collection, data analysis and how the cases were selected as well as the information of these cases. The last part of this chapter describes the quality indicators of this study.

3.1 Case study

The design of this research is a case study. A case study is chosen because it provides accurate and detailed knowledge about a certain social phenomenon (Swanborn, 1996). A case study is necessary because of the particular nature and the complexity of this study (Stake, 1995). As the healthcare sector differs from regular markets because it is asymmetric and highly regulated by rules and laws.

The nature of this study is qualitative; there are only a limited numbers of actors involved in this research, which makes quantitative research impossible. Besides qualitative research is more suited because its ability to take the complete context and setting into account (Bryman, 2008). The research is cross-sectional and makes use of retrospective interviews to reconstruct the complete process of involvement to the effect on the strategy of stakeholders.

The research question is developed upon already existing theory about the inclusion of stakeholders and their effect on the organization, therefore the nature of this study is mostly deductive. However, the theory is linked with hospitals, organizations which differs from previous cases studied. So this thesis has also an explorative character, as there is no sufficient knowledge how this theory is related to the healthcare sector.

3.2 Units of observation and analysis

The units of observation in this research are members of the management of two different hospitals and the stakeholders they have collaborated with when the hospital developed a new strategy. The strategy itself is also studied and is also a unit of observation.

The unit of analysis is the strategy development process of the hospitals in this research. Central question is what effect involved external stakeholders have on the strategy development of a hospital.
3.3 What is studied?

Literature review

Starting point of this study is the elaboration of current literature about concepts used in this research. I have explored the concepts and the already existing theory about the inclusion of external stakeholders within the organization.

Document study

Documents regarding strategy of the hospitals are collected, these documents are social annual reports of hospitals and insurers and documents about the strategy and vision of hospitals. With these documents, I have gained insight in the development process of the strategy, who was involved and to what extent the stakeholder has influenced the strategy.

Interviews

Semi structured interviews are used to get insights in the perspectives on strategies of the hospital and their external stakeholders. The interviews with the hospital are used to identify the external key stakeholders, the motivation and experiences of the hospital to involve or not to involve these stakeholders. Based on these interviews and on the document study the external stakeholders are interviewed. The interviews are semi constructed as the document study provided the basis for questions treated in the interviews (Bryman, 2008). It is possible to extend or adjust the questions if something important and or interesting emerges from earlier interviews.

In appendix two, there is given an overview of all the documents and interviews which are used as sources for this thesis.

3.4 What is done with it?

Document study is the starting point of this study, from several documents essential information can be retrieved. Documents as policy and strategy are studied. To start with an open view, I make use of open coding of the documents, goal of open coding is exploring the field of research, so a good perspective can be created (Boeije, 2005).

Transcripts of each interview are made by using the program „f4 audio” (Audiotranskription, 2009). Selective coding is used in order to come up with a coding frame. The selective coding method contains a selection of the core category, systematically relating it to other categories and filling in categories that need further refinement and development (Boeije, 2005; Bryman,
The transcripts are subdivided into the several elements in the coding frame in order to analyze and compare the interviews.

In order to follow the steps I made in this research and provide more insight in the path I have chosen, I kept a research journal\(^5\), which covers the steps I made in this research.

### 3.5 Why these hospitals?

For the selection of the cases I have made use of purposive selection. According to Boeije (2005) this means cases are selected from a population that shows certain characteristics. The hospitals selected for this research is one hospital which has collaborated closely with stakeholders in order to develop a strategy, the other hospital selected did not collaborated closely. This sampling is done to compare the differences the two cases, the motivation of the hospitals as well as the perception of the external stakeholders of both approaches. By selecting these different cases information richness in the cases is obtained, which gives a better understanding (Patton, 2002). The selection of hospitals was with help of the manager specialist care buyer at CZ.

There was no need for any kind of sampling of the respondents, while there is only small group of people eligible to be interviewed. The document study and the results of interviews with the respondents of the hospital clarified which stakeholders were involved and have to be interviewed as well. As there are only a limited number of people involved in the decision making process of the development of the strategy, usually the management, these were interviewed.

### 3.6 About the quality

For quality indicators I make use of the criteria of Erlandson et al (1993) mention as most appropriate for qualitative studies, these indicators are: credibility, transferability, dependability and conformability.

**Credibility**

In order to increase the credibility of this study members checks are done to verify data and interpretations (Erlandson et al, 1993). Member checks are performed with stakeholders and the board of the hospital in order to prevent interpretation mistakes. This is done by providing the respondents the transcripts of their interview.

\(^{5}\) Can be found in appendix 3
Besides to enhance more credibility I made use of triangulation, which are different methods, questions and sources used in the research (Erlandson et al., 1993).

Transferability
Transferability is enhanced by making use of thick description and purposive sampling. By describing the cases in detail, thick description, this study increased dependability. This is a way of achieving a type of external validity in a qualitative research according to Lincoln and Guba (1985). Due to purposive sampling specific data is retrieved from two diverse cases, this maximized the possibility to transfer outcomes of the study.

Confirmability & Dependability
As single researcher I made use of colleague students within my master circle, supervisor and external experts to enhance the confirmability of this research. To improve the dependability of this study, I made use of members check. To clarify all the decision taken in the research I have made a reflexive journal\(^6\) with notes of every decision being made.

\(^6\) Can be found in appendix 3
4. Results

4.1 The cases

The two cases which are examined are presented in this chapter, it will provide background information which is necessary to put the findings and conclusion in the right context. The two hospitals face different stakeholders and therefore a short introduction of these stakeholders is also given. For anonymity reasons, the hospitals and stakeholders are given different names.

4.1.1 Case A

The Hospital in this case is a tertiary medical teaching hospital (further mentioned as stz, samenwerkende topklinisch opleidingsziekenhuiz) and will be further mentioned as Hospital A. It is a big hospital, with one main location and several small clinics in the nearby area. The catchment area is rather large, as there is only one small hospital in the same region. Competition comes from three other big hospitals from big cities, one of these hospitals is even an academic hospital. The hospital has over 4000 employees, around 500,000 inpatients and 60,000 outpatients a year and has 450 beds. Because of the size of the hospital and the lack of competition in the nearby area, this hospital has a lot of different specialisms. Hospital A also pays a lot of attention to education and training of the staff, as each year they supervise more than 300 co-assistants. And although Hospital A is not an academic hospital, it also sees research as one of its core business. The spearhead of the scientific research are cancer, immunity & infections, innovation in technology, heart & blood vessels and live in balance.

In the vision of Hospital A are central:

- Increasing demand for care
- Critical consumer
- Beside patient care, also education and research
- Social responsibility

Hospital A defined personal attention, quality and innovation as the core values of the organization. Their ambition is to be most patient oriented and safe hospital in the Netherlands.

For this hospital there are two important health insurance companies, CZ and UVIT. The vast majority of their clients are treated in this hospital. UVIT is a label organization, with four
different labels. In this area VGZ represents all the labels, all together they have more than 4 million clients. CZ also consists of several labels, has in general most clients in the south of the Netherlands and has around 3.5 million clients. Over 70 percent of all patients in Hospital A are client of one of these insurers. Both insurers are also well presented in the whole area around the hospital. In the nearby area are also a few clinics, some are collaborations, while others, for example an eye-clinic, are competing with the hospital.

The hospital also has a share in a revalidation centre, and works closely with nursing homes and home care organizations in the nearby area. As every hospital they have a client board and have to deal with the local association of General Practitioners (GPs) and the association of medical specialists at the hospital, they represent a total of 240 medical specialists.

4.1.2 Case B

The hospital in case two will be further mentioned as hospital B. The current situation of this hospital is rapidly changing, as they become the first cooperation. Plans to establish the first hospital cooperation in the Netherlands go back to the early 2009. A small healthcare insurance company DSB and six regional partners are participants of this cooperation. In appendix five, the governance structure used, can be found.

The hospital is a regional, small general hospital with one main hospital and a clinic located in a village nearby. The hospital is located in a highly populated area. In the nearby academic, teaching and high-end clinical hospitals is located. Hospital B has around 100,000 inpatients and 20,000 outpatients a year and has 450 beds. The care of Hospital B is in line with the specific care demands and needs of the population in the area, which is very broad. Besides the hospital provides specialist care like geriatrics, oncology, renal dialysis and there is a chest clinic. This care is provides as a regional need.

Goal is of the hospital is patient satisfaction, in order to reach that, transparency and a healthy financial organization is required. By cooperating with GPs, and diverse care organizations the medical care goes flawlessly into on another.

The stakeholders of this hospital are the insurer, the association of medical specialists of Hospital B the association of General Practitioners (GPs) and three organizations with focus on elderly care, nursing homes and home care. All participate in the cooperation, along with the employees of the hospital as internal party.
The majority of the clients treated in the hospital are also client of the Insurer. Therefore the insurer has a big share in the hospital, which is one of the few were the insurer has the majority. The insurer is a small company with around 350,000 clients located in the same area as the hospital and the vast of their clients are citizens of the region as well.

The three organizations which focus on elderly care, nursing homes and home care are also regional partners, however one organization is also present with several locations in the a wider area. The medical specialists are “vrij gevestigden” and represent 120 specialists. The GPs established in the near periphery, are represented by the GP association, the hospital is dependent on their referrals to the hospital for the influx of patients.

4.2 Results hospital A

In section of my thesis the findings of my research will be presented. The topic lists used regarding to the interviews can be found in appendix four. The transcripts of the interviews are not attached as the over 100 pages are not necessary to read. The coding scheme made of the transcripts is made in an excel file, which cannot be presented in the appendix because of the enormous size. These documents can be viewed on demand. The results are combined with findings in documents of the hospitals and stakeholders.

The results will be presented as a chronological time path, as the development of strategy has different phases and the involvement of stakeholders can occur at different times. In case of involvement of external stakeholders, their views are included and described in the paragraph after the specific phase. By breaking the strategy development into pieces, this chapter becomes a guide of the strategy process. Due to anonymity reasons, interviewees will not be mentioned by name but by their function and stakeholder they represent.
<table>
<thead>
<tr>
<th><strong>Hospital A</strong></th>
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| **Characteristics** | STZ hospital  
| | Large catchment area  
| | Only few competitors  
| | Two major insurers active in the area  
| | Diverse care  |
| **Mission and vision** | Cure  
| | Train employees  
| | Scientific research  
| | Most client friendly and safe hospital of the Netherlands  |
| **Values** | High level of transparency  
| | Open culture for visitors managers and employees  
| | Balance between costs and high qualitative care  |
| **Incentives** | Patient safety, satisfaction, patient oriented and efficiency of care (cost efficiency)  |
| **Stakeholders** | Insurers, Client board, Works council, Medical staff  
| | VAR, Nearest hospitals, Patient associations  
| | GPs association, Pharmacist, Nursing homes  
| | Home care organizations, Revalidation centre  |
| **Kind of collaboration** | Different forms:  
| | Mergers  
| | Long term contracts  
| | Investments  |
| **Consequences for strategy** | More focus on patient friendly  |
| **Stakeholders point of view** | Cooperation because of:  
| | More financial possibilities  
| | More efficient care  |

The mission, why we exist, is the same in all hospitals, to help and cure patients. Hospital A is no exception, but as STZ hospital they also want to train people and as third they want to, despite not being an academic hospital, do scientific research. All three points are aimed at the vision, which is becoming the most client friendly and client safe hospital of the Netherlands.
The values which the hospital takes into account are a high level of transparency and having an open culture for visitors, managers and employees. Also a lot of attention is being paid to the balance of costs and high qualitative care.

The mission and vision leads to the strategy, which is about the objectives, the scope of the organization and how the organization tries to achieve her objectives, the means.

The strategy is aimed at being the most patient friendly and safe hospital. Therefore the hospital came up with three spearheads: patient safety, patient satisfaction with focus on treatment of the patient and being patient oriented and as third the efficiency of care. All are represented by a particular commission, with a member of the board on top of it. Everything however must be attuned to cost efficiency and cost saving, although this is not officially part of the strategy, a lot of attention is being paid to it.

In the creation of the mission and vision of the hospital only the client board was involved. Their input, more focus on patient safety within the hospital, was included in the vision of the hospital. No other party was involved.

“There was a lot of consternation in other hospitals, we thought that the safety could be improved in this hospital if paid more attention to it. We did achieve this.” (Client board)

In a hospital in the near area both insurers were involved by the creation of mission and vision. UVIT and CZ finds it very important to be involved this early in the process (especially in case of a large market share), as mission and vision match the hospital and insurer can act together. As the insurers can be seen as suppliers, in theory they can refuse to contract care in the specific hospital which could lead to a decrease in patients in Hospital A. But insurers are also business partners as the quote above shows that they can invest, or not, in the goals and projects of the hospitals.

“Why? Because it is possible to match with our mission, vision and strategy, and you can see, especially if you have a large market share, if you can act together” (Specialist health negotiator, UVIT)

The strategy

The process of developing the strategy differs according to the financial manager from normal commercial organization as the board cannot put bonuses on targets and everybody will strive to achieve them. As example doctors are mentioned, as they want to participate in the strategy
discussion. The development of a strategy is an iterative process, where continuously
feedback and input is asked. However, only internal parties are involved. Parties mentioned
are the VAR, client board and the medical staff. Although the medical staff and client board
can also be seen as external.

Medical staff

The hospital emphasizes the importance of the medical staff, the board of this staff is involved
in the development of the strategy. The medical staff represents specialists who are employed
by the hospital, but also the independent specialist which are not employed by the hospital.

The “vrij gevestigden” play an important role when it comes to collaboration and threats, as
they can compete with the hospital. With the increased number of B segment treatments, they
can leave the hospital and start a clinic, which executes the profitable surgeries in front of the
hospital. While the loss-making activities stay within the hospital.

To prevent this competition, the hospital also collaborates with the “vrij gevestigden”. As the
hospital tries to create these clinics around them themselves, they avert this competition. They
involve the doctors in these entrepreneurial initiatives so they do not become competitors.

Other internal parties mentioned are the advice association of nurses (further mentioned as
VAR, Verpleegkundige Advies Raad), management of the departments, the works council
(OR) and the client board.

Client Board

The client board has the right of information, consultation, advice, to do inquiries and the
nomination of board, all happens from a client perspective as all members take seat on their
personal title. The hospital involves the client board narrowly in the strategy discussion, and
keep regular meetings with the financial manager of the hospital about the financial side and
the possible consequences for patients, as they try to keep that to a minimum or if possible to
avoid.

The chairman of the client board stated to be closely involved in all kind of processes and
choices of the board of the hospital. With as result for example their input in the vision of the
hospital. The client board has a few spearheads, which are in line with the vision and ambition
of the hospital itself. Patient participation, which can be seen as part of patient satisfaction,
hygiene and cleaning of the hospital, which is in line with the desire to be the most patient
safe hospital and as part of the relocation the client board was involved in drafting a new folder to inform patients, bearing in mind patient oriented.

**Insurers**

Both insurers state not being involved in the strategy, only on execution level, which is part of the stakeholder management strategy of the hospital. Because of lack of competition in the direct environment this way of dealing with the insurers is prejudicial. The hospitals and both insurers admit that the insurers have a leading role in the care sector at the moment. With the ongoing development of insurers, where they develop lists of criteria a hospital needs to meet in order to let the hospital execute certain surgeries. This should raise the quality of care.

In order to meet these criteria, Hospital A works together with the three competitors they have on top referent care, by dividing the operations which have quantity criteria. Interesting note is that both parties do not want to integrate the hospital with the insurance company and thus choose for long term contracts with each other.

“You do not doubt the autonomy of the doctors... The doctors should decide about a treatment, as a financial manager I just have to go along, no matter the costs of the particular treatment. The risk with vertical integration with an insurer is that money becomes more important than the best possible treatment. But the profession, the autonomy of a doctor is sacred.” (Financial Manager, Hospital A)

**Means**

Eventually must be clarified how the organization wants to achieve its objectives, therefore the means are described. These means can provide a competitive advantage, the essence of the strategy with the help of the means chosen. The process of how these means are chosen is described above, the execution will follow here.

Current care will be expanded with new techniques and even a more complete offer of care. For the execution there is chosen to collaborate closely with other and even invest in other parties. In this case especially the relation with the GPs, nursing homes and a revalidation centre is striking.

The GPs will take place with a post within the hospital. As important ‚supplier’ the hospital finds it important to involve the GPs as much as they can.
The revalidation centre is an example of a wider range of care, however instead of collaboration there is chosen for forward vertical integration. This means that the hospital took a majority interest in the revalidation centre, because revalidation is not a primary task of the hospital and is more part of the next step in the healthcare chain.

“By opening a GPs post within the hospital, we provide an extra service for our clients. Now we are often seen as unnecessary gate to the hospital, that will change. Also it is important to cooperate with the hospital to keep abreast of developments within the hospital.” (Member of the GPs association)

The reasons to collaborate with these two parties are also done with an eye on costs savings. As patients without referrals cost around five times more than patients with GPs referrals. Also the vertical integration with the revalidation centre has a costs saving character as treatments which can be done in the revalidation centre are cheaper than in the hospital, as the patients keep an occupied bed where no new patient can be treated which provides money from the insurer. This way of reasoning is also applied to the collaboration with nursing homes, as in even one home also is invested by the hospital. To be more patient oriented, a pharmacy is also started by the hospital so a patient can find everything he needs in the same building.
### 4.3 Results hospital B

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<tr>
<td><strong>Hospital B</strong></td>
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| **Characteristics**  | Small regional hospital  
                      | Small catchment area  
                      | Only few competitors  
                      | Two major insurers active in the area  
                      | Diverse care  |
| **Mission and vision** | Cure  
                      | Quality improvement  
                      | Scale enlargement  
                      | Efficiency  |
| **Values**           | Corporate social responsibility  
                      | Patient satisfaction  
                      | Professionalism  |
| **Incentives**       | Patient satisfaction, vulnerable financial position of hospital  |
| **Stakeholders**     | Insurer, GPs association, nursing homes,  
                      | home care organization, medical staff (all part of the cooperation)  
                      | client board,  |
| **Kind of collaboration** | Cooperation  |
| **Consequences for strategy** | More focus on efficiency of care and chain care  |
| **Stakeholders point of view** | Cooperation because of:  
                      | Possible bankruptcy  
                      | Clients dependent on hospital  |

Besides curing patients, the mission of hospital B is also quality improvement, scale enlargement and increasing efficiency. The values, which are in mind of the hospital, are corporate social responsibility, patient satisfaction and professionalism. Patient satisfaction equals according to hospital B quality of care.
The mission and vision leads to the strategy, which is about the objectives, the scope of the organization and how the organization tries to achieve her objectives, the means.

The strategy is aimed achieving scale enlargement, quality improvement and more efficiency in the whole healthcare. The motive to establish a cooperation was that the current way was inefficient to help patients, not only in the hospital but across the whole chain of care.

“The compartmentalized approach to the problem of the patient is inefficient”(secretary of the board)

First, second and third line care match excellent to each other in case of a cooperation. Instead of a long term contract, which can be ended, there is an intrinsic bond between the partners, with the same goal.

For the mission and vision of the hospital the partners were not explicitly asked for input, however the board of the cooperation is composed relatively to the investment made by the parties. Therefore each party could influence and contribute already in this phase.

Insurer

Hospital B is the only hospital the insurer invested and participated in. A reason for their involvement was maintaining an independence hospital under the administration of the cooperation. As 70% of the patients of hospital B is client of the insurer. When participating in the cooperation, the hospital would be able to increase quality. Besides, most citizens of the area are client of the insurer, so there are beneficial financial reasons to participate as the insurer is lender to most (chain) care organization in the area.

Another important factor is the presence of top clinical, academic and stz hospitals in the nearby area. So there is no level playing field for the hospital, and horizontal integration is not an option because of the high attendance of the insurer’s clients at hospital B. The only way to distinguish the hospital is to establish a cooperation. By starting the cooperation the insurer gained more influence and is able to compete against the other hospitals in the wide area.

Medical staff

According to the hospital and the insurer, it was very important that the medical staff would participate in the cooperation. The hospital stated that because of high competition in the area, the focus on the patient satisfaction could only be realized if the medical staff would
participate. In the hospital there were medical specialists employed by the hospital itself as well as “vrij gevestigden”, both are represented in the medical staff association. Despite there is no opportunity to pay dividend, the medical staff receives a guaranteed return of four percent besides a market compliant compensation relative to the investment made. This compensation is received by every participant.

The medical staff saw the necessity to participate in the initiative as the hospital was in need of investment as the future of the hospital was unsure. The medical staff also endorses the points made by the hospital and insurer. Where other hospitals have to deal with medical staff, who sometimes have contradictive interests to the hospital and insurers. Because of their involvement in the cooperation they are also partly responsible for the results. But also they have a vote in the board of the cooperation, and saw advantages concerning provided quality of care.

Other parties

Other participants of the cooperation are the GPs association, home care organizations and nursing homes. GPs, previous in the chain, were convinced about the importance of the hospital for their own clients. Many of their clients are also dependent of hospital B. Therefore they decided to join the cooperation. However, the insurer invested on behalf of the GPs and so officially the GPs did not invest their own money. Despite their membership of the cooperation, they assure independency is guaranteed, especially because of the freedom of choice their patients have and the many hospitals in the area.

The nursing homes and the home care organizations stated that many of their clients are also clients of the hospital, by a close collaboration efficiency can be ensured.

“There is a lot of traffic between our nursing homes and the hospital, a cooperation can only be in benefit for our joint clients” (Manager nursing home)

Chain care is according to these organizations better for all parties, as efficiency and quality for patients can be better pursued and their own organizations gets more financial stability and opportunities.

A stakeholder which is not part of the cooperation is the client board. The many advantages made them support the cooperation, as the future of the hospital is ensured, waiting lists can
be efficiently addressed and there would be more room for innovative treatments. These advantages lead to a better situation for the patient, which interests we look after.

Means

The three goals of the hospital (quality improvement, scale enlargement and efficiency) can be achieved with the means the cooperation offers. Several participants of the cooperation stated that because of the chain approach, which the healthcare is in their eyes, the patient becomes more central for all parties. This would result in increasing patient satisfaction.

The practical contributions of all participants in the cooperation can be seen as means to achieve all goals. The practical contribution of the nursing homes and home care organizations for example lies in the fact that there would be less bed blocking as such situation is not beneficial for any party. Patients which presents in hospital are no longer needed can immediately go to a nursing home or can be treated by home care.

“Bed blocking costs a lot of money, as occupied beds cannot be used for new patients who make money, instead there are patients which only cost money”(Health buyer DSW)

Besides this is efficient and cost saving, also the patients benefits as they no longer than necessary have to stay and can go home. Also the medical staff have because of their participation more opportunities to develop themselves and take part of innovative initiatives which benefits the quality.

Each participant admits they are concerned with the performance of the hospital. But even without the cooperation the participants had interest in the survival of each other as clients.
5. Conclusions

In order to answer the research question of this thesis, a few sub questions have to be answered. Where in the previous chapter a detailed explanation for all kind of matters concerning the development process, stakeholders and their influence is given, this chapter provides a short overview which answers the sub questions, which will lead to answering the research question. The sub question concerning the differences between the two hospitals examined, are included in the answer to each sub question.

1. Who are the key external stakeholders according to the hospitals researched?

Both hospitals identified the same external key stakeholders. Internally important are all employees, including the medical staff. Both consider the medical staff as intern party, however, they also can be seen as external as they are not necessarily employed by the hospitals.

Besides the insurers, as part of the healthcare system, and the obligated client board, care providers which are in the healthcare chain are considered by both hospitals as very important. Hospital A deals with more key stakeholders, like the revalidation centre and pharmacies. This probably is because of their size and the lack of competition in the area. Other top referent care is discussed with other big hospitals. Hospital B have less stakeholders but all are located nearby.

2. How are external stakeholders involved?

Hospital A has different forms of involvement of their stakeholders. The governance structure is different towards the different stakeholders. There is close collaboration between the hospital and the main insurers and other hospitals which results into long term contracts. Towards the stakeholders who are in the healthcare chain there are also close collaborations, but the hospital also sometimes invests in these stakeholders. The client board is an obligated party which is consulted by the hospital and provides advice. The last form is joint ventures with the medical staff. Several private clinics in the area are started together with the medical staff.

So the normative and instrumental approaches (Berman et al.,1999) are combined for all stakeholders. All stakeholders are involved to achieve the objectives of the hospital, only the client board is involved earlier in the process as they participated in the mission and vision discussion.
In opposite to hospital A, the collaborations in hospital B is formed in a cooperation. This cannot be seen as stakeholder management or approach. All stakeholders, insurers and other care providers, invested in the hospital.

3. Why do hospitals involve these stakeholders?

Both hospitals collaborate with stakeholders for two main reasons: increasing quality of care and efficiency. Stakeholders, part of the healthcare chain, are mainly involved because their involvement can lead to an increase of efficiency.

Hospital A indicated that insurers have a leading role in the healthcare sector at the moment. The attributes both insurers have, power and legitimacy, makes them for the hospital one of the most important parties. Also are the insurers important as they negotiate on behalf of many of their patients.

The medical staff in hospital A is considered as a mixed blessing stakeholder, despite they are being seen as internal party. The strategy use of mixed blessing stakeholders is to collaborate, in order to not let these stakeholders shift from primary social stakeholders towards competitors and protect the hospital for competition.

The incentives of involving these stakeholders for hospital B are similar. However, hospital B operates in a more interlaced network of different kinds of care providers. Therefore the focus of the hospital and the stakeholders are more towards each other, making them important to collaborate in the cooperation.

In contrast to the situation with the medical staff in hospital A, are the medical staff a supportive stakeholder for hospital B. By involving them, the hospital assured that the medical staff would be no threat for the hospital and in this way will also pursue the same goals.

4. Why do the key external stakeholders collaborate?

Stakeholders of both hospitals often have the same interests as the hospitals have. Stakeholders, part of the healthcare chain collaborate to increase efficiency, what for both parties could lead to decreasing costs. But also could increase quality of care, as well patient satisfaction.
Insurers at hospital A, CZ and UVIT, want to cooperate to pursue and realize qualitative high care against a good price. With a close collaboration the insurers can act together with the hospital which is in benefit for their clients. The demands of the insurer are also the reason of the agreements among a couple of hospitals to dividing difficult rare surgeries among each other which is beneficial for efficiency as well as the quality.

In hospital B, the only insurer have 70% market share. By investing together with the other care providers in the healthcare chain they could increase costs as well as guarantee the quality. As all parties have the same target group who are more or less dependent of the hospital, so the future of the hospital is very important for each participant in the cooperation.

Research questions: What effects does involvement of external stakeholders have on the strategy development of a hospital?

As described in the answers to the sub questions, the ways stakeholders are involved differs greatly. The ways the stakeholders are involved has a big impact on the effect and influence they can have on the strategy development of a hospital.

This effect is rather small in case of hospital A. Stakeholders are involved in the execution of the strategy, and only a few stakeholders (medical staff, insurers and client board) are involved more closely. The medical staff and the insurers have the attributes power and legitimacy and to a certain level urgency, the client board is obligatory. However, the client board is important as their primary point of view is the wellbeing of the patient. So there are also involved in the development of the mission and vision of the hospital and their sound can be seen in the attention paid by patient safety and satisfaction.

Both insurers have influences the ongoing discussion about quality, and forces the hospital to cooperate with other hospitals. The involvement of the medical staff results in the entrepreneurial opportunities used by both parties, because of that profitable dbc’s stay within the hospital. So the presence and involvement of the medical staff leads to the commercializing of the hospital.

Hospital B is a complete different story, which is due to the governance structure chosen. The stakeholders are participants in the cooperation, and therefore have an official vote in the cooperation. Although, it is questionable if participants in the cooperation can be seen as stakeholders. The insurer has officially most power, and together with the other members of
the cooperation an official vote in the development of the mission, vision and strategy from
the start.

In this case all the members have as discussed earlier the same goal, because they all address
the same clients. Therefore there is conformity about the goals and how to achieve these.
Important for all employees is the financial stability of the cooperation, which resulted in the
desire to scale enlargement of the hospital.

Final conclusion is that the closer the involvements the more influence and effect a
stakeholder have on the development of the strategy. However, the extent of effect is variable.
This is dependent on the characteristics of the environment the hospital operates in. Most
important are the presence of competition and the insurers active and their vision.
6. Discussion

From the very start of this research it became clear that the strategy of the two hospitals focuses on quality of care and the costs of care. Costs of healthcare are rapidly increasing and are already an important issue, but with the more upcoming free negotiable DBCs, it will get even more important.

Both hospitals cope with this issue, however in different ways. I discuss the different options hospitals choose concerning stakeholder management, the influence it has on their strategy, and the theories involved. At last, although this is not where this research is about, I take a look at the complete market, the imperfections of the market and the consequences it has on the strategy.

Hospital A did not have one clear approach, although they pointed out the same key stakeholders as hospital B did, their management towards them is different per stakeholder. Also the reasons to cooperate are the same, namely increasing costs as well as quality. The normative and instrumental approaches are combined. Berman et al. (1999) showed that the instrumental approach is positively related to financial performances, unlike the normative approach, which has no effect. Agle et al. (2008) proposes that the performance would not increase because of a normative stakeholder management approach. However, it will make the organization more superior in a moral way, even without financial downturn of an organization. Jones (1995) argues that trust will decrease if an organization only uses stakeholders for their own strategic goals, in this way stakeholder management will lose its strategic value for the organization. So no sustainable relationship can be build, if used the instrumental approach. Hospital A uses both approaches, although only a few have influence on the development of the strategy. The hospital could probably afford this, because of their size and the few competitors in the area. This makes many parties dependent on the hospital.

The vertical integration by hospital B (a cooperation), was driven by financial insecurities of the hospital. Stakeholders around, dependent or codependent of the hospital decided to start the cooperation. In my opinion it is doubtful if this can be seen as stakeholder management. As only a few stakeholders cooperate and because of this cooperation can exclude other stakeholders, turning them into competitors. Nevertheless, Bijlsma et al. (2008) researched the possible effects of vertical relations. And especially in case of such a relationship between an insurer and a hospital efficiency can be increased. Empirical research, done in America, showed that vertical integration leads to large investments in preventive care, and lowering
costs of care leading to decreasing insurance prizes (Bijlsma & Shestalova, 2009). Nevertheless, it did not clarify the quality of care, but accessibility and client satisfaction decreased. However, this research would not be applicable in the Netherlands, as in the catchment area there are many care providers as well as insurance companies. So large investment would also lead to high insurance prizes, with as consequence clients defect to another insurer.

The healthcare chain can be seen as selective distribution (Kotler & Keller, 2009). With selective distribution there are only a few intermediaries part of the chain, while there are a lot of other parties which can provide the same care. This kind of distribution can be seen as selective care contracting, only in this case part of one cooperation. As other parties can be excluded, the way of distribution can also be seen as competition distortion. The NZA also has this concern, as the integration is forwards and backwards and therefore clients can be referred to partners which are part of the cooperation and exclude others7.

As said before, strategies of both hospitals focus on reduction of cost, while offering high quality care and being patient friendly. Hospital A chose for all three value strategies, operational excellence, product leadership and customer intimacy, which is according to Treacy and Wiersma (1995) very difficult. However, because of the large catchment area which only knows little competition this is probably less the case for hospital A.

On some procedures however, hospitals divided some highly difficult operations among each other. Hospital A admitted that it was on the edge of competition distortion, if not completely. However, research of Porter and Teisberg (2006) showed that if difficult procedures are done more often, the quality significantly raised. So where in Hospital B questions about competition distortion are raised concerning vertical integration, it also can be doubtful in case of horizontal integration. Accessibility for patients would be lower and competition decrease. Nevertheless, is decided that in case of difficult procedures agreements among hospitals are allowed as quality of care is significantly better and costs will decrease8. In order to keep the profitable operations within the hospital, the hospital choose to collaborate with the medical staff, together with the desire to provide as many services as possible it leads to an economy of scale. The size of hospitals in the Netherlands lies already far beyond the European average (Canoy & Sauter, 2009). While there are numerous authors claim that scale

enlargement results in advantages (Porter, 2008; Potter, 2000), I have some doubts if this is applicable in the Dutch healthcare. While hospitals are bigger then in for example Denmark or Iceland, these countries spend significantly less per person on healthcare, while quality is only minimally less (WHO, 2009).

The operational excellence and customer intimacy strategy chosen by hospital B, these strategies are largely due to the diversity in parties within the cooperation which are serving target group. So the cooperation focuses on the needs of the target group, which leads to concentration and further expansion in order to create more efficiency. So it is divided into submarkets, which is a trend in all hospitals.9

Starting point of the strategy of the cooperation is competing through making the organization more efficient by reducing transaction cost. No longer each stakeholder will try to maximize their own profit which can be detrimental of the total profit (Kotler & Keller, 2009). In this transaction cost theory the pursuit towards more efficiency gets most attention and transaction costs determine the organization form that is chosen (Ter Bogt, 1998). According to the transaction cost theory there are two ideal forms of organizing, through hierarchical coordination (hospital B) or by market mechanisms (hospital A) (Ganzendam & Homburg, 1999).

The market mechanism would be inferior against the hierarchical coordination. As insurers buy their health more selective and differentiated, and therefore make different deals with hospitals resulting in more negotiating and bigger differentiations in contracts and thus higher transaction costs (Lapre et al., 2001). There also could be more conflicts. However, conflicts does not always harm the relationship between the stakeholders, it can also improve and strengthen the chain care (Coughlan et al, 2006). However it would probably not be an option for hospital A to organize their activities with stakeholders through hierarchical coordination. Competition would be distorted as there is almost no competition on hospital level in the area and consequences for quality of care is unknown while many people are dependent on this one hospital. So the difference approach towards stakeholders can be linked to the imperfections of the market, as some options for one hospital are excluded while the other hospital can benefit from these imperfections. Most important imperfections are transparency of quality, power of insurers and the possibility to distribute profits which are also related to

9 http://www.fdselections.nl/zorg/Nieuws/UithetFD/articleType/ArticleView/articleId/23366/Opinie-Klein-ziekenhuis-gebaat-bij-grote-specialisten.aspx retrieved on 18-6-2010
economies of scale\textsuperscript{10}. Because of these imperfections it is difficult for hospitals to deal with stakeholders and is their effect on the strategy variable.

6.1 Limitations

Just as every research, this thesis has also some limitation. Although measures, described in chapter X, were taken to improve the quality of this research and would reduce the limitations to a minimum. The most important limitations of my thesis will be discussed here.

To start with the transferability, despite keeping a research journal, the chosen sampling strategy and providing a thick description of this research, the transferability is limited because of the choice for a case study. Therefore, results of this study cannot simply be applied to other cases.

A limitation with regard to the sample used in this thesis, is in line with the previous limitation. Due to the research conducted in the healthcare sector, and specifically hospitals, the cases researched in this case study cannot be seen as example for other hospitals. Especially in this sector, there are many differences that may make results not be comparable. These issues relate to regional differences, the presence or absence of other parties. And in addition, each region also has different insurance companies, each with its own strategy and to a greater or lesser extent can interfere with hospitals because of their dominance in the current system. So besides the limitation that these cases cannot be an example or comparable to other hospitals, it is also difficult to value the outcomes of the comparison between the two cases I have examined.

At last I want to highlight a limitation relating to myself as researcher, as the credibility of this qualitative research is closely related to the credibility of the researcher (Patton, 2002). As the healthcare sector is very different from all other sectors, although this fact was known upfront still yet I have experienced more difficulties than I had expected in advance. As discussed in the theoretical background, the market model is very different, the sector is extremely complex and complicated and therefore I had to read a lot about the sector and hospitals. In this thesis also a lot of attention is being paid to the financial part of the sector and the finance of hospitals, although as researcher I am not literate with knowledge about finance, nevertheless I included it in this thesis as it was an important incentive for

\textsuperscript{10} Nederlandse zorgautoriteit, visiedocument: “marktimperfecties in de medische specialistsche zorg, juni 2010
cooperation and took a prominent place in the strategy development process. This lack of knowledge was one of the reasons which caused a delay in my research.

6.2 Further research: what is next?

In the conclusions and discussion it became clear that involvement of stakeholders is mainly to accomplish efficiency, resulting in cost reduction and increase of high care quality. The effect the stakeholders have on the strategy development for both hospitals is actually quite minimal because the interests of the stakeholders and the hospital are more or less the same. The way of achieving these goals with stakeholders is different, Hospital A chooses for different stakeholder management approaches, while hospital B chooses for a cooperation governance with the stakeholders.

It would be interesting to pay more attention towards the consequences the structure has on the efficiency. As cost saving is a very big issue for hospitals it is interesting to see what the effect is of a cooperation governance on the performance of the hospital and in particular the financial performance. In current literature there is a gap, besides hospital B is the first hospital which is a cooperation and therefore a good opportunity to investigate.

6.3 Implications

“There is nothing more practical than a good theory” (Lewin)

As there was hardly any research done about the inclusion of stakeholders and their effect on strategy development, this research contributes to the literature of stakeholder management and the effect involved stakeholders have on strategy development. However, just as Lewin already told in 1952, there is nothing more practical than a good theory.

The conclusions made in this research have some implications which have to take into account by other hospitals. The two cases in this thesis stand alone, as the situation and environment a hospital is in differs greatly from case to case. Hospitals can get more insight in the possibilities and the consequences it has for their strategy development process. But important is the size of the hospital, competition in the area, the number of other care providers in the chain present and the financial situation of the hospital all play an important role. Other parties in the healthcare chain can help with the execution of the strategy, while insurers can have a dominant position and have a big effect on the strategy, dependent on the
market share of the insurer. So before involving stakeholders it is necessary to realize the position the hospital finds itself in, and the possible position stakeholders have.

6.4 Reflections

There are many things that I could highlight and discuss here. And exactly that is what gave me such a hard time during my thesis, as I find it difficult to emphasize the key points. From the start I was excited about my subject, as I find stakeholder management and healthcare industry very interesting. However, during this research it became clear that the industry chosen was extremely difficult and took some time to understand.

The whole research was one with ups and downs, some parts were hard to focus on while for example I enjoyed the interviews. During the research I started realizing the research question I had upfront did not had the immersion I was looking for. Besides, I also focused a lot on the possible consequences of the inclusion. Therefore the research question is changed in the writing process and had to write over a big part of my thesis. In this part my biggest problem came along again, separating the main points from the details.

During the whole time of writing this thesis I experienced some health issues myself, what I cannot see separate from my thesis as it affected it a lot. Tight schedules, interviews and writing, everything went different than expected. Nevertheless, I am satisfied with the result. Looking back I think I can say I did the best I can, besides upfront I thought writing a thesis is about showing your abilities, while now I realize it is still about learning. A thesis is never finished and there are always improvements possible.
7. References


8. Appendices

8.1 Appendix 1; letter government

Ministerie van Volksgezondheid,
Welzijn en Sport

> Rustoordstraat Postbus 20303 1006 EJ Den Haag

De Voorzitter van de Tweede Kamer
der Staten-Generaal
Postbus 20018
2500 EA DEN HAAG

Bestinadres:
Parnassiastraat 3
2511 VE Den Haag
T 070 340 79 11
F 070 340 79 34
www.vvzoverheid.nl

Ons kennismerk:
CZ/002.30.4156
Bijlagen
1
De brief

Correspondentie uitsluitend
richting aan het ministerraad
met vermelding van de datum
en het kabinet van deze
brief.

Datum 16 december 2010
Betreff: Korting ziekenhuizen 2011

Geachte voorzitter,

Tijdens het AO ziekenhuiszorg van 9 december 2010 was een van de besproken onderwerpen de korting ziekenhuizen 2011 van € 314 miljoen structureel. Voor deze ziekenhuiskorting heb ik 25 november jongstleden een aanwijzing afgegeven.

De aanwijzing heeft tot doel de overschrijding die bij de ziekenhuizen op basis van 2009 cijfers is geconstateerd vanaf 2011 te redresseren. Toen ik op 25 juni 2010 de voorafgang brief korting ziekenhuizen 2011 (kamerstuknummer 29240 nr. 120) naar de kamer zond was de overschrijding en de voorzien korting 2011 nog vastgesteld op € 549 miljoen. Dit bedrag is in oktober bijgesteld naar € 314 miljoen. De aanzienlijke aanpassing van het bedrag van de overschrijding, en daarmee de korting, is ook besproken in het AO van 9 december.

De opdracht van de PVV heeft ten aanvullen van dit punt geraadpleegd aan een artikel uit de NRC van 30 november (zie bijlage), waarin onder andere wordt gewenst op de aanpassing van het bedrag. Middels deze brief wil ik u nogmaals nadrukkelijk informeren over de aanpassing van de omvang van de overschrijding en de daaraan gerelateerde omvang van de korting. Daarnaast ga ik kort in op de informatievoorziening.

Aanpassing overschrijding en korting

De uitgaven van ziekenhuizen worden door VWS bepaald op basis van twee bronnen: de budgettegengevens van de NZa voor het A-segment en schadelastgegevens van het CVZ met betrekking tot het B-segment. Dat de omvang van de overschrijding, en daarmee ook de korting, aanzienlijk is bijgesteld wordt ten eerste veroorzaakt doordat er in oktober nieuwe, meer definitieve gegevens van de NZa en het CVZ bekend zijn geworden over de uitgaven van ziekenhuizen in 2009.

De reden voor latere bijstellingen van de gebudgeteerde uitgaven (A-segment) is dat definitieve informatie pas beschikbaar is als de zorgverzekeraar en zorgaanbieder het eens zijn over de daadwerkelijke realisatie van de afspraken. Specifiek voor de uitgaven B-segment is het een belangrijke factor dat dBC’s maximaal een jaar open kunnen staan en pas worden geregistreerd na sluiting van de dBC. Het is dus inherent aan de bekostigingssysteem, waarbij dBC’s een lange doorlooptijd hebben, dat we gaandeweg het lepende jaar meer duidelijkheid
### 8.2 Appendix 2; sources used

<table>
<thead>
<tr>
<th>Sources / case A</th>
<th>Date</th>
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<td>Annual report of hospital</td>
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<td>Annual report of Revalidation centre</td>
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<td>Annual report client board</td>
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<td>Annual report medical staff</td>
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<tr>
<td><strong>Strategy / policy documents hospital</strong></td>
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<tr>
<td>Interview 1</td>
<td>5-4</td>
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<tr>
<td>Interview 2</td>
<td>15-4</td>
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<tr>
<td>Interview 3</td>
<td>26-4</td>
</tr>
<tr>
<td>Interview 4</td>
<td>29-4</td>
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<tr>
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<td>14-5</td>
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<tr>
<td>Interview 6</td>
<td>17-5</td>
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<tr>
<td>Interview 7</td>
<td>19-5</td>
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<tr>
<td>Interview 8</td>
<td>7-7</td>
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<tbody>
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<tr>
<td>Annual report of insurer</td>
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<td>Annual report client board</td>
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<td><strong>Strategy / policy documents hospital</strong></td>
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<td>NZA investigation report</td>
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<td>Interview 4</td>
<td>5-7</td>
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<td>Interview 5</td>
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## 8.3 Appendix 3; research journal

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<tr>
<th>Date</th>
<th>Activity</th>
<th>Experience/outcome</th>
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<tbody>
<tr>
<td>14-1</td>
<td>Hand in IRP</td>
<td></td>
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</tbody>
</table>
| 21-1 | IRP Defence | Minor revisions  
Adding stakeholder management  
Critics on relevance |
| 22-1 | Starting Improve IRP | |
| 24-1 | Finding + contacting experts | Contacted Rien Peijnenburg and research editorial office of Elsevier |
| 7-2  | Selecting Hospitals | 4 Hospitals were selected, two were best accessible. |
| 14-2 | Hand in revised IRP | |
| 15-2 | Contacting Hospitals | Start contacting both hospitals |
| 21-2 | Collecting documents | |
| 25-2 | Elaborate healthcare market | I experience I do not have sufficient background knowledge about the whole market |
| 1-3  | Adjust theoretical background | Elaborated healthcare market and stakeholder (management) |
| 4-3  | Start analyzing documents for both hospitals | Approaches are very different. But both seems to reckon the same stakeholders |
| 14-3 | Context and case description | |
| 15-3 | Topic list hospitals | With use of the documents I came up with a topic list for the Hospitals |
| 16-3 | Interview secretary Hospital B | Although he did have a lot of information and good tips, he was not really involved in the whole process. However, I could use this interview to verify outcomes of interviews in the future |
| 18-3 | Start contacting all stakeholders from hospital B | |
| 4-4  | Interview GPs Hospital B | Gained insights in why vertical integration and how the cooperation works in reality. Although they have a vote, they are primarily involved in execution of the strategy |
| 5-4  | Interview financial manager Hospital A | Was in line with the documents, they choose for different approaches on different stakeholders. But find internal stakeholders most important. |
| 6-4  | Make topic list for different stakeholders | With the help of the first interview and the documents of the specific stakeholder I came up with several topic lists |
| 7-4  | Start contacting all stakeholders from hospital A | |
| 14-4 | Interview manager home care | Answer on the question why participating,
<table>
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<tr>
<th>Date</th>
<th>Task</th>
<th>Notes</th>
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<tr>
<td></td>
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<tr>
<td></td>
<td>Jelle Schunselaar</td>
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<td></td>
<td>Page 59</td>
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</table>

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>organization hospital B</td>
<td>the advantages of the hospital and how they influence that the strategy fits their clients</td>
</tr>
<tr>
<td>15-4 Interview GPs case A</td>
<td>Are kept informed about developments regarding the hospital. And involved in executing the strategy</td>
</tr>
<tr>
<td>26-4 Interview insurer case A</td>
<td>Feels not involved, while another hospital do involve them. Maybe a missed opportunity for the hospital, as fitting strategies results in maybe more participation of investments</td>
</tr>
<tr>
<td>29-4 Interview revalidation centre case A</td>
<td></td>
</tr>
<tr>
<td>14-5 Interview with the medical staff Case A</td>
<td>See themselves as an internal party, however switching to competitors is very easy. Feel the pressure of insurers to go along with quality indicators.</td>
</tr>
<tr>
<td>17-5 Interview client board hospital A</td>
<td>Collaborate closely and are consulted many times during the process. They meet regularly with all important parties within the hospital. Hospital find them an internal party.</td>
</tr>
<tr>
<td>19-5 Interview insurer case A</td>
<td>More or less he confirmed the outcomes of the interview with the other insurer. They are not really involved in the strategy process.</td>
</tr>
<tr>
<td>20-5 Start writing results for case A</td>
<td>Per theme, presented the most important findings</td>
</tr>
<tr>
<td>23-5 Rewrite case descriptions</td>
<td>As a few quotes are delicate, and one respondent asked for anonymity I had to rewrite the case description and the context they operate in</td>
</tr>
<tr>
<td>24-5 Circle meeting</td>
<td>Write abstract to get overview Results were not properly presented Some grammar mistakes</td>
</tr>
<tr>
<td>25-5 Writing abstract</td>
<td>By writing my abstract I was forced to write briefly about my research and the main outcome.</td>
</tr>
<tr>
<td>26-5 Writing results</td>
<td>I had to rewrite my results, only did it for one case. As the other is still not finished with data collection. Now it is written as a story from the start to executing the strategy. As it would provide a more clear view on the whole process</td>
</tr>
<tr>
<td>28-5 Started with conclusion</td>
<td>As far as I could I started writing the conclusion in order to provide my</td>
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<tr>
<td>Step</td>
<td>Task</td>
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<tr>
<td>1-6</td>
<td>Write limitations and preface</td>
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<tr>
<td>2-6</td>
<td>Rewrite methodology</td>
</tr>
<tr>
<td>4-6</td>
<td>Checking grammar, sentence constructions, appendices, read whole thesis</td>
</tr>
<tr>
<td>5-6</td>
<td>Rewrite / adjust where necessary</td>
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<tr>
<td>6-6</td>
<td>Hand in concept thesis</td>
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<td>14-6</td>
<td>Defence</td>
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<td>21-6</td>
<td>Adjusting</td>
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<td>22-6</td>
<td>Surgery</td>
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<tr>
<td>5-7</td>
<td>Interview financial manager, hospital B</td>
</tr>
<tr>
<td>7-7</td>
<td>Interview Nursing Home, hospital A</td>
</tr>
<tr>
<td>11-7</td>
<td>Interview member of GPs association, hospital B</td>
</tr>
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<td>5-8</td>
<td>Results hospital A</td>
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<tr>
<td>7-8</td>
<td>Results hospital B</td>
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<tr>
<td>10-8</td>
<td>Conclusion</td>
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<tr>
<td>12-8</td>
<td>Discussion</td>
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<tr>
<td>14-8</td>
<td>Rewriting methodology</td>
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<td>18-8</td>
<td>New research question</td>
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<td>19-8</td>
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<tr>
<td>19-8</td>
<td>Rewriting Conclusion</td>
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<td>Rewriting abstract</td>
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<td>Grammar checks</td>
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<tr>
<td>22-8</td>
<td>Hand in thesis</td>
</tr>
</tbody>
</table>
8.4 Appendix 4; Topic lists

8.4.1 Topic List Hospitals

Achtergrond

- Naam
- Functie + taken
- Hoe lang werkzaam in deze functie

Kenmerken ziekenhuis

- Grootte ziekenhuis, dekkingsgebied, bijzonderheden aan het ziekenhuis

Strategie

- Kunt u kort en bondig de strategie van Ziekenhuis vertellen
- Kunt u uitleggen waarom voor deze strategie is gekozen
- Welke factoren worden in ogenschouw genomen bij het ontwikkelen van strategie
- Financiën, kwaliteit, verhoudingen, regio, overige ziekenhuizen, innovaties
- 5 krachten model, welke macht hebben zij?
- Waarom worden ze al dan wel of niet betrokken?
- New entrants (privé klinieken)
- Buyers (zorgbehoevende, bv cliëntenraad + patiëntenorganisaties)
- Suppliers (Specialisten maar ook zorgverzekeraars)
- Substituten (ziekenhuizen in de regio?)

Partijen

- Welke partijen intern en extern worden betrokken bij dit proces
- Waarom deze externe partijen?
- In welke mate worden zij betrokken?
- In welke fases gebeurt dat?
- Wie heeft de leidende rol?

- Recente ontwikkelingen + voorbeelden van nieuw beleid
- Welke partijen waren betrokken?
Achtergronden

- Is door de gereguleerde marktwerking dit proces veranderd?
- Wordt de strategie geëvalueerd, en zo ja met wie?

Partijen:

- Zorgverzekeraars (in het bijzonder CZ en VGZ)
- Orde van Specialisten (niet in dienst van ziekenhuis)
- Verbond van Huisartsen (in het Jeroen Bosch, 2 partijen)
- Cliëntenraad
- Patiëntenorganisaties
- Overige ziekenhuizen in de regio
- Privéklinieken in de regio
- Apotheken
- Verzorgingstehuizen
- Revalidatiecentra
- Inspectie
- Ministerie van volksgezondheid, welzijn en sport
8.4.2 Topic list insurers

Achtergrond

- Naam
- Functie + taken
- Hoe lang werkzaam in deze functie

Kenmerken ziekenhuis

- Grootte verzekeraar, dekkingsgebied, bijzonderheden
- Regio met meeste klanten, meest actief qua zorginkoop

Strategie verzekeraren

- Wat is de inkoopstrategie
- Welke rol heeft selectieve inkoop
- Is hierdoor de verhouding met ziekenhuizen verandert, op welke manier en waarom?
- Investeert u in ziekenhuizen?
- Op welke manier, en waarom
- Effecten op de realtie
- Effecten op mogelijke strategie

Betrokkenheid

- Wordt u vaak betrokken bij strategie ziekenhuizen
- Op welke manier
- Wilt u betrokken worden, en zoja in welke fase en met welke andere partijen
- Wie moet de leidende rol hebben of nemen, en wie heeft deze nu?
- Kunt u door het marktmodel invloed uitoefenen?
- Wat is de ideale samenwerking met ziekenhuizen?
- Standpunt verticale integratie (voorwaarts en achterwaarts), wat zijn de voordelen en waarom?

Alle vragen in het algemeen en toegepast op het betreffende ziekenhuis.
8.4.3 Topic list stakeholders

Achtergrond

- Naam
- Organisatie
- Functie + taken
- Hoe lang werkzaam in deze functie

Kenmerken

- Taken van de organisatie
- Kenmerken van de organisatie

Strategie

- Wordt u vaak betrokken bij strategie ziekenhuizen
- Op welke manier
- Wilt u betrokken worden, en zo ja in welke fase en met welke andere partijen
- Wie moet de leidende rol hebben of nemen, en wie heeft deze nu?
- Wat is de ideale samenwerking met ziekenhuizen?
- Welke factoren worden in ogenschouw genomen bij het ontwikkelen van strategie
- Financiën, kwaliteit, verhoudingen, regio, overige ziekenhuizen, innovaties
- New entrants, buyers, suppliers en substitutes

Consequenties

- Wat zijn de voordelen?
- De reden voor dit soort samenwerking?
- Bent u tevreden met de uitkomsten?
- Welke partijen ziet u als belangrijkste?
- Recente ontwikkelingen + voorbeelden van nieuw beleid?

Achtergronden

- Is door de gereguleerde marktwerving dit proces veranderd?
- Wordt de strategie geëvalueerd, en zo ja met wie?
8.5 Appendix 5; Governance structure

De bestuursstructuur van de coöperatie in relatie tot de Vlietland BV

1. Coöperatieleden hebben als hoogste orgaan een algemene ledenvergadering (ALV).

2. De coöperatie heeft een bestuur maar is verder geen structuurnootschap.

3. In de ALV worden 5 bestuursleden benoemd voor de coöperatie op basis van een preambule: een (onafhankelijke) voorzitter en 4 (ook onafhankelijke) leden.

4. Het Coöperatie Bestuur benoemt de voorzitter RvB van Vlietland BV (thans SSVZ) als algemeen directeur van de coöperatie.

5. De 5 bestuursleden van de coöperatie vormen namens de coöperatie de AvA van de Vlietland BV.

6. De RvC Vlietland BV bestaat uit 7 leden, te weten de 6 bestuursleden van de coöperatie (door middel van een personele unie) en 2 leden op voordracht van de OR en PAR van Vlietland. De RvC benoemt, ontslaat en schorst de RvB van Vlietland BV.

7. De voorzitter van de RvB van SSVZ wordt voorzitter RvB Vlietland BV.